

Ballymun, Aisling Project, Dublin, Ireland

***STRENGTHENING FAMILIES PROGRAM
(SFP 6-11)***



Strengthening Families Program
EVALUATION REPORT

Programme Reporting Period:
March 14th - June 13th 2012

This report was prepared by:

Karol L. Kumpfer, Ph.D., Keely Cofrin, Ph.D., Jing Xie, M.S. and Henry Whiteside, Ph.D.

LutraGroup, SP

5215 Pioneer Fork Road
Salt Lake City, Utah 84108
(801) 582-1652

Table of Contents

I. INTRODUCTION AND OVERVIEW	2
II. SCOPE AND METHOD OF THE EVALUATION	4
III. OUTCOME EVALUATION RESULTS	8
IV. CONCLUSION AND RECOMMENDATIONS	24
REFERENCES AND BIBLIOGRAPHY	26
APPENDIX 1	29
APPENDIX 2	34

Ballymun Aisling Project

Strengthening Families Program 6-11 Years for Children and Parents

YEAR ONE EVALUATION REPORT (March – June 2012)

I. INTRODUCTION AND OVERVIEW

The *Ballymun Aisling Project* in Dublin, Ireland has implemented an evidence-based model parenting program initiative towards the aim of enacting a region-wide strategy for the prevention of substance abuse and juvenile delinquency in young people and in order to improve the parenting skills of parents of high-risk young people. Based on assessed community needs and risk factors for substance abuse, the evidence-based program chosen to be implemented was the *Strengthening Families Program (SFP)* for families with high-risk children age 6 to 11 years old.

Staffing. This family intervention was implemented by a staff team from the *Ballymun Aisling Project* (Site Coordinator and Group leaders) overseen by Ballymun SFP Programme Manager. Funding for the programme was received through Ballymun Local Drugs Task Force. The Aisling Project is an afterschool intervention aimed at providing purposeful activity in a caring and secure environment from the age of 8-14 years. The children receive assistance with homework, eat a healthy meal and participate in a variety of activities.

Professional Group Leader Training. The Dublin Irish group leaders were professionals trained and certified as SFP group leaders by Dr. Karol Kumpfer, the program developer, and Dr. Henry Whiteside of LutraGroup, the SFP International Training Center in Salt Lake City, Utah. Two students (untrained) were allocated to childrens groups to provide additional support to group leaders.

Introduction to Evaluation Report

This report includes the evaluation findings for the first implementation of SFP 6-11 Years in Ballymun Ireland. Hence, as a pilot study this evaluation only includes their spring group in Year 2012. An independent evaluation is being conducted by Lutra Group, Inc. that included only the outcome evaluation to measure program effectiveness with this population¹. To reduce cost and distance, no process or implementation evaluation was conducted with fidelity checks or observational site visits. In the year of 2012, one SFP 6-11 Years group was completed

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

with 10 families starting and completing the programme². Of the 10 families who graduated, 8 families completed the evaluation (parent retrospective pre and post test) thereby having a completion rate of 80%. Those 8 families were included that had matched pre- and posttests or those completing a Parent Retrospective pre-test and post-test evaluation instrument at the end of the program. While there were more parents and children participating in SFP, only those clients who completed both assessments are including in this evaluation report³.

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 young people attend the SFP Parent Training Program in the first hour. At the same time their children attend the SFP Children'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). Recently the SAMHSA Center for Substance Abuse Prevention (CSAP) published a cost/benefit report showing that SFP was the most effective substance abuse prevention program preventing 18% of youth completing from using alcohol, 15% from using marijuana, 11% from using other drugs and 7% from using tobacco (CSAP, Miller & Hendrie, 2008). These are higher percentages than any other substance abuse prevention program. Hence, Ireland has invested in the most effective programs in the world and even contributed to developing Irish "Green) adaptation (Kumpfer, Whiteside, & O'Driscoll, 2007) as well as a national dissemination and evaluation system (Kumpfer, Xie, & O'Driscoll, 2012).

Strengthening Families Program Description. The recommended SFP budget provides for all necessary and recommended training, program sessions, meals, childcare, staffing, logistics, supplies, incentives, follow-up and program evaluation for the full SFP program. Notable in Ireland for the Ballymun SFP Initiative (in particular the 12-16 yrs programme), is the application and adaptation of SFP, in that it is staffed and delivered by a number of community agencies.

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

³ Referral agents have the designated role within the SFP Program in Ballymun to administer the evaluation questions to their family. This is undertaken during a locally held facilitative evaluation session (parent and referral agent can choose morning or afternoon session). This designated session for parent and referral agent contributes towards a higher completion rate and also allows for referral support and follow up on any issues arising.

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 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: LutraGroup

The contracted evaluator is LutraGroup. 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 LutraGroup. LutraGroup 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 LutraGroup, both nationally and internationally. LutraGroup 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, practitioner friendly evaluation instrument (Appendix 2). In Ballymun SFP, instruments were delivered by referral agents as opposed to site staff. These instruments are designed to assess child and parent mental health, substance abuse risk and resiliencies, family management and cohesiveness, and parent and child social skills and attitudes. The data were recorded by the parents on printed questionnaires. These data on the pre and post-tests were hand-entered and analyzed using SPSS by Dr. Keely Cofrin Allen using standardized scales for 18 outcome variables.

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, practitioner friendly evaluation instrument (Appendix 2). 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. To reduce testing burden, in some cases only sub-scales of selected instruments were used for evaluation. They match the hypothesized dependent variables and were used in the construction of the testing batteries. Each of the program goals and objectives as listed above are matched to the standardized testing scale or measure in the table on the following page.

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

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

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

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

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

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

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

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

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

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

III. BALLYMUN SFP 6-11 YEARS DUBLIN YEAR ONE OUTCOME EVALUATION RESULTS

Baseline Differences from SFP 6-11 Norms. The families in this 2012 spring group that were recruited by Ballymun Aisling, Dublin had more family, parenting problems, and child problems at baseline than the SFP 6-11 norms or average families that have participated in SFP 6-11 age groups all over the world. Because of the lower rates of protective factors and higher levels of risk factors at the baseline pre-test, the amount of change or effect sizes were easier to get larger than for most groups in SFP 6-11 norms theoretically. But it usually takes time and more efforts to get the improvements in higher risk population. With both the parents' and group

leaders' hard work, 86% of the outcomes in Ballymun Aisling group improved greater than the SFP 6-11 norms, which is an excellent result especially for the first year implementation.

Pre- to Post-test Outcome Results. As can be seen from the Table 2 below, there were statistically significant positive results ($p < .05$) for **15 of the 18 outcomes**. The outcomes that were not significantly improved included children's Hyperactivity, Criminal Behaviors, and Adult Alcohol and Drug Use. The result of non-change in Adult Alcohol and Drug Use could be explained by floor effect—there were less room left for the parents to obtain enough decrease to achieve a statistically significant outcome in this item. The other two outcomes are typical of the outcomes for SFP in Ireland as we generally do not get statistically significant improvements in hyperactivity, criminal behaviors with small sample sizes like the 8 parent reports for this group. Also a recent Chronbach's alpha analysis of the Ireland data revealed low levels of consistency in these two scales so there will be removed from the SFP instrument in the future.

