Helping families change: The adoption of the Triple P - Positive Parenting Program in the Netherlands

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6 How to implement a multilevel program in another country?*

Abstract

In this article, we describe the successful implementation process of the multilevel Triple P-program using the REP framework (Kilbourne et al., 2007). We then present the adaptations we made in this framework. In doing this, a practical framework for implementing evidence-based multilevel programs in another country was developed, which may be of interest for other countries that want to implement a multilevel intervention program. Furthermore, we also evaluated the implementation trial by a process evaluation. Finally, we discuss the adaptation of the REP framework for a multilevel program, the main success factors of the implementation trial to the Triple P program, and future research.

6.1 Introduction

Internationally effective interventions are often implemented in other countries. A reason to implement foreign evidence-based interventions is that no such intervention is available in the adopting country. Another reason is that implementing extensively evaluated foreign interventions is relatively inexpensive, easily accessible, and convenient.

In 2006 and 2007, an implementation trial of the multilevel Triple-Positive Parenting Program was executed in The Netherlands, for the following reasons. First, there was a need for an evidence-based parenting intervention. Although several parenting programs were available, most of them were not evidence based. Second, there was a need for a tiered continuum of interventions of increasing intensity, from universal prevention to intensively care for parents and their children.

The Triple P-Positive Parenting Program is a behavioral family intervention (Sanders, Markie-Dadds, Tully & Bor, 2000; Sanders, Turner & Markie-Dadds, 2002; Sanders, Markie-Dadds & Turner 2003). Specific for the program is the multilevel approach of five intervention levels. The implementation trial in the Netherlands was executed successfully. In this trial, 79 professionals followed a training course on level 2/3 or 4 of Triple P. Both parents and professionals were satisfied with the quality and the content of the Triple P program. The multilevel approach of the program improved the collaboration between the participating institutions. Two years later, in January 2009, the program was implemented in 17 municipals, and 1840 professionals have been trained in Triple P. In 18 other municipals, preparations are being made to implement the program in 2009.

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onwards, and 6 other municipals and 4 provinces are interested in the program. Since July 1996, Triple P has been widely disseminated in many countries: Australia, New Zealand, England, Scotland, Germany, Switzerland, Hong Kong, Singapore, Japan, the United States, Canada, Iran, and Turkey. Since 2006, the Netherlands and Belgium have joined in. Evidence supporting the effectiveness and efficacy of the Triple P program is available from studies conducted in most of those countries. The results of meta-analyses (De Graaf, Speetjens, Smit, de Wolff, & Tavecchio, 2008a, 2008b; Nowak & Heinrichs, 2008) indicated that the Triple P interventions reduced disruptive behaviors in children, reduced dysfunctional parenting styles in parents, and improved parental competency. These effects were maintained well through time. Although much is known about the efficacy and effectiveness of the multilevel program, much less is known about the implementation of the program in those countries. Implementing a multilevel program is a very complex process. The different interventions need to be embedded in the different organizations in youth health care, social work, education, youth care and mental health care, implying different cultures and financial structures. From (inter)national research concerning dissemination and implementation, knowledge is available of the steps that should be taken in implementing an innovation and of possible promoting factors and barriers of implementation (Glaser, Abelson & Garrison, 1983; Grol & Wensing, 1991; Rogers, 1995). A structured implementation of an innovation increases the prospects for a successful implementation. No effective strategy for adopting and implementing an evidence-based multilevel program from one country to another was available. So, in the implementation trial of the Triple P program, we applied the effective “Replicating Effective Programs” (REP) framework of Kilbourne, Neumann, Pincus, Bauer, and Stall (2007). REP provides a roadmap for implementing evidence-based interventions into community-based settings. The effectiveness of this framework has been empirically studied in a randomized controlled trial (Kelly et al., 2000; Richardson et al., 2004). According to this framework, the implementation process is divided into four phases: preconditions, preimplementation, implementation, and maintenance and evolution. The attraction of this framework is that it presents a practical guideline for the implementation and the four phases are described in detail.

We applied the REP framework in the implementation trial of the multilevel Triple P-program. We adapted the framework by adding or deleting elements in it to make it suitable for a multilevel intervention program. In this article, we describe the implementation process of the multilevel Triple P-program using the REP framework. We then present the adaptations we made in this framework. In doing this, a practical framework for implementing evidence-based multilevel programs in another country was developed, which may be of interest for other countries that want to implement a multilevel intervention program. Furthermore, we also evaluated the implementation trial by a process evaluation. We shortly present the process evaluation studies and the results. Finally, we will discuss the adaptation of the REP-framework for a multilevel program, the main success factors of the implementation trial to the Triple P program, and future research.
6.2 The multilevel Triple P-Positive Parenting Program

