

Ballymun, Dublin, Ireland

***STRENGTHENING FAMILIES
PROGRAM (SFP)***
(12-16 YRS)

SUBSTANCE ABUSE PREVENTION



Strengthening Families Program
EVALUATION REPORT
(2008 to 2013)

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Ballymun Strengthening Families Program 12-16 for Teens and Parents

SFP 12-16 YEARS OUTCOME EVALUATION REPORT (2008 to 2013)

I. INTRODUCTION AND OVERVIEW

The *Ballymun Strengthening Families Program* in Dublin, Ireland has implemented an evidence-based model parenting program initiative towards the aim of enacting a region-wide strategy for the prevention of substance abuse and juvenile delinquency in youth and in order to improve the parenting skills of parents of high-risk adolescents. Based on assessed community needs and risk factors for substance abuse, the evidence-based program chosen to be implemented was the *Strengthening Families Program (SFP)* for families with high-risk children age 12 to 16 years old.

Staffing: Ballymun SFP is facilitated and supported by a number of local agencies who work together on an interagency basis to deliver and implement the programme. The Programme Manager (BLDTF) and SFP Management Committee oversees the implementation and delivery through ongoing review, monitoring and evaluation. Agency representatives engage in SFP through the roles of; management committee, programme manager, site coordinator, facilitator/assistant facilitator/floater and referral agent.

Professional Group Leader Training. The Dublin Irish group leaders were professionals trained and certified as SFP group leaders by Dr. Karol Kumpfer, the program developer, and Dr. Henry Whiteside of Lutra Group, the SFP International Training Center in Salt Lake City, Utah. The first two-day training for SFP in Ballymun was held in 2007, approximately 130 local workers/volunteers were trained as group leaders in the period 2008-2013 to support the delivery of program implementation.

Introduction to Evaluation Report

This report includes the evaluation overall outcome findings from 2008 to 2013 of this initiative as funded by the Ballymun Local Drug and Alcohol Task Force. An independent evaluation is being conducted by Alta Institute that included only the outcome evaluation to measure program effectiveness with this population. To reduce cost and distance, no process or implementation evaluation was conducted with fidelity checks or observational site visits.¹

All outcomes from spring and fall groups for these six years are included in this evaluation report to produce a larger sample size and get average results of this program.

¹ Team process reviews are a core feature of all SFP programmes implemented in Ballymun. Following each programme, the Programme Manager and site coordinator meet all facilitators and agencies to review the process, delivery and implementation of the programme.

Ireland, Dublin - Ballymun Strengthening Families Program

Year by number of parent tests submitted for each group

Site ID	Retro #	Year	Retro
2008 = 406, 456	7 6	2008	13
2009 = 977, 978	3 4	2009	7
2010 = 621, 622, 623	9 5 4	2010	18
2011 = 729, 730	11 8	2011	19
2012 = 838, 839	10 9	2012	19
2013 = 979, 980	7 4	2013	11
87			

SFP Program Description. The *Strengthening Families Program* (Kumpfer & DeMarsh, 1989; Kumpfer, DeMarsh, & Child, 1989) is an evidence-based 14-week family skills training program that involves the whole family in three classes run on the same night once a week. The parents or caretakers of high-risk youth attend the SFP Parent Training Program in the first hour. At the same time their adolescents attend the SFP Teen’s Skills Training Program. In the second hour, the families participate together in a SFP Family Skills Training Program.

Effectiveness Research on SFP. Multiple replications of SFP in randomized control trials in different countries (United States, Canada, Australia, U.K., Netherlands, Italy, Spain, Portugal, Thailand, Sweden, Norway and France) with different cultural groups by independent evaluators have found SFP to be an effective program in reducing multiple risk factors for later alcohol and drug abuse, mental health problems, and delinquency by increasing family strengths, children’s social competencies, and improving parent’s parenting skills (Kumpfer, Alvarado, Smith, & Bellamy, 2002; Kumpfer, 2007; Bool, 2005; Orte, et al., 2007).

The Cochrane Collaboration Reviews at Oxford University found SFP 10-14 Years to be the most effective school-based program in the world (Foxcroft, et al., 2003). Recently the SAMHSA Center for Substance Abuse Prevention (CSAP) published a cost/benefit report showing that SFP was the most effective substance abuse prevention program preventing 18% of youth completing from using alcohol, 15% from using marijuana, 11% from using other drugs and 7% from using tobacco (CSAP, Miller & Hendrie, 2008). These are higher percentages than any other substance abuse prevention program. Hence, Ireland has invested in the most effective programs in the world and even contributed to developing Irish “Green) adaptation (Kumpfer, Whiteside, & O’Driscoll, 2007) as well as a national dissemination and evaluation system (Kumpfer, Xie, & O’Driscoll, 2012).

New RCTs Find SFP Reduces Genetic Diseases by Half. The exact etiological causes of substance abuse are still unclear; however, previous research concludes that there is a complex interaction between genetic, biological and environmental factors leading to substance abuse and misuse (Beach, Brody, Lie & Philibert, 2010; Ralph, 2002). In the addiction field, substance abuse is described as a “family disease” that is validated by findings that children of substance abusers are two to 18 times more likely to also become alcohol or drug abusers depending on their type and level of inherited genetic risk and family disorganization and stress. Youth with Type II alcoholism (those with many relatives with early onset alcoholism) are the most at risk. Also they are primarily from Northern European descent, such as Irish.

Epigenetic research (Bernal & Jirtle 2010; Champagne, 2009) with mice has demonstrated that even mice bred for certain genetic diseases, such as obesity, substance abuse and heart disease can be protected by a nurturing “licking and grooming” mother mouse; thus, leading to the hypothesis that nurturing parenting skills can reduce substance abuse and other inherited “diseases of lifestyle” (Kumpfer, Fenollar, & Xie, 2011).

Recent RCT research with African American youth by Dr. Brody and associates (2008, 2010) have strengthened the evidence that genetically at-risk youth who participate in an evidence-based family skills training program, with their parents namely the *Strengthening Families Program 10-14 Years* (Kumpfer, Molgaard & Spoth, 1996) will report 50% lower alcohol and drug use, delinquency, depression or anxiety and sexual acting out five years later at 18 years of age in a longitudinal study. Genetic risk was determined by saliva samples. Youth who had one or two short alleles for the 5-HTTLPR serotonin transporter gene were classified as high risk for addictions and depression.

Strengthening Families Program Description. SFP is funded and managed by Ballymun Local Drug and Alcohol Task Force. The SFP budget provides for all necessary and recommended training, program sessions, meals, childcare, staffing, logistics, supplies, incentives, follow-up and program evaluation for the full SFP program. Notable for this initiative, is the application and adaptation of SFP to a coalition of community agencies who come together to deliver the Program in the area.

II. SCOPE AND METHOD OF THE EVALUATION

The major goal of this evaluation is to determine if the program, when conducted with the targeted population is effective and achieves outcomes similar to the established norms for this evidence-based program. The evaluation includes an outcome evaluation conducted by an outside contractor to assure the fidelity and effectiveness of SFP. In the next year, we recommend adding a process evaluation that would include a fidelity survey of funded cycles and site visit to assess program fidelity. The outcome evaluation involves a repeated measures retrospective pre and posttest design with standardized instruments being administered to parents attending the program. The outcome evaluation assesses program effectiveness for a large number of risk and protective factors for substance abuse and delinquency prevention.

Evaluation Contractors: Alta Institute

The contracted evaluator is Alta Institute. The evaluation contractor is comprised of a team of health and human service professionals with combined expertise in evaluation, research, substance abuse treatment and prevention, mental health and multi-system intervention. The professionals in this consulting company are very experienced in conducting research and evaluations of the Strengthening Families Program over the last 20 years. The SFP program developer, Dr. Karol Kumpfer, is the Evaluation Director for Alta Institute. Lutra Group and its contractors have been responsible for SFP training and program development in the United States, Canada, and Europe. Recently Lutra Group turned the evaluation over to Alta Institute and the trainings to the Strengthening Families Foundation. This evaluation contributes to the

overall national and international research, evaluation and program development provided by Alta Institute, both nationally and internationally.

Outcome Evaluation Methods

The Experimental Evaluation Design consisted of a repeated measures, pre- and post-test design with post-hoc subgroup comparisons as recommended by Campbell & Stanley (1967) to control for most threats to internal and external sources of validity. An “SFP Retrospective Parent Pre/posttest”, using standardized CSAP and NIDA core measures, was developed and used because of the need for a short, non-research quality, practitioner friendly evaluation instrument (Appendix 3). Instruments were delivered by the site staff. These instruments are designed to assess child and parent mental health, substance abuse risk and resiliencies, family management and cohesiveness, and parent and child social skills and attitudes. The data were recorded by the parents on printed questionnaires. These data on the pre and post-tests were hand-entered and analyzed using SPSS by Dr. Keely Cofrin Allen using standardized scales for 18 outcome variables.²

Evaluation Measurement Instruments

A multi-measure, multi-informant (child, parent, and possibly in the future – group leader data too) data collection strategy was used to improve triangulation of the data to approximate real changes being measured.

An “SFP Retrospective Parent Pre/posttest”, using standardized CSAP and NIDA core measures, was developed and used because of the need for a short, non-research quality, practitioner friendly evaluation instrument (Appendix 3). The risk and protective factor precursors of substance abuse include negative or positive child behaviors, parenting stress and depression or substance use and lack of effective discipline methods and family dysfunction.

Children’s Behavior and Emotional Scales. The eight child change scales include seven negative child behavior scales such as children’s overt aggression (hitting, bullying, etc.) and covert aggression (lying, stealing, gossiping, etc.), criminality, and hyperactivity, plus emotional and cognitive problems such as (Lack of Concentration or attention), and children’s depression were measured by the Johns Hopkins University Parent Observation of Children’s Activities (POCA) testing items (Kellam). The POCA is similar to the Achenbach and Edelbrock (1988) Child Behavior Checklist (CBCL), but much easier to administer. The POCA has a five-point scale and is more change sensitive than the 3- point CBCL and the wording is simpler for low education families.

² SFP Ballymun is regarded as a 15 week programme as it includes a welcome/induction week in addition to the 14 weeks of skills sessions.

