JEWISH FAMILY SERVICE

POSITIVE PARENTING PROGRAM

EVALUATION REPORT

FISCAL YEAR 2020-2021

PREPARED BY
SUSAN HEDGES, MPH
SUSAN HEDGES CONSULTING
SUSANHEDGESCONSULTING@GMAIL.COM
JULY 2021

TABLE OF CONTENTS

I. BACKGROUND 3
II. WHAT IS TRIPLE P? 4
III. JFS POSITIVE PARENTING PROGRAM 6
IV. THE EVALUATION AND THIS REPORT 8
V. RESULTS 9
SNAPSHOT OF PARTICIPANTS 9
SEMINAR RESULTS 12
SEMINAR DEMOGRAPHICS 12
SEMINAR SATISFACTION 14
INDIVIDUAL RESULTS 17
INDIVIDUAL DEMOGRAPHICS 17
INDIVIDUAL OUTCOMES 18
INDIVIDUAL SATISFACTION 21
GROUP RESULTS 23
GROUP DEMOGRAPHICS 23
GROUP OUTCOMES 24
1. SDQ 26
2. DASS 29
3. PPC 31
4. RQI 33
EFFECT SIZE RESULTS 35
GROUP SATISFACTION 38
IV. CONCLUSION 39

I. BACKGROUND

Jewish Family Service of San Diego (JFS) is a client-centered, impact-driven organization working to build a stronger, healthier, more resilient San Diego by empowering individuals and families to move toward self-sufficiency, supporting aging with dignity, and fostering community connection and engagement. Founded in 1918, JFS is one of San Diego's most impactful non-profit human services agencies – serving more than 30,000 people each year with an annual operating budget of $29,611,218. The agency's broad network of staff, volunteers, supporters, and community partners are committed to the pursuit of one shared goal: helping individuals and families in San Diego Move Forward. With an approach rooted in supportive personal relationships and strong community partnerships, JFS delivers services that foster health, skills, confidence, and resilience in every person served. With time and hard work, JFS clients build a foundation of economic stability, personal well-being, and community connection that empowers them to thrive. Services include but are not limited to homeless resources, parent education, refugee resettlement, case management, mental health counseling, crisis intervention, breast cancer care management, domestic violence services, comprehensive aging and wellness services, emergency and supplemental food distributions, and asset building services. JFS disrupts cycles of poverty by prioritizing the delivery of services to clients with extremely low to moderate incomes; 93% of individuals served live at or below 250% of the Federal Poverty Level. Most services are available free of charge, and while a few have sliding-scale fee structures, no one is denied service due to an inability to pay. JFS's work is guided by the Jewish value of repairing the world, which compels the agency to serve the greater community. JFS serves those in need without regard to religion, race, ethnicity, nationality, age, or sexual orientation.

In 2009, JFS applied for and was awarded by the County of San Diego County, Health and Human Services Agency, Behavioral Health Division, Children's Mental Health Services through the Mental Health Services Act (MHSA) to provide mental health prevention and early intervention services. MHSA, Proposition 63, was approved by California voters in November 2004 and became effective January 1, 2005. MHSA provides funding for the expansion and transformation of mental health services in California. *Prevention* and *Early Intervention* (PEI) is one of five program components of MHSA that target those community members that do not meet standard criteria for receiving mental health services, such as the general public, a whole population group, and/or individuals whose risk of developing mental illness is significantly higher than average. PEI priority populations this program targets include: children and youth in stressed families; children and youth at risk for school failure; and underserved cultural populations.

Consistent with MHSA guidelines, between 2005 and 2009 the County of San Diego conducted an inclusive community planning process by soliciting input through numerous venues and a broad range of stakeholders, resulting in the selection of Early Childhood and Parenting as one of the ten MHSA PEI priority focus areas. Following the extensive community input process, a workgroup was formed to focus on the needs for children zero to five. Based on the assessment of need, Head Start and Early Head Start Centers were selected as a way of reaching high-risk children in families with income levels at or below the federal poverty level.

JFS is using the County of San Diego selected evidence-based model *Triple P* as its PEI approach to promote social and emotional wellness for children and their families who live in at-risk, low socio-economic communities with a high concentration of ethnic minorities. Triple P provides assistance for parents/caregivers/families (referred to as parents hereafter) of young children who demonstrate typical to moderate behavioral or emotional difficulties. The objective of the PEI funding focuses on reducing the risk for behavioral/emotional problems in young children. This outcome will be achieved through reducing the prevalence of coercive or inappropriate parenting behaviors.

II. What Is Triple P?

Triple P is a multi-level, preventively-oriented parenting and family support strategy developed by researchers at The University of Queensland in Brisbane, Australia[i] (all information in this section comes from the Triple P America website, see reference citation). The program aims to prevent severe behavioral, emotional, and developmental problems in children by enhancing the knowledge, skills and confidence of parents. It incorporates five levels of intervention on a tiered continuum of increasing strength for parents of children from birth to age 16. Triple P draws on social learning, cognitive-behavioral and developmental theory, as well as research into risk and protective factors associated with the development of child social and behavioral problems. The program aims to tailor information, advice, and professional support to the needs of individual families. It recognizes that parents have differing needs regarding the type, intensity, and mode of assistance they may require.

The following bullets described the five levels of Triple P:

- Level 1: universal parent information strategy that provides information about parenting through a coordinated promotional campaign using print and electronic media as well as user-friendly parenting tip sheets and videos that demonstrate specific parenting strategies. The aim is to increase community awareness of parenting resources and the receptivity of parents to participating in programs, and to create a sense of optimism by depicting solutions to common behavioral and developmental concerns.
- Level 2: brief, one to two-session primary health care guidance to parents of children with mild behavior difficulties or developmental issues.
- Level 3: four-session intervention, targets children with mild to moderate behavior difficulties and includes active skills training for parents.
- Level 4: intensive eight to ten-session individual, group or self-directed parent training program for children with more severe behavioral difficulties.
- Level 5: enhanced behavioral family intervention program for families where child behavior problems persist or where parenting difficulties are complicated by other sources of family distress (e.g., marital conflict, parental depression or high levels of stress).

The social learning theory approach used by Triple P to treat and prevent childhood disorders has the strongest empirical support of any intervention with children, particularly those with conduct problems. Triple P aims to enhance family protective factors and to reduce risk factors associated with severe behavioral and emotional problems in children and adolescents. Specifically the program aims to: 1) enhance the knowledge, skills, confidence, self-sufficiency, and resourcefulness of parents; 2) promote nurturing, safe, engaging, non-violent, and low-conflict environments for children; and 3) promote children's social, emotional, language, intellectual, and behavioral competencies through positive parenting practices.

Triple P content draws on the following:

- Social learning models of parent-child interactions that highlight the reciprocal and bidirectional nature of such interactions. Triple P teaches parents positive child management skills as an alternative to coercive, inadequate or ineffective parenting practices.
- Research in child and family behavior therapy and applied behavior analysis, which has developed useful behavior change strategies, particularly focused on rearranging antecedents of problem behavior through designing more positive engaging environments for children.
- Developmental research on parenting in everyday contexts. Children's risk of developing severe behavioral and emotional problems is reduced by teaching parents to use naturally occurring

daily interactions to teach children language, social skills, developmental competencies and problem solving skills in an emotionally supportive context.
- Social information processing models that highlight the important role of parental cognitions such as attributions, expectancies and beliefs as factors, which contribute to parental self-efficacy, decision-making and behavioral intentions. Parents' attributions are targeted in the intervention by encouraging parents to identify alternative social interactional explanations for their child's and their own behavior.
- Developmental psychopathology research that has identified specific risk and protective factors that are linked to adverse developmental outcomes in children. Specifically, poor parent management practices, marital family conflict, and parental distress are targeted.
- A population health perspective to family intervention that involves the explicit recognition of the role of the broader ecological context for human development. Triple P's media and promotional strategy as part of a larger system of intervention aims to change this broader ecological context of parenting. It does this by normalizing parenting experiences, particularly the process of participating in parent education, by breaking down parents' sense of social isolation, increasing social and emotional support from others in the community, and validating and acknowledging publicly the importance and difficulties of parenting.

Triple P's approach to promoting parental competence views the development of a parent's capacity for self-regulation as a central skill and involves teaching parents skills that enable them to become independent problem solvers. This self-regulatory framework is operationalized to include:

- <u>Self-sufficiency:</u> a parenting program is time limited, parents need to become independent problem solvers so they trust their own judgment and become less reliant on others in carrying out basic parenting responsibilities. Self-sufficient parents have the resilience, resourcefulness, knowledge, and skills to parent with confidence.
- <u>Parental self-efficacy:</u> refers to a parent's belief that he or she can overcome or solve a parenting or child management problem. Parents with high self-efficacy have more positive expectations about the possibility of change.
- <u>Self-management:</u> tools or skills that parents use to become more self-sufficient include self-monitoring, self-determination of performance goals and standards, self-evaluation against some performance criterion, and self-selection of change strategies. As parents are responsible for the way they choose to raise their children, parents select which aspects of their own and their children's behavior they wish to work on, set goals for themselves, choose specific parenting and child management techniques they wish to implement, and self-evaluate their success with their chosen goals against self-determined criteria.
- <u>Personal agency:</u> the parent increasingly attributes changes or improvements in his or her situation to his or her own or child's efforts rather than to chance, age, maturational factors or other uncontrollable events. This outcome is achieved by prompting parents to identify potentially modifiable causes or explanations for their child's or their own behavior.

Encouraging parents to become self-sufficient means that parents become more connected to social support networks (partner, extended family, friends and child care supports). However, the broader ecological context within which a family lives cannot be ignored (poverty, dangerous neighborhood, community, ethnicity and culture). It is hypothesized that the more self-sufficient parents become, the more likely they are to be resilient in coping with adversity, seek appropriate support when they need it, advocate for children, become involved in their child's schooling, and protect children from harm (e.g., by managing conflict with partners, and creating a secure, low-conflict environment).

Five core positive parenting principles form the basis of the program. These principles address specific risk and protective factors known to predict positive child developmental and mental health outcomes.

- **Safe and engaging environment:** children need a safe, supervised, and protective environment that provides opportunities for them to explore, experiment, and play. This principle is essential to promote healthy development and to prevent accidents and injuries in the home.
- **Positive learning environment:** involves educating parents in their role as their child's first teacher. Triple P targets how parents can respond positively and constructively to child-initiated interactions (e.g., requests for help, information, advice, attention) through incidental teaching to assist children to learn to solve problems for themselves.
- **Assertive discipline:** child management strategies are taught that are alternatives to coercive and ineffective discipline practices (shouting, threatening, physical punishment). A range of behavior change procedures are demonstrated to parents including: selecting ground rules for specific situations; discussing rules with children; giving clear, calm, age appropriate instructions and requests; logical consequences; quiet time (non-exclusionary time out); time out; and planned ignoring. Parents are taught to use these skills in the home as well as in community settings to promote the generalization of parenting skills to diverse parenting situations.
- **Realistic expectations:** explores with parents their expectations, assumptions and beliefs about the causes of children's behavior, and choosing goals that are developmentally appropriate for the child and realistic for the parent. There is evidence that parents who are at risk of abusing their children are more likely to have unrealistic expectations of children's capabilities.
- **Parental wellbeing:** parenting is affected by a range of factors that impact on a parent's self-esteem and sense of wellbeing. Triple P addresses this issue by encouraging parents to view parenting as part of a larger context of personal self-care, resourcefulness, and wellbeing and by teaching parents practical parenting skills that are easy to do.

III. JFS POSITIVE PARENTING PROGRAM

As the previous information illustrates, the Triple P model offers a range of interventions in which to provide parenting information. JFS call its program, ***Positive Parenting Program (PPP),*** and is utilizing the following Triple P interventions:

1. Seminar (Level 2): series of three, one-time seminars delivered to a large group of parents, teachers/school staff, and child care staff that is designed to introduce positive parenting principles and building blocks for raising confident and resilient children. *Seminar* is prevention focused.

- Seminar 1 – *The Power of Positive Parenting* introduces the five core principles of positive parenting: safe, engaging environment; positive learning environment; assertive discipline; realistic expectations; and well-being.
- Seminar 2 – *Raising Confident, Competent Children* shows how to use positive parenting principles to teach children important values and skills, including: encouraging respect, cooperation, getting along with others, learning to be independent, learning to develop healthy self-esteem and learning to become good problem solvers.
- Seminar 3 – *Raising Resilient Children* helps children learn emotional regulation skills.

2. Individual (Level 3): consists of four, 30-60 minute sessions that incorporate active skills training and the selective use of parenting tip sheets covering common developmental and behavioral problems. It also builds in generalization enhancement strategies for teaching parents how to apply knowledge and

skills gained to non-targeted behaviors and other siblings. *Individual* is prevention and early intervention focused.

- Session 1 clarifies the history and nature of the presenting problem (through interview and direct observation), negotiates goals for the intervention and sets up a baseline monitoring system for tracking the occurrence of problem behaviors.
- Session 2 reviews the initial problem to determine whether it is still current; discusses the results of the baseline monitoring, including the parent's perceptions of the child's behavior; shares conclusions with the parent about the nature of the problem (i.e. the diagnostic formulation) and its possible etiology; and negotiates a parenting plan (using a tip sheet or designing a planned activities routine). This plan may involve the introduction of specific positive parenting strategies through discussion, modeling or presentation of segments from *Every Parent's Survival Guide* video. This session also involves identifying and countering any obstacles to implementation of the new routine by developing a personal coping plan with each parent. The parents then implement the program.
- Session 3 involves monitoring progress and discussing any implementation problems, and may involve the introduction of additional parenting strategies. The aim is to refine the parents' implementation of the routine as required and provide encouragement for their efforts.
- Session 4 involves a progress review, trouble shooting for any difficulties the parent may be experiencing, positive feedback and encouragement, and termination of contact. If no positive results are achieved after several weeks, the family may be referred to a higher level of service.

3. Group (Level 4): an eight-session program, ideally conducted in groups of 10–12 parents. It employs an active skills training process to help parents acquire new knowledge and skills and provides opportunities for parents to learn through observation, discussion, practice and feedback. Segments from *Every Parent's Survival Guide* video are used to demonstrate positive parenting skills. These skills are then practiced in small groups. Parents receive constructive feedback about their use of skills in an emotionally supportive context. Between sessions, parents complete homework tasks to consolidate their learning from the group sessions. Thirty-minute follow-up telephone sessions provide additional support to parents as they put into practice what they have learned in the group sessions. The final session covering skill generalization and maintenance may be offered as a group session and celebration, or as a telephone session, depending on available resources. Although delivery of the program in a group setting may mean parents receive less individual attention, there are several benefits of group participation for parents. These benefits include support, friendship and constructive feedback from other parents as well as opportunities for parents to normalize their parenting experience through peer interactions. *Group* is prevention and early intervention focused.