Triple P aims to enhance family protective factors and to reduce risk factors associated with severe behavioral and emotional problems in children 0 – 16 years old. The intervention system aims to help parents to develop a safe, nurturing environment, and to promote positive, caring relationships with their children, and to develop effective, nonviolent management strategies for dealing with a variety of childhood and adolescent behavioral and developmental issues (Sanders et al., 2000; Sanders & Turner, 2005). The Triple P system is based on the principle of sufficiency. There are differences in the severity of problems experienced, breadth of knowledge, motivation, access to support, and additional family stress (Sanders & Turner, 2005). Specific for the program is the multilevel approach of five intervention levels. Thereby, a chain of parenting support is created to advise parents with different problems. The Triple P program has existed for 30 years and was developed by Matthew R. Sanders, professor of clinical psychology and director of the The Parenting and Family Support Centre at the University of Queensland. In this 30-year period, the program has been further developed and extended with extra modules for parents of children with specific problems. Level 1, a universal parent information strategy, provides all interested parents with access to useful information about parenting through a coordinated promotional campaign, using print and electronic media, which demonstrates specific parenting strategies. Level 2 is a brief, one to two sessions of primary health care intervention, providing early anticipatory developmental guidance to parents of children with mild behavior difficulties or developmental issues. Level 3, a four-session intervention, targets children with mild-to-moderate behavior difficulties, and includes active skills training for parents. Level 4 is an intensive eight- to ten-session individual, group or self-directed parent training program for children with more severe behavioral difficulties. Level 5 is an enhanced behavioral family intervention program for families where child behavior problems persist or where parenting difficulties are complicated by other sources of family distress. For the implementation trial in The Netherlands, the interventions on levels 1, 2, 3, and 4 were selected.

6.3 Situation before implementation

Before the implementation of the Triple P-program, in 2005, several programs had been developed in the Netherlands in the field of parenting support. There were, however, a number of problems with these programs. First, although the demand for parenting programs is high and various initiatives were undertaken, no (prevention) programs — apart from Families First — were as yet developed for parents of children with emotional and behavioral problems. The available programs were primarily aimed at either the parental skills for supporting the normal development of children, or — in the case of severe problems — at the clinical treatment. But precisely in the area in between, i.e., the prevention of (severe) emotional and behavioral problems, few developments had been made. Second, in most regions, an integrated approach
often did not exist. Although parenting support programs are being offered by some local organizations, there is ample room for improvement in terms of overall guidance of and connectivity between the services. The need for an integrated approach of effective parenting support services was great at that time (Berger and Menger, 2002; Bakker et al, 2001). The multilevel Triple P-program fitted in well with the increasing collaboration between child health care and the basic services and the projects of the Union of Dutch Cities (VNG) in the framework of an integrated child policy strategy. A great deal of attention was devoted on regional and local levels to a more integrated parenting support offer. This issue was high on the agenda of the organizations involved: the municipal health services, consultation agencies, education authorities, mental health services (prevention units), and welfare services for children. The fact that other more generic preventive programs had already been developed in the Netherlands was considered in the implementation, as it builds on the results of the program Parenting Support & Development Stimulation in the community (O&O), Communities that Care (CtC), and other programs. O&O targets parenting problems in general and CtC is aimed at community-oriented strategies for addressing general problem behavior in (high-risk) teenagers aged 12+ (e.g., drug-related public nuisance, aggressive behavior, etc.). Triple P differs from O&O and CtC in that it aims specifically to provide parenting support in order to prevent emotional and behavioral problems in children and offers support on individual (family) level.

6.4 The REP framework

The REP framework was developed by the U.S. Centers for Disease Control and Prevention (CDC) to package and disseminate HIV behavioral and treatment interventions for implementation in community-based service settings, notably AIDS service organizations (2006). The aim of the REP framework is to close the gap between research and practice. It offers a framework that tries to “achieve a balance between adequate fidelity to the intervention and accommodating differences across organizations to maximize the effectiveness of the intervention” (Kilbourne et al., 2007). Because few interventions were successfully disseminated into nonacademic-affiliated organizations, an effective strategy for implementing clinical and health services interventions was developed. The concept underlying the REP packaging process derives from action anthropology (Tax, 1958) and principles of health promotion (Green & Kreuter, 1991). The underlying theories of the REP framework are Diffusion of Innovation (Rogers, 1995) and Social Learning Theory (Bandura, 1977). The framework is divided into four phases (Kraft, 2000): preconditions, preimplementation, implementation, and maintenance & evolution. These are well-known steps in the implementation-process. For a full description of the framework and the underlying theories, we refer to Kilbourne and colleagues (2007). They described “the use of the REP framework and implementation protocol to prepare effective health services interventions for implementation in community-based settings.”
## 6.5 Description of the implementation trial in the Netherlands

In table 1, an overview is given of the implementation steps according to the REP model (Kilbourne et al., 2007) and activities in implementing the multilevel Triple P program.

