

An Independent Evaluation of
The Strengthening Families Programme
in The WRDTF Region

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Produced by Orla Irwin (WRDTF Co-ordinator) in consultation with the cathaoirleach and members of the Western Region Drugs Task Force

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in The WRDTF Region**

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Report structure

This report provides a general introduction, short literature review, the study aims and objectives which provide the context to the research report. This is followed by a description of the methodology used. The findings are presented structured around the evaluation research objectives, followed by a discussion of these results and, finally, conclusions are drawn and recommendations made.

Definitions:

Programme authors: Dr Karol L. Kumpfer and associates, University of Utah, USA

Programme providers: Western Region Drugs Task Force

SFP: Strengthening Families Programme

NDS: National Drugs Strategy

WRDTF: Western Region Drugs Task Force

Facilitators: Group leaders who delivered the SFP

Strengthening Family Programme Funders:

- Western Region Drugs Task Force
- Le Chéile
- Social and Family Affairs
- Galway County VEC
- Galway City VEC Youth Service
- Connemara North & West School Completion Programme
- Foroige
- Forum Connemara Ltd
- Clada Group

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Contents

Introduction	5
Family Support and Substance Use Prevention	6
Family and Community Support and Interventions	8
Evaluation of Family Support Interventions	9
The Strengthening Families Programme	10
SFP in Action	10
Aims and Objectives	12
Evaluation Constraints	12
Methodology	13
Process evaluation	14
Impact evaluation	15
Findings	17
To determine if the programme has been implemented as planned and what, if any, are the deviations from the plan? What are the reasons for these?	18
What are the perspectives of participating adolescents and parents on programme content and delivery?	20
Is the mealtime an important element of the programme for both parents and adolescents?	21
Is the training adequate for the facilitators to deliver the programme overall and in this setting?	21
What alterations to the process and programme are necessary to ensure successful outcomes in future delivery?	22
Has the programme had an impact on the individual participants and if so what is the impact?	23
Does the programme reduce drug and alcohol use by the participants?	25
Discussion	27
Referral processes	28
Deviations from plan	29
Expectations of programme success	29
Conclusion and Recommendations	31
References	35

The background of the page is a solid light green color. Overlaid on this background are several large, stylized leaf shapes in a slightly darker shade of green. The leaves are arranged in a way that they appear to be part of a larger plant, with some leaves pointing upwards and others downwards. The overall aesthetic is clean and modern.

Introduction

5

Introduction

The National Drugs Strategy (NDS), 2009-16 (Department of Community, Rural and Gaeltacht Affairs, 2009), developing from the previous National Strategy, identifies its overall strategic objective as, 'to continue to tackle the harm caused to individuals and society by the misuse of drugs through a concerted focus on the five pillars of supply reduction, prevention, treatment, rehabilitation and research' (p6). Action 29 under the prevention pillar is to

develop a series of prevention measures that focus on the family to include:

- supports for families experiencing difficulties due to drug/alcohol use
- parenting skills
- targeted measures focusing on the children of problem drug and/or alcohol users aimed at breaking the cycle and safeguarding the next generation

(The National Drugs Strategy, 2009-16, p100)

This National Strategy provides the context for a co-ordinated approach to drugs prevention explicitly acknowledging the centrality, through action 29, of family to such endeavours. Also referenced in the Strategy are the importance of inter-agency co-ordination and an identified need for an evidence-based approach, highlighting the role of evaluation. At a regional level, the stated aims of the Western Region Drugs Task Force (WRDTF) reflect the National Strategy with reference to the need 'to propose a range of solutions and service interventions' in line with the Strategy and to ensure that these 'responses are monitored and evaluated' (Walsh & Comer, 2006).

In 2009, the WRDTF was funded by the Department of Community, Rural and Gaeltacht Affairs to deliver a regional, family support programme. The Task Force chose to deliver the Strengthening Families Programme (SFP) and evaluate its implementation within 5 pilot sites throughout the region.

Family support and substance use prevention

In the context of the family, the relationship between parent and adolescents can serve as a protective factor to drug misuse by providing a secure base for the adolescent (Piko & Kovacs, 2010; Hair, Moore, Garrett, Ling & Cleveland, 2008). The impact of this influence can exist into, and through late adolescence (Wood, Read, Mitchell & Brand, 2004). Parental monitoring reduces opportunity for involvement in risky situations and association with undesirable peers (Piko & Kovacs, 2010; Li, Staunton, & Feigelman, 2000). Strong family bonds have been shown to protect against substance use as has inter-family communication. Explicit disapproval by parents of smoking has been shown to act as a deterrent to children smoking (Sargent & Dalton, 2001) whereas low levels of parental supervision and monitoring is a strong predictor of smoking in young females and higher levels of drinking and delinquent behaviour in young males (Griffin, Botvin, Scheier, Diaz & Millar, 2000; Jackson et al, 1999 in Petrie, Bunn, & Byrne, 2007).

Interestingly, van der Vorst, Engels, Dekovic, Meeus, & Vermulst, (2007) argue that the relationship between the problem behaviour of an adolescent and the parenting they receive is actually bi-directional, with the adolescent influencing the behaviour of the parent(s) as well as the parent(s) influencing the behaviour of the teen

with respect to alcohol, parental strict control prevents early adolescents' drinking, but early adolescents' drinking also leads to a decline in the degree to which parents provide strict control. In other words, parents are responding to their children's alcohol involvement by loosening their control (van der Vorst et al, 2007, p2).

Montoya, Atkinson and McFaden, (2003) argue that the most effective programme depends on the risk factors to which particular adolescents are exposed. Thus, if the primary risk factor is a chaotic or poorly-functioning home life

then the appropriate programme will have a family-based focus; if the adolescent is exposed to negative social influences such as a high crime environment then an effective programme will be predominately community-based while peer-based factors will be best addressed in a programme that is predominantly school-based. They go on to suggest that

if the goal of program designers is to implement all key features into one prevention regime, a combination of at least two types of prevention programs would be necessary. For instance, a prevention regime that combines school and family-based programs could include all features: parents, skills training, normative education, peers, media (in the form of leaflets or website advertising, most likely) and a plan to retain participants. On the other hand, a SBP [school based programme] or CBP [community based programme] operating alone may not include parents or address peer influences (Montoya, Atkinson and McFaden, 2003, p82).

The role of the family in the development or prevention of delinquent behaviours in adolescents and children has come under ever-increasing scrutiny. Indeed Moran et al, (2004) commented that

you could be forgiven for thinking that there were few headlining social problems – from anti-social behaviour on our streets to childhood obesity and falling standards in schools – for which ‘better parenting’ was not the solution (Moran, et al, 2004, in Shulruf, 2008).

