

North Dublin Regional Drugs & Alcohol Task Force, Dublin, Ireland

***STRENGTHENING FAMILIES
PROGRAM
(SFP 12-16 YEARS)
SUBSTANCE ABUSE PREVENTION***



FY 2014
Strengthening Families Program
EVALUATION REPORT

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North Dublin Regional Drugs & Alcohol Task Force, Dublin, Ireland

Strengthening Families Program for Teens and Parents

Year 1 SFP 12-16 Years Evaluation Report Executive Summary

The North Dublin Regional Drugs & Alcohol Task Force (NDRDATF) in Dublin, Ireland has implemented an evidence-based model parenting program initiative to improve the parenting skills of parents of high-risk adolescents with the aim of the prevention of substance abuse and juvenile delinquency in high risk youth. 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 adolescents ages 12 to 16 years old. The North Dublin Regional Drug & Alcohol Task Force funded this initiative.

Staffing. The agencies involved in the implementation included North Fingal School Completion Programme; Foroige Balbriggan; Baldoyle & Swords Youth Service; and Fingal Travellers Organisation. Referrals of 21 families were made by in following agencies:

- 4 x Mater CAMHS
- 1 x Fingal Travellers Organisation
- 3 x Skerries Community College
- 1 x Bracken Educate Together
- 4 x St Joseph's School
- 4 x Balbriggan Youth Service
- 2 x Swords Youth Service
- 1 x HSE Mental Health Service

Summary of Pre- to Post-test Outcome Results

Retention and Major Outcome Results. Overall, the family changes were most impressive for this Strengthening Families Program (SFP 12 –16 Years) group with adolescents at risk for substance abuse, delinquency and early school dropout in Dublin, Ireland. The SFP weekly group sessions were held from the January 28th to April 29th at a children's holiday home run by a charitable organisation. The families were mostly White Irish families with also Polish and Black Irish. The youth were high risk for substance abuse, delinquency and early school dropout.

They had 15 families begin and 13 families completing the program. Hence, their retention rate was quite high. Retention can be as low as 40 to 65% for the first few implementations with high risk families (Aktan, et al., 1992; Kumpfer, 1997; Kumpfer, Alvarado, Smith, & Bellamy, 2002).

The number of parents or caretakers who started was 22 from 15 families with 19 completing from 13 families. The site information document suggests there were eight males or fathers who attended. The groups started with 16 teens and 14 teens completed the 14 SFP sessions.

High Retention with Excellent Implementation. This agency created high family satisfaction by providing lots of support for the families in terms of high quality implementation, home cooked meals, desirable incentives for attendance, reducing barriers to attendance, such as transportation when needed, and excellent coordination with meetings reviewing before and after the sessions the needs of each family. The families have requested to continue their meetings and the staff offered to facilitate monthly meetings. This indicates a high degree of satisfaction as well as need in these families for SFP or family support groups. Refer to Site Information sheets at the end of this report for more detail on the implementation fidelity and supports.

Statistically Significant Results with Large Effect Sizes Found. Additionally, the pre- to posttest changes were considerably greater than normally expected by the 4-month posttest. There were statistically significant positive results ($p. < .05$) for 93% or 14 of the 15 outcomes measured, or for 100% if a one-tailed t-test was conducted. Additionally 10 of these 15 outcomes had large effect sizes over Cohen's $d. = .50$.

The amount of positive mean changes for parent, family, and child outcomes were often not as large as those found for the Irish norms. At program intake or pre-test the youth were at greater risk behaviorally overall with fewer social skills and greater concentration problems than the Irish at-risk youth attending this program in the past. Their overt and covert aggression levels were lower which is good and their depression levels about the same as the norms. Thus the larger magnitude of improvements gained in youth variables such as Overt Aggression, Covert Aggression, and Social Skills indicated the larger changes found mainly was produced by the successfulness of the program implementation.

Recommendations for Improvements. While the outcomes are excellent especially for such high risk parents and families, having more process or implementation data would help. Hiring someone in Ireland or the Alta Institute Process Evaluation Director, Dr. Jeanie Ahearn Greene from the Ahearn Greene and Associates in Washington, D.C. office is recommended to conduct a site visit and also training a process evaluator in Ireland to do the type of process evaluation that we do on all of the agency groups in the U.S.A. In addition, Dr. Kumpfer has an online supervision program that will allow the implementers of SFP to also contact each other once a week in a chat room to share tips and ideas to improve recruitment, retention and cultural adaptation ideas.

There is now an Ireland SFP Council to support quality implementation of SFP in Ireland. Contacting members of that group for tips on how to improve the amount of change or deal with such high risk parents would be advisable. Some of the providers said they would like Alta Institute or one of the agencies to schedule an annual SFP Provider “show and tell” or presentations on areas of their successes and challenges. So in 2012, Lutra Group in conjunction with an agency in Ljubljana, Slovenia, hosted a SFP conference at the Lex Hotel. SFP agencies from all over Europe presented their outcome results and successes in implementation. Also, Ballymun also hosted a two day conference last fall that was attended by Dr. Whiteside of Lutra Group. After several meetings in Ireland organized by Ballymun, the SFP program director, Dr. Kumpfer is working on having a meeting in Paris in October or in Palma, Mallorca for at the EU Society for Prevention Research (EUSPR) meeting where many SFP providers from different EU countries will be meeting and presenting papers.

North Dublin Regional Drugs and Alcohol Task Force, Dublin, Ireland

Strengthening Families Program for Teens and Parents

EVALUATION REPORT

June 26, 2014

I. INTRODUCTION AND OVERVIEW

Strengthening Families Program (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.

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. 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). 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).

SFP Cost Benefit Results. Recently CSAP (2009) has released a cost/benefit study that suggests that no other prevention program implemented in schools or communities protects as many youth from not becoming substance users. Miller and Hendry (2009) reported based on original research by the program developers of many prevention programs that SFP prevented 18% of youth from becoming alcohol users whereas the next best program Dishion's Adolescent

Transitions Program was the next best program preventing 11% of youth from becoming alcohol users or abusers. SFP prevented 15% of youth from using marijuana, 11% from using other drugs and 7% from smoking tobacco. No other prevention program matched these levels of preventive effect except Project Northland for tobacco that had the same 7% preventive effect. While SFP does cost more because of the 14-sessions length and running three groups each week—one for parents, one for children and one for the family together so that five staff are required, it provides greater benefits because of its intensity and changing the whole family system. The cost/benefit ratio was calculated to be \$11 in benefits compared to costs per family. However, all the other prevention programs were calculated by individual student benefit and since at least three to four family members on average per family participate in SFP, the actual cost/benefit ratio is more like \$33 to \$44 per person. Aos and associates (2004) also calculated the SFP cost-benefit ratio high as did Spoth and associates (2003) at \$9.60. The Cochrane Collaboration Reviews in Medicine and Public Health (Foxcroft, et al, 2003) concluded in a meta-analysis that SFP was twice as effective as any other prevention program implemented in schools which was also a parenting program, Guiding Good Choices. SFP was also found to be three times as effective as the best youth only prevention program implemented in schools—Botvin's Life Skills Program.