4. Group (Level 4) Online: a comprehensive, eight-session web-based program that guides parents through Triple P's 17 core parenting skills. Based on the Standard Triple P program it includes opt-in text or email reminders of session goals and strategies. This format was introduced around March 2020 due to the Covid-19 pandemic that restricted the program's ability to provide in person sessions.

IV. THE EVALUATION AND THIS REPORT

Key to understanding a program's effectiveness is learning about both process measures (amount of service provided) and outcomes (how clients are fairing). The overarching goal of PPP is to improve the parenting skills of parents with the result that their children are less likely to experience mental illness. To that end, JFS contracted with Susan Hedges, Susan Hedges Consulting (SHC), (formerly with the Maternal and Child Health Initiative at the Institute for Public Health, Graduate School of Public Health, San Diego State University) to analyze their data and produce the annual outcomes report.

This report has been strategically designed to provide information and results that have not already been compiled and presented throughout the year via the Quarterly Service Report (QSR) that is required by the County of San Diego. The QSR is primarily a quarterly and cumulative annual total of the number of participants that have received services by level, site (i.e., Head Start/Early Head Start, school-based, and community sites), military status, and often by region. A snapshot of outcomes is also reported that consists of the percentage of clients that have completed evaluation assessments and have improved scores at posttest. In comparison, this report presents detailed outcomes based on the level of Triple P intervention (Seminar, Individual, and Group).

The results reported in this document are based upon electronic data provided to SHC by JFS. All analyses are based upon the availability and validity of these data. The results are reported for services provided during the eighth year of program operation; July 1, 2020 to June 30, 2021 (FY 20-21). Percentages have been rounded to the next highest value and may not always total 100%.

DATA COLLECTION

PPP utilizes outcome assessments as recommended by the Triple P developers. In addition, the contract with the County of San Diego also stipulates a variety of desired outcomes. These outcomes include not only the number of participants completing the various programs, but also their level of satisfaction with the programs. In FY 16-17 JFS switched from a program-specific excel database to its agency-wide ETOi database to record and store participant data. Each month data are emailed to SHC for analysis for monthly reports. The data that are sent include a unique participant identification number, which ties all the assessments to the participant's demographics. Participant names and addresses are not included in the data sent to SHC. The type of data collected, entered, and sent to SHC include:

Demographics

- Participant (adult): date of birth, gender, race/ethnicity, primary language, marital status, relationship to child, type and location of PPP service received, instructor, affiliation with military, postal zip code, PPP service(s) completed, and month(s) completed.
- Child: age by age category, race/ethnicity, and gender.

Assessments

- Satisfaction Survey: version 1 administered at the end of each three-seminar session in PPP Seminar and version 2 administered at the end of PPP Individual and Group.
- Parenting Experience Survey administered at the first (pre) and final session (post) in Individual.
- PPP Group uses four outcome measurement tools. Each tool is administrated at the first (pre) and final session (post).
    - Strengths and Difficulties Questionnaire (SDQ)
    - Depression, Anxiety, Stress Scale (DASS)
    - Parent Problem Checklist (PPC)
    - Relationship Quality Index (RQI)

DATA CAVEATS

An important note to discuss is that the majority of data and results reported herein are based upon participant self-report. The reader is cautioned to interpret these results with the understanding that there are inherent biases with all data that are self-reported. One of the most common biases affecting self-reported data is social desirability[ii]. Social desirability is the tendency of an individual to convey an image in keeping with social norms and to avoid criticism from the person collecting his or her data[iii]. Social desirability bias can significantly obscure or distort the measurement of the variable of interest.

V. RESULTS

OVERALL SNAPSHOT OF PARTICIPANTS

Table 1 and Figure 1 show the distribution of PPP services by level along with the completion rate. *Seminar* had the greatest number of participants (1,110) but the lowest completion (graduation) rate (52%). Conversely, *Individual* had the smallest number of participants (212) but the highest completion rate (91%). Lastly, *Group* had 351 participants and a completion rate of 64%.

TABLE 1. PPP SERVICE PROVISION AND PARTICIPATION BY LEVEL

	SEMINAR	INDIVIDUAL	GROUP
SERVICES PROVIDED AT	15 COMMUNITY SITES 28 ELEMENTARY SCHOOLS 51 CHILD DEVELOPMENT SITES	11 COMMUNITY SITES 30 ELEMENTARY SCHOOLS 36 CHILD DEVELOPMENT SITES	5 COMMUNITY SITES 6 ELEMENTARY SCHOOLS 23 CHILD DEV. SITES
# OF PARTICIPANTS	1,110	212	351
# OF GRADUATES	573	192	226
COMPLETION RATE	52%	91%	64%

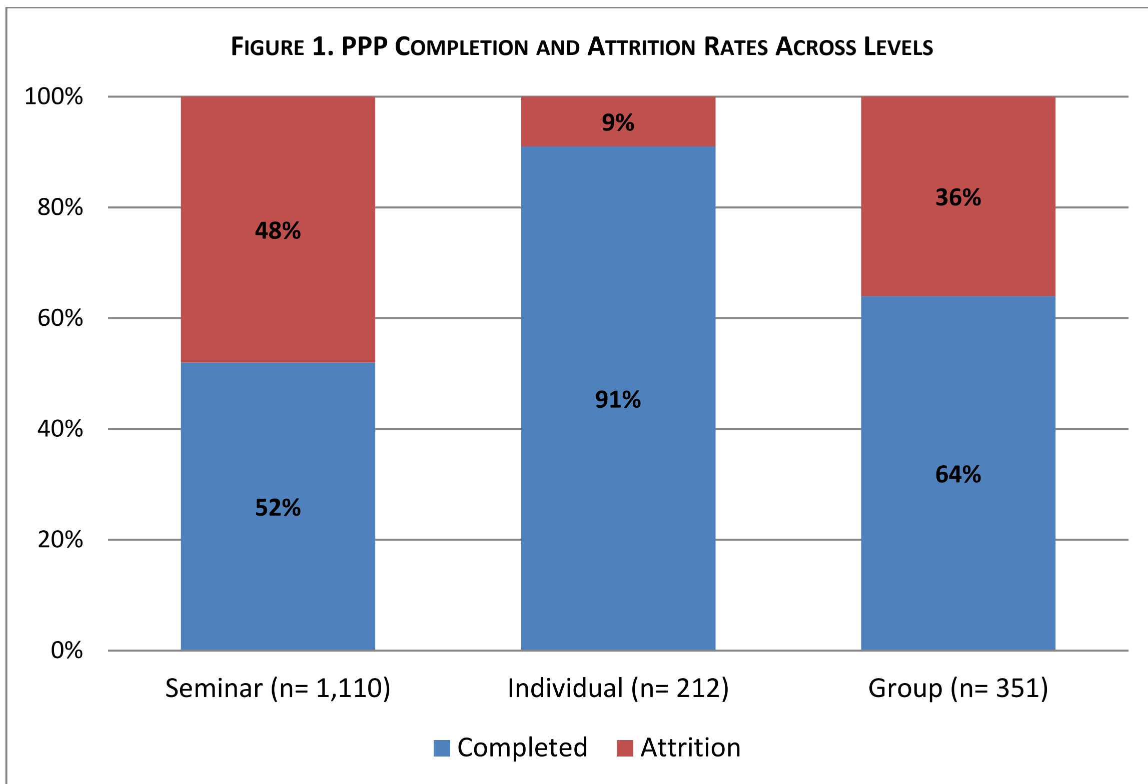
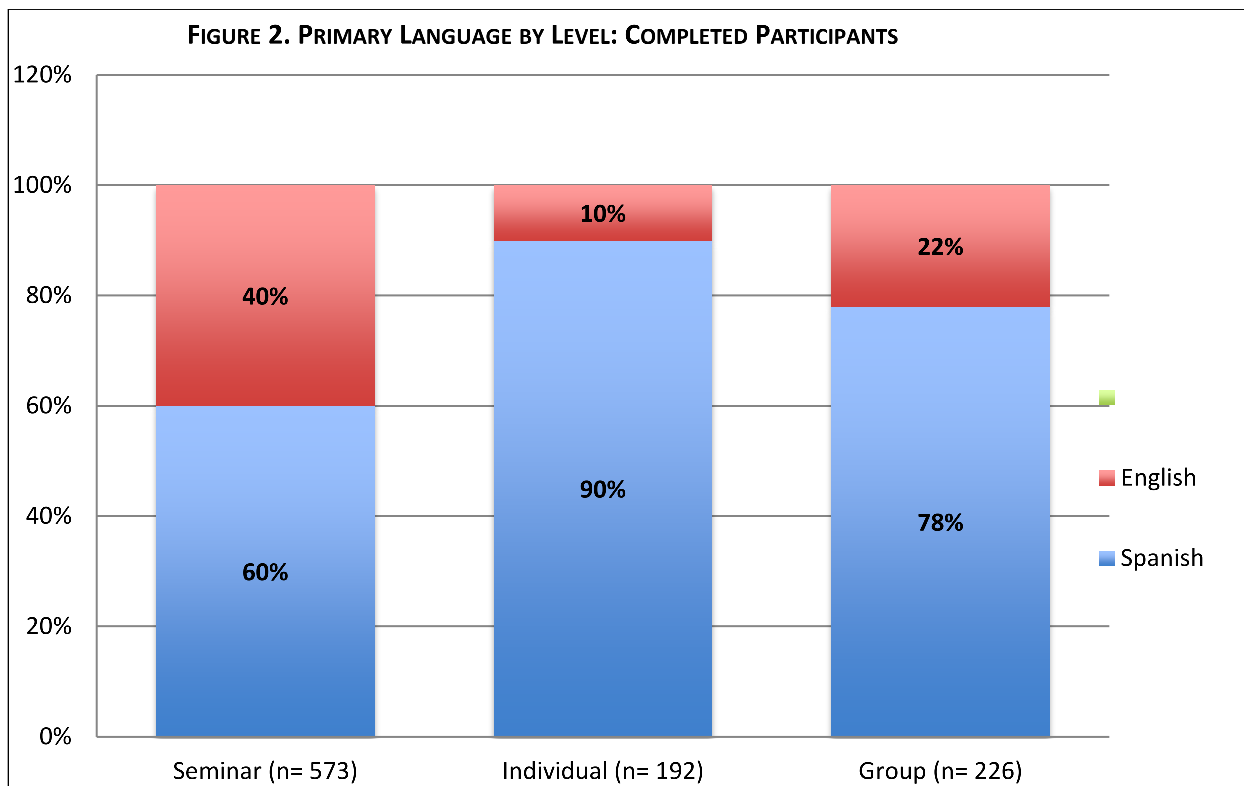
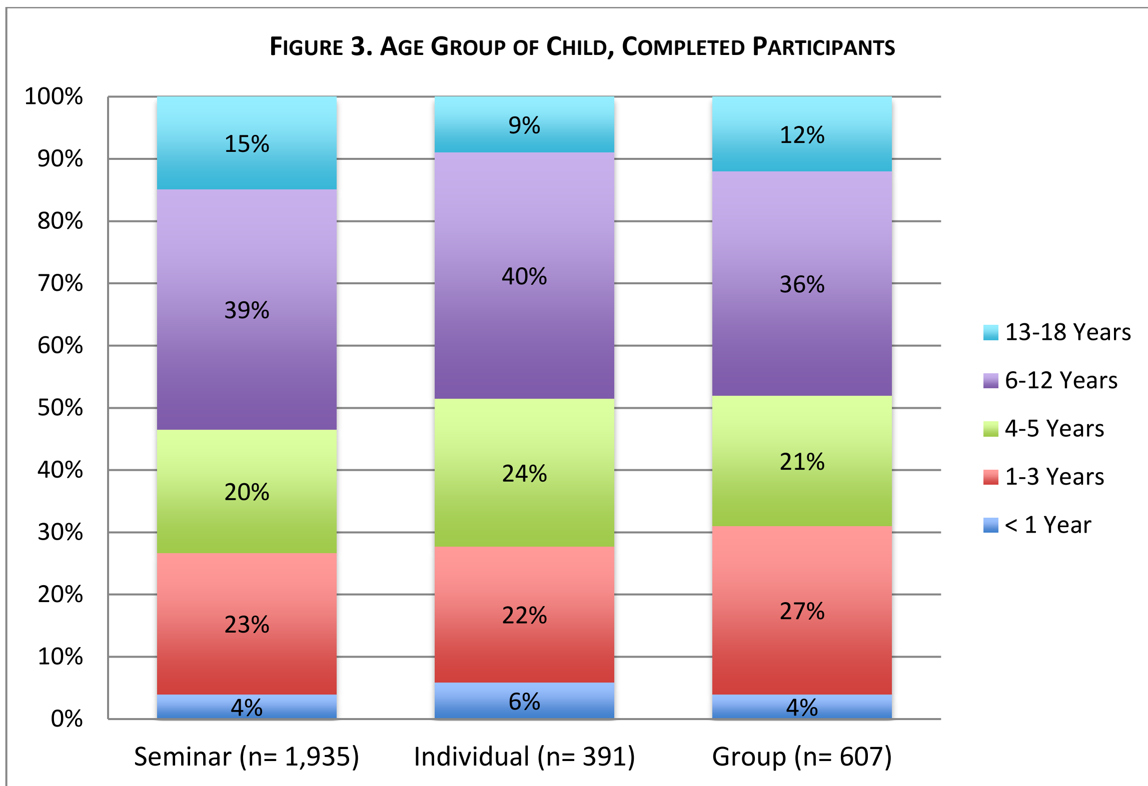


Figure 2 shows the primary language distribution of PPP graduates by level. Across all levels, the greatest percentage of completed participants reported Spanish as their primary language (60% *Seminar*, 90% *Individual*, and 78% *Group*).



While the children of participants do not actively participate in PPP, the goal is that they will be directly affected by the services received by their parents. It is of interest to JFS and the County of San Diego to capture their basic demographic information. Figure 3 shows the aggregate number of children and their age distribution as self-reported by completed participants. Children are counted by household, not by participant, which avoids double counting children when both parents are involved in PPP. Results show that 42% of children were in the target range of 0-5 years of age in *Seminar* and *Individual* while *Group* results show 38%. The sample sizes in Figure 3 do not include missing data.



PPP SEMINAR RESULTS

Seminar (series of three, approximately 2-hour sessions) is provided to a variety of target audiences: parents, teachers/school staff, and child care staff through the following target locations: child development sites, community sites, and low-income elementary schools. During FY 20-21, JFS proposed to serve 2,200 parents and 175 school staff and child care providers. Results show that *Seminar* provided services to 873 parents (40% of its goal) and 237 school staff and child care providers (135% of its goal). Participants are considered completed if they attended all three sessions. Of those 873 parents[1], 432 completed (50% completion rate). Of the 237 school staff or child care providers, 141 completed all three sessions (59% completion rate). A total of 573 participants completed Seminar. JFS provided *Seminar* services to 51 unique child development sites, 15 community sites, and 28 elementary school locations throughout San Diego County. Of the 573 participants completing *Seminar*, 12% (67) also completed *Individual* and 18% (101) completed *Group*.