Referral agents have the designated role within the SFP Program in Ballymun to administer the evaluation questions to their family. This is undertaken during a locally held facilitative evaluation session (parent and referral agent can choose morning or afternoon session). This designated session for parent and referral agent contributes towards a higher completion rate and also allows for referral support and follow up on any issues arising.

The children's level of positive competencies/assets or social and life skills were measured by selected items from the *Gresham and Elliot Social Skills Scale* (1990). The parent and child version of the Social Skills Rating System (SSRS) (Gresham & Elliott, 1990) was used for measuring social/life skills. The SSRS measures the following dimensions: Cooperation, Assertion, Responsibility, and Self-Control. The parents completed both parent versions of the SSRS and POCA and the children completed the student version of the SSRS. For the main SSRS subscales, higher scores indicate more positive outcomes (e.g. more cooperation, assertion, responsibility and self-control). For the problem behavior subscales, lower scores indicate more positive outcomes (e.g. fewer internalizing, externalizing, and hyperactivity problems).

Parent's Behavior and Emotional Scales. The parent's parenting scales, namely parenting efficacy, parenting skills, parent/child involvement, positive parenting style, and parental supervision were measured by the 10-item *Kumpfer Parenting Skills*. These were derived from the *Alabama Parenting* test. Parental Depression was measured by the 20-item Radloff CES-D depression scale, which works better than the longer *Beck Depression Inventory* used in prior SFP research. The parent 30-day substance use rates for tobacco, alcohol, marijuana, binge drinking, and other illicit drugs was measured using the CSAP/GPRA drug use measures from the Monitoring the Future (Johnston, O'Malley, and Bachman, 1997).

Family Environment and Relations Scales. The five family outcomes measured consisted of four family environmental measures-- family conflict, organization, communication and cohesion. These were measured by *Family Environment Scales*, (Moos, 1974). The fifth family scale was family strengths and resilience as measured by the 12- item Kumpfer and Dunst *Family Strengths and Resilience Scale*. This measure was created for the American Humane Society's child welfare division as an easy way to measure improvements in the family dynamics for the prevention of child maltreatment. This measure of family strengths and resilience is generally very change sensitive and is one of the first and largest changes in the families after SFP participation.

Parent and Youth Substance Abuse Change Measures. The parent and youth alcohol, and illicit drug use were measured using a 30-day substance use rates for tobacco, alcohol, marijuana, binge drinking, prescription drugs, and other illicit drugs was measured using the CSAP/GPRA drug use measures from the Monitoring the Future (Johnston, O'Malley, and Bachman, 1998) and the National Household Survey (SAMHSA/OAS, 2000).

Psychometric Properties. These measurement instruments and scales have been found to have high reliability and validity in prior SFP studies with similar participants. To reduce testing burden, in some cases only sub-scales of selected instruments were used for evaluation. They match the hypothesized dependent variables and were used in the construction of the testing batteries. Each of the program goals and objectives as listed above are matched to the standardized testing scale or measure in the table on the following page.

Table 1: Hypothesized Outcomes Matched to Measures

<u>SFP Outcome Variables</u>	<u>Measures</u>
<u>Parent Immediate Change Objectives</u>	
1. increase positive parenting	1. SFP parenting skills
2. increase in parenting skills	2. SFP parenting skills
3. increase parental supervision	3. SFP parenting skills
4. increase parental efficacy	4. Alabama Parenting Scale
5. increase in parental involvement	5. Alabama Parenting Scale
6. decrease in parental substance use or misuse	6. CSAP30-day use rates
7. decrease parent's depression	7. NIDA Radloff CES-D
<u>Child Change Objectives</u>	
1. increase social skills (cooperation, assertion, responsibility, and self-control)	1. Social Skills Rating Scale (parent and child)
2. reduced overt aggression (externalizing)	3. POCA Child Rating Scale
3. reduced covert aggression	4. POCA covert aggression scale
4. reduced concentration problems (ADD)	5. POCA ADD scale
5. reduced criminal behavior	7. POCA criminal behavior scale
6. reduced hyperactivity	8. POCA hyperactivity scale
7. reduced depression	9. POCA depression scale
<u>Family Change Objectives</u>	
1. increase positive parent/child relationship or family cohesion	1. Moos FES cohesion
2. reduce family conflict	2. Moos FES family conflict
3. increase family organization and order	3. Moos FES family organization
4. increase family communication skills	4. Moos FES communication
5. increased overall family strengths and resilience	5. Kumpfer & Dunst Family Strengths and Resilience scale

**This does not include 3 cluster variables at a parent, teen or family level.*

Retrospective Pre- and Post-tests. To check for bias on the pre-test due to lack of trust in the confidentiality of the data (found more often in disenfranchised ethnic immigrant youth and families for illegal behaviors such as child and drug abuse), a short retrospective pre-test and post-test (see Appendix) was administered at the post-test. This data collection procedure has been found to be more effective than regular pre-tests when testing for sensitive topics where the clients can be concerned about pre-test identifiers that might allow courts or someone to identify their answers. Hence, this method was first perfected for school-based studies of drug-abusing adolescents (Rhodes & Jason 1987) and family intervention programs with child abusers (Pratt, McGuigan, & Katzev, 2000). In this method of data collection, the parents and youth are asked about their baseline (pre-test) behavior on the post-test. This retrospective pre-test method was tested in earlier evaluation studies with Hispanic and Asian immigrants participating in SFP and other parenting programs in the Salt Lake City area and San Francisco area, such as Celebrating Families, for drug abusers and then correlated with the actual pre-test data to determine the degree of potential bias. Also, we collected pre and post data on the same scales from the group leaders and also teachers in one study. We found that the retrospective pre-test more accurately

reflected needs and strengths in the parents, family and children as more highly correlated with the independent observations by the four group leaders and the teachers.

On a regular pre-test, parents tended to report a positive response bias due to possible fear of lack of confidentiality of the data, because identifiers are required to match up the pre- and post-tests of individual parents so those with no post-test can be removed from the outcome analysis due to bias in including them. Another possible reason for parents reporting perfect scores on the pre-test is that they just do not know the concepts, have not been monitoring their children's behaviors to be mindful parents, and just do not know.

The retrospective pre-and post-test also controls for a major Threat to Internal Validity of the reported outcomes, namely the Instrument. The concern here is that if the measurement tool, such as a scale to measure weight has been recalibrated from the pre- to the post-test, then the change score is not accurate. Now consider that for self-report questionnaires, the "instrument" is the parents' judgments, values, knowledge, and attitudes. During the intervention, these are changing with new knowledge, behavior tracking home practice assignments, and sharing information with group leaders and other parents. Hence the parents become more "mindful" and aware parents of their strengths and needs as well as their behaviors and their children behaviors. Hence, a retrospective "single point in time" test with a THEN and NOW rating for each question removes this testing bias.

The need for a Retrospective Pre-and Post-test developed about 15 years ago with SFP participants who were recent immigrants from Asian countries where they were at war and lived in refugee camps. These parents didn't trust that their children would not be taken away from them if they reported any problems on the pre-test. Hence, their pre-test answer contained a very strong positive bias in which they essentially reported that "They were perfect parents, their kids were perfect and their family was perfect", when the group leaders report substantial behavioral problems. Prior triangulated SFP data samples comparing parent, teacher, group leader and youth self-report on each family found that the retrospective test was more accurate and correlated more highly to that of external objective observers (group leaders and teachers).

What a retrospective pre- and post-test could suffer from is difficulty on the part of parents in remembering 14 weeks earlier or trying to please the group leaders by reporting more positive outcomes than actually occurred. However, this last biasing factor can also happen with the regular post-test. Hence, we recommend that agencies concerned about the validity of the retrospective pre-and post-test method also conduct a regular pre-test. We can then correlate the outcomes to determine which is more accurate if the group and youth leaders also rate the families as well.

If the actual and retrospective items are not consistent, statistical adjustments will be performed in the analyses. The parent or youth tests cover over 21 outcome variables. The Principal Investigator has used this testing method in other studies involving immigrant Latino, Asian, and African American parents, youth, and their teachers, because intervention staff believed subjects were more honest about sensitive questions on the post-test than the pre-test. If clients underreport their negative maltreatment behaviors on the pre-test, but are more honest on

the post-test, programs can appear to have negative results when they actually had positive results.

Data Analysis. All outcome data was collected on the SFP questionnaire. After data cleaning (removing any names, assuring readable marks, checking for missing data and random markings) by the researchers, the data was entered into a computer for analysis on a network PC using SPSS for Windows.

For this study, only the de-identified (coded) parent pre- and post-test quantitative data is used using SPSS program.

A total change score is calculated as well as summed scores for the parent, child and family outcomes. The effect sizes of the outcomes are calculated using both an eta squared or Cohen's (d) and the d' statistics for the cluster variables and 18 individual outcome variables related to parent, family, and child risk factor improvements and improved protective factors for substance abuse. Analyses of Variance (ANOVAs) and the Effect Sizes for the pre- to post-test changes are conducted and reported in outcome tables categorically by parent, family and child variables.

III. BALLYMUN, DUBLIN - OUTCOME EVALUATION RESULTS (2008-2013)

Baseline Differences from SFP 12-16 Norms. The families from years 2008-2013 recruited by Ballymun Strengthening Families had slightly fewer family, parenting problems, and youth problems at baseline than the Irish 12-16 norms or average families that have participated in SFP 12-16 years in Ireland. Because of the higher rates of protective factors and lower levels of risk factors at the baseline pre-test, the amount of change or effect sizes were slightly smaller because it is harder to get large effect sizes when there are fewer problems than for most groups in SFP 12-16 Irish norm. However, the effect sizes are large. In addition, it usually takes time and more efforts to get the improvements. With both the parents' and group leaders' hard work, 58% of the outcomes in Ballymun SFP group improved greater than the SFP 12-16 Irish norms, which is an excellent result.

Pre- to Post-test Outcome Results. As can be seen from the Table 2 below, there are statistically significant positive results ($p < .05$) for **16 of the 16 outcomes**. All outcomes were significantly improved. This result is to be expected with the large sample size if the program is working at all.

Despite the reduced problems reported by the parents on the pre-test, fifty-eight percent (58%) of the effect sizes in this group were larger than found for the SFP 12-16 Irish norms (*11 out of 19 variables*). The parents in this group had slightly lower risk in all five parenting scales, all areas in family relations except family Conflict, and all five children outcomes suggesting they had slightly fewer room for improvement by the end of the SFP classes or group. However, 58% of the effect sizes for were larger than the SFP 12-16 Irish norms even though they had fewer problems for most variables at intake, indicated the staff and group leaders did a great job on implementing the program to their participants.

