# Supporting Indigenous Health Professionals:

# Key issues and supports for the adoption of evidence–based behavioural family intervention in Indigenous communities

Prepared by

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*Facilitators:*

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| Dr Karen Turner | Parenting and Family Support Centre, The University of Queensland |
| Anna Clarkson | Triple P International |

*Project team:*

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| Mary Richards | Calvary Health Care and Royal Hobart Hospital, Tasmania |
| Professor Matt Sanders | Parenting and Family Support Centre, The University of Queensland |
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*Think tank participants:*

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| Jan Doherty | Inala Child Health, Southern Area Health Service, Qld Health |
| Sonetta Fewquandie | Aboriginal & Torres Strait Islander Community Health Service Mackay Ltd |
| Machelle Flowers-Smith | Triple P International |
| Wendy Harald | Central Area Health Service, Qld Health |
| Janell Harris | Southern Area Health Service Clinical Support Team, Qld Health |
| Joanne Mizen | Child and Adolescent Community Health, Western Australia |
| Dr Alina Morawska | Parenting and Family Support Centre, The University of Queensland |
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| Robyn Slee | Child and Adolescent Community Health, Western Australia |
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## Executive Summary

Diffusion of clinical innovations must be seen as a multi-phase process, with potential barriers to success at each phase (Turner & Sanders, 2007). In our own experience, with a program that was initially sought by Indigenous workers, developed through years of community consultation relating to program resource development, with proven outcomes evidenced through stringent research methodology, successful training processes and consumer satisfaction with training, program implementation and maintenance are not guaranteed.

This ARACY ARC/NHMRC Research Network Encouragement Grant facilitated consultation with Indigenous professionals and government representatives who have been involved in the implementation of the Triple P – Positive Parenting Program with Indigenous communities. Based on this consultation process this consensus statement was developed detailing training and post-training issues for Indigenous health professionals. It has also informed the development of a framework for culturally sensitive training and post-training support components and processes.

The consultation revealed a general consensus from practitioners that:

- Triple P is appropriate for use with Indigenous families, is received well by families and has shown positive outcomes (although resources have varying levels of acceptability in different communities requiring flexibility in approaches to delivering program content).
- Training leads to improved confidence in parent consultation skills, but more support through the training process and following training is desirable.

Key recommendations were as follows:

- Consider practitioners' expertise, ability and commitment to running groups prior to the allocation of training places. Some preparatory training may be advised such as group facilitation skills training and cultural awareness training.
- Promote organisational involvement in making the commitment to program implementation beyond staff release time for training, including sensitivity to existing workload, administrative support, and supervision opportunities.
- Recruit and train up an Indigenous trainer. In the interim, enlist the active involvement of Indigenous co-trainers, and invite selected community members to be involved in training or parent group sessions.
- Adopt a staged approach to training involving an orientation day (Selected Triple P training) for practitioners and community members; Indigenous Triple P training (Primary Care or Group Triple P); accreditation; and update days / refresher courses.
- Focus on increasing accreditation attendance through organisational support, decreasing anxiety and promoting practitioner preparation.
- Promote supervision opportunities through guidelines and modelling of best practice, cross-departmental collaboration, cross-district support, and other avenues such as telephone and online contact.
- Support peer networking through distribution of a contact list of Indigenous Triple P practitioners to facilitate communication and networking.

This project has provided a foundation for future research into the determinants of program adoption and optimal training processes addressing the provision of relevant and culturally appropriate training and post-training support for Indigenous Health Workers to effectively deliver to Aboriginal and Torres Strait Islander families an evidence-based parenting program that has been proven to reduce the prevalence of risk factors known to contribute to poor child outcomes.

## Introduction

### Background

Indigenous children and youth are extremely disadvantaged on most indices of health and wellbeing: they have higher rates of health risk behaviours, early school drop out, suicide, juvenile offending, family fragmentation, abuse and neglect (Australian Bureau of Statistics and the Australian Institute of Health and Welfare, 2003; Human Rights and Equal Opportunities Commission, 1997; National Public Health Partnership, 2004). Approximately 24% of Indigenous children are reported by their carers to be at high risk of clinically significant emotional or behavioural difficulties, in comparison to 15% of non-Indigenous children (Zubrick et al., 2004). For children living in families with poor quality parenting (25%), risk for clinically significant emotional or behavioural problems is four times greater than in families with good quality parenting (Zubrick et al., 2004).

