TRIPLE P PARENTING PILOT HOUSTON, TEXAS

Evaluation Report

MARCH 2013 – JUNE 2014

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CONTENTS

Parents are the greatest influence on a child's life. Healthy parent-child relationships are fundamental to children's brain development as well as their physical, emotional, social, and behavioral health. Since parents play such an integral role in their children's development, it remains important they receive support and education that enables them to best care for their child throughout their child's life. Research has demonstrated that effective parent education has a positive impact on families, including lowering rates of social, emotional, and behavioral disorders in children, parental stress and anxiety, and child maltreatment.[1,2] Parent education is designed to improve parenting skills and family communication, prevent child and family problems, and educate parents on child development and positive parenting practices with a goal of developing safe, stable, and nurturing parent-child relationships.[2] Given the many benefits of parent education, in 2011 CHILDREN AT RISK established the Center for Parenting and Family Well-Being (CPFWB). The goals of the CPFWB were to conduct a needs assessment of parent education services, develop community partnerships, analyze the potential community impact of evidence-based parent education classes, and develop a comprehensive strategy to scale up evidence-based parent education in Houston. The CPFWB consulted with many local community organizations, academics, and the private sector to accomplish these goals.

Needs Assessment: In 2012, the CPFWB completed its needs assessment on parent education. The assessment revealed that less than 1% of parents in the greater Houston area access evidence-based parent education each year, despite the benefits to children, families, and the community. The methodology, findings, and recommendations were published in the report *The State of Parent Education in Houston, Texas: An Opportunity to Strengthen Family Well-Being, Prevent Child Maltreatment, and Prepare Children for a Brighter Houston.*[3]

Key findings of the needs assessment report include:

- There is a need in Houston, Texas for a population-based approach to parent education to reach more parents with evidence-based programming. A population-based approach is designed to support all families in a community as opposed to high-risk families only, by providing varying levels of parent support programs to meet the differing needs of families.
- The research and academic literature on the evidence-based parent education program called Positive Parenting Program (Triple P) is compelling, and the CPFWB anticipates Triple P could have a significant positive impact on the well-being of children, families, and community health indicators. Triple P is an evidence-based parent education program that uses a population-based approach and offers parenting support programs of different intensities to meet the varying needs of families.
- There is community support for the implementation of a population-based parenting support system. Triple P provides a model for a population-based approach, but the Triple P program should be integrated with other evidence-based programs that are used or supported by the Greater Houston community.
- Implementing a population-based parenting support system will require substantial infrastructure and coordination between agencies and organizations. Current agencies that provide parenting classes have limited capacity. To train enough providers for a population-based approach will require training of staff at schools, hospitals, medical practices, faith-based organizations, etc.

- More research is needed on how to structure, fund, and prioritize populations to effectively implement a population-based approach to parent education.
- Implementing Triple P will require a significant financial investment; however, research suggests that it is a cost-effective program.

With generous funding from the Houston Endowment, Community Health Choice, and the Harris County Hospital District Children's Health Fund, the CPFWB launched a pilot program using the Positive Parenting Program (Triple P) that utilized a population-based approach to program dissemination. This approach does not solely focus on high-risk families, but instead targets all families by offering different program types and intensities to match the needs and preferences of families. The goals of the pilot program were to: increase the number of parents accessing evidence-based parent education each year, utilize both traditional and non-traditional parent education organizations to offer services to diverse audiences, decrease the stigma associated with attending parenting classes, and to become more facile with implementing evidence-based programs in a large, multicultural community such as Houston. The following report describes the pilot program and its evaluation. The purpose of the evaluation was to assess the reach, effectiveness, and parent satisfaction of the program and to gain insight on how to improve and expand the program in the future.

The Positive Parenting Program (Triple P, TP)

The Triple P Positive Parenting Program is a population-based parenting and family support system designed to prevent and treat behavioral and emotional problems in children up to 12 years of age. Triple P utilizes a variety of research-based theoretical frameworks, including social learning, cognitive behavioral and developmental theory to empower parents to attain the skills, confidence and self-efficacy needed to effectively manage family issues and build positive relationships with their children. It is based on 35 years of research and has demonstrated positive outcomes in children, families, and the community.

Triple P utilizes a tiered parent support system that provides multiple types and intensities of parent support programs such as group classes, individual consultations, and large seminars to meet the varying needs of parents across the community. See Table 1 for a description of the five levels of intervention.

Table 1. Triple P Levels of Intervention

Level of Intervention	Description of Intervention	Delivery
Level 1 Social Media Campaign	A media campaign designed to raise awareness of the availability of parenting support programs and decrease the stigma associated with attending classes. This level of intervention is appropriate for all parents.	Media (brochures, billboards, television advertisements, radio, internet ads, etc.)
Level 2 Selected Seminars	Provides an overview of the principles of positive parenting and raising confident, resilient children.	A series of three 1.5-2 hour seminars
Level 3 Primary Care	Provides guidance to parents on specific concerns such as sleeping, toilet training, tantrums, etc.	Delivered individually through three or four 30-minute sessions
Level 4 Group and Standard	A more intensive intervention for parents needing help managing children's behaviors.	Delivered to groups of 5-12 parents during an 8 week program; 5 sessions are in a group format and 3 sessions are individual phone consultations. Also can be delivered through ten 1-hour individual sessions
Level 5 Enhanced	An intensive, individually tailored program for families with child behavior problems and family dysfunction that puts them at risk for child maltreatment.	Three to ten individual 90-minute sessions in addition to the level 4 curricula

Triple P Pilot Description

Three cohorts of Triple P trainings occurred between March 2013-January 2014 (Table 2). In total, 66 unique providers were trained across three levels of intervention: 20 trained in Level 2, 27 trained in Level 3, and 47 trained in Level 4. Twenty-three providers were trained in multiple levels. Twelve community organizations participated in the pilot program, representing four different sectors: education, social service agencies, faith-based and afterschool/ enrichment organizations. See Appendix A for a description of each community partner. Partner agencies were recruited through the extensive parent education partnership coalition established by the CPFWB in 2012, and partners were selected based on organizational type and potential reach, with an emphasis on geographic and organizational diversity. Partner agencies were briefed on the principles of Triple P and signed a memorandum of understanding with CHILDREN AT RISK to ensure their commitment to delivering the program.

Community providers were trained by a Triple P trainer, accredited to deliver the Triple P program, and received the necessary materials to offer the classes (e.g. presentation materials, parent workbooks, tips sheets) and promotional materials from Triple P's Stay Positive Campaign. Additionally, the CPFWB coordinated monthly peer support meetings that allowed providers to learn from one another and share successes and challenges. The CPFWB staff had weekly phone check-ins with Triple P America to discuss strategies to better support the providers, recruit parents, troubleshoot implementation challenges, and generate ideas on how to grow and sustain the pilot program.

Description of Providers (Cohorts 1 and 2, 53/66 providers): Providers were predominantly female (87%) and between the ages of 30 – 39 (36%). They were also racially and ethnically diverse: 27% Black, 25%

Caucasian, and 47% Hispanic. Almost half of the providers (53%) held a master's or doctoral degree and 42% of the providers held a bachelor's degree. The remaining 9% of providers had an associate's degree or attended some college. The most common fields of study were counseling (27%), psychology (26%), education (12%), and social work (12%). On average, the providers worked in their current field for just under 9 years.

Table 2. Timeline of the Triple P Pilot

	Cohort 1	Cohort 2	Cohort 3
Training Date	March 2013	August 2013	January 2014
Accreditation Date	April 2013	October 2013	March 2014
Pilot Duration	March 2013-May 2014	August 2013-October 2014	January 2014-January 2015
Number of Training slots	20 slots in Level 2 20 slots in Level 3 20 slots in Level 4	20 slots in Level 4	7 slots in Level 3 6 slots in Level 4
Unique Providers	33 providers 10 trained in a single level 23 trained in multiple levels	20 providers	13 providers
Community Partners	Archdiocese of Galveston-Houston, Boys and Girls Club of Greater Houston, Collaborative for Children, Communities in Schools-Houston, Spring Branch ISD	DePelchin Children's Center	Archdiocese of Galveston-Houston, Children's Museum, Collaborative for Children, Communities in Schools-Baytown, Galena Park ISD, Harris County Dept. of Education, Neighborhood Centers, Sheldon ISD
Funder	Community Health Choice	Community Health Choice	Community Health Choice and Harris County Hospital District Children's Health Fund

EVALUATION

The evaluation and data collection plan is outlined in Table 3 and includes process evaluation tools, measures collected on the providers delivering the program, and outcome measures completed by the program participants.