Family support and community initiatives may be of significant relevance to services involved in substance use, and interventions that have targeted family support rather than specific substance use behaviours have resulted in positive outcomes, including a reduction in substance misuse (Zigler, Taussig & Black, 1992). As discussed above, lack of parental support and supervision may lead to weak family attachment and increased likelihood of interaction with substance-abusing peers and conversely, enhancing parental ability to support and supervise their children may decrease the children’s vulnerability to substance use (Morgan, 2001). Increased vulnerability to substance use can be related to both specific risk factors such as exposure of children to drugs, negative role models with regard to drug use and parental attitudes to drugs and drugs availability. Other, non-specific risk factors include

- dysfunctional families and conflict
- parental relationship conflict
- poor parenting
- exposure of children to stress
- family psychological illness; and neglect and abuse (Kumpfer, 1998 in Watters & Byrne, 2004).

Family-based drug prevention emphasises family strengths and works to enhance the family protective factors used to address the problem of drugs (Watters & Byrne, 2004). Nic Gabhainn & Walsh (2000) identified that the support systems required by people are as diverse as their individual needs. They also stressed the importance of the family and community in the context of multimodal strategies for drug prevention. The National Drugs Strategy (2001) placed an emphasis on family and community contexts of drug use prevention, and research by the National Advisory Committee on Drugs (NACD) highlights that family process is more important than family structure as a risk factor for the development of substance use

... the fact of living in a single parent family or a reconstituted family is less significant than the family process e.g. conflict between parents, absence of affection or parental supervision. In other words, variables like parental warmth, affection and consistency in supervision which are known to be important parameters of effective parenting are also major influences in the development of substance misuse (Morgan, 2001, p56).

In a review of alcohol prevention programmes, Velleman (2009) poses the question as to why programmes which use inputs which are predicated to strengthening family processes and structures and positively impact young people's values, self esteem, relationships and behaviour as well as preventing substance use, position themselves as substance use prevention programmes. Velleman (2009) goes onto answer his question

in some ways the fact that these programmes are often funded within the US by the National Institute of Alcoholism and Alcohol Use (NIDA) is an oddity, explicable by the funding: if funding existed to develop more general prevention programmes, they might equally have been funded by these funding streams (Velleman, 2009, p14).

Family and Community Support and Interventions

Family support has been described as

a perspective on child welfare, a method of service provision, an 'ethos' guiding the delivery of services, the services themselves (or) a movement (Chaskin, 2006, p42).

The family support approach to the provision of care and welfare to children and families has become an increasingly important paradigm in recent decades (Canavan & O'Brien, 2005). Pinkerton, Dolan & Canavan (2004) define family support as

both a style of work and a set of activities; which reinforce positive informal social networks through integrated programmes; combining statutory, voluntary community and private services, primarily focused on early intervention across a range of levels and needs with the aim of promoting and protecting the health, wellbeing and rights of all children and young people in their own homes and communities, with particular attention to those who are vulnerable or at risk (in Canavan & O'Brien, 2005, p21).

Family support encompasses both formal and informal support. Generally, people may turn first to informal sources of support (Dolan & McGrath, 2006) and although family members often provide the most dependable and durable sources of support (Nic Gabhainn, 2000) such support can also be delivered through friends and neighbours.

Formal support can be provided by a range of people including teachers, youth workers or mental health professionals (Dolan & McGrath, 2006). Dolan and Holt (2002) cite a growing debate that family support should seek not to replace natural support systems but to enhance them with formal sources of support (Dolan & Holt, 2002). Informal support can be complemented and supplemented by formal support (Pinkerton & Dolan, 2007). Dolan and Holt, (2002) argue that family support has only been officially recognised at a national policy level in Ireland in the last number of decades.

In a review of parenting education and support policies in selected OECD countries, Shulruf, O'Loughlin, & Tolley, (2009) distinguished Irish government policy as one that

emphasises that a primary goal of its policies and services is to promote continuity and stability in family life and to prevent family breakdown; it views family strength a fundamental factor underpinning the health and well-being of children and parents (Shulruf, O'Loughlin, & Tolley, 2009, p528).

Family support is most effective when it is delivered locally, is accessible and a wide range of organisations can be involved in its provision (Brady, Merriman & Canavan, 2008). McGrath, (2003) considered the theoretical and practical

commonalities between family support and community development and identified that family and support services are inextricably associated with the community contexts in which they exist (Brady, Merriman & Canavan, 2008). Family support encompasses a diverse range of interventions but Keenan (1998) posits that

fundamental to the concept of family support services is the conviction that families – however difficult or apparently intransigent their problems – contain within them resources and strengths that, if harnessed and nurtured, can produce beneficial outcomes (in McKeown, 2000, p13).

Evaluation of family support interventions

Bruner (2006) calls for practitioners of family support to carefully consider how they measure success and give 'specificity' to their achievements. Families, he argues,

are messy units of analysis and do not fit into regression analysis easily. Families change and growth is not linear (Bruner, p246).

Indicators for measuring the success of family support interventions may be difficult to develop as their impacts may be both long-term and filtered through other experiences and systems. Thus, the extent to which a parenting support programme keeps the young children of those families in the education system for longer or out of the justice system is problematic to assess and certainly cannot be assessed within the timescale of the intervention.

Bruner (2006) further argues that family support is about more than the specific activities that constitute a programme; that much of the real value is in the opportunities that those activities present for family relationship building and that traditional evaluations often miss these gains.

Moran, Ghate & van der Merwe (2004) highlight the difficulties in defining and measuring 'outcomes' in the context of evaluating parenting support interventions, as 'outcomes'

can be used to cover a vast range of things, including states of mind, attitudes, beliefs or bodies of knowledge; behaviours, skills and competencies; states of health or well being; relationships, community engagement and social functioning; the ability or willingness to access services, and so on (Moran, Ghate & van der Merwe, 2004, p22).

Thus, the traditional yardstick of measuring whether undesirable or negative factors have been decreased and/or positive factors or behaviours have been increased by an intervention offer a very limited framework for evaluating a service. Such definitions and measurement cannot capture incremental changes that become evident over time or the impact of a myriad of mediating influences that may act on individuals and families. It is also the case that families who are involved in a specific intervention may also be involved in other services and interventions (Lyons, Collins & Staines, 2001).

Internationally, within the Strengthening Families Programme, the LutraGroup carries out the evaluations and analyses the data. Acknowledging this fact, the emphasis on the necessity for an independent, Irish, evidence-based research approach (reiterated by the WRDTF) supported the need for this process and impact evaluation research to be undertaken.

