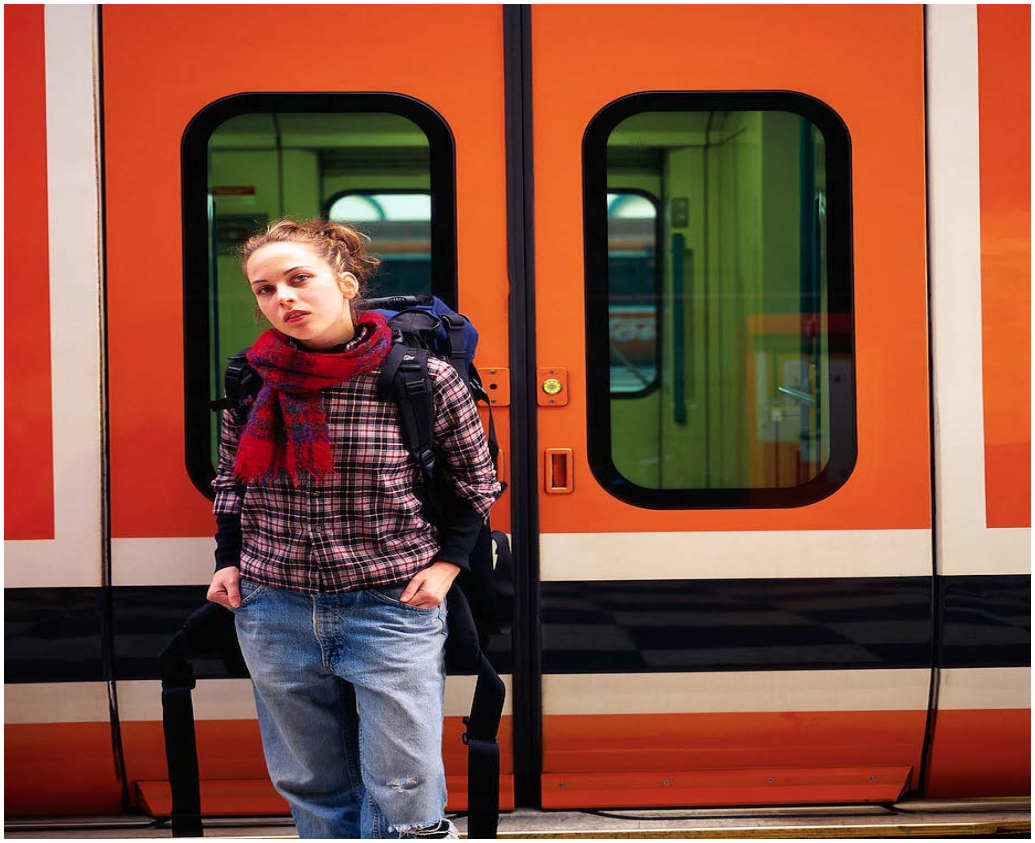
LUTRA GROUP

Ballymun Local Drugs Task Force, Dublin, Ireland

STRENGTHENING FAMILIES PROGRAM (SFP 12-16)



Year 4 (2011) Evaluation Report

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Ballymun Local Drugs Task Force Strengthening Families Program for Teens and Parents (SFP 12-16)

YEAR FOUR - EVALUATION REPORT (2011)

I. INTRODUCTION AND OVERVIEW

The *Ballymun Local Drugs Task Force* in Dublin, Ireland has implemented an evidence-based family program as part of a locally based strategy aimed at the prevention of substance abuse and juvenile delinquency in youth and to improve the parenting skills of parents of high-risk adolescents. Based on assessed community needs and risk factors for substance abuse, the evidence-based program chosen to be implemented was the *Strengthening Families Program (SFP)* for families with high-risk adolescents age 12 to 16 years old. The Strengthening Families Programme is funded and managed by Ballymun Local Drugs Task Force and is supported and delivered by local statutory, community and voluntary agencies. The Ballymun Local Drugs Task Force is funded through the Irish government.

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

Professional Group Leader Training. Individuals are trained and certified as SFP group leaders by Dr. Karol Kumpfer, the program developer and Dr. Henry Whiteside of Lutragroup, the SFP International Training Centre in Salt Lake City, Utah. Group leaders since 2007, have being trained either directly by Lutragroup or by authorized local trainers. In 2011, 33 individuals were trained as group leaders, 12 of which represented Ballymun.

Introduction to Evaluation Report

This report includes the evaluation findings from the spring and fall groups in Year 2011 of this initiative as funded by BLDTF. An independent evaluation is being conducted by Lutra Group, Inc. that included only the outcome evaluation to measure program effectiveness with this population[1]. In 2011 (January to December, 2011), two SFP groups were 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.

(February – May 2011 and September – December 2011) [2]. Between the 2 programs, 26 families started the program and 21 families completed the family intervention and graduated, thereby having a completion rate of 81%. Of the 21 graduate families, 19 families completed the questionnaires (parent retrospective pre and post test) and this 2011 data was sent to Lutragroup for analysis and outcome report. However, the data in this report is based on 18 families as this was the highest number of valid data on the scales used; this corresponds to 86% of families who graduated in 2011[3].