Table 3. Data Collection and Evaluation Plan

Process Evaluation				
Tool	**Measure/tool**	**Notes**		
Program Log	Session information: provider, place, time, frequency			
Session Checklist	Triple P checklists for each session	Provided, not collected		
Sign-In Sheet	Session attendance			
Providers				
Construct	**Assessment Tool**	**Pre-Training**	**Accred--itation**	**1 year post**
Demographics /Work History	C@R created survey using questions from other sources	X		
Consultation Self-Efficacy	TP parent consultation skills checklist	X	X	
Perceived Support/ Barriers From Agency	Altered version of survey developed by K. Turners (for TP)			X (ongoing)
Implementation Barriers	Focus group, interviews, notes from peer support			X (ongoing)
Participants				
Construct	**Assessment Tool**		**Pre**	**Post**
Level 2: Seminars				
Demographics	C@R created survey using questions from other sources			X
Parenting Confidence & Self-Efficacy	4 questions created by C@R			X
Knowledge & Intentions to use TP	TP's client satisfaction survey			X
Satisfaction/Benefits	TP's client satisfaction survey			X
Level 3: Primary Care				
Demographics	C@R created survey using questions from other sources		X	
Relationship/ Behavior Management	Combined TP and C@R self-efficacy questions		X	X
Knowledge & Intentions to use TP	TP's client satisfaction survey			X
Satisfaction/Benefits	TP's client satisfaction survey			X
Level 4: Group				
Demographics	C@R created survey using questions from other sources		X	
Discipline Style	The Parenting Scale*		X	X
Parenting Confidence & Self-Efficacy	4 questions created by C@R		X	X
Child Adjustment	Strength and Difficulties Questionnaire*		X	X
Satisfaction/Benefits	TP's client satisfaction survey			X

*See below for a description of these validated survey instruments

Process evaluation: Process evaluation tools, including program logs and attendance sheets, were collected by providers to determine the number of total participants receiving the program and the geographic availability of classes.

Provider Measures: Providers supplied demographic information and completed questionnaires before training and after TP accreditation to assess their prior experience in delivering parenting consultations/education as well as their confidence and self-efficacy in the specific skills required to effectively deliver parent consultations/education in group and individual settings. During the spring and summer of 2014, providers who had completed one year of program delivery were invited to participate in a focus group and complete a questionnaire eliciting information about things that made them successful and barriers that limited their ability to deliver the program completely or as intended. Provider demographics and a brief description of implementation barriers are described in this evaluation report. A more extensive section on implementation challenges will be made available in summer 2015, once all of the providers have completed one year of program delivery and have had the opportunity to participate in the survey, support meetings, interviews, and focus group.

Participant Measures: Depending on the level of the TP program offered, participants provided demographic information and completed questionnaires. Those attending a level 2 seminar were asked to complete a post-seminar questionnaire that included questions regarding their parenting self-efficacy and confidence, their knowledge and intentions to use the parenting strategies presented in the seminar and their satisfaction with the program.

Participants seeking individual consultations through level 3 Primary Care were asked to complete a pre-test questionnaire that elicited demographic information as well as information on their current relationship with the child and behavior management style. After receiving 2-4 consultations with the trained provider, they were asked to complete a post-test questionnaire that included questions regarding their knowledge and intentions to use the strategies discussed and their satisfaction with the program.

Those participating in the level 4 Group sessions were asked to complete a pre-intervention questionnaire that included demographic questions, questions regarding their relationship to their child, parenting self-efficacy and confidence, and two validated survey instruments to assess child behavior/adjustment (Strengths and Difficulties Questionnaire) and parenting style (Parenting Scale). During the last session of the parenting classes, participants were asked to complete a post-intervention questionnaire that included the same validated survey instruments, relationship, parenting self-efficacy and confidence questions as well as questions regarding program satisfaction. See below for a description of the Strengths and Difficulties Questionnaire and Parenting Scale surveys.

The Strengths and Difficulties Questionnaire (SDQ) was utilized to assess child behavior/adjustment. This questionnaire is widely used in research as well as in mental health clinics as a brief screening tool to identify mental health problems in children.[4] There are a total of 25 items relating to 5 subscales: emotional symptoms, conduct problems, hyperactivity, peer problems, and prosocial behavior. The items are summed to create a “total difficulties score” ranging from 0-40, with higher scores correlated with greater rates of mental disorders in children.[4] Population norms and clinical cutoff points have been established in the United States (Table 4), and the questionnaire has been validated in English and Spanish.

Table 4. Strengths and Difficulties Questionnaire: Means (standard deviation) and clinical cutoff points for US children ages 4-17 years.[5,6]

	US Norms: Mean (s.d.)	Normal	Borderline	Clinical
Total Difficulties	7.1 (5.7)	0-13	14-16	17-40
Emotional Symptoms	1.6 (1.8)	0-3	4	5-10
Conduct Problems	1.3 (1.6)	0-2	3	4-10
Hyperactivity	2.8 (2.5)	0-5	6	7-10
Peer Problems	1.4 (1.5)	0-2	3	4-10
Prosocial Behavior	8.6 (1.8)	6-10	5	0-4

The Parenting Scale (PS) was utilized to measure parental discipline strategies using 30 situations relating to three dysfunctional discipline subscales: Laxness (permissive discipline); Over-reactivity (authoritarian discipline, displays of anger, meanness and irritability); and Hostility (use of verbal or physical force).[7] Scores on each item range from 1 to 7. The three scales can be used separately or summed to create a total score, which has been shown to be strongly associated with observed dysfunctional discipline and child misbehavior.[7] The Parenting Scale is one of the most widely used scales in measuring parenting practices and evaluating parenting programs.[8,9] Clinical cutoff points have been established for the 3 subscales for both mothers and fathers (Table 5).

Table 5. The Parenting Scale: Normal and Clinical Cutoff Scores by Subscale

Construct	Parent	Normal	Clinical
Laxness	Mothers	<3.6	≥3.6
	Fathers	<3.4	≥3.4
Over-reactivity	Mothers	<4.0	≥4.0
	Fathers	<3.9	≥3.9
Hostility	Mothers	<2.4	≥2.4
	Fathers	<3.5	≥3.5
Total	Mothers	<3.2	≥3.2
	Fathers	<3.2	≥3.2

RESULTS

Analysis of the response rate, reach, effectiveness, and program satisfaction from those completing questionnaires after participating in levels 2 and 4 are described below. Due to the low response rate for level 3, the effectiveness and program satisfaction results in this level are not available.

SURVEY RESPONSE RATE

Despite our best efforts to collect information on the sessions and participants, this proved to be quite challenging for many of our providers. The level 3 intervention was particularly challenging and completing the pre- and post- questionnaires were identified early on by providers as a deterrent to participation. For this reason, most of the level 3 providers opted to not give the questionnaires in order to reach more parents. Table 6 describes the response rate for each level of intervention.

Table 6. Response Rate for Process and Outcome Measures

	Level 2	Level 3	Level 4	Total
Number of parents reached	2,495	211	437	3,143
Number (%) of surveys collected*	Post: 1120 (44.9%)	Pre: 5 (2.4%) Post: 1 (<1%)	Pre: 386 (88.4%) Post: 280 (57.6%)	-
Number of sessions offered	102	211	61	374
Session information collected (location, date and number of parents reached)	95	14	46	141