### Table 1. The application of the REP model to implement a multilevel program in another country.

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Preconditions

Identify need
Before the actual implementation of the Triple P interventions, we identified the need for a new program for an at-risk population. Scientists, policy makers, and experts in the field of parenting collaborated and combined their knowledge of behavior and emotional problems in children and the value of the addition of a new parenting program in the Netherlands compared to care as usual. It is important to weigh the pros and cons against each other before adopting a new program. It was concluded that an evidence-based integrated parenting program was needed in the Netherlands.

Identify effectiveness of the program
The next step was to assess the level of evidence and grade of recommendation for adoption. The recommendation to adopt a new intervention is strongest when the intervention has been proven to be more effective than the existing interventions or when the costs of the new intervention are lower than the existing intervention (Laupacis et al., 1992; Cuijpers, De Graaf & Bolhmeijer, 2006). Worldwide, many studies have been conducted on Triple P. In 2007, 55 efficacy and effectiveness studies had been conducted on a form of Triple P. In general, it was concluded that the Triple P program showed that parenting skills training used in Triple P produce predictable decreases in child behavior problems, which have typically been maintained over time (Sanders, 2003).

Identify barriers
Before starting an implementation trial, information should be collected to know whether the program is feasible in local settings, whether it is an addition to the care as usual and gather information about the potential barriers. The implementation process can be influenced by many factors and cannot be discussed in one theory (Fleuren, Wiefferink & Paulussen, 2002; Fleuren & Paulussen, 2004). We assessed the characteristics of the five following determinants that may influence the implementation: the social-political environment, the organization, the professional, and the innovation, and implementation strategies (Fleuren et al., 2002). We interviewed experts, managers, and professionals, and assessed the implementation factors by questionnaires among managers and professionals.
Determinants that influenced the implementation trial of the Triple P program

- Social-political environment: degree of collaboration between organizations, involvement of policymakers at the start, national policy in parenting.
- Organization: commitment in the organization, attitude of the manager, time to work with the new program, fit between organization and innovation.
- Professional: self-efficacy, enthusiasm, experiences in parenting.
- Innovation: quality and content of the innovation: training courses, resources, structure of the program, evidence-based character, multilevel approach.
- Implementation strategies: communication, availability resources, involvement in research, coordination of the implementation.

Source: questionnaires and interviews

In general, it was found that most determinants were judged positive at the start of the program, and we decided to conduct an implementation trial.

Identify cultural transferability

Identification of cultural transferability is necessary because fundamental differences can arise. We consulted a national expert group, in which experts from practice, scientists, and policymakers were represented. The contrast between the professional delivery services (expertise, training, resources, etc.), the target population (demographic characteristics, risk status), and the health care system (financing system, the costs for patients or care receivers, alternative interventions available) needs to be examined (Cuijpers et al., 2006). Because Triple P had already successfully been implemented in other comparable European countries, e.g., Germany, England, and Switzerland, and no great contrast was found, we concluded that that the Triple P program was transferable to the Dutch situation.

Organize national team to lead the implementation trial

In the REP model, this team is called the Community Working Group (CWG), in which the comprehensive definition of stakeholders based on the Pincus multilevel 6-P framework was made (Pincus, Hough, Houtsinger, Rollman & Frank, 2003). We installed a national project team that consisted of representatives from research, practice, and experts in the field.

Seek collaboration with the international owners

We decided to seek contact with the Australian owner. The owner of the program is the University of Queensland. They developed the core program and are still continuing with developing and researching additional modules for the program. The organization Triple P International (TPI) is responsible for the international dissemination of the program (e.g., organization of training courses, distribution of manuals for
practitioners, and workbooks for parents). An official agreement needed to be written and signed. Collaboration with other countries needs time, because of language and culture differences, and long-distance communication.

**Draft package**
The final precondition step is to translate the resources and create an implementation toolkit. In this toolkit are specific details regarding the intervention, as well as operationalized options for adapting delivery of intervention core elements to local organizations in a way that does not compromise the intervention’s core elements (Kilbourne et al., 2007). In the Triple P implementation trial, the toolkit consisted of a fact sheet with the core elements described, the translated resources for professionals, and a flow chart for implementation.

**Closure**
This phase is closed with a final choice of a program, an official juridical agreement with the international owners of the program, and the identification of a national team to lead the implementation.