The Strengthening Families Programme

The Strengthening Families Programme (SFP) was developed in the early 1980s by Dr Karol L. Kumpfer, Professor of Health Promotion and Education, University of Utah, USA. The programme targets risk factors such as poor discipline skills, low quality parent-child relationships and protective factors such as resilience characteristics in youths and parent-child bonding (Spoth, Redmond & Shin, 2001). SFP was designed to enhance resilience and reduce risk factors for alcohol and substance misuse, depression, violence and aggression, delinquency and school failure in high risk children and their substance-abusing parents (Coombes, Allen, Marsh & Foxcroft, 2006) by increasing parenting skills, improving family relationships and developing the life skills of young people (Hodgson, 2004).

It was originally developed for use with 6–12 year old children of substance-abusing parents. Since then it has been extensively revised and adapted and has been run in 17 countries to date. It is designed to be

culturally sensitive rather than culturally specific but has also been successfully adapted for African American, Asian Pacific Islander, Hispanic and American Indian families and is available in Spanish, Portuguese, Russian, Dutch, Swedish and Thai languages (Strengthening Families Program retrieved 17th June 2010).

The programme is now available in a number of versions and the Strengthening Families Organisation offers the following guidelines:

- **Pre-school children, SFP 3-5 years, higher risk:** SFP3-5 parallels SFP6-11 and can easily be delivered at the same time;
- **Elementary school children, SFP 6-11 years, higher risk:** Use the original SFP6-11, available in English and with Spanish language handouts for parents;
- **Junior high students, SFP 10-14, general/universal population:** Use the seven-session plus four booster session SFP10-14; and
- **Early Teens and High School, SFP 12-16, higher risk:** Use SFP12-16, (<http://www.strengtheningfamiliesprogram.org/about.html>)

The SFP has been implemented approximately 20 times in Ireland, each time with the SFP 12-16 version. The Drugs Task Forces were among the first groups to deliver this programme within the country.

The Strengthening Families Programme authors supply the co-ordinators of each programme with the requisite materials including an implementation manual, parents' facilitator manual, teens' facilitator manual, family facilitator manual, handbooks and handouts for parents and teens, LutraGroup evaluation instruments and implementation documents. Facilitators must undergo two day SFP training before delivering the programme.

SFP in action

SFP 12-16 comprises three skills courses – 'Parenting', 'Teens', and 'Family Skills' which are taught together over 14 weeks. Each session starts with a meal for all the families and the facilitators. The inclusion of meals is an integral component of the Strengthening Families Programme.

The extent to which family mealtime can be used as an indicator of family functioning has come under some scrutiny. Certainly, adequate nutritional intake has been shown to be associated with weight-control behaviours, self-esteem,

depression and substance use behaviour (Neumark-Sztainer, Larson, Fulkerson, Eisenberg & Story, 2010). Recently published results from Project EAT-1 and Project EAT-11 - (Eating Among Teens), a ten-year research project on family meals, confirmed previously cited benefits such as a reduction in eating disorders, substance use and improvements in nutrition and psychosocial health (Neumark-Sztainer et al, 2010).

Fiese & Schwartz (2008) describe family mealtime as a densely packed event and state that

while lasting only twenty minutes, on average, family mealtimes are embedded in a social, cultural, and economic context that are associated with a variety of indicators of children's health and wellbeing. Shared family mealtimes have been associated with such diverse outcomes as reduced risk for substance use, promotion of language development, academic achievement, and reduced risk for paediatric obesity (Fiese & Schwartz, 2008, p3).

After the meal, the teens' group and the parents' group separately attend a one-hour session. Following this, participants return to the full group for a one-hour family session to practise the skills covered. Both groups cover the same issues at the same point in the programme and the family session offers the opportunity to share their learning. Participants are given 'homework' or exercises to carry out at home during the week and handouts to reinforce the learning. The facilitators work from manuals which give a complete outline of each lesson including suggested exercise and activities. However, the programme authors encourage programme providers to adapt the lessons to make them a more sensitive fit to the particular culture, custom, or religious sensitivities of the families. Adaptation is considered

essential to the success of the program. It makes lessons come alive. Adaptations can be made in advance by cultural consultants, program developers, group leaders and parents or on the spot by group leaders in response to families. (SFP, 2008)

Research on the impact of such adaptations indicated that they did not improve outcomes but did improve recruitment and retention by 40% (Kumpfer et al, 2002).

Transport is made available to families who would not otherwise be able to attend. The programme offers childcare provision to participating families for children who are too young to participate in the programme. This provision as well as the provision of a meal is designed to reduce barriers to attendance and also to provide a level of incentive for the families who may welcome a night away from household chores and a break from routine. Small incentives such as telephone credit may also be offered to the participants on an ongoing basis.

Each group is staffed by two facilitators and another time-out facilitator is available on the premises to interact with any parent or teen that does not attend a particular session or leaves a session early.

Paid staff members are also required to provide childcare within the programme. The provision of a meal and transport also has resource and/or personnel demands.

The SFP had previously been delivered in one centre in the west of Ireland. Following on from its success and commencing in January 2010, the WRDTF rolled out the programme on a pilot basis in 5 centres across the region. This was the first time that the programme had been simultaneously implemented from multiple centres across the region. The 5 centres were Galway City, Galway County, Roscommon, Castlebar and Ballina. In the event, the roll-out only went ahead in 4 centres with starting dates in February 2010 and finishing in May 2010. Three centres ran the 14 week programme as planned and one reduced it by one week.

The programmes were managed by site co-ordinators who were Community Liaison Workers with the Western Region Drugs Task Force with a local steering committee established by them for the programme. Steering committee members varied across centres but included representation from services involved in substance misuse. SFP training for potential programme facilitators took place in each area where the programme was scheduled to be implemented.

Research Aim and Objectives

The overall aim of this research, as stated by the WRDTF was to determine the effectiveness of the Strengthening Families Programme in the west of Ireland.

The research objectives include:

1. To determine if the programme has been implemented as planned and what if any, are the deviations from the plan? What are the reasons for these?
2. What are the perspectives of participating adolescents and parents on programme content and delivery?
3. Is the mealtime an important element of the programme for both parents and adolescents?
4. Is the training adequate for the facilitators to deliver the programme overall and in this setting?
5. What alterations to the process and programme are necessary to ensure successful outcomes in future delivery?
6. Has the programme had an impact on the individual participants and if so what is the impact?
7. Does the programme reduce drug and alcohol use by the participants?
(from WRDTF Research Brief, n.d. p1-2)

Evaluation Constraints

The extent to which the evaluation was able to address Objective 7 was constrained both by a technical difficulty which resulted in the loss of some of the pre-test data in one centre and by the fact that there were fewer participants than was initially anticipated in each of the groups. However, the impact was minimised because the data for the analysis was aggregated across the four centres as per the evaluation design. In addition the process evaluation information contributed to providing insight into perceived programme impacts from SFP providers and participants.