SFP Reduces Mental Health and Health Problems in Genetically At-risk Participants.

Recently, Brody and associates (2009, 2010, 2012; 2013; 2014) have found that their culturally adapted version of SFP for African American students in schools, reduced the incidence by 50% at 18 years of age for substance use, depression, anxiety, delinquency, and HIV risk in genetically at risk youth. These youth were identified by saliva samples taken five years after participating in SFP in a randomized control trial of randomized school. The at-risk youth were those who had to short alleles of the serotonin transporter gene, 5-HTTLPR gene. Having short alleles vs. long alleles is related to increased substance abuse and mental health problems. Hence, SFP can reduce risk in even genetically at-risk youth. This year, this research team (Brody, et al., 2014) also reported lower cortisol stress levels and longer telomere DNA length in youth getting SFP earlier. Lower cortisol and longer telomere length is related to improved health and longevity. Also, a five year study of many family services agencies found that SFP reduced days in foster care by half (258 days to 125 days) (Brook, McDonald, & Yan, 2012), making SFP one of the first proven child maltreatment prevention programs.

SFP Implementation Description. SFP is funded with funds from the North Dublin Regional Drugs and Alcohol Task Force. The SFP budget provides for all necessary and recommended group leader training, program sessions, meals, childcare, staffing, logistics, supplies, incentives, reunion sessions, follow-up and program evaluation for the full SFP program. See Executive Summary for more details on implementing agencies, staffing and recruitment of families.

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. Alta Institute is also the contractors responsible for SFP training and program development in the United States, Canada, and Europe. This evaluation contributes to the overall national and international research, evaluation and program development provided by Alta Institute, both nationally and internationally. Alta Institute has provided the SFP training of group leaders, evaluation and technical assistance for this initiative.

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 by Jing Xie, MS., and analyzed using SPSS by Dr. Keely Cofrin-Allen using standardized scales for 18 outcome variables plus three cluster summary variables (Family, Parent and Child outcomes combined) as well as the alcohol and drug measure for a total of 21 outcomes. Dr. Karol Kumpfer interpreted the data and wrote this report.

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.

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, all except the youth Criminality and Hyperactivity scales that were found in the Ireland study (Kumpfer, Xie, & O'Driscoll, 2012) to have Chronbach alpha reliability scores too low to be consider reliable. Hence, the non-statistically significant results for these two outcomes should be disregarded.

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 1 below.

Table 1: Hypothesized Outcomes Matched to Measures

<u>SFP Outcome Variables</u>	<u>Measures</u>
<u><i>Parent Immediate Change Objectives</i></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><i>Child Change Objectives</i></u>	
1. increase social skills (cooperation, assertion, responsibility, and self-control)	1. Social Skills Rating Scale (parent and child)
2. reduced externalizing	2. POCA Child Rating Scale
3. reduced covert aggression	3. POCA covert aggression scale
4. reduced concentration problems (ADD)	4. POCA ADD scale
6. reduced criminal behavior	5. POCA criminal behavior scale
7. reduced hyperactivity	6. POCA hypeactivity scale
8. reduced depression	7. POCA depression scale
<u><i>Family Change Objectives</i></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

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 be 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.

Outcome Data Collection Procedures. Immediately before at an orientation session and after completion of SFP at graduation, participating families should completed a number of outcome instruments selected to measure the hypothesized change variables or outcomes for the family changes, child changes and the parent changes. In this pilot study for the fall groups, only the retrospective pre-and post-test data was collected but for both the parents and the youth over 9 years of age.

Instruments were delivered by the site staff to the parents generally on the last of the family sessions. The data were recorded on the printed questionnaires confidentially by the parents when read to them in a group by the evaluation staff or group leaders. All outcome data were collected on the SFP questionnaire with no names or code numbers needed on the retrospective questionnaires.

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. OUTCOME EVALUATION RESULTS

Summary of Pre- to Post-test Outcome Results

Retention and Major Outcome Results. Overall, the family changes were most impressive for this Strengthening Families Program (SFP 12 –16 Years) group with adolescents in Dublin, Ireland. They had 22 adults begin and 19 adults complete the program. Hence, their retention rate is 86%, which was higher than expected when retention can be as low as 65% for the implementation with high risk families (Aktan, et al., 1992; Kumpfer, 1997; Kumpfer, Alvarado, Smith, & Bellamy, 2002). This retention rate is also amazing given that these parents were higher risk than generally seen in the Ireland SFP groups.

There were statistically significant positive results ($p < .05$) for 93% or 14 of the 15 outcomes measured, or for 100% if one-tailed t-test was conducted. Additionally 10 of these 15 outcomes had large effect sizes over Cohen's $d = .50$. The amount of mean positive pre to posttest changes for parent, family, and child outcomes was not as good as the Irish norm. However, their effect sizes were frequently larger than the norms. Only way to explain these paradoxical results statistically is that they had less variability in outcomes that contributes to larger effect sizes. There was relatively lower level of reported risk at SFP intake for youth variables in these families compared to other Irish families participating in SFP. When risk is lower, it is harder to achieve as larger improvements—called a “floor effect”. Thus the larger magnitude of improvements gained in youth variables such as Overt Aggression, Covert Aggression, and Social Skills indicated the larger changes found mainly contributed by the successfulness of the program implementation.

These were clearly higher risk and more disengaged parents who needed parent training classes. We are very pleased with the quality of implementation and large positive outcomes of SFP in the North Dublin Regional Drugs and Alcohol Task Force implementation and results of the program. These data suggest that SFP is being implemented with quality and sensitivity to the needs of the higher risk youth and families, which is creating significant positive changes in parents, children and the families.

It appears that the Swords, Dublin implementation program is having a remarkable impact on the overall family environment. This is a very positive effect and a tribute to the dedicated SFP manager, facilitators and referral agents supporting the families. These results suggest that even by the immediate 4-month post-test families are making major strides in improving their interaction patterns, which appears to be resulting very impressive changes almost immediately in the adolescents. These behavioral changes in reducing risky behaviors in the teenagers, such as overt and covert aggression and improving social skills and competencies should according to tested theories of the etiology of adolescent substance abuse (Kumpfer,

Alvarado, & Whiteside, 2003, Ary, et al., 1988) should result in less substance abuse, delinquency, and arrests for crimes in the future.