**Preimplementation**
Local project groups were arranged with representatives of the local organizations (managers and professionals), researchers, local policy makers, and parenting experts functioning at a national level. A local coordinator to stimulate and support the collaboration between organizations turned out to be crucial for the success of the implementation. The members of this project group met regularly with the aim of organizing the local implementation. Again, a discussion of the addition of a new parenting program was held (the pros and cons). Local implementation plans were made with a description of the role and tasks of each organization.

**Coordination**
Because the Triple P program is multileveled and many organizations are involved in delivering the different interventions, it became crucial that a regional coordinator is selected as “puller” of the local implementation of the program. A local coordinator is essential for the success of the implementation. It is necessary to appoint a coordinator in the institution in order to support the professionals in the execution of the program. The tasks of such coordinator are, e.g., organization of the peer support, being a contact person between managers and professionals, and giving support in registration and research tasks. Managers and policy makers need to be involved in the implementation so as to enlarge the prospects for structural continuation of the program. The presence of a local coordinator was assessed as a critical success factor by most involved professionals.

*Source: questionnaire and interviews with professionals*
**Stimulate collaboration with local institutes**

To improve the success of the implementation trial and participate in the evaluation, official agreements were made with participating organizations. If policy makers are involved from the beginning, it will improve the prospects that the program will be structurally implemented after the pilot period.

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**Collaboration**

45 practitioners who had experienced an intervention of level 2, 3, or 4 of Triple P completed the questionnaire called Wizdiz (Raak et al., 2005). This instrument was developed in the Netherlands and measures whether the conditions for collaborating in a multilevel program are present. The practitioners worked in several primary care institutions and Mental Health institutions or Youth Care. Although the participating institutions had already worked together with each other, 50% (n = 22) mentioned that a new collaboration had taken place through executing the Triple P program. First, the practitioners judged the local context as positive: the willingness of working together and the harmonious relations between the local institutions. Obstacles for collaboration are the fusion processes that are taking place in several institutions. Second, the commitment of the practitioners is also judged positive. The participants have faith in each other, and think that the aims of Triple P fit in with their interests. Third, the respondents judged positive concerning the management, especially on negotiating and reaching compromises. Less positive are the responses concerning the organization of the project: they do not feel that there is much room for change, which can limit flexibility. Fourth, the respondents indicated that the external circumstances were positive. All the respondents think that Triple P fits in the governmental policy of parenting support and that the program is a value addition in the Dutch society. Furthermore, all the respondents were positive about the results on the formulated aims: better equipped to handle questions of parenting, better answering the needs of parents, more flexible parenting support, more contact between institutions, and more aware of each other’s expertise.
The interviews (n=16) indicated that an important reason for participating organizations to choose Triple P was its multilevel approach. Many professionals (n=14) reported that through implementing the different levels of the Triple P program collaboration grows between the organizations. They had more knowledge concerning everyone’s expertise and they could locate each other more easily. Furthermore, the professionals of the mental health institutions and the youth care, who are both responsible for the execution of the Level 4 –interventions, indicated that they work more together than they used to do. The managers experienced that a “warm transfer” of parents took place between different professionals and institutions. Parents are more prepared in terms of what is going to happen, and as a result the more intensive care is less threatening. Moreover, the uniformity in the manner of working is valuable for parents.

Source: Questionnaire Wiz/Diz (Raak & Mur-Veeman, 2006), questionnaire

**Orientation**
The implementation trial followed both a “top-down” and a “bottom-up” strategy. Taking time for discussion about the additional value of the new program to the “care as usual” is important, and preparing them for, and involving them in the next steps of implementation. Because the implementation trial covered four intervention levels of the Triple P-program, much time was spent in embedding the interventions into the right institutions. From the beginning, most of the participants were enthusiastic. It was difficult for some institutions to participate, such as educational institutions and social work institutions, in which parenting is not their core business. The next step is to arrange the implementation within the organizations. The importance of program champions has been documented in the implementation literature (Rogers, 1995). A program champion, or program advocate, can play a role because such a person advocates the program and can plead from a strategic place in the organization in an informal way for adopting the program. Thus, for selecting coordinators within the organization to be responsible for the implementation and involving staff members for support, the coordinator and practitioners need to be organized (e.g., have time to participate). Finally, the practitioners have to be informed very carefully. Because the decision was made for them to execute the program, they have a lack of information that needs to be filled.

**Closure**
This phase was closed with establishment of an official collaboration agreement on the local level, final local project groups, and a kick-off meeting for participants.
Implementation trial

Training and accreditation
The implementation trial began with the training courses for the practitioners and staff managers of the participating organizations. The training program and the accreditation were delivered by experienced Australian trainers. To improve the implementation in the organization on the longer term, supervisors and managers in the organization were trained too.

