Triple P – The Positive Parenting Program:

A Developmental Evaluation of

Manitoba's Provincial Implementation

Data from the

2008 Comprehensive Practitioner and Manager Interview

(CPMI)

Report completed: Fall 2010

Healthy Child Manitoba
Putting children and families first
Manitoba

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Executive Summary

Triple P in Manitoba

Triple P is a world-renowned parenting program which promotes positive, caring relationships between parents and their children and helps parents learn effective management strategies for dealing with a variety of childhood developmental and behavioural issues.

In order to reach all parents, the Triple P system is designed as a training initiative to broaden the skills of the current service delivery systems (e.g. those working in health, early learning and child care, social services, education, etc.) promoting the integration of Triple P into services already delivered, as well as the addition of Triple P as a stand-alone program – a new service offered by those whose roles are sufficiently flexible to do so. Parents, thus, have the opportunity to access evidence-based information and support, when they need it, from Triple P practitioners in their local community.

The Comprehensive Practitioner and Manager Interview (CPMI)

The CPMI is based on an interview script created by Dr. Matt Sanders, creator of Triple P, and Dr. Ron Prinz, director of the Triple P implementation in South Carolina, USA where a large-scale Triple P rollout was funded by the Centres for Disease Control and Prevention. The interview script was adapted to address the features of implementation most salient to the province of Manitoba.

Results for the CPMI are presented in this report based on province-wide data, to the extent that it was available, with highlights on implementation in the Northern regions of the province (Burntwood and Norman). Overall, the responses from practitioners in the North were not significantly different from province-wide responses.

This report summarizes data collected in the fall and winter of 2008 about the implementation of the Triple P program. It is important to note that, as this report summarizes data collected in the fall of 2008, the last wave of regions brought on (i.e. Winnipeg areas: Fort Garry, River East, Transcona, River Heights, St. Vital, St. Boniface, St. James, and Assiniboine South, as well as Assiniboine, Central, and Churchill regions) were not eligible to participate in the survey because they had not yet had an opportunity to complete accreditation and implement the program. ***This report is thus preliminary and does not represent the entire province.***

The invitation to complete the CPMI was extended to 1,249 practitioners and managers, 664 of whom responded. This represents an excellent completion rate of 53%.

Use of the program

Of the 557 trained practitioners, the vast majority (81%; *n* = 453) have incorporated Triple P ideas or principles into their work in general since they were trained. Many have integrated Triple P within another parenting program or curriculum that they already were using prior to Triple P training (42%; *n* = 232). The majority of practitioners also report providing Triple P to neighbors, friends, adult family members, or someone else in a setting outside of their normal work setting (58%; *n* = 322).

The 81% who report having incorporated Triple P into their work is very encouraging as Triple P is built on the principle of minimal sufficiency, and can be meaningfully delivered and incorporated into ongoing practice without the inclusion of all elements of the manualized intervention being used with every family. Triple P is a unique program in that the principles and strategies it teaches can be integrated into a practitioner's current cadre of services without the usual time and resources required to add a new program to one's offerings. It can also be used as a stand-alone program by those whose roles are sufficiently flexible to allow for this.

Manitoba has implemented Triple P by training the existing workforce and so it was expected that there would be a body of practitioners who would integrate the program into their existing services, for example, the public health nurse who can hand out a tip sheet and conduct a brief consultation around temper tantrums during the course of an immunization appointment. It was also anticipated that there would be a body of practitioners who could deliver the Triple P program in a stand-alone fashion, for example, counselors or therapists who would be able to deliver a full 8-session group or individual intervention. Survey respondents included 337 practitioners who had tried delivering Triple P in a stand-alone fashion. Of these 337, the majority (*n* = 240; 71%) continue to use it this way. *The 2008 CPMI focuses largely on the experience of practitioners who are delivering Triple P in a stand-alone fashion as they contribute a unique perspective on implementation of the program to its fullest extent.*

Practitioners were more likely to use Triple P and to continue using it if they work with others who also use Triple P.

Practitioners use the various levels of Triple P with varying numbers of parents and uptake has occurred across sectors and settings.

Factors facilitating program use

Of the practitioners who continue to use Triple P in a stand-alone fashion, 146 (61%) of them consult with other Triple P practitioners to give or receive advice, suggestions, or support in using the program. The practitioners who use Triple P are confident in their skills.

Workplace support for the use of the program was high among the practitioners using Triple P.

Practitioners using Triple P reported on many things that facilitated their use of the program, specifically indicating that the resources accompanying Triple P were the most important in facilitating the use of the program.

Most parents were receptive to the use of the program. Relatively few practitioners reported contradictions between Triple P and other parenting advice they already provide, or resistance from parents to using Triple P. When resistance was reported, most practitioners described how they were able to deal with the issue successfully.

Barriers to program use

Barriers to implementation were also reported, most commonly literacy and language barriers.

Those who continued and those who did not continue to use Triple P encountered the same variety of barriers.

Supervisors of Triple P practitioners

Supervisors offered many supports to their Triple P trained practitioners.

Supervisors also reported on many organizational changes that had occurred as a result of the incorporation of Triple P into their service delivery.

Practitioners were aware of the multi-level, cross-sectoral nature of the Triple P implementation in Manitoba and were able to identify benefits and challenges inherent in this approach.

Future recommendation

Based on the findings of this report, additional support has been offered to practitioners to

- facilitate implementation,
- maximize uptake of the program, and
- assist in navigating the barriers and obstacles that do arise.

Consideration will be given to re-administering the CPMI with the current population of accredited practitioners at a future time to provide a measure of the success that has been achieved in meeting these goals, to provide an updated estimate of program reach, and to delve further into the delivery of Triple P by practitioners who have integrated the program within their current services rather than delivering it in a stand-alone manner.

Triple P – The Positive Parenting Program:
A developmental evaluation of Manitoba's provincial implementation

What is Triple P?

Triple P is a world-renowned parenting program which promotes positive, caring relationships between parents and their children and helps parents learn effective management strategies for dealing with a variety of childhood developmental and behavioural issues. Research shows that positive parenting is the single most important factor in building a strong foundation for a child's life. The Triple P approach strengthens parent's knowledge, skills and confidence to better meet the needs of their children, increases the parent's sense of competence in their parenting ability and reduces parenting stress.

Positive parenting is described as: ensuring a safe, engaging environment; creating a positive learning environment; using assertive discipline; having realistic expectations; and taking care of yourself as a parent.

The program is delivered at 5 levels:

- At Level 1, universal parenting messages are provided through various media channels.
- Level 2 offers parenting seminars and brief consultation at a level that is appropriate for any parent and can be provided by most practitioners who have a solid background in parenting and behavioural intervention.
- Level 3 is a primary-care intervention where parents can receive consultation around a discreet child behavior issue from a practitioner with whom they are already in contact such as a public health nurse, day care staff, or school counselor
- Level 4 is offered to families looking for broad-based parenting skills training, and who are experiencing significant behavioural issues with their children.
- Clinical professionals provide Level 5 to families who continue to face significant behavioral issues after completion of a Level 4 intervention, or who have additional challenges within the family.

Triple P is a population level prevention strategy to strengthen parents' confidence, skills and knowledge of caring and effective parenting. Twenty-five years of research and evaluation have demonstrated that Triple P is very effective in supporting families. The program has been implemented in more than eighteen countries around the world.

Implementation in Manitoba – Background:

- On March 21, 2005, the Healthy Child Committee of Cabinet (HCCC) announced $1.4 million to implement the Triple P (Positive Parenting Program) in Manitoba. Since that time, the Healthy Child Manitoba Office (HCMO) has been presenting to and consulting with community agencies, regional health authorities (RHAs), child care centres, family resource centres, school divisions, and others to inform and seek partners on this new approach to supporting Manitoba's parents, with an initial focus on families with children under the age of twelve and especially under age six.

- In order to reach all parents, the Triple P system is designed as a training initiative to broaden the skills of the current service delivery systems (e.g. those working in health, early learning and child care, social services, education, etc.) promoting the integration of Triple P into services already delivered, as well as the addition of Triple P as a stand-alone program – a new service offered by those whose roles are sufficiently flexible to do so. Parents should, thus, have the opportunity to access evidence-based information and support, when they need it, from Triple P practitioners in their local community.

- Agencies and organizations with trained staff are able to offer Triple P to clients within their particular mandate. Thus, for some agencies this means providing Triple P services to the general public while for others it is limited to those clients within the mandate that they currently serve (e.g., mental health services of an RHA, clinical support services of a school division, or parents whose children attend a local child care facility).

- Triple P has been phased in across the province. Based on the HCCC-approved, two-part selection process, five initial communities were selected from four geographic categories (inner-city, suburban, rural and northern) using RHA and Winnipeg Community Area (CA) boundaries. This process included identifying communities with the highest need as determined by results from the Early Development Instrument (EDI) (a measure of Kindergarten students' "readiness to learn") and community capacity and readiness.

- For 2005/06, the five regions that were identified to receive training and implement Triple P based on the above criteria were: North End/Point Douglas, Elmwood and Seven Oaks in Winnipeg, as well as North Eastman and Burntwood.

- Based on the same selection criteria, an expansion of training to the following regions and communities was announced in August 2006: Nor-Man, Parkland, Interlake, South Eastman, Brandon, and in Winnipeg: Downtown and Inkster.

- In April 2008 training was opened to the remaining regions (i.e., Assiniboine, Central and Churchill) and Winnipeg community areas (i.e., Fort Garry, River East, Transcona, River Heights, St. Vital, St. Boniface, St. James, and Assiniboine South). This report summarizes data collected in the fall and winter of 2008 about the implementation of the Triple P program. ***It is important to note that these remaining regions were not eligible to participate in the survey as they had not yet had opportunity to complete accreditation and implement the program. This report is thus preliminary and does not represent the entire province.***

Provincial Evaluation Plan for Triple P: The Comprehensive Practitioner and Manager's Interview (CPMI):