SFP Program Description. The *Strengthening Families Program* (Kumpfer & DeMarsh, 1989; Kumpfer, DeMarsh, & Child, 1989) is an evidence-based 14-week family skills training program that involves the whole family in three classes run on the same night once a week. The parents or caretakers of high-risk youth attend the SFP Parent Training Program in the first hour. At the same time their adolescents attend the SFP Teen's Skills Training Program. In the second hour, the families participate together in a SFP Family Skills Training Program. Multiple replications of SFP in randomized control trials in different countries (United States, Canada, Australia, U.K., Netherlands, Italy, Spain, Portugal, Thailand, Sweden, Norway and France) with different cultural groups by independent evaluators have found SFP to be an effective program in reducing multiple risk factors for later alcohol and drug abuse, mental health problems, and delinquency by increasing family strengths, children's social competencies, and improving parent's parenting skills (Kumpfer, Alvarado, Smith, & Bellamy, 2002; Kumpfer, 2007; Bool, 2005; Orte, et al., 2007). The Cochrane Collaboration Reviews at Oxford University found SFP 10-14 Years to be the most effective school-based program in the world (Foxcroft, et al., 2003). 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 an 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 SFP budget provides for all necessary and recommended training, program sessions, meals, childcare, staffing, logistics, supplies, incentives, follow-up and program evaluation for the full SFP program. Notable for this initiative, is the application and adaptation of SFP to a coalition of community agencies and the application for high-risk Irish families.

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

[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 includes a fidelity survey of funded cycles and site visit to assess program fidelity. The outcome evaluation involves a repeated measure 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: Lutra Group

The contracted evaluator is Lutra Group. 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 Lutra Group. Lutra Group 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 Lutra Group, both nationally and internationally. Lutra Group has provided the SFP training of group leaders through authorized local trainers, evaluation and technical assistance for this initiative.

Outcome Evaluation Methods

The Experimental Evaluation Design consisted of a repeated measures, pre- and post-test quasi-experimental 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 3). Instruments were delivered by referral agents in Ballymun SFP as opposed to the site staff. These instruments are designed to assess child and parent mental health, substance abuse risk and resiliencies, family management and cohesiveness, and parent and child social skills and attitudes. The data were recorded by the parents on printed questionnaires. These data on the pre- and post-tests were hand-entered by Jing Xie, M.S. and analyzed using SPSS by Dr. Keely Cofrin Allen of the Utah State Health Department using her computer program to analyzed the standardized scales for 18 outcome variables.

Evaluation Measurement Instruments

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

SFP Outcome Variables	**Measures**
Parent Immediate Change Objectives	
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
Child Change Objectives	
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
Family Change Objectives	
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

**Above table does not include 3 cluster scores as outcome variables*

Explanation for use of Retrospective Pre- and Post-tests. To check for bias on the pre-test due to lack of trust in the confidentiality of the data (found more often in disenfranchised ethnic immigrant youth and families for illegal behaviors such as child and drug abuse), a short retrospective pre-test and post-test (see Appendix) was administered at the post-test. This data collection procedure has been found to be more effective than regular pre-tests when testing for

sensitive topics where the clients can be concerned about pre-test identifiers that might allow courts or someone to identify their answers. Hence, this method was first perfected for school-based studies of drug-abusing adolescents (Rhodes & Jason 1987) and family intervention programs with child abusers (Pratt, Mcguigan, & Katzev, 2000). In this method of data collection, the parents and youth are asked about their baseline (pre-test) behavior on the post-test. This retrospective pre-test method was tested in earlier evaluation studies with Hispanic and Asian immigrants participating in SFP and other parenting programs in the Salt Lake City area and San Francisco area, such as Celebrating Families, for drug abusers and then correlated with the actual pre-test data to determine the degree of potential bias. Also, we collected pre and post data on the same scales from the group leaders and also teachers in one study. We found that the retrospective pre-test more accurately reflected needs and strengths in the parents, family and children as more highly correlated with the independent observations by the four group leaders and the teachers.

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

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

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

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

retrospective pre-and post-test method also conduct a regular pre-test. We can then correlate the outcomes to determine which is more accurate if the group and youth leaders also rate the families as well.

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

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

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

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

III. BALLYMUN, DUBLIN - YEAR FOUR (2011) OUTCOME EVALUATION RESULTS

Baseline Differences from Irish Norms. The families in these two groups that were recruited by Ballymun Dublin had less family and parenting problems, and slightly fewer youth problems at baseline than the Irish norms or average families that have participated in Ireland. Because of the higher rates of protective factors and lower levels of risk factors at the baseline pre-test, the amount of change or effect sizes were harder to get larger than for most groups in Ireland. However, 71% of the outcomes in Ballymun group improved greater than the Ireland norms, which is an excellent result (15 out of 21 outcomes had larger effect sizes than Irish norms).