Of the many risk factors for poor outcomes for children, family interaction and parenting practices are potentially modifiable. Substantial evidence shows that behavioural family intervention programs based on social learning models are the most extensively evaluated form of psychosocial intervention for children, and are effective in reducing family risk factors associated with child behaviour problems. However, little research has been conducted on the effects of parenting programs with Indigenous communities. Mainstream parenting programs have difficulty in recruiting and maintaining the involvement of Indigenous parents and carers, suggesting the need for more culturally appropriate programs tailored to the needs of Indigenous families.

Our team has developed and evaluated a culturally tailored approach to the Group Triple P — Positive Parenting Program for Aboriginal and Torres Strait Islander families. Group Triple P is an early intervention program that aims to promote positive, caring family relationships and to help parents develop effective strategies for dealing with common behaviour problems and developmental issues. It is an 8-session program, conducted in groups of up to12 parents. It uses active skills training to help parents acquire new knowledge and skills.

Broad community consultation occurred in the development of a culturally sensitive adaptation of the mainstream program that takes into consideration the cultural values, traditions and needs of the Indigenous people of Australia. Changes were made to the language and images used in program resources, and the examples used to depict parenting strategies (e.g., a culturally tailored video, workbook and visual aids were developed). The structure of group sessions was altered to allow more time to discuss the social and political context for parenting, develop trust, slow the pace of presentation, and share personal stories.

### Efficacy of the Intervention

Two trials have been conducted to date, with funding from Queensland Health and the National Health and Medical Research Council respectively.

The first, a randomised controlled efficacy trial (Turner, Sanders & Richards, 2007), examined the impact and cultural appropriateness of the tailored group program implemented by an Indigenous Project Officer with a local Indigenous Health Worker and Child Health Nurse in urban settings. In comparison to waitlisted parents, those who attended the program reported significant decreases in problem child behaviour (with a mean shift out of the clinical range). Parents receiving the intervention also reported significantly lower reliance on dysfunctional parenting practices, particularly, use of long reprimands and talking rather than taking action, and lax or permissive discipline. There were high rates of consumer satisfaction, and positive comments about the program's cultural acceptability. There was also a reduction in obstacles to accessing mainstream services for individual assistance, such as personal coping skills and mood management. These results provide some of the first outcomes from an RCT of a family intervention for Australian

Indigenous families, providing support for the effectiveness and acceptability of a culturally tailored approach to Group Triple P.

These outcomes are a step towards increasing appropriate service provision for Indigenous families and reducing barriers to accessing available services. However, the rate of program completion (60.9%) and low number of waitlist families (28%) who subsequently attended groups point to the importance of engaging families when they first make contact, helping families deal with competing demands, and offering flexible service delivery so families can resume contact when circumstances permit.

The second trial (Turner & Sanders, in prep), aimed to evaluate the effectiveness and acceptability of the tailored program delivered by Child Health and Indigenous Health Workers in 12 diverse urban, rural and remote sites across Australia. The study also provided a mechanism for feedback from practitioners in relation to supports and barriers to program implementation in their communities. As hypothesized, outcomes were similar to those found in the efficacy trial: significant decreases in problem child behaviour and dysfunctional parenting practices (particularly authoritarian discipline, displays of anger and irritability), and high rates of consumer satisfaction. In addition, there were significant decreases in parental depression and stress, and a significant increase in parenting confidence.

Practitioners reported finding the program useful and appropriate, but many interested sites faced obstacles to program implementation, such as community perception of the priority of parenting support, lack of availablility of trained professionals and lack of opportunities for supervision and skill rehearsal, difficulties in rearranging workload to allow for group sessions, engagement issues, and perceived reluctance for completion of questionnaires and data collection (Turner & Sanders, 2007). For example, some practitioners prompted families to complete only some of the assessment measures, or failed to complete post-intervention assessments.

A consideration arising from this study is the need for specialised training and support for Indigenous Health Workers to best equip them with the skills and support needed for optimal delivery of evidence-based parent skills training programs for Indigenous families. This research series has led to the current focus on identifying barriers to program dissemination and tailoring training and post-training support.

