Delivering and Sustaining Evidence Based Interventions: Triple P in San Francisco

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Presenters

- Sylvia Deporto
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  - Director, Parent Training Institute

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  - Program Director and Consultant, Formerly of South of Market Child Care, Inc.
Evidence based interventions in San Francisco

- Triple P parenting
- Safecare
- Value of EBPs for child welfare
Supporting and Sustaining EBPs in Child Welfare

- Administrative commitment & ongoing support
- Consistent messaging to staff about EBP purpose, population target & outcomes
- Commitment to design, implementation, assessment/evaluation, review of outcomes
- Commitment to funding– creative thinking & blended funding
Challenges for Child Welfare

- Adherence to fidelity of model – time consuming, lower caseloads for providers
- Lack of flexibility of EBPs
- Lack of specific research on different ethnic populations
- High turnover rate with paraprofessionals – requires ongoing resources for training
- Constant need to communicate with child welfare line staff about EBPs purpose & target population
Implementing & Sustaining Triple P in Child Welfare

Stephanie Romney, PhD
Director, Parent Training Institute
San Francisco Department of Public Health
Parent Training Institute

www.pti-sf.org

- Provide training, technical assistance, and evaluation for nonprofit and civil service programs delivering evidence-based parenting in San Francisco

- Identify and champion “practice-based evidence” – local home-grown programs that achieve outcomes comparable to EBPs

- Receives blended funding from 4 family-serving agencies
Triple P Parenting System

Level 1 – Media Campaign

Level 2 – Brief Parenting Advice

Level 3 – Narrow Focus Skills Training

Level 4 – Broad Focus (Group & Standard)

Level 5 – Behavioral Family Intervention (Pathways)
2013: Triple P in San Francisco

- English
- Spanish
- Cantonese
- Teen
Important Considerations for Child Welfare

- Reducing barriers to participation
  - Free food, childcare, transportation, incentives

- Reduce resistance / stigma
  - No separate classes for child welfare
  - Caregiver sets goals for self and child, & caregiver selects which strategies to use

- Triple P is not appropriate for caregivers with sexual abuse allegations against *any* child
Critical Considerations for Sustainability

- Selection of Staff for Training
- Outcome Monitoring
- Continuous Quality Improvement
Selection: Why a Readiness Process?

- Lessons learned from previous EBP rollouts
  - high staff turnover – interns trained and then leave
  - concerns about cultural fit
  - lack of fit between practitioner’s work and the new intervention
  - lack of clarity around performance expectations
  - data collection
  - lack of supervisor or administrator buy-in

- Triple P – no train the trainer program
Readiness Process

Components
- Written readiness assessment
- Face-to-face follow up with staff to be trained
- Provision of practitioner kits prior to the training

Purpose
- Transparency about expectations and benefits of participating
- Problem-solve concerns before staff are trained

Example of written readiness worksheet
Impact of Readiness: Parent Completion Rates (Pilot)

No Readiness Assessment

With Readiness Assessment

Site 1: 20%
Site 2: 17%
Site 3: 75%
Site 4: 72%
Site 5: 70%
Site 6: 50%
Outcome Monitoring

- **Access:**
  - Are child welfare-involved families accessing Triple P?

- **Engagement:**
  - Are child welfare-involved families completing Triple P?

- **Effectiveness:**
  - Are child welfare-involved families achieving the outcomes that we expect from Triple P?

- **Linkages / Follow-up:**
  - Are caregivers who need additional services following Triple P identified and connected to those services?
Sources of Information

- **Access:**
  - Matching Triple P participants with child welfare participants (quarterly)

- **Engagement**
  - Graduation rates (attendance sheets)

- **Effectiveness**
  - Caregiver-report measures at pretest, posttest, 3, 6, & 12 months

- **Linkages**
  - Child behaviors, parental stress still over the clinical cutoff at posttest
  - Unmet service needs at posttest

*Example of Outcome Report*
Caregiver Feedback

• Focus Groups
  • Conducted with group participants ~1 week after every Triple P group
  • Participants paid $25 (giftcard)
  • Approximately 1.5 hours
  • Conducted in the caregiver’s preferred language