Summary of 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 (83%).** The outcomes that had not significantly improved included children's Hyperactivity, Social Skills, and Adult Alcohol and Drug Use. Improvements in Social Skills usually can be easily achieved in most agencies, the reason for the insignificant

improvement in the Social Skills of the youth in the Ballymun group is probably because of ceiling effect—participants in Ballymun group have such high scores in this variable at intake or pre-test that, there are less room for improvement to get a statistically significant result. The non-significant result of the Adult Alcohol and Drug Use scale could not likewise be explained by a similar reason—a floor effect—because the parents had higher use rates at intake. Hence, there was more room for the parents to obtain a decrease to achieve a statistically significant outcome in this item. The reasons for the limited reduction in alcohol and drug use in the parents by the end of the program should be explored with the group leaders as they know this group the best. The other youth outcome is typical of the outcomes for SFP in Ireland as we generally do not get statistically significant improvements in hyperactivity as well as criminal behaviors with small sample sizes like the 18 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 they will be removed from the SFP instrument in the future. However, for the Ballymun youth, Criminal Behaviors were statistically significantly reduced.

71% of the effect sizes in this group were larger than found for the Irish norms. The parents in this group had lower risk in the areas of parenting skills and family relations suggesting they had less room for improvement by the end of the SFP classes or group. However, as 71% of the effect sizes (15 out of 21 outcomes) for Ballymun were larger than the Ireland SFP norms even though they had fewer problems at intake, this indicates that the staff and group leaders did a good job on implementing the program to their participants.

In addition, 83% of the effect sizes or amount of change ranged from medium to large SFP norms as can be seen in the tables (15 out of 18 outcomes). 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 Communication (d = .86). The next largest improvement was for Family Organization (d = .84) or a large change.

In summary, 15 of 18 scales of the hypothesized and measured outcome variables where shown to have significant positive changes even with a small sample size of 18 families completing the posttest. If the cluster variables for parents, family and child outcomes are included there were 18 of 21 outcomes significant (86%). The comparison group was the norms for the Irish SFP of about 209 families. It should be pointed out that this large sample is not all of the families that participated in SFP in Ballymun in Dublin Ireland, during 2011, but represents only the data that was completed and sent to LutraGroup by March 2012 for data entry, analysis and report writing (represents 86% of those who graduated).

Family Outcomes Summary. 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 large effect size was .86 for Family Communication, followed by .84 for Family Organization, .73 for Family Strengths and Resilience, .67 for Family Cohesion, and .51 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*. = .51 compared to the Irish Norms of *d*. = .39. Hence, it is clear that getting as large an effect size for reductions in Family Conflict is rare.

Parenting Outcomes Summary. 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 largest effect sizes were d = .79 for Parenting Efficacy improvements.

Youth Outcomes Summary. Five of the seven hypothesized youth outcome variables were found significantly improved by the post-test, namely decreased Overt Aggression, Covert Aggression, Criminality, Depression, and large increases in Concentration.

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 18 families in this 2011 year data analysis. The major reason is the large mean changes and effect sizes. This suggests that even by the immediate 4-month post-test families are making major strides in improving their interaction patterns, which appears to be resulting in smaller but very impressive changes in the children. These behavioral changes in increasing Parental Supervision and reducing risky behaviors in the children, such as overt aggression and improving concentration should according to tested theories of the etiology of adolescent substance abuse (Kumpfer, Alvarado, & Whiteside, 2003, Ary, et al., 1988) result in less substance abuse and delinquency as the youths develop.

Most impressive for this year's implementation is that by the post-test the SPSS data analysis suggests reductions in Family Conflict, which decreased significantly ($p < .00$) with a large effect size of d = .51. This amount of change was 31% larger than the Irish norms of .39, which is usually very hard to attain.

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

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

Protective Factor	Sig. Level (p=)	2011 Effect Size (*d*) vs Irish Norms
1. Family Organization	.00	.84 (large) vs. .79
2. Family Cohesion	.00	.67 (large) vs. .63
3. Family Communication	.00	.86 (large) vs. .77
4. Family Conflict	.00	.51 (large) vs. .39
5. Family Resilience	.00	.73 (large) vs. .76
6. Positive Parenting	.00	.71 (large) vs. .66
7. Parental Involvement	.00	.68 (large) vs. .63
8. Parenting Skills	.00	.69 (large) vs. .63
9. Parental Supervision	.00	.77 (large) vs. .72
10. Parenting Efficacy	.00	.79 (large) vs. .69
11. Overt Aggression.	.00	.46 (medium) vs. .52
12. Covert Aggression	.01	.36 (medium) vs. .41
13. Concentration	.00	.65 (large) vs. .59
14. Criminal Behavior	.03	.20 (medium) vs. .10
15. Hyperactivity	.15	.12 (small) vs. .05
16. Social Behavior	.41	.04 (small) vs. .31
17. Depression	.00	.47 (medium) vs. .47
18. Alcohol and Drug Use	.26	.08 (small) vs. .15

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 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 Ballymun, Dublin, Ireland reported fewer problems in almost all of the measured family relations than their other Irish counterparts participating in SFP groups at the pretest but higher levels of Family Conflict. From these intake scores, we could assume that these families had more protective factors in the area of family relations compared to other Irish sites or that they have a higher positive response bias except for being more honest about their higher levels of family conflict. 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=)	2011-12 Effect Size (d') vs Irish Norms
1. Family Organization	.00	.84 (large) vs. .79
2. Family Cohesion	.00	.67 (large) vs. .63
3. Family Communication	.00	.86 (large) vs. .77
4. Family Conflict	.00	.51 (large) vs. .39
5. Family Resilience	.00	.73 (large) vs. .76

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 Communication (mean change 1.45 and effect size d = .86). Family Organization (mean change 1.78 and effect size d = .84) was the next largest improvement followed by Family Strengths and Resilience (mean change 1.06 and effect size d = .73). The next largest effect size was for improvements in the Family Cohesion (Effect Size d = .67). The smallest positive change was for Family Conflict (d = .51), which was also a large effect size and larger than generally found in SFP in Ireland or in other countries. This large effect size in reductions in Family Conflict could also be enhanced by the fact they reported higher levels of Family Conflict on the pre-test. However, they are also reporting more improvements because of hopefully an effective implementation. Changes in family conflict generally take more time to change as family communication patterns improve. Hence, such a large d value is rare by the immediate post-test. 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 Irish national 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, and strength, and a slightly higher family conflict and lower family organization.