- Triple P evaluation is overseen by Dr. Rob Santos, Scientific Director (Healthy Child Manitoba) and Dr. Steven Feldgaier, Triple P Director (Healthy Child Manitoba). Evaluation is generally carried out internally by HCM staff within the Policy Development, Research and Evaluation area. To date, evaluation has been limited to the 2008 administration of the Comprehensive Practitioner and Manager's Interview (CPMI), an initial survey of practitioners and agency managers who came for training in the first two years of the initiative. The detailed results of this survey make up the body of this report. For more information on the ongoing evaluation plan for Triple P in Manitoba, refer to the final section of this report.
- The CPMI is based on an interview script created by Dr. Matt Sanders, creator of Triple P, and Dr. Ron Prinz, director of the Triple P implementation in South Carolina, USA where a large-scale Triple P roll-out was funded by the Centres for Disease Control and Prevention. The interview script was adapted to address the features of implementation most salient to the province of Manitoba. The number of respondents to the Manitoba CPMI was very similar to the number who responded to the South Carolina data collection analyzed in Sanders, Prinz, and Shapiro's 2009 publication: Predicting utilization of evidence-based parenting interventions with organizational, service-provider and client variables. The samples were also very similar demographically. (For complete results of the South Carolina survey collection, see: Sanders, M. R., Prinz, R. J., & Shapiro, C. J. (2009). Predicting utilization of evidence-based parenting interventions with organizational, service-provider and client variables. *Administration and Policy in Mental Health, 36,* 133-143.)
- Data collection for the CPMI was conducted by Prairie Research Associates (PRA) who successfully bid for this contract in an RFP process. PRA delivered an on-line interview that all practitioners and managers who had been trained prior to the spring of 2008 were invited to complete. For those who did not respond to the on-line application, telephone follow-up provided the opportunity to complete the interview verbally with an interviewer from PRA. PRA provided the data and a brief description of the data to HCMO. HCMO then analyzed the data and compiled this report.
- The CPMI required between 20 – 60 minutes of practitioners'/managers' time. The number of questions they were asked depended on the number of levels of training they had received and on the extent to which they had implemented the program and had feedback to offer on their experiences.
- Results for the CPMI are presented in this report for the province as a whole (excluding Assiniboine, Central and Churchill regions, and the Winnipeg community areas of Fort Garry, River East, Transcona, River Heights, St. Vital, St. Boniface, St. James, and Assiniboine South who had not yet had the opportunity to deliver the program at the time of survey administration) with highlights on implementation in the Northern regions of the province (Burntwood and Norman) where many remote and isolated communities experience unique challenges to implementation. Notably, the responses from practitioners in the North were not significantly different from responses of practitioners from the whole province. Also of note, one of the two Triple P coordinators is located in the north, residing in The Pas and serving these regions exclusively, making frequent visits to many communities in the region. The addition of this role may have mitigated some of the potential for significant differences being seen between the North and the province as a whole.

CPMI Survey Completion

The invitation to complete the CPMI was extended to 1,249 practitioners and managers, 664 of whom responded. This represents an excellent completion rate of 53%. Among those who completed the CPMI, 497 (75%) completed it online and 167 (25%) completed it by phone. Further details regarding reasons for non-completion appear in Table 1 below. While every effort was made to obtain current contact information, it is evident that this was not possible in all cases. Of note, only 2% of those invited actually refused to respond to the interview.

Table 1: Completion by method of survey

Outcome	**% (n = 1,249)**
Total completes	**53%**
Completed surveys online	40%
Completed survey by phone	13%
Valid contact, no survey completed	**29%**
Busy/answering machine/no answer*	11%
Practitioner at telephone number	6%
Not trained in Triple P	6%
On leave/retired	2%
Non-qualified	2%
Refusal/terminate mid-interview	2%
Deceased	<1%
Invalid contact information, no survey completed**	**17%**
Practitioner no longer works there	12%
Wrong number	3%
Not in service/fax	3%

CPMI Respondents

1,249 practitioners and agency managers were invited to complete the CPMI. The group of 644 individuals who responded is described below

- 557 were Trained Practitioners
- 107 were Supervisors
    - 50 of these Supervisors had been trained themselves
    - 57 of these Supervisors had not been trained themselves, but supervised staff who were trained

- 90% female, 10% male
- Average age = 44 years (See Figure 1)
- Average number of years providing services to families = 14 years (See Table 2)
- Average number of years of experience in current position = 7 years (See Table 2)

In The North

- 92 practitioners and supervisors responded from the northern regions of the province (Burntwood = 36, Norman = 56).
- 10 supervisors (9 trained, 7 accredited)
- 82 practitioners (58 accredited)

Figure 1: Age distribution for trained practitioners

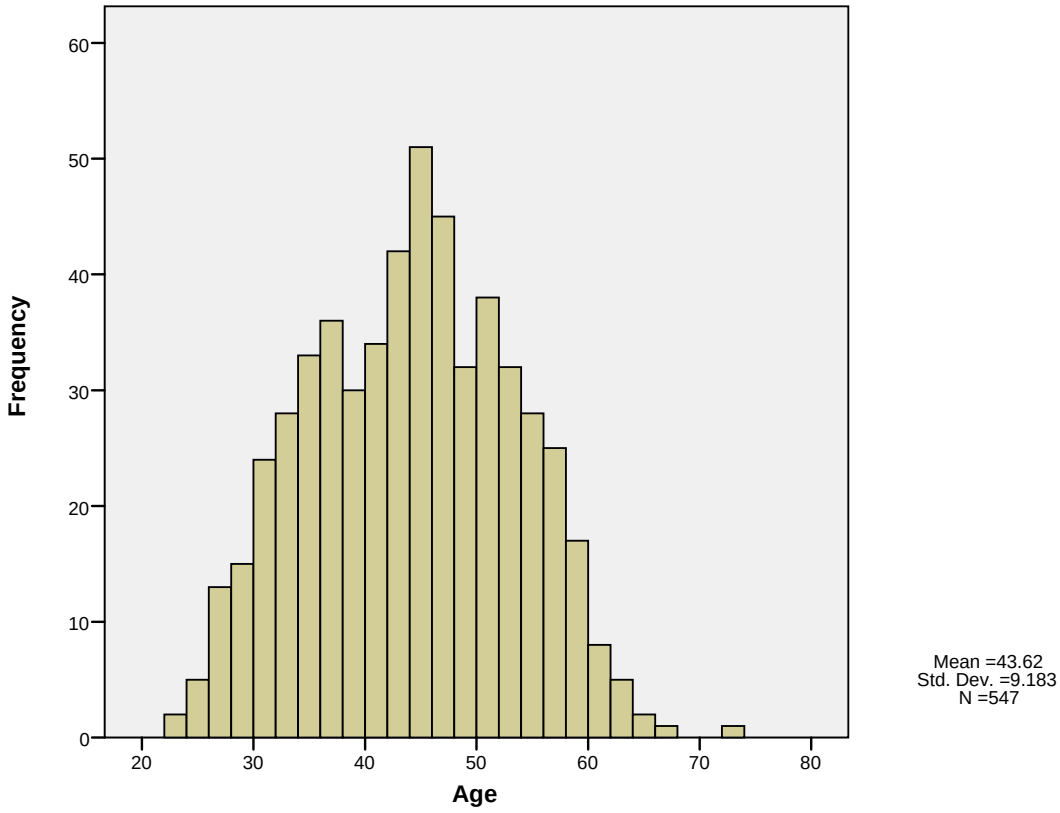


Table 2. Practitioners' years of experience

	% Respondents (*n* = 664)
Years providing services to families	
Less than 1 year	3%
1 to 4 years	11%
5 to 9 years	17%
10 to 19 years	31%
20 years or more	30%
Don't know/no response	8%
Average number of years	14 years
Range	0 – 49 years
Years in present position	
Less than 1 year	6%
1 to 2 years	18%
3 to 4 years	17%
5 to 9 years	30%
10 to 19 years	19%
20 years or more	6%
Don't know/no response	4%
Average number of years	7 years
Range	0 – 35 years

CPMI Results

Use of Triple P since training:

Of the 557 trained practitioners, the vast majority (81%; *n* = 453) have incorporated Triple P ideas or principles into their work in general since they were trained. Many have incorporated Triple P within another parenting program or curriculum that they already were using prior to Triple P training (42%; *n* = 232). The majority of practitioners also report providing Triple P to neighbors, friends, adult family members, or someone else in a setting outside of their normal work setting (58%; *n* = 322).

Of the 557 trained practitioners, 337 (60%) have used Triple P with the families they work with in a stand-alone fashion, and 220 (40%) report that they have not used it at all. The latter is contrary to the statistic cited above indicating that 81% of trained practitioners have incorporated Triple P into their work. It is possible that practitioners indicated that they "used Triple P" with families only if they had delivered some variant of the program in its entirety, as a stand-alone program (e.g. 4 full sessions of the level 3 intervention, or all 10 sessions of the individual level 4 intervention).

The 81% who report having incorporated Triple P into their work is very encouraging as Triple P is built on the principle of minimal sufficiency, and can be meaningfully delivered and incorporated into ongoing practice without the inclusion of all elements of the manualized intervention being used with every family. Triple P is a unique program in that the principles and strategies in the program can be integrated into a practitioner's current cadre of services *or*, it can be used as a complete, stand-alone program by practitioners whose roles are flexible enough to accommodate the requirements of adding a new program to one's offerings.

Manitoba has implemented Triple P by training the existing workforce and so it was expected that both of these models would be used. It was anticipated that there would be a body of practitioners who would integrate the program within their existing services. An example of this type of integrated delivery is the public health nurse who can hand out a tip sheet and conduct a brief consultation around temper tantrums during the course of an immunization appointment. It was also expected that there would be a body of practitioners who would deliver the Triple P program in a stand-alone fashion. An example of this type of delivery would be a counselor or therapist who can deliver a full 8-session group or individual intervention.

The 557 survey respondents included 337 practitioners who had tried delivering Triple P in a stand-alone fashion. Of these 337, the majority (*n* = 240; 71%) continue to use it as a stand-alone program.

In The North

- 55% (51/92) report having used Triple P as a stand-alone intervention at some point since their training.

- Of this group, 65% (33/51) continue to use Triple P in a stand-alone fashion

Lesson Learned: Since collection of this data, a strategy has been implemented to encourage the principal of minimal sufficiency and ensure that practitioners are aware of the effectiveness of Triple P components, or doses that represent less than a "complete" delivery of the entire manualized intervention at any given level. It is important that practitioners realize that Triple P is flexible in its ability to be tailored to the service delivery needs of an organization or practitioner, and to the needs, strengths, and limitations of individual families. It is hoped that future evaluation will indicate that practitioners who integrate the program into their existing service delivery also feel that they are delivering Triple P, and that their contribution is valuable.

Of the 97 trained practitioners who tried using Triple P in a stand-alone manner once or twice and then stopped, the following are the reasons that they report for no longer using it. Responses were not significantly different when examining the responses from the Northern regions.

Table 3. Reasons for not continuing use of Triple P	**Main reason**	**2nd reason**	**3rd reason**
	% (*n*/97)	% (*n*/97)	% (*n*/97)
Changed positions – no longer appropriate/maternity leave	16	2	
Resistance from parents	14	3	
Not appropriate for clientele	14	7	
Workload too heavy (too many clients)	8	6	1
No opportunity to offer it	6		
More familiar/comfortable with a different program	6	3	
Use parts of Triple P/adapted it	6	2	1
Don't work directly with families/parents	5	2	
Triple P too difficult to use/time consuming	5		
Don't like Triple P/don't agree with Triple P	4	4	
Others in organization are using it	2		
Not enough time with clients (too much other material)	2		
Not part of program/mandate/job	2	1	
I am a manager/administrator/supervisor	2		
Other reasons	4	4	
Don’t know/No response	2	1	
Total	100		

Of the 337 Trained practitioners who have used Triple P in a stand-alone fashion, the following were the levels being used:

Table 4. Levels of Triple P in use

	Province-wide	In The North
Level	**% (*n*/338)**	**% (*n*/33)**
2 Selected	18	25
3 Primary	61	79
4 Standard	25	24
4 Group	22	21
4 Stepping Stones	12	9
5 Enhanced	10	9
5 Pathways	0	9

Practitioners were asked if others in their workplace also use Triple P. Of those 240 practitioners who continue using Triple P in a stand-alone manner, 153 (64%) reported that others in their workplace also use Triple P. Of those 97 practitioners who have stopped using Triple P as a stand-alone program, 48 (50%) report that others in their workplace use it. Of those 220 trained practitioners who report not using it at all, only 70 (32%) reported that others in their workplace are using it.