PPP SEMINAR DEMOGRAPHICS

At the beginning of each seminar session, attendees were asked to sign in and provide basic demographic information. At the end of each session, participants completed a Satisfaction Survey.

Table 2 shows the demographic information collected for adult participants for those who completed and did not complete *Seminar*. Of those completed participants that provided demographic information, the majority were parents (72%), female (90%), and the largest percentage speak Spanish as their primary language (60%). The greatest percentage of completed participants attended services at a Child

[1] Table 2 displays the distribution of Participant Type (parent, relative, and educator/child care staff member). There were 109 adult completed participants that did not disclose their "participant type" and they have been included in the parent category for the completion rate for simplicity's sake but have been excluded from Table 2.

Development site (49%). The greatest percentage of completed participants occurred in the North Inland (32%). Completed participants had a total of 1,993 children.

Table 2. PPP Seminar Participant Demographics: Adults				
	Completed (N= 573*)		Non-Completed (N= 537*)	
Demographic	Percent	Number	Percent	Number
Participant Type (N= 555)			**Participant Type (N= 521)**	
Parent/Step-Parent	72%	402	80%	414
Grandparent	1%	6	2%	7
Other Relative/Caregiver	1%	6	1%	4
Early/Head Start Staff	13%	72	5%	26
Other Staff	12%	69	13%	70
Gender (N= 559)			**Gender (N= 524)**	
Female	90%	502	87%	454
Male	10%	57	13%	70
Venue				
Community Site	24%	140	32%	172
Child Development Site	49%	282	34%	184
Elementary School	26%	151	34%	181
Primary Language				
English	40%	230	52%	280
Spanish	60%	343	48%	257
Race/Ethnicity (N= 554)			**Race/Ethnicity (N=501)**	
African American	3%	19	4%	22
Asian/Pacific Islander	2%	12	6%	29
Hispanic/Latino	81%	446	69%	348
Native American	<1%	1	1%	3
White	12%	64	16%	82
Multi-Racial	2%	12	3%	17
Marital Status (N= 559)			**Marital Status (N= 523)**	
Single	24%	136	27%	142
Married	62%	344	60%	315
Divorced	6%	31	5%	28
Separated	5%	25	4%	23
Widow	1%	4	1%	4
Other	3%	19	2%	11
Region				
Central	11%	63	10%	52
East	6%	34	6%	33
North Central	16%	93	20%	106
North Coastal	17%	96	17%	90
North Inland	32%	182	33%	176
South	18%	105	15%	80

*Only valid data are included in the table (missing data excluded).

Table 3 shows the demographic information for <u>all children</u> of participants in the household. Thus the total number of children served may include siblings of the child targeted for PPP intervention. Additionally, children are only counted once per household. Therefore if both parents attend *Seminar*,

their child(ren) will only be counted once. A total of 1,993 children are assumed to have benefited by adults completing *Seminar*. Forty-one percent (41%) of these children for whom we have data are between 0-5 years of age. The majority of completed children are of Hispanic/Latino ethnicity (79%). There do not seem to be any notable differences between child completes and non-completes.

Table 3. PPP Seminar Participant Demographics: Children				
	Completed (n= 1,993*)		**Non-Completed (n= 1,077*)**	
Demographic	**Percent**	**Number**	**Percent**	**Number**
Age (n= 1,167)			**Age (n= 1,050)**	
< 1 Year	5%	59	4%	39
1-3 Years	20%	228	21%	219
4-5 Years	17%	197	16%	168
6-12 Years	42%	487	43%	449
13-18 Years	17%	196	17%	175
Gender (n= 1,133)			**Gender (n= 1,035)**	
Female	48%	543	46%	481
Male	52%	590	55%	554
Race/Ethnicity (n= 1,145)			**Race/Ethnicity (n= 1,011)**	
African American	2%	24	5%	47
Asian/Pacific Islander	2%	22	4%	43
Hispanic/Latino	79%	905	70%	707
Native American	1%	11	1%	5
White	12%	137	15%	150
Multi-Racial	4%	46	6%	59

*Only valid data are included in the table (missing data excluded).

PPP Seminar Satisfaction

The key outcome measure for *Seminar* is the Satisfaction Survey. This assessment is administered at the end of each session and is designed to collect information to evaluate the different PPP levels and help to improve the program. The Satisfaction Survey addresses the quality of the intervention, the extent to which it met participant needs, the effect it had on parenting skills and the child's behavior problems.

The Satisfaction Survey for seminar sessions one and two consists of ten questions. In FY 14-15 an additional question was added to the third seminar's survey for a total of 11 questions. This additional question was taken from the *Individual* and *Group* Satisfaction Survey and asks if the program has helped the child's behavior. In FY 16-17 the additional question (question 11) was also added to seminar sessions one and two. It is hoped that the additional question will help leadership better understand the impact of *Seminar* services. Both survey versions use a rating scale from one to seven (1-7, higher score optimal). JFS has determined that a score of six (6.0) or higher equals the level of service that they strive to provide - one of excellence.

Table 4 shows the mean score and the percentage of responses that were a six or higher for each question by seminar, the total mean score and the percentage of responses that were a six or higher by question summed across seminars, and the total mean score and the percentage of responses that were a six or higher for all questions combined by seminar for only completed participants. Results are not presented for missing data. Thus in order to be calculated in the Total Column (column 5) a participant had to respond to the same question for each of the three seminar sessions. The same method was used

to calculate the overall mean score for each seminar (final row in Table 4), a participant had to fill out the entire survey with no missing data.

TABLE 4. PPP SEMINAR SATISFACTION SURVEY RESULTS: COMPLETED PARTICIPANTS ONLY								
	POWER OF POSITIVE PARENTING		CONFIDENT, COMPETENT CHILDREN		RAISING RESILIENT CHILDREN		TOTAL	
	MEAN	% ≥ 6	MEAN	% ≥ 6	MEAN	% ≥ 6	MEAN	% ≥ 6
	N		N		N		N	
1. HOW WOULD YOU RATE THE QUALITY OF THE SEMINAR PRESENTATION?	6.81	96%	6.81	97%	6.87	97%	**6.83**	**96%**
	496		471		477		**391**	
2. DID THE SEMINAR PROVIDE SUFFICIENT OPPORTUNITIES FOR QUESTIONS?	6.78	94%	6.80	97%	6.88	98%	**6.82**	**96%**
	495		471		477		**390**	
3. WAS THE SEMINAR INTERESTING TO YOU?	6.83	96%	6.85	97%	6.90	99%	**6.86**	**96%**
	496		471		477		**391**	
4. DID THE PRESENTER USE CLEAR EXAMPLES TO ILLUSTRATE PARENTING ISSUES?	6.83	96%	6.85	97%	6.90	98%	**6.87**	**97%**
	496		471		476		**390**	
5. DID THE PRESENTER PROVIDE CLEAR EXPLANATIONS?	6.84	97%	6.87	97%	6.89	98%	**6.87**	**97%**
	496		468		477		**389**	
6. DID YOU GAIN SUFFICIENT KNOWLEDGE TO IMPLEMENT THE PARENTING ADVICE YOU HEARD?	6.79	96%	6.80	96%	6.86	98%	**6.82**	**96%**
	496		470		477		**391**	
7. OVERALL, HOW WOULD YOU RATE THE CONTENT OF THE SEMINAR?	6.84	97%	6.85	97%	6.91	98%	**6.88**	**98%**
	496		470		477		**390**	
8. WAS THE SEMINAR HELPFUL IN GAINING AN UNDERSTANDING OF WHAT TO DO TO HELP CHILDREN LEARN NEW SKILLS AND BEHAVIOR?	6.76	95%	6.83	96%	6.86	98%	**6.83**	**95%**
	497		471		477		**391**	
9. IF YOU RECEIVED AND READ A PARENTING TIP SHEET, WAS THE INFO IN THE TIP SHEET USEFUL?	6.54	91%	6.56	91%	6.78	95%	**6.67**	**93%**
	288		282		313		**170**	
10. DO YOU INTEND TO IMPLEMENT THE PARENTING ADVICE RECEIVED?	6.83	97%	6.87	98%	6.89	98%	**6.87**	**97%**
	496		471		477		**391**	
11. HAS THE PROGRAM HELPED YOU TO DEAL MORE EFFECTIVELY WITH YOUR CHILD'S BEHAVIOR?	6.58	87%	6.59	89%	6.73	92%	**6.63**	**88%**
	461		455		466		**349**	
TOTAL	**6.78**	**94%**	**6.82**	**96%**	**6.88**	**98%**		
	281		**273**		**308**			

Table 5 shows the mean score and the percentage of responses that were a six or higher for each question by seminar and the total mean score and the percentage of responses that were a six or higher for all questions combined by seminar for non-completed participants. Results are not presented for missing data. Thus in order to be calculated in overall mean score for each seminar (final row in Table 5), a participant had to fill out the entire survey with no missing data.

TABLE 5. PPP SEMINAR SATISFACTION SURVEY RESULTS: NON-COMPLETED PARTICIPANTS ONLY						
	POWER OF POSITIVE PARENTING		CONFIDENT, COMPETENT CHILDREN		RAISING RESILIENT CHILDREN	
	MEAN	% ≥ 6	MEAN	% ≥ 6	MEAN	% ≥ 6
	N		N		N	
1. HOW WOULD YOU RATE THE QUALITY OF THE SEMINAR PRESENTATION?	6.56	91%	6.65	94%	6.79	95%
	239		158		108	
2. DID THE SEMINAR PROVIDE SUFFICIENT OPPORTUNITIES FOR QUESTIONS?	6.60	89%	6.72	94%	6.85	97%
	239		158		108	
3. WAS THE SEMINAR INTERESTING TO YOU?	6.66	93%	6.73	94%	6.88	97%
	238		158		108	
4. DID THE PRESENTER USE CLEAR EXAMPLES TO ILLUSTRATE PARENTING ISSUES?	6.68	94%	6.74	94%	6.84	96%
	239		158		108	
5. DID THE PRESENTER PROVIDE CLEAR EXPLANATIONS?	6.74	96%	6.79	96%	6.86	97%
	239		158		108	
6. DID YOU GAIN SUFFICIENT KNOWLEDGE TO IMPLEMENT THE PARENTING ADVICE YOU HEARD?	6.59	90%	6.67	94%	6.79	96%
	239		158		107	
7. OVERALL, HOW WOULD YOU RATE THE CONTENT OF THE SEMINAR?	6.61	91%	6.68	93%	6.82	96%
	239		158		108	
8. WAS THE SEMINAR HELPFUL IN GAINING AN UNDERSTANDING OF WHAT TO DO TO HELP CHILDREN LEARN NEW SKILLS AND BEHAVIOR?	6.53	89%	6.69	92%	6.73	93%
	239		157		108	
9. IF YOU RECEIVED AND READ A PARENTING TIP SHEET, WAS THE INFO IN THE TIP SHEET USEFUL?	6.25	81%	6.59	90%	6.64	94%
	135		92		69	
10. DO YOU INTEND TO IMPLEMENT THE PARENTING ADVICE RECEIVED?	6.71	93%	6.73	93%	6.84	97%
	239		158		108	
11. HAS THE PROGRAM HELPED YOU TO DEAL MORE EFFECTIVELY WITH YOUR CHILD'S BEHAVIOR?	6.28	75%	6.40	78%	6.57	86%
	216		149		104	
TOTAL	**6.63**	**91%**	**6.74**	**92%**	**6.79**	**97%**
	130		**90**		**68**	

Mirroring past years' results, the mean for each question, regardless of the seminar and for both completed and non-completed participants, exceeded the minimum level of satisfaction (6.0) set by JFS.

PPP Individual Results

PPP Individual consists of four, 30 to 60 minute one-on-one sessions with a JFS educator. During FY 20-21, JFS proposed to serve 180 participants. Results show that *Individual* provided services to 212 participants, reaching 118% of its goal. Participants that attend all four sessions are considered completed. A total of 192 out of 212 participants completed Individual, resulting in a 91% completion rate. Of the 192 participants completing *Individual*, 36% (69) also completed *Seminar* and 20% (38) completed *Group*.

PPP Individual Demographics

Table 6 shows the demographic results for adults. For those participants for whom we have demographic data, the majority of completed participants are female (84%), Hispanic/Latino (91%), Spanish speaking (90%), and married (57%). The largest percentage of completed participants (37%) received services in the North Inland region of San Diego County.

Table 6. PPP Individual Participant Demographics: Adults				
	Completed (n= 192*)		**Non-Completed (n= 20*)**	
Demographic	**Percent**	**Number**	**Percent**	**Number**
Gender (n= 187)			**Gender (n= 19)**	
Female	84%	158	68%	13
Male	16%	29	32%	6
Primary Language				
English	10%	20	40%	8
Spanish	90%	172	60%	12
Participant Type (n= 184)			**Participant Type (n= 19)**	
Parent/Step-Parent	90%	166	95%	18
Grandparent	2%	4	-	-
Other Relative/Caregiver	-	-	-	-
Early/Head Start Staff	2%	3	-	-
Other Staff	6%	11	5%	1
Race/Ethnicity (n= 188)			**Race/Ethnicity (n= 19)**	
African American	1%	1	-	-
Asian/Pacific Islander	1%	2	-	-
Native American	1%	1	-	-
Hispanic/Latino	91%	172	84%	16
White	5%	9	16%	3
Multi-Racial	2%	3	-	-
Marital Status (n= 183)			**Marital Status (n= 19)**	
Single	24%	44	21%	4
Married	57%	104	58%	11
Divorced	8%	14	11%	2
Separated	9%	16	11%	2
Widowed	1%	1	-	-
Other	2%	4	-	-
Region				
Central	14%	27	-	-
East	3%	6	-	-
North Central	17%	32	55%	11
North Coastal	22%	42	5%	1

Table 6. PPP Individual Participant Demographics: Adults, Continued	Completed (n= 192*)		Non-Completed (n= 20*)	
Demographic	Percent	Number	Percent	Number
North Inland	37%	70	25%	5
South	8%	15	15%	3
Venue				
Community Site	22%	42	70%	14
Elementary School	32%	62	5%	1
Child Development Site	46%	88	25%	5

*Only valid data are included in the table (missing data excluded).

Table 7 shows the demographic results for children. Less than half (42%) of the completed children were between 0-5 years.