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

Scale Name	Sample	Pre-Test	SD	Post-Test	SD	Change	F	sig	Effect Size d	ES d'
Family Cohesion							0.38	0.54	0.00	0.08
Irish SFP Norms	209	3.18	1.03	4.28	0.65	1.10	359.67	0.00	0.63	2.63
Ballymun	18	3.25	0.81	4.22	0.43	0.97	35.12	0.00	0.67	2.87

Family Communication							0.21	0.65	0.00	0.06
Irish SFP Norms	209	2.80	0.76	4.17	0.52	1.37	691.82	0.00	0.77	3.65
Ballymun	18	2.82	0.67	4.28	0.40	1.45	104.11	0.00	0.86	4.95
Family Conflict							0.04	0.85	0.00	0.03
Irish SFP Norms	209	3.17	1.11	2.41	0.85	0.76	130.59	0.00	0.39	1.58
Ballymun	18	3.50	0.79	2.69	0.68	0.81	17.35	0.00	0.51	2.02
Family Organization							1.06	0.30	0.00	0.14
Irish SFP Norms	208	2.24	0.84	3.81	0.70	1.57	767.07	0.00	0.79	3.85
Ballymun	18	2.22	0.84	4.00	0.41	1.78	90.08	0.00	0.84	4.60
Family Strengths/Resilience							0.80	0.37	0.00	0.12
Irish SFP Norms	204	2.88	0.76	4.09	0.56	1.20	645.84	0.00	0.76	3.57
Ballymun	18	3.03	0.76	4.09	0.58	1.06	46.06	0.00	0.73	3.29
Family Cluster Scale							0.03	0.86	0.00	0.02
Irish SFP Norms	203	2.78	0.67	4.01	0.48	1.23	758.51	0.00	0.79	3.88
Ballymun	18	2.81	0.59	4.01	0.39	1.20	90.18	0.00	0.84	4.61

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 18 parents, and at the same time, 100% or all five of the outcomes had large effect sizes over d = .65. These families reported being higher in three of the parent variables than other families in Ireland 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 parent norms for Ireland. However, the Ballymun improvements in outcomes for parenting variables had all five of the variables which were statistically significantly better for the parenting outcomes than the Irish norms.

Table 6: Changes in Parenting Risk and Protective Factors

Protective Factor	Sig. Level (p=)	2011-12 Effect Size (d') vs Irish Norms
1. Positive Parenting	.00	.71 (large) vs. .66

2. Parental Involvement	.00	.68 (large) vs. .63
3. Parenting Skills	.00	.69 (large) vs. .63
4. Parental Supervision	.00	.77 (large) vs. .72
5. Parenting Efficacy	.00	.79 (large) vs. .69

The area of Parenting Efficacy (Effect Size *d* = .79) had the largest amount of positive change for SFP, and 14% larger than the national norm with *d*. = .69. Next largest changes were reported in Parental Supervision with Effect Size *d*. = .77. The improvements in positive parenting also got a large effect size with *d*. = .71, followed by large improvements in Parenting Skills, and Parental Involvement with effect size of *d*. = .69 and .68 separately.

Overall, these are amazing increases in parent child management skills with Cohen d effect sizes ranging from .68 for parental involvement to .79 for parenting efficacy. 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 '11 Changes in Parenting Risk and Protective Factors Compared to the Irish Norms

Scale Name	Sample	Pre-Test	SD	Post-Test	SD	Change	F	sig	Effect Size d	ES d'
Parental Involvement							1.41	0.24	0.01	0.16
Irish SFP Norms	205	3.09	0.94	4.20	0.64	1.10	354.74	0.00	0.63	2.64
Ballymun	18	3.57	0.75	4.43	0.44	0.86	35.44	0.00	0.68	2.89
Parental Supervision							2.86	0.09	0.01	0.23
Irish SFP Norms	208	2.78	0.83	4.12	0.59	1.35	527.66	0.00	0.72	3.19
Ballymun	18	2.53	0.87	4.23	0.59	1.70	55.48	0.00	0.77	3.61
Parenting Efficacy							0.21	0.65	0.00	0.06
Irish SFP Norms	207	2.78	0.96	4.04	0.71	1.26	453.56	0.00	0.69	2.97
Ballymun	18	2.74	0.78	4.09	0.55	1.35	63.75	0.00	0.79	3.87