* Not all surveys collected were complete

REACH

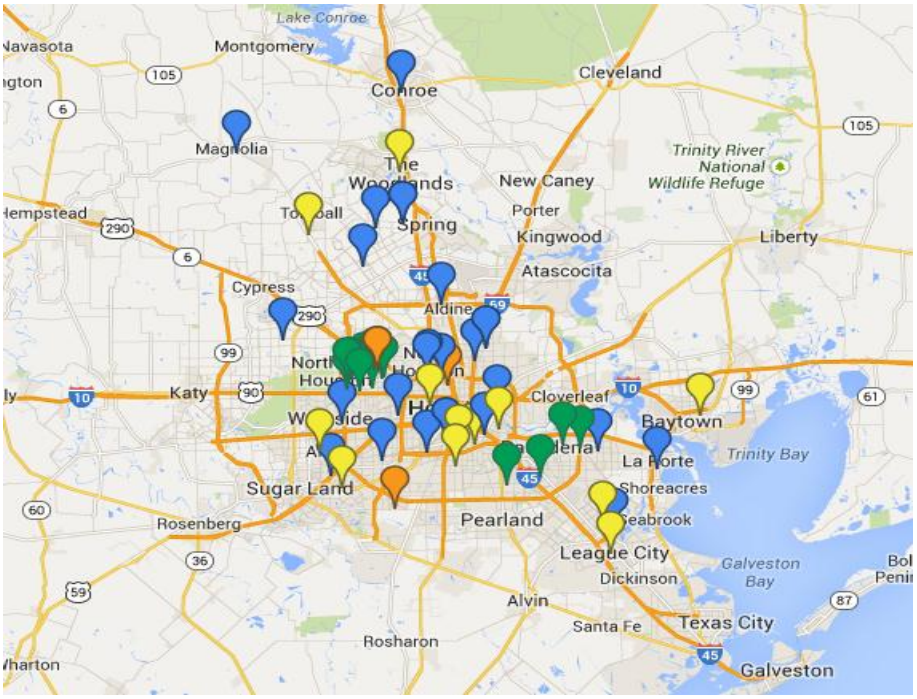
Reach of the program was calculated using a combination of session logs, attendance sheets and demographic characteristics of participants. In total, the Triple P pilot reached **3,143** parents/ caregivers through 374 parenting sessions delivered between March 2013 and June 2014 (Table 7). Sessions were offered at 67 locations across the greater Houston area (Figure 1).

Table 7. Reach of the Triple P Pilot

	Level 2	Level 3	Level 4	Total
Number of parents/caregivers reached	2,495	211	437	3,143
Number of children impacted*	6,661	211	857	7,729
Number of sessions offered	102	211	61	374
Average number of parents per session	24	1	7	--

**The level 2 and 4 intervention addresses general parenting skills so the mean number of children per family was used to determine the number of children impacted. The level 3 intervention addresses specific behaviors of one child so it is assumed that the number of children impacted is the same as the number of parents reached. The mean number of children of parents participating in level 2 was 2.67. The mean number of children participating in level 4 was 1.96.*

Figure 1: Map of Locations Where Triple P Sessions Were Offered



Demographics

Table 8 provides a description of the demographic characteristics of the participants and their families. As one of the goals of the Triple P pilot was to reach parents from diverse backgrounds, several demographic findings are noteworthy:

- *Language*: The majority (57%) completed the questionnaires in Spanish, and 61% reported Spanish as the primary language spoken in their home.
- *Gender:* 78% of the parents/caregivers were female, 22% male. Because many parenting programs have trouble recruiting males to attend, 22% male participation is felt to be quite high.
- *Educational attainment:* Parents/caregivers had a wide range in educational achievement with a fairly even split with the highest level of education obtained being: grades 0-8, grades, 9-11, high school or GED, some college, and college graduate.
- *Country of origin:* The parents/caregivers reported 34 different countries of origin from 5 continents.
- *Marital status:* The majority of the participants were married (63%) with an additional 16% living together as married. This could reflect the fact that most participants were recruited by the Archdiocese of Galveston-Houston, an organization that values and promotes traditional marriage. Only 18% of the participants reported only having one adult living at home.
- *Income:* 30% of parents/caregivers reported that they received public assistance to help pay for food, housing, bills, and medical costs.
- *Residence:* The children of participants resided in 14 counties and 162 unique zip codes (Figure 2).

Table 8. Demographic Description of Participants

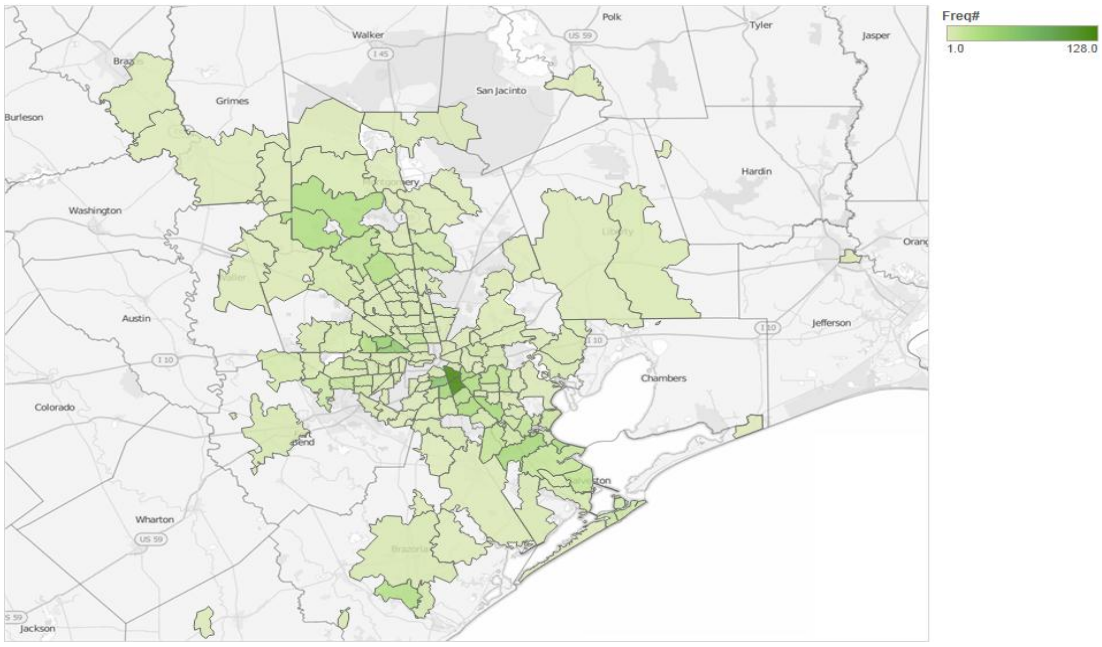
	Level 2 N=1,120		Level 4 N=386		Total N=1,506	
	n	(%)	n	(%)	n	(%)
Survey Language						
English	382	(34%)	271	(70%)	653	(43%)
Spanish	738	(66%)	115	(30%)	853	(57%)
Gender						
Male	228	(21%)	86	(24%)	314	(22%)
Female	845	(79%)	270	(76%)	1115	(78%)
Race						
Black, Non-Hispanic	37	(3%)	62	(16%)	99	(7%)
White, Non-Hispanic	126	(11%)	107	(28%)	233	(15%)
Hispanic	879	(78%)	189	(49%)	1068	(71%)
Asian	10	(1%)	9	(2%)	19	(1%)
Other	68	(6%)	19	(5%)	87	(6%)
Highest Level of Education Completed						
Grades 0-8	238	(23%)	33	(9%)	271	(19%)
Grades 9-11	202	(19%)	65	(17%)	267	(19%)
High School or GED	211	(20%)	118	(31%)	329	(23%)
Some College	169	(16%)	112	(30%)	281	(20%)
College Graduate	237	(17%)	50	(13%)	287	(20%)
Age						
Under 20	6	(1%)	20	(5%)	26	(2%)
20-34	357	(36%)	197	(51%)	554	(40%)
35-54	612	(61%)	137	(35%)	749	(55%)
55+	25	(3%)	16	(4%)	41	(3%)
Marital Status						
Single, never married	67	(6%)	96	(25%)	163	(11%)
Married	750	(70%)	160	(42%)	910	(63%)
Widowed	15	(1%)	2	(1%)	17	(1%)
Separated or Divorced	72	(7%)	61	(16%)	133	(9%)
Living together as if married	166	(16%)	62	(16%)	228	(16%)
Primary Language Spoken at Home						
English	314	(29%)	240	(63%)	554	(38%)
Spanish	770	(71%)	129	(34%)	899	(61%)
Other	8	(1%)	12	(3%)	20	(1%)
Receives public assistance						
Yes	258	(25%)	168	(45%)	426	(30%)
No	792	(75%)	207	(55%)	999	(70%)

Table 8 (continued)

