Reflections on the Challenges of Effective Dissemination of Behavioural Family Intervention: Our Experience with the Triple P – Positive Parenting Program

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Abstract This paper draws on learnings from dissemination and diffusion research to discuss predictors of dissemination outcomes, obstacles to effective dissemination, and phases of dissemination failure. A model is presented of effective dissemination of a multilevel system of intervention known as the Triple P-Positive Parenting Program (Triple P). This model takes a systems-contextual approach, addressing program design, skills training, practitioner confidence and self-regulation, and workplace support. Recommendations are made for agencies adopting evidence-based programs, particularly in relation to the selection, establishment and maintenance of new programs as well as guiding ongoing program development. Future directions for research into the dissemination of evidence-based practice are also discussed.

Introduction

The development of interventions that promote positive, caring and consistent parenting practices has been repeatedly highlighted as critical to any attempt to reduce the incidence of child maltreatment or behavioural disorders in children (Azar, 1997; Sanders & Cann, 2002; Wekerle & Wolfe, 1993). Behavioural family interventions (BFIs) are amongst the most extensively evaluated interventions available to assist children with mental health problems, particularly those with conduct problems (see reviews by Dimond & Hyde, 1999; Taylor & Biglan, 1998). Typically, parents are taught to increase positive interactions with children and to reduce coercive and inconsistent parenting practices. These programs are associated with large effect sizes (Serketich & Dumas, 1996), which often generalise to a variety of home and community settings (McNeil et al., 1991; Sanders & Dadds, 1982). Intervention outcomes are maintained over time (Long et al., 1994), and are associated with high levels of consumer satisfaction (Webster-Stratton, 1989). These programs may also produce improvements on measures of parental adjustment such as depression, stress and marital conflict (see Barlow, Coren, & Stewart-Brown, 2002). A variety of different delivery formats have been demonstrated to be effective, including individually administered face-to-face programs (e.g. Forehand & McMahon, 1981), group programs (e.g. Webster-Stratton, 1990), telephone-assisted programs (e.g. Connell, Sanders & Markie-Dadds, 1997) and self-directed programs (e.g. Markie-Dadds & Sanders, 2005). The success of BFI as a selective and targeted prevention and early intervention approach highlights the importance of including parenting interventions in any comprehensive strategy designed to prevent child maltreatment and conduct problems in children.

As the evidence supporting the effectiveness of parenting interventions based on social learning approaches strengthens, so do demands that such interventions are made widely available to mental health practitioners and parents. However, much less attention has been given to what is required to make these interventions accessible to parents or to professionals serving the public. Historically, clinical researchers have not paid a lot of attention to whether
practitioners adopt evidence-based approaches. Consequently, there are few examples of the successful dissemination of psychological interventions. This lack of application of existing knowledge about parent training is a major obstacle to effective treatment of many mental health problems in children.

There has been general acknowledgement of the gap between clinical research in psychological interventions and the common practices of clinicians in the field (Fixsen & Blase, 1993; Taylor & Biglan, 1998; Wilson, 1997). Knowledge obtained from randomised controlled trials about the treatment or prevention of behavioural or emotional problems through parenting interventions has had little impact on prevalence rates of childhood behavioural and emotional problems. Only a minority of children with identifiable mental health problems receive any form of treatment. In Australia, it has been estimated that between 2% and 20% of children with identified mental health problems receive any form of treatment from specialist mental health services (Sawyer et al., 2000; Zubrick et al., 1995), and only about 10% of parents participate in parent education (Sanders et al., 1999). The majority of parents are not aware that effective interventions exist and even if they seek help, the accessibility of empirically-supported interventions is typically poor (Barlow & Hofmann, 1997). Many services continue to use ineffective, non-empirically supported psychotherapeutic interventions or non-evaluated parenting and family support programs (Webster-Stratton & Taylor, 1998).

This lack of adoption of empirically-supported prevention and intervention programs by practitioners is a major concern (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). It is our contention that to reduce community prevalence rates of dysfunctional parenting practices and therefore emotional and conduct problems in children and adolescents, an approach that addresses the broader ecological context of parenting (e.g. Biglan, 1995; National Institute of Mental Health, 1998) as well as the knowledge, skills and confidence of parents is required. This paper discusses dissemination and diffusion research and our experience in disseminating the Triple P-Positive Parenting Program as a system of parenting intervention, and provides recommendations for successful program dissemination, adoption and implementation by community service providers. Triple P is a multilevel, parenting and family support strategy developed by the authors and colleagues at the University of Queensland in Brisbane, Australia. Interventions range from a universal media information campaign targeting all parents and brief primary care consultations targeting mild behaviour problems to intensive parent training and family intervention programs for families with multiple risk factors (e.g. relationship problems, family violence or parental adjustment problems) or children with severe conduct problems. The empirical basis of Triple P has been detailed elsewhere (e.g. Sanders, 1999; 2001; Sanders et al., 2004; Sanders, Turner, & Markie-Dadds, 2002) and will not be discussed in detail here.