Table 7. PPP Individual Participant Demographics: Children				
Demographic	Completed (n= 437*)		Non-Completed (n= 43*)	
	Percent	Number	Percent	Number
Age (n= 435)			**Age**	
< 1 Year	4%	17	9%	4
1-3 Years	19%	82	33%	14
4-5 Years	19%	84	21%	9
6-12 Years	43%	189	33%	14
13-18 Years	14%	63	5%	2
Gender (n= 435)			**Gender (n= 42)**	
Female	43%	185	43%	18
Male	57%	250	57%	24
Race/Ethnicity (n= 399)			**Race/Ethnicity (n= 37)**	
African American	2%	6	-	-
Asian/Pacific Islander	<1%	1	-	-
Hispanic/Latino	90%	359	84%	31
Native American	1%	5	-	-
White	5%	18	8%	3
Multi-Racial	3%	10	8%	3

*Only valid data are included in the table (missing data excluded).

PPP Individual Outcomes

The Parenting Experience Survey (PES) is the primary outcome measure for those participating in *Individual*. The PES is a self-report measure completed by the parent. It is designed to provide information about a parent's sense of effectiveness in his or her parenting role and consists of 11 questions. Areas of measure include:

- Perceived difficulty of the child's behavior
- Experience in parenting role
- The level of confidence and support felt as a parent
- Extent of agreement between parents over discipline (among those in a two-parent family)
- The level of support provided by a partner regarding his or her role as a parent

A total of 186 participants completed each a PES pre and posttest. These 186 participants with a completed pre and posttest are referred to as a *matched sample*. Looking at participants with both a pre and posttest allows us to determine if a learning or behavior change has occurred. Results presented below are for this matched sample. While a total of 186 participants did complete each a pre and posttest, skipped or missed answers may occur for one or more question on either test. Only results with both a pre and posttest answer by each participant are used in the analysis. The sample size for each question is noted at the end of the question to show the reader the number of valid responses.

Participants responded to each question using a five-point scale ranging from "1" *Not At All* to "5" *Extremely*. Typically, assessments are designed so that a higher score is optimal for each question. However, the PES contains some questions that are reversed coded, meaning that a lower score is optimal. Those questions with a reverse code are notated with a ***(RC)***. Table 8 displays the PES results. The table's first column shows each assessment question, the second column shows each average pretest score and standard deviation (SD), the third column shows each average posttest score and standard deviation (SD), the fourth column shows each outcome and statistical significance, and the fifth column shows the effect size. If the outcome for the question showed improvement, that result is denoted with a "🡅"; if the outcome for the question showed decline that result is denoted with a "🡇"; and if the outcome resulted in no change, that result is denoted with a "➔". Statistical significance was tested using a Paired-Samples T Test. Statistically significant means that change in scores are due to the likelihood that it is caused by something other than mere chance. Statistical significance was set at $p < .05$.

The **standard deviation** (**SD**) is included in the report. Measures of average such as the mean represent the typical value for a dataset. Within the dataset the actual values usually differ from one another and from the average value itself[2]. The extent to which the mean is a good representative of the values in the dataset depends upon the variability (also called, dispersion) in the original data. Datasets are said to have high variability when they contain values considerably higher and lower than the mean value. The standard deviation is a measure that summarizes the amount by which every value within a dataset varies from the mean. Effectively it indicates how tightly the values in the dataset are bunched around the mean value. It is the most robust and widely used measure of dispersion since it takes into account every variable in the dataset. When the values in a dataset are pretty tightly bunched together the standard deviation is small. When the values are spread apart the standard deviation will be relatively large. The standard deviation is usually presented in conjunction with the mean and is measured in the same units. A standard deviation close to 0 indicates that the data points tend to be very close to the mean of the set, while a high standard deviation indicates that the data points are spread out over a wider range of values. The reason for including standard deviations this year and moving forward is that they are used to calculate the effect size and are of interest to other researchers in understanding these outcomes.

Effect sizes are calculated scores that reflect the *magnitude* of change seen following an intervention. They indicate the amount of change from pretest to posttest after taking into consideration the distribution (spread) of the scores. In general, .20-.30 is considered a *small* effect, .50 is a *medium* effect, and .80 or larger is considered a *large* effect. For evidence-based interventions provided with fidelity in community settings, ***medium* effect sizes** (.50) or higher are expected on measures of the target outcomes (i.e., the PES).

[2] http://libweb.surrey.ac.uk accessed July 30, 2015

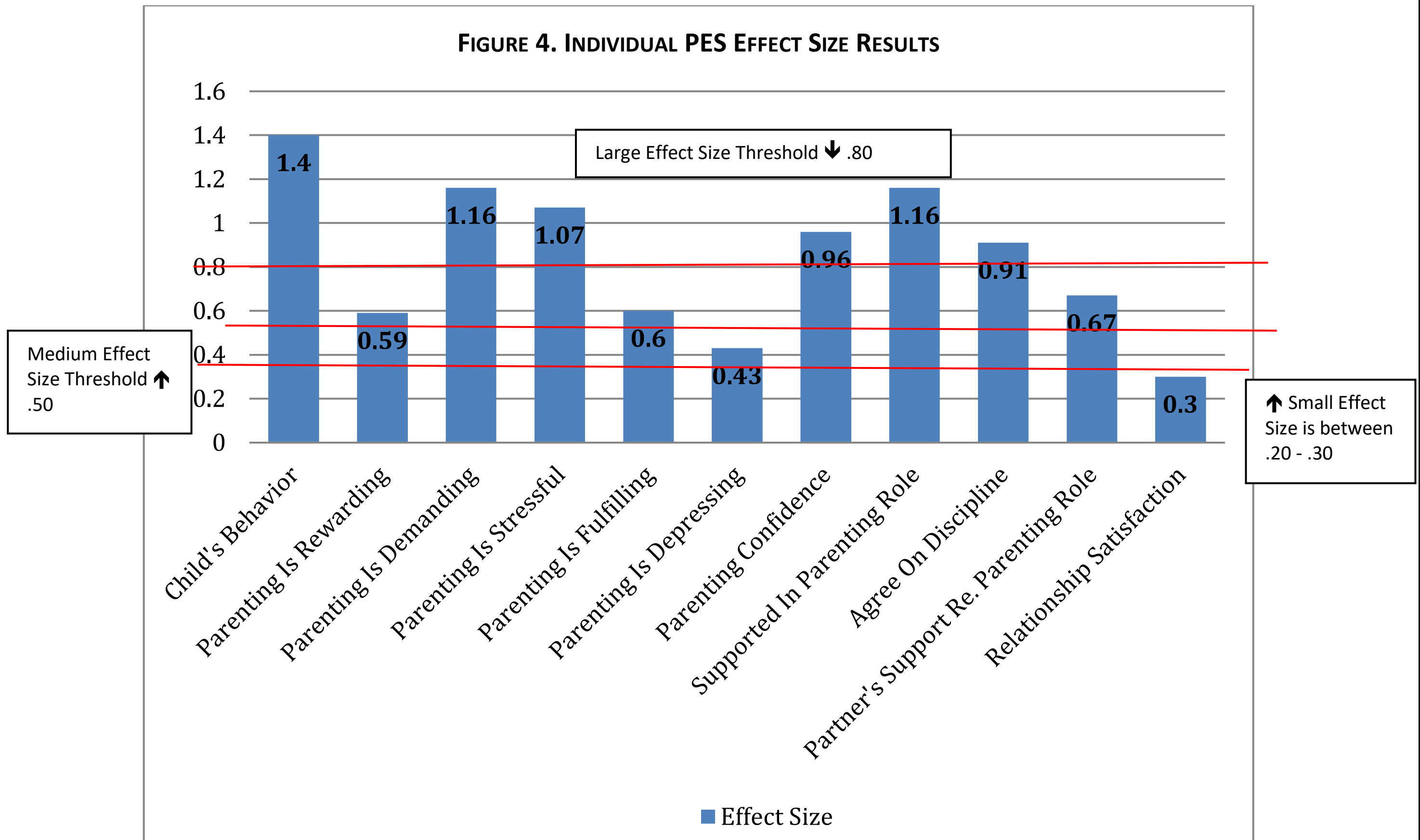
The bullets below provide a quick snapshot of PES results.

- 188 matched pre and posttest were completed
- 11 out of 11 measures (100%) showed improved scores
- 2 of 11 measures (18%) showed a *small* effect size
- 3 of 11 measures (27%) showed a *medium* effect size
- 6 of 11 measures (55%) showed a *large* effect size

TABLE 8. PPP INDIVIDUAL PARENTING EXPERIENCE SURVEY OUTCOMES (N= 186)				
MEASURE	**PRE ASSESSMENT MEAN SCORE (SD)**	**POST ASSESSMENT MEAN SCORE (SD)**	**OUTCOME**	**EFFECT SIZE**
1. IN AN OVERALL SENSE, HOW DIFFICULT HAS YOUR CHILD'S BEHAVIOR BEEN OVER THE LAST 6 WEEKS? (N= 179) ***(RC)*** ***LOWER SCORE OPTIMAL***	3.43 (.84)	2.25 (.85)	↑**	1.40
To what extent do the following statements describe your experience as a parent in the last 6 weeks?				
2. PARENTING IS REWARDING (N= 186)	4.37 (.75)	4.75 (.53)	↑**	.59
3. PARENTING IS DEMANDING (N= 186) ***(RC)*** ***LOWER SCORE OPTIMAL***	3.65 (.92)	2.50 (1.05)	↑**	1.16
4. PARENTING IS STRESSFUL (N= 185) ***(RC)*** ***LOWER SCORE OPTIMAL***	3.14 (1.03)	2.07 (.96)	↑**	1.07
5. PARENTING IS FULFILLING[3] (N= 182)	4.51 (.64)	4.84 (.45)	↑**	.60
6. PARENTING IS DEPRESSING (N= 182) ***(RC)*** ***LOWER SCORE OPTIMAL***	1.52 (.72)	1.22 (.67)	↑**	.43
7. IN THE LAST 6 WEEKS, HOW CONFIDENT HAVE YOU FELT TO UNDERTAKE YOUR RESPONSIBILITIES AS A PARENT? (N= 180)	3.57 (.89)	4.34 (.70)	↑**	.96
8. HOW SUPPORTED HAVE YOU FELT IN YOUR ROLE AS A PARENT OVER THE LAST 6 WEEKS? (N= 181)	3.35 (1.03)	4.34 (.63)	↑**	1.16
IF YOU HAVE A PARTNER, PLEASE COMPLETE THE FOLLOWING ITEMS:				
9. TO WHAT EXTENT DO YOU BOTH AGREE OVER METHODS OF DISCIPLINING YOUR CHILD? (N= 131)	3.31 (.98)	4.14 (.84)	↑**	.91
10. HOW SUPPORTIVE HAS YOUR PARTNER BEEN TOWARD YOU IN YOUR ROLE AS A PARENT OVER THE LAST 6 WEEKS? (N= 130)	3.40 (1.14)	4.11 (.96)	↑**	.67
11. IN AN OVERALL SENSE, HOW HAPPY DO YOU CONSIDER YOUR RELATIONSHIP WITH YOUR PARTNER TO BE? (N= 131)	3.68 (1.37)	4.08 (1.27)	↑**	.30
KEY: RC (Reverse Code) ↑ = Improvement ↓ = Decline * Statistically significant at p <.05 ** Statistically significant at p = .000				

[3] The FY 12-13 results showed the only PES measure not showing improvement, actually showing a slight decline, was question five which asked participants to reflect on how fulfilling their parenting role is. Anecdotal evidence from PPP educators suggested that Spanish-speaking parents had a difficult time understanding the Spanish translation of the question. When we looked at those FY 12-13 results by language we discovered that English-speaker scores improved from 3.89 at pretest to 4.11 at posttest (n= 19) while Spanish speaker scores decreased from 4.35 at pretest to 4.15 at posttest (n= 46). It was decided that future versions of the Spanish PES would include a JFS translated version of the question in parenthesis under the original Spanish translation. It was hoped that by including a more locally relevant version of the question in Spanish it would be more understandable to participants. JFS left the original wording intact (*Ser padre es satisfactorio*), but added a prompt underneath the original statement *"Como padre me siento realizado."* The prompt best translates in English to: "To be a parent makes me feel whole/like I am doing what I want for myself."

PES scores improved for all 11 measures (100%). Of those improvements, all (100%) were statistically significant. Further, a *small* effect size was calculated for two of the 11 measures (18%), a *medium* effect size was calculated for three of the 11 measures (27%), and a *large* effect size were calculated for six of the 11 measures (55%).



PPP INDIVIDUAL SATISFACTION SURVEY

The second and final outcome measure for *Individual* is the Satisfaction Survey. This assessment is administered at the final session and is designed to collect information to evaluate the different Triple P levels and help to improve the program. The Satisfaction Survey addresses the quality of the intervention, the extent to which it met participant needs, the effect it had on parenting skills and the child's behavior problems.

The Satisfaction Survey consists of 13 questions and uses a rating scale from one to seven (higher score optimal). JFS has determined that a mean (average) score of six or greater is considered the target threshold for an acceptable score. Table 9 shows both the mean score and the percent of respondents that selected a "6" or "7" for each item.

Table 9. PPP Individual Satisfaction Survey (n= 186)		
Question	**Mean Score**	**% Participants Reporting ≥ 6**
1. How would you rate the quality of the service you and your child received?	6.92	99%
2. Did you receive the type of help you wanted from the program?	6.84	96%
3. To what extent has the program met your child's needs?	6.68	92%
4. To what extent has the program met your needs? (n= 185)	6.74	96%
5. How satisfied were you with the amount of help you and your child received?	6.95	99%
6. Has the program helped you to deal more effectively with your child's behavior? (n= 185)	6.78	96%
7. Has the program helped you to deal more effectively with problems that arise in your family? (n= 185)	6.66	95%
8. Do you think your relationship with your partner has been improved by the program? (n= 140)	6.29	81%
9. In an overall sense, how satisfied are you with the program you and your child received?	6.91	97%
10. If you were to seek help again, would you come back to the Positive Parenting Program?	6.87	97%
11. Has the program helped you to develop skills that can be applied to other family members? (n= 184)	6.59	90%
12. In your opinion, how is your child's behavior at this point? (n= 184)	6.58	96%
13. How would you describe your feelings at this point about your child's progress? (n= 185)	6.71	94%

The Satisfaction Survey results indicate that participants were pleased with the services they received. The mean score for 13 out of 13 questions (100%) met the threshold of excellence set by JFS (score of 6.0 or higher).

PPP Group Results

PPP Group consists of eight sessions with a JFS Educator in a group setting of 10-12 participants. During fiscal year 2020-2021, JFS proposed to serve 500 participants. Results show that *Group* provided services to 351 participants, reaching 70% of its goal. Participants that attend at least seven sessions are considered completed. Of those 351 participants, 226 completed (64% completion rate). Of the 351 participants completing *Group*, 45% (101) also completed *Seminar* and 16% (37) completed *Individual*.