Evaluation of the training courses
The training program was delivered by experienced Australian trainers. A total of 79 professionals followed a training course on Level 2, 3, or 4 of Triple P: 97% were female and 3% were male. The mean years of experience in parenting support was 10.4 years. The participants were satisfied with the trainer and reported that their competences improved by following the course. These participants reported a significant overall increase in adequacy of training to conduct parenting consultations about child behavior from pre to post and follow-up assessment, and significant increase in self reported confidence in conducting parenting consultations about child behavior. Participants also reported significant improvements in proficiency in parenting consultation skills after completing training. The English language was an obstacle for many practitioners, especially to feel free and confident to discuss the program and share experiences. Not only was the spoken language a problem, but also all resources in this trial were in English. Another obstacle was that professionals with different levels of experiences in giving parenting support were combined in the same group.

Source: registration forms, questionnaire

Evaluation
According to Kilbourne and colleagues (2007), four types of evaluation ought to be considered: a) a process evaluation of the program implementation process via qualitative interviews; b) measurement of intervention fidelity at the organization and parent level; c) parent-level outcomes; d) return on investment (e.g., costs). In the implementation of the multilevel program Triple P, we added a fifth type: the assessment of the collaboration between organizations. A thorough evaluation should be conducted by independent researchers. Here, we give a summary of the evaluation methods we used in the implementation trial of the multilevel Triple P program. An overview of the methods can be found in table 2. First, we conducted a process evaluation to determine how the intervention was actually implemented, and to determine to what extent the users (managers, professionals, parent) were satisfied with the interventions, and to get
insights in how the implementation can be improved. The training program was
evaluated by means of questionnaires assessing the satisfaction (at post-training),
competences and confidence of the professionals (at pre- and post training).
Moreover, parents and professionals completed a satisfaction questionnaire.
We also collected information concerning the intervention (e.g., which Triple P
intervention, number and duration of sessions), and concerning the number of the
reach of the parents. Furthermore, a questionnaire was sent to the professionals
with questions about their working routines and experiences in applying Triple P.
And we developed a questionnaire to investigate the promoting and hindering
factors in implementing the program by professionals and managers. Finally,
interviews were held with managers and professionals about their experiences with
the implementation.
Second, the program fidelity was measured by taking a sample of video tapes of
practitioners working with their parents. Intervention fidelity measures should be
developed to determine whether core elements were successfully implemented
(Kilbourne, et al., 2007). In the assessment of the video tapes, we used a list with the
most important competences, based on the Triple P manuals.
Third, parent-level outcomes were measured by two evaluation studies on the interven-
tions concerning levels 3 and 4 of Triple P (De Graaf, Onrust, Haverman, Janssens, in
press; De Graaf, Haverman, Onrust, Breukelen, Overgaag, & Tavecchio, submitted). We
measured the effects on parenting behavior and problem child behavior.
Fourth, the return on investment is important in making the business case for the
program to stakeholders. In our study, we collected information about the duration of
the innovation compared to the care as usual.
Fifth, we measured the collaboration between all participating organizations by a
questionnaire and interviews among managers and professionals.

Satisfaction
A total of 79 professionals followed a training course on Level 2, 3, or 4 of Triple P: 97% were female and 3% were male. The mean years of experience in parenting support was 10.4 years. In general, the professionals were satisfied about the intervention, with the resources and the multilevel approach of Triple P, especially the standardized approach. The majority (89%) will recommend the program to colleagues. The satisfaction of the work of social nurses has been improved, and they feel more competent to support parents with the psychosocial problems in the children.

Sources: questionnaire and interviews
Outcomes’ Effect Studies
Level 3 Primary Care Triple P (n = 87):
Both regular Dutch parenting consultations and the Triple P approach were found to produce reductions that also remained after three months in child emotional and behavior problems. For both groups, parenting styles were also found to have improved at both post-test and follow-up measurement. When compared to the regular Dutch parenting consultation practices, however, the Primary Care Triple P approach produced greater improvement in parental laxness, total parenting dysfunction, and total parenting competence at both post-test and follow up (De Graaf, Onrust, Haverman, & Janssens, in press).

Level 4 Standard and Group Triple P (n = 298):
A total of 298 parents were included in this study. Data indicate that the Standard and Group Triple P interventions are effective in reducing behavioral and emotional problems in children, dysfunctional parenting styles, improving parental competences reducing depression, anxiety, and stress in parents. Treatment effects are maintained after three and six months

(De Graaf, Haverman, Onrust, Breukelen, Overgaag, & Tavecchio, submitted).