	Level 2 N=1,120		Level 4 N=386		Total N=1,506	
	n	(%)	n	(%)	n	(%)
Age range of children*						
0-3 years	361	(15%)	109	(28%)	470	(17%)
4-8 years	836	(36%)	159	(41%)	995	(37%)
9-14 years	629	(27%)	87	(23%)	716	(26%)
15-18 years	296	(13%)	13	(3%)	309	(11%)
19+	226	(10%)	3	(<1%)	229	(8%)
Number of children (under 18 years of age) living at home						
0	21	(3%)	44	(12%)	65	(6%)
1	152	(19%)	107	(29%)	259	(22%)
2	322	(41%)	111	(30%)	433	(37%)
3	205	(26%)	72	(19%)	277	(24%)
4	71	(9%)	26	(7%)	97	(8%)
5	15	(2%)	5	(1%)	20	(2%)
6+	3	(<1%)	9	(2%)	12	(1%)
Number of adults (over 18 years of age) living at home (including parents)						
1 or fewer	117	(15%)	86	(23%)	203	(18%)
2	527	(68%)	217	(58%)	744	(64%)
More than 2	136	(17%)	73	(19%)	209	(18%)

* Level 2 participants listed the ages of all of the children, level 4 only gave the date of birth for the specific child they were seeking advice for/ about whom they answered the survey

Figure 2: Zip Codes Where Participants' Children Live



Level 2: Seminars

Methods

Participants in the level 2 Seminars were asked to complete a post-seminar questionnaire that included questions regarding their parenting self-efficacy and confidence, their knowledge and intentions to use the parenting strategies presented in the seminar, and their satisfaction with the program. Counts and frequencies were used to describe parent/caregiver reported responses.

Results

Approximately half of the parents/caregivers reported a high level of confidence in their parenting skills. 53% reported they were very confident in managing their child's behavior; 51% reported that they feel like what they are doing to deal with their child's behavior is working; and 51% reported that they always know what to do when their child misbehaves (Figures 3-5).

Figure 3. Overall, how confident are you in managing your child(ren)'s behavior?

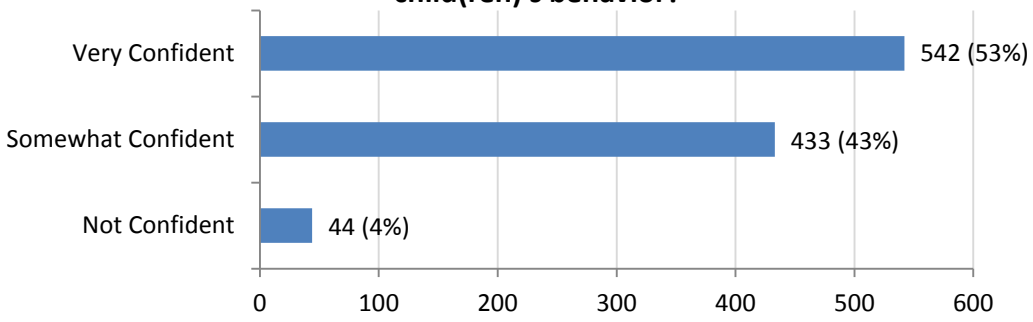


Figure 4. I feel like what I am doing now to deal with my child's/children's behavior is working

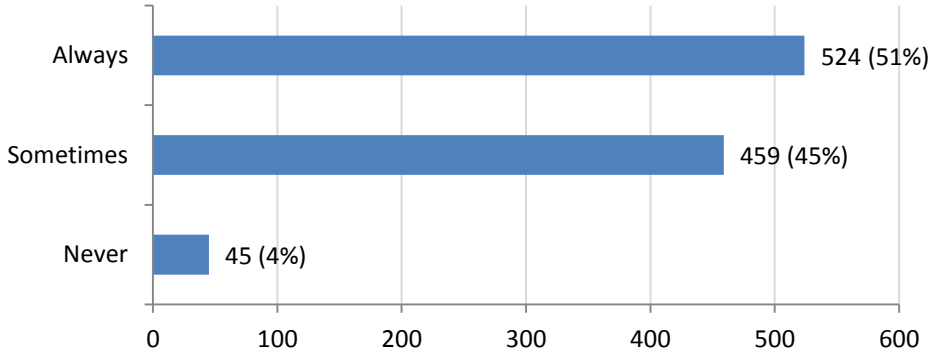
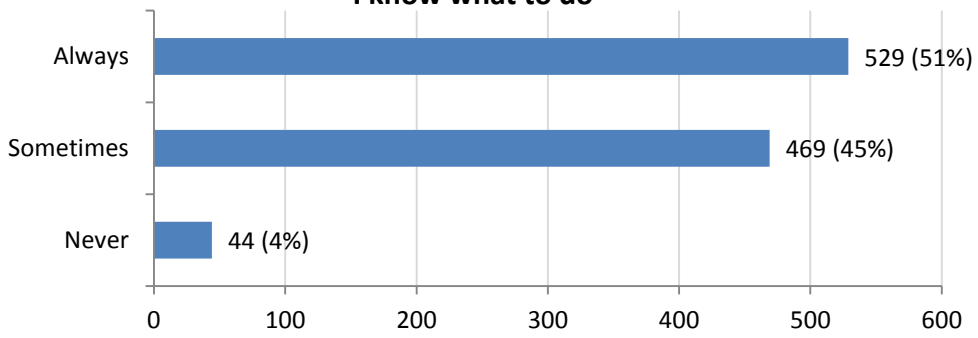


Figure 5. When my child(ren) misbehaves, I know what to do



The overwhelming majority of parents/caregivers reported that they intended to implement the strategies they learned. 88% reported that they gained sufficient knowledge to implement the parenting advice; 91% reported the seminar was helpful in understanding how to help their children learn new skills and behaviors; and 93% reported that they intended to implement the parenting advice they received (Figures 6-8).

Figure 6. Did you gain sufficient knowledge or information to be able to implement the parenting advice you heard about?

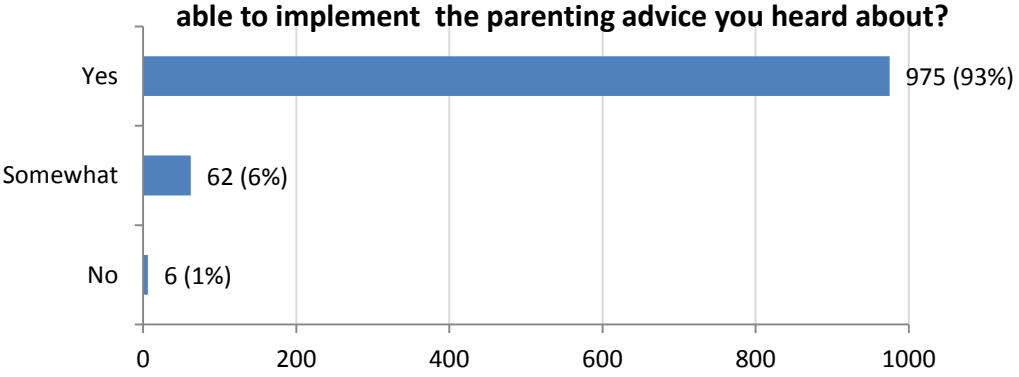


Figure 7. Do you intend to implement the parenting advice you received ?

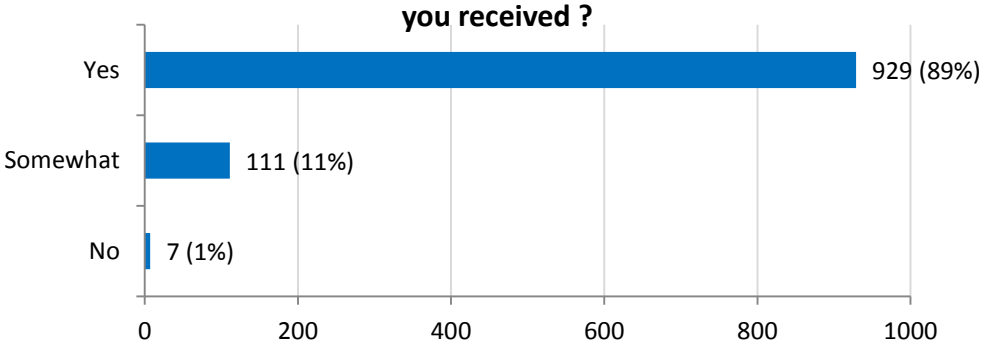
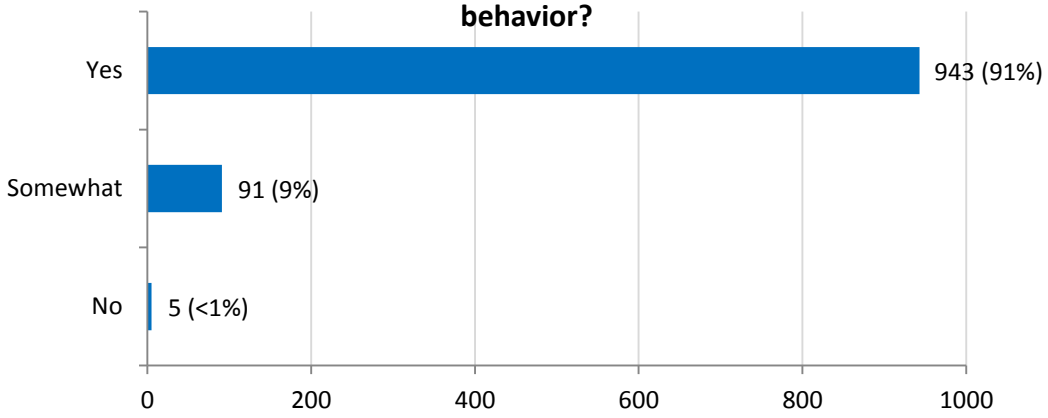


Figure 8. Was the seminar helpful in gaining an understanding of what you can do to help your child learn new skills and behavior?