Covid-19 necessitated using remote/distance methods to provide services. Some of the group sessions were conducted over the phone and 232 clients used the Triple P On-Line curriculum- a comprehensive, eight-session web-based program that guides parents through Triple P's 17 core parenting skills.

PPP Group Demographics

Table 10 shows the demographic results for adults. For those participants that provided demographic information, the majority of completed participants are female (90%), Hispanic/Latino (84%), Spanish speaking (78%), and married (69%). The largest percentages of the completed participants received services in North Central San Diego County (49%). The 226 completed participants have a total of 505 children.

Table 10. PPP Group Participant Demographics: Adults				
Demographic	Completed (n= 226*)		Non-Completed (n= 125*)	
	Percent	Number	Percent	Number
Gender (n= 221)			**Gender**	
Female	90%	198	88%	110
Male	9%	20	12%	15
Other	1%	3	-	-
Primary Language				
English	22%	49	61%	76
Spanish	78%	177	39%	49
Race/Ethnicity (n= 216)			**Race/Ethnicity (n= 119)**	
African American	-	-	3%	4
Asian/Pacific Islander	4%	9	3%	3
Hispanic/Latino	84%	182	64%	76
White	10%	22	28%	33
Native American	-	-	2%	2
Multi-Racial	1%	3	1%	1
Participant Type (n= 220)			**Participant Type (n= 117)**	
Parent/Step-Parent	85%	186	87%	102
Grandparent	1%	1	-	-
Other Relative/Caregiver	1%	2	-	-
Early/Head Start Staff	5%	11	2%	2
Other Staff	9%	20	11%	13
Marital Status (n= 219)			**Marital Status (n= 123)**	
Single	17%	38	23%	28
Married	69%	151	66%	81
Divorced	6%	14	8%	10
Separated	6%	13	1%	1
Widowed	1%	1	-	-
Other	1%	2	2%	3

Table 10. PPP Group Participant Demographics: Adults Continued	Completed (n= 226*)		Non-Completed (n= 125*)	
	Percent	Number	Percent	Number
Venue				
Child Development Site	25%	56	18%	22
Community Site	64%	145	78%	97
Elementary School	11%	25	5%	6
Region				
Central	6%	14	3%	4
East	-	-	-	-
North Central	49%	111	74%	93
North Coastal	19%	42	11%	14
North Inland	13%	30	7%	9
South	13%	29	4%	5

***Only valid data are included in the table (missing data excluded).**

Table 11 shows the demographic results for children of completed and non-completed participants. Less than half (38%) of the completed children for whom we have data on were in the age range of 0-5.

Table 11. PPP Group Participant Demographics: Children				
Demographic	Completed (n= 505*)		Non-Completed (n= 242*)	
	Percent	Number	Percent	Number
Age (n= 500)			**Age (n= 241)**	
< 1 Year	5%	25	5%	13
1-3 Years	20%	98	21%	51
4-5 Years	13%	67	17%	41
6-12 Years	45%	228	43%	104
13-18 Years	16%	82	13%	32
Gender (n= 484)			**Gender (n= 238)**	
Female	47%	227	50%	120
Male	53%	257	50%	118
Race/Ethnicity (n= 495)			**Race/Ethnicity (n= 234)**	
African American	1%	3	3%	6
Asian/Pacific Islander	1%	7	1%	3
Hispanic/Latino	83%	411	67%	156
Multi-Racial	3%	16	11%	26
Native American	2%	8	<1%	1
White	10%	50	18%	42

*Only valid data are included in the table (missing data excluded).

PPP Group Outcomes

Group utilizes a set of four assessments to measure change in participants. All four measures are self-report and are administered at the first and final sessions.

- SDQ: Strengths and Difficulties Questionnaire
- DASS: Depression Anxiety Stress Scale
- PPC: Parent Problem Checklist
- RQI: Relationship Quality Index

How To Read The Results

For each of the four assessments, only those assessments that have a completed pretest and posttest by a participant are analyzed. Participants with a completed pre and posttest are referred to as a *matched sample*. Looking at participants with both a pre and posttest allows us to determine if a learning or behavior change has occurred. Results presented below are for these matched samples. Additionally, within a matched sample, skipped or missed answers may occur for one or more question on either test. Only results with both a pre and posttest answer by each participant are used in these analyses. The sample size for each question is noted at the end of the question to show the reader the number of valid responses.

If the outcome for the scale or measure showed improvement, that result is denoted with a "🡅"; if the outcome showed decline that result is denoted with a "🡇"; and if the outcome resulted in no change, that result is denoted with a "➔". Statistical significance was tested using a Paired-Samples T Test. Statistically significant means that change in scores are due to the likelihood that it is caused by something other than mere chance. Statistical significance was set at $p < .05$.

The **standard deviation** (**SD**) is included in the report. Measures of average such as the mean represent the typical value for a dataset. Within the dataset the actual values usually differ from one another and from the average value itself[4]. The extent to which the mean is a good representative of the values in the dataset depends upon the variability (also called, dispersion) in the original data. Datasets are said to have high variability when they contain values considerably higher and lower than the mean value. The standard deviation is a measure that summarizes the amount by which every value within a dataset varies from the mean. Effectively it indicates how tightly the values in the dataset are bunched around the mean value. It is the most robust and widely used measure of dispersion since it takes into account every variable in the dataset. When the values in a dataset are pretty tightly bunched together the standard deviation is small. When the values are spread apart the standard deviation will be relatively large. The standard deviation is usually presented in conjunction with the mean and is measured in the same units. A standard deviation close to 0 indicates that the data points tend to be very close to the mean of the set, while a high standard deviation indicates that the data points are spread out over a wider range of values. The reason for including standard deviations this year and moving forward is that they are used to calculate the effect size and are of interest to other researchers in understanding these outcomes.

Effect sizes are calculated scores that reflect the *magnitude* of change seen following an intervention. They indicate the amount of change from pretest to posttest after taking into consideration the distribution (spread) of the scores. In general, .20-.30 is considered a small effect, .50 is a medium effect, and .80 or larger is considered a large effect. For evidence-based interventions provided with fidelity in community settings, **medium effect sizes** (.50) or higher are expected on measures of the target outcome.

1. Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a 25-item questionnaire designed to measure parents' perceptions of pro-social (caring for or helping others) and difficult behaviors in children aged three to ten years. The SDQ consists of five scales: Emotional Problems, Conduct Problems, Inattention/Hyperactivity Problems, Peer Relationship Problems, and Pro-social Behavior. Each scale is measured by five items and then four problem scales (excludes Pro-Social Behavior) are summed to create a Total Difficulties Score. The SDQ has two versions based on child's age: 3-4 or 5-10 years of age (SDQ 3-4 and SDQ 5-10). The context is the same however the wording of two questions, 18 and 20, (both in the Conduct Problems scale) varies slightly to account

[4] http://libweb.surrey.ac.uk accessed July 30, 2015

for different developmental levels. Participants are asked to think about the child's behavior for the last six months and respond to each question using a three-point scale ranging from "0" *Not True* to "2" *Certainly True*. **A lower score is optimal for all measures except Pro-Social Behavior, which a higher score is optimal.**

In October 2013, PPP leadership decided to update the SDQ administration protocol by asking participants to complete only one SDQ version and only for children three to five years of age with which they have a behavioral concern. Previously, parents would complete a SDQ for up to two children, even if only one child was displaying any behavioral issues of concern. Because the SDQ has two versions (3-4 and 5-10) with two differing questions (questions 18 and 22) it was determined that the SDQ 3-4 would be used with an addition to question 22 (revised to "Can be spiteful to others and/or steals from home, school, or elsewhere"). Question 18 was left as is. This new version is now called the SDQ.

SDQ Question Wording Differences

Question 18
SDQ 3-4: Often argumentative with adults.
SDQ 5-10: Often lies or cheats.
SDQ 3-5: OFTEN ARGUMENTATIVE WITH ADULTS.

Question 22
SDQ 3-4: Can be spiteful to others.
SDQ 5-10: Steals from home, school, or elsewhere.
SDQ 3-5: CAN BE SPITEFUL TO OTHERS AND/OR STEALS FROM HOME, SCHOOL, OR ELSEWHERE.

Table 12 displays the SDQ results. The table's first column shows each scale along with the normal, borderline and abnormal scoring ranges, the second column shows each scale's mean (average) pretest score and SD, the third column shows each scale's mean posttest score and SD, the fourth column shows each outcome and if statistically significance, and the final column shows the effect size. The bullets below show a quick snapshot of the SDQ results.

SDQ

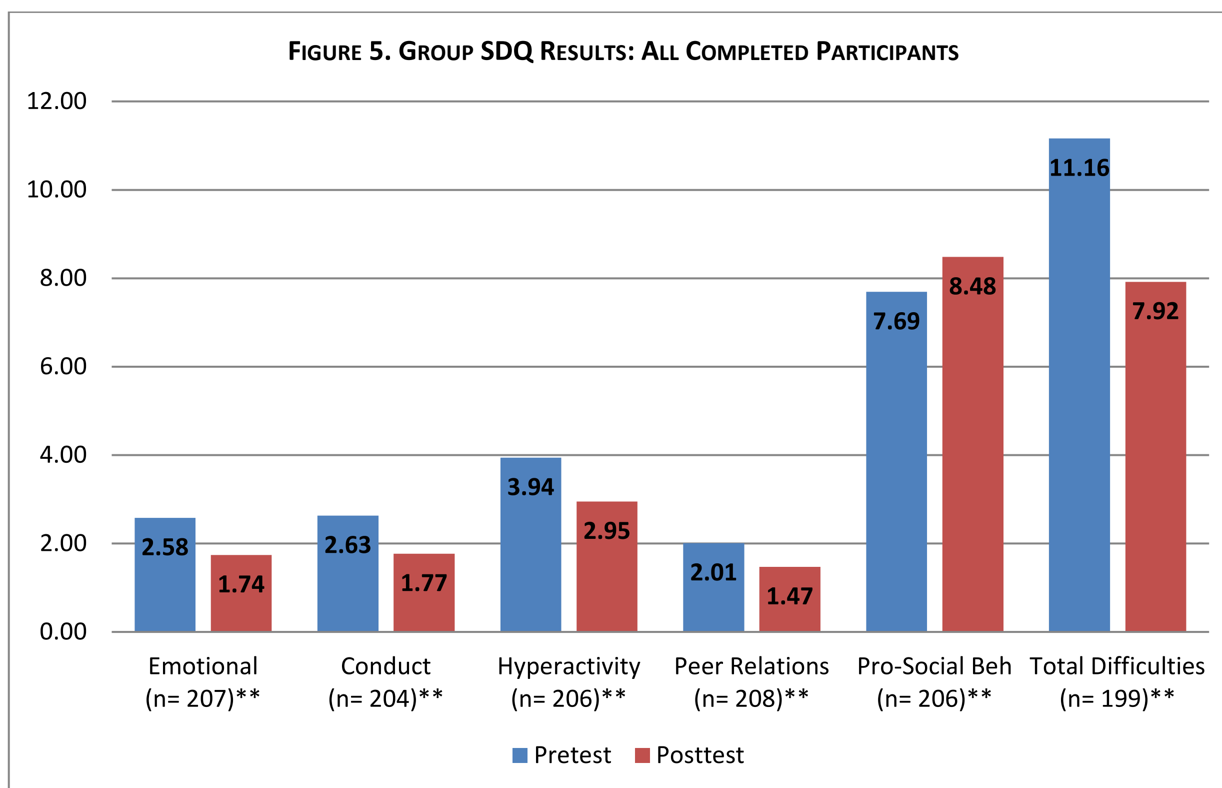
- 209 matched pre and posttest were completed
- All six measures (100%) showed statistically significant improved scores
- Five measures (83%) showed *small* and one measure (17%) showed a *medium* effect size

TABLE 12. PPP GROUP SDQ OUTCOMES (N= 209)
LOWER SCORE OPTIMAL (EXCEPT PRO-SOCIAL BEHAVIOR)

	PRE MEAN SCORE (SD)	POST MEAN SCORE (SD)	OUTCOME	EFFECT SIZE
EMOTIONAL PROBLEMS (N= 207) 0-3 NORMAL 4 BORDERLINE 5-10 ABNORMAL	2.58 (1.99)	1.74 (1.85)	↑**	.44
CONDUCT PROBLEMS (N= 204) 0-2 NORMAL 3 BORDERLINE 4-10 ABNORMAL	2.63 (1.85)	1.77 (1.63)	↑**	.49
HYPERACTIVITY (N= 206) 0-5 NORMAL 6 BORDERLINE 7-10 ABNORMAL	3.94 (2.24)	2.95 (2.01)	↑**	.47
PEER RELATIONSHIP PROBLEMS (N= 208) 0-2 NORMAL 3 BORDERLINE 4-10 ABNORMAL	2.01 (1.63)	1.47 (1.59)	↑**	.34

TABLE 12. PPP GROUP SDQ OUTCOMES (N= 209) CONTINUED *LOWER SCORE OPTIMAL (EXCEPT PRO-SOCIAL BEHAVIOR)*				
	PRE MEAN SCORE (SD)	**POST MEAN SCORE (SD)**	**OUTCOME**	**EFFECT SIZE**
PRO-SOCIAL BEHAVIOR (N= 206) 6-10 NORMAL 5 BORDERLINE 0-4 ABNORMAL	7.69 (2.06)	8.48 (1.69)	↑**	.42
TOTAL DIFFICULTIES SCORE (N= 199) 0-13 NORMAL 14-16 BORDERLINE 17-40 ABNORMAL	11.16 (5.78)	7.92 (5.61)	↑**	.57
<u>KEY</u>: ↑ = Improvement ↓ = Decline → = No change *Statistically significant at p <.05 **Statistically significant at p = .000				

The mean pretest scores for the six scales indicate that children's behavior was in the normal range. All six scales showed positive and statistically significant improvement at posttest. Five (83%) of the measures showed a *small* effect size while one measure (17%) showed a *medium* effect size. Figure 5 displays the SDQ pre and posttest mean results in a chart format.