**Training Methods and Outcomes**

An active skills training process is incorporated into Triple P practitioner training to enable skills to be modelled and practised. In contrast to expectations that this process may not be acceptable to Indigenous workers, training participants have typically embraced such practice tasks and report the value of this process in their skill development. Based on self-regulation theory (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. Through training and accreditation, practitioners are encouraged to actively problem solve so they become more confident and trust their own judgment, and become less reliant on others in clinical decision-making. A summary of outcomes from Triple P training of almost 2000 practitioners in Australia since 2002 follows.

In comparing practitioners working with Indigenous families (8.1%) and non-Indigenous practitioners, some significant differences were found: number of years experience in parent consultation (*M* = 5.3 and 7.2 respectively); number of hours per week in parent consultations (*M* = 5.2 and 9.3 respectively; greater proportion of Diploma level training (70.9% vs 9.6%) rather than Bachelor level and above 29.1% vs 90.5%); and a greater number of allied health and support worker roles (69% vs 13.7%) rather than other professional positions such as psychologist, teacher or counsellor. While there were significant increases following training in practitioners' ratings of confidence in

conducting parent consultations and feeling adequately trained, these ratings, consumer satisfaction and accreditation rates were consistently lower than for non-Indigenous practitioners.

While the majority of these practitioners attended mainstream training, some attended 'Indigenous-focus' training which used the resources tailored for Indigenous parents (i.e. DVD and workbook), however there was little other cultural tailoring. Since 2006, a more culturally sensitive training program has been developed with: clear (non-academic language) used by the presenter; a slower pace and more time for discussion, repetition of DVD scenarios and consolidation of key concepts; discussion about program implementation and tailoring for local community; additional support at accreditation; and use of Indigenous co-facilitators where possible. This tailored approach to training warrants further examination, community consultation and refinement.

## Project Outline

An ARACY ARC/NHMRC Research Network Encouragement Grant provided support for consultation relating to professional training in the program and issues impacting on program implementation in the community.

The primary objective of this project was to develop a collaborative process to identify specific issues experienced by Indigenous Health Workers in the delivery of the Triple P — Positive Parenting Program to Indigenous families; in particular, supports and barriers to program introduction, implementation and maintenance in the community. The key areas to be explored were: consideration of staff selection for training, culturally-sensitive training and adult learning processes, proficiency-based accreditation, community and workplace partnerships, and post-training clinical support for practitioners to offer parenting programs in their community.

The process involved consultation with Indigenous professionals and policy makers. Two methods were employed: an follow-up survey for practitioners who had completed Triple P training and identified themselves as having Aboriginal or Torres Strait Islander heritage, or who were working in Indigenous communities; and a 1-day think tank held in Brisbane. This think tank brought together psychology, nursing and community health professionals and Health Department representatives from Queensland, Western Australia, Tasmania and the Northern Territory, who have been involved in the implementation of Triple P. All contactable practitioners were invited to the think tank, however, attendance was primarily ascertained by practitioners' worksites, such as Queensland Health nominating attendance by practiioners from each Regional Health Service across the state.

## Results

### Follow-up Survey

A follow-up survey for practitioners using Triple P with Indigenous families was developed by the collaboration team at the Parenting and Family Support Centre and Triple P International. The survey was designed to examine program use, practitioner confidence, and aids and obstacles to implementation of the program as part of usual service delivery. Survey design was informed by a similar project involving focus group testing of Indigenous Health Workers' reactions to training in Primary Care Triple P (Slee, 2007). The survey was distributed via mailed and email. A copy is included in the Appendix.

There were 140 practitioners identified through the Triple P International training database for Queensland, New South Wales, South Australia and the Northern Territory (NB. training is conducted under license in Western Australia and Victoria therefore these data were unavailable). Of these, contact details were current for only 83 practitioners. The return rate was low: 13 surveys were returned (15.66%). Although it is not possible to assume the representativeness of this sample, results are included below as these informed the focus of some of the discussion in the 1-day think tank.