Level 4: Group Classes

Methods

Parents /caregivers participating in level 4 group classes were asked to complete pre- and post-intervention questionnaires that included questions on child behavior/adjustment using the Strengths and Difficulties Questionnaire (SDQ), their discipline strategies using The Parenting Scale (PS), questions regarding their relationship with their child currently, and their parenting self-efficacy and confidence. To assess the effectiveness of the program and note any changes, we compared the pre- and post-intervention scores for those participants completing both the pre- and post- questionnaires.

There were 280 pairs of level 4 pre- and post-questionnaires. Of those, 99 (35%) were completed with more than 14 days between the pre and post-test (traditional administration) and 181 (65%) were completed within 14 days of each other (condensed administration). Two agencies delivering the level 4 intervention condensed the sessions to make them two daylong sessions over a single or two consecutive weekends (vs. traditional administration of 6-8 sessions over multiple weeks). Because we were attempting to measure change in child and parent behaviors after implementing learned strategies using an evidenced-based program designed to be delivered over multiple weeks and sessions, we stratified the results into 2 groups. Results from those completing the program as intended, over multiple weeks, are presented below. Results from those participating in the condensed version can be found in Appendix B.

Inclusion criteria for validated survey instruments: In order for the results of the SDQ and PS to be valid and included in these analyses, the caregiver had to complete pre- and post- questionnaires on the same child that was between the ages of 4-18 years at the time of the assessment and had to answer over 50% of the questions for each subscale (e.g., at least 3 of the 5 questions had to be answered for the SDQ subscales to be considered valid).

Data analysis: Paired t-tests were used to determine if there were significant differences between mean pre- and post-intervention scores on the SDQ, PS, and self-efficacy and confidence questions. For the PS, McMemar tests were used to compare changes in the proportion of parents scoring in the normal and clinical ranges before and after the intervention. Normal and clinical ranges were calculated

separately for mothers and fathers. For those who participated and reported a different relation to the child (e.g. step-parent, grandparent), clinical norms for mothers were used. P-values less than 0.05 were considered statistically significant.

Results

Of the 99 participants that completed the pre and post-intervention questionnaires with more than 2 weeks in between administrations, 72 (73%) had valid SDQ results and 66 (67%) had valid PS results.

Strengths and Difficulties Questionnaire (SDQ): The SDQ measured parent reported child difficulties in 5 key areas: emotional symptoms, conduct problems, hyperactivity, peer problems, and prosocial behavior. The items are summed to create a "total difficulties score" ranging from 0-40, with higher scores correlated with greater rates of mental disorders in children.[4]

The mean total difficulties score on the pre-test was 11.63 (*s.d.= 6.35)* and decreased to 9.57 *(s.d.=5.34)* post-intervention (Table 9). Pre-intervention, 20.8% of the parents indicated their child exhibited abnormal behavior/adjustment, 8.3% borderline, and 70.8% had total scores indicating normal overall behavior/adjustment. Post-intervention, 11.1% of the parents indicated their child exhibited abnormal behavior/adjustment, 9.7% borderline, and 79.2% had total scores indicating normal overall behavior/adjustment (Table 10).

Post-intervention, parents reported significant improvements in total difficulties and 4 of the 5 subscales of the SDQ (Table 9). The mean score for peer problems indicated an improvement in this area, but the mean score was not statistically significant from the pre-intervention mean score. On all subscales, there were reductions in the number of children scoring in the abnormal range, and on all subscales except peer problems, there were more children scoring in the normal range post- intervention (Table 10, Figure 9).

Table 9. Pre vs. Post Intervention SDQ

	Pre-Intervention			Post-Intervention		
Scale	**n**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**	**p-value**
Total***	72	11.63	6.35	9.57	5.34	<0.001
Emotional Symptoms*	72	2.58	2.23	2.08	2.13	0.047
Conduct Problems**	72	2.5	1.92	1.93	1.6	0.007
Hyperactivity**	72	4.08	2.54	3.38	2.14	0.004
Peer Problems	72	2.46	1.81	2.18	1.69	0.181
Prosocial Behavior***	72	7.08	2.13	8.01	1.69	<0.001

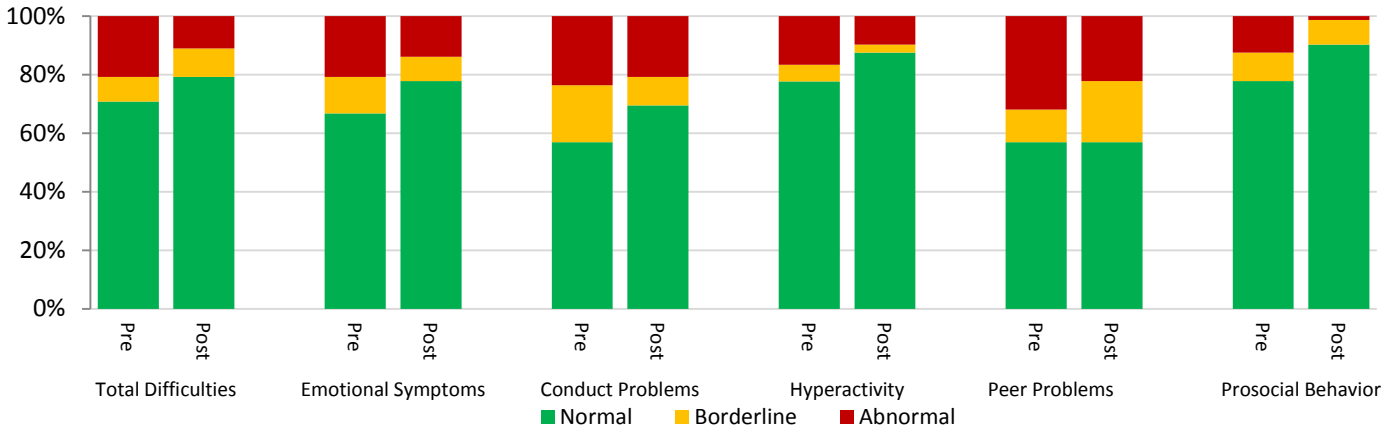
Mean pre vs. post intervention scores significantly different

*p-value<.05; ** p-value<.01; ***p-value<.001

Table 10. Percent of Children Scoring in the Normal, Borderline and Abnormal Ranges for Child Behavior/Adjustment on the Pre and Post SDQ

		Normal	Borderline	Abnormal
Total Difficulties	Pre	70.8%	8.3%	20.8%
	Post	79.2%	9.7%	11.1%
Emotional Symptoms	Pre	66.7%	12.5%	20.8%
	Post	77.8%	8.3%	13.9%
Conduct Problems	Pre	56.9%	19.4%	23.6%
	Post	69.4%	9.7%	20.8%
Hyperactivity	Pre	77.8%	5.6%	16.7%
	Post	87.5%	2.8%	9.7%
Peer Problems	Pre	56.9%	11.1%	31.9%
	Post	56.9%	20.8%	22.2%
Prosocial Behavior	Pre	77.8%	9.7%	12.5%
	Post	90.3%	8.3%	1.4%

Figure 9. SDQ Subscale Clinical Cutoff Points: Pre vs. Post Intervention



Parenting Scale (PS): The PS measured parent/caregiver reported discipline strategies using 30 situations relating to three dysfunctional discipline subscales: Laxness (permissive discipline); Over-reactivity (authoritarian discipline, displays of anger, meanness and irritability); and Hostility (use of verbal or physical force). The score for each question ranges from 1 to 7. All 30 items can be summed and averaged to create a total mean score, with higher scores indicating dysfunctional discipline practices.