Positive Parenting							0.48	0.49	0.00	0.09
Irish SFP Norms	208	3.38	0.97	4.49	0.55	1.12	397.80	0.00	0.66	2.77
Ballymun	18	3.54	0.77	4.52	0.51	0.98	40.85	0.00	0.71	3.10
SFP Parenting Skills							0.39	0.53	0.00	0.08
Irish SFP Norms	205	3.11	0.74	3.92	0.65	0.82	347.60	0.00	0.63	2.61
Ballymun	18	3.30	0.72	4.02	0.54	0.72	37.55	0.00	0.69	2.97
Parent Cluster Scale							0.01	0.90	0.00	0.02
Irish SFP Norms	198	3.02	0.69	4.13	0.46	1.11	600.44	0.00	0.75	3.49
Ballymun	18	3.11	0.53	4.24	0.38	1.13	85.99	0.00	0.83	4.50

Parent Substance Abuse

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

In this case of this Ballymun groups for this year, the mean change was m = .10 which is slightly lower than m = .16 of Irish norms. This improvement was not statistically significant (*p*. = .26) for their decreased use, and the effect size of *d*. = .08 is a small effect size as shown in the table below. The pretest score was at m. = 1.71 which was slightly higher than the Irish norms' low baseline of m. = 1.66, suggesting this group has slightly higher risk than the national norms.

Table 8: Changes in Parent Risk and Protective Factors

Alcohol & Drug Use							0.37	0.54	0.00	0.08
Irish SFP Norms	204	1.66	0.65	1.51	0.51	0.16	35.60	0.00	0.15	0.84
Ballymun	17	1.71	0.75	1.61	0.67	0.10	1.34	0.26	0.08	0.58

Positive Youth Behavior Changes

Five of the youth outcomes were statistically significant. The positive changes in the youth ranged from small to large effect size improvements. The average youth mental and behavioral variables or the Child Cluster Variable had statistically significantly improved after the program with also a large effect size of *d*. = .69, with significant level of *p*. = .00. The most improved child variables are increased Concentration with a large effect size of *d*. = .65,

followed with decreased Depression with a medium effect size *d* of .47, Overt Aggression with *d*. = .46, Covert Aggression with *d*. = .36 or medium decrease.

The other three variables achieved small improvements, namely Criminal Behavior, Social Skills, and Hyperactivity with *d*. = .20, *d*. = .12, and *d*. = .04 separately, which were not statistically significant improvements.

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 youths who had participated in SFP 10-14 ten years earlier (Trudeau & Spoth, 2005; Spoth & Trudeau, 2005). This possibly makes SFP the most effective mental health initiative that any state could implement and suggests that SFP results are not specific to just major reductions in tobacco, alcohol and drug abuse, but also in mental health and juvenile delinquency services costs.

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

Protective Factor	Sig. Level (p=)	2011-12 Effect Size (d') vs Irish Norms
1. Overt Aggression.	.00	.46 (medium) vs. .52
2. Covert Aggression	.01	.36 (medium) vs. .41
3. Concentration Problems	.00	.65 (large) vs. .59
4. Criminal Behavior	.03	.20 (medium) vs. .10
5. Hyperactivity	.15	.12 (small) vs. .05
6. Social Behavior	.41	.04 (small) vs. .31
7. Depression	.00	.47 (medium) vs. .47

Overall, looking at the intake or base rates in the youth's problems at entry into SFP, the adolescents in Ballymun had fewer problems as reported by their parents except for Hyperactivity at intake than the Irish norms. Five of these youth outcomes were significantly improved with medium and large effect sizes. Some these positive outcomes had larger effect sizes than the Irish norms—namely concentration, criminal behavior, and hyperactivity, despite parents reporting fewer problems in the youth as program intake.

Improved Concentration or Reduced Attention Deficit. The effect size for reductions in attention deficit or problems in concentration in the child was d = .65. This is a 10% larger effect size than the Irish norms (*d*. = .59). This is a statistically significant improvement (*p*. < .00) with a large effect size. At intake, the youth in Ballymun were higher in their level of Concentration (m = 3.05, compared to m = 2.72 for the national 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 assignation) than boys. The Cohen's d effect size for this variable was medium with d = .36, smaller than the effect size of the Irish norms of d = .41. The pretest score was m = 2.31 compared to a higher risk for the Irish norms of m = 2.48. Hence, with this lower baseline of Covert Aggression in the youth, it would have been harder to get a statistically significant improvement. Hence, getting one 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 is medium with d = .46 compared to d. = .52 for the Irish norm. The statistically significant value was as low as p. = .00. A lower intake of m. = 2.35 compared to m. = 2.57 for the national norms, suggested the youth were rated lower at risk by their parents' report than their Irish counter parts. For these low risk families, getting statistically and practically significant outcome indicated this group benefited from the program, and group leaders did a wonderful job in implementing the program.

Criminal Behavior. Antisocial criminal behavior was reported by parents to be significantly improved (p. < .03), despite a floor effect. The youth in this sample had much lower values of reported criminal behavior at the intake or the pretest (m. = 1.17 compared to m. = 1.30 for Irish Norm), and decreased to noncriminal risk at the posttest (m. = 1.03 compared to m. = 1.15 for Irish Norm). The effect size for the improvement of this item is larger than the Irish norm with d. = .20 compared to d. = .10.

Hyperactivity. This variable increased insignificantly with p < .15. This can be understood, 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. = 3.15, and posttest score of m. = 3.38 were not larger scores which suggests a medium risk in this area.