Methodology

13

Design

A mixed methods design was used in this study with a qualitative approach taken to the process evaluation (Patton, 2002) and a quantitative approach to impact evaluation.

Process Evaluation

Process evaluation is, at its most simple, an evaluation of whether the programme has been implemented as planned (Hawe, Degeling & Hall, 1990). According to Coffman (2002) process evaluation focuses on effort, not effect.

Sample

Programme stakeholders, both participants and programme providers in the west were chosen to form the basis of the sample for the process evaluation. It was initially proposed that 20 participants would be recruited in total, across the five centres. One centre did not deliver the programme due to low levels of recruitment. However, in total, 30 people were invited to participate in interviews. One facilitator declined to be interviewed as did two teens; everyone else, who was invited to be interviewed, agreed. The final sample for process evaluation comprised of 27 participants who were interviewed individually and in addition, 5 group interviews were also undertaken with the steering committees. See Table 1.

Table 1: Sample for process evaluation

Stakeholder	Centre Location					Total
	Ballina	County Galway	Galway City	Roscommon	Castlebar	
Interviews:						
Site co-ordinators	1	1	1	1	n/a	3
Facilitators*	2	2	1	1	n/a	6
Parents**	2	2	3	3	n/a	10
Teen	2	2	1	2	n/a	7
Total	7	7	6	7		27
Group Interview						
Steering committee members	1	1	1	1	1	5

* including 'time-out' facilitator

** including parent in family who did not complete the programme

Data collection

Semi-structured interviews were used to gather data from programme providers and participants. Some interviews were face-to-face and others were telephone interviews. Group interviews were carried out with steering committee members.

Data analysis

All individual and group interviews were digitally recorded with the permission of the participant, professionally transcribed and ascribed a unique number identifier. The transcribed interviews were imported into NVIVO. A

template approach was taken and *a priori* codes were developed from the evaluation research objectives (Miles & Huberman, 1994; Altheide, 1996; Robson, 2002). Quotes can be used in a myriad of ways in the presentation of the analysis of qualitative data and in this report quotes from participants are used to illustrate points, as an aid to explanation and to enhance readability (Cordon & Sainsbury, 2006).

Impact Evaluation

Impact evaluation measures the immediate effects of an intervention. A pre and post intervention measurement design was employed through a questionnaire administered by researchers in the first session of the programme and at the final session.

Sample

All participants in the programme in each of the four centres, parents and young people, were invited to participate. The numbers given below (Total 62-60) are the numbers of participants who responded to at least some of the questions asked. Parents and young people were advised that the voluntary nature of their participation included that they could choose to answer or not answer individual questions.

Table 2: Sample of participants for impact evaluation

	Ballina		County Galway		Galway City		Roscommon		Total	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Parent	4	6	6	6	5	7	13	6	28	25
Teen	9	10	4	9	8	8	13	8	34	35
Total	13	16	10	15	13	15	26	14	62	60

Data collection

Data collection processes and instruments were developed and piloted prior to entry to the field. The questionnaire comprised three domains from the Family Environment Scale (Moos & Moos, 2002) and pertinent questions from the SLÁN Survey (adults) (Morgan et al, 2008) and the Health Behaviours in School-aged Children Study (children) (Nic Gabhainn, Kelly & Molcho, 2007) about consumption of alcohol and drugs.

The Family Environment Scale (FES) is a 90-item scale which measures the family environment across the three dimensions of: Relationships, Personal Growth and Systems Maintenance. The evaluation used the Relationship dimension with its three domains of Cohesion (the degree of commitment, help, and support family members provide for one another); Conflict (the amount of openly expressed anger and conflict among family members) and Expressiveness (the extent to which family members are encouraged to express their feelings directly) (Moos & Moos, 2002). Each of the domains contains 9 items, giving a total of 27 items for this aspect of the measurement with participants asked to assess each item or statement as either true or false in their opinion. A single-use licence was purchased for the application of this measure.

SLÁN is a national survey carried out in 1998, 2002 and 2007 of the lifestyle, attitudes and nutrition of adults, aged 18 years and over, living in Ireland (Morgan et al, 2008). The survey collects data across a wide range of health issues including the use of alcohol and illicit substances. Permission to use relevant questions from this measure was sought and granted.

Health Behaviour in School-aged Children (HBSC) study is currently conducted in 43 countries and collects data on young people's health and wellbeing, health behaviours and their social contexts. The survey has been undertaken in Ireland for a number of years (Nic Gabhainn, Kelly & Molcho, 2007). The questions on health behaviour include questions on the use of alcohol and illicit drugs use. Permission to use relevant questions from this measure was sought and granted.

A retrospective pre-test was also carried out in respect of the Family Environment Scale. The authorised evaluators of the SFP use a retrospective pre-test as part of its evaluation tools. Retrospective pre-tests involve asking participants to indicate how they would have answered questions at a specified point in the past – such as before participating in a programme. Such retrospective pre-tests generate a level of debate with its proponents arguing that it produces a more reliable measure of pre-test, post-test comparisons than traditional methodology (Pratt, McGuigan & Katzev, 2000).

To obviate literacy concerns and promote privacy, the Interwrite™ Response System was used. Participants were given a wireless handset (clicker) on which they could register a response which could be either numerical or true or false, as appropriate. Each statement was projected onto a screen or the wall and read to the participants who then had 30 seconds during which to register their answer. Participants were able to ask for clarification about words or statements during this time. Depending on the time available, the size and composition of the group, and the perceived commitment of the group to the data collection process, the SLÁN and HBSC data were collected on paper or through the clicker system. When this data was collected on paper, adults and teens sat at separate tables to fill in the questionnaires and researchers were available to the participants during this time to help with any reading, writing or comprehension difficulties. A technical difficulty with the Interwrite™ Response System resulted in the loss of data in one centre at the pre-test stage.

Analysis

Data was analysed using SPSS statistical software; where appropriate paired T-tests were carried out.

Ethical Considerations

The proposal was submitted for independent ethical review to the National University of Ireland Galway Research Ethics Committee prior to commencement of the process and impact evaluation, and was approved. Written consent was obtained from parents participating in the programme for themselves and their children, with teens providing their written assent.

Findings

17

Findings

The results of the analysis are presented in this section under the headings provided by the evaluation research objectives.