In addition, 87% of the effect sizes or amount of change ranged from medium to large (14 out of 16 variables as per Table 2). SFP Irish norms as can be seen in the tables. Hence, besides the positive findings that the families are changing in more areas, the size of the change by the end of the program or the effect sizes as measured by Cohen's d were very large. The largest effect size change was for improvements in Family Communication ($d = .83$). The next largest improvement was for Family Organization ($d = .81$) or a large change.

In summary, 16 of 16 scales of the hypothesized and measured outcome variables were shown to have significant positive changes. If the cluster variables for parents, family and child outcomes are included there were 19 of 19 outcomes significantly improved. The comparison group was the norms for the SFP 12-16 Irish norms of about 305 families. It should be pointed out that this large sample is not all of the families that participated in Irish SFP, but represents only the data that was completed and sent to Alta Institute by March 2015 for data entry, analysis and report writing.

Five of the five parent change variables (100%) were improved significantly. This area of change in parent's parenting skills and style or efficacy had the largest improvements in the effect sizes (d) compared to family and child outcomes. The effect sizes are all large changes. The largest effect size was .76 for Parental Supervision, followed by .73 for Parenting Efficacy, .72 for Positive Parenting, .67 for Parenting Skills, and Parental Involvement. This is a very positive effect and a tribute to the Site Coordinator and the Group Leaders. The cluster variables for all parents outcomes had a statistically significant decrease in parent self-reported questionnaire, with a larger effect size of $d = .82$ compared to the SFP 12-16 Irish Norms of $d = .74$.

The second largest effects are for changes in the family variables with 100% of the five outcome variables showing significant improvements, including Family Conflict which sometimes does not improve significantly by the immediate class ending or the posttest. The effect sizes are all large changes, except the decreased Family Conflict with a medium magnitude of change of $d = .42$. The largest effect sizes were $d = .83$ for improvements in Family Communication.

Five of the five hypothesized youth outcome variables were found significantly improved by the post-test, namely decreased Overt Aggression, Covert Aggression, Depression, and increased Concentration and Social Skills.

Taken as whole, finding positive changes in 16 of 16 scales of outcome variables for the SFP program suggesting positive changes in the parenting skills of the parents, the family relationships and in the children's behaviors is an important finding. Changes in all of the parenting and family variables by the post-test are wonderful and should later result in greater improvements in the children.

These positive changes could be partially explained by a large sample size because there were 73 families in this FY '08 - '13 analysis. The major reason is the large mean changes and effect sizes. This suggests that even by the immediate 4-month post-test families are making

major strides in improving their interaction patterns, which appears to be resulting in smaller but very impressive changes in the children. These behavioral changes in increasing Parental Supervision and reducing risky behaviors in the children, such as overt aggression and improving concentration should according to tested theories of the etiology of adolescent substance abuse (Kumpfer, Alvarado, & Whiteside, 2003, Ary, et al., 1988) result in less substance abuse and delinquency as the youths develop.

Most impressive for these year's implementation is that by the post-test the SPSS data analysis suggests reductions in Family Conflict, which decreased significantly ($p < .00$) with a medium effect size of $d = .42$. This amount of change was equal to the SFP 12-16 Irish norms.

Reported in the tables below are the significant values or p . values for pre to posttest changes as well as a more important statistical outcome called "effect size". Similar to percent change, effect size is a more scientific way that researchers today report how much participants in an intervention have changed. The effect sizes reported are calculated in SPSS software by eta squared or Cohen's d as well as d' . It can be seen that they are medium to large and replicate the large effect sizes found to SFP in randomized control trials (Kumpfer & DeMarsh, 1986; Spoth, et al., 1999; 2002; 2003; Trudeau & Spoth, 2005), Gottfredson, Kumpfer, et al., 2006), except they are even larger. To put the effect sizes reported here into perspective, the average effect size of all obesity prevention programs was found to be $d = .006$ (Stice, Shaw & Marti, 2006). The overall effect size in reducing drug use of all youth-only substance abuse prevention programs is $d = .10$. The effect size of the DARE program was .08 and the best social skills training prevention programs only have an effect size of about .30 (Tobler & Stratton, 1997; Tobler & Kumpfer, 2000). Parenting and family interventions have larger effect sizes. See table below.

Table 2: Total Outcomes (Parent, Family & Child) for Pre- to Posttest Changes

Protective Factor	Sig. Level ($p=$)	2008-13 Effect Size (d) vs 12-16 Norms
1. Family Organization	.00	.81 (large) vs. .76
2. Family Cohesion	.00	.64 (large) vs. .62
3. Family Communication	.00	.83 (large) vs. .76
4. Family Conflict	.00	.42 (medium) vs. .42
5. Family Resilience	.00	.76 (large) vs. .74
6. Positive Parenting	.00	.72 (large) vs. .63
7. Parental Involvement	.00	.67 (large) vs. .61
8. Parenting Skills	.00	.67 (large) vs. .62

9. Parental Supervision	.00	.76 (large) vs. .71
10. Parenting Efficacy	.00	.73 (large) vs. .69
11. Overt Aggression.	.00	.45 (medium) vs. .52
12. Covert Aggression	.00	.31 (medium) vs. .38
13. Concentration Problems	.00	.55 (large) vs. .60
14. Social Behavior	.00	.15 (small) vs. .32
15. Depression	.00	.43 (medium) vs. .47
16. Alcohol and Drug Use	.00	.16 (small) vs. .63

Meta-analysis Study of Prevention Approaches. Dr. Nancy Tobler has conducted a number of meta-analysis studies of drug prevention approaches. Dr. Kumpfer worked with her to develop a meta-analysis of family approaches and to compare these to child-only approaches. Overall, family-focused approaches average effect sizes that are nine times larger than youth-only prevention approaches (.96 ES versus .10 ES) as shown in the Table 1 below. This meta-analysis suggests that family skills training approaches, such as Strengthening Families have a very large effect size in reducing substance abuse ($d = .82$) second only to In-home Family Support approaches which had a very large effect size of 1.62.

Table 3: Average Effect Sizes for Universal School-based and Family-based Prevention Programs (Tobler & Stratton, 1997; Tobler & Kumpfer, 2001)

Prevention Intervention Approach	Average Effect Size
Knowledge plus Affective Education	-.05
Affective Education	+.04
Life or Social Skills Training	+.30
Average Universal Child-only Approaches	+.10
Parenting Skills Training	+.31
Family Skills Training	+.82
In-home Family Support	+1.62
Average Mean Family Interventions	+.96

Based on these large effect sizes, Foxcroft and associates (2003) at Oxford University concluded that the Strengthening Families Program (Kumpfer, Molgaard & Spoth, 1996) was twice as effective as the next best prevention program—also a parenting program. These reviews were conducted using meta-analyses conducted for the World Health Organization and the international Cochrane Collaboration Reviews in Medicine and Public Health (see www.cochranereviews.org)

Effect Sizes by Area of Risk and Protective Factors Addressed

Family Dynamics

The families in the *Ballymun Strengthening Families Program* in Dublin, Ireland reported fewer problems in the measured family relations than their other counterparts participating in SFP 12-16 Irish groups in other agencies in Ireland at the pretest. From these intake scores, we can assume that these families had more protective factors in the area of family relations compared to other agencies in the norm. However, their level of Family Conflict was slightly higher and their levels of Family Cohesion, Family Communication, Family Resilience, and Family Organization were lower.

The table 4 below reports the p values or statistical significance values. All or 100% of the five measured family outcomes were statistically significant because the amount of change or effect size (Cohen's d) was large as shown below.

Table 4: Changes in Family Risk and Protective Factors

Protective Factor	Sig. Level (p=)	2008-13 Effect Size (d) vs 12-16 Norms
1. Family Organization	.00	.81 (large) vs. .76
2. Family Cohesion	.00	.64 (large) vs. .62
3. Family Communication	.00	.83 (large) vs. .76
4. Family Conflict	.00	.42 (medium) vs. .42
5. Family Resilience	.00	.76 (large) vs. .74

The largest changes being reported by the parents by the immediate posttest at the end of the SFP class are in the area of family dynamics with Family Communication (mean change 1.33 and effect size $d = .83$) and Family Organization (mean change 1.65 and effect size $d = .81$). Improvements in Family Strength and Resilience and Family Cohesion were also large changes, with effect size $d = .76$ and $.64$ separately. The smallest positive change in family dynamics was for Family Conflict ($d = .42$), which was a medium effect size. Changes in family conflict take more time to change as family communication patterns improve. All of these are medium to large clinically significant improvements in the families.

Below are the results for the comparisons of the Ballymun SFP group to the SFP 12-16 Irish norms. By examining the average means at the pre-test, one can see that the families reported fewer problems in all areas except Family Conflict.

Table 5: Mean Changes in Family Risk and Protective Factors Compared to SFP 12-16 Norms

Scale Name	Sample	Pre-Test	SD	Post-Test	SD	Change	F	Sig	Effect Size d
Family Cohesion							0.18	0.67	0.00
SFP Irish Norms	305	3.06	0.98	4.22	0.65	1.16	559.88	0.00	0.62
Ballymun project	73	3.23	0.98	4.34	0.60	1.11	125.35	0.00	0.64
Family Communication								0.05	0.82
SFP Irish Norms	304	2.85	0.76	4.16	0.51	1.31	1048.45	0.00	0.76
Ballymun project	73	2.91	0.64	4.24	0.47	1.33	361.58	0.00	0.83
Family Conflict							1.82	0.18	0.00
SFP Irish Norms	304	3.19	1.06	2.44	0.82	(0.74)	236.11	0.00	0.42
Ballymun project	73	3.38	1.09	2.47	0.83	(0.91)	53.16	0.00	0.42
Family Organization							0.79	0.38	0.00
SFP Irish Norms	303	2.24	0.79	3.79	0.68	1.55	1049.93	0.00	0.76
Ballymun project	73	2.27	0.81	3.92	0.62	1.65	304.92	0.00	0.81
Family Strengths/Resilience								0.03	0.86
SFP Irish Norms	298	2.86	0.76	4.08	0.55	1.22	965.98	0.00	0.74
Ballymun project	72	2.90	0.78	4.13	0.56	1.23	223.70	0.00	0.76
Family Cluster Scale								0.23	0.64
SFP Irish Norms	295	2.77	0.66	3.99	0.47	1.22	1167.54	0.00	0.78
Ballymun project	72	2.79	0.66	4.05	0.46	1.26	301.22	0.00	0.81

Ballymun SFP - Improvements in Parenting Skills and Behaviors

The other amazingly large changes were in the area of parenting skills and behaviors. All of the five (100%) of the parent outcomes changed significantly from pre- to posttest with a size group for the analysis of 73 parents. At the same time, 100% or all five of the outcomes had large effect sizes over $d = .67$.