**Learnings from dissemination and diffusion research**

The dissemination of effective interventions is one of the most important challenges faced by those who seek to improve the mental health of the population (Persons, 1997). There is now little opposition to the importance of service providers using empirically-supported interventions (Taylor & Biglan, 1998) and the importance of disseminating to service providers and the public those interventions with proven efficacy and effectiveness (Chambless, 1996; Crits-Cristoph, 1996; Task Force, 1995). When intervention approaches have adequate empirical support, as is the case with BFI, the next focus of research must be...
the evaluation of mechanisms for disseminating these approaches and ensuring their effectiveness when used outside controlled experimental situations.

Effective dissemination is critical for evidence-based research to have significant community impact. It is commonly accepted that awareness of evidence relating to effectiveness is not enough to ensure adoption of an innovation (Rogers, 1995). Knowledge of, and even ability to implement a particular procedure or skill, does not ensure sufficient competence in the clinical application of the skill (e.g. teaching a parenting strategy); specific training in consultation skills is generally regarded as essential (McGimsey, Greene, & Lutzker, 1995). Biglan and Metzler (1999) argue that the translation of intervention research findings into practice requires replacing traditional methods of dissemination (e.g. scientific publication and meetings). In particular, they argue that future research should focus on services that currently provide interventions for families in order to determine how to move current practices away from the use of non-validated approaches. Such research would need to consider a range of organisational issues that may affect program adoption, in particular, funding and management issues. The challenge is not only to find better ways of disseminating validated interventions to practising clinicians (Goldfried & Wolfe, 1998) but to study the larger social context that influences program adoption and maintenance (Biglan & Metzler, 1999).

**Predictors of dissemination outcomes**

For an intervention to be determined ready for dissemination, practitioners must be able to recognise its relevance and benefits, as well as tangible means of translating the intervention into their clinical practice (Folette et al., 2002). While dissemination may occur in the absence of effectiveness data (Persons, 1997), ideally, effectiveness data should be available before system level dissemination to organisations (Folette et al., 2002). Implementation of a new program should preferably be in incremental stages, with observable improvement over current practices (Glaser, Abelson, & Garrison, 1983). While adaptability to suit the clinical context and client population are important (Stolz, 1981), there is concern that tailoring of an intervention may result in poorer outcomes than adherence to a standard protocol (Schulte et al., 1992). With the primary focus on maintaining treatment integrity, tailoring may be possible through the separation of interventions into components that can be implemented or omitted (Backer, Lieberman, & Kuehnel, 1986).

A number of the innovation characteristics detailed in the diffusion literature (Rogers, 1995) mirror those postulated to influence the successful dissemination of psychological interventions. The issues are summarised as: *compatibility* with the theoretical and sociocultural value system of the adopter; *flexibility* to allow adaptation to fit different adoption settings; *reversibility* to allow for discontinuance without great cost to the adopter; *relative advantage* over previous or current approaches; lack of *complexity* so the innovation is easy to understand and to put into practice; *cost-efficiency* in producing desired outcomes; and minimal *risk* to the potential adopter (Schinke, Botvin, & Orlandi, 1991).

Several organisational supports have also been identified in successful dissemination efforts. The provision of funding is required for training, resources, allocation of staff time, administrative and data management support, or the creation of new positions (Backer et al., 1986; Stolz, 1981). This funding is usually seen as a cost-saving strategy that will result in the streamlining of services. In fact, an innovation is more likely to be accepted because of its economic implications than on the grounds of welfare, equity or justice (Linney, 1990). A
second contextual consideration is the demand from (or at least receptivity of) practitioners for the innovation, and the openness of management to both the innovation and the investment required to support the process of change. Several reviews have cited the importance of having a champion of the program within the organisation (Backer et al., 1986; Stolz, 1981) who has sufficient power and persuasion skills to influence whether an innovation is adopted and to persist through political battles to ensure its maintenance.

The process of persuading an organisation or an individual practitioner to adopt an innovation is a crucial step in the dissemination effort. Initially, there is a need to increase access to information about an innovation (Beutler, Williams, & Wakefield, 1993). Personal contact between developers and potential users may be critical in demonstrating methods, enhancing credibility, and providing opportunities to tailor the program to different adoption settings (Glaser et al., 1983). Another of Glaser's recommendations is the establishment of rewards for adoption among front-line staff to encourage the maintenance of competent performance levels and promote ongoing implementation. It is also important to consider how to support clinicians (Backer et al., 1986). This requires the careful design of training and program resources, and establishment of support networks to optimise the likelihood of adoption and minimise the threat of the change process.

**Obstacles to effective dissemination**

Dissemination failure has previously been attributed to lack of training in empirically-supported interventions during university and internship training (Task Force, 1995) and the tendency for some practitioners to be dismissive of randomised controlled trials and their relevance to clinical practice (Addis, Wade, & Hatgis, 1999; Wilson, 1997). According to Barlow (1981), most clinicians continue to use treatment techniques learned during their early professional training and modify these procedures through trial and error in clinical practice, with little impact from continuing education (Barlow, 1981). Dissemination barriers may be conceptualised as relating to complexities of the innovation, practitioner concerns or resistance, or political and logistical barriers in the adopting organisation.