The association is significant, in that the degree to which trained practitioners use Triple P is associated with whether or not others in their workplace also use Triple P ($F = 33.55$, $p < .000$) More specifically, practitioners who were trained, are more likely to use Triple P if others in their workplace are also using it ($\alpha = .25$, $p < .001$), and practitioners who are trained and use Triple P are more likely to continue using Triple P if they work with others who also use Triple P ($\alpha = .105$, $p = .04$)

In The North:
While province-level data shows that there is a significant association between having other practitioners in one's agency who use Triple P and continuing to use Triple P yourself, in the North, there is no association, meaning that practitioners are neither more, nor less likely to continue using Triple P if others in their organization are using it.

The following Table shows the number of families that practitioners have used each level with. Note that for Level 2 Selected, reference is to the number of seminars delivered, rather than the number of parents who have attended.

Table 5. Implementation by level

Province-wide:	Since training		Last 4 weeks		Families whom you have "completed" this level with	
	Average	Range	Average	Range	Average	Range
2 Selected (# of seminars delivered)	4	1 – 20	1	1 – 4		
3 Primary ("completed" = 3+ sessions)	8	1 – 50	3	1 - 30	3	1 - 40
4 Standard	9	1 – 70	2	1 – 7	7	1 – 50
4 Group	22	1 – 130	8	1 – 18	19	1 – 100
4 Stepping Stones	4	1 – 20	2	1 – 2	2	1 – 6
5 Enhanced	3	1 – 10	2	1 – 4	2	1 – 6
5 Pathways	5	1 – 14	2	1 – 5	5	1 – 14
In The North:						
2 Selected (# of seminars delivered)	4	2 – 8	2	2 – 2		
3 Primary ("completed" = 3+ sessions)	9	1 – 30	6	1 – 30	3	1 – 12
4 Standard	9	2 – 40	3	1 – 7	3	2 – 4
4 Group	10	5 – 13	3	1 – 5	9	8 – 10
4 Stepping Stones	5	1 - 12	1	1 – 1	1	1 – 1
5 Enhanced	6	2 – 10	0	n/a	2	2 – 2
5 Pathways	8	8 – 8	0	n/a	0	n/a

Practitioners use Triple P in various settings. Following is a breakdown of the different settings in which Triple P is used by the 240 practitioners who continue to use stand-alone Triple P.

Table 6. Implementation by setting

Province-wide:	**Practitioners' primary Triple P setting**	**Total % practicing Triple P in this setting**
Setting	**% (n/240)**	**% (n/240)**
Client's home	31	49
Clinic	20	26
School	20	28
Day care	7	13
Community club	6	9
Hospital	3	4
Private practice	3	14
Specific centres, agency & facilities	3	6
Don't know/No response	2	2
Over the telephone	0	36
Other	4	1
Total	100	
In the North:	**% (n/33)**	**% (n/33)**
Client's home	30	64
Clinic	21	24
School	21	33
Day care	9	15
Don't know	6	3
Private practice	3	30
Community club	3	6
Primary health care centre	3	9
Specific centres, agency & facilities	0	12
Hospital	0	3
In my home	0	9
Over the telephone	0	27
Total	100*	

* Total % does not = 100 due to rounding

Note: 27% of the practitioners from the Northern regions conduct some Triple P consultation over the telephone. This seems like an under-use of this delivery method in the Northern region, where geography dictates that service providers are not always in close proximity to the families they serve.

The 240 practitioners who continue to use Triple P in a stand-alone manner, spend varying amounts of time, within the scope of their respective positions, in parent consultation, and varying amounts of this time is spent using Triple P with the parents they consult with.

These practitioners spend an average of 7.5 hours per week in parenting consultation, with a range of less than one hour per week up to 50 hours per week.

These practitioners spend an average of 22 % of their parenting consultation time using Triple P, with a range of less than 1% of their parenting consultation time up to 100% of their parenting consultation time.

More often than not, practitioners use Triple P with families who have a child 6 years or younger. On average, practitioners report that 68% of the parents they use Triple P with have a child in this age range. This also varies by practitioner with reports ranging from less than 1% to 100% of parents who receive Triple P having a child in this age range.

Following is a summary of the average amount of time per visit practitioners have to spend with families that they use Triple P with:

Table 7. Duration of Triple P sessions

Amount of time per visit	**%**
Less than 15 minutes	13
15-30 minutes	30
31-45 minutes	10
46 minutes to 1 hour	27
More than 1 hour	17
Don't know/No response	4
Total	100

Practitioner confidence:

The 240 practitioners who use stand-alone Triple P are confident in their skills. Forty-nine percent are *very* confident, and 49% are *somewhat* confident in their general ability to provide consultation to parents about child behavioural, emotional, and developmental issues.

Only 2% of these 240 practitioners were not very, or not at all confident in this skill set.

In addition, 67% of the 240 Triple P practitioners were somewhat confident in their use of Triple P in particular.

28% of the 240 were *very* confident in using Triple P, only 5% were not very confident, and no one who uses Triple P reported being not at all confident in using it.

Support:

Of the 240 practitioners who continue to use Triple P in a stand-alone manner, 146 (61%) of them consult with other Triple P practitioners to give or receive advice, suggestions, or support in using the program.

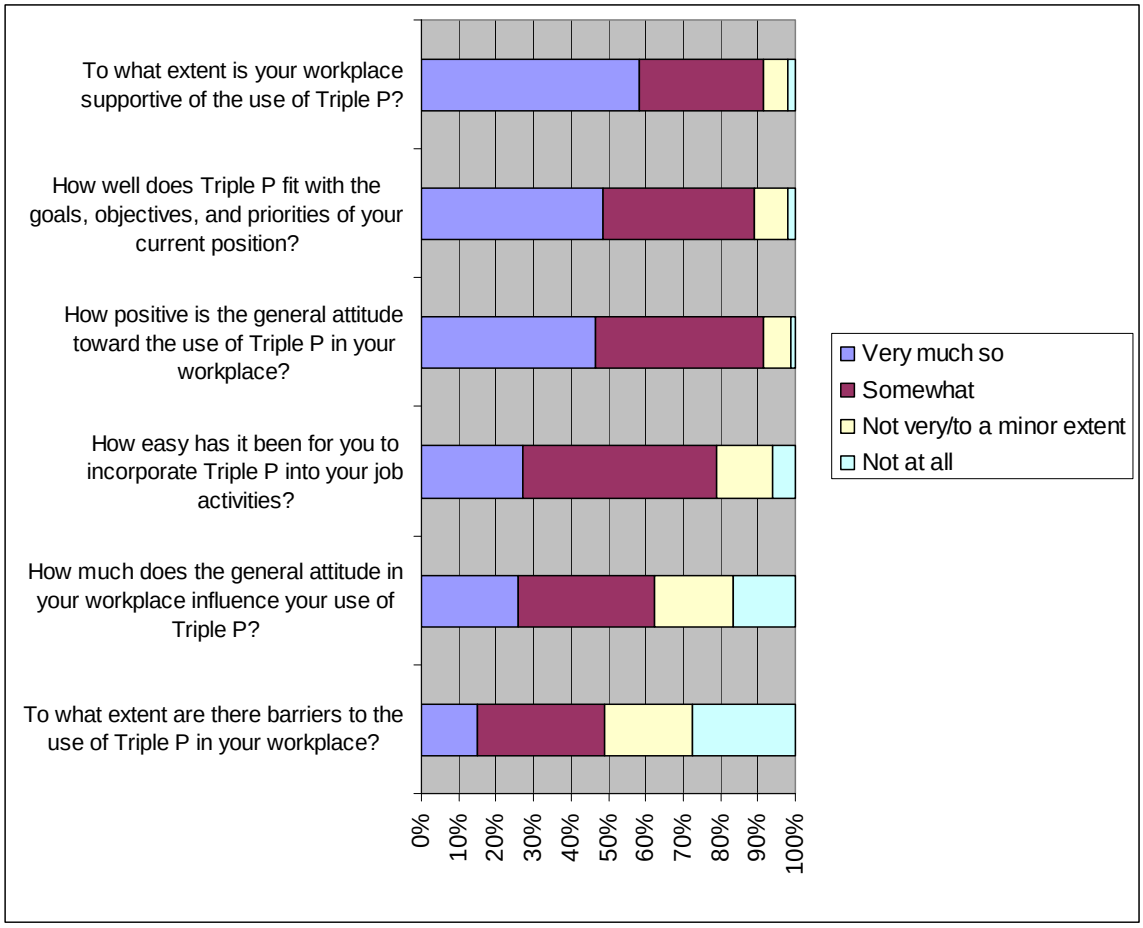
Sixty (25%) of the 240 practitioners have practiced Triple P consultation skills with peers, such as role playing, other than during training. All 60 of these practitioners reported that this practice with peers was helpful.

Of the 240 practitioners who continue to use Triple P in a stand-alone manner, 77 (31%) have had contact with one of Healthy Child Manitoba's Triple P coordinators. Of those 77 practitioners, 46 (60%) found this contact to be very helpful, 28 (36%) found it to be moderately helpful, and 3 (4%) found that this contact was not helpful at all.

Workplace Support:

The following table reports the ratings of workplace support of the 240 practitioners who continue using Triple P in a stand-alone manner. Responses were very similar when looking only at the Northern regions.