Table 1. Quantitative Results from Triple P for Indigenous Families Follow-up Survey

| Question | Response |
|---|---|
| Have used Triple P in your work with Indigenous families? | 69.23% |
| Have used any of the Triple P resources with Indigenous families? | 61.54% |
| Overall, how would you rate your confidence in using Triple P with Indigenous families? | *M* = 4.69* |
| Do you have a supervisor/mentor? | 46.15% |
| Are there any other people you have used to help support you in using Triple P? | 53.85% |
| Overall, do you think that Triple P is appropriate for use with Indigenous families? | 76.92% |
| Do you think you will use Triple P with Indigenous families in the future? | 92.31% |
| Did training adequately prepared you for using Triple P with Indigenous families? | *M* = 4.23† |
| Do you think the training was appropriate for Indigenous workers (culturally sensitive)? | 61.54% |
| Would you recommend Triple P training to your Indigenous colleagues? | 84.61% |

*Rating scale ranges from 1 (not at all confident) to 7 (very confident).
†Rating scale ranges from 1 (no definitely not) to 7 (yes definitely).

It is worth noting that about half of these practitioners attended mainstream training and half had attended training with an Indigenous focus (i.e. using Indigenous DVD and workbook). No culturally tailored training had been conducted at this time. Some had not yet completed accreditation and others expressed a desire for more training before they would feel comfortable in using the program.

Qualitative results from open-ended questions are summarised below. Practitioners had used a mixture of Primary Care and Group Triple P, that is, individual consultations (one-off, repeat, informal) and group sessions. Resources used included the DVD, tip sheets, group workbook and PowerPoint presentation.

Examples of practitioners' reports of Indigenous families' reactions to program included:

- The response is great
- It is easy to understand
- Parents enjoy the program and getting ideas from other parents
- Mostly well-received when tailored to suit families' needs
- Positive strategies such as praise, talking and rewards seem more popular
- Parents are generally receptive, some have tried some strategies and felt they didn't work
- The strategies work for families
- Families understand but need more follow-up to reinforce their learning
- Homework exercises can create extra burden if families have literacy issues or drug and alcohol problems
- Even men mandated to attend found it a big help

Suggestions for tailoring of the program included:

- Working in the home with the whole family so that carers are given the same strategies
- Responding to incidental questions with Triple P information (e.g. to a group of women sitting on a hospital lawn)
- Having groups in venues that are close to families and staff are familiar
- Using tip sheets in other programs such as Baby Club and Growing Strong Babies
- Would be good to have Indigenous tip sheets or something to take tor other family members
- Being flexible in sessions and giving less information at one time

The major obstacles to implementation were:

- Other colleagues don't understand the program

- Limited access to resources
- Limited funding for venues
- Didn't understand the mainstream training
- No support to deliver the program
- There are some barriers to 'Triple P' – families don't continue and say it doesn't work
- Hard for Indigenous people to understand
- There can be information overload without mentoring before and after training to increase confidence and understanding

Suggestions for training included:

- Train people who are good role models and have personal experience to draw on
- Non-Indigenous staff who work with Indigenous families should do cultural awareness training
- Refresher courses to provide clinical support and problem solving, maybe once a year
- Would be good to have more time to try out with families when doing training
- Work through the program with someone else running it – see it in action
- More Indigenous trainers
- Limit book time
- Help practitioners to manipulate the information to be more presentable and meaningful for their communities
- Need regular support
- Would like mentoring and supervision specific to Triple P – in person, phone or email
- Enlisting support from work colleagues
- Networking: a list of contacts for support; an online discussion forum
- Advertising training dates with Indigenous organisations

**Think Tank**

The think tank was held in Brisbane and was attended by 22 practitioners and policy officers from Queensland, Western Australia, Tasmania and the Northern Territory (see p. 3). The agenda included an introductory session with a Welcome to Country, discussion of the aims of the think tank, and sharing of practitioners' roles and experiences in using Triple P in their communities. Subsequent sessions covered the history of the development of Triple P for Indigenous Families, the evolution of the training program and advances to date in cultural tailoring. Core issues for discussion were: supports and obstacles to using Triple P, use and reactions to resources, selection for training and pre-training preparation, how well training prepared staff for using Triple P, discussion of training processes, suggestions for improving training, availability of supervisors and other support, suggestions for support before and after training, general comments, feedback, and future directions.