The parenting risk at intake was smaller than the other Ireland sites. This is determined by comparing the Ballymun SFP parent's pretest scores for each of the five parenting outcomes measured to the SFP 12-16 Irish norms. However, the Ballymun SFP improvements in outcomes for parenting variables had all five of the variables that statistically significantly improved with larger magnitude than the SFP Irish norms.

Table 6: Changes in Parenting Risk and Protective Factors

Protective Factor	Sig. Level (p=)	2008-13 Effect Size (d) vs 12-16 Norms
1. Positive Parenting	.00	.72 (large) vs. .63
2. Parental Involvement	.00	.67 (large) vs. .61
3. Parenting Skills	.00	.67 (large) vs. .62
4. Parental Supervision	.00	.76 (large) vs. .71
5. Parenting Efficacy	.00	.73 (large) vs. .69

The area of Parental Supervision (Effect Size $d = .76$) had the largest amount of positive change for SFP, and 7% larger than the 12-16 Irish norm with $d = .71$. The next largest changes was reported in Parental Efficacy with Effect Size $d = .73$. The improvements in Positive Parenting also got a large effect size with $d = .72$, and 14% larger than the 12-16 Irish norm; followed by large improvements in Parenting Skills and Parental Involvement with effect size of $d = .67$.

Overall, these are amazing increases in parent child management skills with Cohen d effect sizes ranging from .67 for Parenting Skills and Parental Involvement to .76 for parental supervision. Parental supervision improved dramatically which is typical for SFP outcomes as can be seen by the comparison norms. It is a critical risk factor for children's later drug and alcohol use, so improvements in this area should be worked on in the future. The other positive parenting skill outcomes however, bode well for the long-term effectiveness of this program in preventing later behavioral problems and substance use in the children.

Table 7: Changes in Parenting Risk and Protective Factors Compared to the SFP 12-16 Irish Norms

Scale Name	Sample	Pre-Test	SD	Post-Test	SD	Change	F	Sig	Effect Size d
Parental Involvement							0.10	0.75	0.00
SFP Irish Norms	298	3.11	0.95	4.15	0.67	1.04	513.80	0.00	0.61
Ballymun project	72	3.22	0.89	4.30	0.59	1.08	144.18	0.00	0.67
Parental Supervision							0.40	0.53	0.00
SFP Irish Norms	304	2.73	0.83	4.10	0.58	1.36	826.04	0.00	0.71
Ballymun project	72	2.76	0.77	4.19	0.51	1.44	222.12	0.00	0.76
Parenting Efficacy							0.03	0.85	0.00
SFP Irish Norms	305	2.69	0.93	3.98	0.66	1.29	750.31	0.00	0.69
Ballymun project	73	2.77	0.85	4.08	0.66	1.32	198.67	0.00	0.73
Positive Parenting							0.00	0.95	0.00
SFP Irish Norms	304	3.39	0.95	4.46	0.56	1.07	579.83	0.00	0.63
Ballymun project	73	3.53	0.83	4.61	0.48	1.08	183.70	0.00	0.72
SFP Parenting Skills							0.63	0.43	0.00
SFP Irish Norms	298	3.10	0.69	3.88	0.62	0.78	535.83	0.00	0.62
Ballymun project	73	3.19	0.75	4.03	0.56	0.84	145.72	0.00	0.67
Parent Cluster Scale							0.29	0.59	0.00
SFP Irish Norms	292	3.00	0.66	4.09	0.45	1.09	924.52	0.00	0.74
Ballymun project	71	3.07	0.58	4.21	0.39	1.14	318.76	0.00	0.82

Parent Substance Abuse

One of the outcomes found for SFP is that as the parent's learn better parenting skills, spend more time with their children, and find that the parent's overall mental health status and substance abuse improves.

In this case of the six-year Ballymun SFP groups, the mean change was larger at $m = .14$ compared to $m = .11$ of SFP 12-16 Irish norms, which was a statistically significant improvement. In addition, the effect size was larger at $d. = .16$ compared to $d. = .13$ for the SFP

Irish norms as shown in the table below. This small change was because of floor effect. As one can tell from Table 8, the pretest score for Ballymun group (2008-2013) was very low at $m. = 1.58$ which means parents self-reported their amount of substance usages to be between 6 days to 12 days in a month.

Table 8: Changes in Parent Risk and Protective Factors

Alcohol & Drug Use							0.52	0.47	0.00
SFP Irish Norms	298	1.58	0.59	1.47	0.52	(0.11)	51.03	0.00	0.13
Ballymun project	71	1.58	0.59	1.45	0.47	(0.14)	12.90	0.00	0.16

Positive Youth Behavior Changes

Overall, looking at the intake or base rates in the youth's problems at entry into SFP, the six-year adolescents in Ballymun SFP group were slightly lower risk in all five variables at intake than the 12-16 Irish norms, namely Concentration, Social Skills, Depression, Overt Aggression, and Covert Aggression. All of them were significantly improved. Despite these differences, the parents reported slightly smaller positive changes in the youth.

Five (100%) of the five youth outcomes were statistically significant. The positive changes in the youth were ranged from small to large effect size improvements. The average youth mental and behavioral variable was statistically significant improved after the program with also a large effect size of $d. = .55$, with significant value of $p. = .00$. The most improved child variables are increased Concentration with the largest magnitude of change ($d. = .55$), followed with decreased Overt Aggression, Depression, and Covert Aggression with medium effect sizes of $d. = .45$, $.43$ and $.31$ separately. Improvements in Social Skills have small effect size with $d. = .15$ separately.

Some agencies do not find improvements in the children until months after the family systems dynamics have changed after SFP. These changes generally occur later with the 6 and 12-month follow-up tests. Most studies of SFP find increased positive results with time in the children rather than diminished results (Kumpfer, et al, 2002). Spoth and his associates have recently reported 2 to 3 times reductions in lifetime diagnoses of any type of mental health problem (depression, anxiety disorder, social phobias, and even personality disorder) in 22 year old youth who had participated in SFP 10-14 ten years earlier (Trudeau & Spoth, 2005; Spoth & Trudeau, 2005). This possibly makes SFP the most effective mental health initiative that any state could implement and suggests that SFP results are not specific to just major reductions in tobacco, alcohol and drug abuse, but also in mental health and juvenile delinquency services costs.

Table 9: Changes in Youth's Risk and Protective Factors

Protective Factor	Sig. Level (p=)	2008-13 Effect Size (d) vs 12-16 Norms
1. Overt Aggression.	.00	.45 (medium) vs. .52
2. Covert Aggression	.00	.31 (medium) vs. .38
3. Concentration Problems	.00	.55 (large) vs. .60
4. Social Behavior	.00	.15 (small) vs. .32
5. Depression	.00	.43 (medium) vs. .47

Improved Concentration or Reduced Attention Deficit. The effect size for reductions in attention deficit or problems in concentration in the child was $d = .55$. This is a smaller effect size compared to the 12-16 Irish norms ($d = .60$). This is also a statistically significant improvement ($p < .00$) with a large effect size. At intake, the youth Ballymun Strengthening Families group were higher at their level of Concentration ($m = 2.82$, compared to $m = 2.70$ for the SFP Irish norms). However, the youth improved in their ability to concentrate by a significant level of $p = .00$, which was statistically significant. A major complaint of parents is that children today do not focus and pay attention. This large change in the children's ability to concentrate, at least in the view of the parents, is very positive. Inability to concentrate causes children to have school academic problems which are a major risk factor for later association with antisocial peers and drug use (Kumpfer, Alvarado, & Whiteside, 2003).

Covert Aggression. Generally girls are more likely to engage in covert aggression (stealing, lying, gossiping, whispering, eye rolling, character assassination) than boys. The Cohen's d effect size for this variable was medium with $d = .31$ (smaller than the effect size of the 12-16 Irish norms of $d = .38$). The pretest score was $m = 2.40$ compared to a slightly higher risk for the SFP 12-16 Irish norms of $m = 2.44$. This lower baseline and statistically significant improvement could be explained by the reason that families and staff in Ballymun SFP group did a good job on improving this variable.

Overt Aggression. The Overt Aggression variable is generally found to be difficult to change and sometimes does not improve significantly by the posttest. In the Washington D.C. study (Gottfredson, Kumpfer, et al., 2005) overt aggression did not have a statistically significant improvement.

However, the effect size for youth in this SFP group in Overt Aggression was $d = .45$ as compared to $d = .52$ for SFP 12-16 Irish norm. The statistically significant value was as low as $p = .00$. A lower intake of $m = 2.52$ compared to $m = 2.58$ for the Irish norms, suggested the youth were lower at risk by their parents' report than their SFP 12-16 counter parts. For these low risk families, getting statistically and practically significant outcome indicated this group benefited from the program, and group leaders did a wonderful job in implementing the program.

Social Skills and Competencies. There were positive changes in the youth's Social Skills and Competencies. This Ballymun SFP group youth had a higher baseline of $m. = 3.97$ compared to $m. = 3.85$ for the 12-16 Irish norms. There is less room to improve, as the intake is relatively high which leave less room to get improvement to gain a large change. Thus, the effect size for Social Skills was a small size with $d. = .15$. SFP includes a 14 session children social skills curriculum based on the best evidence based social skills models, such as Shure and Spivack's *I Can Problem Solve (ICPS)* program. It includes sessions on problem solving, decision making, communication skills, coping with anger and depression, and even dating relationships in the child version of SFP 12 – 16 Years.

Children's Depression. The youth's depression was the other statistically significant improved variable with medium effect size of $d = .43$ which was smaller than the norms' effect size of $d = .47$. One possible reason was that the youth in this sample were less depressed at intake than is generally found in SFP 12-16 Irish groups ($m=2.62$ vs. $m=2.73$).