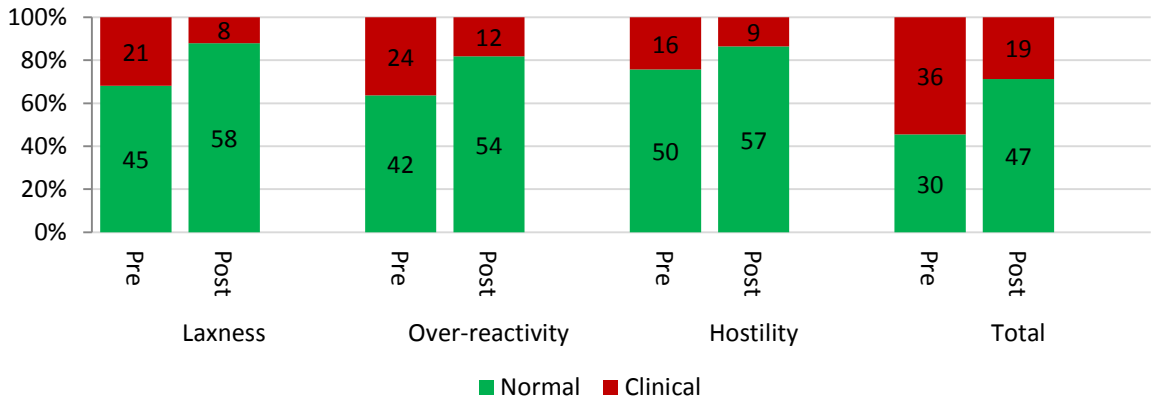
The total mean score on the pre-intervention PS questionnaire was 3.31 (*s.d. =0.63*) and at post, the total mean score decreased to 2.94 (*s.d.=0.62*) (Table 11). The total mean and all 3 subscale scores had significantly improved at post-intervention. Additionally, there were significantly more parents/caregivers scoring in the "normal" range on the PS post-intervention when comparted to pre-intervention (laxness, p<0.001; over-reactivity, p=0.016; hostility, p=0.011; total, p<0.001) (Figure 10).

Table 11. Pre vs. Post Intervention Parenting Scale

		Pre-Intervention		Post-Intervention		
	n	Mean	Std. Dev.	Mean	Std. Dev.	p-value
Laxness***	66	3.04	1.18	2.38	1.05	<0.001
Over-reactivity*	66	3.27	1.34	2.91	1.20	0.016
Hostility*	66	1.92	1.24	1.55	0.76	0.011
Total***	66	3.31	0.63	2.94	0.62	<0.001

Mean pre vs. post intervention scores significantly different
*p-value<.05; ** p-value<.01; ***p-value<.001

Figure10. The Parenting Scale Subscale Clinical Cutoff Points: Pre vs. Post Intervention



Self-Efficacy and Confidence: 92% of participants responded to the four questions regarding parenting self-efficacy, confidence, and the status of their relationship with their child pre and post-intervention. Scores ranged from 1-7 on each item. Statistically significant improvements (p<0.05) were observed in the participants beliefs that they knew what to do to manage their child's behavior, that the things they

were doing to manage behavior were working, and in their overall confidence in managing behavior after participating in the program (Table 12).

Table 12. Pre vs. Post Intervention Parenting Self-Efficacy and Confidence

		Pre-Intervention		Post-Intervention		
	n	Mean	Std. Dev.	Mean	Std. Dev.	p-value
Knowledge*	92	5.20	1.64	5.66	1.45	0.021
Confidence***	91	4.88	1.78	5.73	1.39	<0.001
Things are working***	92	5.13	1.65	5.96	1.31	<0.001
Relationship	92	6.01	1.23	6.10	1.34	0.574

Mean pre vs. post intervention scores significantly different
* p-value<.05; ** p-value<.01; ***p-value<.001

Overall Improvements Reported by Parents/Caregivers: 92% of participants reported that since attending the Triple P sessions their child's problems had improved (53% improved "a great deal", 38% were "a bit better"). 91% reported that the sessions had been helpful in other ways, e.g. providing information or making the problems more bearable. 93% of participants reported that the program helped them "a great deal" in being able to more effectively deal with their child's behavior, and 91% stated that the program helped them "a great deal" in being able to more effectively deal with problems that arose in their family.

Participants Completing Pre-Intervention Questionnaire Only: Of the 386 participants that submitted a questionnaire at some point during the program, 77 (20%) had a valid pre-intervention SDQ and 72 (19%) had a valid PS but no post-questionnaire submitted. A comparison of pre-intervention mean SDQ subscale results are described in Table 13, and the mean PS subscale results are described in Table 14. In general, those completing only a pre-questionnaire reported more child difficulties than those completing the pre- and post-questionnaires. The mean total PS score as well as the mean score for over-reactivity and hostility were higher in those only completing the pre-questionnaire as compared to those completing both pre- and post- questionnaires, indicating a higher degree of parenting dysfunction in this group.

Table 13. Pre SDQ Scores for those completing only the pre-test and those completing the intervention (both pre- and post-tests)

	Incomplete (Pre only)		Complete (Pre and Post)	
	Mean	Std. Dev.	Mean	Std. Dev.
Total Difficulties	13.48	6.35	11.63	6.35
Emotional Symptoms	2.60	2.23	2.58	2.23
Conduct Problems	3.17	2.21	2.50	1.92
Hyperactivity	4.94	2.68	4.08	2.54
Peer Problems	2.78	1.83	2.46	1.81
Prosocial Behavior	7.14	2.47	7.08	2.13

Table 14. Pre PS Scores for those completing only the pre-test and those completing the intervention (both pre- and post-tests)

	Incomplete (Pre only)		Complete (Pre and Post)	
	Mean	**Std. Dev.**	**Mean**	**Std. Dev.**
Laxness	2.95	1.21	3.04	1.18
Over-reactivity	3.69	1.31	3.27	1.34
Hostility	2.01	1.18	1.92	1.24
Total	3.39	0.57	3.31	0.63

PROGRAM SATISFACTION

Level 2 Seminars
Total satisfaction for those participating in level 2 seminars was 6.6/7.0, suggesting participants were highly satisfied with the program.

Level 4 Group
Those participating in the traditional administration of level 4 group reported a mean overall satisfaction of 6.35/7.0. Overall, participants reported being very satisfied with the program and the guidance/support they received. 98% of participants reported that they would come back to Group Triple P if they need help again.

CHALLENGES & LIMITATIONS

Implementation Challenges
Providers reported a range of implementation challenges through peer support meetings, a focus group, and an anonymous survey. The most common challenge reported was parent recruitment. Other challenges reported include: poorly translated Spanish materials, difficulty in covering all of the material in the allotted time, difficulty in managing the flow of the different teaching materials (powerpoint, videos, and script), integrating the classes with their other job responsibilities, and lack of awareness of the program by their colleagues.

Limitations
Survey Instruments: In designing the evaluation, the CPFWB selected validated survey instruments along with survey instruments that are commonly used by other Triple P providers to enable us to compare our results to other communities. However, there were some limitations to these instruments. The survey instruments that measure behavior change and parenting style are designed for parents of children ages 4 years and older. Approximately 30% of parents that participated in the program had children under the age of 4 or over the age of 18 and were excluded from the analyses relating to behavior change and parenting style. Similarly, the surveys were designed for parents with custody of their children. A few parents did not have custody of their children and therefore were unable to report on changes in their children's behavior and changes in their parenting style. These parents were also excluded from the analyses relating to behavior change and parenting style. Finally, a couple of the

providers piloted offering the level 4 program in a 2-day format. The results were stratified to take into account the variation in program delivery and its potential effect on the results.

Survey Response Rate: Overall, the response rate for the surveys for this pilot was low. The response rate for level 2 was 45% and level 4 was 58%. The funding and design of this pilot aimed primarily to increase access to evidence-based services. Consequently, there were no incentives provided to complete surveys and limited staff time was allocated towards evaluation. In some cases, the parents chose not to complete the survey and in other cases the providers did not distribute the surveys.