**Statistically significant at p = .000

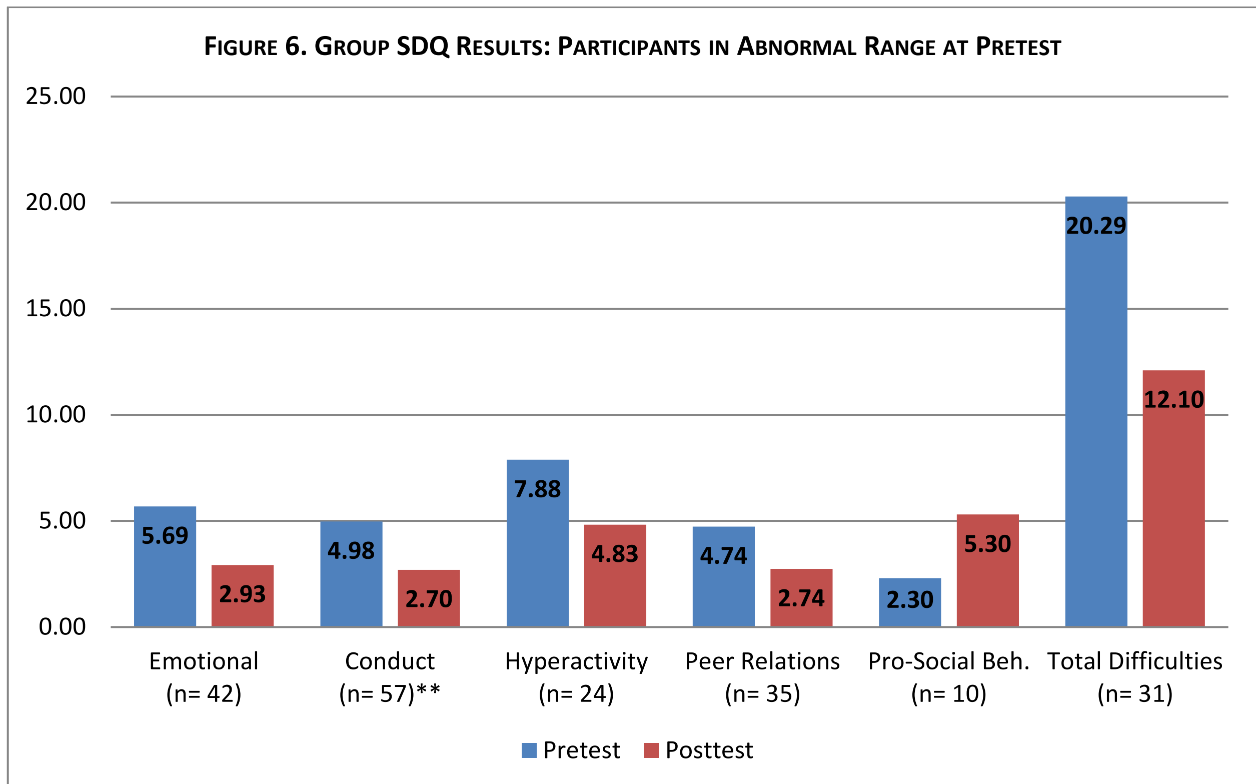
Table 13 and Figure 6 show the SDQ results but only for those clients scoring in the abnormal range at pretest. By looking at only those participants we may be able to tease out results that may have been watered down in the overall sample. For some families, PPP is utilized as a more preventive measure for child behavior. These clients would be more likely to score in the normal range and may not have much room to improve, no improvement is needed. However, for those clients that are utilizing PPP as an

intervention, meaning there is a problem with their children's behavior, there is more room for improvement to occur. Indeed, the results support these statements as the effect size for **all (100%) of the five measures in which an effect size could be calculated showed *large* effect sizes**.

TABLE 13. PPP GROUP SDQ OUTCOMES: PRETEST SCORES IN THE ABNORMAL RANGE
LOWER SCORE OPTIMAL (EXCEPT PRO-SOCIAL BEHAVIOR)

	PRE MEAN SCORE (SD)	POST MEAN SCORE (SD)	OUTCOME	EFFECT SIZE
EMOTIONAL PROBLEMS (N= 42) 5-10 ABNORMAL	5.69 (.95)	2.93 (2.37)	↑ N/A	1.53
CONDUCT PROBLEMS (N= 57) 4-10 ABNORMAL	4.98 (1.17)	2.70 (1.96)	↑ **	1.41
HYPERACTIVITY (N= 24) 7-10 ABNORMAL	7.88 (.85)	4.83 (2.04)	↑ N/A	1.95
PEER RELATIONSHIP PROBLEMS (N= 35) 4-10 ABNORMAL	4.74 (1.01)	2.74 (2.16)	↑ N/A	1.19
PRO-SOCIAL BEHAVIOR (N= 10) 0-4 ABNORMAL	2.30 (1.57)	5.30 (2.71)	↑ N/A	N/A
TOTAL DIFFICULTIES SCORE (N= 31) 17-40 ABNORMAL	20.29 (3.44)	12.10 (7.32)	↑ N/A	1.43

KEY: ↑ = Improvement ↓ = Decline → = No change *Statistically significant at $p < .05$ **Statistically significant at $p = .000$
N/A Sample Size too small to test for statistical significance



**Statistically significant at p = .000

2. Depression Anxiety Stress Scale (DASS)

The DASS is a set of three self-report scales designed to measure the degree of depression, anxiety and stress in an individual over the past week. Respondents are asked to rate the extent to which they have experienced the state using a four-point scale from "0" *Did Not Apply To Me At All* to "3" *Applied To Me Very Much, or Most Of The Time*. The DASS has 42 items with each scale (depression, anxiety, and stress) measured via 14 items. **With the DASS a lower score is optimal.** The bullets below show a quick snapshot of the DASS results.

- 206 matched pre and posttest were completed
- 3 of the 3 measures (100%) showed improved scores, all statistically significant
- All 3 measures showed *small* effect sizes

Table 14 and Figure 7 display the DASS results. The table's first column shows each scale along with the normal to extremely severe scoring ranges and the valid sample size, the second column shows each scale's mean (average) pretest score and SD, the third column shows each scale's mean posttest score and SD, the fourth column shows each outcome and statistical significance, and the fifth column shows the effect size.

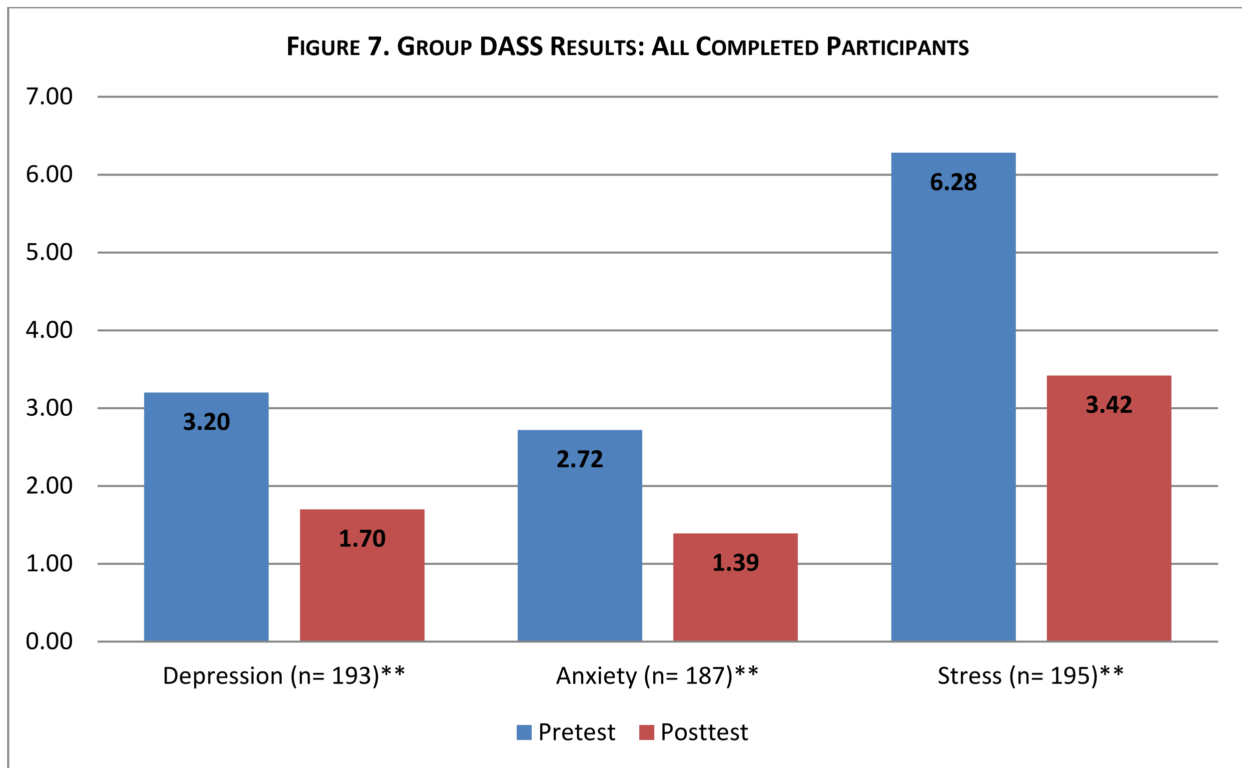
The DASS mean pretest scores for each measure were in the normal range. Each measure showed significant improvement and a small effect size with Depression at .36, Anxiety at .34, and Stress at .49.

Table 14. PPP Group DASS Outcomes (n= 206)

Lower Score Optimal

	Pre Assessment Mean Score (SD)	Post Assessment Mean Score (SD)	Outcome	Effect Size
Depression (n= 193) • 0-9 Normal • 10-13 Mild • 14-20 Moderate • 21-27 Severe • 28+ Extremely Severe	3.20 (4.61)	1.70 (3.70)	↑**	.36
Anxiety (n= 187) • 0-7 Normal • 8-9 Mild • 10-14 Moderate • 15-19 Severe • 20+ Extremely Severe	2.72 (4.48)	1.39 (3.20)	↑**	.34
Stress (n= 195) • 0-14 Normal • 15-18 Mild • 19-25 Moderate • 26-33 Severe • 34+ Extremely Severe	6.28 (6.94)	3.42 (4.51)	↑**	.49

KEY: ↑ = Improvement ↓ = Decline → = No change *Statistically significant at p <.05 **Statistically significant at p =.000



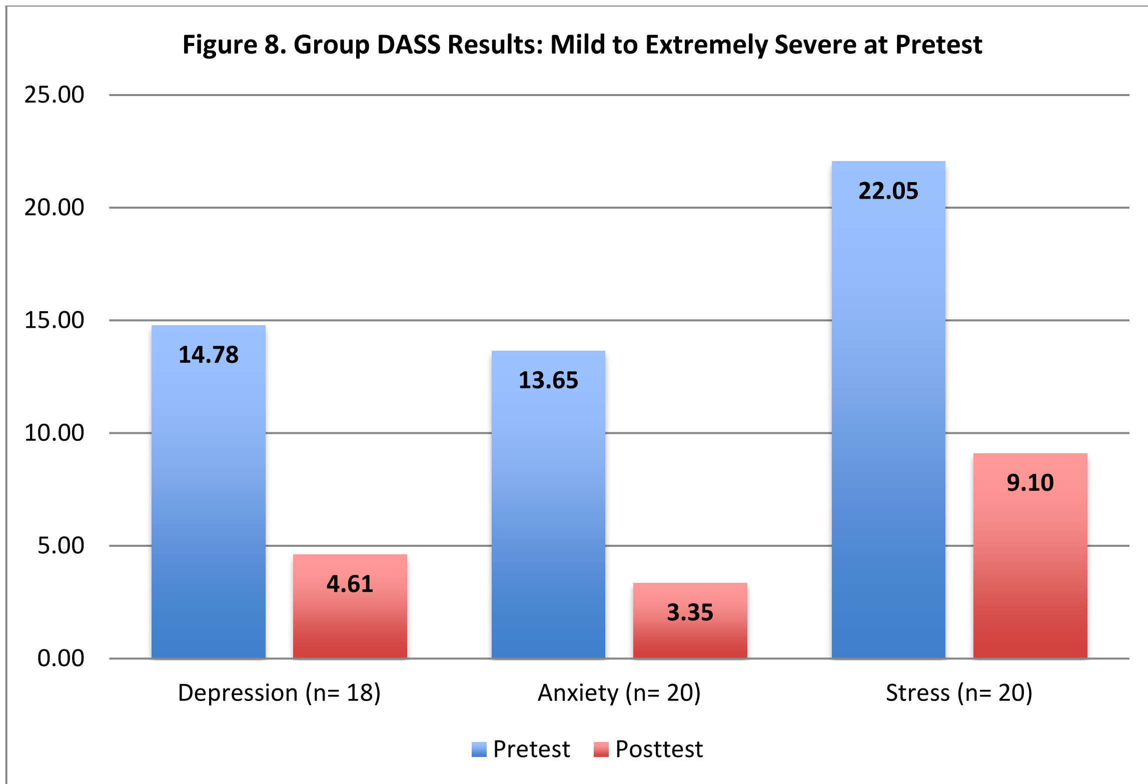
**Statistically significant at p = .000

Table 15 and Figure 8 show the DASS results for those participants scoring in the mild to extremely severe categories at pretest. While Table 14 and Figure 7 show statistically significant improvement in each depression, anxiety, and stress for the overall matched sample of participants, results can be muddied by those participants starting in the normal range for a measure (e.g., when the pretest score is in the normal range, there isn't much room for improvement). The sample sizes for Table 15 and Figure 8 are too small to test for statistical significance. Both measures in which an effect size could be measure showed *large* effect sizes and all three measures showed positive outcomes.

TABLE 15. PPP GROUP DASS OUTCOMES: MILD TO EXTREMELY SEVERE AT PRETEST
LOWER SCORE OPTIMAL

	PRE MEAN SCORE (SD)	POST MEAN SCORE (SD)	OUTCOME	EFFECT SIZE
DEPRESSION (N= 18) • 10-13 MILD • 14-20 MODERATE • 21-27 SEVERE • 28+ EXTREMELY SEVERE	14.78 (4.78)	4.61 (5.41)	↑	N/A
ANXIETY (N= 20) • 8-9 MILD • 10-14 MODERATE • 15-19 SEVERE • 20+ EXTREMELY SEVERE	13.65 (5.18)	3.35 (3.53)	↑	2.32
STRESS (N= 20) • 15-18 MILD • 19-25 MODERATE • 26-33 SEVERE • 34+ EXTREMELY SEVERE	22.05 (7.70)	9.10 (8.64)	↑	1.58

KEY: ↑ = Improvement ↓ = Decline → = No change



3. Parent Problem Checklist (PPC)

The PPC is a 16-item self-report assessment that measures conflict between partners over child-rearing. Six items measure disagreement between parents about rules and discipline for child behavior, six items measure open conflict over childrearing, and four items measure the extent to which parents undermine each other's relationships with their children. For each item, participants are asked to think about the last four weeks and indicate whether there is a concern over the issue. If the answer to that item is *Yes*, they next indicate the extent of the problem on a seven-point scale from "1" *Not At All* to "7" *Very Much* again for the past four weeks. The PPC measures both the number and intensity of problems. Problem scores greater than five are considered to be in the clinical range[iv]. **Lower score is optimal.** The bullets below show a quick snapshot of the PPC results.