*Characteristics of the innovation.* A program or innovation may not be adopted if there is a lack of fit between its theory or practical implementation and the existing orientation and practices of a practitioner or organisation (Backer et al., 1986). Given practitioner concerns about the applicability of evidence-based interventions in clinical practice, innovations that are complex, demanding, long or involving team implementation are likely to encounter problems with implementation fidelity (Yeaton & Sechrest, 1981). This will impact on their effectiveness in the field, and consequently their appeal to practitioners and service organisations.

*Practitioner concerns.* In exploring the failure of empirically-based interventions to be optimally disseminated to clinicians, Addis and colleagues (1999) identified a lack of attention to practitioner concerns. Common concerns were the possible detrimental effects on the therapeutic relationship, unmet client needs due to standard protocols, threat due to uncertainty about professional competence in learning new interventions, loss of job satisfaction, restriction of clinical innovation, lack of treatment credibility and poor feasibility of manual-based interventions. Although there may be little basis to these concerns, Addis et al. (1999) have proposed that dissemination of empirically-based interventions will not progress markedly until researchers and program proponents consider the attitudes, concerns, experiences and working contexts of practitioners. This raises the question of how various
training models impact on clinician satisfaction and self-efficacy or confidence in delivering an intervention. The notion of self-efficacy is highly relevant to understanding practitioners’ capacity to implement a new intervention. Many practitioners see research as a threat designed to expose their shortcomings in clinical practice. If they decide to adopt an evidence-based intervention and they do not produce successful client outcomes, the threat remains that this will reflect negatively on their clinical skills and the blame for poor outcomes will fall on them (Addis et al., 1999; Jacobson & Gortner, 2000). Practitioners also express concerns about how well a new program will integrate with other work responsibilities and whether they will receive adequate time and support from their agency to undertake the program (Kavanagh et al., 1993). There may be a perception of the adoption of the program as a loss, when practitioners have strong ties to previous methods or job roles (Diamond, 1996) and there is a lack of perceived relative advantage of the program over current practices. Backer and colleagues (Backer & Glaser, 1979a, b; Backer et al., 1986) reinforce the call for attention to be paid to the feelings, attitudes and emotional reactions of practitioners, suggesting that psychologically-induced resistance to change can in fact sabotage dissemination efforts.

**Resistance within the adopting organisation.** Traditional organisational structures, where decisions are made by management and a memo sent out calling for a decision to be implemented (Backer et al., 1986), are not necessarily optimal for the change process. This kind of top-down imposition of an innovation, without consultation, input or ownership by the staff designated to implement it, may serve to increase staff resistance to the change (Webster-Stratton & Taylor, 1998) and result in failure of the innovation to be implemented. Barriers within an adopting organisation may also be a function of clinical practice guidelines imposed by the organisation or financiers such as third-party payers (Barlow, 1994). For example, consultation numbers and program formats may be restricted, and new intervention approaches may need to go through an approval process according to their evidence base. Indeed, there are moves to use such clinical practice guidelines to provide immunity from malpractice litigation (Barlow & Hofmann, 1997) and to meet quality assurance criteria for accreditation (Barlow, Levitt, & Bufka, 1999), creating more pressure on agencies to carefully consider the interventions and services they offer.

**Phases of dissemination failure**

Barriers to successful dissemination may occur during any stage of the dissemination process. A number of potential system-failure points have been identified in the multistep communication process that is required for successful dissemination. These potential points of dissemination failure were identified in the area of substance abuse prevention dissemination (Schinke et al., 1991). However, they are equally applicable to other areas of psychological innovation dissemination. There are five critical points at which dissemination failure may occur. 1) **Innovation failure**: If the issue of clinical utility has not been appropriately addressed, an innovation may be inappropriately designed, lack appropriate evaluation or fail to match the needs and sociocultural attributes of the target adopters. 2) **Communication failure**: Even with proven efficacy and effectiveness, an innovation may be poorly communicated, leaving target adopters uninformed about its availability or improperly informed about its applicability. 3) **Adoption failure**: An efficacious intervention, communicated properly may fail to be adopted due to factors such as lack of funding or resources, or a clash with existing value and belief systems. 4) **Implementation failure**: Though efficacious, well-communicated and adopted successfully, an innovation may fail to be implemented or implemented properly. Aspects of the dissemination effort (e.g. training,
data collection requirements, integrity protocols) may be omitted or abbreviated resulting in improper implementation. If the innovation is adopted at the organisational level, without consultation with clinicians, resistance may impede its successful implementation. 5) **Maintenance failure**: Innovations that have been successfully evaluated, communicated, adopted and implemented may still lose momentum and be implemented less, or funding and resources may be lost, making sustained implementation difficult.