To determine if the programme has been implemented as planned and what, if any, are the deviations from the plan? What are the reasons for these?

Delivery of the SFP was actively planned by the Western Region Drugs Task Force on a pilot basis to be rolled out in 5 centres in the west of Ireland. The programme is a structured intervention which includes guidelines on the management and organisation of the programme. The role of the site co-ordinators was central to programme implementation from setting up a steering committee through to co-ordinating and managing programme roll-out.

Programme Preparation

Steering committees were convened in all centres, successfully achieving multi-agency representation with members predominantly from agencies or in posts that collaborate on drug misuse prevention – such as school liaison officers and the probation services, which was as planned. While multi-agency representation was achieved in principle, levels of participation in the steering committees varied with several groups experiencing the non-involvement of individuals and agencies. In one centre, the lack of participation within the steering committee and particularly in referral activities of a co-funding agency was considered to have been detrimental, and contributed to the programme not running in that location. This highlights the central role played by the steering committee in referral and participant selection processes for the programme.

Although all referrals went through the steering committees, the actual referral processes differed across centres. Two centres got referrals across a number of agencies; the referrals for one were mainly from the education sector and another received most referrals from the mental health and addiction services. Some centres had representatives from the referring agencies on the steering committee and another did not receive any referrals from the steering committee. For some steering committees, the referral system did not work as had been expected or planned, and this was evident by the number and type of referrals, as well as the involvement of the referral agency. Significantly, this was also evident by the level of support that the agencies gave to the families. The expectation of SFP is that the referring agency will provide regular ongoing support for the duration of the programme. These differences may reflect local variations in the types and levels of services and agencies available to refer, and possibly the relationships between agencies. A potential lack of awareness by agencies of the SFP, its approach and aims, was also identified as an explanation for a lack of referrals to the programme. A lack of training for referral agencies was identified in some locations as a limitation which resulted in a lack of understanding of what the SFP could offer, restricting the selection of potential participants.

Steering committees largely decided on referral criteria themselves and a lack of clarity as to the target group for the programme was identified as an issue which made it more difficult to recruit families and led to some inconsistency in participant selection. A contributing factor to differential participant selection across centres was considered to be the eligibility criteria for participation, particularly in relation to age and risk factors. SFP 12-16 was developed for use with teenagers aged between 12 and 16 years of age with programme activities designed around this age range. In itself, this age span was considered problematic by some SFP providers who felt it was too wide. However, the steering committee for the centre that did not deliver the programme had adhered to the age range as stipulated and some members considered this to have hindered recruitment.

In contrast, other centres broadened the age range. One worked with an age span of 11 to 19 years in response to requests from parents and from a perspective that a family intervention should be available to all family members who

are willing to become involved. The deviation from the plan in this instance appears to be due to the centrality of, and value placed on, the family approach over and above stipulated inclusion criteria of chronological age. This family-centred approach was consistently identified by SFP providers as important to the appeal and perceived effectiveness of the programme. In contrast, chronological age was questioned, as an appropriate criterion, as it belied the developmental needs of many young Irish people. Nevertheless, it should also be acknowledged that in order to deliver the programme a minimum number of families were required to be recruited. This was a potential incentive and reason to widen stipulated inclusion criteria.

Further difficulty can be demonstrated by the differing approaches of the steering committees to the question of substance use as a referring criterion. For one member of a steering committee it was a defining issue

I had a very clear vision that it was at risk or high risk; I suppose how you categorise those two, at risk of substance misuse, serious substance misuse and or drugs and alcohol (15:5S).

For another steering committee member, substance use was considered to be too narrow a basis for inclusion

But we were very clear...that we're not going to target specific risk factors because we just fear that if we do that then we're potentially excluding families just on the basis that they haven't yet developed a specific issue (13:6S).

This illustration clearly raises issues when defining the terms 'at risk' and 'high risk'. It also highlights inconsistencies around the understanding of which risk factors were appropriate ones to determine eligibility for the programme. Likewise, some referrers were said to be unclear that the programme was not suitable for crisis intervention and were inclined to refer families for whom they had run out of other options. In contrast, other referrers were reported to have recruited families whom they felt would most benefit from the programme and be unlikely to drop out, presenting the programme in a positive light to garner future support. The reason for this ambiguity about perceived target group can be linked to expressed perceptions of the programmes' intended outcomes and a lack of clarity as to whether primary and/or secondary prevention of substance misuse is, or indeed should be, the focus.

From the perspective of the WRDTE, this pilot was focused clearly and explicitly on reducing drug misuse by both parents and teens and the SFP was expected to contribute to that aim. However, site co-ordinators considered the programme in a broader context of providing life and parenting skills through a family-centred approach that was likely to impact on risk factors which contribute to substance misuse. Steering committee members generally talked about the programme in terms of education and prevention with a practical skills base for risk factors with various outcomes, of which substance misuse was one. Parents and teens, while acknowledging the drug and alcohol content of the programme, considered it an intervention providing family support through practical skills acquisition. The planning process does not appear to have mitigated the ambiguities in relation to the target group, nor provided a shared understanding of the programme's core purpose in this application.

Programme Delivery

Each centre required the selection of a minimum of seven facilitators. There had been an expectation that referring agencies would contribute to the programme by releasing staff to work as facilitators. Although this happened in some instances, and was perceived as advantageous, in most cases it did not. It was suggested that this was due to the prevailing economic climate with agencies unable to release staff in this way. Instead facilitators were identified in various ways such as through work, education programmes and information meetings. A consequence of facilitators not being sourced through agencies as planned was that most were involved with the programme as volunteers and they came from a different and more diverse pool.

To support family participation, the programme features a number of planned supports which were provided and included: transport if required to and from the sessions; incentives to participate; childcare for families with children

too young to participate, and a time-out facility. Although the time-out facility was used rarely, there was variation in the perception of its purpose, suggesting that while it was planned for and provided there was a lack of clarity around its application in the programme. This was demonstrated through its reported application. In one centre, teens who were timed-out did the programme on a one-to-one basis with the time-out person. In another, teens were permitted to play pool, in contrast to a centre which specifically banned activities such as this during a time-out period. Facilitators identified situations where it would have been appropriate in their opinion to use time-out, particularly when teens were being disruptive in a group. However, they did not feel supported to take such action.

It was reported that the model of delivery as described in the introduction was generally followed by all four centres that ran the programme. Nevertheless, there were some deviations. Some of the adaptations were made prior to the sessions, some with the site co-ordinators following discussion. Other changes were made during the sessions in response to perceived group need.