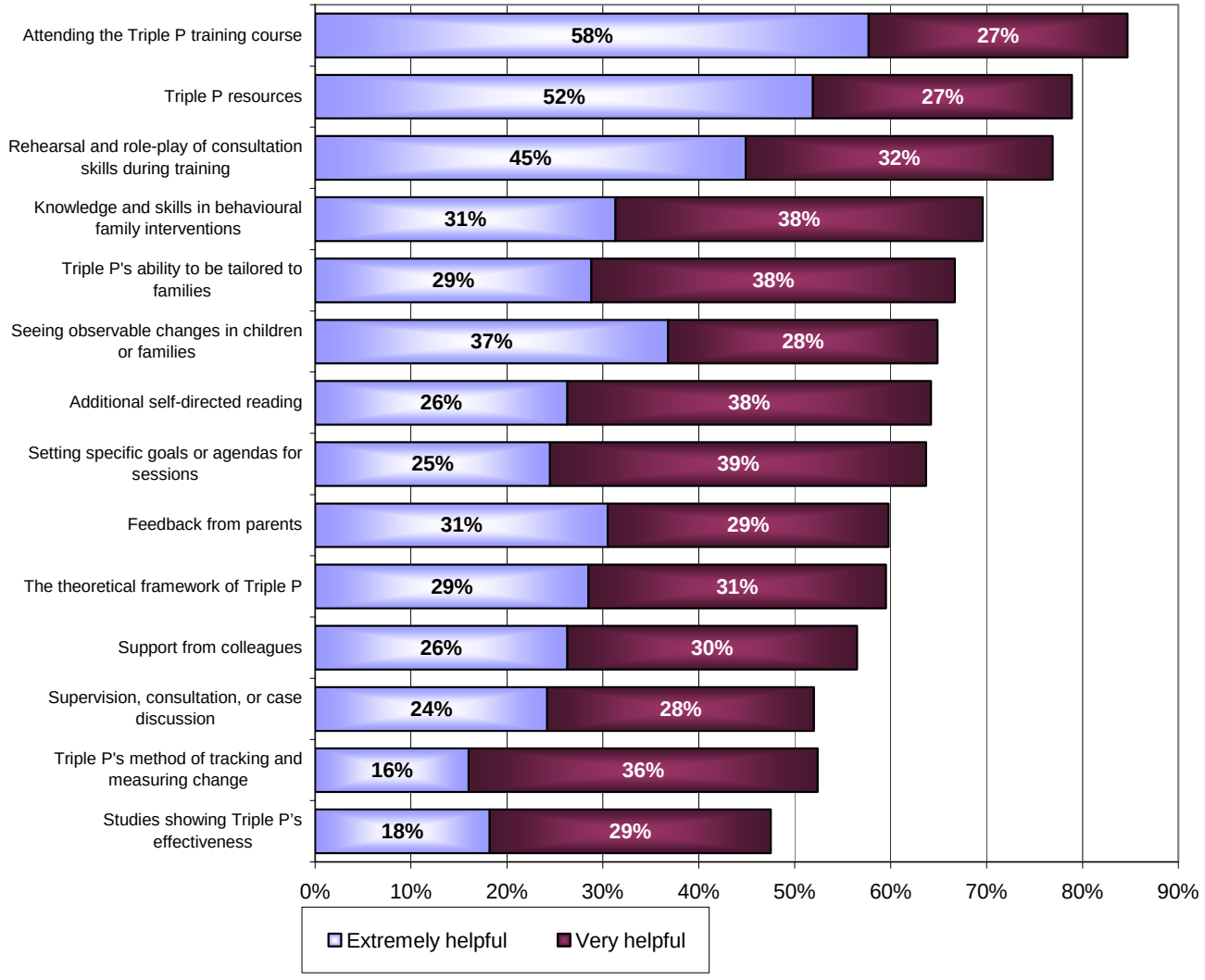
Figure 2. Workplace support



Factors facilitating implementation

The 240 practitioners who continue to use Triple P in a stand-alone manner report that the following were moderately to extremely helpful in facilitating their implementation of the program:

Figure 3. Factors facilitating implementation



Practitioners reported that of the above "facilitators" to implementation, the following was the MOST helpful:

Table 8. Most helpful facilitating factor

Facilitator	%
Tip sheets	19
Triple P resources (flips charts/manuals/workbooks)	17
Rehearsal/role-play of consultation skills during training	11
Attending the Triple P training course	10
Support from colleagues	4
Easy to use/simple/effective	4
Working with parents/families	2
Supervision/consultation with supervisor/co-workers	2
Seeing observable change in children or families/success	2
Triple P strategies and structure	2
Feedback from parents regarding Triple P	2
Your knowledge and skills in behavioural family intervention	2
Triple P tailors to the needs of individual families	2
The theoretical framework of Triple P	2
Videos	2
Using it	2
Other	13

Obstacles to implementation

All trained practitioners were able to identify barriers to the use of Triple P. As you can see in the graphs below, practitioners who continue to use Triple P in a stand-alone manner reported encountering the same barriers as those who have not continued to use Triple P in this way.

Figure 4. Obstacles to the use of Triple P – Practitioners using Stand-Alone Triple P

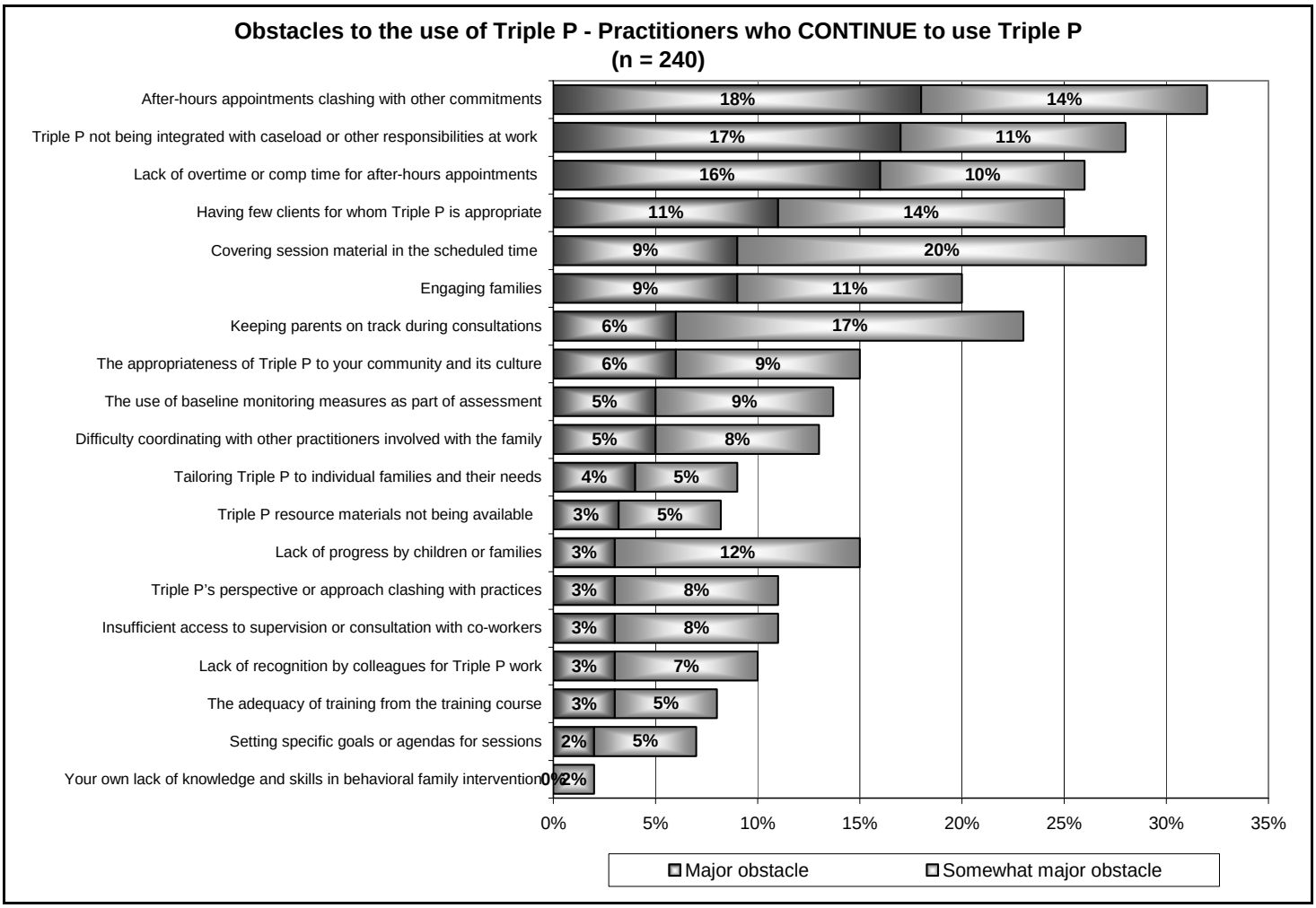
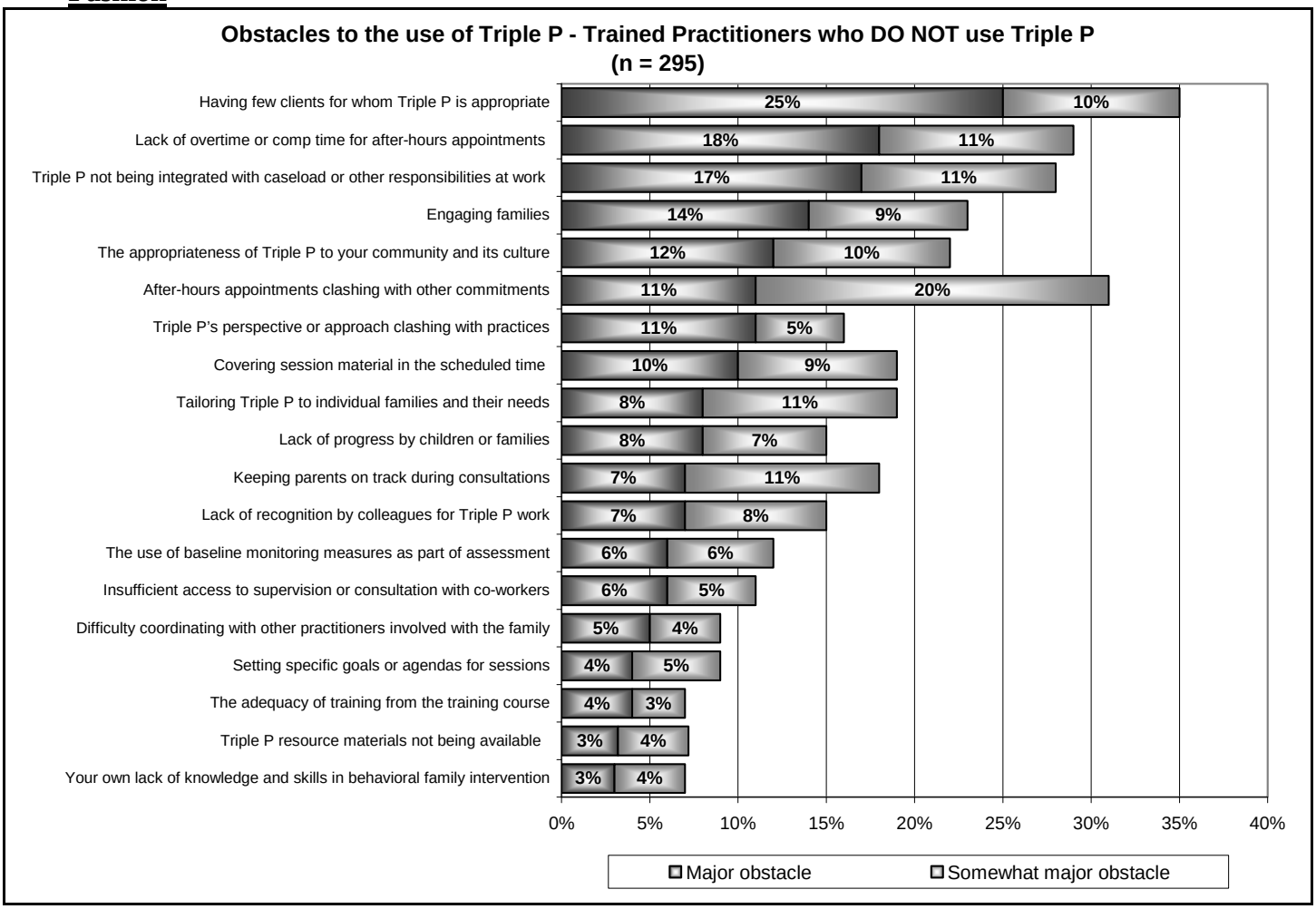