Social Skills and Competencies. There were positive changes in the youth's Social Skills and Competencies. However, this improvement was despite parents reporting much higher levels of social skills in the youth at baseline or pre-test. They reported a mean of 4.22 compared to a mean of 3.84 for the national norms. There is less room to improve, as the intake is very high which leaves less room to get an improvement to gain a large change. Thus, the effect size for Social Skills was considerably lower than the national norms with d. = .04 compared to d. = .31. SFP includes a 14-session children social skills curriculum based on the best evidence based social skills models, such as Shure and Spivack's *I Can Problem Solve (ICPS)* program. It includes sessions on problem solving, decision making, communication skills, coping with anger and depression, and even dating relationships in the teenager version of SFP 12 – 16 Years.

Children's Depression. The youth's depression was the other statistically significant improved variable with medium effect size of d = .47 which was same as d = .47 for the Irish norms. One possible reason was that the youth in this teenage sample were less depressed at intake than is generally found in Irish group (m=2.40 vs. m=2.68).

Table 10: FY'11 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							0.15	0.70	0.00	0.05
Irish SFP Norms	201	2.72	0.79	3.40	0.74	0.67	288.34	0.00	0.59	2.40
Ballymun	17	3.05	0.82	3.78	0.51	0.73	29.22	0.00	0.65	2.70
Covert Aggression							1.28	0.26	0.01	0.15
Irish SFP Norms	203	2.48	0.78	1.93	0.54	0.55	142.96	0.00	0.41	1.68
Ballymun	18	2.31	0.78	1.94	0.59	0.37	9.62	0.01	0.36	1.50
Criminal Behavior							0.01	0.94	0.00	0.01
Irish SFP Norms	204	1.30	0.61	1.15	0.42	0.15	23.21	0.00	0.10	0.68
Ballymun	18	1.17	0.34	1.03	0.12	0.14	4.21	0.03	0.20	1.00
Depression							1.90	0.17	0.01	0.19
Irish SFP Norms	204	2.68	0.88	2.01	0.62	0.67	177.31	0.00	0.47	1.87
Ballymun	18	2.40	0.77	1.97	0.55	0.43	15.23	0.00	0.47	1.89

Hyperactivity							0.01	0.93	0.00	0.01
Irish SFP Norms	201	2.87	0.83	3.01	0.79	0.14	10.84	0.00	0.05	0.47
Ballymun	18	3.15	1.00	3.28	1.00	0.13	2.28	0.15	0.12	0.73
Overt Aggression							2.91	0.09	0.01	0.23
Irish SFP Norms	201	2.57	0.80	1.87	0.51	0.69	217.36	0.00	0.52	2.08
Ballymun	18	2.35	0.79	1.93	0.74	0.42	14.60	0.00	0.46	1.85
Social Behavior							3.66	0.06	0.02	0.26
Irish SFP Norms	201	3.84	0.73	4.13	0.62	0.29	91.93	0.00	0.31	1.36
Ballymun	18	4.22	0.69	4.31	0.61	0.09	0.72	0.41	0.04	0.41
Child Cluster Scale							1.64	0.20	0.01	0.18
Irish SFP Norms	187	3.36	0.52	3.86	0.40	0.51	280.90	0.00	0.60	2.46
Ballymun	17	3.65	0.44	4.03	0.36	0.38	36.33	0.00	0.69	3.01

Summary of Overall Results and Family Changes

In summary, 15 of 18 scales of the hypothesized and measured outcome variables where shown to have significant positive changes even with a small sample size of 18 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 Irish SFP of about 209 families. The three outcomes that didn't improve significantly were the variables of Hyperactivity, Social Skills, and Adult Alcohol and Drug Use. Recently an internal consistency analysis revealed that the scales of Hyperactivity and Criminality had low Chronbach's alphas so they are not reliable 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 in Ireland in 2011, but represents only the data that was completed and sent to LutraGroup for data entry, analysis and report writing. These results are therefore based on 18 families, corresponding to 86% of families who graduated in 2011.

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 Communication, .84 for Family Organization, .73 for Family Strength and Resilience, .67 for Family Cohesion, and .51 for Family Conflict. The reported Family Conflict got a large effect size, and changes in this area were 31% larger than the Irish SFP norms, and also larger than the results for the USA national SFP database and the NIDA SFP cross-site study in Washington, D.C. Hence, it appears that the Ballymun Ireland SFP programs are having a dramatic impact on the overall family environment equivalent to that found normally in other SFP sites in the USA. This is a very positive effect and a tribute to the Site Coordinator and the Group Leaders.

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 = .79 for Parenting Efficacy. This result was 14% larger in effect size compared to the Irish norms.

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

Taken as a whole, the findings show 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 post-test are wonderful and should later result in greater improvements in the children.

In addition, in terms of effect sizes, 83% (15 out of 18) or 86% (18 out of 21- *when cluster variables are included*) are medium to large suggesting that staff implementing in Ballymun, Dublin, Ireland, SFP group are more capable in implementing SFP effectively with low risk families than were the agencies in Washington, D.C. area participating in the NIDA research grant even under Dr. Kumpfer's part time supervision while she was the CSAP Director in Washington, D.C.. Following the analysis of additional cycles and tests, extended findings of the outcome evaluation will be available. We will then be able to test moderator variables such as gender, ethnicity, attendance, and level of risk at baseline.