In terms of program use and acceptability, the experiences shared amongst participants mirrored those elicited through the follow-up survey. In brief, supports to program implementation related primarily to building on existing relationships with community members (e.g. inviting attendance, fitting Triple P content in with other programs such baby club, sobriety house); promoting the program positively as skill development; and having good supervision for clinical issues and colleague support. Obstacles related to lack of resources such as funding for venues, child care, transport and catering; isolation; lack of mentoring; lack of support in the workplace (e.g. colleagues not understanding the program, unrealistic time allocation for groups).

Detailed below are general recommendations from the think tank attendees relating to enhancing professional training and support.

Selection for training and pre-training preparation:

- Consider the practitioner's level of expertise and ability to run groups (e.g. select practitioners with mental health training or good clinical support), however, workers in isolated areas do

not want to be excluded.
- Consider the practitioner's commitment to working in a parenting support role and specifically to run Triple P groups (e.g. co-facilitate prior to accreditation and commit to running two groups per year).
- Some practitioners may benefit from group facilitation skills training prior to training in program content, which may help address anxiety and lack of confidence – the alternative would be to ensure adequate opportunities for practice.
- Non-Indigenous practitioners should do cultural awareness training, develop trust, and try to link with an Indigenous co-worker or community member for group sessions.

Organisational involvement:
- When training is booked, line managers need to be aware of the commitment to program implementation as well as training time – including awareness of existing workload demands – as well as the administrative support required (e.g. booking venues, collating outcome measures). As benchmarks and guidelines currently available may not be accessed or distributed by coordinators, it may be helpful to hold briefings for line managers and district managers.
- Organisations should work towards developing supervision opportunities and peer support networks (while this is promoted in training to individual practitioners, organisational level involvement is desirable).

Trainers:
- The ideal is to identify and train up an Indigenous trainer/s with appropriate professional qualifications (i.e. clinical psychology or social work).
- A second option is to have an Indigenous co-trainer, although this must be an active role not a token role.
- A third option is to invite selected community members to attend training or at least to attend parent group sessions and share knowledge incidentally in the community – with awareness of potential issues relating to literacy, educational background, and English as a second language.
- Indigenous trainers would also be good resource for supervision, content and process questions, peer support.

Training processes:
- Repeated exposure to the program content was seen as desirable, both within a training course (e.g. multiple examples, repetition of DVD demonstrations of parenting strategies) and over time.
- The proposed model is a staged approach to training:
  1) An orientation day prior to Indigenous Triple P training. This 1-day Selected Triple P training course introduces Triple P strategies and provides skills to engage families, provide brief support and refer families to appropriate services as needed. This day may provide an opportunity to select practitioners who would be suitable for later group training. As community engagement is vital, orientation days held in communities will also provide an opportunity to involve Elders and community members to become involved, which may improve engagement, support and referrals.
  2) Indigenous training in Primary Care or Group Triple P. If both levels are covered, Primary Care and Group Triple P training can be split into separate training blocks with repetition of key learning points.
  3) Accreditation (detailed below).
  4) Update days / refresher courses.
- To make the training content more user-friendly, suggestions included reducing sections presenting research data and statistics, and keeping training sessions interactive.

- While there has been some feedback that smaller groups are preferable, the general feeling was that the size of the group would not matter in groups that were entirely made up of Indigenous practitioners.

Accreditation:

- There must be an ongoing focus on increasing accreditation attendance (e.g. line managers to ensure accreditation happens, opportunities for practitioners to practice competencies, reminders to attend, help to prepare).
- The power of advocacy was noted, using word of mouth to stress that it is a learning process, explain the process and its benefits.
- There was agreement that smaller groups are preferable for accreditation days. This is a process that can make practitioners feel vulnerable as their skills are on show (for some it is the first experience of clinical supervision and personal feedback) but is also an opportunity to watch colleagues and learn from them, and generates a sense of achievement and confidence.

Post-training support:

- There was consensus that supervision and peer support are vital in improving practitioner confidence, skill development, maintaining motivation and facilitating clinical problem solving. Where possible, local coordinators should act as mentors. For practitioners in remote areas, opportunities for supervision were discussed, including cross-departmental collaboration, cross-district support, and other avenues such as telephone and online contact. This is particularly important for practitioners who are new to behavioural family intervention or need support in modifying delivery of the program to suit their community while maintaining program integrity.
- Recognition of the importance of networking for peer support led to the suggestion of a contact list of Indigenous Triple P practitioners to be included in training participant notes, or at least denoting on the existing Triple P Practitioner Network webpage whether practitioners have completed Indigenous Triple P training.
- Newsletters to keep practitioners updated and connected.