One centre reduced the programme by one night in response to most participants not turning up on a night when there was an alternative, local attraction for the teens. Most facilitators, when asked, said that there were very few deviations from the programme as planned and in their view, those that were, were minor. Facilitators provided examples of alterations which included substituting the programme's warm-up exercises with alternative activities which they had successfully used on previous occasions and adapting the manual to compensate for the perceived 'Americanism' of the content. Facilitators also referred to abridging content as illustrated by the quote below

Take the family meeting section, right, which is fantastic, but they had like six subheadings underneath that and they just were ridiculous, do you know what I mean? We left them out altogether and just did the importance of having a family meeting (14:2F).

Other facilitators were less specific in describing changes but stated that the major content was presented with the themes adhered to. One facilitator considered that if 50-60% of the planned content of a session was covered that was acceptable. Several facilitators identified that they believed some families deviated from the plan when it came to homework. One suggested that this may have been the result of a lack of emphasis that was given to it by programme providers. However, the suggestion that families may have carried out the principle of the homework without applying it formally was one that was also put forward. Families did not refer to homework.

What are the perspectives of participating adolescence and parents on programme content and delivery?

Delivery

The SFP uses participatory approaches to delivery of the programme through weekly facilitated sessions with groups of teens and parents separately, and then jointly in families. This facilitated approach to delivery appears to be valued by participants both teens and parents. One teen stated that it was good as you, 'got to give your opinion' (11:4T) and a parent identified that you were 'not talked down to' (16:2P). The facilitators were perceived as supportive, approachable and credible.

The variety of activities was also seen as positive with reference made to role play, games and art. A central feature consistently cited by the teens, although also referred to by some parents, was that the activities engendered fun which had not been anticipated but it appears to be what engaged and sustained them in the programme.

While teens expressed a liking for the structure of the groups and the fact that they were with their peers for part of the time, some parents expressed some disquiet and felt the composition of the groups and relationships between participants within groups may compromise open communication, such as that between siblings.

Content

The content of the Strengthening Families Programme is divided into 14 sessions and covers skills such as communication and problem solving as well as specific topic areas such as sexuality, drugs and alcohol.

Specific topic areas and skills covered in the programme were referenced by teens and included: drugs and alcohol, sexuality, conflict, controlling your temper, emotions and communications skills. Parents tended to talk about the content of the programme in a general way rather than focus on specific topic areas in terms of their own learning, but they also referred to their perceptions of their teens learning with reference to content areas such as sexuality and drugs and alcohol. Neither teens nor parents identified content areas that they perceived were missing from the programme and should have been included. Some facilitators considered that the content of some of the earlier sessions on communication skills were repetitive and drawn out. However, this was not identified by any parents or teens.

Is the mealtime an important element of the programme for both parents and adolescence?

The mealtime, an integral part of the SF programme, was considered an important element by parents, teens and SFP providers. The role of the meal and the positive contribution it was perceived to have made to the programme was constructed in various ways. At one level it was considered as an icebreaker or warm-up activity at the beginning of every session, a familiar non-threatening neutral activity, shared by all participants including facilitators, which put people at their ease. This construction was put forward, particularly, by facilitators. An alternative construction presented by SFP providers and parents was as a vehicle for interpersonal communication within families and between families, and between parents, teens and facilitators. The outcome of this opportunity for communication according to SFP providers was contributing to bonding within families, building relationships and trust. The mealtime was also considered to act as a model, with families reporting it as a positive family experience and so more likely to try to incorporate it into family living, thereby reinforcing lessons learnt through the SF programme. The parents identified that the mealtime was worth replicating at home, although barriers to this were also acknowledged.

Parents and teens tended to construct the role of the meal in more pragmatic ways, although this was also recognised by facilitators; an example would be the meal as an incentive to participation in the programme with reference made to the fact that the meal was free, not having to cook or wash up and a break from routine. Facilitators also identified that the provision of a meal acted as an enabler to programme participation for families as there was little time between the end of the school day and start of the SFP sessions for teens and/or families to eat. This was particularly the case if participants had to travel any distance to the programme centre. One teen identified that a lack of food can impact negatively on mood which could impact on programme participation, and in a similar vein one facilitator identified that the basic human need for food was being met by the programme. The meal was seen as an integral and valued element of the programme by parents, teens and SFP providers.

The cost to the programme of the meal was referred to by some steering committee members and site co-ordinators; it was generally considered good value for money.

Is the training adequate for the facilitators to deliver the programme overall and in this setting?

An information seminar preceded a two-day training session for each site. The seminar introduced the programme to interested parties and attendees included potential referrers to the programme, steering committee members and potential facilitators. The training session itself was targeted at potential facilitators and was specific to the SFP 12-

16. Two sessions were run in Galway city where 37 people attended and one each in Connemara (8 people), Castlebar (12 people), Ballina (42 people) and in Roscommon (24 people).

The need for additional training of facilitators, specifically for the SF programme was identified by SFP providers. Overall, the lack of targeted training for referrers was consistently identified as a limitation to programme effectiveness although it appears referrers attended the two-day training sessions in at least one centre which was considered to have a number of benefits as illustrated below

So it was just everybody that was involved in the programme was all in the one room for two days and there was good learning, good teamwork and we were all working for the same aim (18:4S).

If offered, the provision of training for referrers would focus participant selection in a more consistently targeted way and facilitate buy-in from referrers to more actively support referred participating families during the programme. It was also acknowledged that the expectation that referrers would be in a position to commit to a day or more of training, specifically relating to referrals to the SFP, was unrealistic.

Those who attended the training reported that day one provided insight into the origins of the programme and how it was developed. Day two focussed on group leadership skills, which included role play, where participants had to plan and run a session on an identified topic. The other participants acted as teens and parents in the scenario. It was felt by some participants that too much emphasis was placed on the history of programme development rather than acquiring or honing group leadership skills through experiential learning.

Although several of the participants positively commented on the training, most of them also had some reservations about it. Several expressed the view that the training was only adequate because of the skills which they brought with them and essential skills were neither given nor tested. This was particularly the case for facilitation skills and it was suggested that the training alone would not have prepared them to run the programme. Although the training incorporated some role playing of SFP sessions, it was identified that as this participation was voluntary only a few were given the opportunity to experience the running of a group. Likewise, it was pointed out that although teen and parent sessions were 'role played' during the training, the family session was not and therefore some facilitators considered themselves unprepared for these sessions. The concern was also raised that the training did not equip or prepare facilitators for the potential emotional responses that some of the material could provoke, requiring the facilitators to draw on their pre-existing skill set, assuming they had such. Another area that was perceived to be lacking in the training was that it did not prepare or train people to deal with the organisational issues involved in running the SFP. Some facilitators suggested that the training should be longer and should give participants a more thorough grounding in the structure and content of the modules.