Table 10: Child Outcomes for All Seven Measured Pre- to Posttest Change Scores

Scale Name	Sample	Pre-Test	SD	Post-Test	SD	Change	F	Sig	Effect Size d
Concentration							0.19	0.66	0.00
SFP Irish Norms	291	2.70	0.77	3.36	0.73	0.66	481.43	0.00	0.60
Ballymun project	66	2.82	0.81	3.52	0.66	0.69	79.65	0.00	0.55
Covert Aggression							1.27	0.26	0.00
SFP Irish Norms	299	2.44	0.78	1.93	0.58	(0.51)	203.00	0.00	0.38
Ballymun project	68	2.40	0.70	1.99	0.57	(0.41)	30.62	0.00	0.31
Depression							1.42	0.23	0.00
SFP Irish Norms	298	2.73	0.82	2.05	0.58	(0.68)	292.70	0.00	0.47
Ballymun project	73	2.62	0.84	2.05	0.58	(0.57)	55.13	0.00	0.43
Overt Aggression							0.62	0.43	0.00
SFP Irish Norms	296	2.58	0.81	1.91	0.58	(0.67)	351.79	0.00	0.52
Ballymun project	71	2.52	0.78	1.92	0.62	(0.60)	57.71	0.00	0.45
Social Behavior							1.71	0.19	0.00
SFP Irish Norms	294	3.85	0.71	4.13	0.61	0.28	151.04	0.00	0.32
Ballymun project	70	3.97	0.79	4.17	0.68	0.21	12.23	0.00	0.15

Child Cluster Scale							0.62	0.43	0.00
SFP Irish Norms	276	3.36	0.49	3.86	0.40	0.50	471.32	0.00	0.61
Ballymun project	65	3.43	0.48	3.89	0.38	0.46	77.44	0.00	0.55

Summary of Overall Results and Family Changes

In summary, 16 of 16 scales of the hypothesized and measured outcome variables were shown to have statistically significant positive changes with a sample size of 73 families completing the evaluation test. If the cluster variables for parents, family and child outcomes are included there were 19 of 19 outcomes significant. The comparison group was the norms for the SFP 12-16 Irish Norms of about 305 families.

It should be pointed out that this large sample is not all of the families that participated in SFP, but represents only the data that was completed and sent to either the former Lutra Group or now the Alta Institute by March 2015 for data entry, analysis and report writing.

The largest effects compared to improvements in family and youth variables are changes in the parent's parenting skills and style or efficacy with 100% of the five outcome variables showing significant improvements. 100% of the effect sizes are large, with the largest effect sizes of $d = .76$ for Parental Supervision. In addition, all effect sizes of the parent variables were larger than the SFP 12-16 Irish norms.

All five of the five family change variables (100%) were improved significantly, including Family Conflict that sometimes doesn't improve significantly. This family relationship area of change had the large improvements in the effect sizes (d) of .83 for Family Communication, .81 for Family Organization, .76 for Family Strength and Resilience, .64 for Family Cohesion, and .42 for Family Conflict. The reported Family Conflict got a medium effect size, and changes in this area were equal to the SFP 12-16 Irish norms, and also larger than the results for the USA national SFP database and the NIDA SFP cross-site study in Washington, D.C. Hence, it appears that the Ballymun, Ireland SFP programs are having a dramatic impact on the overall family environment equivalent to that found normally in other SFP sites in the USA. This is a very positive effect and a tribute to the Site Coordinator and the Group Leaders.

Five of the five hypothesized youth outcome variables were found significantly improved by the post-test, namely increased Concentration, Social Skills, decreased Overt Aggression, Covert Aggression, and Depression.

Taken as a whole, finding positive changes in 19 (or 100%) of 19 scales of outcome variables for the SFP program suggesting positive changes in the parenting skills of the parents, the family relationships and in the children's behaviors is an important finding. Changes in all of the parenting and family variables by the post-test are wonderful and should later result in greater improvements in the children.

In addition, 89% or 17 out of 19 effect sizes (d) (includes cluster variables) are medium to large suggesting that staff implementing in Ballymun, Dublin, Ireland, SFP group are more

capable in implementing SFP effectively with low risk families than were the agencies in Washington, D.C. area participating in the NIDA research grant even under Dr. Kumpfer's part time supervision while she was the CSAP Director in Washington, D.C.. Following the analysis of additional cycles and tests, extended findings of the outcome evaluation will be available. We will then be able to test moderator variables such as gender, ethnicity, attendance, and level of risk at baseline.

The total data table for all of the parenting, Family and Child outcomes are reported below.

Table 11: 2008-13 Group Outcomes Compared to SFP 12-16 Irish Norms

Scale Name	Sample	Pre-Test	SD	Post-Test	SD	Change	F	sig	Partial Eta Squared
Parental Involvement							0.10	0.75	0.00
SFP Irish Norms	298	3.11	0.95	4.15	0.67	1.04	513.80	0.00	0.61
Ballymun project	72	3.22	0.89	4.30	0.59	1.08	144.18	0.00	0.67
Parental Supervision							0.40	0.53	0.00
SFP Irish Norms	304	2.73	0.83	4.10	0.58	1.36	826.04	0.00	0.71
Ballymun project	72	2.76	0.77	4.19	0.51	1.44	222.12	0.00	0.76
Parenting Efficacy							0.03	0.85	0.00
SFP Irish Norms	305	2.69	0.93	3.98	0.66	1.29	750.31	0.00	0.69
Ballymun project	73	2.77	0.85	4.08	0.66	1.32	198.67	0.00	0.73
Positive Parenting							0.00	0.95	0.00
SFP Irish Norms	304	3.39	0.95	4.46	0.56	1.07	579.83	0.00	0.63
Ballymun project	73	3.53	0.83	4.61	0.48	1.08	183.70	0.00	0.72
SFP Parenting Skills							0.63	0.43	0.00
SFP Irish Norms	298	3.10	0.69	3.88	0.62	0.78	535.83	0.00	0.62
Ballymun project	73	3.19	0.75	4.03	0.56	0.84	145.72	0.00	0.67
Parent Cluster Scale							0.29	0.59	0.00
SFP Irish Norms	292	3.00	0.66	4.09	0.45	1.09	924.52	0.00	0.74
Ballymun project	71	3.07	0.58	4.21	0.39	1.14	318.76	0.00	0.82

Family Cohesion							0.18	0.67	0.00
SFP Irish Norms	305	3.06	0.98	4.22	0.65	1.16	559.88	0.00	0.62
Ballymun project	73	3.23	0.98	4.34	0.60	1.11	125.35	0.00	0.64
Family Communication							0.05	0.82	0.00
SFP Irish Norms	304	2.85	0.76	4.16	0.51	1.31	1048.45	0.00	0.76
Ballymun project	73	2.91	0.64	4.24	0.47	1.33	361.58	0.00	0.83
Family Conflict							1.82	0.18	0.00
SFP Irish Norms	304	3.19	1.06	2.44	0.82	(0.74)	236.11	0.00	0.42
Ballymun project	73	3.38	1.09	2.47	0.83	(0.91)	53.16	0.00	0.42
Family Organization							0.79	0.38	0.00
SFP Irish Norms	303	2.24	0.79	3.79	0.68	1.55	1049.93	0.00	0.76
Ballymun project	73	2.27	0.81	3.92	0.62	1.65	304.92	0.00	0.81
Family Strengths/Resilience							0.03	0.86	0.00
SFP Irish Norms	298	2.86	0.76	4.08	0.55	1.22	965.98	0.00	0.74
Ballymun project	72	2.90	0.78	4.13	0.56	1.23	223.70	0.00	0.76
Family Cluster Scale							0.23	0.64	0.00
SFP Irish Norms	295	2.77	0.66	3.99	0.47	1.22	1167.54	0.00	0.78
Ballymun project	72	2.79	0.66	4.05	0.46	1.26	301.22	0.00	0.81
Concentration							0.19	0.66	0.00
SFP Irish Norms	291	2.70	0.77	3.36	0.73	0.66	481.43	0.00	0.60
Ballymun project	66	2.82	0.81	3.52	0.66	0.69	79.65	0.00	0.55
Covert Aggression							1.27	0.26	0.00
SFP Irish Norms	299	2.44	0.78	1.93	0.58	(0.51)	203.00	0.00	0.38
Ballymun project	68	2.40	0.70	1.99	0.57	(0.41)	30.62	0.00	0.31
Depression							1.42	0.23	0.00

SFP Irish Norms	298	2.73	0.82	2.05	0.58	(0.68)	292.70	0.00	0.47
Ballymun project	73	2.62	0.84	2.05	0.58	(0.57)	55.13	0.00	0.43
Overt Aggression							0.62	0.43	0.00
SFP Irish Norms	296	2.58	0.81	1.91	0.58	(0.67)	351.79	0.00	0.52
Ballymun project	71	2.52	0.78	1.92	0.62	(0.60)	57.71	0.00	0.45
Social Behavior							1.71	0.19	0.00
SFP Irish Norms	294	3.85	0.71	4.13	0.61	0.28	151.04	0.00	0.32
Ballymun project	70	3.97	0.79	4.17	0.68	0.21	12.23	0.00	0.15
Child Cluster Scale							0.62	0.43	0.00
SFP Irish Norms	276	3.36	0.49	3.86	0.40	0.50	471.32	0.00	0.61
Ballymun project	65	3.43	0.48	3.89	0.38	0.46	77.44	0.00	0.55
Alcohol & Drug Use							0.52	0.47	0.00
SFP Irish Norms	298	1.58	0.59	1.47	0.52	(0.11)	51.03	0.00	0.13
Ballymun project	71	1.58	0.59	1.45	0.47	(0.14)	12.90	0.00	0.16

V. CONCLUSION AND RECOMMENDATIONS

Overall, these preliminary results provide an indication of the robustness of SFP when implemented by dedicated Group Leaders and Site Coordinators in the field. These data refute the general notion of the “watering down of effectiveness” when an evidence-based program is implemented in the field and not in research controlled by the program developer (Backer, 2000). In this case, the program developer is implementing the evaluation to assure quality of measures and data analysis, but is not involved as much in the assurance of quality in the training and implementation. A publication on the positive results of this study compared with two of the existing SFP research studies using randomized control trials should be written to disseminate evidence that it is still possible to get good results—even better results when SFP is implemented by staff who really care that their clients improve. Our experience with research studies is that these are artificial creations and that SFP is not implemented as well as by research assistants or external contract employees as by experienced prevention practitioners in real world settings.