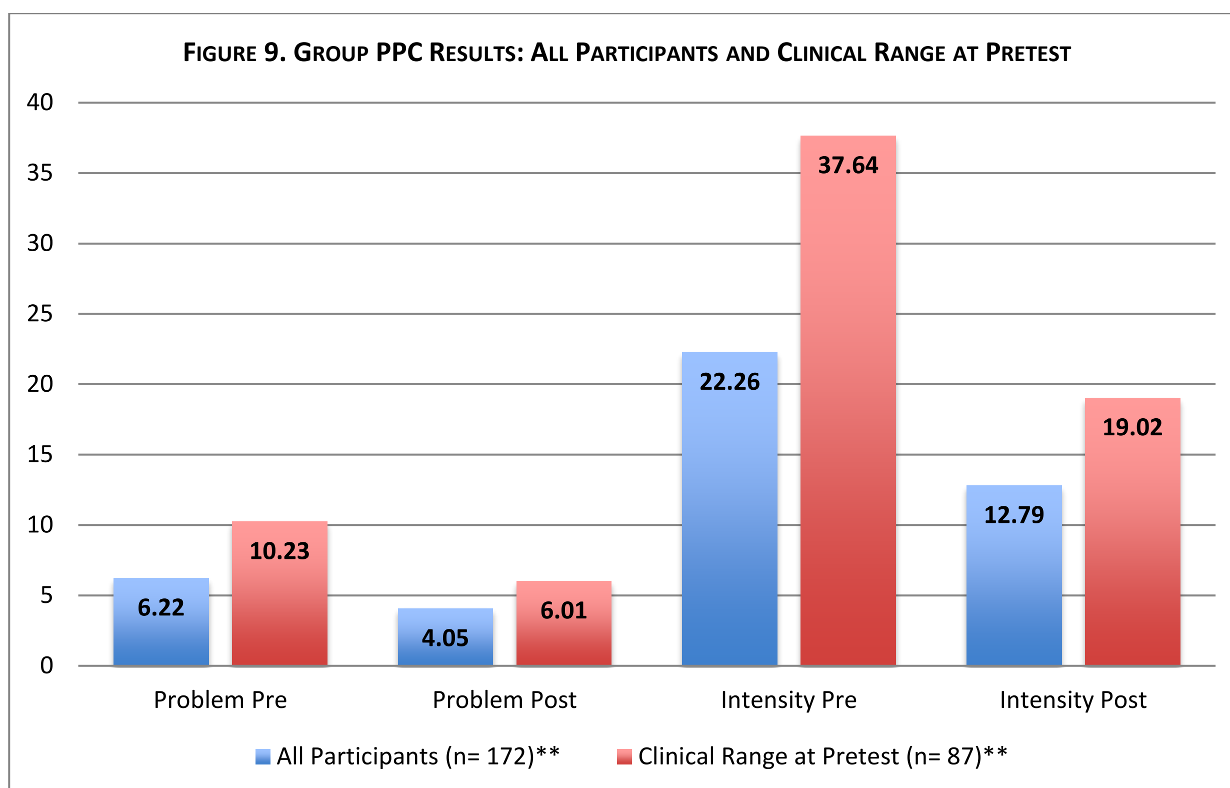
- 172 matched pre and posttest were completed
- Both of the 2 measures (100%) showed statistically significant improved scores
- Problem and Intensity Measures for the entire sample showed *medium* Effect Sizes (.49 and .52)
- Problem and Intensity Measures for the sample in the clinical range at pretest both showed *large* Effect Sizes (1.12 and 1.03, respectively)

Table 16 displays the PPC results. The table's first column shows each scale by participant type (all and scoring in clinical range at pretest) along with the valid sample size, the second column shows each scale's mean (average) pretest score and SD, the third column shows each scale's mean posttest score and SD, the fourth column shows each outcome and statistical significance, and the fifth column shows the effect size.

Table 16. PPP Group PPC Outcomes *Lower Score Optimal*				
Scale	**Pre Mean Score (SD)**	**Post Mean Score (SD)**	**Outcome**	**Effect Size**
Problem All Participants (n= 172)	6.22 (4.81)	4.05 (3.94)	↑**	.49
Problem Participants >5 at Pretest (Clinical Concern) (n= 87)	10.23 (3.17)	6.01 (4.27)	↑**	1.12
Intensity All Participants (n= 172)	22.26 (20.61)	12.79 (15.35)	↑**	.52
Intensity Participants >5 on Problem at Pretest (Clinical Concern) (n= 87)	37.64 (17.96)	19.02 (18.05)	↑**	1.03

KEY: ↑ = Improvement ↓ = Decline → = No change *Statistically significant at p <.05 **Statistically significant at p = .000

PPC results for all participants show *medium* effect sizes, .49 for Problem and .52 for Intensity. At posttest, the Problem results were below the clinical range of five (4.05) and scores showed improvement in both the Problem and Intensity. When we look at only the results for those participants that scored above a five on the Problem scale at pretest, we find both *large* effect sizes for Problem (1.12) and Intensity (1.03). Figure 9 presents the same information but in a chart format.



**Statistically significant at p = .000

4. Relationship Quality Index (RQI)

The RQI is a six-item index of relationship quality and satisfaction used to assess the quality of a relationship prior to implementing *Group*, and to monitor changes in relationship quality as an indicator of the intervention's effectiveness. Five items assess various aspects of committed relationships using a seven-point scale from "1" *Very Strongly Disagree* to "7" *Very Strongly Agree*. The final question is a global measure of the happiness of the relationship on a ten-point scale from "1" *Unhappy* to "10" *Perfectly Happy*. **A higher score is optimal and scores of less than or equal to 29 are indicative of relationship distress.**

Table 17 displays the RQI results for 1) all completed participants with a matched pre and posttest, and 2) completed participants with a matched sample scoring at 29 or less on the pretest (indicative of relationship distress). The table's second column shows the mean pretest score, the third column shows the mean posttest score, the fourth column shows the outcome and statistical significance, and the fifth column shows the effect size.

The bullets below show a quick snapshot of the RQI results.

- 146 matched pre and posttest were completed
- RQI results for those in relationship distress at pretest showed improvement with a *large* effect size (.92)

Table 17. PPP Group RQI Outcome

Higher Score Optimal

	Pre Mean Score (SD)	Post Mean Score (SD)	Outcome	Effect Size
All Participants (n= 146)	35.63 (9.38)	36.97 (9.07)	↑	.15
Participants in Relationship Distress at Pretest (n= 30) • ≤29 Clinical	21.03 (7.85)	30.40 (12.07)	↑ N/A	.92

KEY: ↑ = Improvement ↓ = Decline → = No change *Statistically significant at p <.05 **Statistically significant at p = .000
N/A= unable to calculate

The overall mean pretest score (35.63) does not indicate relationship distress and the overall mean posttest result (36.97) shows improvement but is not statistically significant. Similar to results for the other *Group* measures, when we look at results for the entire matched sample, positive outcomes are achieved, however, these outcomes usually show a *small* effect size. In addition, the RQI is a measure of adult relationships in the household; participants may have issues with their children's behavior but not with their relationship with their partner. Finally, when a participant scores in the normal range at pretest it is difficult to effect much change as there is not much room to improve. Therefore, when we look at just those participants that were in relationship distress at pretest (score of 29 or less) we see a positive result with a *large* effect size (.92).

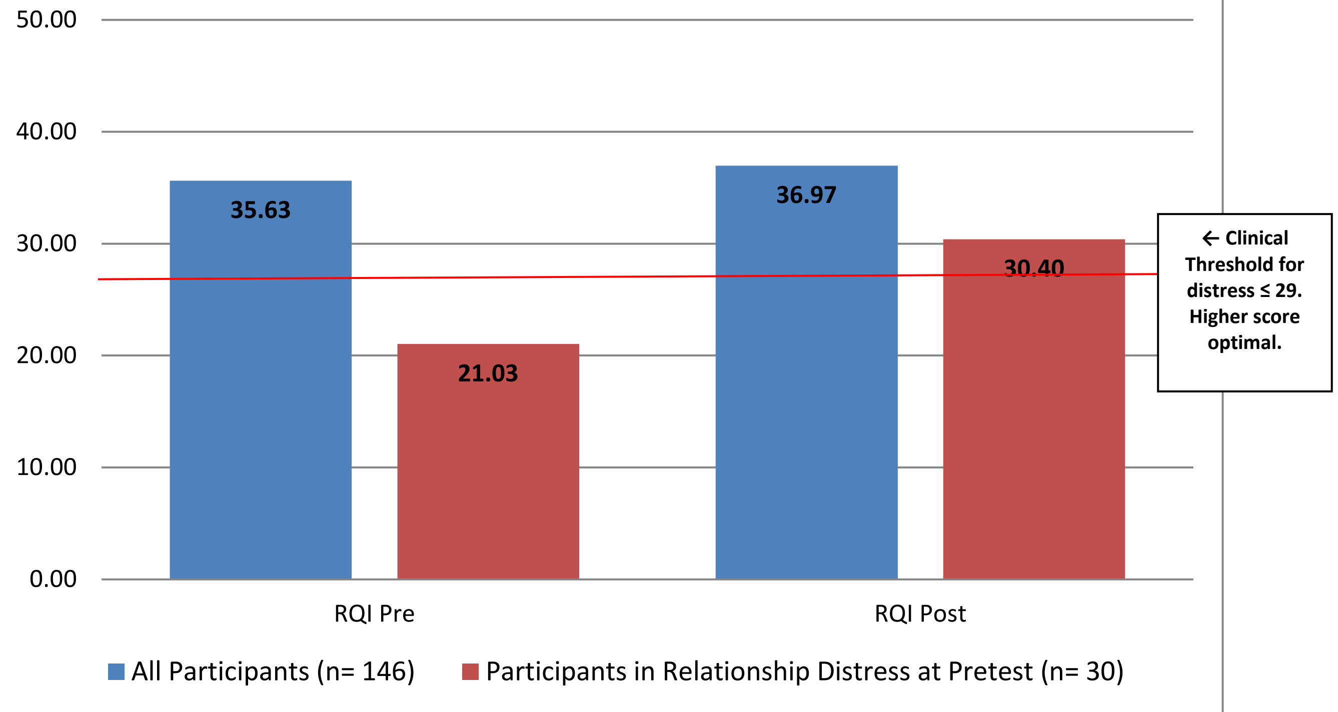
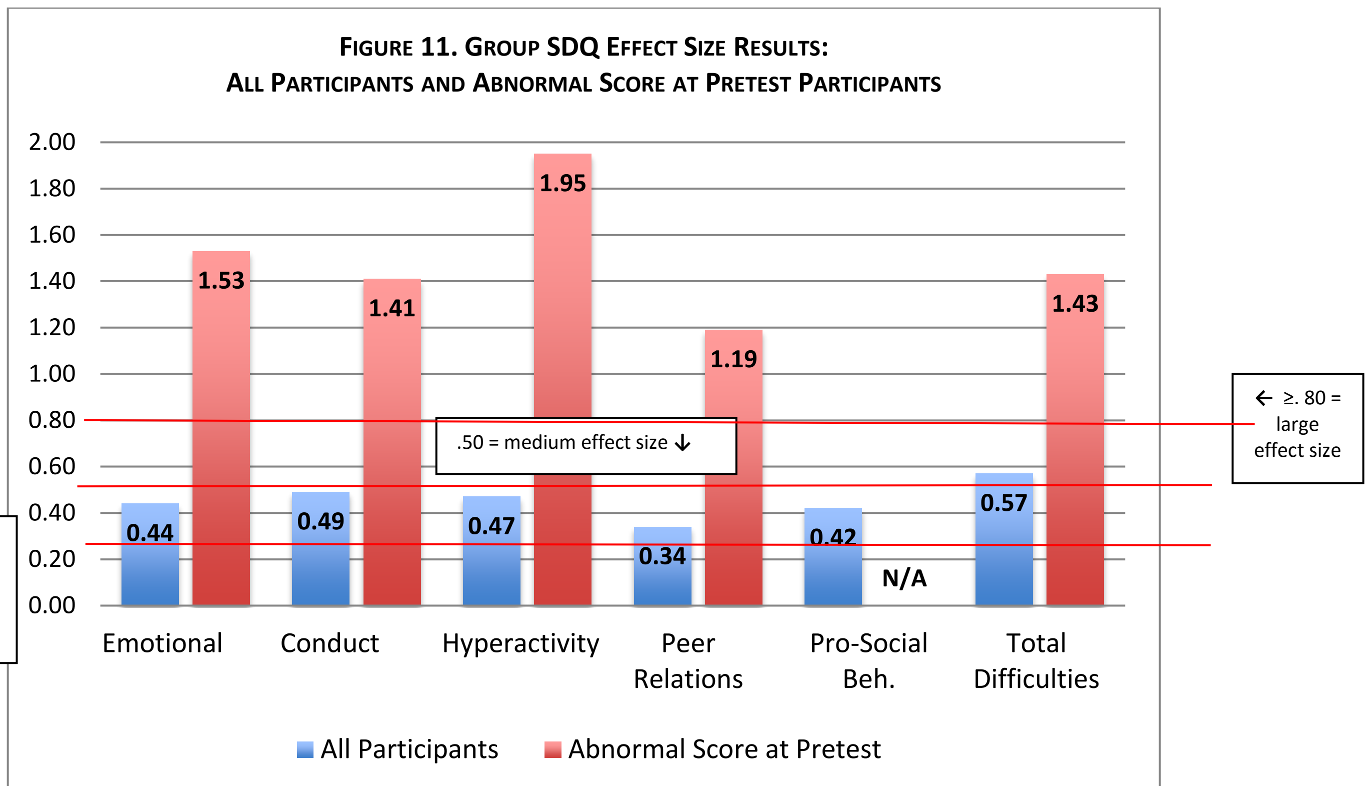


FIGURE 10. GROUP RQI RESULTS: ALL AND DISTRESSED SAMPLES
50.00
40.00
30.00
20.00
10.00
0.00
35.63
21.03
36.97
30.40
← Clinical Threshold for distress ≤ 29. Higher score optimal.
RQI Pre
RQI Post
All Participants (n= 146)
Participants in Relationship Distress at Pretest (n= 30)

EFFECT SIZE RESULTS

Figures 11 through 13 display the effect sizes for all four *Group* measures: SDQ, DASS, PPC, and RQI. In Figure 11, the effect sizes for the SDQ show that when looking at those client scoring in the abnormal range at pretest a *large* effect size was achieved for all five measures (100%) in which the sample size was large enough to test for effect size. When we look at the entire matched sample however, the effect size results are smaller, with all six measures (100%) showing a *small or medium* effect size.



N/A: Sample size too small to reliably test for effect size.