86% of the effect sizes in this group were larger than found for the SFP 6-11 norms (cluster variables included). The parents in this group had higher risk in all areas of parenting skills, family relations and children outcomes suggesting they had more room for improvement by the end of the SFP classes or group. However, 86% of the effect sizes were larger in this group than the SFP 6-11 norms even though they had fewer problems at intake, indicated the staff and group leaders did a great job on implementing the program to their participants.

In addition, 86% of the effect sizes or amount of change ranged from medium to large (cluster variables included). SFP norms as can be seen in the tables. Hence, while the families are changing in more areas, the size of the change by the end of the program or the effect sizes as measured by Cohen's d were very large. The largest effect size change was for improvements in Family Organization ($d = .86$). The next largest improvement was for Family Cohesion ($d = .84$) or a large change.

In summary, 15 of 18 scales of the hypothesized and measured outcome variables were shown to have significant positive changes even with a small sample size of 8 families completing the posttest. If the cluster variables for parents, family and child outcomes are included there were 18 of 21 outcomes significantly improved. The comparison group was the norms for the SFP 6-11 of about 1393 families. It should be pointed out that this large sample is not all of the families that participated in SFP, but represents only the data that was completed and sent to LutraGroup at the end of the Programme for data entry, analysis and report writing.

Five of the five family change variables (100%) were improved significantly including Family Conflict which sometimes does not improve significantly by the immediate class ending or the posttest. This family relationship area of change had the largest improvements in the effect sizes (d) compared to parent and child outcomes. The largest effect size was .86 for Family Organization, followed by .84 for Family Cohesion, .83 for Family Communication, .73 for Family Strength and Resilience, and .58 for Family Conflict. This is a very positive effect and a tribute to the Site Coordinator and the Group Leaders. Even the area of Family Conflict had a statistically significant decrease in parent self-reported Family Conflict, with a larger effect size of $d = .58$ compared to the SFP 6-11 Norms of $d = .24$.

The second largest effects are for changes in the parent's parenting skills and style or efficacy with 100% of the five outcome variables showing significant improvements. The effect sizes are all large changes. The largest effect sizes were $d = .80$ for improvements in Parental Supervision.

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

Taken as whole, finding positive changes in 15 of 18 scales of outcome variables for the SFP program suggesting great positive changes in the parenting skills of the parents, the family relationships and in the children's behaviors is an important finding. Changes in all of the parenting and family variables by the post-test are wonderful and should later result in greater improvements in the children.

These positive changes were not solely due to a large sample size because there were only 8 families in this programme from March – June 2012. The major reason is the large mean changes and effect sizes. This suggests that even by the immediate 4-month post-test families are making major strides in improving their interaction patterns, which appears to be resulting in smaller but very impressive changes in the children. These behavioral changes in increasing Parental Supervision and reducing risky behaviors in the children, such as overt aggression and improving concentration should according to tested theories of the etiology of adolescent substance abuse (Kumpfer, Alvarado, & Whiteside, 2003, Ary, et al., 1988) results in less substance abuse and delinquency as the youths develop.

Most impressive for this year's implementation is that by the post-test the SPSS data analysis suggests reductions in Family Conflict, which decreased significantly ($p < .02$) with a large effect size of $d = .58$. This amount of change was 142% larger than the SFP 6-11 norms of .24, which is usually very hard to attain.

Reported in the tables below are the significant values or p . values for pre to posttest changes as well as a more important statistical outcome called "effect size". Similar to percent change, effect size is a more scientific way that researchers today report how much participants in an intervention have changed. The effect sizes reported are calculated in SPSS software by eta squared or Cohen's d as well as d' . It can be seen that they are medium to large and replicate the large effect sizes found to SFP in randomized control trials (Kumpfer & DeMarsh, 1986; Spoth, et al., 1999; 2002; 2003; Trudeau & Spoth, 2005), Gottfredson, Kumpfer, et al., 2006), except they are even larger. To put the effect sizes reported here into perspective, the average effect size of all obesity prevention programs was found to be $d = .006$ (Stice, Shaw & Marti, 2006). The overall effect size in reducing drug use of all youth-only substance abuse prevention programs is $d = .10$. The effect size of the DARE program was .08 and the best social skills training prevention programs only have an effect size of about .30 (Tobler & Stratton, 1997; Tobler & Kumpfer, 2000). Parenting and family interventions have larger effect sizes. See table 2 below.

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

Protective Factor	Sig. Level (p=)	2012 Effect Size (<i>d</i>) vs 6-11 Norms
1. Family Organization	.00	.86 (large) vs. .67
2. Family Cohesion	.00	.84 (large) vs. .50
3. Family Communication	.00	.83 (large) vs. .67
4. Family Conflict	.02	.58 (large) vs. .24
5. Family Resilience	.01	.73 (large) vs. .67
6. Positive Parenting	.00	.77 (large) vs. .55
7. Parental Involvement	.01	.71 (large) vs. .52
8. Parenting Skills	.00	.74 (large) vs. .49
9. Parental Supervision	.00	.80 (large) vs. .63
10. Parenting Efficacy	.01	.67 (large) vs. .57
11. Overt Aggression.	.01	.66 (large) vs. .34
12. Covert Aggression	.02	.56 (large) vs. .19
13. Concentration Problems	.02	.56 (large) vs. .52
14. Criminal Behavior	1.00	.00 (small) vs. .00
15. Hyperactivity	.35	.12 (small) vs. .01
16. Social Behavior	.05	.35 (medium) vs. .38
17. Depression	.05	.45 (medium) vs. .27
18. Alcohol and Drug Use	1.00	.00 (small) vs. .03

Meta-analysis Study of Prevention Approaches. Dr. Nancy Tobler has conducted a number of meta-analysis studies of drug prevention approaches. Dr. Kumpfer worked with her to develop a meta-analysis of family approaches and to compare these to child-only approaches. Overall, family-focused approaches average effect sizes that are nine times larger than youth-only prevention approaches (.96 ES versus .10 ES) as shown in the Table 3 below. This meta-analysis suggests that family skills training approaches, such as Strengthening Families have a very large effect size in reducing substance abuse ($d = .82$) second only to In-home Family Support approaches which had a very large effect size of 1.62.

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

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

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

Effect Sizes by Area of Risk and Protective Factors Addressed

Family Dynamics

The families in the *Ballymun Aisling Project* in Dublin, Ireland reported more problems in the measured family relations than their other counterparts participating in SFP 6-11 groups at the pretest. From these intake scores, we can assume that these families had fewer protective factors in the area of family relations compared to other agencies in the norm. 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=)	2012-13 Effect Size (d') vs 6-11 Norms
1. Family Organization	.00	.86 (large) vs. .67
2. Family Cohesion	.00	.84 (large) vs. .50
3. Family Communication	.00	.83 (large) vs. .67
4. Family Conflict	.02	.58 (large) vs. .24
5. Family Resilience	.01	.73 (large) vs. .67

The largest changes being reported by the parents by the immediate posttest at the end of the SFP class are in the area of family dynamics with the largest improvements for the Family Organization (mean change 1.78 and effect size $d = .86$). Family Cohesion (mean change 1.56 and effect size $d = .84$) was the next largest improvement followed by Family Communication (mean change 1.33 and effect size $d = .83$). The next largest effect size was for improvements in the Family Strength and Resilience (Effect Size $d = .73$). The smallest positive change was for Family Conflict ($d = .58$), which was also a large effect size. Changes in family conflict take more time to change as family communication patterns improve. All of these are large clinically significant improvements in the families.