Statistically Significant Results with Large Effect Sizes Found. Reported in the tables below are the significance value or *p*. value for pre to posttest changes as well as a more important statistical outcome called “effect size”. Statistical significance only means that these mean differences from pre-to posttest are likely to represent true positive changes in the families and are not likely to have occurred by chance. In fact, the *p*. values for this group are below *p*. < .05 for 14 of the 15 (93%) of the outcome variables. Also, these statistically significant positive changes were not solely due to a large sample size because there were 12 families completing the posttest in this June FY’14 analysis. The major reason was the large mean changes and effect sizes.

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 very large and replicate the large effect sizes found for 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 Cohen’s *d* = .006 or a miniscule positive change that is clinically insignificant and probably not worth the time or money to implement the obesity prevention programs (Stice, Shaw & Marti, 2006). The overall effect size in reducing or preventing substance use for all youth-only substance abuse prevention programs is about *d* = .10. The effect size of the DARE program was *d* = .08 and the best social skills training prevention programs only have an effect size of about *d* = .30 (Tobler & Stratton, 1997; Tobler & Kumpfer, 2000). Parenting and family interventions have larger effect sizes averaging nine times larger than youth-only prevention programs. See table below.

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 (*d* = .96 ES versus *d* = .10 ES) as shown in the Table 2 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 *d* = 1.62.

Table 2: Average Effect Sizes (Cohen’s *d*) 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)

Table 3: Total Outcomes (Parent, Family & Child) for Pre- to Posttest Changes

Protective Factor	Sig. Level (p=)	2014 Effect Size (<i>d</i>) vs Irish Teen Norms
1. Family Organization	.00	.73 (large) vs. .76
2. Family Cohesion	.01	.56 (large) vs. .62
3. Family Communication	.00	.69 (large) vs. .76
4. Family Conflict	.01	.49 (medium) vs. .41
5. Family Resilience	.00	.66 (large) vs. .74
6. Positive Parenting	.00	.61 (large) vs. .63
7. Parental Involvement	.00	.64 (large) vs. .61
8. Parenting Skills	.00	.66 (large) vs. .62
9. Parenting Efficacy	.00	.64 (large) vs. .69
10. Overt Aggression.	.01	.60 (large) vs. .52
11. Covert Aggression	.01	.60 (large) vs. .38
12. Concentration Problems	.03	.47 (medium) vs. .60
13. Social Behavior	.04	.42 (medium) vs. .32
14. Depression	.05	.34 (medium) vs. .47

15. Alcohol and Drug Use	.05	.28 (medium) vs. .13
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Effect Sizes by Area of Risk and Protective Factors Addressed

Family Dynamics

The families in North Dublin Regional Drugs Task Force (NDRDATF) reported relative more problems in the measured family relations than their other Irish counterpart participating in SFP groups at the pretest. Overall the families appear to be quite disengaged with lower levels of cohesion, communication, family organization and family strengths and resilience which might explain their much lower reported level of Family Conflict at the pretest. From these intake scores, we can assume that these families had more risk factors in the area of family relations compared to other agencies in the Irish SFP norms.

The table 4 below reports the *p* values or statistical significance values. All or 100% of the five measured family outcomes were statistically significant with even such a small sample size 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=)	2014 Effect Size (<i>d</i>) vs Irish Teen Norms
1. Family Organization	.00	.73 (large) vs. .76
2. Family Cohesion	.01	.56 (large) vs. .62
3. Family Communication	.00	.69 (large) vs. .76
4. Family Conflict	.01	.49 (medium) vs. .41
5. Family Resilience	.00	.66 (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. And the largest improvements in family variable was Family Organization (mean change 1.07 and effect size *d* = .73). Family Communication (mean change .80 and effect size *d* = .69) was the next largest improvement followed by Family Strength and Resilience (mean change .91 and effect size *d* = .66). The next largest effect size was for improvements in the Family Cohesion (Effect Size *d* = .56). And the smallest was for Family Conflict with *d* = .49. Changes in family conflict generally take more time to change as family communication patterns improve, but this NDRDATF group improved their Family Conflict mean outcome significantly, but with a smaller pre-to- post-test mean improvement than the norms.

Eighty percent of these changes in family variables are large clinically significant improvements in the families with very extreme significant values. A p value of $p < .05$ is the criteria for statistically significant results, which means that the result is likely to occur by chance only 5 times in 100 times. Hence, any results with p value of less than 0.05 are likely to represent a real change in the participants. For Dublin group, $p < .00$ suggested the result is likely to occur by chance 0 times in 100 times of program implementation.

Below are the results for the comparisons of the NDRDATF group to the SFP Irish national norms. By examining the average means at the pre-test, one can see that the families reported more problems in areas of the family communication, organization, and strength, and family cohesion. Despite more room for improvement with being higher risk, this didn't result in as large family improvements in this group compared to those reported by other parents in Ireland participating in. Generally, we see larger mean changes and effect sizes when the pre-test scores are lower.

Table 5: Mean Changes in Family Risk and Protective Factors Compared to SFP Irish National Norms

[illegible]

Family Cluster Scale							4.65	0.03	0.01	0.25
Irish 12-16 norms	301	2.78	0.66	4.00	0.47	1.22	1167.54	0.00	0.78	3.77
RDTF	9	2.63	0.56	3.38	0.63	0.74	17.67	0.00	0.69	2.97

Parenting Skills and Behaviors

The parents in this group clearly needed parenting skills training since at program intake they were much lower in parental involvement with their child, positive parenting, and parenting skills. These families reported being lower in 75% of the parenting skills outcome variables than other families in Ireland participating in SFP at the beginning of the program, all except Parenting Efficacy. This is determined by comparing the NDRDATF parent's pretest scores for each of the four parenting outcomes measured to the SFP parenting skills norms for Ireland.

In this case, the lower parenting skills resulted in large positive changes in the area of parenting skills and behaviors. All four (100%) of the parent child management skills outcomes changed significantly from pre- to posttest even with a small sample or group size for the analysis of only 12 parents. At the same time, 100% or all five of the outcomes had large effect sizes over $d = .60$.

Table 6: Changes in Parenting Risk and Protective Factors

Protective Factor	Sig. Value ($p=$)	2014 Effect Size (d) vs Irish Norms
1. Positive Parenting	.00	.61 (large) vs. .63
2. Parental Involvement	.00	.64 (large) vs. .61
3. Parenting Skills	.00	.66 (large) vs. .62
4. Parenting Efficacy	.00	.64 (large) vs. .69

The area of Parenting Skills (Effect Size $d = .66$) had the largest amount of positive change for SFP, and 6% larger than the national norm with $d = .62$. The next largest changes were reported in Parental Efficacy and Parental Involvement with Effect Size $d = .64$. The improvements in Positive Parenting also got a large effect size with $d = .61$.