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

Table 11: 2011 Group Outcomes Compared to SFP Irish National Norms

Scale Name	Sample	Pre-Test	SD	Post-Test	SD	Change	F	sig	Effect Size d	ES d'
Parental Involvement							1.41	0.24	0.01	0.16
Irish SFP Norms	205	3.09	0.94	4.20	0.64	1.10	354.74	0.00	0.63	2.64
Ballymun	18	3.57	0.75	4.43	0.44	0.86	35.44	0.00	0.68	2.89

Parental Supervision							2.86	0.09	0.01	0.23
Irish SFP Norms	208	2.78	0.83	4.12	0.59	1.35	527.66	0.00	0.72	3.19
Ballymun	18	2.53	0.87	4.23	0.59	1.70	55.48	0.00	0.77	3.61
Parenting Efficacy							0.21	0.65	0.00	0.06
Irish SFP Norms	207	2.78	0.96	4.04	0.71	1.26	453.56	0.00	0.69	2.97
Ballymun	18	2.74	0.78	4.09	0.55	1.35	63.75	0.00	0.79	3.87
Positive Parenting							0.48	0.49	0.00	0.09
Irish SFP Norms	208	3.38	0.97	4.49	0.55	1.12	397.80	0.00	0.66	2.77
Ballymun	18	3.54	0.77	4.52	0.51	0.98	40.85	0.00	0.71	3.10
SFP Parenting Skills							0.39	0.53	0.00	0.08
Irish SFP Norms	205	3.11	0.74	3.92	0.65	0.82	347.60	0.00	0.63	2.61
Ballymun	18	3.30	0.72	4.02	0.54	0.72	37.55	0.00	0.69	2.97
Parent Cluster Scale							0.01	0.90	0.00	0.02
Irish SFP Norms	198	3.02	0.69	4.13	0.46	1.11	600.44	0.00	0.75	3.49
Ballymun	18	3.11	0.53	4.24	0.38	1.13	85.99	0.00	0.83	4.50
Family Cohesion							0.38	0.54	0.00	0.08
Irish SFP Norms	209	3.18	1.03	4.28	0.65	1.10	359.67	0.00	0.63	2.63
Ballymun	18	3.25	0.81	4.22	0.43	0.97	35.12	0.00	0.67	2.87
Family Communication							0.21	0.65	0.00	0.06
Irish SFP Norms	209	2.80	0.76	4.17	0.52	1.37	691.82	0.00	0.77	3.65
Ballymun	18	2.82	0.67	4.28	0.40	1.45	104.11	0.00	0.86	4.95
Family Conflict							0.04	0.85	0.00	0.03
Irish SFP Norms	209	3.17	1.11	2.41	0.85	0.76	130.59	0.00	0.39	1.58
Ballymun	18	3.50	0.79	2.69	0.68	0.81	17.35	0.00	0.51	2.02
Family Organization							1.06	0.30	0.00	0.14
Irish SFP Norms	208	2.24	0.84	3.81	0.70	1.57	767.07	0.00	0.79	3.85
Ballymun	18	2.22	0.84	4.00	0.41	1.78	90.08	0.00	0.84	4.60

Family Strengths/Resilience							0.80	0.37	0.00	0.12
Irish SFP Norms	204	2.88	0.76	4.09	0.56	1.20	645.84	0.00	0.76	3.57
Ballymun	18	3.03	0.76	4.09	0.58	1.06	46.06	0.00	0.73	3.29
Family Cluster Scale							0.03	0.86	0.00	0.02
Irish SFP Norms	203	2.78	0.67	4.01	0.48	1.23	758.51	0.00	0.79	3.88
Ballymun	18	2.81	0.59	4.01	0.39	1.20	90.18	0.00	0.84	4.61
Concentration							0.15	0.70	0.00	0.05
Irish SFP Norms	201	2.72	0.79	3.40	0.74	0.67	288.34	0.00	0.59	2.40
Ballymun	17	3.05	0.82	3.78	0.51	0.73	29.22	0.00	0.65	2.70
Covert Aggression							1.28	0.26	0.01	0.15
Irish SFP Norms	203	2.48	0.78	1.93	0.54	0.55	142.96	0.00	0.41	1.68
Ballymun	18	2.31	0.78	1.94	0.59	0.37	9.62	0.01	0.36	1.50
Criminal Behavior							0.01	0.94	0.00	0.01
Irish SFP Norms	204	1.30	0.61	1.15	0.42	0.15	23.21	0.00	0.10	0.68
Ballymun	18	1.17	0.34	1.03	0.12	0.14	4.21	0.03	0.20	1.00
Depression							1.90	0.17	0.01	0.19
Irish SFP Norms	204	2.68	0.88	2.01	0.62	0.67	177.31	0.00	0.47	1.87
Ballymun	18	2.40	0.77	1.97	0.55	0.43	15.23	0.00	0.47	1.89
Hyperactivity							0.01	0.93	0.00	0.01
Irish SFP Norms	201	2.87	0.83	3.01	0.79	0.14	10.84	0.00	0.05	0.47
Ballymun	18	3.15	1.00	3.28	1.00	0.13	2.28	0.15	0.12	0.73
Overt Aggression							2.91	0.09	0.01	0.23
Irish SFP Norms	201	2.57	0.80	1.87	0.51	0.69	217.36	0.00	0.52	2.08
Ballymun	18	2.35	0.79	1.93	0.74	0.42	14.60	0.00	0.46	1.85