• Feedback from caregivers who do not complete Triple P

Example of Focus Group Questions
Quality Improvement

Evaluation answers *what are the outcomes?*

Quality improvement asks *why is this happening* and *how can we improve?*
Continuous Quality Improvement

1) Timely feedback loops with all stakeholders
   - Parents
   - Practitioners
   - Supervisors / Administrators
   - Funders

2) Disaggregated data for specific populations / agencies

Enables problems to be resolved quickly and best practices to be shared
## Customized Feedback

<table>
<thead>
<tr>
<th>Recipient</th>
<th>Content</th>
<th>Timing</th>
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</table>
| **Practitioners & Supervisors** | Outcome report and focus group findings  
List of participants over the clinical cutoff or having unmet service needs | Within 2 weeks following group completion  
Before the first group session and within 2 weeks following group completion |
| **Administrators**          | Agency-level report in which outcomes are compared to same agency in the previous year and also to other comparable agencies | Annually unless requested more frequently                               |
| **Funders**                 | Aggregated reports based on specific populations  
Comparison of performance by funded agencies                          | 2x per year unless requested more frequently  
Funders will also be cc’d on other reports if identified problems are outside the scope of the practitioner/agency to solve alone |
| **Caregivers**              | Family-level outcomes                                                   | By request – not routine yet                                           |
The Importance of Disaggregated Data: Triple P Graduation Rates

<table>
<thead>
<tr>
<th></th>
<th>No history of CPS involvement</th>
<th>CPS involvement</th>
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<tbody>
<tr>
<td>No history of CPS involvement</td>
<td>94% 91% 90% 90% 80% 73% 68% 57% 53%</td>
<td>75% 75% 75% 75% 75% 75% 75% 75% 75%</td>
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<tr>
<td>CPS involvement</td>
<td>75% 60% 71% 75% 63% 40% 80% 33% 33%</td>
<td>68% 68% 68% 68% 68% 68% 68% 68% 68%</td>
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Translating outcomes into improvement

- Hypotheses about why the outcome occurred
  - Practitioner & caregiver perspectives

- Develop a plan to address the problem

- Try out the plan to see if it works
  - With Triple P you’ll have an answer within 12 weeks

- May need to include higher administrators or funders in the plan development

- Share successes with other agencies
Triple P: A Practitioner’s Perspective

Judith Baker, MA
Program Director / Consultant
Delivery Context for Triple P

- **My background**
  - 40 years in child development field
  - Director of the South of Market (SOMA) family resource center when Triple P was first implemented

- **South of Market** – a family resource center that is part of a child development agency
  - Diverse populations served
    - Immigrants (primarily Spanish and Filipino)
    - Some low income and homeless families
    - Some undocumented immigrants
    - Some child welfare-involved / court mandated parents
Selecting Triple P

Prior to Triple P, we had utilized a support group model (vs. skills training)

Why Triple P?

- Language capacity: English, Spanish, other
- Can be delivered by diverse workforce (clinicians and paraprofessional family advocates)
- Flexibility emphasized in addition to fidelity
## Implementation Challenges

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<tr>
<th>Challenge</th>
<th>How Challenge was Addressed</th>
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<td>Low literacy level of parents – difficulty using the parent workbooks,</td>
<td>Asking parents to draw instead of write, modifying homework to eliminate writing, allowing parents to take the DVD home</td>
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<td>understanding the powerpoints</td>
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<td>Parents reacting strongly to parts of curriculum (e.g., when parents are</td>
<td>A minimum of 2 facilitators ran each class, so 1 facilitator could work separately with parents should individual needs arise</td>
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<td>asked to reflect on their own childhood experiences in the Pathways</td>
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<td>curriculum)</td>
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<td>Other concerns of families in addition to parenting (e.g., parental</td>
<td>The family resource center provided multiple other services to address families’ needs</td>
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<td>depression, case management needs)</td>
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<td>Group process issues (e.g., time management)</td>
<td>• Monthly support calls with a Triple P trainer</td>
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<td>• Facilitators worked together and improved with each class</td>
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Triple P Experiences

- 12–15 caregivers per class
- Supports provided at all classes to reduce barriers to participation and enhance retention
  - food, childcare, transportation support
  - use of incentives, graduation gift (gift certificate and family photo), class trip at the end of the class to practice skills
- No “typical” class or “typical” family
- Examples of families taking Triple P