Overall, these are excellent increases in parent child management skills with Cohen d effect sizes ranging from d of .61 for Positive Parenting to d of .66 for Parenting Skills. Parental supervision usually improved largely which is typical for SFP outcomes. But since one parent question was missing in the questionnaire, which influenced the reliability of the parental supervision instrument, this variable was not available for analysis this year for NDRDATF evaluation. It is a critical risk factor for children's later drug and alcohol use, so improvements in parental supervision 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: FY '14 Changes in Parenting Risk and Protective Factors Compared to the Irish Norms

Scale Name	n	Pre-Test	SD	Post-Test	SD	Change	F	sig	ES d	ES d'
Parental Involvement							0.47	0.49	0.00	0.08
Irish 12-16 norms	304	3.12	0.95	4.16	0.67	1.04	513.80	0.00	0.61	2.48
RDTF	10	2.78	0.61	3.63	0.69	0.85	15.67	0.00	0.64	2.64
Parenting Efficacy							2.40	0.12	0.01	0.17
Irish 12-16 norms	311	2.69	0.93	3.99	0.66	1.29	750.31	0.00	0.69	2.98
RDTF	11	2.76	0.90	3.64	0.72	0.88	17.97	0.00	0.64	2.68
Positive Parenting							0.09	0.77	0.00	0.03
Irish 12-16 norms	310	3.40	0.95	4.47	0.56	1.07	579.83	0.00	0.63	2.62
RDTF	11	2.94	1.01	3.94	0.85	1.00	15.47	0.00	0.61	2.49
SFP Parenting Skills							0.89	0.35	0.00	0.11
Irish 12-16 norms	304	3.11	0.69	3.89	0.62	0.78	535.83	0.00	0.62	2.54
RDTF	9	2.73	0.28	3.31	0.46	0.58	15.45	0.00	0.66	2.78

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 year NDRDATF group, the changes were not statistically significant when two-tailed t-test was conducted ($p = .10$) for their decreased use, but the effect size of $d = .28$ is a larger effect size compare to the Irish norms as shown in the table below. This insignificant improvement is caused by floor effect, which means when the pretest score is very low, meaning that the NDRDATF parent report less alcohol and drug use than other parents participating in SFP in Ireland, it will be very hard to get enough room to show a significant improvement. In the

case of this 2014 NDRDATF Spring group, the pretest score was at $m. = 1.48$ which was smaller than the Irish norms' low baseline of $m. = 1.58$ and decreased posttest score of $m. = 1.40$, suggesting this group has lower risk than the national norms, which is even better than the norm's improved outcome. When adjust the statistical significance value by using a one-tailed t-test, the p-value can be cut in half which would be a significant outcome ($p. = .05$).

Table 8: Changes in Parent Risk and Protective Factors

Scale Name	n	Pre-Test	SD	Post-Test	SD	Change	F	sig	ES d	ES d'
Alcohol & Drug Use							0.10	0.75	0.00	0.04
Irish 12-16 norms	304	1.58	0.60	1.47	0.52	(0.11)	51.03	0.00	0.13	0.78
RDTF	10	1.48	0.48	1.40	0.40	(0.08)	3.46	0.10	0.28	1.24

Positive Youth Behavior Changes

At program intake or pre-test the youth were at greater risk behaviorally overall with fewer social skills and greater attention deficits or concentration problems than the Irish at-risk youth attending this program in the past. Their overt and covert aggression levels were lower, but their depression levels about the same as the norms.

Five (100%) of the five youth outcomes measured were statistically significant. These positive changes in the youth were ranged from medium to large effect size improvements. The average youth mental and behavioral Child Cluster variable was statistically significant improved after the program; however, their mean positive change scores were lower while their average effect size of $d. = .65$ was 7% larger than $d. = .61$ in the Irish norms. The most improved child variables are decreased Overt Aggression and Covert Aggression with large effect sizes of $d. = .60$, followed with increased Concentration with a medium effect size d of $.47$, Social Skills with $d. = .42$. Improvement in Depression was another medium magnitude of change with effect size of $d. = .34$. These improvements in Overt and Covert Aggression plus Depression are unusual when the youth have less risk in this area at program intake.

Some agencies do not find improvements in the children until months after the family systems dynamics have changes 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 how had participating 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. Value (p.)	2014 Effect Size (d) vs Irish Norms
1. Overt Aggression.	.01	.60 (large) vs. .52
2. Covert Aggression	.01	.60 (large) vs. .38
3. Concentration Problems	.03	.47 (medium) vs. .60
4. Social Behavior	.04	.42 (medium) vs. .32
5. Depression	.05	.34 (medium) vs. .47

Overall, looking at the intake or base rates in the youth's problems at entry into SFP, these NDRDATF adolescents were reported having fewer problems in 60% of the youth variables, all except Concentration and Social Skills at intake than the Irish norms.

Conduct Disorders: 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, there were 15% larger effect sizes for youth in this SFP group in Overt Aggression in youth with d = .60 compared to d = .52 for the Irish norm. And this large effect size made the variable of Overt Aggression the largest improved youth variable this year.

The statistically significant value was as low as p = .01. A lower intake of m = 2.36 compared to m = 2.59 for the Irish teen norms, suggested the youth were lower at risk by their parents' report than their Irish counter parts. Lower risk at intake usually means harder to gain significant outcomes. For these lower risk families, getting statistically and practically significant outcome which was 15% better than other agencies in Irish indicated this group benefited from the program, and group leaders did a wonderful job in implementing the program.

Conduct Disorders: 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 large with d = .60 or 58% larger than the effect size of the Irish norms of d = .38. This large magnitude of change made Covert Aggression as another of the largest improvements in the youth this year.

The pretest score for NDRDATF youth covert aggression was m = 2.27 compared to a higher risk/more covert aggression issues for the Irish norms of m = 2.45. This lower baseline, and dramatically improvement could be explained by the reason that families and staff in NDRDATF group did a good job on improving this outcome in the youth.

Improved Concentration or Reduced Attention Deficit. The second largest effect size is for reductions in attention deficit or problems in concentration in the child with $d = .47$ which is a medium improvement. This is a 22% smaller effect size than the Irish norms ($d = .60$). There is a statistically significant improvement ($p < .03$) in Concentration improvement. At intake, the youth in NDRDATF were reported by parents to be lower in their level of Concentration ($m = 2.51$, compared to $m = 2.71$ for the national norms). However, the youth improved in their ability to concentrate over a significant level of $p = .03$, 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).

Social Skills and Competencies. There were significant improvements in the youth's Social Skills and Competencies for this NDRDATF SFP group youth who had significantly few social skills at pretest baseline of $m = 3.22$ compared to $m = 3.84$ for the national norms. Possibly because of this lower level of social skills, the improvements were larger. The effect size for Social Skills was 31% larger than the national norms with $d = .42$ compared to $d = .32$. 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 teenager version of SFP 12 – 16 Years.