**Our experience with Triple P**

**The Triple P system of intervention**

The Triple P system of parenting and family support involves a BFI approach that aims to promote social competence and prevent severe behavioural and emotional disturbances in children and adolescents. The intervention system aims to help parents develop a safe, nurturing environment and promote positive, caring relationships with their children, and to develop effective, non-violent management strategies for dealing with a variety of childhood and adolescent behavioural and developmental issues (Sanders et al., 2000). Apart from improving parenting skills, the program aims to increase parents’ sense of competence in their parenting abilities, reduce couples’ conflict over parenting, and reduce parenting stress.

The Triple P system is based on the principle of sufficiency. For parents concerned about their parenting skills or child's behaviour, there are differences in the severity of problems experienced, breadth of knowledge, motivation, access to support and additional family stresses (e.g. substance abuse, financial difficulties). The Triple P model assumes that any one family intervention program is unlikely to cater for the requirements of all parents, therefore differing levels of support are offered. Consequently, Triple P allows the strength of the intervention to be tailored to the assessed needs and preferences of individual families. It incorporates five levels of intervention on a tiered continuum of increasing strength (see Table 1) to maximise efficiency, contain costs, avoid over-serving and to ensure the program has wide reach in the community. The varied delivery modalities and multidisciplinary reach of the program promote better utilisation of the existing professional workforce in promoting competent parenting. The program aims to determine the minimally sufficient intervention a parent requires in order to deflect a child away from a trajectory towards more serious problems, while focusing on the self-regulation of parental skill to increase self-sufficiency and future problem solving.

**The Triple P approach to dissemination**

Following many successful efficacy and effectiveness trials, the challenge was to undertake and evaluate the dissemination of the Triple P system. We have taken an ecological approach to dissemination (see Table 2) that views the process of changing professionals’ consulting practices as a complex interaction between the quality of the intervention, the skills training and the practitioner's post-training environment. Dissemination does not commence until a program variant has undergone rigorous scientific evaluation with significant positive outcomes for parents and children. With empirical validation satisfied, two complementary perspectives underpin our dissemination efforts.

Firstly, our dissemination efforts are based on the same self-regulatory approach used in our parent education programs. The focus here is on promoting professional behaviour change through self-directed learning and personal responsibility for skill development (e.g.
Karoly, 1993). We propose that practitioners are more likely to implement a new program if they are given appropriate training and support to feel confident in their ability to implement the program, and are taught skills to monitor, set personal goals, self-evaluate and improve their consulting practices. Practitioners are encouraged to actively problem solve so they become more confident and trust their own judgement, and become less reliant on others in clinical decision-making. As with the parenting sessions, an active skills training process is incorporated into Triple P training for practitioners to enable skills to be modelled and practised.

Secondly, we take a systems-contextual approach that aims to support practitioners’ program use in their workplace. This approach views the attitudes, knowledge, and consulting practices of professionals as being embedded within the broader working environment (Biglan, Mrazek, & Carnine, 1999). Three specific processes are hypothesised to influence adoption: internal advocacy, administrative support, and supervisory structures. Professional change is thought more likely to occur when managers, administrators and professional colleagues support the adoption of the innovation (Backer et al., 1986), and when supervision, feedback and support is available (Henggeler et al., 1997). In organisations where innovation is supported by management, through the provision of resources and attention, greater success in implementing new projects is predicted (Ash, 1997).

Consequently, an effective dissemination process must not only adequately train practitioners in the content and processes of an intervention, but must also strategically form alliances with participating organisations to ensure that program adoption is supported by administrators and staff (Parcel, Perry, & Taylor, 1990; Webster-Stratton & Taylor, 1998). Central to this is the identification of at least one internal advocate from an organisation who can foster internal support for the program, and the development of strategies for informing administrators about the distinguishing features of the intervention, its potential benefits, and the procedures and cost of adoption. Triple P has introduced a training and accreditation program and a range of workplace support strategies in line with its ecological perspective.
<table>
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<tr>
<th>Level of intervention</th>
<th>Target population</th>
<th>Intervention methods</th>
<th>Possible target areas</th>
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<tr>
<td>1. Universal Triple P Media-based parenting information campaign</td>
<td>All parents interested in information about parenting and promoting their child's development.</td>
<td>A coordinated information campaign using print and electronic media and other health promotion strategies to promote awareness of parenting issues and normalize participation in parenting programs such as Triple P. May include some contact with professional staff (e.g. telephone information line).</td>
<td>General parenting issues Common every day behavioural and developmental issues</td>
</tr>
<tr>
<td>2. Selected Triple P Information and advice for a specific parenting concern</td>
<td>Parents with specific concerns about their child's behaviour or development.</td>
<td>Provision of specific advice on how to solve common child developmental issues and minor child behaviour problems. May involve face-to-face or telephone contact with a practitioner (about 20 minutes over two sessions) or (60–90 minute) seminars.</td>
<td>Common behaviour difficulties or developmental transitions, such as toilet training, bedtime problems</td>
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<tr>
<td>3. Primary Care Triple P Narrow focus parenting skills training</td>
<td>Parents with specific concerns about their child's behaviour or development who require consultations or active skills training.</td>
<td>A brief program (about 80 minutes over four sessions) combining advice with rehearsal and self-evaluation as required to teach parents to manage a discrete child problem behaviour. May involve face-to-face or telephone contact with a practitioner.</td>
<td>Discrete child behaviour problems, such as tantrums, whining, fighting with siblings</td>
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<td>4. Standard Triple P Group Triple P Self-Directed Triple P Broad focus parenting skills training</td>
<td>Parents wanting intensive training in positive parenting skills. Typically targets parents of children with more severe behaviour problems.</td>
<td>A broad focus program (up to 12 one hour sessions) for parents requiring intensive training in positive parenting skills and generalization enhancement strategies. Application of parenting skills to a broad range of target behaviours, settings and children. Program variants include individual, group or self-directed (with or without telephone assistance) options.</td>
<td>Multiple child behaviour problems Aggressive behaviour Oppositional Defiant Disorder Conduct Disorder Learning difficulties</td>
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<tr>
<td>5. Enhanced Triple P Behavioural family intervention</td>
<td>Parents of children with concurrent child behaviour problems and family dysfunction.</td>
<td>An intensive individually tailored program (up to 11 one hour sessions) for families with child behaviour problems and family dysfunction. Program modules include home visits to enhance parenting skills, mood management strategies and stress coping skills, and partner support skills.</td>
<td>Concurrent child behaviour problems and parent problems (e.g. relationship conflict, depression, stress)</td>
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The Triple P system of professional training