FUTURE PLANS

The CPFWB plans to use the results from the Triple P pilot to continue to expand and better support community partners. Five out of the six community partners in the first two cohorts plan to continue to use Triple P beyond the pilot year. Spring Branch ISD has included training and program costs to their annual budget to allow the Spring Branch ISD and Communities in Schools providers to continue to offer classes as well as to train additional providers. The Archdiocese of Galveston-Houston has named Triple P as their official parenting program and is actively scheduling future classes and seeking funding for program materials and to train additional providers. Collaborative for Children and DePelchin's Children Center plan to continue to offer Triple P as part of their core services.

The CPFWB will continue to support the community partners by providing program support, coordinating peer support meetings, and conducting program evaluation. The CPFWB is also actively fundraising to train additional providers throughout the Houston area and to purchase program materials accordingly. The CPFWB is also advocating at the local and state level to create a sustainable public funding stream for evidence-based parent education classes.

SUMMARY & HIGHLIGHTS

The purpose of this evaluation was to assess the reach, effectiveness, and parent satisfaction of Triple P Pilot Program and to gain insight on how to improve and expand evidenced-based parent education in Houston in the future. A summary for each area are detailed below.

Reach

- The Triple P pilot reached 3,143 parents through 374 sessions at more than 67 locations, increasing the availability of evidenced-based parent education in our community.
- The pilot reached a diverse group of parent/caregivers in terms of gender, countries of origin (34 countries), income, educational attainment and race/ethnicity.
- Approximately 7,700 children from 14 countries (162 zip codes) were potentially impacted by this program.
- The diversity of providers and agencies allowed classes to be offered in many locations around the Greater Houston area.

Effectiveness

- Questionnaire response rates were lower than expected and limit the generalizability of results.

- Though generalizability is limited, results from level 4 group are similar to findings from other published studies including statistically significant decreases in child problem behaviors and significant improvements in parenting style.
- 93% of parents reported that they gained knowledge and 89% reported that they plan to implement the parenting advice (level 2).

Satisfaction

- Participants reported high levels of satisfaction with the program and nearly all of the participants in level 4 reported that they would consult TP if they had future problems.
- High levels of reported improvements managing child behavior and effectively dealing with other problems in the home were reported by the vast majority of respondents.

Implementation Insights

- Parent recruitment is a major challenge for providers, even agencies accustomed to providing parent education programs.
- Collecting up-to-date information on program delivery from community partners is challenging and consistent follow-up is needed.
- Questionnaires, even relatively short ones, can be a deterrent to program delivery and not all community organizations are as comfortable requiring or distributing questionnaires to participants in their programs.

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Organization	Description	No. of Triple P providers
Faith		
Archdiocese of Galveston-Houston	The Archdiocese of Galveston-Houston is a multicultural Church, with 146 parishes. It serves over 1.2 million members in the greater Houston area.	10; 9 trained in multiple levels
Communities in Schools--Houston	Communities in Schools (CIS) is a nonprofit dropout prevention program. CIS works with over 100 campuses in Houston to provide direct social services to at-risk students, as well as to connect students and their families to critical community resources.	10; 4 trained in multiple levels
Education		
Spring Branch ISD	The Spring Brank Independent School District is located in west Houston and serves 33,000 students in 46 campuses.	5; 2 were trained in multiple levels
Galena Park ISD	Galena Park Independent School District is based in the Channelview CDP of unincorporated Harris County. The district serves the city of Galena Park, Jacinto City, Houston, as well as unincorporated areas in Harris County. The district includes 15 elementary schools, 5 middle schools and 4 high schools.	2
Goose Creek CISD	The Goose Creek Consolidated Independent School District is headquartered in Baytown, Texas. The district includes 14 elementary schools, 5 junior high schools and 4 high schools.	2
Sheldon ISD	Sheldon Independent School District is a public school district in unincorporated northeast Harris County with 10 schools and 2 early childhood academies.	2
Afterschool and Enrichment		
Boys and Girls Club of Greater Houston	The Boys and Girls Club of Greater Houston is a nonprofit organization that serves nearly 10,000 children and teens ages 6 to 17 each year. Their organization works to engage, educate and empower low-income young people and equip them to achieve academic and economic success.	8; 8 trained in multiple levels
Children's Museum	The Children's Museum of Houston seeks to transform communities through innovative, child-centered learning and by engaging parents in their children's learning.	1
Harris County Department of Education—Cooperative for Afterschool Enrichment	The Cooperative for After-School Enrichment was formed by the Harris County Department of Education in 1999. The goal of the cooperative is to ensure that every child in Harris County has access to an after-school program, supporting the educational needs of 25 school districts in Harris County.	1

Social service agencies		
Collaborative for Children	Collaborative for Children is a nonprofit organization aimed to improve the quality of early education in Greater Houston through working with parents, educators, and leaders to ensure that children have the learning opportunities needed to be successful in life.	3; 1 trained in multiple levels
DePelchin Children's Center	DePelchin Children's Center is a nonprofit organization which aims to strengthen the lives of children by enhancing their mental health and physical well-being. DePelchin Children's Center focuses on mental health, foster care and adoption services through comprehensive care for children.	20
Neighborhood Centers	Neighborhood Centers is a nonprofit human resources organization which aims to bring resources, education and connection to emerging neighborhoods through community-based initiatives, educational opportunities, and through public sector solutions.	2

APPENDIX B. LEVEL 4 GROUP: CONDENSED ADMINISTRATION RESULTS

Two organizations piloted a condensed administration of TP to increase the parents/caregivers completing the series of sessions. Unfortunately the evaluation measures completed by the participants were not intended to be administered with only a few days between administrations making the results difficult to interpret. The significant changes in parenting behavior and not child behavior demonstrated in this evaluation is consistent with expected results from parents having newly learned skills but little time for the improved child behavior to be exhibited.

Methods

Of the 181 participants that participated in the TP level 4 intervention and completed pre- and post-questionnaires with 14 days or fewer between administrations, 81 (45%) had valid SDQ results and 74 (41%) had valid PS results. 52 (61%) of these participants completed the post-intervention questionnaire within 1 day of the pre-test. An additional 27 (31%) completed the post-test within 7 days of the pre-test.

Strengths and Difficulties Questionnaire (SDQ): The SDQ measured parent reported child difficulties in 5 key areas: emotional symptoms, conduct problems, hyperactivity, peer problems, and prosocial behavior. The items are summed to create a "total difficulties score" ranging from 0-40, with higher scores correlated with greater rates of mental disorders in children.[4]

The mean total difficulties score on the pre-test was 10.93 (*s.d.= 6.38)* and decreased to 10.21 *(s.d.=6.99)* post intervention (Table 15). The results of the paired t-tests suggest there was not a significant change between pre- and post- intervention child behavior as depicted by the results of the SDQ for total adjustment and 4 of the 5 subscales. Conduct problems did show a significant decrease from pre- to post- intervention (mean scores went from 1.91 to 1.86).

Pre-intervention, 22.2% of the parents/caregivers indicated their child exhibited abnormal behavior/adjustment, 4.9% borderline, and 72.8% had results indicating normal overall behavior/adjustment. Post-intervention there were few changes in the proportion of children scoring in the normal, borderline and abnormal ranges (Figure 11), with 21.0% of the parents indicated their child exhibited abnormal behavior/adjustment, 9.9% borderline, and 69.1% had results indicating normal overall behavior/adjustment (Table 16, Figure 11).