Table 2. Overview evaluation methods

<table>
<thead>
<tr>
<th>Factor</th>
<th>Example question</th>
<th>Instrument</th>
</tr>
</thead>
<tbody>
<tr>
<td>Execution and reach</td>
<td>How often was the intervention applied? How often was it made use of?</td>
<td>Registration forms</td>
</tr>
<tr>
<td>Program-integrity</td>
<td>To what degree was the program executed as intended? Have the competences and knowledge in Triple P been improved in the professionals after the training course and accreditation?</td>
<td>Video-tapes • Questionnaires, pre, post, follow-up assessments by training courses and accreditation</td>
</tr>
<tr>
<td>Opinion of managers and directors of participating institutes</td>
<td>Do the managers experience advantages for their organizations in the primary process? What are the promoting and obstructing factors in implementing the program?</td>
<td>Semistructured interviews</td>
</tr>
<tr>
<td>Opinion of parent</td>
<td>To what degree are the parents satisfied with the intervention?</td>
<td>Satisfaction questionnaire</td>
</tr>
<tr>
<td>Topic</td>
<td>Questions</td>
<td>Methods</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Opinion of professionals</td>
<td>To what degree do the professionals experience the innovation as an improvement?</td>
<td>• Questionnaires</td>
</tr>
<tr>
<td></td>
<td>What are the promoting and obstructing factors in implementing the program?</td>
<td>• Semistructured interviews</td>
</tr>
<tr>
<td>Opinion of local and national project leaders</td>
<td>What are the promoting and obstructing factors in implementing the program?</td>
<td>Semistructured interviews</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>What are the effects on relevant outcomes (child behavior problems, parenting styles)?</td>
<td>Effect studies</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Effectiveness:</td>
<td>- Level 3 Triple P:</td>
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<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>- Level 4 Triple P: four samples pre, post, and follow-up assessments</td>
<td>quasi-experimental design</td>
</tr>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Collaboration in the multilevel approach</td>
<td>Does the multilevel approach result in a better collaboration?</td>
<td>• Semistructured interviews</td>
</tr>
<tr>
<td></td>
<td>What are the promoting and obstructing factors in achieving a good collaboration?</td>
<td>• WIZ/DIZ, a validated questionnaire</td>
</tr>
</tbody>
</table>

**Ongoing support**

After being trained and accredited, the practitioners started with the intervention in which they were trained. During the implementation, proactive support needs to be given by an expert for several reasons. First, small and larger implementation problems will occur (e.g., ranging from missing documents to nonparticipation by institutions). Second, the challenge is to ensure that core elements are maintained (fidelity) while its implementation can be adapted to local needs and infrastructure (flexibility) (Kilbourne et al., 2007). Program integrity is a main issue in implementing evidence-based interventions. In Triple P, the quality of the Triple P program is controlled by a system of professional training and workplace support. Peer support and supervision should be organized to control the quality and improve the participation in the implementation.
Program fidelity

Four families were videotaped while receiving the Triple P intervention and twelve professionals completed the questionnaire about the program fidelity. The videotapes indicated that the session topics were all executed, and most of the competences were executed as intended. However, the interventions to stimulate self-regulation in parents were less well executed. The majority (n=10) sometimes deviated from the program. Often, this concerned leaving out some parts of the session. Sometimes, they included subjects from another method, or psycho education was given. The written resources in English influenced the execution of the program in a positive way because they made it easier to keep to the original program. Conditions that improved the program integrity were, e.g., the presence of an approachable person within the organization and a positive attitude of the professional toward the innovation.

Resource: videotapes and questionnaire

Feedback and refinement

The results of the evaluation give input and suggestions to improve the implementation of the program in the participating organizations and give insights how to conduct a broader dissemination of the program.

Closure

This phase is closed with trained professionals with experiences in the application of the Triple P-program. Furthermore, data are gathered with the objective of evaluating the implementation, and the outcomes give information how to continue.

Maintenance and evolution

Organizational, financial changes

This phase is often the most challenging and least studied, in part because sustaining interventions involves concerted multilevel efforts to change the current practice and the organizational and financial incentives necessary for long-term national adoption (Kilbourne et al., 2007). There is always a risk that further dissemination of the program will collapse after the pilot period and the professionals return to their earlier experiences. Therefore, stakeholders (financial and organizational) were involved in the implementation process from the beginning, to enlarge the prospects for further dissemination. Following a successful implementation trial, a plan was made for a national implementation. The experiences and learned lessons of the implementation trial are described in this national plan, e.g., the pros and cons for implementing a multilevel program or one intervention of the program, the importance of a national coordination, a local coordinator, workplace support, and supervision. A discussion needs to be held concerning the responsibilities of (inter)national and
local organizations. To guarantee the quality of an implemented program, it is important that the ownership of the program and the responsibilities of the implementation, as well as the quality in executing the program and the maintenance of the program, are well organized and provided for. A national institute in the adopting country needs to be responsible for setting up and guaranteeing the quality system in collaboration with the Australian owners of the program. A number of questions need to be answered in this. Who exactly is responsible for the national enrolment and guaranteeing the quality of the execution? How will the organization of the national enrolment be financial supported? After how long can a national organization withdraw and the implementation of the program be left to the local institutions?