Below are the results for the comparisons of the Ballymun group to the SFP 6-11 norms. By examining the average means at the pre-test, one can see that the families reported fewer problems in areas of the family communication, cohesion, strength and organization, and a slightly higher family conflict.

Table 5: Mean Changes in Family Risk and Protective Factors Compared to SFP 6-11 Norms

Scale Name	Sample	Pre-Test	SD	Post-Test	SD	Change	F	sig	Effect Size d	ES d'
Family Cohesion										
SFP 6-11 Norms	1393	3.71	0.94	4.54	0.56	0.83	1404.09	0.00	0.50	2.01
Ballymun Aisling	8	2.88	0.88	4.44	0.73	1.56	36.76	0.00	0.84	4.58
Family Communication										
SFP 6-11 Norms	1373	3.19	0.79	4.23	0.57	1.03	2818.82	0.00	0.67	2.87

Ballymun Aisling	8	2.67	0.56	4.00	0.40	1.33	35.14	0.00	0.83	4.48
Family Conflict										
SFP 6-11 Norms	1362	2.31	1.05	1.86	0.83	(0.45)	424.42	0.00	0.24	1.12
Ballymun Aisling	8	3.38	0.95	2.75	0.83	-0.63	9.72	0.02	0.58	2.36
Family Organization										
SFP 6-11 Norms	1383	2.77	0.92	4.05	0.68	1.28	2816.91	0.00	0.67	2.86
Ballymun Aisling	8	2.00	0.57	3.78	0.65	1.78	42.51	0.00	0.86	4.93
Family Strengths/Resilience										
SFP 6-11 Norms	1376	3.36	0.81	4.36	0.54	1.00	2746.37	0.00	0.67	2.83
Ballymun Aisling	7	3.04	0.77	3.99	0.68	0.95	16.15	0.01	0.73	3.28
Family Cluster Scale										
SFP 6-11 Norms	1327	3.31	0.70	4.27	0.47	0.95	3261.78	0.00	0.71	3.14
Ballymun Aisling	7	2.71	0.48	3.86	0.47	1.14	32.39	0.00	0.84	4.65

Ballymun Dublin Participants Improvements in Parenting Skills and Behaviors

The other amazingly large changes were in the area of parenting skills and behaviors. All of the five (100%) of the parent outcomes changed significantly from pre- to posttest even with a small size group for the analysis of only 8 parents. At the same time, 100% or all five of the outcomes had large effect sizes over $d = .67$. These families reported being lower in all five of the parent variables than other families participating in SFP. This is determined by comparing the Ballymun parent's pretest scores for each of the five parenting outcomes measured to the SFP 6-11 norms. However, the Ballymun improvements in outcomes for parenting variables had all five of the variables that statistically significantly better for the parenting outcomes than the SFP norms.

Table 6: Changes in Parenting Risk and Protective Factors

Protective Factor	Sig. Level (p=)	2012-13 Effect Size (d') vs 6-11 Norms
1. Positive Parenting	.00	.77 (large) vs. .55
2. Parental Involvement	.01	.71 (large) vs. .52
3. Parenting Skills	.00	.74 (large) vs. .49

4. Parental Supervision	.00	.80 (large) vs. .63
5. Parenting Efficacy	.01	.67 (large) vs. .57

The area of Parental Supervision (Effect Size $d = .80$) had the largest amount of positive change for SFP, and 27% larger than the 6-11 norm with $d = .63$. Next largest changes were reported in Positive Parenting with Effect Size $d = .77$. The improvements in Parenting Skills also got a large effect size with $d = .74$, followed by large improvements in Parental Involvement, and Parenting Efficacy with effect size of $d = .71$ and $.67$ separately.

Overall, these are amazing increases in parent child management skills with Cohen d effect sizes ranging from $.67$ for parenting efficacy to $.80$ for parental supervision. Parental supervision improved dramatically which is typical for SFP outcomes as can be seen by the comparison norms. It is a critical risk factor for children's later drug and alcohol use, so improvements in this area should be worked on in the future. The other positive parenting skill outcomes however, bode well for the long-term effectiveness of this program in preventing later behavioral problems and substance use in the children.

Table 7: FY '12 Changes in Parenting Risk and Protective Factors Compared to the SFP 6-11 Norms

Scale Name	Sample	Pre-Test	SD	Post-Test	SD	Change	F	sig	Effect Size d	ES d'
Parental Involvement										
SFP 6-11 Norms	1370	3.55	0.90	4.38	0.59	0.83	1508.67	0.00	0.52	2.10
Ballymun Aisling	8	3.13	0.94	4.22	0.90	1.09	16.78	0.01	0.71	3.10
Parental Supervision										
SFP 6-11 Norms	1378	3.30	0.75	4.26	0.51	0.96	2385.35	0.00	0.63	2.63
Ballymun Aisling	8	2.38	0.75	4.8	0.46	1.80	27.33	0.00	0.80	3.95
Parenting Efficacy										
SFP 6-11 Norms	1387	3.28	0.84	4.18	0.64	0.90	1830.21	0.00	0.57	2.30
Ballymun Aisling	8	2.63	0.84	3.75	0.58	1.13	13.90	0.01	0.67	2.82
Positive Parenting										
SFP 6-11 Norms	1391	3.83	0.88	4.66	0.48	0.83	1674.08	0.00	0.55	2.19
Ballymun Aisling	8	3.17	0.94	4.71	0.38	1.54	23.09	0.00	0.77	3.63

SFP Parenting Skills										
SFP 6-11 Norms	1373	3.47	0.71	4.03	0.61	0.56	1344.78	0.00	0.49	1.98
Ballymun Aisling	8	2.93	0.44	3.73	0.58	0.80	19.48	0.00	0.74	3.34
Parent Cluster Scale										
SFP 6-11 Norms	1330	3.47	0.64	4.28	0.42	0.81	2475.07	0.00	0.65	2.73
Ballymun Aisling	8	2.82	0.51	4.09	0.50	1.27	30.72	0.00	0.81	4.19

Parent Substance Abuse

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

In this case, for the first programme of Ballymun Aisling group, the mean change was $m = .00$ compared to $m = .06$ of SFP 6-11 norms, and the effect size was $d = .00$ compared to $.03$ for the SFP norms as shown in the table below. This result of non-change was because of floor effect. As one can tell from the Table 8, the pretest score for Aisling group was extremely low at $m = 1.06$ which was much lower than both the norms' low baseline of $m = 1.24$ and final score of $m = 1.18$, suggesting the Aisling group has lower risk than the 6-11 norms.