Figure 12 shows the DASS effect size results for the entire matched sample and those scoring Mild to Extremely Severe at pretest. Similar to the SDQ results, the entire matched sample shows two *small* and one *medium* effect sizes. However, when we look at those with a Mild to Extremely Severe score at pretest, the effect size results are all *large* (sample size was too small to calculate an effect size for depression).

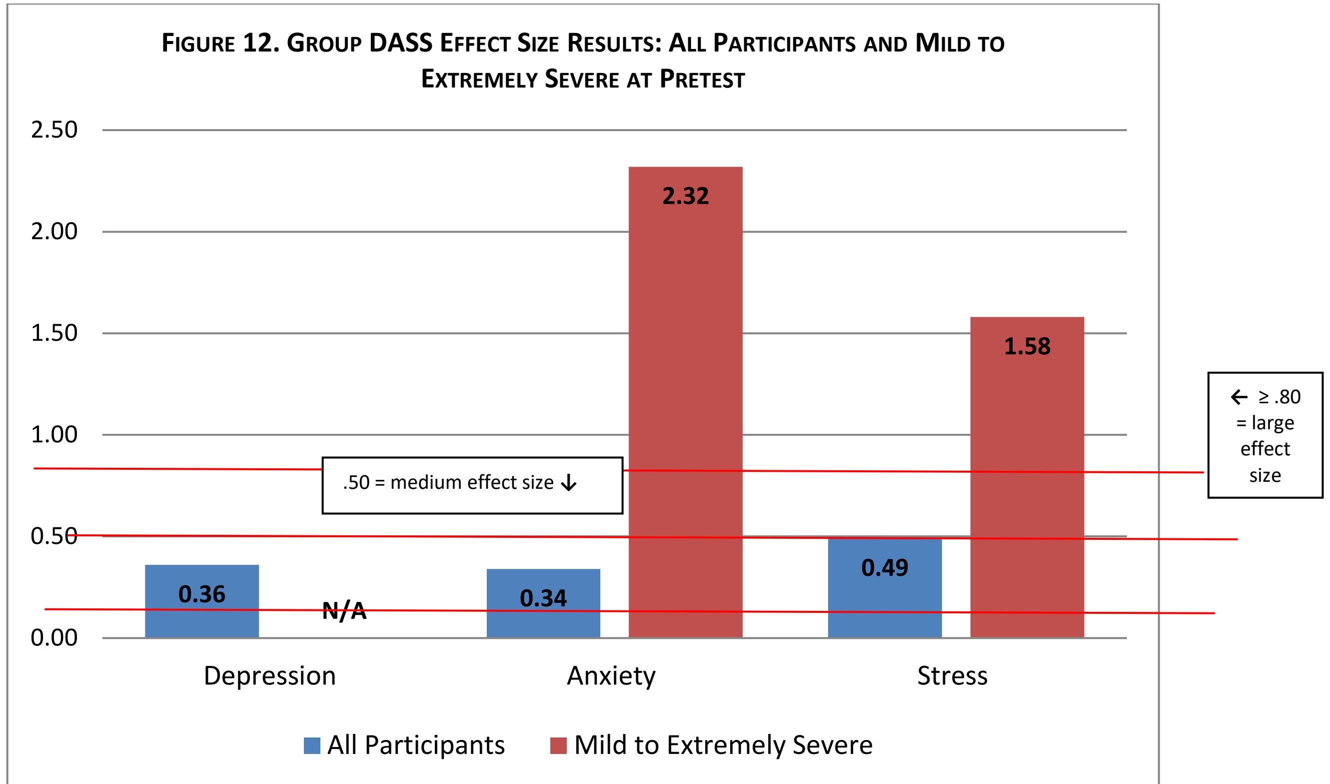
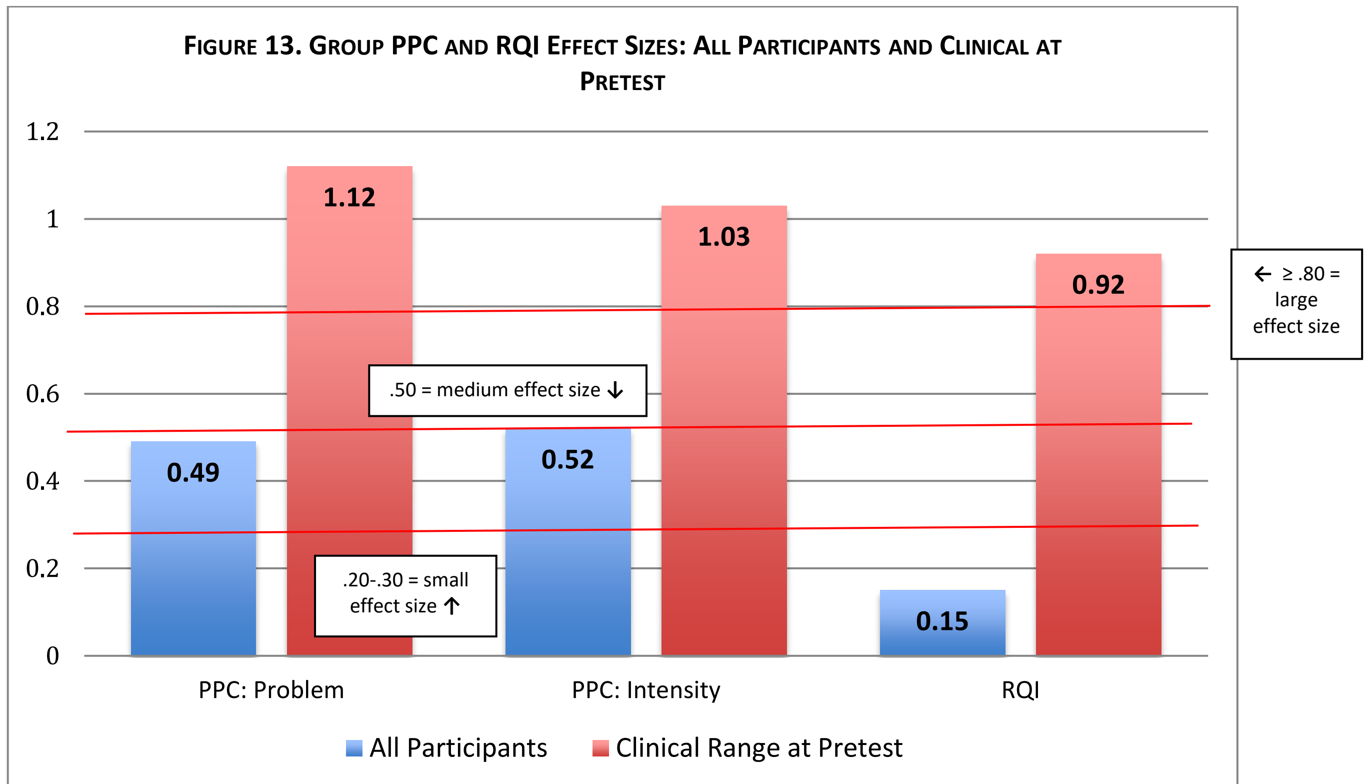


FIGURE 12. GROUP DASS EFFECT SIZE RESULTS: ALL PARTICIPANTS AND MILD TO EXTREMELY SEVERE AT PRETEST

N/A: Sample size too small to reliably test for effect size.

Figure 13 shows the PPC and RQI effect size results for the entire matched sample and those scoring in the Clinical range at pretest. Consistent with the other *Group* results, the entire matched sample shows smaller effect size results. However, when we look at those scoring in the Clinical range at pretest, all three effect size results are *large*.



PPP GROUP SATISFACTION

The final key outcome measure for *Group* is the Satisfaction Survey. This assessment is administered at the final session and is designed to collect information to evaluate the different PPP levels and help to improve the program. The Satisfaction Survey addresses the quality of the intervention, the extent to which it met participant needs, the effect it had on parenting skills and the child's behavior problems.

The Satisfaction Survey consists of 13 questions and uses a rating scale from one to seven (higher score optimal). JFS has determined that a mean (average) score of six or greater is considered an excellent score. Table 18 shows both the mean score and the percentage of respondents that selected a six or seven for each item.

TABLE 18. PPP GROUP SATISFACTION SURVEY (N= 183)

QUESTION	MEAN SCORE	% PARTICIPANTS REPORTING ≥ 6
1. HOW WOULD YOU RATE THE QUALITY OF THE SERVICE YOU AND YOUR CHILD RECEIVED?	6.72	91%
2. DID YOU RECEIVE THE TYPE OF HELP YOU WANTED FROM THE PROGRAM?	6.66	87%
3. TO WHAT EXTENT HAS THE PROGRAM MET YOUR CHILD'S NEEDS?	6.46	79%
4. TO WHAT EXTENT HAS THE PROGRAM MET YOUR NEEDS?	6.51	82%
5. HOW SATISFIED WERE YOU WITH THE AMOUNT OF HELP YOU AND YOUR CHILD RECEIVED? (N= 182)	6.74	93%
6. HAS THE PROGRAM HELPED YOU TO DEAL MORE EFFECTIVELY WITH YOUR CHILD'S BEHAVIOR?	6.73	95%
7. HAS THE PROGRAM HELPED YOU TO DEAL MORE EFFECTIVELY WITH PROBLEMS THAT ARISE IN YOUR FAMILY?	6.65	90%
8. DO YOU THINK YOUR RELATIONSHIP WITH YOUR PARTNER HAS BEEN IMPROVED BY THE PROGRAM? (N= 151)	6.25	72%
9. IN AN OVERALL SENSE, HOW SATISFIED ARE YOU WITH THE PROGRAM YOU AND YOUR CHILD RECEIVED?	6.72	91%
10. IF YOU WERE TO SEEK HELP AGAIN, WOULD YOU COME BACK TO THE POSITIVE PARENTING PROGRAM?	6.74	91%
11. HAS THE PROGRAM HELPED YOU TO DEVELOP SKILLS THAT CAN BE APPLIED TO OTHER FAMILY MEMBERS?	6.64	88%
12. IN YOUR OPINION, HOW IS YOUR CHILD'S BEHAVIOR AT THIS POINT?	6.46	94%
13. HOW WOULD YOU DESCRIBE YOUR FEELINGS AT THIS POINT ABOUT YOUR CHILD'S PROGRESS?	6.46	83%

The Satisfaction Survey results indicate that participants were pleased with the PPP services they received. The mean score for each question achieved the threshold of excellence set by JFS (score of six or higher).

IV. Conclusion

JFS continues to provide excellent and results-driven services. To sum up FY 20-21, PPP provided services to 1,390 unique (unduplicated) participants, of which 58% (806) completed at least one level of service[5]. JFS served 66 Child Development sites, 23 community sites, and 44 low-income elementary sites across San Diego County. The Satisfaction Survey results show regardless of the type of PPP intervention received (Seminar, Individual, or Group) participants were satisfied with the content of the information provided and felt that their family had benefited. Further, all measures showed positive change at posttest.

These results are even more impressive when you factor in COVID-19. The virus has resulted in closed school sites where the majority of PPP services traditionally occur. PPP quickly implemented an online version of Group PPP (Level 4 Triple P) along with offering services via telehealth in order to continue serving the community.

Lastly, the reader is left with select comments from Group participants. We hope these comments help illustrate how PPP helps support families and improves their lives.

Select Group Comments

- *Grateful for the help received in the program, for the understanding and patience of the presenter. For the support and advice received. Excellent program.*
- *Great set up for interactive sessions. I liked having the first few sessions with other parents and the last half with only the facilitator. Julio was wonderful! Very personable, relatable, and showed genuine interest/concern for us during our one on ones.*
- *I just love it because it has helped me to be a better person to be good with myself and so my family is better. If I am well, my husband and my children are too*
- *I learned more about how to educate my daughters in a better way, this kind of program is excellent because they serve as support and mentors in the growth stages of our children. I am grateful for the help and for what I learned in the course.*
- *I loved taking these classes! Not only does it help me learn new techniques in child development, but I also see it as a therapy for me. It helps me better understand my daughters and myself. If possible, I'd like to receive emails from future classes.*
- *I loved the program I saw the change in me first, then in my son. Slowly advancing, quality of communicating is different for both of us for which I am grateful. His attitude has improved a lot; we've created habits in practice one day at a time.*
- *I'll describe it as a cake; it is rich in strategies, examples, and full of many tools to be able to enjoy the good taste that it leaves you after having learned everything. Best thing is the kindness and patience, advice, recommendations, encouragement*
- *I've learned a new way of dealing with disciplining my grandson and it has helped tremendously. Thanks for this program!*
- *It helped me a lot to realize that the bad behavior of my daughters was not a result of their way of being but of the way in which I handled situations. I thought a lot about my attitude towards raising my daughters and I really liked the program.*

[5] FY 16-17 was the start of a new five year contract period with the County of San Diego. The main changes were two, 1) the County of San Diego awarded only one contract to provide services countywide and 2) the County of San Diego changed the way participants were "counted" towards target numbers. Previous years participants were only counted if they completed services. FY 16-17 the County of San Diego revised the reporting structure to allow JFS to count participants regardless if they completed or not.

- *It is a phenomenal program. I wish every single parent could use this program, no matter how confident they are; this has been such a gift to my family and I know other families would benefit as well. Thank you!*
- *It really helped me work on my relationship with my kids, and taught me to work on myself and being calmer and more consistent with my positive parenting.*
- *My deepest appreciation for offering these types of webinars and tell you that I learned many techniques and strategies that I was not aware of or simply had not contemplated. What a charm this program, I will continue to apply what I have learned.*
- *This program helped me to grow as a mother and wife.*
- *Yes! This program was really interesting and really helpful. I loved how they provide us with some positive ways to deal with different kind of behaviors.*
- *Thank you so much for these classes. I learned a lot from them.*

REFERENCES

[i] Theoretical, Scientific and Clinical Foundations of the Triple P-Positive Parenting Program: A Population Approach to the Promotion of Parenting Competence. Matthew R. Sanders, Carol Markie-Dadds, and Karen M.T. Turner *Parenting and Family Support Centre, The University of Queensland*Parenting Research and Practice Monograph No. 1. http://triplep-america.com.

[ii] Methods of coping with social desirability bias: A review. Anton J. Nederh of LISPOR, University of Leyden, Stationsplein 242, 2372 AR Leiden, The Netherlands.

[iii] Hebert J R (Division of Preventive and Behavioral Medicine, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655, USA), Clemow L, Pbert L, Ockene I S and Ockene J K. Social desirability bias in dietary self-report may compromise the validity of dietary intake measures. *International Journal of Epidemiology* 1995; 24: 389-398.

[iv] Sabine J, Sanders MR, and Turner KMT. Reducing Preschoolers Disruptive Behavior in Public with a Brief Parent Discussion Group. Journal of Child Psychiatry and Human Development, July 25, 2009.