Closure
This phase can be closed with a national plan for the implementation of the Triple P program and a plan for structural implementation on the local level.

6.6 Discussion

Adaptation of the REP framework to implement a multilevel program
The REP model was very usable for the implementation of the multilevel program Triple P. The framework was a structured approach to implement this program. Because the main steps in the four implementation-phases were described in detail, it was very helpful to organize the implementation trial and in developing a model for multilevel programs.

There are three main adaptations made in implementing an evidence-based multilevel program in another country. The adaptations in the framework are presented in figure 1. First, a cultural transferability is indispensable to determine potential fundamental differences. Furthermore, the resources have to be translated in other speaking countries. This job should be executed carefully, because no changes should be made in the core elements of the program. Second, the organization of the implementation differs. The organization of implementing a multilevel program in another country is more complex as it is for a standalone intervention. In the original REP model, one group organizes and leads the implementation, the so-called Community working group (CWG). This is a group of stakeholders from organizations serving the target populations and consists of representatives of the following levels: populations, purchasers, plans, practices, providers, and patients (Kilbourne et al., 2007). To implement an evidence-based intervention in another country, we made an organization structure on four levels: on international, national, local, and institutional level. A national team was formed, including stakeholders, to conform the CWG in the REP model. The project leader communicated with the international owners of the program. Because in a multilevel program more than one (sometimes more than ten) local organization is involved, a local project team was formed with stakeholders from the local organizations and local policy. Our findings of the process evaluation showed that a local coordinator is
crucial for a successful implementation. Moreover, a coordinator in the institution self is also important, because workplace support is an important condition for a successful implementation. This is a well-known topic and described in the (inter)national literature (Rogers, 1995; Sanders & Turner, 2005). If professionals are supported by managers and colleagues in their institutions, the innovation will be implemented more easily. The study by Turner (2003) shows that workplace support is directly connected with the implementation of a Triple P intervention at Level 2. Supervision can play a role in the implementation of innovations. The presence of supervision in an organization results in more productive employees, who are more able to reach their aims (Latham, 2000).

Furthermore, a multilevel approach is not achievable for all municipalities. In such cases, all interventions separately should be effective so that they can be implemented separately. This needs to be considered in the preimplementation phase. The third adaptation concerns the collaboration. In the implementation of the multilevel program, it is important that the conditions necessary for collaboration are present to guarantee or improve the collaboration in the long term. This can be examined in the preconditional phase of the implementation process. The attraction of the multilevel Triple P program is in the fact that it offers possibilities to realize a tailored system. However, collaboration between organizations with all different cultures is not automatically done; it needs to be organized and stimulated by the national team and the local coordinator.

Figure 1 Adaptation of the REP- framework (Replicating Effective Programs) for implementation of multilevel health care program to another country (adaptations are written in bold).

<table>
<thead>
<tr>
<th>Preconditions</th>
<th>Preimplementation</th>
<th>Implementation</th>
<th>Maintenance and evolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of need for new intervention</td>
<td>Orientation</td>
<td>Staff training</td>
<td>Organizational and financial changes to sustain intervention</td>
</tr>
<tr>
<td>Identification of effective intervention that fits local settings</td>
<td>- Explain core elements</td>
<td>Ongoing support of and partnership with community organizations</td>
<td>Prepare package for national dissemination</td>
</tr>
<tr>
<td>Identify cultural transferability</td>
<td>- Customize delivery</td>
<td>Booster training</td>
<td>Recustomize delivery as need arises</td>
</tr>
<tr>
<td>Organize national team</td>
<td>Logistics planning</td>
<td>Process evaluation including collaboration</td>
<td></td>
</tr>
<tr>
<td>Seek collaboration with international owners</td>
<td>Technical assistance</td>
<td>Feedback and refinement of intervention package and training</td>
<td></td>
</tr>
<tr>
<td>Packaging intervention for training and assessment</td>
<td>Stimulate collaboration between local institutes</td>
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</tbody>
</table>
Main success factors in the implementation of a multilevel program

Overall, we can conclude that the implementation trial was successful. In both local regions, the interventions were embedded structurally into the care system and the program is now implemented in 17 other municipals and new ones are interested. Here, we will discuss the main success factors in implementing the multilevel Triple P program in the Netherlands.