Depression. The youth's depression was another statistically significantly improved variable with medium effect size of $d = .34$ which was 28% smaller than $d = .47$ for the Irish norms. Youth in this teenage sample were slightly less depressed at intake than is generally found in Irish group ($m = 2.70$ vs. $m = 2.73$); however, they didn't improve as much as the Irish norms so their effect size was smaller at $d = .34$ vs. $.47$ for the Irish norms.

Table 10: FY'14 Child Outcomes for All Seven Measured Pre- to Posttest Change Scores

Scale Name	n	Pre-Test	SD	Post-Test	SD	Change	F	sig	ES d	ES d'
Concentration							1.26	0.26	0.00	0.13
Irish 12-16 norms	296	2.71	0.77	3.37	0.73	0.66	481.43	0.00	0.60	2.44
RDTF	9	2.51	0.45	2.96	0.40	0.45	7.16	0.03	0.47	1.89
Covert Aggression							0.20	0.65	0.00	0.05
Irish 12-16 norms	304	2.45	0.79	1.93	0.58	(0.52)	203.00	0.00	0.38	1.57
RDTF	8	2.27	0.58	1.85	0.77	(0.42)	10.29	0.01	0.60	2.43

Depression							2.83	0.09	0.01	0.19
Irish 12-16 norms	303	2.73	0.82	2.04	0.58	(0.68)	292.70	0.00	0.47	1.88
RDTF	11	2.70	0.56	2.39	0.62	(0.32)	5.21	0.05	0.34	1.44
Overt Aggression							0.20	0.65	0.00	0.05
Irish 12-16 norms	301	2.59	0.82	1.91	0.58	(0.68)	351.79	0.00	0.52	2.07
RDTF	9	2.36	0.45	1.78	0.34	(0.58)	12.01	0.01	0.60	2.45
Social Behavior							0.23	0.63	0.00	0.05
Irish 12-16 norms	299	3.84	0.72	4.13	0.61	0.29	151.04	0.00	0.32	1.36
RDTF	9	3.22	0.50	3.44	0.58	0.22	5.76	0.04	0.42	1.70
Child Cluster Scale							0.97	0.32	0.00	0.12
Irish 12-16 norms	279	3.36	0.50	3.86	0.40	0.51	471.32	0.00	0.61	2.50
RDTF	4	3.23	0.09	3.54	0.32	0.31	5.61	0.10	0.65	2.73

Summary of Overall Results and Family Changes

In summary, 14 of 15 scales of the hypothesized and measured outcome variables were shown to have significant positive changes even with a small sample size of 12 families completing the posttest. If the cluster variables for family and child outcomes are included there were 15 of 17 outcomes significant. By adjusting the significant values for Adult Substance Use and Child Cluster Scales from two-tailed t-test to a one-tailed t-test, the significant values for these two variables can be cut in half from .10 to .05, and there will be two more variables improved with statistical significant meaning. Thus 100% or all 17 variables for NDRDATF 2014 spring group are improved significantly. The comparison group was the norms for the Irish SFP of about 311 families. It should be pointed out that this large sample is not all of the families that participated in SFP in Ireland, but represents only the data that was completed and sent to Alta Institute by June 2014 for data entry, analysis and report writing. The two outcomes that were not shown in this report were Parental Supervision and Parent Cluster Scales. One missing item measuring Parental Supervision impacted the reliability of this variable, and the Parent Cluster Scale, so they are not included in this evaluation report.

All five of the five family change variables (100%) were improved significantly, including Family Conflict that sometimes doesn't improve significantly. 80% of the effect sizes are large, with the largest effect sizes of .73 for Family Organization, .69 for Family

Communication, .66 for Family Strength and Resilience, .56 for Family Cohesion, and .49 for Family Conflict. It's very impressive to get the result of Family Conflict improvement with significance, especially when this change achieved a 20% larger effect size compared to the Irish norms. This effect size of $d = .49$ was 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 NDRDATF 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.

The equivalent large effects compared to improvements in family variables are changes in the parent's parenting skills and style or efficacy with 100% of the four outcome variables showing significant improvements. This parenting skills and styles area of change had the large improvements in all four of the effect sizes (d) with $d = .66$ for Parenting Skills, .64 for Parenting Efficacy and Parental Involvement, and .61 for Positive Parenting.

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 14 (or 93%) of 15 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, 100% or 15 out of 15 effect sizes (d' and d) are medium to large suggesting that staff implementing in NDRDATF, Ireland, SFP group are not only capable in implementing SFP effectively with high risk families as suggested in the past, but they are also very good at implementing the program successfully with low risk families. 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: 2013-14 Group Outcomes Compared to SFP Irish National Norms

Strengthening Family Program Evaluation Project										
Dublin site 935 7 vs. Irish norms										
Tuesday, June 24, 2014										
Scale Name	n	Pre-Test	SD	Post-Test	SD	Change	F	sig	ES d	ES d'
Parental Involvement							0.47	0.49	0.00	0.08

Irish 12-16 norms	304	3.12	0.95	4.16	0.67	1.04	513.80	0.00	0.61	2.48
RDTF	10	2.78	0.61	3.63	0.69	0.85	15.67	0.00	0.64	2.64
Parenting Efficacy							2.40	0.12	0.01	0.17
Irish 12-16 norms	311	2.69	0.93	3.99	0.66	1.29	750.31	0.00	0.69	2.98
RDTF	11	2.76	0.90	3.64	0.72	0.88	17.97	0.00	0.64	2.68
Positive Parenting							0.09	0.77	0.00	0.03
Irish 12-16 norms	310	3.40	0.95	4.47	0.56	1.07	579.83	0.00	0.63	2.62
RDTF	11	2.94	1.01	3.94	0.85	1.00	15.47	0.00	0.61	2.49
SFP Parenting Skills							0.89	0.35	0.00	0.11
Irish 12-16 norms	304	3.11	0.69	3.89	0.62	0.78	535.83	0.00	0.62	2.54
RDTF	9	2.73	0.28	3.31	0.46	0.58	15.45	0.00	0.66	2.78
Family Cohesion							1.13	0.29	0.00	0.12
Irish 12-16 norms	311	3.08	0.98	4.23	0.65	1.15	559.88	0.00	0.62	2.57
RDTF	11	2.77	0.82	3.64	0.74	0.86	12.53	0.01	0.56	2.24
Family Communication							4.40	0.04	0.01	0.24
Irish 12-16 norms	310	2.87	0.77	4.17	0.51	1.30	1048.45	0.00	0.76	3.52
RDTF	10	2.72	0.71	3.52	0.72	0.80	19.64	0.00	0.69	2.95
Family Conflict							1.52	0.22	0.00	0.14
Irish 12-16 norms	310	3.20	1.05	2.44	0.83	(0.75)	236.11	0.00	0.41	1.67
RDTF	11	2.80	0.59	2.39	0.53	(0.41)	9.64	0.01	0.49	1.96
Family Organization							3.15	0.08	0.01	0.20
Irish 12-16 norms	309	2.25	0.80	3.80	0.68	1.55	1049.93	0.00	0.76	3.52
RDTF	11	2.23	0.36	3.30	0.65	1.07	27.07	0.00	0.73	3.29
Family Strengths/Resilience							1.82	0.18	0.01	0.15
Irish 12-16 norms	304	2.86	0.75	4.08	0.55	1.22	965.98	0.00	0.74	3.41
RDTF	10	2.56	0.68	3.47	0.80	0.91	17.45	0.00	0.66	2.78