Social Behavior							3.66	0.06	0.02	0.26
Irish SFP Norms	201	3.84	0.73	4.13	0.62	0.29	91.93	0.00	0.31	1.36
Ballymun	18	4.22	0.69	4.31	0.61	0.09	0.72	0.41	0.04	0.41
Child Cluster Scale							1.64	0.20	0.01	0.18
Irish SFP Norms	187	3.36	0.52	3.86	0.40	0.51	280.90	0.00	0.60	2.46
Ballymun	17	3.65	0.44	4.03	0.36	0.38	36.33	0.00	0.69	3.01
Alcohol & Drug Use							0.37	0.54	0.00	0.08
Irish SFP Norms	204	1.66	0.65	1.51	0.51	0.16	35.60	0.00	0.15	0.84
Ballymun	17	1.71	0.75	1.61	0.67	0.10	1.34	0.26	0.08	0.58

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 as 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 SFP 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.

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. Between the 2 programs, 26 families started the program and 21 families completed the family intervention and graduated, thereby having a completion rate of 81%. Of the 21 graduate families, 19 families completed the questionnaires. The data in this report is based on information from 18 families, this corresponds to 86% of families who graduated in 2011.

The outcome results are encouraging suggesting significant improvements in 100% or all five parenting outcomes, 100% or five of five family outcomes and 65% 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, 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 Irish norms in the Ballymun, Dublin teens, there was less 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 in Year 05 (2012).

- *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*. This year the Ballymun groups had a very high recruitment and retention rate. So we recommend they continue with their good recruitment and retention efforts. As a generally rule, more families should be recruited from Dublin communities with a target achieving retention of 80% of families in cycles in Year 05. 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 excellent for Ballymun families. We are wondering why the parents reported fewer problems in the youth, parenting and family relations except for higher levels of Family Conflict.

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

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APPENDIX 1

Strengthening Families Program Fidelity Benchmarks

FIDELITY BENCHMARKS: SFP Recommended Best Practices and Program Standards

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

Funding

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

Target Population

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

Staffing

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

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

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

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

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

Sites and Logistics

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

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

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

Curriculum Fidelity

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

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

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

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

Recruitment and Retention

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

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

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

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

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

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

Evaluation Methodology

A combined process evaluation and outcome evaluation is recommended. Standardized assessment instruments have been developed and are available for measurement of program effectiveness and fidelity. Additionally site visits and video taping are recommended to confirm findings and make observations. The recommended outcome instrument is the SFP Parent Retrospective Pre/Posttest to be administered during the 13^{th} or 14^{th} 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!*™ 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 <u>you?</u> (0 if child never lived with you)

13. _____ Where are you living now?
    1=home or apartment **2**=rented home or apartment **3**=group home
    4=residential treatment center **5**=prison or jail **6**=Other: specify:_____

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

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

15. _____(hours/week) How many hours per week do you work in paid employment?

16. _____ (thousand/yr.) What is the family's total yearly income from all sources?

17. _____ (# kids) How many children do you have?

18._____ Where were your children living prior to your participation in class? (circle all that apply)
1=with you **2**=with a relative **3**=foster home **4**=other (specify) _____

19. _____Where are your children living now?
1=with you **2**=with a relative **3** =foster home **4**=other (specify) _____

20. ____In the last six months, have you had an open DYFS (Division of Youth and Family Services) case or do you have an open case at this time? 1= No 2 = Yes

Client Satisfaction (Kumpfer, 2002)

1. _____ (Hours/Week) Prior to beginning SFP, how many hours of service per week did you or your family receive from this agency?

2._____ Who told you about this class?
1= friend , 2= program staff, 3= case manager, 4= counselor, 5= court staff, 6= read about it, 7= other: (specify:_____

3. _____ How well did you know any of the program staff prior to signing up for this program?
1= Not at all 2 Very little 3= Somewhat 4 = Well 5= Very Well

4. _____ How many sessions did you attend of this program?

5. _____ How many sessions did this child attend?

6._____How satisfied were you with this program?
1= Not at all 2 Very little 3= Somewhat 4 = Well 5= Very Well

7. _____ Would you like to come back for refresher classes or family reunions?
1= Yes, weekly 2= once a month 3= every six months 4 =once a year 5=Never

8. _____ Would you recommend this course to other families?
1= Yes, definitely 2= Yes, 3= Maybe 4= No

9. _____ How much has this class helped your family?
1= Not at all 2 Very little 3= Somewhat 4 = A lot

10. ____ Overall how would you rate your satisfaction with your group leaders?

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

PARENTING SCALE (Kumpfer, 1989)

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

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

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

OVERALL FAMILY STRENGTHS/RESILIENCE (Kumpfer, 1997)

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

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

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

DRUG & ALCOHOL USE (CSAP GRPA)

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

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

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

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

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

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

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

About You (CES-D, Radloff, 1977)

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

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

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

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

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