The effective dissemination of Triple P required a cost-effective method of training the professional workforce. Over a 3-year period (1996–1998), a standardised professional training program was developed for all levels of Triple P intervention. In designing the training program, the following principles were adhered to.

Table 2. An ecological model of dissemination

<table>
<thead>
<tr>
<th>Phases</th>
<th>Program development and evaluation</th>
<th>Social marketing and promotion</th>
<th>Training and accreditation</th>
<th>Workplace support</th>
<th>Quality maintenance</th>
</tr>
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<tbody>
<tr>
<td>Aim</td>
<td>To develop the program and determine its effectiveness.</td>
<td>To build awareness and advocacy for the program.</td>
<td>To develop a quality professional training program.</td>
<td>To create a supportive environment for practitioners.</td>
<td>To design a system of quality maintenance.</td>
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<tr>
<td>Key activities</td>
<td>Randomized controlled efficacy and effectiveness trials with defined clinical or at-risk populations.</td>
<td>Scientific publication and presentation at international conferences.</td>
<td>Development of curriculum objectives for each level of training.</td>
<td>Orientation and training of key administrative and management staff.</td>
<td>Focus on self-regulation and protocol adherence.</td>
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<td></td>
<td>Development of user-friendly practitioner manuals and parent resources.</td>
<td>Preparation of an annual report to communicate to policy advisors, funding bodies and others in the scientific community about research activities.</td>
<td>Design of training materials (handouts, video demonstrations, activities).</td>
<td>Support for practitioners to establish peer supervision.</td>
<td>Regular newsletters, conferences and update sessions for practitioners.</td>
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<td></td>
<td>Scientific investigation into the training and dissemination process.</td>
<td>Consultation with agency management about the compatibility and fit of the program to the organization's needs and client groups.</td>
<td>Development of competency-based accreditation requirements.</td>
<td>Adequate resourcing of practitioners.</td>
<td>Regular meetings of an International Scientific Advisory Committee.</td>
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<td></td>
<td>Continued research and development once the program has been disseminated.</td>
<td>Marketing of the training program using web and targeted mailing (e.g., <a href="http://www.triplep.net">http://www.triplep.net</a>).</td>
<td>Ongoing evaluative back-up.</td>
<td>Support to establish efficient distribution of resources.</td>
<td>Ongoing research and development.</td>
</tr>
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Note: The table above illustrates the various phases and their corresponding aims, key activities, and specific strategies for program development, social marketing, training, and workplace support, along with quality maintenance measures.
Active skills-based training. A skills training approach was adopted, involving a combination of didactic input, video and live demonstration of core consultation skills, small group exercises to practise skills, problem solving exercises, recommended reading, and competency-based assessment.

Brevity and cost-effectiveness. Triple P training was designed to be relatively brief to minimise disruption to work schedules and reduce the need for relief workers. The training experience was structured to include attendance at a 2–5 day training workshop (based on the level of intervention), and attendance at a 1-day accreditation workshop 8–12 weeks after initial training.

Data responsiveness. Every training course is carefully evaluated and feedback elicited on the content, quality of presentation, opportunities for active participation and practitioners’ overall consumer satisfaction. Practitioner feedback is incorporated into revisions of the training courses.

Viability of the training program. As we have had no specific grants to disseminate Triple P, a training cost structure was required that was affordable for agencies and individuals, and that was financially viable. Training was originally conducted by staff from the Parenting and Family Support Centre at the University of Queensland. However, as demand increased, a new entity, Triple P International, was established and was licensed by the University of Queensland to disseminate Triple P. Hence, the research and development functions were consolidated within the university and the publishing and training functions were outsourced.