Family Cluster Scale							4.65	0.03	0.01	0.25
Irish 12-16 norms	301	2.78	0.66	4.00	0.47	1.22	1167.54	0.00	0.78	3.77
RDTF	9	2.63	0.56	3.38	0.63	0.74	17.67	0.00	0.69	2.97
Concentration							1.26	0.26	0.00	0.13
Irish 12-16 norms	296	2.71	0.77	3.37	0.73	0.66	481.43	0.00	0.60	2.44
RDTF	9	2.51	0.45	2.96	0.40	0.45	7.16	0.03	0.47	1.89
Covert Aggression							0.20	0.65	0.00	0.05
Irish 12-16 norms	304	2.45	0.79	1.93	0.58	(0.52)	203.00	0.00	0.38	1.57
RDTF	8	2.27	0.58	1.85	0.77	(0.42)	10.29	0.01	0.60	2.43
Depression							2.83	0.09	0.01	0.19
Irish 12-16 norms	303	2.73	0.82	2.04	0.58	(0.68)	292.70	0.00	0.47	1.88
RDTF	11	2.70	0.56	2.39	0.62	(0.32)	5.21	0.05	0.34	1.44
Overt Aggression							0.20	0.65	0.00	0.05
Irish 12-16 norms	301	2.59	0.82	1.91	0.58	(0.68)	351.79	0.00	0.52	2.07
RDTF	9	2.36	0.45	1.78	0.34	(0.58)	12.01	0.01	0.60	2.45
Social Behavior							0.23	0.63	0.00	0.05
Irish 12-16 norms	299	3.84	0.72	4.13	0.61	0.29	151.04	0.00	0.32	1.36
RDTF	9	3.22	0.50	3.44	0.58	0.22	5.76	0.04	0.42	1.70
Child Cluster Scale							0.97	0.32	0.00	0.12
Irish 12-16 norms	279	3.36	0.50	3.86	0.40	0.51	471.32	0.00	0.61	2.50
RDTF	4	3.23	0.09	3.54	0.32	0.31	5.61	0.10	0.65	2.73
Alcohol & Drug Use							0.10	0.75	0.00	0.04
Irish 12-16 norms	304	1.58	0.60	1.47	0.52	(0.11)	51.03	0.00	0.13	0.78
RDTF	10	1.48	0.48	1.40	0.40	(0.08)	3.46	0.10	0.28	1.24

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 agencies in Ireland. The results for Ireland are better than those found in the USA possibly because they are serving higher risk families of teens who have identified problems.

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 NDRDATF, 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 NDRDATF 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. Therefore, at the end of Year 01, only one SFP 12-16 Years group was conducted in the spring of 2014. Twelve families had completed the program and also the posttests. For every family there were one to two youth and parents attending for a total of 38 participants.

The outcome results are encouraging suggesting significant improvements in 100% or all four parenting outcomes, 100% or five of five family outcomes and 100% or all 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, Concentration, and Social Skills 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. The pre-to posttest means are not as large as generally seen; however these appear to be very difficult families with more disengagement and lower parenting skills. Getting tips from other SFP providers on how to improve the amount of positive change would be advisable or talk with group leaders about what they feel needs to be done. Also that they get implementation and fidelity support from 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 quasi-experimental evaluation design be continued next year.
- *Add SFP 6-11 Years Groups for the Younger Children.* The Site Coordinator said she would like to also run SFP 6 – 11 age group programme next year at the same time as the 12-16 group, because she feels that it will incorporate all the family and hopefully help with home practice and more of an opportunity for change when the whole family are working together. We recommend she talk with other agencies who have rolled out the SFP 6-11 programme and how they have facilitated it in a joint programme.
- *Training for the Site Coordinator in Process Evaluation.* Most USA agencies also contract for a process evaluation that includes also a site visit by a process evaluators with suggestions for fidelity and quality improvements. This agency's Site Coordinator would be a good candidate to be trained by Dr. Jeanie Ahearn Greene from the Ahearn Greene and Associates in Washington D.C. office to conduct process evaluations at this agency and others. The process evaluation includes measuring curriculum fidelity and observing the implementation in terms of staffing, context and program components. In Ireland, I am sure that the SFP National Council housed in Ballymun could suggest site visitors who could provide tips and ideas on how to improve outcome means for such high risk parents.

- *Continue the High Levels of Retention and Recruitment.* The excellent recruitment and retention methods, such as high quality meals, transportation support, excellent and relaxed facility, and group leader supportiveness have contributed to high levels of client satisfaction and retention with very high risk parents and families. The 92% retention level including a large number of fathers is very commendable. Keep up the good work. Recruitment efforts should continue and be aggressive with such a high graduation rate. Ireland knows how to do it right with their collaborative agency model that means that no one agency is responsible for all of the implementation, staffing, and family recruitment.
- *Continue Having Male Group Leaders.* The high degree of father participation can be attributed to having a man in both the parents and children's groups as group leaders. This agency is to be commended in being able to have men facilitating the SFP groups as recommended for fidelity.
- *Have Monthly Reunion Family Support Sessions.* The parents formed a close bond within their groups and all said that they didn't want the programme to finish as they felt that they got a lot of support from each other. The parents have requested and the staff offered to facilitate a support group for them on a monthly basis. If financially feasible, this is a great idea to reinforce gains and reduce social isolation in these high risk families.

Overall, the results are very good for these higher risk parents and families than normally seen in SFP. 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.

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

INSTRUCTIONS TO PERSONS ADMINISTERING THIS QUESTIONNAIRE **(Please read in advance. Do NOT read aloud!)**¹

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 teen'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 prove to your funders that this family program is maximally effective for your participating families. The evaluation outcomes help your agency to continue to receive funding for this program. 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 Teen or Child*** to be rated. The parents are asked to rate **only the one** teen referred by probation to the SFP program so that they don't have to fill out forms for all of their children. If they have more than one teen participating, and they want to rate more children then are free to do that.

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.

¹ This SFP for families in Ireland is being evaluated by this agency with support by the Strengthening Families Program (SFP) program developer, Karol Kumpfer, Ph.D. Psychologist, University of Utah. This survey can be used only by authorized personnel on this project.