Table 8: Changes in Parent Risk and Protective Factors

Alcohol & Drug Use										
SFP 6-11 Norms	1353	1.24	0.44	1.18	0.45	0.06	43.13	0.00	0.03	0.36
Ballymun Aisling	8	1.06	0.09	1.06	0.09	0.00	0.00	1.00	0.00	1.00

Positive Child Behavior Changes

Five (71%) of the youth outcomes were statistically significant. The positive changes in the youth were ranged from small to large effect size improvements. The average youth mental and behavioral variable was statistically significant with also a large effect size of $d = .58$, with significant value of $p = .02$. The most improved child variables are decreased Overt Aggression with the largest magnitude of change ($d = .66$), followed with decreased Covert Aggression and increased Concentration with also large effect sizes of $d = .56$, decreased Depression with a medium effect size d of $.45$, and increased Social Skills with $d = .35$ or medium improvement.

The other variables achieved small improvement namely was Hyperactivity with $d = .12$, which were not statistically significant change, but a rare to be observed improvements. The Criminal Behavior was not changed in Ballymun Aisling Spring group, which effect size was the same as 6-11 norms with $d = .00$. This non-change result was caused by floor effect—the pretest score for Aisling group was too low at $m = 1.06$ (which means almost none risk of criminality), and it's too hard any improvements to gain statistically significant changes or large magnitude of change.

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

Table 9: Changes in Child’s Risk and Protective Factors

Protective Factor	Sig. Level (p=)	2012-13 Effect Size (d') vs 6-11 Norms
1. Overt Aggression.	.01	.66 (large) vs. .34
2. Covert Aggression	.02	.56 (large) vs. .19
3. Concentration Problems	.02	.56 (large) vs. .52
4. Criminal Behavior	1.00	.00 (small) vs. .00
5. Hyperactivity	.35	.12 (small) vs. .01
6. Social Behavior	.05	.35 (medium) vs. .38
7. Depression	.05	.45 (medium) vs. .27

Overall, looking at the intake or base rates in the youth’s problems at entry into SFP, the Year 1 adolescents in Ballymun Aisling group were lower in all variables except Social Skills at intake than the 6-11 norms, and five of them were significantly improved.

Improved Concentration or Reduced Attention Deficit. The effect size for reductions in attention deficit or problems in concentration in the child was $d = .56$. This is a 7% larger effect size than the 6-11 norms ($d = .52$). This is a statistically significant improvement ($p < .00$) with

a large effect size. At intake, the youth in Ballymun Aisling were lower at their level of Concentration ($m = 2.88$, compared to $m = 3.23$ for the SFP norms). However, the youth improved in their ability to concentrate by a significant level of $p = .00$, which was statistically significant. A major complaint of parents is that children today do not focus and pay attention. This large change in the children's ability to concentrate, at least in the view of the parents, is very positive. Inability to concentrate causes children to have school academic problems which are a major risk factor for later association with antisocial peers and drug use (Kumpfer, Alvarado, & Whiteside, 2003).

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 $d = .56$ (almost twice as large as the effect size of the 6-11 norms of $d = .19$). The pretest score was $m = 2.25$ compared to a slightly lower risk for the SFP 6-11 norms of $m = 2.20$. This higher baseline and statistically significant improvement could be explained by the reason that families and staff in Ballymun group did a good job on improving this variable.

Conduct Disorders: Overt Aggression. The hardest child outcome variables to change by the post-test are Criminal Behavior and Hyperactivity. However, the Overt Aggression variable is also generally found to be difficult to change and sometimes does not improve significantly by the posttest. In the Washington D.C. study (Gottfredson, Kumpfer, et al., 2005) overt aggression did not have a statistically significant improvement.

However, the effect sizes for youth in this SFP group in Overt Aggression was large with $d = .66$ compared to $d = .34$ for the SFP 6-11 norm, which was 94% larger effect size than the norms. The statistically significant value was as low as $p = .01$. A higher intake of $m = 2.79$ compared to $m = 2.09$ for the SFP 6-11 norms, suggested the youth were higher at risk by their parents' report than their SFP 6-11 counterparts. For these high risk families, getting statistically and practically significant outcome indicated this group benefited from the program, and group leaders did a wonderful job in implementing the program.

Criminal Behavior. Antisocial criminal behavior was reported by parents to be no improvement, mainly because of the floor effect. The youth in this sample had lower values of reported criminal behavior at the intake or the pretest ($m = 1.06$ compared to $m = 1.07$ for SFP 6-11 Norm), and maintained this noncriminal risk at the posttest ($m = 1.06$).

Hyperactivity. This variable was decreased insignificantly with $p < .35$. This improvement is rare to be observed, as hyperactivity is very difficult to change within a 4-month period and the SFP National Database does not generally find significant improvements in Hyperactivity in the children, and the pretest score of $m = 3.29$, and posttest score of $m = 3.25$ suggested medium risk in this area.

Social Skills and Competencies. There were positive changes in the youth's Social Skills and Competencies this Ballymun Aisling SFP group youth with a better baseline of $m = 4.01$ compared to $m = 3.83$ for the 6-11 norms. There is less room to improve, as the intake is very high which leave less room to get improvement to gain a large change. Thus, the effect size for Social Skills was lower than the SFP norms with $d = .34$ compared to $d = .38$, but this is still

a medium magnitude of improvement. SFP includes a 14 session children social skills curriculum based on the best evidence based social skills models, such as Shure and Spivack's *I Can Problem Solve (ICPS)* program. It includes sessions on problem solving, decision making, communication skills, coping with anger and depression, and even dating relationships in the child version of SFP 6 – 11 Years.

Children's Depression. The youth's depression was the other statistically significant improved variable with medium effect size of $d = .45$ which was 67% larger than the norms' effect size of $d = .27$. One possible reason was that the youth in this sample were slightly more depressed at intake than is generally found in SFP 6-11 group ($m=2.59$ vs. $m=2.01$).

Table 10: FY'12 Child Outcomes for All Seven Measured Pre- to Posttest Change Scores

Scale Name	Sample	Pre-Test	SD	Post-Test	SD	Change	F	Sig	Effect Size d	ES d'
Concentration										
SFP 6-11 Norms	1319	3.23	0.72	3.80	0.64	0.58	1433.63	0.00	0.52	2.09
Ballymun Aisling	8	2.88	0.55	3.40	0.40	0.52	8.91	0.02	0.56	2.26
Covert Aggression										
SFP 6-11 Norms	1301	2.00	0.60	1.73	0.50	(0.27)	295.69	0.00	0.19	0.95
Ballymun Aisling	8	2.25	0.50	1.90	0.51	(0.35)	8.76	0.02	0.56	2.24
Criminal Behavior										
SFP 6-11 Norms	1347	1.07	0.32	1.05	0.32	(0.01)	3.22	0.07	0.00	0.10
Ballymun Aisling	8	1.06	0.18	1.06	0.18	0.00	0.00	1.00	0.00	1.00
Depression										
SFP 6-11 Norms	1319	2.02	0.66	1.71	0.56	(0.31)	486.44	0.00	0.27	1.22
Ballymun Aisling	8	2.59	0.58	2.13	0.50	(0.47)	5.65	0.05	0.45	1.80
Hyperactivity										
SFP 6-11 Norms	1346	2.85	0.85	2.91	0.85	0.05	11.34	0.00	0.01	0.18
Ballymun Aisling	8	3.29	0.58	3.25	0.53	(0.04)	1.00	0.35	0.12	0.76
Overt Aggression										
SFP 6-11 Norms	1336	2.09	0.69	1.70	0.53	(0.39)	677.00	0.00	0.34	1.42