Eligibility to participate. The Triple P system of intervention involves a wide range of professions in the health, education and welfare sectors. The only prerequisite is professional training in psychology, medicine, nursing, social work, counselling, education or related fields providing exposure to principles of child development. Most training courses involve an interdisciplinary mix and bring together professionals with diverse backgrounds, theoretical orientations, and clinical experience.

Course requirements. Triple P training and accreditation involve completion of set readings, attendance at a training course, and completion of accreditation requirements that include: a short quiz assessing knowledge of theory, program content and process issues; and live or videotaped demonstration of core competencies specific to the level of training undertaken. Only practitioners completing accreditation requirements are considered properly trained to deliver the interventions.

Selection, training and accreditation of trainers. Professional training is typically conducted by clinical or educational psychologists with training and experience in the field of behavioural family intervention. After initial induction, trainers are provisionally accredited and can begin conducting training courses under supervision. To be considered fully trained, trainers also have to complete a skills-based accreditation process. Trainers may be accredited in all of the intervention levels or a subset of the available Triple P courses.

Maintaining the quality of training. To maintain intervention integrity, it is essential that the training process is carefully controlled to minimise program drift at source. Hence, all trainers use standardised materials (including participant notes, training exercises, and training videotapes demonstrating core skills), join a trainer network, and adhere to a quality assurance process.
The Triple P approach to workplace support

Our ecological approach has focused on the goals of internal advocacy, supervision and administrative support. It has been further informed by a survey of over 1000 professionals following training in Primary Care Triple P (Turner, 2003), which identified a number of barriers for primary care staff in delivering the program following training. Many of the common barriers were related to the post-training work environment, such as integration of the program with their usual caseload or responsibilities, access to supervision, and ability to schedule after-hours appointments. To circumvent such issues, and maximise agency support for the introduction of Triple P, the following strategies have been employed. These strategies have been developed through the state-wide dissemination of Triple P within the Queensland Health Department (Markie-Dadds, Brechman-Toussaint, & Sanders, 2000).

Information and administrative support. The Triple P team endeavours to provide information and support specific to the needs of each agency adopting the program. This support may include an orientation for administrators, supervisors or managers about the program being introduced (e.g. its evidence base, format and target populations), the training and accreditation procedures, and the expectations of the agency and staff members to be involved in implementing the program (e.g. flexible work hours to allow for late appointments and evening groups). Other strategies include development of procedural guidelines and performance targets, regular updates and reviews of performance targets, and assisting sites to identify and overcome any barriers to implementation. We also aim to support staff by ensuring access to adequate training, supervision and resources, providing strategies and materials for program promotion (e.g. brochures, posters and press releases), and providing regular updates on Triple P research via newsletters, conferences and web sites (e.g. http://www.triplep.net). As advocates for agencies, we have provided briefings to policy advisers and ministers, and regular updates to key stakeholders.

Promotion of supervision networks. We encourage establishment of peer support networks and adopt a self-regulatory approach to supervision. The self-regulatory perspective to dissemination involves training practitioners to use self-directed learning strategies such as self-monitoring and self-evaluation, personal goal setting and self-reward for goal attainment (Halford & Sanders, 1994). These self-regulatory skills enable practitioners to direct their own learning, skill acquisition and problem solving subsequent to training. Strategies employed to support the establishment of supervision networks include provision of supervision guidelines, identification of a coordinator, and support to overcome administrative obstacles and process issues.

Consultation backup. The Triple P team has encouraged practitioners to access ongoing consultative advice post-training. Triple P staff have also had ongoing e-mail contact, held teleconferences, attended staff meetings and arranged update days to address administrative issues (e.g. data management, performance indicators), logistical issues (e.g. avoidance of accreditation workshops due to anxiety, referral strategies) and clinical issues (e.g. dealing with specific populations, clinical process problems) identified by practitioners. Agency staff are actively engaged in ‘troubleshooting’.

Strategies for defusing misinformation and resistance. Our efforts to inform staff and management of the program, respond to their concerns, and engage them in the process of dissemination have helped to defuse potential organisational resistance. We have also
developed strategies to address misinformation or myths about Triple P that have come to our attention. Often these myths (e.g. ‘It only works with middle class families’, ‘It's inflexible’, ‘It's too behavioural’) are based on hearsay rather than experience or evidence, or are contrary to evidence. Despite trialling Triple P with large samples of high-risk, multiproblem families, myths perpetuate regarding its ability to benefit families with low income, low literacy or low education levels. The approach we take, and encourage others to take, is to be open, non-defensive and present factual information (e.g. data illustrating that family income does not predict intervention outcomes). When individuals other than the program developers defend the program with strong arguments or data, critics may be disarmed.

The Triple P approach to quality maintenance

Quality of implementation. In any dissemination effort, maintenance of program integrity is crucial to minimise drift from validated methodology. We have endeavoured to develop high quality training materials, practitioner manuals (e.g. Sanders, Markie-Dadds & Turner, 2001) and parent resources (e.g. Sanders, Markie-Dadds, & Turner, 1996b) to ensure that the program is standardised, easy to follow, accessible, and culturally sensitive. Strategies to further support program integrity include the provision of protocol adherence checklists detailing session content.