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 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. Jing Xie at address below in Houston, Texas for data entry,
- (2) Have the parents place the completed Questionnaires in the envelope.
- (3) When you have collected them all, make a photocopy and then mail them in a reinforced manila envelope or better a plastic envelop (because some Ireland envelops get badly torn and battered in transatlantic shipping) 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. Another option is to scan into a DropBox and email to Jing Xie at elviraxie@gmail.com with a cc to Dr. Kumpfer's email at kkumpfer@xmission.com.
Dr. Jing Xie,
2686 Murworth Drive Apt 1408,
Houston, TX 77054, USA.
- (4) Keep the photocopies in a labeled file so you can find them in case the originals are lost in the mail.
- (5) 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. **ALSO email** this form to Dr. Kumpfer to include in the appendix of your evaluation report.
- (6) 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: 801.582.1652 mornings or 801 583 4601 or 801 581 7718 afternoons or at kkumpfer@xmission.com. Thank you for your efforts in this evaluation.

Dr. Karol Kumpfer

Alta Institute
5215 Pioneer Fork Road
Salt Lake City, Utah 84108 USA
801 583 4601

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 SFP evaluators at LutraGroup who will group all results and write a report on positive changes for all the families in this group. The report will be sent to Le Cheile who are coordinating the evaluation on 12 SFP groups this year from all over Ireland. We hope to show the effectiveness of SFP to our government to continue funding for this agency to continue providing SFP to other families.

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 = SPF 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 = Irish 5 = Other Black background
2 = Irish Traveler 6 = Chinese
3 = Other White 7 = Other Asian background
4 = African /Black 8 = Other (Specify) _____

4. _____ What is the language you use most often at home?
1= English 2 = Irish 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 teen 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 teen 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. _____ How many times has your teenager been arrested? (0 if never) _____

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= probation staff, 3= program staff, 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 your teenager 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 teen 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.	_____
_____	14. I reward completed chores with affirmations/praise, allowances or privileges.	_____
_____	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.)	_____

Before Program	1= Never, 2= Seldom 3= Sometimes, 4= Frequently, 5= Almost Always	NOW
_____	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 OBSERVATION OF TEEN (POCA-R, Kellam)

How often did your identified teen do the following in the last month? Write your answer under **NOW** and also then rate under **BEFORE** how they behaved in the month prior to starting this 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 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!!

APPENDIX III

THE STRENGTHENING IRISH FAMILIES PROGRAM 12-16 YEARS **EVALUATION** **SITE INFORMATION SURVEY**

The Lutra Group, Inc. is conducting an independent process and outcome evaluation of the implementation and program delivery of your Strengthening Families Programmes (12- 16 Years) document in your annual evaluation report of SFP the activities you implemented, number and description of the families and possible reasons for results, such as high attendance and high quality group leaders.

Please send to:

Karol L. Kumpfer
Strengthening Families Evaluation Director
Alta Institute
5215 Pioneer Fork Road
Salt Lake City, UT 84108-1678

Phone: 801.582.1652 or 801.583.4601
Fax: 801.583.7979
Email: kkumpfer@xmission.com

PLEASE TYPE IN WORD AND EMAIL !!!!!

DATE: 13th May 2014

NAME OF AGENCY and SFP Programme (and region)

North Dublin Regional Drugs & Alcohol Task Force

SFP 12 – 16

North Dublin

CONTACT NAME Jacki Thompson

TITLE: Strengthening Families Programme Manager/Site Coordinator

PHONE NUMBER: 00353 860485862

FAX NUMBER:

EMAIL: jacki@ndublinrdtf.ie

ADDRESS:

North Dublin Regional Drugs & Alcohol Task Force
Unit 25 Town Centre
Swords Village
Co Dublin
Ireland

In order to better understand your agency and SFP program delivery, please complete the following table.

PROGRAM INFORMATION	IMPLEMENTATION
Funding Source for this Implementation:	North Dublin Regional Drug & Alcohol Task Force
SFP Curriculum (12-16 yrs)	12-16 yrs
Geographic (Rural/ Urban/Suburban)	Rural/Urban
Predominant Ethnicity(ies): eg (a)White: Irish, Traveller, any other white background (b) Black or Black Irish: African, any other Black background (c) Asian or Asian Irish: Chinese, any other Asian background (d) Other, including mixed background.	White: Irish, Polish Black:Irish
Languages (English/Irish/Other(list))	English
No. of “Parents” enrolled in Parent Sessions	
No. of Teens enrolled in Teen Session	
Target Child Age Range	12-16 yrs
Special Eligibility Criteria (e.g., risk factor/ethnicity)	Risk factor for substance abuse, delinquency and early school dropout.
Start Date	28 th January 2014
Finish Date	29 th April 2014
Day of Week and Time of SFP:	Tuesdays 6 – 8.30pm
_____No. of Sessions in total	14
_____No. Families Referred in total	21
_____No. of Families Accepted on to the programme in total	16
_____No. of Families Started (i.e. enrolled on the first night).	15
_____No. of Families Completed	13
_____No. of Families Attended Less Than 8 Sessions	2

_____No. of Families Attended 8-11 Sessions	6
_____No. of Families Attended 12-14 Sessions	7
_____No. of Teens Started Program	16
_____No. of Adults Started Program	22
_____No. of Teens Completed Program	14
_____No. of Adults Completed Program	19
Site (example: Clinic/Church/Agency/Housing/School,etc.)	Children's holiday home run by charitable organisation
Partner Agency(ies) Please list the agencies that were involved in the delivery of this SFP.	North Fingal School Completion Programme; Foroige Balbriggan; Baldoyle & Swords Youth Service; Fingal Travellers Organisation
Meal (Dinner/Lunch/Breakfast)-Please state information regarding the provision of meals at this SFP.	Meals were provided weekly at 6pm by a contracted catering company
In-Session Incentives Type: Cash/Vouchers/Grab Bags etc.	Phone Credit or Sports Vouchers for teens
In-Session Incentives Intensity: Weekly/Intermittent	Weekly
Completion Incentives Type: Cash/Vouchers/Gifts etc (Please state the type)	Phone credit for teens. Gifts: Framed Family portrait and Certificate of completion for each family and goodie bag for children in childcare graduation party: buffet, etc
Special Graduation Activities (describe)	Had a graduation ceremony with parents & facilitators spoke of their experiences and journey. Buffet and celebration. Every family member could invite guests.
Evaluation:_____ # tests completed/submitted	12
Referral Information:	
____No. of Probation Service (YPP) Referrals	0
____No. of HSE Child protection Referrals	0
____No. of JLO or Garda Diversion Project referrals	0
____No. of Substance Abuse Treatment Referrals.	0
____No. of Faith-based Referrals	0
21 No. of other referrals (Please state the agencies).	4 x Mater CAMHS 1 x Fingal Travellers Organisation 3 x Skerries Community College 1 x Bracken Educate Together 4 x St Joseph's School 4 x Balbriggan Youth Service 2 x Swords Youth Service 1 x HSE Mental Health Service

Transportation Provided (Y/N)	Yes
On-site Child Care for younger children(Y/N). If no, then please state whether there was a different arrangement in place re: childcare.	Yes (Primary school teacher provided childcare)
_____No. of Teen Group Leaders	8
_____No. of Teen Group Leaders completed Curriculum Training	8
_____No. of Parent Group Leaders	4
_____No. of Parent Group Leaders Completed Curriculum Training	4
Separate Site Coordinator (Y/N)	No
Booster/Follow-Up Session Details (Date)	September (Date to be confirmed) Parents requested to meeting on monthly basis to continue giving each other support

Family Roster

Use one row for each family that was enrolled in the program, even if they did not complete.