Table 15. Pre vs. Post Intervention SDQ

	Pre-Intervention			Post-Intervention		
Scale	**n**	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**	**p-value**
Total	81	10.93	6.68	10.21	6.99	0.092
Emotional Symptoms	81	1.91	2.13	1.86	2.10	0.788
Conduct Problems***	81	2.35	2.19	1.86	2.10	<0.001
Hyperactivity	81	4.57	2.91	4.21	2.82	0.106
Peer Problems	81	2.10	1.71	2.27	1.84	0.262
Prosocial Behavior	81	8.06	2.03	8.07	2.20	0.949

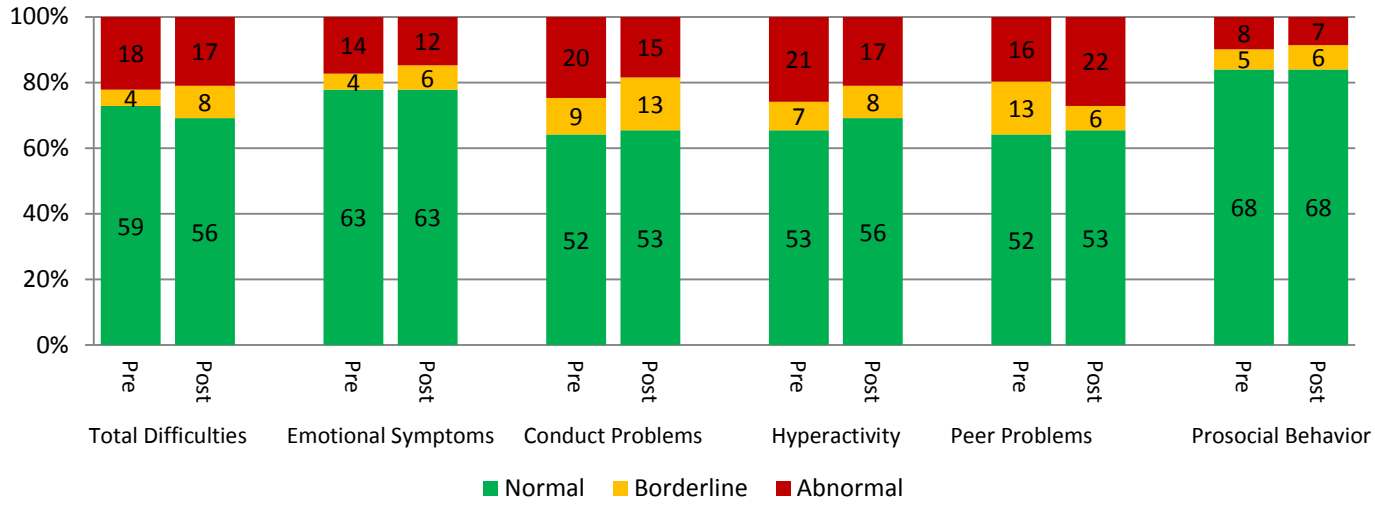
Mean pre vs. post intervention scores significantly different

***** p-value<.05; ** p-value<.01; ***p-value<.001

Table 16. Percent of Children Scoring in the Normal, Borderline and Abnormal Ranges for Child Behavior/Adjustment on the Pre and Post SDQ

		Normal	Borderline	Abnormal
Total Difficulties	Pre	72.8%	4.9%	22.2%
	Post	69.1%	9.9%	21.0%
Emotional Symptoms	Pre	77.8%	4.9%	17.3%
	Post	77.8%	7.4%	14.8%
Conduct Problems	Pre	64.2%	11.1%	24.7%
	Post	65.4%	16.0%	18.5%
Hyperactivity	Pre	65.4%	8.6%	25.9%
	Post	69.1%	9.9%	21.0%
Peer Problems	Pre	64.2%	16.0%	19.8%
	Post	65.4%	7.4%	27.2%
Prosocial Behavior	Pre	84.0%	6.2%	9.9%
	Post	84.0%	7.4%	8.6%

Figure 11. SDQ Subscale Clinical Cutoff Points: Pre vs. Post Intervention



The Parenting Scale (PS): The PS measured parent/caregiver reported discipline strategies using 30 situations relating to three dysfunctional discipline subscales: Laxness (permissive discipline); Over-reactivity (authoritarian discipline, displays of anger, meanness and irritability); and Hostility (use of verbal or physical force). The score for each question ranges from 1 to 7. All 30 items can be summed and averaged to create a total mean score, with higher scores indicating dysfunctional discipline practices.[7]

The total mean score on the pre-intervention PS questionnaire was 3.07 (*s.d. =0.63*), and at post, it had decreased to 2.66 (*s.d.=0.70*) (Table 17). The mean total and 2 of the 3 subscale scores had significantly improved post-intervention. Additionally, there were significantly more parents/caregivers scoring in the "normal" range on the PS post-intervention when compared to pre-intervention for total/overall discipline practices and in laxness (laxness, p=0.01; total, p<0.001) (Figure 12).

Table 17. Pre vs. Post Intervention Parenting Scale

		Pre-Intervention		Post-Intervention		
	n	Mean	Std. Dev.	Mean	Std. Dev.	p-value
Laxness***	74	2.71	1.13	2.29	1.01	<0.001
Over-reactivity**	74	2.42	1.09	2.15	1.01	0.002
Hostility	74	1.80	1.02	1.75	0.98	0.669
Total***	74	3.07	0.63	2.66	0.70	<0.001

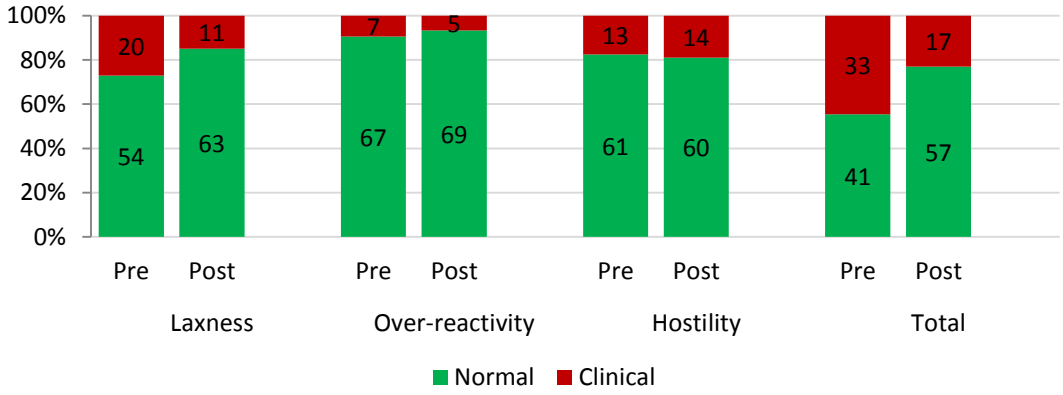
Mean pre vs. post intervention scores significantly different

***** p-value<.05; ** p-value<.01; ***p-value<.001

Table 18. Parenting Scale Clinical Cutoff Points, Pre vs. Post Intervention

		Normal	Clinical
Laxness	Pre	73.0%	27.0%
	Post	85.1%	14.9%
Over-reactivity	Pre	90.5%	9.5%
	Post	93.2%	6.8%
Hostility	Pre	82.4%	17.6%
	Post	81.1%	18.9%
Total	Pre	55.4%	44.6%
	Post	77.0%	23.0%

Figure 12. The Parenting Scale Subscale Clinical Cutoff Points: Pre vs. Post Intervention



Self-Efficacy and Confidence: 137-143 (76-79%) completed the four questions regarding parenting self-efficacy, confidence, and the status of their relationship with their child at both pre- and post-intervention. Scores ranged from 1-7 on each scale. Paired t-tests were used to assess the mean difference of pre and post reported scores. Statistically significant improvements ($p<0.05$) were observed in the participants beliefs that they knew what to do to manage their child's behavior, that the things they were doing to manage behavior were working, and in their overall confidence in managing behavior (Table 19).

Table 19. Pre vs. Post Intervention Parenting Self-Efficacy and Confidence (condensed version)

		Pre-Intervention		Post-Intervention		
	n	**Mean**	**Std. Dev.**	**Mean**	**Std. Dev.**	**p-value**
Knowledge**	137	5.56	1.49	5.96	1.30	0.003
Confidence*	142	5.77	1.45	6.08	1.12	0.013
Things are working*	137	5.41	1.49	5.64	1.30	0.048
Relationship	143	6.27	1.08	6.31	0.92	0.633

***** p-value<.05; ** p-value<.01; ***p-value<.001

Overall Improvements: 52% of participants reported that since coming to the Triple P sessions their child's problems had improved (23% improved "a great deal", 29% were "a bit better"). 90% reported that the sessions had been helpful in other ways, e.g. providing information or making the problems more bearable. 91% reported that the sessions had been helpful in other ways, e.g. providing information or making the problems more bearable. 72% of participants reported that the program helped them "a great deal" in being able to more effectively deal with their child's behavior and with problems that arose in their family.

PROGRAM SATISFACTION

Those participating in the condensed administration of level 4 group reported a mean satisfaction of 5.95/7.0. 93% of participants reported that they would come back to Group Triple P if they need help again.