Ballymun Aisling	8	2.79	0.48	2.36	0.54	(0.43)	13.37	0.01	0.66	2.76
Social Behavior										
SFP 6-11 Norms	1284	3.83	0.69	4.18	0.57	0.35	798.37	0.00	0.38	1.58
Ballymun Aisling	8	4.01	0.56	4.14	0.64	0.13	3.75	0.05	0.35	1.46
Child Cluster Scale										
SFP 6-11 Norms	1179	3.73	0.48	4.10	0.39	0.37	1126.36	0.00	0.49	1.96
Ballymun Aisling	8	3.41	0.19	3.76	0.25	0.34	9.73	0.02	0.58	2.36

Summary of Overall Results and Family Changes

In summary, 15 of 18 scales of the hypothesized and measured outcome variables were shown to have significant positive changes even with a small sample size of 8 families completing the posttest. If the cluster variables for parents, family and child outcomes are included there were 18 of 21 outcomes significant. The comparison group was the norms for the SFP 6-11 of about 1393 families. The three outcomes that didn't improve significantly were for variable of Hyperactivity, Criminality, and Adult Alcohol and Drug Use. Recently an internal consistency analysis of these two scales revealed that they had low Chronbach's alphas so they are not good scales (Kumpfer, Xie, & O'Driscoll, 2012). They have too few questions in them to be reliable.

It should be pointed out that this large sample is not all of the families that participated in SFP 6-11 years (March –June 2012), but represents only the data that was completed and sent to LutraGroup for data entry, analysis and report writing (80%).

All five of the five family change variables (100%) were improved significantly, including Family Conflict that sometimes doesn't improve significantly. This family relationship area of change had the large improvements in the effect sizes (d) with a large effect size of .86 for Family Organization, .84 for Family Cohesion, .83 for Family Communication, .73 for Family Strength and Resilience, and .58 for Family Conflict. The reported Family Conflict got a large effect size, and changes in this area were 2.5 times larger than the SFP 6-11 norms, and also larger than the results for the USA national SFP database and the NIDA SFP cross-site study in Washington, D.C. Hence, it appears that the Ballymun Aisling 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 second largest effects compared to improvements in family variables are changes in the parent's parenting skills and style or efficacy with 100% of the five outcome variables showing significant improvements. 100% of the effect sizes are large, with the largest effect

sizes of $d = .80$ for Parental Supervision. This result was 27% larger in effect size compared to the SFP 6-11 norms.

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

Taken as a whole, finding positive changes in 18 (or 86%) of 21 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, 86% or 18 out of 21 effect sizes (d' and d) are medium to large suggesting that staff implementing in Ballymun, Dublin, Ireland, SFP Aisling group are more capable in implementing SFP effectively with high risk families than were the agencies in Washington, D.C. area participating in the NIDA research grant even under Dr. Kumpfer’s part time supervision while she was the CSAP Director in Washington, D.C.. Following the analysis of additional cycles and tests, extended findings of the outcome evaluation will be available. We will then be able to test moderator variables such as gender, ethnicity, attendance, and level of risk at baseline.

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

Table 11: 2011-12 Group Outcomes Compared to SFP 6-11 Norms

Scale Name	Sample	Pre-Test	SD	Post-Test	SD	Change	F	sig	Effect Size d	ES d'
Parental Involvement										
SFP 6-11 Norms	1370	3.55	0.90	4.38	0.59	0.83	1508.67	0.00	0.52	2.10
Ballymun Aisling	8	3.13	0.94	4.22	0.90	1.09	16.78	0.01	0.71	3.10
Parental Supervision										
SFP 6-11 Norms	1378	3.30	0.75	4.26	0.51	0.96	2385.35	0.00	0.63	2.63
Ballymun Aisling	8	2.38	0.75	4.8	0.46	1.80	27.33	0.00	0.80	3.95
Parenting Efficacy										
SFP 6-11 Norms	1387	3.28	0.84	4.18	0.64	0.90	1830.21	0.00	0.57	2.30
Ballymun Aisling	8	2.63	0.84	3.75	0.58	1.13	13.90	0.01	0.67	2.82
Positive Parenting										

SFP 6-11 Norms	1391	3.83	0.88	4.66	0.48	0.83	1674.08	0.00	0.55	2.19
Ballymun Aisling	8	3.17	0.94	4.71	0.38	1.54	23.09	0.00	0.77	3.63
SFP Parenting Skills										
SFP 6-11 Norms	1373	3.47	0.71	4.03	0.61	0.56	1344.78	0.00	0.49	1.98
Ballymun Aisling	8	2.93	0.44	3.73	0.58	0.80	19.48	0.00	0.74	3.34
Parent Cluster Scale										
SFP 6-11 Norms	1330	3.47	0.64	4.28	0.42	0.81	2475.07	0.00	0.65	2.73
Ballymun Aisling	8	2.82	0.51	4.09	0.50	1.27	30.72	0.00	0.81	4.19
Family Cohesion										
SFP 6-11 Norms	1393	3.71	0.94	4.54	0.56	0.83	1404.09	0.00	0.50	2.01
Ballymun Aisling	8	2.88	0.88	4.44	0.73	1.56	36.76	0.00	0.84	4.58
Family Communication										
SFP 6-11 Norms	1373	3.19	0.79	4.23	0.57	1.03	2818.82	0.00	0.67	2.87
Ballymun Aisling	8	2.67	0.56	4.00	0.40	1.33	35.14	0.00	0.83	4.48
Family Conflict										
SFP 6-11 Norms	1362	2.31	1.05	1.86	0.83	(0.45)	424.42	0.00	0.24	1.12
Ballymun Aisling	8	3.38	0.95	2.75	0.83	-0.63	9.72	0.02	0.58	2.36
Family Organization										
SFP 6-11 Norms	1383	2.77	0.92	4.05	0.68	1.28	2816.91	0.00	0.67	2.86
Ballymun Aisling	8	2.00	0.57	3.78	0.65	1.78	42.51	0.00	0.86	4.93
Family Strengths/Resilience										
SFP 6-11 Norms	1376	3.36	0.81	4.36	0.54	1.00	2746.37	0.00	0.67	2.83
Ballymun Aisling	7	3.04	0.77	3.99	0.68	0.95	16.15	0.01	0.73	3.28
Family Cluster Scale										
SFP 6-11 Norms	1327	3.31	0.70	4.27	0.47	0.95	3261.78	0.00	0.71	3.14
Ballymun Aisling	7	2.71	0.48	3.86	0.47	1.14	32.39	0.00	0.84	4.65