Figure 5. Obstacles to the use of Triple P – Practitioners not using Triple P in a Stand-Alone Fashion



While these two groups: Trained practitioners who continue to use Triple P and Trained practitioners who do not use Triple P both report the same obstacles, there are significant differences between them. The trained practitioners who DO NOT use Triple P are more likely to report the following obstacles compared to the trained practitioners who DO use Triple P:

- Having few clients for whom Triple P is appropriate ($F = 12.26$, $p = .001$)
- Triple P's theoretical perspective clashes with my current practice ($F = 3.11$, $p = .079$)
- Tailoring Triple P to individual families and their needs ($F = 2.62$, $p = .11$)
- Appropriateness of Triple P to your community and culture ($F = 5.84$, $p = .02$)

Overall, practitioners reported the following were the GREATEST obstacle to using Triple P:

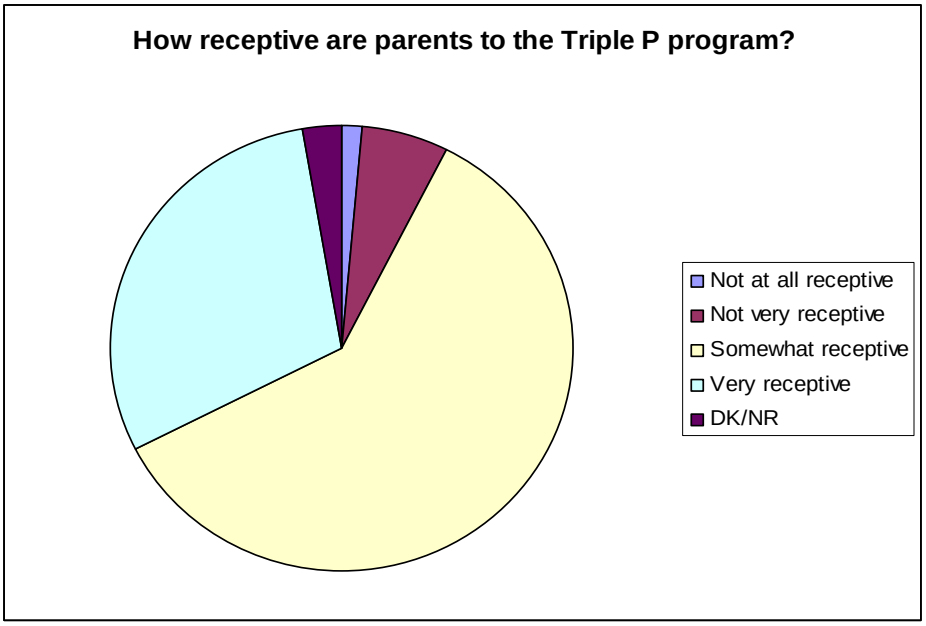
Table 9. Greatest obstacle to use of Triple P

Obstacle:	% (*n*/557)
Nothing/No greatest obstacle	55
Engaging families/interest	13
Not enough time/too busy/caseload too high	13
Having few clients for whom Triple P is appropriate	8
Triple P's theoretical perspective clashing (your practice)	2
Appropriateness of Triple P to your community & its culture	2
Don't use/supervisor	2
Triple P program too long/multiple sessions not available	2
Other	3

Parental acceptance/resistance

Overall, practitioners reported that parents were receptive to the use of Triple P.

Figure 6. Parental receptivity to Triple P



Where parental resistance was encountered, it was for the following reasons:

Table 10. Reasons for parental resistance to Triple P

Parental resistance encountered	% *n*/240
The time involved	55
None	41
Literacy levels	28
Language barriers	17
Racial or cultural	11
Parents do not follow through/complete tasks	10
Resistance/lack of commitment/interest from parents	10
Other	5
Don't like Triple P/don't agree with Triple P	4
Parents say that Triple P is the same as other strategies	4
Not appropriate for clientele	3
Parent/family have multiple issues	3
Barriers to attending Triple P	3

Practitioners reported that there are some things that keep them from using Triple P with families. The following table shows that only a small percentage of practitioners encountered barriers that kept them from using the program with families.

Table 11. Barriers to implementing with clients

Barrier	% (*n*/557)
Literacy levels	17
Client needs a different level of Triple P than I am trained to provide	16
Not appropriate for the presenting problem, e.g. severe psychopathology	15
Language barriers	13
Not enough time/workload to heavy	10
Racial or cultural concerns	7
Resistance/lack of commitment/interest from parents	3
Parent/family have multiple issues	2
Other	10
Don't like Triple P/don't agree with Triple P	2
Lack of resources such as staff or finances	2

Contradictions to the use of Triple P

Some practitioners report that the advice provided to parents in Triple P contradicts some of the other parenting advice they already provide to parents. Of the 240 practitioners who continue to use Triple P, 56 (23%) reported this. The following were the contradictions they cited:

Table 12. Contradictions with current practice

Strategy	% using Triple P who report this contradiction (*n*/240)
Timeouts (general)	9
Praise and rewards	3
Punitive approach to discipline/physical force being used	2
Other	9

And these are the approaches that practitioners reported using to deal with these contradictions:

Table 13. Strategies for dealing with contradictions

Strategy	% (*n*/240)
Discuss contradiction/options with parents	7
Don't use this area/resource of Triple P	6
Adapted the Triple P method	4
Incorporated other styles/treatments	3
Other	5

Deciding to offer the program to a family

Practitioners have various strategies for deciding when it is appropriate to offer Triple P to a family. The 240 practitioners who continue to use Triple P reported these strategies for deciding to use Triple P (*n* > 240 and % > 100 because practitioners could report more than one strategy)

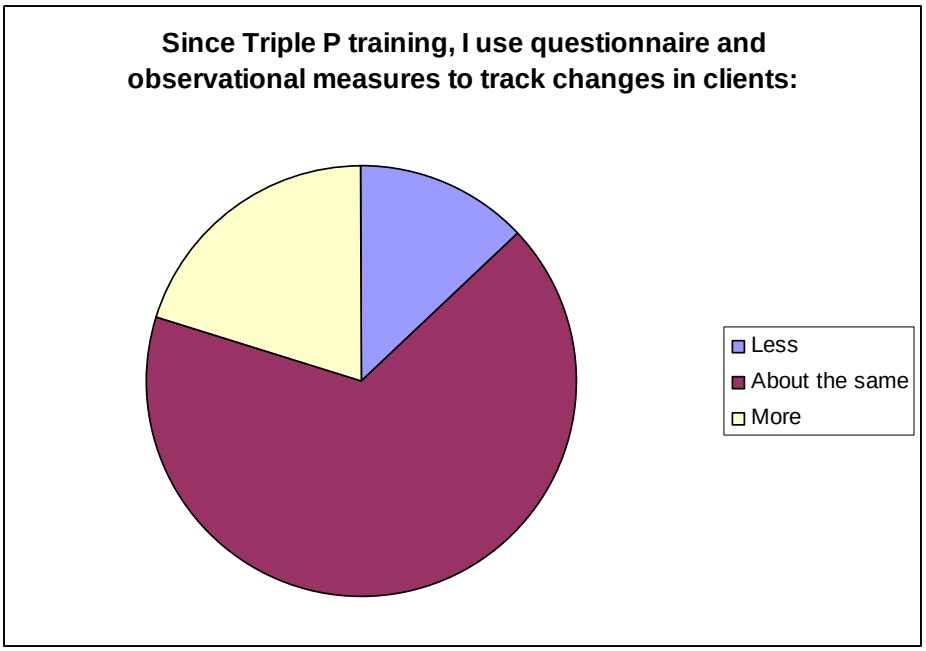
Table 14. Deciding to offer Triple P

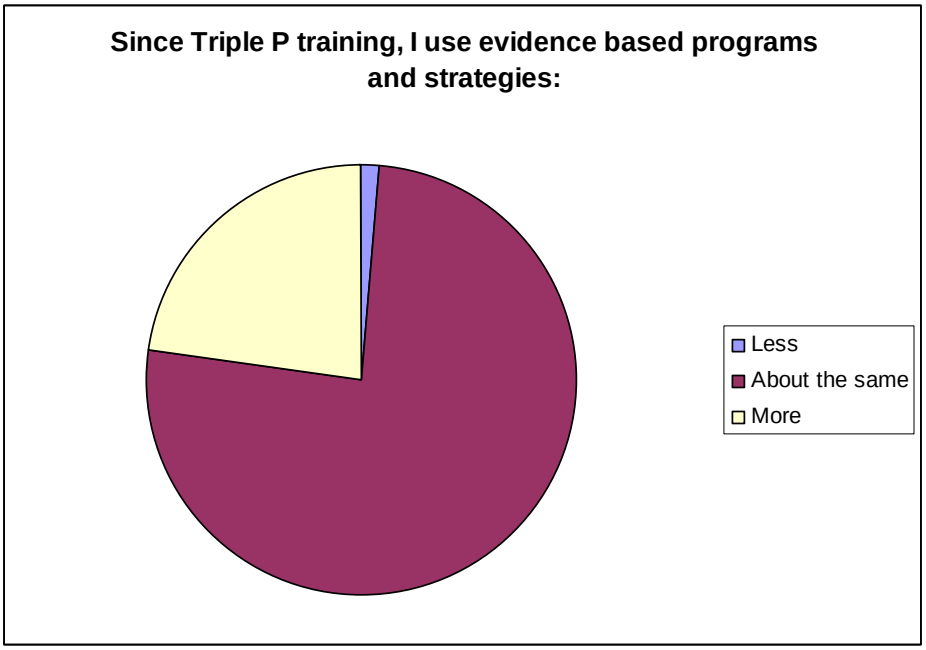
Reason	% (*n*/240)
Willingness of parents	28
Presenting problem/needs	20
Other	11
Parent has a problem/concern	9
Child's behaviour/problem	8
Parenting skills	8
Age of the child	8
Triple P/behaviour management is best approach	6
Literacy/education	6
Time availability (i.e., enough time)	5
Culture	3
Parent has used other approaches unsuccessfully	3
If tip sheets/resources are available	3
Always use Triple P	3
Family characteristics	2
Parents ask for it/for help	2
Not using	2
Offer groups	2

Use of measures and evidence based programs

Practitioners reported on how their use of questionnaire and observational measures to track change, and their use of evidence based programs and strategies had changed since they took their Triple P training.