Having the group leaders be experienced staff in agencies that are connected to their clients improves the quality of the implementation and research effectiveness. We are very pleased with the quality of implementation and very large positive outcomes of SFP in the Ballymun, Dublin, Ireland SFP implementation program. These data suggest that SFP is being implemented with quality and sensitivity to the needs of the families, which is creating significant positive changes in parents, children and the families. The cultural adaptations made

appear to be working well for Ireland and bode well for nationwide dissemination of the “Green” version of SFP for Irish families and youth.

The Ballymun in Dublin, Ireland and their coalition of participating agencies have implemented the Strengthening Irish Families Program towards a multi agency-wide effort to improve parenting, improve family functioning and prevent substance abuse and juvenile delinquency. This family-based strategy targets boarder families with children who are high risk for alcohol misuse. In order to evaluate the program fidelity and effectiveness a multi-methods evaluation is being conducted. The agencies involved have mounted an aggressive implementation adapting the program to the needs of Irish families and youth in probation or high risk.

SFP is provided in serial cycles that are continuous throughout the year, allowing for maximum opportunities for youth and families of the agencies to participate in the program. In the first year, one cycle or group had been conducted in Ballymun Geraldstown House and 73 families had completed the program and also the posttests.

The outcome results are encouraging suggesting significant improvements in 100% or all five parenting outcomes, 100% or five of five family outcomes and 100% or five of the five youth outcomes. The results suggest large improvements in the parents and in the family environment and family resilience. Even by this immediate posttest the data suggest that the children’s behaviors are already showing statistically significant improvements in Overt Aggression, Covert Aggression, Depression, Social Skills and Concentration this year which is typical of SFP youth groups.

Recommendations

It is recommended that this program continue as it is being delivered presently as the results are excellent. Also that they provide implementation and fidelity support to other agencies in the Ireland with the following recommendations for maintaining and improving program fidelity, effectiveness and evaluation:

- *Evaluation Design.* It is recommended that the same evaluation design be continued in future years. Also, a gender analysis be conducted to see if the program is as effective for girls as for boys. The results of these two larger group analyses should be published. Dr. Kumpfer will help the staff to get these published and has helped them to present their results at the European Society for Prevention Research (EUSPR).
- *Training for the Site Coordinator in Process Evaluation.* Most USA agencies also contract for a process evaluation that includes a site visit by a process evaluator with suggestions for fidelity and quality improvements. This agency’s Site Coordinator would be a good candidate to be trained by an Irish Process Evaluator. The process evaluation includes measuring curriculum fidelity and observing the implementation in terms of staffing, context and program components.

- *Maintain High Retention and Recruitment.* Currently Ballymun is doing a very good job with recruitment. In the future, they should keep up the good job of recruiting and retaining families. If recruitment decreases, more families should be recruited from Dublin communities with a target achieving retention of 80% of families in all cycles. Recruitment efforts should continue and be aggressive. It is recommended that the cycles seek to over-recruit (10-12 families) based on the current level of enrollment and completion (noting, however, that retention often increases in subsequent cycles). Target a minimum retention rate of 6 families, with a goal of 8 graduating families. Fewer than six families completing compromises group process and hampers execution of the curriculum. Further, fewer than six families have implications for the cost effectiveness of the program.

Overall, the results are very good for Ballymun families and better than the Irish SFP 12-16 norms. We are sure this was a challenging implementation and could offer phone or online consultation to the group leaders and site coordinator of the families to improve outcomes concerning reducing conflict. One recommendation made last year also was to dedicate some funds to have a least a single fidelity site visit to document what is happening to develop such good results. A site visit would provide a more detailed process evaluation report that would measure curriculum fidelity and observe the implementation in terms of staffing, context and program components. Recommendations for improvement would be more useful when knowing more about the program implementation qualities.

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APPENDIX 1

Strengthening Families Program Fidelity Benchmarks

FIDELITY BENCHMARKS: SFP Recommended Best Practices and Program Standards

SFP is designed to reduce family environmental risk factors and improve protective factors with the ultimate objective of increasing personal resilience to drug use in high-risk youth. Research has demonstrated that the program is equally effective in reducing risk precursors for mental disorders and juvenile delinquency. SFP has been recommended as a science-based substance abuse and delinquency prevention program by all federal agencies conducting expert reviews of individual programs, such as NIDA, CSAP, CMHS, DOE Safe and Drug-free Schools, NIAAA, and OJJDP. These expert reviews have based their analysis of SFP on over 15 studies that have been identified and are recommended based on evidence-based research conducted since 1983.

Funding

Strengthening Families Program has a recommended budget based on a capacity of 12 families, but in reality many groups begin with 12 families (over-recruiting) to end up with a functionally sized group of about 8 families. Expenses for conducting the program include site coordination, group leaders for delivering the program to families, food for a family meal, supplies (including grab bag-session incentives), graduation celebration, transportation, childcare and booster sessions. In-kind contributions are encouraged. This includes soliciting incentives, in the form of gifts from the community, for family participation. It is usual and customary for the physical site to be at no direct cost and located in the host or a partner facility (i.e., school, church, library, treatment facility).

Target Population

SFP can be used with universal, selected, and indicated populations and have been tested with all three types of primary prevention approaches. SFP version that was originally designed for families with children ages 6 – 11 years of age. SFP is able to accommodate families with single or multiple primary caretakers (parenting) figures and multiple or single children within the age range. Parent is defined as the child's primary caregiver(s) and is interpreted in a broad context (e.g., foster parents, boyfriends, step parents, adoptive parents, kinship care, etc.). The program was designed for families with risk factors for substance abuse and delinquency.

Staffing

A total of four group leaders are recommended to deliver the program. The program works best having a group leader and co-group leader for the Parent Training group and another group leader and co-group leader for the Children's Skill Training group. During the Family Skills Training sessions, the families may split into two groups with two group leaders in each group, or meet as a whole with four group leaders. It is strongly recommended that the two

group leaders be gender balanced (both a man and a woman) and ethnically matched to the participants.

A Site Coordinator is responsible for oversight, logistics, staff supervision and coordinating the program implementation and delivery. This includes being accessible to families between sessions, towards assuring retention.

The staff implementing SFP is to have completed the SFP two-day training. It is not necessary for staff to be credentialed in mental health or substance abuse treatment or prevention, although it may be helpful with some higher-risk populations.

Additional staff includes childcare providers, food preparation, staff and van drives, as needed for program implementation. Childcare providers are recommended to provide on-site childcare and supervision of families' youth not participating in the curriculum due to age inappropriateness. In some communities staff includes food preparation, staff and van drivers.

Sites and Logistics

Sites are selected based on accessibility and appropriateness for families to come together for a positive skills building program. The site must avoid stigmatizing or labeling attending families based on the local community's perception of the activities and persons that generally frequent the site. For example, in some communities the substance abuse treatment center is only frequented by persons who are diagnosed with substance abuse treatment disorders, which deters families from "being seen there." Some correctional facilities do not permit or are not considered appropriate for children. The site must be accessible by public transportation in those communities where the families utilize such transportation and/or have parking available in convenient well-lit lots. The site must not only be safe, but must be perceived as safe, particularly for young and vulnerable children.

The program recommends that the site have adequate facilities for separate rooms for the children and parents to meet for one hour and for the families to meet together for a meal and one hour of program curriculum. Additionally, there must adequate space for childcare while parents are attending sessions. If the meal is to be prepared or stored on-site, there must be adequate facilities for food safety.

The Strengthening Families Program is designed to be conducted in 14 consecutive sessions, with each session lasting approximately two hours. In some sites the program has been delivered twice a week over 7 weeks, but the recent analysis of the data in the NIDA research study suggests that the results for reductions in antisocial behavior is not as good if the program doesn't run for 14 weeks. This additional time allows the parents more practice time with their children to reduce their acting out behaviors. Generally a light meal is served to families as they arrive, making the activities 2 ½ hours in duration at each session. Following the general welcome, the first hour is spent with the parents and children meeting in their own respective groups. At the end of these groups, families are reunited and have a short break together. The second hour is spent in the Family Skills Training portion of the program. Depending on the number of participants, this group may be divided into smaller groups or may remain together.

Curriculum Fidelity

Skills training methods for the parents', children's and family groups include lecture, demonstration, discussion, role playing, audio-visuals, charts, homework assignments, practicum exercises, peer support, puppet shows, games, Child's Game, Parents' Game, supervised practice and video-taping practicum exercises. Actual delivery of the direct services will vary depending on the individual characteristics of the group leaders. The curriculum is spelled out in manuals complete with instructions for delivery, key lecture content, details of activities, lists of materials needed, homework assignments and handouts for copying and distribution. An overview of the Parent Training, Child Training and Family Training curriculum is indicated in the Table of Contents of each module.

Curriculum fidelity is dependent on group leaders' delivering all 14 sessions, assigning and reviewing homework and including the content areas specified for each session in sequence. Additionally, group leaders are expected to model the tenants of the program when interacting with the families, including at the family meal. Activities and skills are designed for and appropriate to children ages 6 – 11 years.

It is recommended that each local site tailor the program to accommodate cultural and community diversity. The program is designed to provide a framework and an outline of activities that will meet each program lessons objectives. The skills and activities are prescriptive and designed to be sequentially lead to the families (both children and parents) developing skills proven to result in improved family, child and parent behavioral and affective outcomes and reduced risk behaviors. (These outcomes are assessed in the outcome evaluation instruments). However, the group leaders are encouraged to make the program more culturally and locally appropriate by changing the names of people in the stories or puppet plays, using more appropriate ethnic stories for story telling, adding food, cultural and dances or games that the participants find reflect their traditional family values.

Group leaders are not encouraged to read from the training manuals during the sessions, but rather to present the material in a well-thought out professional manner. They are encouraged to use personally developed flip charts or poster boards for visual outlines of their major points. This helps visual learners to learn better, personalizes the program (vs. power point presentations or overheads), and helps the Group Leaders not to read from their books. They look better prepared and respectful to the families with prepared material in advance of the group. Group leaders should personalize the delivery to fit their style, local language and examples.