Future directions:

- Continue cultural tailoring with other levels of Triple P training, such as for Level 3 brief primary care consultations, and Level 4 individual sessions.
- Explore avenues for media messages such as NITV and Murri Radio.
- Consider developing Indigenous tip sheets incorporating pictures and less text.
- Explore whether training could be counted as part of further education (e.g. contributing to Cert IV for Indigenous Heath Workers).

## Discussion

Current services targeting the social and emotional wellbeing of Indigenous children are not adequate (Australian Institute of Health and Welfare, 2001; Zubrick et al., 2004) and need to be a key focus in policy initiatives. As 30–50% of Indigenous people have no access to allied health or mental health care workers (Carson and Bailie, 2004), there is a great need to build a skilled workforce, with quality degree training for Indigenous primary health care field workers, and courses for non-Indigenous primary health care staff addressing cultural issues (Ring, 1995). It is this workforce that can become skilled in offering scientifically-validated prevention and early intervention programs addressing both health and mental health issues (Queensland Health, 2005).

With evidence for the effectiveness and acceptability of a program such as Triple P (Turner, Richards & Sanders, 2007), there are then considerations relating to program sustainability and wider dissemination(Turner & Sanders, in prep). The processes of dissemination and diffusion of innovations into Indigenous communities need further exploration. Community implementation requires further

support for workers through tailored training to increase confidence; assistance in dealing with logistical barriers to gaining community support and engaging families; support in tailoring and flexibility in service delivery; and fostering workplace and community support.

Although Indigenous Health Workers report good consumer satisfaction following training, many still have limited confidence to administer a group program following training and have expressed a need for additional support and skills to implement the program successfully. We have found that some workers are reluctant to accept offers of supervision from program developers even when it was freely available. The lack of a personal relationship with program developers may create barriers for workers to feel sufficient trust to agree to remote consultative support. The challenge is how best to provide support to practitioners in remote communities.

Once a program has been established, there are various threats to its sustainability. These include lack of funding to support the delivery of the program, movement of staff and lack of mainstreaming of the service. An effective dissemination process must not only adequately train practitioners in the content and processes of an intervention, it must also form alliances with participating organisations and communities 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 advocate from an organisation who can foster support for the program, and the development of strategies for sharing information about the distinguishing features of the intervention, its potential benefits, and the procedures and cost of adoption.

The Triple P system of intervention involves a wide range of professions in the health, education and welfare sectors, with diverse backgrounds, theoretical orientations, and clinical experience. For Indigenous trials to date, participating professionals have typically been Child Health Nurses (both Indigenous and non-Indigenous) and Indigenous Health Workers. Those involved in the recent community implementation evaluations may be seen as 'innovators' who were motivated to implement Triple P in their communities and approached the program developers for the resources tailored for indigenous families. Other issues relating to program acceptance and staff support arise when a program becomes integral to the routine service delivery of an organisation.

We are currently developing further training supports to increase practitioner confidence, and aim to evaluate the impact of improved personal relationships with research staff, workplace support, supervision and peer networking on the rate of program uptake.

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## Appendix

### Triple P for Indigenous Families
### Follow-up Survey

The Parenting and Family Support Centre and Triple P International are currently looking for feedback from **all practitioners** who have completed training in Group Triple P for Indigenous Families, or who have completed standard training but have identified themselves as working in Indigenous communities.

Feedback from you on Triple P training and issues faced in implementing the program in the workplace will help us to continually work on the appropriateness of training and support for practitioners in the future.

As **all feedback is important** it would be greatly appreciated if you could **please complete the attached survey and return it by 16th November.**

- in hard copy in the enclosed reply paid envelope or to
  Karen Turner
  Parenting and Family Support Centre, School of Psychology
  The University of Queensland, Brisbane QLD 4072
- or in electronic form by email to kturner@psy.uq.edu.au.

**Please note:**

- This survey is looking for your feedback on the ways you have used Triple P in your daily work practice.
- There are no right or wrong answers – any information or feedback is valuable.
- All feedback will be used to improve training and support for other Indigenous staff.
- Confidentiality will be maintained – no names will be attached to final reports or summaries.
- A copy of the outcomes will be made available to all participants.