Figure 7. Use of measures and evidence based programs





Recommending Triple P training to colleagues

Many of the respondents (362/557 or 65%) have recommended to other practitioners that they take Triple P training. Of those who have recommended this, most (81%) have recommended to between 1 and 6 other practitioners that they also take Triple P training.

Most commonly, people make this recommendation to people in the following occupations:

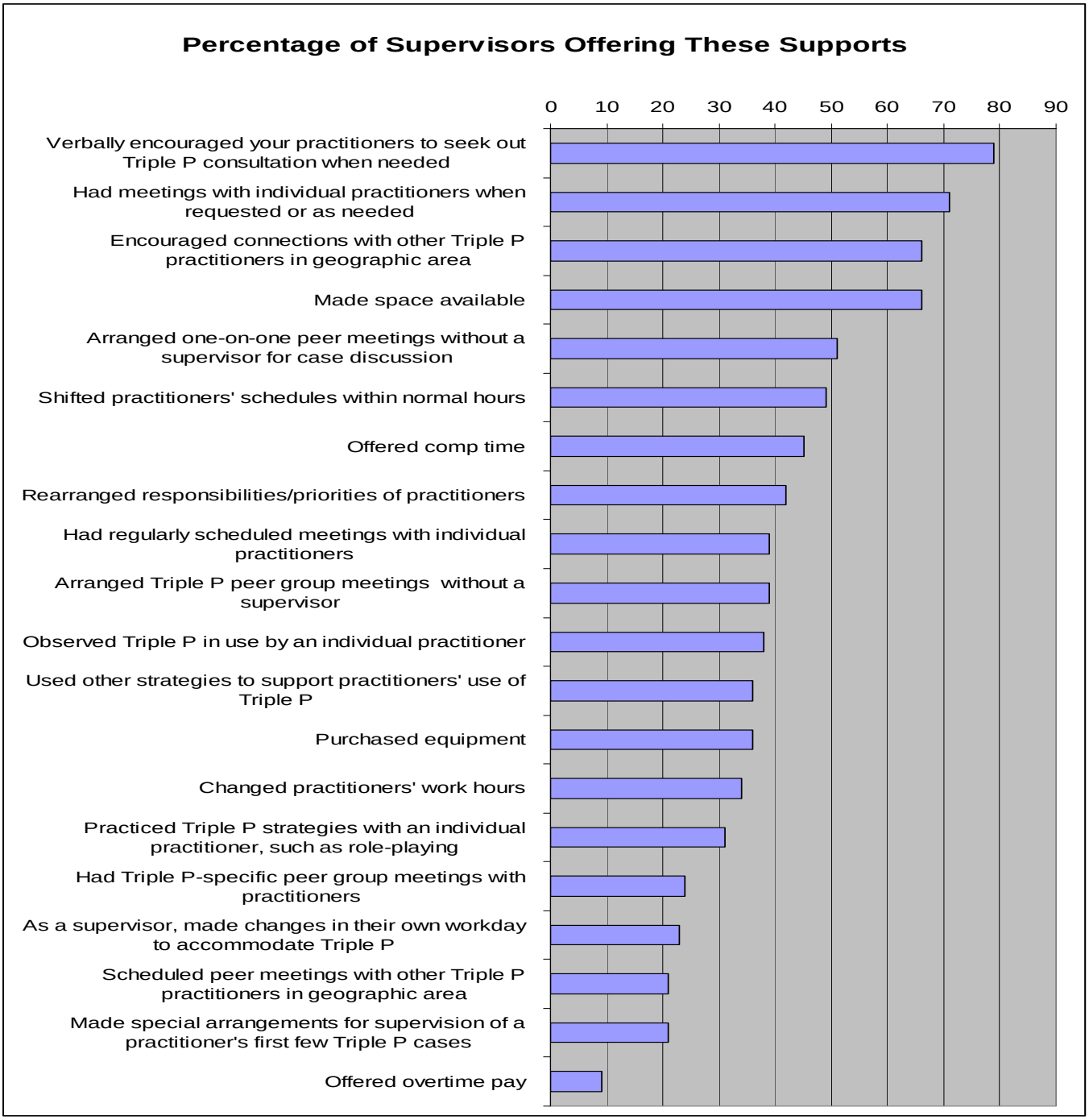
Table 15. Practitioners recommended to take Triple P training

Occupation	% (*n*/557)
Social worker/social work students	14
Teachers/education	13
Child care/day care/early childhood educators etc.	12
Nurse/public health nurse	10
Counselors/therapists	8
Other	8
Family support workers/family first	6
CFS/Social services/child welfare/foster care	6
Education assistants/paraprofessionals	4
Community workers	4
Mental health workers	4
Home visitors/assistants	4
Supervisors/directors/managers/administrator	3
Psychologists/clinician	3
Prenatal/maternal health workers	2
Guidance counselors	2
Parents	2
Support workers (general)	1
Outreach workers	1
Occupational therapists (OT)	1
Language/speech pathologists	< 1

Supervisors of Triple P practitioners

107 supervisors responded to the interview. Supervisors of Triple P practitioners do the following to support the implementation of Triple P in their organizations:

Figure 8. Support offered by supervisors



These 107 Supervisors, supervise between 1 – 40 practitioners (average = 5) in the use of Triple P. Fifty of these supervisors have Triple P training themselves.

Of these 107 supervisors, 10% (11 supervisors) reported that the number of hours per week they spend supervising staff has increased, by between one to five hours per week as a result of their organizations' implementing Triple P.

Supervisors reported the following as the number of hours per week that they typically spend supervising their practitioners' use of Triple P:

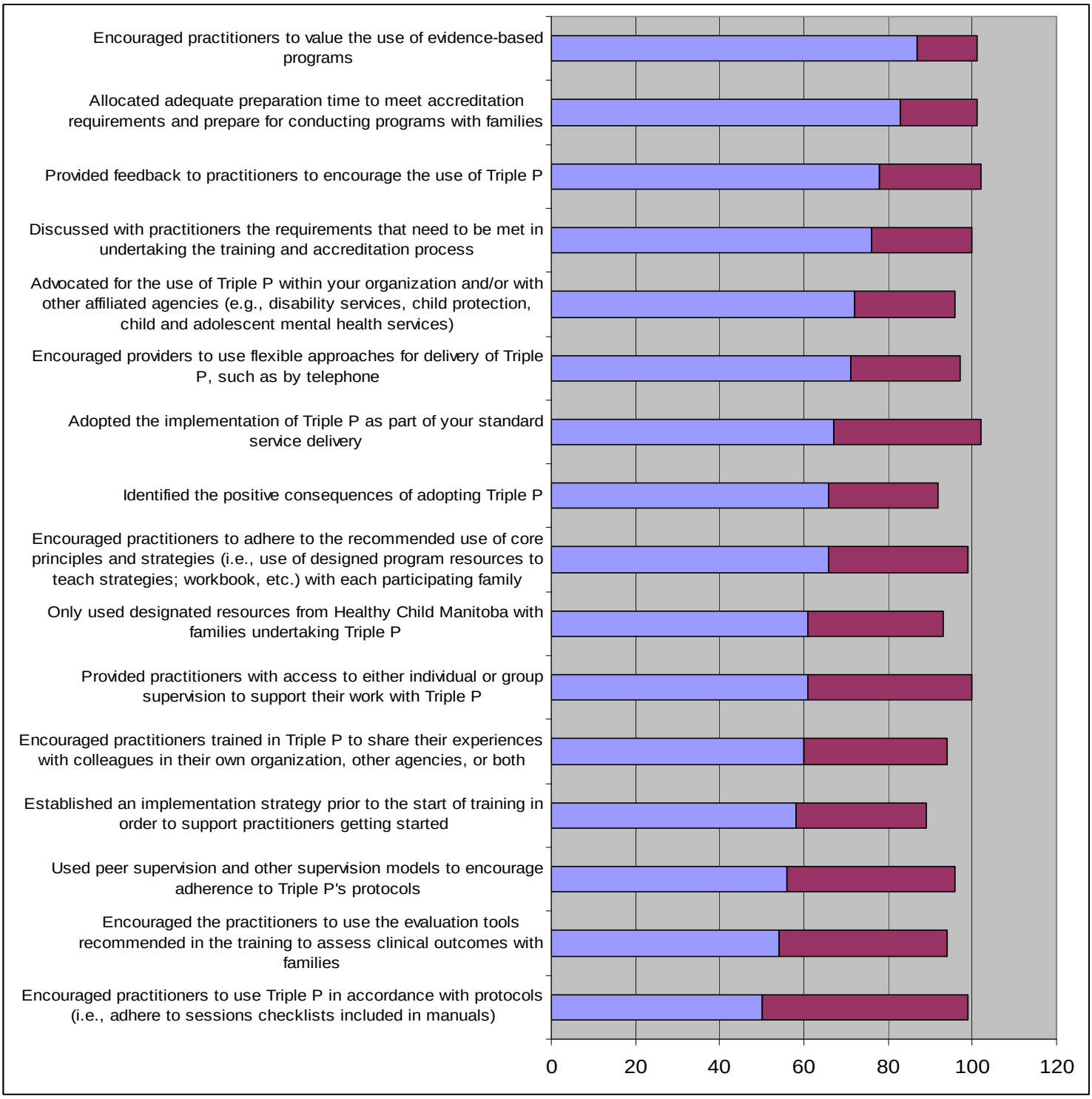
Table 16. Supervision time spent on Triple P