First, the systematic approach of the REP-model has supported a successful implementation. Following all the steps in the four different phases of the implementation process allows careful planning of the implementation and makes one alert in not missing one essential step. Second, the high quality of the triple-P program itself was a success factor. The evidence of its effectiveness had been established in many studies; high-quality training courses, training materials, practitioner manuals, and parent resources were available. Overall, the program is standardized, easy to follow, accessible, and culturally sensitive (Sanders & Turner, 2005). Third, the results in this study show that workplace support is an important condition for a successful implementation. This is a well-known topic and described in the (inter)national literature (Rogers, 1995; Sanders & Turner, 2005). If professionals are supported by managers and colleagues in their institutions, the innovation will be implemented more easily. Support of the organization can be seen as one of the factors that can diminish or limit resistance to change in an organization (Beer, 2000; Martin, 2001; Robbins, 1994). Workplace support can diminish the feelings of stress that can result from working with an innovation. The study by Turner (2003) shows that workplace support is directly connected with the implementation of the brief one- to two-session primary health care intervention at Level 2. Supervision can play a role in the implementation of innovations. The presence of supervision in an organization results in more productive employees, who are more able to reach their aims (Latham, 2000). Positive forms of supervision, e.g., convincing a person of his or her own competences, will improve the personal efficacy of the employees. A high level of personal efficacy influences the tendency to change (Bandura, 2000). The study by Turner (2003) shows that a lack of supervision is an important obstacle for implementing the brief one- to two-session primary health care interventions. In implementing an innovation, it can be crucial whether an innovation is connected to the task interpretation of the professional (Fleuren et al., 2002). Finally, it can be important that specific conditions are met, such as sufficient time to execute the innovation (Wensing, Splunteren & Grol, 2000; Fleuren et al., 2002). In our study all the organizations were willing to invest in the implementation of Triple-P by making time available for coordination and supervision. The fourth success factor is the fact that it is a multilevel program, which offers possibilities to realize a tailored system. Working with the same pedagogic vision connects the different organizations. Triple P offered the possibility to develop a stepped care program. Here it should be noted that Primary Care institutions and Youth Care / Mental Health institutions are divided by the Dutch system. The local institutions and the provincial operating institutions are divided in terms of financial support, but more importantly, by the referral of the families.
The two divided sectors were not accustomed to working together. However, in executing the Triple P program they had to work together. The Level 3 interventions were implemented in the local Primary Care institutions, and the Level 4 interventions in the Youth Care / Mental Health institutions. Implementing level 1 through level 5 of the Triple P-program at once is preferable above implementing one intervention level of the Triple P program, because of the impact on population level. In a 3-year period, from 2008 to 2010, the whole Triple P program will be implemented in the Dutch capital, Amsterdam. A total of 800 professionals will be trained in level 2 through level 5 of Triple P. Also a universal media and communication strategy (level 1) is organized in the Netherlands. In the United States, a randomized trial to the entire Triple P program was conducted (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009). Large effect sizes were found for three independently derived population indicators: substantiated child maltreatment, child out-of-home placements, and child maltreatment injuries. The study found that making Triple P available to all parents led to significantly lower rates of confirmed child abuse, fewer out-of-home placements, and fewer hospitalizations from child abuse injuries, when compared to communities without access to Triple P. However, a multilevel approach is not achievable for all municipalities. It is possible that little connection in tasks is available, or that the tasks in parenting support can be conducted within one organization. In such cases, Triple P can also be an improvement compared to the present situation, because all interventions are separately effective and can be implemented separately.

**Future research**

The original REP model was assessed in a randomized controlled trial by Kelly and colleagues (2000). The study among 70 AIDS service organizations focused on the outcome on intervention fidelity and using the intervention, and delivery in different formats, type of population. In this study, we adapted the REP model for the implementation of a multilevel program. It is recommended to assess this adapted model, preferably in a randomized controlled trial. Besides outcome measures such as “likeness to use the program, program fidelity, outcomes on parent and child level, cost effectiveness,” we recommend to assess also the surplus of a multilevel approach for parents and professionals, on both outcome effects on client level or implementation effects (e.g., likeness to use the intervention, program fidelity) and the collaboration between organizations. Furthermore, it is recommended to develop and test the model for the time beyond the implementation phase. There is always the risk that the program fidelity will not sustain some years after the implementation phase. A thorough quality system needs to be developed in the adopting country to guarantee the sustainability of the program in the future. Guidelines for municipals, organizations, and professionals should be made to know what steps they have to make.
6.7 Conclusions

Developing evidence-based stepped care programs (consisting of campaigns, self-help, consultation, training, and therapy) is a major challenge in mental health care. If such programs are available in other countries, it may be efficient to implement these programs if conditions for intercultural transfer are met. In this article, we presented an example of a successful implementation of a multilevel program. Careful planning and creating the right conditions for implementation are the key factors for success. With a few additions, it was found that the REP framework is an excellent framework to guide this process.

References