First three letters of last name of Family	# Adults Enrolled	Sex of Adults <i>Use commas to list and separate if more than one</i>	Ethnicity of Parent(s) <i>– Use commas to list and separate if more than one</i>	# Teens 12-16 Group	Sex of Children in Group <i>Use commas to list and separate if more than one</i>	Ages of Children in Groups <i>Use commas to list and separate if more than one</i>	# Sessions attended by Family (at least one parent and one child)	Did Family Graduate? (Y/N)
ORO	1	M	White: Irish	1	M	13	12	Y
SCO	2	M,F	White: Irish	1	M	12	14	Y
MUX	2	M,F	Black: Irish	2	M	13,12	11	Y
CLA	2	M,F	White: Irish	1	F	13	13	Y
O'CO	1	F	White: Irish	1	F	13	11	Y
AHE	1	F	White: Irish	1	M	13	13	Y
BAT	1	F	White: Irish	1	M	13	8	Y

SMI	1	F	White: Irish	1	F	15	11	Y
MAR	1	F	White: Irish	1	M	13	9	Y
DOD	1	F	White: Irish	1	F	14	11	Y
GIL	2	M,F	White: Irish	1	F	14	12	Y
WEB	2	M,F	White: Irish	1	F	13	12	Y
SUK	1	F	White: Other	1	M	14	2	N
MCG	2	M,F	White: Irish	1	M	17	12	Y
GAF	1	F	White: Irish	1	M	15	0	N
NOL	2	M,F	White: Irish	1	M	13	4	N

ETHNICITY CODES:

Staffing Details- Please complete for all staff

Rating for #6 & 7:

1- Poor, 2- Below Expectations, 3- Meets Expectations, 4- Exceed Expectations, 5- Exceptional

Staff Position	Parent GL #1	Parent GL #2	Child GL #1	Child GL #2	Site Coordinator
1. Completed SFP Training (Y/N)	Y	Y	Y	N	
2. Employee of Agency (Y/N)	N	N	N	N	
3. No. of Sessions Attended	11	14	13	13	
4. Ethnicity	Irish	Irish	Irish	Irish	
5. Gender	F	M	M	F	
6. Rate Quality of Leadership/ Ability to Deliver SFP (Scale of 1 to 5)	4	3	5	5	
7. Rate Level of Delivering Program with Fidelity to Curriculum (Scale of 1 to 5)	4	3	4	4	

Staff Position	Parent GL #1	Parent GL #2	Child GL #1	Child GL #2	Site Coordinator
8. Completed SFP Training (Y/N)	Y	Y	Y	Y	
9. Employee of Agency (Y/N)	N	N	N	N	
10. No. of Sessions Attended	14	14			
11. Ethnicity	Irish	Irish	Irish	Irish	
12. Gender	M	F	M	F	
13. Rate Quality of Leadership/ Ability to Deliver SFP (Scale of 1 to 5)	4	4	4	3	
14. Rate Level of Delivering Program with Fidelity to Curriculum (Scale of 1 to 5)	4	4	4	4	

CONTINUED ON NEXT PAGE

Additional Innovations:

The venue used was very central, with parking and had a lovely relaxed feeling, the catering was very important and as everything was homemade, the families enjoyed a lovely meal and all diets were catered for. Even when requested were made for certain dessert these were taken into account. The facilities that are available in Sunshine House are excellent and with the addition of an outdoor playground and theatre the younger children had plenty of places to play.

Incentives The organisation of transport and childcare and dinner was particularly appreciated and noted by the families. Additional incentives such as weekly phone credits or sports vouchers for the teenagers based on attendance worked very well. The family picture which was taken of each family and presented in a frame as a gift at the graduation ceremony was really appreciated,

although I am not sure if the certificate commending the family was appreciated or wanted. The younger children in Childcare also received a bag at the graduation with colouring pens etc. in so that they did not feel left out

Ongoing Supports leading up to and during Programme Delivery Phase

We incorporated a reflection and planning time for the group leaders both before and after each session which worked very well.

In the planning phase before programme delivery we internally reviewed the case examples provided in the workbook to ensure they are as realistic as possible and culturally relevant and discussed family exercises and other materials required so that we have everything prepared well in advance. Details any problems that had accorded with the families during the previous week was also discussed

Level of Support

All of the families felt that the level of support provided during the programme was excellent. The families found the facilitators to be very helpful and supportive and they often waited at the end of the sessions to speak to a facilitators on a one to one. I was also available to the families on site if they wanted to process any difficulties they were having in the family home. I liaised with both the families and the referral agents by telephone each week prior to the delivery of the programme. The families were grateful for this ongoing support and if needed I would be available to them on site following on from the phone conversations. The referral agents reported that the families were very satisfied with the level of support provided. We were also in a position to offer the parents independent counselling, which a number of parents took up and found it very helpful.

Lessons Learned:

It is very important to have structure to the sessions and that the facilitators are comfortable working with each other. Having good facilitators made the programme run smoothly as this was the first time I had Programme managed and Site Co-ordinated a SFP I was extremely pleased with the support I received from the facilitators.

Additional Comments/Insights/Suggestions (use space below or attach pages as needed):

I will be looking at running the 6 – 11 age group programme next year at the same time as the 12-16 group as I feel that it will incorporate all the family and hopefully help with home practice and more of an opportunity for change when the whole family are working together. I am looking at other SFP who have rolled out the 6-11 programme and how they have facilitated it in a joint programme.

The parents formed a close bound within their groups and all said that they didn't want the programme to finish as they felt that they got a lot of support from each other. We have therefore offered to facilitate a support group for them on a monthly basis.

Attach any useful information to help us understand your program better.

When completing the Evaluation Forms with the parents they felt uncomfortable with a couple of questions on the form. (Number 14 and number 16) they felt that these questions were not relevant and some parents did not answer the questions.

THANK YOU!