We are also planning to hold a focus group in Brisbane on the 21st November. This will be facilitated by program developers Professor Matt Sanders and Dr Karen Turner, Indigenous Research Officer Mary Richards, and Anna Clarkson, Director of Training, Triple P International.

We would like to invite you to participate in focus group discussions, either at this forum depending on available places, or by teleconference. Please indicate whether you would like to be involved:

☐ in person in Brisbane on 21st November

☐ by teleconference

☐ only via the attached survey

Please supply current contact details if you would like to be involved in further focus group discussions.

Telephone: _____

Email: _____

THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

# Triple P for Indigenous Families
# Follow-up Survey

Name: _____

Workplace (service organisation): _____

Current role at work: _____

Do you have Aboriginal or Torres Strait Island heritage? _____

What language do you usually work in? _____

## Program use

**1.** Have you used Triple P in your work with Indigenous families? **(Please tick one only)**

☐ Yes ☐ No **(Please go to Q1c)**

**1a.** If *Yes*, how have you used Triple P? (e.g. groups, one off consultation with parent, discussion with same parent over several sessions)

**1b.** If *Yes*, how did the Indigenous families you work with respond to Triple P strategies?

**1c.** If *No*, what is the main reason you have not used Triple P?

**2.** Have you used any of the Triple P resources with Indigenous families? **(Please tick one only)**

☐ Yes ☐ No **(Please go to Q2b)**

**2a**. If *Yes*, which ones? (e.g. Indigenous video/DVD, Indigenous workbook, PowerPoint presentation, tip sheets)

**2b.** If *No*, please describe the reasons why you have been unable to use the resources with Indigenous families.

**3**. Overall, how would you rate your confidence in using Triple P with Indigenous families?

☐ ☐ ☐ ☐ ☐ ☐ ☐

Not at all confident Not very confident Confident Very confident

## Professional support

**4**. Has there been anything that has helped you to use Triple P in your workplace? **(Please describe)**

**5**. Has there been anything that has made it difficult for you to use Triple P in your workplace? **(Please describe)**

**6.** Do you have a supervisor/mentor for your work with Triple P? **(Please tick one only)**

☐ Yes ☐ No **(Please go to Q6c)**

**6a.** If *Yes*, how helpful have you found this person?

**6b.** If *Yes*, how did you use them? (e.g. phone calls, meetings)

**6c.** If *No*, what would have made it easier to use a supervisor/mentor in relation to Triple P?

**7.** Are there any other people you have used to help support you using Triple P? **(Please tick one only)**

☐ Yes ☐ No

**7a.** If *Yes*, please provide details of the work/community role of this person. (e.g. School Psychologist, local GP - no names are required)

**8.** Do you have any suggestions on how you could be better supported to use Triple in your workplace?

## Program

**9**. Overall, do you think that Triple P is appropriate to use with Indigenous families? **(Please tick one only)**

☐ Yes ☐ No

**Please give reasons for your answer.**

**10.** Do you have any suggestions on how Triple P could be made more appropriate for Indigenous families?

**11**. Do you think you will use Triple P with Indigenous families in the future? **(Please tick one only)**

☐ Yes ☐ No

**Please give reasons for your answer.**

## Training

**12**. Do you think the training adequately prepared you for using Triple P with Indigenous families?

☐ ☐ ☐ ☐ ☐ ☐ ☐

No definitely not No not really Yes generally Yes definitely

**12a.** Do you have any suggestions on how the training could be improved so that you would be better prepared to use Triple P with Indigenous families?

**13.** Do you think the training was appropriate for Indigenous workers (e.g. culturally sensitive)?

☐ Yes ☐ No

**13a.** Do you have any suggestions on how the training could be made more culturally sensitive?

**14.** Would you recommend Triple P training to your Indigenous colleagues? **(Please tick one only)**

☐ Yes ☐ No

**Please give reasons for your answer.**

**15.** Have you any other comments, feedback about Triple P?

**Thank you for providing this valuable feedback.**

Please return this form to Karen Turner
Parenting and Family Support Centre, School of Psychology
The University of Queensland, Brisbane QLD 4072