Concentration										
SFP 6-11 Norms	1319	3.23	0.72	3.80	0.64	0.58	1433.63	0.00	0.52	2.09
Ballymun Aisling	8	2.88	0.55	3.40	0.40	0.52	8.91	0.02	0.56	2.26
Covert Aggression										
SFP 6-11 Norms	1301	2.00	0.60	1.73	0.50	(0.27)	295.69	0.00	0.19	0.95
Ballymun Aisling	8	2.25	0.50	1.90	0.51	(0.35)	8.76	0.02	0.56	2.24
Criminal Behavior										
SFP 6-11 Norms	1347	1.07	0.32	1.05	0.32	(0.01)	3.22	0.07	0.00	0.10
Ballymun Aisling	8	1.06	0.18	1.06	0.18	0.00	0.00	1.00	0.00	1.00
Depression										
SFP 6-11 Norms	1319	2.02	0.66	1.71	0.56	(0.31)	486.44	0.00	0.27	1.22
Ballymun Aisling	8	2.59	0.58	2.13	0.50	(0.47)	5.65	0.05	0.45	1.80
Hyperactivity										
SFP 6-11 Norms	1346	2.85	0.85	2.91	0.85	0.05	11.34	0.00	0.01	0.18
Ballymun Aisling	8	3.29	0.58	3.25	0.53	(0.04)	1.00	0.35	0.12	0.76
Overt Aggression										
SFP 6-11 Norms	1336	2.09	0.69	1.70	0.53	(0.39)	677.00	0.00	0.34	1.42
Ballymun Aisling	8	2.79	0.48	2.36	0.54	(0.43)	13.37	0.01	0.66	2.76
Social Behavior										
SFP 6-11 Norms	1284	3.83	0.69	4.18	0.57	0.35	798.37	0.00	0.38	1.58
Ballymun Aisling	8	4.01	0.56	4.14	0.64	0.13	3.75	0.05	0.35	1.46
Child Cluster Scale										
SFP 6-11 Norms	1179	3.73	0.48	4.10	0.39	0.37	1126.36	0.00	0.49	1.96
Ballymun Aisling	8	3.41	0.19	3.76	0.25	0.34	9.73	0.02	0.58	2.36
Alcohol & Drug Use										

SFP 6-11 Norms	1353	1.24	0.44	1.18	0.45	(0.06)	43.13	0.00	0.03	0.36
Ballymun Aisling	8	1.06	0.09	1.06	0.09	0.00	0.00	1.00	0.00	1.00

V. CONCLUSION AND RECOMMENDATIONS

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

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

The Ballymun Local Drugs Task Force 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. The agencies involved have mounted an aggressive implementation adapting the program to the needs of Irish families and youth in Ballymun.

SFP is provided in serial cycles that are continuous throughout the year, allowing for maximum opportunities for youth and families of the agencies to participate in the program. In 2012, one cycle or group of SFP 6-11 years had been conducted by Ballymun Aisling (with 10 families graduating) and 8 of these families had completed the retrospective pre and posttests.

The outcome results are encouraging suggesting significant improvements in 100% or all five parenting outcomes, 100% or five of five family outcomes and 71% or five of the seven youth outcomes. The results suggest large improvements in the parents and in the family environment and family resilience. Even by this immediate posttest the data suggest that the children’s behaviors are already showing statistically significant improvements in Overt Aggression, Covert Aggression, Depression, Social Skills and Concentration this year which is typical of SFP youth groups. Improvement in other child outcomes were not significant, because

the level of reported intake was lower than the SFP 6-11 norms, there was barely room for improvement.

Recommendations

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

- *Evaluation Design.* It is recommended that the same evaluation design be continued.
- *Training for the Site Coordinator in Process Evaluation.* Most USA agencies also contract for a process evaluation that includes a site visit by a process evaluator with suggestions for fidelity and quality improvements. This agency's Site Coordinator would be a good candidate to be trained by Dr. Jeanie Ahearn Greene from the Lutra Group 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.
- *Increase Retention and Recruitment.* Recruitment efforts should continue and be aggressive. It is recommended that the cycles seek to over-recruit (10-12 families) based on the current level of enrollment and completion (noting, however, that retention often increases in subsequent cycles). Target a minimum retention rate of 6 families, with a goal of 8 graduating families. Fewer than six families completing compromises group process and hampers execution of the curriculum. Further, fewer than six families have implications for the cost effectiveness of the program.

Overall, the results are very good for Ballymun families. 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. One recommendation made last year also was to dedicate some funds to have a least a single fidelity site visit to document what is happening to develop such good results. A site visit would provide a more detailed process evaluation report that would measure curriculum fidelity and observe the implementation in terms of staffing, context and program components. Recommendations for improvement would be more useful when knowing more about the program implementation qualities.

REFERENCES AND BIBLIOGRAPHY

- Achenbach, T.M., & Edelbrock, C. (1988). *Child Behavior Checklist (CBCL)*. Center for Children, Youth, & Families, University of VT, Burlington, VT
- Aktan, G. (1995). Organizational framework for a substance use prevention program. *International Journal of Addictions, 30*, 185-201.
- Aktan, G., Kumpfer, K. L., & Turner, C. (1996). The Safe Haven program: Effectiveness of a family skills training program for substance abuse prevention with inner city African American families. *International Journal of the Addictions, 31*, 158-175.
- Alvarado, R., & Kumpfer, K.L. (2000). Strengthening America's families. *Juvenile Justice, 7* (2), 8-18.
- Aos, S., et al., (2004). *Benefits and costs of prevention and early intervention programs for youth*. Washington State Policy Institute, available at <http://www.wsipp.wa.gov/rptfiles/04-07-3901.pdf>.
- Biglan, T., Mrazek, P.J., Carnine, D., & Flay, B.R. (in press). The integration of research and practice in the prevention of youth problems. *American Psychologist*.
- Bry, B. H., Catalano, R. F., Kumpfer, K. L., Lochman, J. E., & Szapocznik, J. (1998). Scientific findings from family prevention intervention research. In Ashery, Robertson, & Kumpfer (Eds.) *Family focused prevention of drug abuse: Research and interventions*. NIDA Research Monograph, Washington, DC: Superintendent of Documents, US Government printing office, 103-129.
- Cook, T.D., & Campbell, D.T. (1979). *Quasi-experimentation: Design and analysis issues in field settings*. Chicago: Rand-McNally, 1979.
- DeMarsh, J. K., & Kumpfer, K. L. (1985). Family environmental and genetic influences on children's future chemical dependency. *Journal of Children in Contemporary Society: Advances in Theory and Applied Research, 18* (1/2), 117-152.
- Foxcroft, D. R. (2006). Alcohol misuse prevention in young people: a rapid review of recent evidence. *WHO Technical Report*, Oxford Brookes University, Oxford, UK.
- Foxcroft D. R., Ireland, D., Lister-Sharp, D. J., Lowe, G., Breen, R. (2003). Longer-term primary prevention for alcohol misuse in young people: a systematic review. *Addiction; 98*: 397-411.
- Harrison, S., Proskauer, S., & Kumpfer, K. L. (1995). *Final evaluation report on Utah CSAP/CYAP project*. Submitted to the Utah State Division of Substance Abuse. Social Research Institute, University of Utah.
- Harrison, S., Boyle, S.W., & Farley, O.W. (1999). Evaluating the outcomes of a family-based intervention for troubled children: A pretest-posttest study. *Research on Social Work Practice, 9* (6), 640-655.
- Miller, T. A., & Hendrie, D. (2008). *Substance Abuse Prevention: Dollars and Cents: A Cost-Benefit Analysis*; Center for Substance Abuse Prevention (CSAP), SAMHSA. DHHS Pub. No 07-4298, Rockville, MD.