Researcher-practitioner collaboration. A Triple P International Scientific Advisory Committee has been established that provides a context for identifying research questions, curriculum development targets and new project ideas to be pursued. Direct contact with program developers has also been made possible through a Triple P Practitioner Network for trained and accredited providers. Members of this network have access to a web site that provides downloadable clinical tools and promotional materials, program updates, a clinical database, and a frequently asked questions forum.

Ongoing refinement of intervention programs. As the Triple P system is strongly aligned with a scientist-practitioner perspective, once an intervention has been disseminated, practitioners provide a rich source of feedback used to refine the intervention and revise resources. Any intervention level may be revised in the light of new data, theory or feedback from program users and consumers. This feedback is incorporated into revised editions (e.g. altering session format) and program extensions (e.g. from childhood to adolescent issues), culturally based adaptations (e.g. for Australian Indigenous families) and derivative programs (e.g. for parents of children with disabilities). Each variant then undergoes further stringent evaluation prior to dissemination.

The reach of Triple P dissemination

Since July 1996, Triple P has been widely disseminated to health, education and welfare professionals. At the time of writing, over 16,000 professionals in 14 different countries (Australia, New Zealand, England, Scotland, Germany, Switzerland, Netherlands, Hong Kong, Singapore, Japan, the United States, Canada, Iran and Turkey) have received Triple P training. The program is currently being delivered through a number of services and agencies including general medical practices, child health services, mental health services, preschools, schools, places of work, through telephone counselling services, and in several non-government organisations.
As an example of dissemination activity, Triple P has become a core evidence-based parenting and family support initiative funded by the Queensland State Government in Australia. All five levels of the program have been implemented through Community Child Health Services within Queensland Health in 100 Child Health Clinics as a free to the public service. In any given year, an estimated 5000 parents participate in Triple P groups and 50,000 individual consultations are conducted. A population survey of 4010 families with a child 12 years or under conducted in 1999 showed that 43% of parents were aware of the program and 15% reported some level of participation (Sanders et al., 2001). Parents reported hearing of the program most commonly through school or preschool newsletters, word of mouth, and television coverage. As another example, since its introduction through the Ministry of Community Development and Sports in Singapore, Triple P has been announced the compulsory parenting program mandated by court in all child protection cases in Singapore.

In a relatively short space of time, the program has developed from largely a clinical research activity based in a university research centre to a government-funded service widely available in the community – in many different countries. This process has resulted in thousands of families having access to evidence-based parenting interventions.

Recommendations for agencies adopting evidence-based programs

Increasingly, programs promote themselves as having an evidence base that attests to their efficacy and effectiveness. This is generally a positive outcome; however, the decision to adopt an empirically-supported intervention is a complex process and represents a major commitment for agencies. Adequate consideration must be given to the implications for an agency or service in embracing such programs. Our experience in disseminating Triple P to organisations and agencies in several different countries has reminded us of the need to view adoption of innovation in an ecological framework that views practitioner uptake and implementation as an organisational change process that includes proper preparation of staff and undertaking a variety of organisational tasks. The following have been key organisational tasks related to program adoption, implementation and maintenance.

Program selection

In many instances, the decision to adopt a program is fairly straightforward when there is a single program developed specifically to cater for the clinical needs of a defined client population. In that instance, an agency can try to gauge whether the validation sample used to establish the efficacy of the program is similar enough to the current population of the service to be seen as relevant. However, for a program such as Triple P that includes several different variants, delivery modalities, and has been trialled with a range of conditions or problems, the task is more complex. An agency needs to be clear about what an intervention does and does not offer. There needs to be clarification of the client population for whom the intervention is relevant, as well the costs of training of staff and any recurrent costs associated with program implementation. These costs need to be weighed up against potential benefits and relative advantage of a particular program in comparison to others.

Sometimes web sites are available that list relevant publications documenting the evidence supporting an intervention. The ease of accessing these reports may be an index of how much value program developers place in their program's evidence base. If preliminary investigation indicates that a program looks promising, identifying specific colleagues from within an
organisation to discuss issues with and gain support becomes important. Internal advocacy often requires more than one champion of the merits of the program. Agencies require specific information about what is involved in the training (how long, who should be present, facilities and equipment required) and what resources and clinical tools are needed by providers to deliver the intervention.

Program establishment

Program developers typically are convincing advocates for a program. They generally have a lot of working knowledge about the intervention and can answer practical questions about its application. An invitation for program developers to brief administrators about the program can be helpful in persuading a bureaucracy to support an initiative. Careful consideration should be given to identifying the levels of training and modes of program delivery that would best suit the agency's client population or strategic priorities. For example, some agencies may be in a position to run parenting groups and are therefore likely to need staff training that focuses on group intervention, whereas others deal primarily with individual parents and are more likely to need training in an individually administered program.