Recruitment and Retention

SFP is a 14 session curriculum that allows for adequate time and dosage for families to learn, implement, practice and evaluate their progress in skill building, particularly in areas of family communication, positive discipline and family organization. Retention of families in a 14-session program today is very challenging. SFP recommends meals, childcare, transportation, and culturally matched group leaders to increase retention. SFP considers families completing 12 of 14 sessions to graduate.

Attrition has been higher in the initial implementation and retention should increase in subsequent cycles. Incentives for attendance, offering services that are needed to remove barriers to attendance and staff that are sensitive to and responsive to the target population are keys to reducing attrition.

Reducing Barriers to Attendance: Incentives, Child Care, and Transportation

Program incentives for participation increase retention and reinforce the program. Incentives that are tied to, build on and reinforce the curriculum are recommended. These include a family meal provided at each session, transportation, childcare, graduation certificates and completion rewards, and intermittent grab bags and supplies necessary for the family to complete the homework assignments and weekly curriculum activities. Many programs offer additional incentives, including weekly vouchers for attendance with cash value.

Childcare is recommended to be provided at the site during the sessions. Since the program is promoting parental responsibility and family organization, the program needs to facilitate and assure age appropriate care for other children in the family, both younger and older than the participating children. Childcare provision or babysitting is to be in keeping with providing safety and fun for children not including in the skills training.

Transportation to and from the program needs to be assured and coordinated within the resources of the community and program. This is particularly true since the families this program targets often do not have access to private transportation and/or cannot afford the gas to attend a program of this duration. Additionally, many of these families do not want and should not have to disclose that transportation is the barrier, particularly in the recruitment and early sessions of the program. Taking “hand outs” can be stigmatizing and shaming for some families.

Evaluation Methodology

A combined process evaluation and outcome evaluation is recommended. Standardized assessment instruments have been developed and are available for measurement of program effectiveness and fidelity. Additionally site visits and video taping are recommended to confirm findings and make observations. The recommended outcome instrument is the SFP Parent Retrospective Pre/Posttest to be administered during the 13th or 14th session to all participating parents.

Follow-up Booster Sessions

Following the completion of the fourteen sessions, programs need to address follow-up and on-going support for families. This includes linkage when necessary to community services. This also includes any plan for a 6-month Follow-up or Booster Session. At these sessions the families come together again. It is an opportunity for the families to reflect on the programs impact on their lives, receive assistance in content areas unclear or problematic, to receive new educational or family skill building, participate in program evaluation and, moreover, reinforce the positive bonds they built with each other in the program. The format for these sessions is

flexible and determined by the needs of the families, programs, evaluators and funding prerequisites.

APPENDIX 2

STRENGTHENING FAMILIES PROGRAM **PARENT/GUARDIAN RETRO PRE/POST TEST QUESTIONNAIRE**

INSTRUCTIONS TO PERSONS ADMINISTERING THIS QUESTIONNAIRE **(Please read in advance. Do NOT read aloud!)**³

Have the parents/guardians take the retrospective/post-questionnaire at an additional session if possible. If not, administer it either a week prior to graduation or at the graduation. This questionnaire asks the parents to report on their parenting skills and their identified child's skills in the month BEFORE beginning this class and in the last month before THE CLASS ENDS. We know that the evaluation process can feel intrusive. We apologize, but we need your help and support to make this work – so that CF! can become an “evidence based program.” This designation is crucial to the long term functioning and financing of the program. Without this level of evaluation, funding will not be available through state, federal, and county funding sources. This is an opportunity to find out how successful this program is for your community. Your attitude is contagious as you have established yourself as a leader and role model for these families.

QUESTIONNAIRE INSTRUCTIONS

(Please read in advance. Do NOT read aloud)

Have Parents determine the Identified Child to be rated. The parents are asked to rate only one child in the program so that they don't have to fill out forms for all children.

For those sites that are receiving funding for a specific SFP age version, the parents MUST rate a child in that age range (SFP 3-5, 6-11, 10-14, or 13 –17) attending the program as the “identified” child.

If the parent has more than one child in the SFP program age range attending groups, it is best for them to select the child with the most behavioral problems or the oldest child in that age range. If more than one adult is attending, the mother or father should rate the identified child and the second adult (e.g., spouse, step parent, foster parent, grandparent) should rate the child with the next most behavior problems.

Read each of the Questionnaire's questions and the answers out loud to the parents as a group. (Write the scale on a flip chart or the board to point to them). Have participants confidentially write their answers in the answer spaces on the questionnaire. If no answer fits the response categories, have the parents mark "Other" and write down their answer. The evaluation staff will use this data to create new categories on the next version of this questionnaire. The parents have the right to not complete any question that they don't want to.

IMPORTANT INSTRUCTIONS FOR MONITORING POST/RETRO QUESTIONNAIRE **(Please read in advance. Do NOT read aloud)**

Please monitor that the parents have written down *two numbers* next to each question. Remind parents as they complete the questionnaire for each question that they should write a number for how things were *when they started* the class and then a number for *now*. *Monitor after the first few questions, and check again when they turn in their sheets. If some are not completed, ask them to finish the questionnaire with two numbers per question.* (The questionnaires are useless if they only write down one score for each question or mark the same number (5) for all questions. So please stress to parents that the numbers should be different if they think that their family has

³ Karol Kumpfer, Ph.D. Psychologist, Department of Health Promotion and Education, University of Utah for *Celebrating Families!*TM and Strengthening Families Program evaluation. It can be used only by authorized personnel on this project.

improved or changed.) It may be helpful to have blank pieces of paper available that parents can use like rulers to line up under the questions and answer blanks to be sure they put the numbers in the correct spaces.

COLLECTING THE QUESTIONNAIRES FROM PARENTS

(1) Have a manila envelope addressed to Dr. Kumpfer at Alta Institute, (2) Have the parents place the completed Questionnaires in the envelope. (3) When you have collected them all, make a photocopy and then mail by regular postal service or Federal Express the originals to Dr Kumpfer. Please do not send by Certified Mail as they get returned if no one is at office to sign for them. Keep the photocopies in a labeled file so you can find them in case the originals are lost in the mail. (4) In the envelope, please include your one page Site Coordinator Information Survey, Retro/Post Questionnaires parent with Client Satisfaction, youth surveys for youth 10 and above, and new Group Leader surveys. **Include a cover sheet that states:**

The agency

The beginning and end days of the cycle

The number of families starting and completing the cycle.

A contact person at the agency if we have any questions.

If you have any questions you can contact Dr. Karol Kumpfer, evaluator, directly at: 801 583 4601 afternoons or at kkumpfer@xmission.com.

Dr. Karol Kumpfer
Alta Institute
5215 Pioneer Fork Road
Salt Lake City, Utah 84108
801 583 4601

Thank you! We appreciate all your efforts!

Retro/Post-Questionnaire Instructions to the Parent
(To be read EXACTLY AS WRITTEN)

You and your family have completed the Strengthening Families Program to help your family to be stronger, kinder, and more organized. You have learned how to be a better parent and your child or children learned many new social skills to make friends more easily, behave better at home, and do better in school. To know how much you and your child(ren) have changed, we are asking you some questions. First we will ask about you and your family **BEFORE the class**, and then we will ask how your family is **NOW**. Please answer these questions as honestly and accurately as you can. Your answers are confidential and will not be told to any one, including any agency staff working with your family. The results will be sent without names attached to our evaluator at the University of Utah.

This is not a test. The information from this questionnaire is used to monitor the program; to see how families have changed; and to recommend ways to improve the program in the future. You don't have to answer any question that you don't want to. I will read the questions and the possible answers to you. Please write down the number of the best answer for you. Remember, there are no right or wrong answers. If you have any questions, just ask.

Thank you.

When you have finished section one and are ready to begin the “parenting scale,” read the following instructions:

For the rest of the questionnaire, you will need to write two answers to every question. On the left side of the page you will write a number for how things were **BEFORE** you started the program. On the right side you will write a number for how things are **NOW**. That means if you think your family has changed because of participation in Strengthening Families, the two numbers you write down will be **DIFFERENT**. If you have any questions, please ask.

STRENGTHENING FAMILIES PROGRAM: ABOUT YOUR FAMILY

Name (First Name and Initial of Last Name only): _____

Agency: _____ **Today's Date** |__| |__| / |__| |__| / |__| |__|

Which version of the Strengthening Families Program (SFP) did you complete?

1 = SFP 3- 5 , 2 = SFP 6 –11, 3 = SFP 10- 14, 4 = SFP 12-16

Is this your first time participating in Strengthening Families Program Yes No

If No, how many sessions of your previous round did you and your family attend? _____

1. _____ Gender of Adult Completing This Form 1 = Male 2 = Female

2. _____ Gender of identified Child 1 = Male 2 = Female

3. _____ What is your ethnicity? (if mixed, circle all that apply)

1 = African American/Black 5 = Alaska Native

2 = Asian 6 = White

3 = American Indian 7 = Hispanic or Latino

4 = Pacific Islander 8 = Other (Specify) _____

4. _____ What is the language you use most often at home?

1= English 2 = Spanish 3 =Other Language: specify: _____

5. _____ (years) How old are you?

6. _____ (years) How old is your identified teen? (select one you hope to most improve)

7. _____ (grade) What is this child's grade in school?

8. _____ (# kids) How many children under 18 years of age live in your home?

9. _____ Has the identified child taken medications for behavioral/emotional problems in the last year?

1=No 2=Ritalin 3=Dexedrine 4=Cylert 5=Imipramine 6=Prozac

7=Other (specify): _____

10. _____ What is your current parenting status?

1= Single Parent 2=Two parents at home 3=Joint or shared custody

4= Child(ren) in foster care 5=Children with relatives 6=Other: (specify): _____

11. _____ What is your relationship to the identified child in program?

1 = Mother 4 = Aunt or Uncle 7 = Close Non-relative

2 = Father 5 = Older Sister or Brother (Mentor/Advocate)

3 = Grandparent 6 = Foster Parent 8 = Other (Specify) _____

12. _____ (years) How long has the identified child lived with you? (0 if child never lived with you)

13. _____ Where are you living now?

1=home or apartment 2=rented home or apartment 3=group home

4=residential treatment center 5=prison or jail 6=Other: specify: _____

14. _____ What is the highest grade in school you finished regardless of getting a degree?