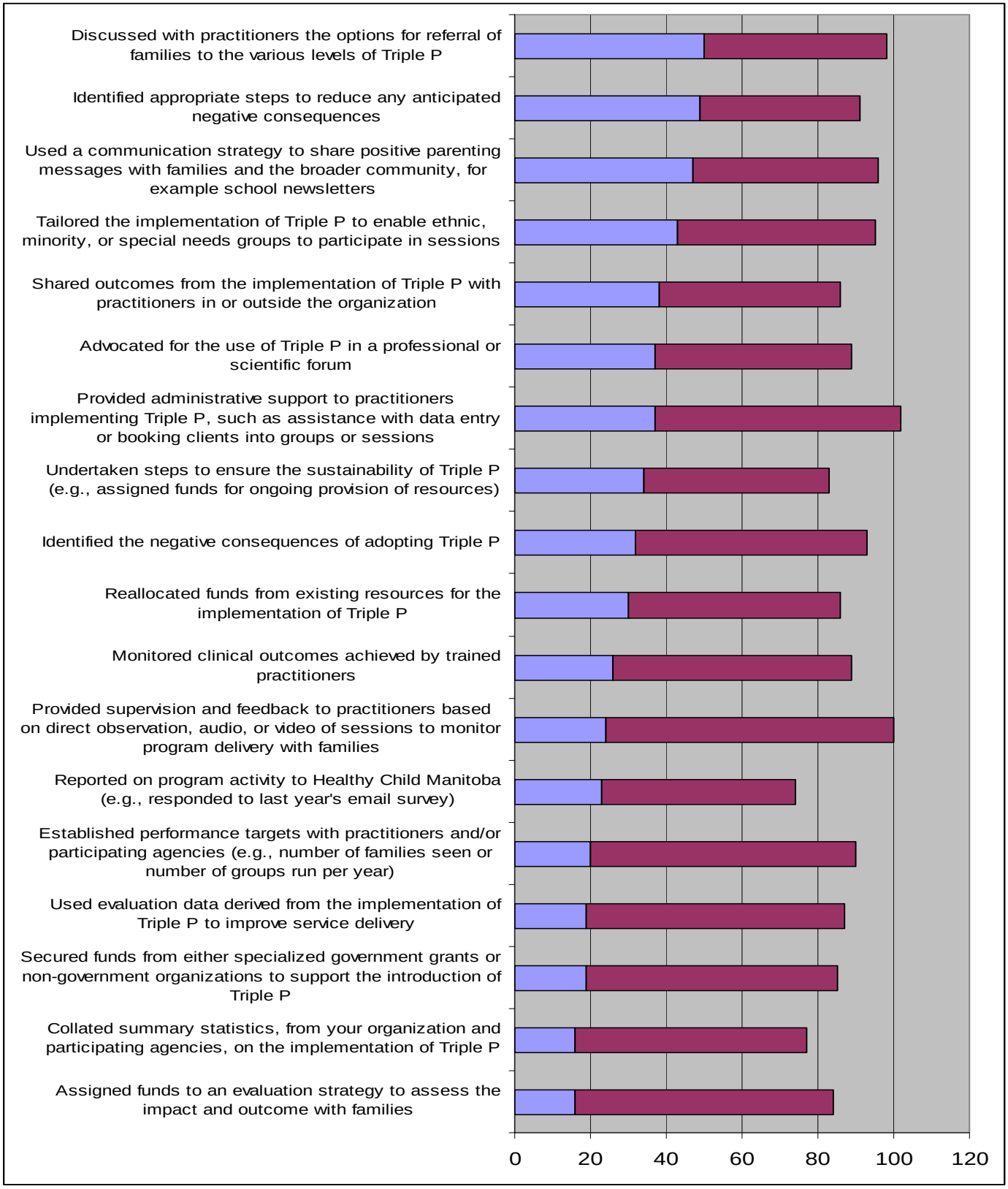
Number of Hours	Percentage of Supervisors
1	15
2	9
3	3
4	1
5	3
8	2
9	1
10	2
None	30
No Response	34

n = 107

Supervisors were asked about the changes their organization has made in relation to the implementation of Triple P. To what extent have your organization…

Figure 9. Organizational change




Discussed with practitioners the options for referral of families to the various levels of Triple P
Identified appropriate steps to reduce any anticipated negative consequences
Used a communication strategy to share positive parenting messages with families and the broader community, for example school newsletters
Tailored the implementation of Triple P to enable ethnic, minority, or special needs groups to participate in sessions
Shared outcomes from the implementation of Triple P with practitioners in or outside the organization
Advocated for the use of Triple P in a professional or scientific forum
Provided administrative support to practitioners implementing Triple P, such as assistance with data entry or booking clients into groups or sessions
Undertaken steps to ensure the sustainability of Triple P (e.g., assigned funds for ongoing provision of resources)
Identified the negative consequences of adopting Triple P
Reallocated funds from existing resources for the implementation of Triple P
Monitored clinical outcomes achieved by trained practitioners
Provided supervision and feedback to practitioners based on direct observation, audio, or video of sessions to monitor program delivery with families
Reported on program activity to Healthy Child Manitoba (e.g., responded to last year's email survey)
Established performance targets with practitioners and/or participating agencies (e.g., number of families seen or number of groups run per year)
Used evaluation data derived from the implementation of Triple P to improve service delivery
Secured funds from either specialized government grants or non-government organizations to support the introduction of Triple P
Collated summary statistics, from your organization and participating agencies, on the implementation of Triple P
Assigned funds to an evaluation strategy to assess the impact and outcome with families
0
20
40
60
80
100
120

Supervisors reported that the following would be the most helpful supports that HCMO could provide to assist them in supporting their practitioners implementing Triple P.

Table 17. Helpful supports

Type of Help	% of Supervisors who asked for this (*n*/107)
Provide funding/money	11
Raise profile of Triple P/more information about program	10
Training issues (more training, change training)	7
Continue with current initiatives	4
Allow for changes to Triple P/adapt it	4
Need more time for staff to use/implement program	3
Updated/translated tip sheets	2
Offer free training	2
Other	26
Don't Know	5
Nothing	40

Note: the number of requests is more than the total number of supervisors who responded (n = 107) because some supervisors indicated more than one type of assistance that would be helpful to their organization.

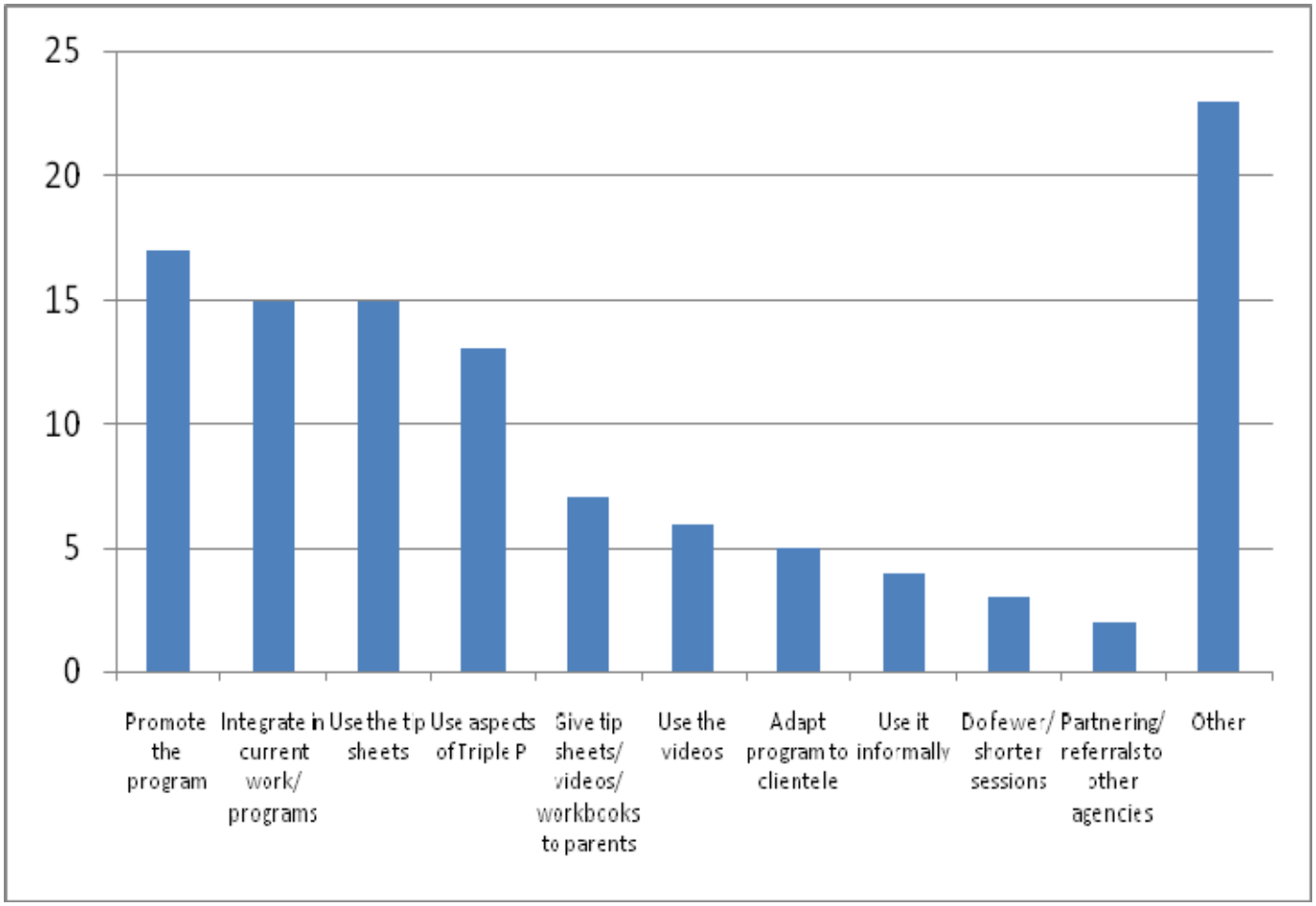
Creative implementation

Practitioners report making adaptations to their use of the Triple P materials in order to suit the needs of the families they work with and the structure and constraints of their current service delivery models.

Commonly, practitioners report giving out tip sheets or showing the Triple P videos to parents even when there is no opportunity to discuss or provide consultation (55%; *n* = 308).

Following are some of the ways practitioners reported creatively using Triple P flexibly to adapt to the needs of their clients and the contexts of their organizations:

Figure 10. Percent of practitioners using creative strategies for implementation



Cross-sectoral implementation

For the most part, practitioners were aware of the multi-level, cross-sectoral nature of the Triple P roll-out (87%).

While most practitioners (67%) did not identify any benefits of challenges that they had experienced as a result of the cross-sectoral implementation, some practitioners did have experiences to share. Those who had experienced changes commented on both benefits and challenges, that have resulted from the cross-agency delivery of Triple P:

Figure 11. Benefits of cross-agency implementation

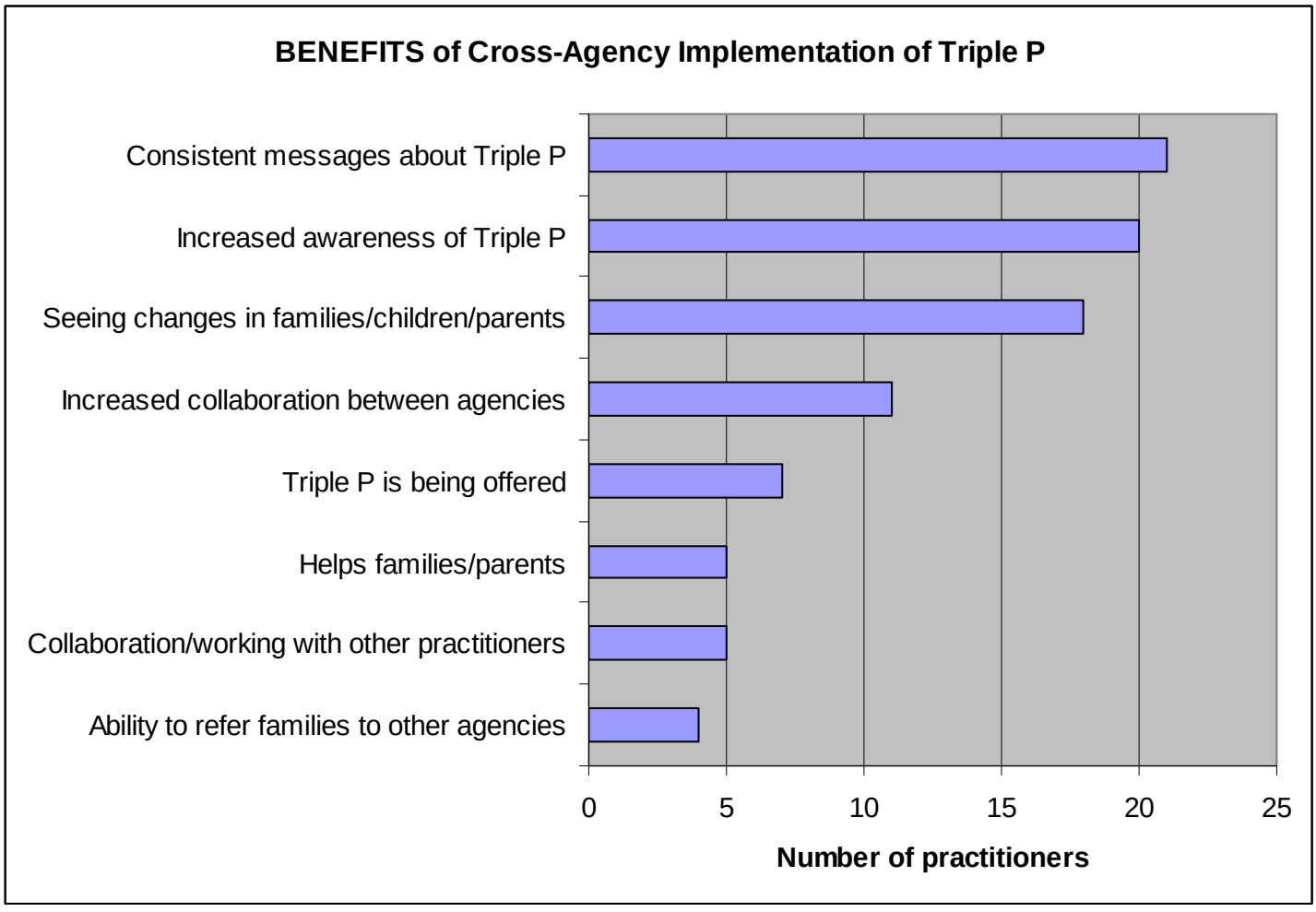
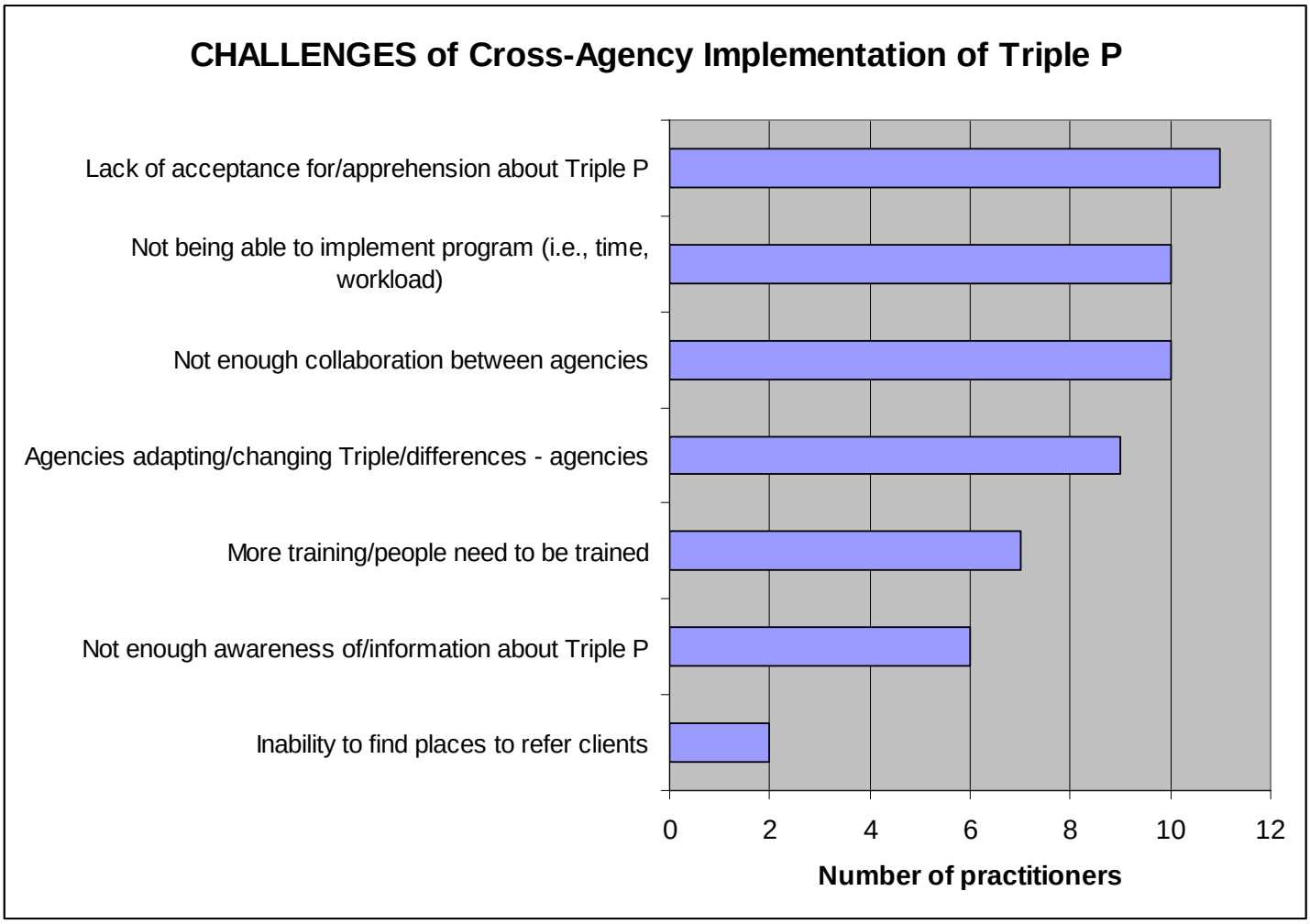


Figure 12. Challenges of cross-agency implementation



Ongoing Evaluation of Triple P in Manitoba

While in the long-term, an evaluation of the outcomes achieved by Triple P for Manitoba's children and families is the ultimate goal, the nature of the Triple P design and delivery system makes it very difficult to accurately track, not only the individual outcomes, but even something as simple as the number of parents who have accessed services. Accessing Triple P services can take many forms, from a short conversation with a Triple P trained public health nurse at the time of an immunization, to the provision of a Triple P tip sheet by a day care director, to attendance at a Triple P seminar for hundreds of parents in a school auditorium, to participation in an eight week group program or individual family counseling with a clinician. Each organization that has trained and accredited practitioners determines what service delivery mechanism(s) they are able to provide. While being able to capture the number of families who receive Triple P services in the future is desired, there are a number of challenges to being able to accurately and adequately do this including:

- Many of the partner agencies that currently have trained Triple P service providers do not typically keep stats on the number of families seen for various services (including Triple P) that they may provide. Examples of this are childcare staff, school guidance counselors and other school personnel, etc.
- While some sectors may collect stats in one fashion or another, the manner in which these are collected varies both across sectors and within some sectors. Finding a common template for collecting this information that works for all sectors and agencies is not easily accomplished.
- Many agencies and their practitioners embed Triple P services to a family within the delivery of other services to that family (e.g., Families First home visitor delivering the FF curriculum may include some Triple P information, public health nurse seeing a parent regarding immunization may provide Triple information as well). It is extremely difficult to pull out in their record keeping where a Triple P consultation may have occurred.
- With approximately 1,200 trained and accredited practitioners and more than 200 partner agencies and organizations across sectors, there are capacity issues that preclude the province-wide collection of practitioner- and family-level data.
- Partnerships between agencies delivering Triple P and the Healthy Child Manitoba Office are voluntary. Once a practitioner has come for training and accreditation (funded by HCMO), they have free access to Triple P materials and are not bound to any type of service delivery contract regarding implementation of Triple P services. This has implications for HCMO's ability to track service delivery, and to motivate agencies to complete ongoing tracking measures as they are not explicitly accountable to HCMO for this information, and their continued access to Triple P program materials and training is not tied to submission of service delivery data.
- While targeted outcome evaluation may be feasible by partnering with trained agencies that are enthusiastic and well equipped to conduct the required data collection, preliminary feedback from many partner agencies regarding this type of data collection has been mixed.

While the provincial government provides training and resources to the organizations, there is no provision for funding the delivery of the program, making it very difficult to compel organizations to collect and provide data in an ongoing manner as would be necessary for a thorough outcome evaluation.

The central objective with a universal program such as Triple P, is to broaden the reach to as many organizations and parents as possible. Also key, is to embed the concept of parenting advice and training into the broad culture of the province. In this way, the public at large and parents, in particular, will feel far more comfortable in seeking parenting information and support from local agencies and service providers. The best determinants of the effectiveness of Triple P will be in the outcomes measured at a population level across Manitoba. Thus, for example, will the availability of Triple P to families across Manitoba lead to general reductions in prevalence rates for social-emotional difficulties in children, reductions in child maltreatment rates, etc? Answers to these questions will be the most feasible and potentially most useful outcome measures, and are best evaluated over the long term, using archival data already collected by the province in one or more departments.

Recall that Triple P is an evidence-based intervention with more than 25 years of rigorous scientific evaluation to speak to its effectiveness when implemented well. It is thus imperative that Manitoba evaluate the reach and quality of implementation in order to ensure that positive long term outcomes will be possible. This report has detailed the progress made in implementing the program up to the fall of 2008 and described how the data has already been used to enhance ongoing implementation and support to practitioners and agencies.

Recommended Future Action

This report represents a preliminary examination of the Triple P roll-out in Manitoba. Currently, training has been expanded to the whole province, including areas that were not ready to participate at the time that the CPMI 2008 was conducted. Based on the findings of this report, additional support has been offered to practitioners to facilitate implementation, maximize uptake of the program, and assist in navigating the barriers and obstacles that do arise.

Anecdotal evidence suggests that practitioners are increasingly able to integrate Triple P into their existing service delivery. It is natural when introduced to a new program to want to deliver it "by the book". This is possible for many practitioners as seen by the responses of those who continue to deliver Triple P as a stand-alone program. This group of practitioners has provided valuable feedback on the 2008 CPMI. A future evaluation priority is to examine more closely the activity of the group of practitioners who have integrated Triple P within their existing services, as this group will likely grow as practitioners become more comfortable with the principles and strategies included in the program.

Consideration will be given to re-administering the CPMI with the current population of accredited practitioners at a future time to provide a measure of the success that has been achieved in meeting these goals, to provide an updated estimate of program reach, and to delve further into the delivery of Triple P by practitioners who have integrated the program within their current services rather than delivering it in a stand-alone manner.