What alterations to the process and programme are necessary to ensure successful outcomes in future delivery?

The referral process was repeatedly identified as being in need of change and development in order to contribute to programme success. The lack of clarity of the role of the referral agencies was consistently cited as a limitation which restricted the participant selection process. It was suggested that it would have been beneficial if a participant selection procedure had been carried out for families which laid out how the process was to be undertaken. However, for referrers, it was not just their role in participant selection that required clarification but their role throughout the programme, such as their expected contribution to retention of families on the programme and family support following programme completion. In future, this could be reinforced through training aimed at referral agents, as

suggested by SFP providers. However, this has work load implications for referral agencies that have already been found to be reluctant and/or unable to release staff to act as facilitators. An explicit participant selection procedure could provide clarity to the apparent ambiguity in the target group for the programme which was identified as a limitation to programme success. The mix of the families was flagged as an issue that should be relevant to future considerations. A steering committee that had experienced more than one programme discussed the difference in the group dynamic and raised the possibility that for a group to be successful, the members must have enough in common to be able to empathise with each other.

Most, though not all, steering committees were said to have worked well and effectively together. It was suggested that for future programmes the committee should convene earlier in order for it to work more strategically. It was also suggested that some of the responsibilities of the site co-ordinators might be taken on by members of the steering committee. This was in the context of the level of work required in organising and managing the SF programme that fell to the site co-ordinators.

Discrepancies around expectations of programme intent by the various stakeholders compromised what could be considered to be success, as different stakeholders had different expectations of what success might be. These discrepancies came to the fore and were expressed by steering committee members in relation to future funding of SF programmes. Secure funding was recognised to be necessary for optimal programme roll-out as programme implementation could be actively planned in a timely fashion if funding was assured. A realistic timeframe for programme delivery from multi-agency buy-in to programme roll-out was recommended with more lead-in time identified as necessary.

The agenda of the programme providers in terms of impact on substance misuse was acknowledged

I don't mean this in a very blunt way, but why would I fund a programme or why would the task force apply and fund programmes that are not related to substance misuse, our very specific target audience, or groups (15:5S).

Recognition was given to the appropriateness of alternative sources of funding in terms of programme outcomes and these included, as stated by participants: 'Department of Social Community and Family Affairs', 'Department of Education', 'Department of Health', 'Department of Justice' and the 'Health Service Executive' (12:3S). A multi-agency approach to funding with one agency acting as lead, but without dominating the agenda, was suggested as a practical solution as all could potentially benefit, and costs would be shared.

SFP providers indicated that they felt that the programme would be more usefully targeted towards families with younger children. This was also supported by a number of parents. Younger teens were perceived as being more amenable to behavioural change and within the programme some of the older teens were characterised as very challenging to work with. If the SFP 12-16 programme was to run again it was recommended that the stipulated age profile of 12 to 16 years should be adhered to.

Most parents and teens were not inclined to suggest any alterations to the programme as they had experienced it, although a few suggested that the programme should be longer or ongoing.

Has the programme had an impact on the individual participants and if so what is the impact?

The impact of the programme was explored through the impact evaluation and measures of family environment (Moos & Moos, 2002) as well as in the process evaluation with programme stakeholders.

Note: Due to loss of data as outlined on page 12 the impact findings should be read with caution.

Family Environment Data

The size of the sample severely constrained the undertaking of a meaningful analysis. This was compounded by some participants choosing not to answer some questions. However, the data was analysed using SPSS statistical software and where appropriate, paired T-tests were carried out and the pre and post data was tested for statistical differences. Three domains of the Family Environment Scale were used to evaluate changes between the commencement of the SFP and the completion of the programme. These were: Family Cohesion, Expressiveness and Conflict. The results are presented in Table 3 below:

Table 3: Family Environment Scale

Domain	Pre-test (n)	Post-test (n)	Retrospective pre-test (n)
Cohesion (mean)	5.23 (47)	5.24 (58)	4.71 (42)
Expressiveness (mean)	3.47 (47)	3.93 (41)	4.64 (56)
Conflict (mean)	5.32 (47)	4.64 (56)	4.34 (38)

Although it would appear that there are differences in the data presented in table 3 between the pre, post and retrospective pre-test data, on analysis, no statistical differences were found between the scores. If the programme significantly impacted on the families in terms of family cohesion, expressiveness and conflict then statistical differences should be discernable between the pre and post-test.

Although the quantitative data does not demonstrate statistically significant changes in the family environment, information gathered through the process evaluation suggested some programme impact. All the family members who were interviewed said that they and/or their family had benefited from participating in the programme with the programme positively impacting on them individually and as a family. Both teens and parents cited increased communication within the family. This was considered to have resulted in increased understanding between parents and teens as they learned to see things from the others' perspective and described negotiating through talking rather than demanding. Both teens and parents spoke of developing communication skills that helped them deal with situations while remaining calm and this was perceived as having a positive impact

If we argue we stop and then sit down and talk about it. I think it's improved the family because we always talk instead of arguing a lot more (11:4T).

This demonstrates that the impact of the programme not only raised awareness of an issue but enabled participants to develop skills which were then successfully applied in their home situation.

Parents reported an increased confidence in their parenting abilities as a result of participation in the programme and this was also observed and commented on by facilitators. SFP providers described impacts on family members which they had observed over the duration of the programme. As with the parents' and teens' responses, a frequently cited benefit was that of enhanced communication within the families as a result of the acquisition and successful application of communication skills. Facilitators spoke of family members who were not speaking to each other at the start of the programme who were talking freely by the end. However, most facilitators were not inclined to ascribe dramatic differences in the families over the course of the programme but were clear that the families had new skills that were going to continue to benefit them in the long term.

Other impacts of the programme were reported by steering committee members, one of which was an increase in engagement of some teens with other services, although this was not referred to by the teens themselves. Another

was a report from schools that some teen participants' behaviour was said to have improved since attending the programme. One steering committee discussed a concern raised by one parent of a possible negative impact. The parent expressed unease that her teen was becoming friendly with another teen on the programme whom she considered to be a bad influence. While this negative impact must be acknowledged, overall the impacts reported were positive.

Several facilitators stated that they themselves had benefited from their involvement on the programme, and for some it was the opportunity to work in different ways. Many members of the steering committees spoke very positively about the benefits of the inter-agency approach of the SFP. In terms of the impact of the programme, families and agencies were considered beneficiaries of this method of working.

Does the programme reduce drug and alcohol use by the participants?