- Kumpfer, K.L. (1991). How to get hard-to-reach parents involved in parenting programs. In Pines, D., Crute, D., & Rogers, E. (Eds.), *Parenting as prevention: Preventing alcohol and other drug abuse problems in the family* (pp.87-95). Rockville, MD: Office of Substance Abuse Prevention Monograph.
- Kumpfer, K.L. (2000). Strengthening family involvement in school substance abuse programs. In W.B. Hansen, S.M.Giles, & M.D. Fearnow-Kenney (Eds.). *Improving Prevention Effectiveness*, (pp. 127-140), Tanglewood Research, Inc., Greensboro, North Carolina.
- Kumpfer, K.L. (1999). Factors and processes contributing to resilience: The resilience framework. In M.D. Glantz and J.L. Johnson (Eds.) *Resilience and Development: Positive Life Adaptions*, 179-224. New York: Kluwer Academic/Plenum Publishers.
- Kumpfer, K.L. (1998). The Strengthening Families Program. In R.S. Ashery, E. Robertson, & K.L. Kumpfer (Eds.) (1998). *Drug Abuse Prevention Through Family Interventions*, NIDA Research Monograph #177, DHHS, National Institute on Drug Abuse, Rockville, MD, NIH Publication No. 97-4135.
- Kumpfer, K.L., & Alvarado, R. (in press). Family interventions for the prevention of drug abuse. *American Psychologist*, (special issue on prevention). Editors: Weissberg, R., and Kumpfer, K.L.
- Kumpfer, K.L., & Alvarado, R (1998). *Effective Family Strengthening Interventions. Juvenile Justice Bulletin, Family Strengthening Series*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention (OJJDP). November, 1998.
- Kumpfer, K.L., & DeMarsh, J.P. (1983). *Strengthening families program: Parent training curriculum manual*. (Prevention Services to Children of Substance-abusing Parents). Social Research Institute, Graduate School of Social Work, University of Utah
- Kumpfer, K. L., & DeMarsh, J. P. (1985). Prevention of chemical dependency in children of alcohol and drug abusers. *NIDA Notes*, 5, 2-3.
- Kumpfer, K. L., & Kaftarian, S. J. (2000). Bridging the gap between family-focused research and substance abuse prevention practice: Preface. *Journal of Primary Prevention*, 21(2), 169-183.
- Kumpfer, K. L., DeMarsh, J. P., & Child, W. (1989). *Strengthening families program: Children's skills training curriculum manual, parent training manual, children's skill training manual, and family skills training manual* (Prevention Services to Children of Substance-abusing Parents). Social Research Institute, Graduate School of Social Work, University of Utah.
- Kumpfer, K.L., & Turner, C.W. (1990-1991). The social ecology model of adolescent substance abuse: Implications for prevention. *The International Journal of the Addictions*, 25(4A), 435-463.
- Kumpfer, K.L., Molgaard, V., & Spoth, R. (1996). The Strengthening Families Program for prevention of delinquency and drug use in special populations. In R. DeV Peters, & R. J. McMahon, (Eds.) *Childhood Disorders, Substance Abuse, and Delinquency: Prevention and Early Intervention Approaches*. Newbury Park, CA: Sage Publications.

- Kumpfer, K.L., Xie, J. & O'Driscoll, R. (2012). Effectiveness of a culturally adapted Strengthening Families Program 12-16 Years for high risk Irish families. *Child and Youth Care Forum*, 39 (1), Sage Publications, LA, CA. (DOI) 10.1007/s10566-011-9168-0
- Kumpfer, K. L., Alvarado, R., Smith, P., & Bellamy, N. (2002). Cultural sensitivity in family-based prevention interventions. In K. Kavanaugh, R. Spoth, & T. Dishion (Special Edition Eds.), *Prevention Science*, New York, Kluwer Academic/Plenum Publishers,
- Kumpfer, K.L., Alvarado, R., Tait, C., & Turner, C. (2002). Effectiveness of school-based family and children's skills training for substance abuse prevention among 6-8 year old rural children, *Psychology of Addictive Behavior* (Special Issue), Editors:, R. Tarter, P.Tolan, & S. Sambrano.
- Miller, T. A., & Hendrie, D. (2008). *Substance Abuse Prevention: Dollars and Cents: A Cost-Benefit Analysis*; Center for Substance Abuse Prevention (CSAP), SAMHSA. DHHS Pub. No 07-4298, Rockville, MD.
- Molgaard, V., Kumpfer, K. L., & Spoth, R. (1994). *The Iowa strengthening families program for pre and early teens*. Ames, IA: Iowa State University.
- Spoth, R., & Molgaard, V. (1999). Project Family: A partnership integrating research with the practice of promoting family and youth competencies. In T.R. Chibucos & R. Lerner (Eds.). *Serving children and families through community-university partnerships: Success stories* (pp.127-137). Boston: Kluwer Academic.
- Spoth, R., Redmond, C., Hockaday, C., & Shin, C. (1996). Barriers to participation in family skills preventive interventions and their evaluations: A replication and extension. *Family Relations*, 45, 247-254.
- Spoth, R., Redmond, C., & Lepper, H. (1999). Alcohol initiation outcomes of universal family-focused preventive interventions: one- and two-year follow-ups of a controlled study. *Journal of Studies on Alcohol*, 13, 103-111.
- Spoth, R., Gyll, M., & Day, S. (2002) Universal family-focused interventions in alcohol-use disorder prevention: Cost-effectiveness and cost-benefit analysis of two interventions. *Journal of Studies on Alcohol*, 63 (2), 219-228.

Strengthening Families Program Fidelity Benchmarks

FIDELITY BENCHMARKS: SFP Recommended Best Practices and Program Standards

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

Funding

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

Target Population

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

Staffing

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

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

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

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

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

Sites and Logistics

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

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

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

Curriculum Fidelity

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

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

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

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

Recruitment and Retention

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

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

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

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

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

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

Evaluation Methodology

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

Follow-up Booster Sessions

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

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

APPENDIX 2

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

INSTRUCTIONS TO PERSONS ADMINISTERING THIS QUESTIONNAIRE (Please read in advance. Do NOT read aloud!)⁴

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

QUESTIONNAIRE INSTRUCTIONS

(Please read in advance. Do NOT read aloud)

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

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

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

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

IMPORTANT INSTRUCTIONS FOR MONITORING POST/RETRO QUESTIONNAIRE

(Please read in advance. Do NOT read aloud)

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

⁴ Karol Kumpfer, Ph.D. Psychologist, Department of Health Promotion and Education, University of Utah for *Celebrating Families!*TM and Strengthening Families Program evaluation. It can be used only by authorized personnel on this project.