Some agencies that seek to have their staff trained simply do not have the capacity to implement the program effectively, without other significant organisational changes. We have encountered agencies that have sought Triple P training for staff to overcome major organisational problems including inadequate funding, poor facilities and equipment, and internal dissent reflected in high staff turnover, poor leadership, lack of clear mission statements or a consistent theoretical framework. In such circumstances, the identification of organisational obstacles may preclude proceeding with training.

On the other hand, we have encountered a number of situations where the provision of staff training was an essential part of enabling an organisation to improve the level of skill of the workforce within an organisational change strategy. Managers should consider contacting other similar agencies or services already using the program that are prepared to attest to the program's relevance, effectiveness and applicability. Government agencies in different states often compare notes about how the program has been received by staff and parents.

The mobilisation of support for the initiative may involve seeking additional funding support to cover extra costs for training or program implementation, including back-filling positions to enable staff to participate in training. A variety of funding sources can be explored to identify potential sources of funds.

The introduction of evidence-based programs can initially create a certain amount of resistance within the organisation. Old ways of service delivery, even when they are not demonstrably effective, can be safe and low risk. In our experience, managers who view the adoption process as a collaborative endeavour experience the least resistance. This can involve negotiating with staff the goals, program options, and tailoring and customisation of the program to the needs of the client population. The management of resistance is best handled by being open and non-defensive. Acknowledging legitimate concerns of staff, and clarifying how these concerns can be addressed, conveys a preparedness to consult and seek staff opinions in determining how best to use the approach.

The adoption of a program such as Triple P means building in mechanisms to evaluate outcomes being achieved with families from the outset. While this process of routine
evaluation can initially be threatening to staff, it is often embraced once in place as it provides staff with feedback about the success of their interventions with families. In addition, it provides a valuable source of information relating to the use of the interventions with specific client populations.

**Program maintenance**

Once staff members have been trained and have begun implementing the program, staff require a support structure to encourage program fidelity and the continued use of the program. Peer supervision support networks can be helpful to maintain program integrity and prevent program drift over time. The Triple P Practitioner Network, for example, was developed to facilitate open communication between program developers, researchers and service providers, and provide a vehicle for sharing clinical resources and program updates. The proper documentation of decision making processes through keeping regular minutes and records of meetings and agreed upon actions and decisions is also helpful.

The establishment of a peer supervision network within an organisation is an extremely useful way of increasing practitioner confidence and self-efficacy in using a program. The supervision process can be designed to promote practitioner self-regulation. A useful format involves 5–6 staff, with a rotating peer facilitator and a nominated practitioner to be responsible for presenting a case in each session. We encourage staff to bring along either a videotape or audiotape of a parent consultation session. A review process involves the practitioner stopping the tape periodically to self-evaluate their performance and then to receive peer comments and suggestions. The practitioner is responsible for determining how to use the feedback provided in establishing personal goals for change.

We have also found that it is important to honour and celebrate the success of staff implementing the program. This can involve celebrating important milestones in the role out of the program (e.g. ceremony to acknowledge the first 100 parents who have completed, anniversary celebrations marking program commencement, and provision of public feedback to congratulate staff on achievements).

**Influencing ongoing program development**

Agencies should be proactive in seeking to influence the future development of a program in which they have invested. Informing program developers of implementation difficulties and successes or new materials that are needed to meet the needs of specific client groups can produce a useful dialogue between researchers, program developers and practitioners. Agencies can also advocate for the importance of researchers undertaking research based on practice or field-generated issues. There are many research questions that relate to the practical and logistic use of a program that can be explored through collaborations with research groups (e.g. research examining predictors of or solutions to problems such as engagement of families, dropout, supervision, or tailoring to difficult families).

**Conclusions**

The Triple P model of family intervention was developed as a broad community-level prevention initiative that would provide a generic strategy to enhance the competence and confidence of parents and thereby reduce the risk of children developing serious behavioural and emotional problems, and reduce the risk of child maltreatment. Following the
development and extensive evaluation of our system of family intervention, orchestrating its dissemination into regular clinical services, ensuring its continued implementation, and conducting ongoing evaluation and refinement of Triple P have challenged us as clinical researchers to move well beyond the traditional concerns of teams conducting clinical trials. We have needed to examine and develop strategies to address the broader ecological and organisational context within which clinical services are delivered. For further discussion of the nature of the ecological issues we have faced (e.g. changes of government, mobility of staff, cost and sustainability) and solutions we have found helpful, see Sanders et al. (2002).

Our experience with Triple P has convinced us that a carefully planned strategy can lead to the successful dissemination of evidence-based programs. Furthermore, we have found that in its disseminated form, when delivered through regular clinical services, Triple P interventions have remained effective, producing good parent and child outcomes (e.g. Leung et al., 2003; Turner & Sanders, in press; Zubrick et al., in press). Population level strategies have great potential to shift the prevalence of parenting difficulties associated with social problems such as child maltreatment, youth violence, juvenile crime, and drug abuse. However, to achieve such an outcome, programs need to evolve over time, remain data responsive and establish a working dialogue with users of the system.

References