(for example: 1=1st grade, 8=8th grade, 12=12th grade, 13=college freshman,
16=college graduate)

15. ____ (hours/week) How many hours per week do you work in paid employment?
16. ____ (thousand/yr.) What is the family's total yearly income from all sources?
17. ____ (# kids) How many children do you have?
18. ____ Where were your children living prior to your participation in class? (circle all that apply)
1=with you 2=with a relative 3=foster home 4=other (specify) _____
19. ____ Where are your children living now?
1=with you 2=with a relative 3=foster home 4=other (specify) _____
20. ____ In the last six months, have you had an open DYFS (Division of Youth and Family Services) case or do you have an open case at this time? 1= No 2= Yes

Client Satisfaction (Kumpfer, 2002)

1. ____ **(Hours/Week) Prior to beginning SFP, how many hours of service per week did you or your family receive from this agency?**
2. ____ **Who told you about this class?**
1= friend , 2= program staff, 3= case manager, 4= counselor, 5= court staff,
6= read about it, 7= other: (specify: _____)
3. ____ **How well did you know any of the program staff prior to signing up for this program?**
1= Not at all 2 Very little 3= Somewhat 4 = Well 5= Very Well
4. ____ **How many sessions did you attend of this program?**
5. ____ **How many sessions did this child attend?**
6. ____ **How satisfied were you with this program?**
1= Not at all 2 Very little 3= Somewhat 4 = Well 5= Very Well
7. ____ **Would you like to come back for refresher classes or family reunions?**
1= Yes, weekly 2= once a month 3= every six months 4 =once a year 5=Never
8. ____ **Would you recommend this course to other families?**
1= Yes, definitely 2= Yes, 3= Maybe 4= No
9. ____ **How much has this class helped your family?**
1= Not at all 2 Very little 3= Somewhat 4 = A lot
10. ____ **Overall how would you rate your satisfaction with your group leaders?**

1= Not at all 2 Very little 3= Somewhat 4 = Well 5= Very Well

PARENTING SCALE (Kumpfer, 1989)

Please use the following scale to rate yourself or your identified child before and after this program. (Two numbers should be written down and should be different if you saw change):

1= Never, 2= Seldom 3= Sometimes, 4= Frequently, 5= Almost Always		
Before Program		Now
_____	1. I praise my child when he/she has behaved well.	_____
_____	2. I use clear directions with my child.	_____
_____	3. My child controls his or her anger.	_____
_____	4. My child helps with chores, errands, and other work.	_____
_____	5. I handle stress well.	_____
_____	6. I feel I am doing a good job as a parent.	_____
_____	7. We talk as a family about issues/problems, or we hold family meetings.	_____
_____	8. We go over schedules, chores, and rules to get better organized.	_____
_____	9. I spend quality time with my child.	_____
_____	10. I let my child know I really care about him or her.	_____
_____	11. I am loving and affectionate with my child.	_____
_____	12. I enjoy spending time with my child.	_____
_____	13. I follow through with reasonable consequences when rules are broken.	_____
Before Program	1= Never, 2= Seldom 3= Sometimes, 4= Frequently, 5= Almost Always	NOW
_____	15. I talk to my child about his or her plans for the next day or week.	_____
_____	16. I talk to my child about his or her friends.	_____
_____	17. I know where my child is and who he/she is with.	_____
_____	18. I talk to my child about his/her feelings.	_____

_____	19. I use appropriate consequences when my child will not do what I ask.	_____
_____	20. I use physical punishment when my child will not do what I ask.	_____
_____	21. I yell or shout when my child misbehaves.	_____
_____	22. I talk to my child about how he/she is doing in school (write 0 if your child is not in school.)	_____
_____	23. I check to see if my child completes his/her homework (write 0 if your child is not old enough for homework.)	_____
_____	24. I feel happy about my life most of the time.	_____
_____	25. Our family has clear rules about alcohol and drug use.	_____
_____	26. People in my family often insult or yell at each other.	_____
_____	27. People in my family have serious arguments.	_____
_____	28. We argue about the same things in my family over and over.	_____
_____	29. We fight a lot in our family.	_____
_____	30. My child is happy most of the time.	_____
_____	31. My child's friends are a good influence.	_____
_____	32. My child gets good grades (A's or B's, or "satisfactory"). (write 0 if your child is not in school).	_____
_____	33. My child gets into trouble at school (or other organized setting if not old enough for school).	_____
_____	34. My child uses tobacco. (Age of first use: _____ years)	_____
_____	35. My child drinks alcohol. (Age of first use: _____ years)	_____
_____	36. My child uses illegal drugs. (Age of first use: _____ years. Drugs used?: _____.)	_____
_____	37. I use alcohol or drugs around my child.	_____
_____	38. I have 5 or more drinks of alcohol in a day.	_____
_____	39. I use illegal drugs (marijuana, etc.)	_____
_____	40. I talk with my child about the negative consequences of drug use.	_____

OVERALL FAMILY STRENGTHS/RESILIENCE (Kumpfer, 1997)

How much strength would you say your family had when starting the program (Before Program) and Now? (Two numbers needed. Second number should be larger if family improved)

1 = None 2 = Little strength 3 = Some strength 4 = Considerable strength 5 =Very Strong

Before Program		Now
_____	1. Family Supportiveness/Love/Care	_____
_____	2. Positive Family Communication (clear directions, rules, praise)	_____
_____	3. Effective Parenting Skills (reading to child, rewarding)	_____
_____	4. Effective Discipline Style (less spanking, consistent discipline)	_____
_____	5. Family Organization (rules, chores, self responsibility)	_____
_____	6. Family Unity (togetherness, cohesion)	_____
_____	7. Positive Mental Health (generally feeling good about selves)	_____
_____	8. Physical Health	_____
_____	9. Emotional Strength	_____
_____	10. Knowledge and Education	_____
_____	11. Social Networking (making or talking with friends, building community)	_____
_____	12. Spiritual Strength	_____

DRUG & ALCOHOL USE (CSAP GRPA)

In the <u>past 30 days</u>, on how many days have you used the following?			In the <u>past 30 days</u>, on how many days do you think your child used the following?		
Before Program		Now	Before Program		Now
_____	1. Alcohol	_____	_____	1. Alcohol	_____
_____	2. Alcohol to intoxication	_____	_____	2. Alcohol to intoxication	_____
_____	3. Tobacco	_____	_____	3. Tobacco	_____
_____	4. Marijuana/hashish/pot	_____	_____	4. Marijuana/hashish/pot	_____
_____	5. Other illegal drugs (type?_____)	_____	_____	5. Other illegal drugs (type?_____)	_____
_____	6. Prescription drugs not prescribed by your doctor (type?_____)	_____	_____	6. Prescription drugs not prescribed by your doctor (type?_____)	_____

PARENT OBSERVATIONS OF CHILD'S ACTIVITIES (POCA-R, Kellam)

How often did your identified child do the following activities in the last month? (For the "Before Program" column, refer to the month before you began the program).

1. Never 2. Sometimes 3. Often 4. Almost always 5. Always

Before Program		Now	Before Program		Now
___	1. Completes work and chores	___	___	22. Mind wanders	___
___	2. Is friendly	___	___	23. Shows off or clowns	___
___	3. Is stubborn	___	___	24. Doesn't listen to others	___
___	4. Concentrates	___	___	25. Helps others	___
___	5. Breaks rules	___	___	26. Is polite	___
___	6. Socializes with other kids	___	___	27. Has nightmares	___
___	7. Shows poor effort	___	___	28. Has trouble sleeping	___
___	8. Works well alone	___	___	29. Knows how to communicate	___
___	9. Hurts others physically	___	___	30. Knows how to stay out of trouble	___
___	10. Pays attention	___	___	31. Can resolve conflicts without fights	___
___	11. Breaks things	___	___	32. Lies	___
___	12. Is rejected by other kids	___	___	33. Seeks out peers for activities together	___
___	13. Learns up to ability	___	___	34. Argues with adults	___
___	14. Yells at others	___	___	35. Works hard	___
___	15. Interacts well with other Kids	___	___	36. Teases other kids	___
___	16. Is easily distracted	___	___	37. Stays on task until completed	___
___	17. Takes others' property	___	___	38. Can sit still	___
___	18. Avoids other kids	___	___	39. Skips school (0 if not old enough for school)	___
___	19. Fights	___	___	40. Uses a weapon in a fight	___

_____	20. Is eager to learn	_____	_____	41. Friends seek him/her out for social activities	_____
_____	21. Damages other's property on purpose	_____	_____	42. Runs around a lot, climbs on things	_____
Before Program		Now	Before Program		Now
_____	43. Runs away from home overnight	_____	_____	49. Looks sad or down	_____
_____	44. Starts physical fights	_____	_____	50. Interrupts or intrudes on others	_____
_____	45. Has lots of friends	_____	_____	51. Has low energy	_____
_____	46. Is always "on the go"	_____	_____	52. Blurts out answers before the question is completed	_____
_____	47. Is irritable	_____	_____	53. Stutters	_____
_____	48. Loses temper	_____	_____		_____

About You (CES-D, Radloff, 1977)

How often you have felt the following ways during the past week?

1. Never 2. Sometimes (1-2 days) 3. Often (3-4 days) 4. Most days (5-6 days) 5. All days

Before Program		Now
_____	1. I was bothered by things that usually don't bother me.	_____
_____	2. I did not feel like eating; my appetite was poor.	_____
_____	3. I felt that I could not shake off the blues even with help from family/friends.	_____
_____	4. I felt that I was just as good as other people.	_____
_____	5. I had trouble keeping my mind on what I was doing.	_____
_____	6. I felt depressed.	_____
_____	7. I felt that everything I did was an effort.	_____
_____	8. I felt hopeful about the future.	_____
_____	9. I thought my life had been a failure.	_____
_____	10. I felt fearful.	_____
_____	11. My sleep was restless.	_____
_____	12. I was happy.	_____
_____	13. I talked less than usual.	_____

_____	14. I felt lonely.	_____
_____	15. People were unfriendly.	_____
_____	16. I enjoyed life.	_____
_____	17. I had crying spells.	_____
_____	18. I felt sad.	_____
_____	19. I felt that people dislike me.	_____
_____	20. I could not get “going”.	_____

Thanks you so much for your time in completing this survey!