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

COLLECTING THE QUESTIONNAIRES FROM PARENTS

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

The agency

The beginning and end days of the cycle

The number of families starting and completing the cycle.

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

If you have any questions you can contact Dr. Karol Kumpfer, evaluator, directly at: 801. 582.1652 mornings or 801 583 4601 or 801 581 7718 afternoons or at kkumpfer@xmission.com.

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

Thank you! We appreciate all your efforts!

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

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

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

Thank you.

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

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

STRENGTHENING FAMILIES PROGRAM: ABOUT YOUR FAMILY

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

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

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

1 = SFP 3- 5 , 2 = SFP 6 –11, 3 = 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 = African American/Black 5 = Alaska Native

2 = Asian 6 = White

3 = American Indian 7 = Hispanic or Latino

4 = Pacific Islander 8 = Other (Specify) _____

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

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

5. _____ (years) How old are you?

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

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

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

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

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

7=Other (specify): _____

10. _____ What is your current parenting status?

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

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

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

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

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

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

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

13. _____ Where are you living now?

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

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

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

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

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

Client Satisfaction (Kumpfer, 2002)

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

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

PARENTING SCALE (Kumpfer, 1989)

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

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

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

OVERALL FAMILY STRENGTHS/RESILIENCE (Kumpfer, 1997)

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

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

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

DRUG & ALCOHOL USE (CSAP GRPA)

In the past 30 days, on how many days have you used the following?			In the past 30 days, on how many days do you think your child used the following?		
Before Program		Now	Before Program		Now
_____	1. Alcohol	_____	_____	1. Alcohol	_____
_____	2. Alcohol to intoxication	_____	_____	2. Alcohol to intoxication	_____
_____	3. Tobacco	_____	_____	3. Tobacco	_____
_____	4. Marijuana/hashish/pot	_____	_____	4. Marijuana/hashish/pot	_____
_____	5. Other illegal drugs (type?_____)	_____	_____	5. Other illegal drugs (type?_____)	_____

_____	6. Prescription drugs not prescribed by your doctor (type?_____)	_____	_____	6. Prescription drugs not prescribed by your doctor (type?_____)	_____
-------	---	-------	-------	---	-------

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

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

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

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

___	18. Avoids other kids	___	___	39. Skips school (0 if not old enough for school)	___
___	19. Fights	___	___	40. Uses a weapon in a fight	___
___	20. Is eager to learn	___	___	41. Friends seek him/her out for social activities	___
___	21. Damages other's property on purpose	___	___	42. Runs around a lot, climbs on things	___
Before Program		Now	Before Program		Now
___	43. Runs away from home overnight	___	___	49. Looks sad or down	___
___	44. Starts physical fights	___	___	50. Interrupts or intrudes on others	___
___	45. Has lots of friends	___	___	51. Has low energy	___
___	46. Is always "on the go"	___	___	52. Blurts out answers before the question is completed	___
___	47. Is irritable	___	___	53. Stutters	___
___	48. Loses temper	___	___		___

About You (CES-D, Radloff, 1977)

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

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

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

_____	12. I was happy.	_____
_____	13. I talked less than usual.	_____
_____	14. I felt lonely.	_____
_____	15. People were unfriendly.	_____
_____	16. I enjoyed life.	_____
_____	17. I had crying spells.	_____
_____	18. I felt sad.	_____
_____	19. I felt that people dislike me.	_____
_____	20. I could not get “going”.	_____

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

**STRENGTHENING FAMILIES PROGRAM EVALUATION
SITE INFORMATION SURVEY**

RETURN TO:
Karol L Kumpfer, Ph.D.
LutraGroup
5215 Pioneer Fork Road
Salt Lake City, UT 84108

LutraGoup, Inc. is conducting an independent process evaluation of the implementation and program delivery of Strengthening Families Program. Please complete the following survey and return it to the above address. These will help to extend the information that is gathered at site visits in the coming year.

I can be contacted with any questions and to help clarify. If it would be easier to fill this out electronically, email me or fax to me at 801 583-7979.

Karol L. Kumpfer, Ph.D.
kkumpfer@xmission.com
(801) 582-1652 or (801) 583-4601
Fax: (801) 583-7979

**PLEASE COMPLETE IN WORD, PRINT (SEND WITH TESTS)
but also EMAIL to be used in the your report!!!!**

DATE: _09/08/2012_____

AGENCY: Aisling Project

CONTACT NAME: Peter Doherty

TITLE: Site Co-ordinator/Project Co-ordinator

PHONE NUMBER: 0979629507

FAX NUMBER: _____

EMAIL: aislingproject@eircom.net

ADDRESS: 25 Druid Court

Ballymun

Dublin 11

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

<u>PROGRAM INFORMATION</u>	IMPLEMENTATION DATA
Funding Source:	BLDTF
SFP Curriculum (3-5, 6-11,10-14,12-16)	6-11
Geographic (Rural/Sub/Seasonal/Urban)	Urban
Predominant Ethnicity(ies) (W/B/H/O)	White
Languages (English/Spanish/Other(list))	English
# “Parents”/Adults enrolled in Parent Sessions	12
# Children enrolled in Child Sessions	17
Target Child Age Range (e.g.3-5, 6-11, 11-14, 12-16)	6-11
Special Eligibility Criteria (e.g., risk factor/ethnicity)	Risk Factor – Family communication
Start Date	14 th March 2012
Finish Date	13 th June 2012
Day of Week and Time	Wednesday – 6:00pm
# Sessions	14
# Families Recruited	13
# Families Started	10
# Families Completed	10
# Families Attended Less Than 8 Sessions.	1
# Families Attended 8-11 Sessions	6
#Families Attended 12-14 Sessions	3
# Children Started Program	17
# Adults Started Program	12
# Children Completed Program	17
# Adults Completed Program	11
Site (Clinic/Church/Agency/Housing/School, etc.)	Youth Centre
Partner Agency, if any (include type, e.g. preschool, church, Tx agency)	
Meal (Dinner/Lunch/Breakfast)	Dinner
In-Session Incentives Type: Cash/Vouchers/Grab Bags	Grab Bags
In-Session Incentives Intensity: Weekly/Intermittent	Weekly
Completion Incentives Type: Cash/Vouchers/Gifts	Vouchers
Special Graduation Activities	
Evaluation: # retro parent tests completed/submitted	8
# Child Protective Services Referrals	0

# Court Ordered Referrals	0
#Criminal Justice Referrals	0
#Substance Abuse Treatment Ref.	0
# Protective Services Involved Families	0
# Work Training Involved Families	0
#Criminal Justice Involved Families	0
#Substance Abuse Treatment Involved Families	0
Transportation Provided (Y/N)	Yes
On-site Child Care (Y/N)	No
# Child Group Leaders	4
# Parent Group Leaders	2
Separate Site Coordinator (Y/N)	Yes
Booster/Follow-Up Session (Date)	

Additional Innovations:

While following the manual we found it necessary to adapt the activities and we used a computer application to involve the children

Lessons Learned:

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

THANKYOU!!!