The impact evaluation addressed this question directly through the use of questions drawn from the SLÁN survey and Health Behaviour in School-aged Children survey. These are reported separately in Table 4 and Table 5, respectively.

Data from SLÁN questions

The results of the SLÁN questions are presented in Table 4. Some of the questions could not be meaningfully analysed as too few participants answered. From the questions that could be analysed, no statistical differences were found between the pre and post-test responses, indicating that the programme had no measurable impact on adults' alcohol intake and behaviour.

Table 4: Data from SLÁN questions

SLÁN	Pre (n)	Post (n)
Those reporting having an alcoholic drink more than once a month	40.9% (22)	34.2% (23)
Those reporting having drunk alcohol in the last week	31.8% (22)	30.4% (23)
Those reporting never having 6+ drinks	40.9% (22)	29.2% (24)
Those who felt they should cut down on drinking (last 12 months)	11.1% (18)	18.2% (22)
Those who regretted something they said or did (last 12 months)	15.8% (19)	18.2% (22)
Those reporting family problems due to someone else's drinking (last 12 months)	33.3% (18)	37.5% (24)
Number of drinks per day: mean	2.46 (28)	3.16 (16)

**Again due to sample size constraints, interpretation of the data and must be treated with caution. While no statistical differences can be observed, the data provides a simple description of self-reported behavioural differences.*

Health Behaviour in School-aged Children (HBSC) data

The amount and consistency of the data generated by the HBSC questions in both the pre and post-test responses was insufficient for a statistical analysis of difference but data gathered is presented below. This suggests that no difference in alcohol or substance use can be credited to the programme.

Health Behaviour of School aged Children (HBSC) questions	Pre (n)	Post (n)
Those reporting that they ever smoked a cigarette	45.0% (20)	42.4% (33)
Those reporting that they ever drank alcohol	60.0% (20)	57.6% (33)
Those reporting that they ever sniffed (glue or other solvents)	10.0% (20)	6.1% (33)
Those reporting that they had ever taken drugs other than those listed	20.0% (20)	24.2% (33)
Those reporting drinking beer monthly	33.3% (21)	28.1% (32)
Those reporting drinking wine monthly	14.3% (21)	18.8% (32)
Those reporting drinking spirits monthly	33.3% (21)	25.0% (32)
Those reporting drinking alcopops monthly	28.6% (21)	21.9% (32)
Those reporting drinking cider monthly	26.3% (19)	26.7% (30)
Those reporting drinking any alcohol monthly	36.8% (19)	33.3% (30)
Those reporting that they had ever got really drunk	55% (20)	48.3% (29)
Those reporting ever using cannabis	15.8% (19)	26.7% (30)
Those reporting using cannabis in the last 12 months	15.0% (20)	17.2% (29)
Those reporting using cannabis in the last 30 days	20.0% (20)	7.4% (27)
Those reporting drinking alcohol in the last 30 days	35.0% (20)	68.4% (19)
Those reporting having been drunk in the last 30 days	31.6% (19)	50.0% (19)

The qualitative data from the interviews provides some insight into the results from the impact evaluation. Parents only addressed the question of whether the programme would reduce drug and alcohol use in terms of the teens rather than themselves. Although the teens identified that issues concerning drugs and alcohol were covered during the programme, and some agreed in response to a question that the programme might reduce drug and alcohol use, they were not able to articulate why they thought this to be the case. For some, it seemed that drugs and alcohol did not feature highly enough in their lives for the issue to be of concern.

A widely expressed opinion of the SFP authors was that the programme would impact on the substance-using behaviour of the participants through its provision of life, and particularly, communication skills. Substance use was categorised with other issues that are often not discussed within families so that communication was considered to strengthen the parents' capacity to respond.

Some participants stressed that the issue of substance use should be seen in perspective and not dominate the discussion about the value of the programme. The substance use module, it was pointed out, was one module of 14 and only carried the same weight as the other modules. While the reduction in substance use, it was argued, was an important outcome and objective, there are others that are at least as important. One facilitator suggested that it was not because of substance use issues that the families were involved in the programme but because they were generally overwhelmed by family life.

An interviewee described a quite dramatic impact of the SFP on a parent who disclosed the consequences her family was suffering as a result of alcohol use, and following this disclosure took steps to make major changes to her life and that of her children. However, the majority of interviewees did not consider that substance use was a major issue for most of the families taking part in the programme. One parent was said to have been offended by the substance use questions that formed part of the evaluation of the programme, whereas for others it was not thought to have any particular relevance.

Discussion

The declared remit of the SFP is expansive and appeals to a range of agencies with a multiplicity of agendas. The programme claims to enhance resilience and reduce risk factors for alcohol and substance misuse, depression, violence and aggression, delinquency and school failure in high-risk children and their substance-abusing parents (Coombes, Allen, Marsh & Foxcroft, 2006) by increasing parenting skills, improving family relationships and developing the life skills of young people (Hodgson, 2004). In this instance, the programme providers' core function is in relation to substance misuse working within the framework provided by the National Drugs Strategy (Department of Community, Rural and Gaeltacht Affairs, 2009). Reference is given to the importance of family to substance misuse prevention endeavours through Action 29 under the prevention pillar which refers to the need for supporting families who experience difficulties due to drug/alcohol use, parenting skills and targeted measures focusing on children.

It would appear at first sight that the SFP should meet the specific needs of the programme providers as it addresses aspects identified in the National Drugs Strategy and explicitly includes the topic of alcohol, drugs and families in one of its sessions for teens and parents. This is further supported by the multi-agency approach advocated by the NDS to substance misuse which is also congruent with and can be accommodated by the implementation of the SFP. However, the specificity of the substance misuse agenda contrasts sharply with the broad remit claimed by the SFP. This contrast is further demonstrated in a number of ways throughout programme implementation, from differences and difficulties in the referral activities and ambiguity around target group for the programme, to some differential in implementation of the programme as planned, variations in expectations for programme success and the evaluation process itself.

Referral Processes

The diffusion of the focus on substance misuse was demonstrated and to some extent reinforced by a lack of clearly agreed and monitored family selection and referral criteria across the centres. One centre did not run the programme as they failed to recruit enough families, a recognised difficulty with parenting skills programmes (Moran et al, 2004). Given the fact that existing networks have been identified as key to successful participant selection (Velleman et al, 2000) it is interesting to note that these were reported to be poorly developed in this particular centre. The family-centred focus of the programme was valued by SFP authors and evidence from the literature supports this approach, with the identification of key predictors of substance misuse for young people being related to aspects of parental substance use (Velleman & Templeton, 2007), family structure and limitations in parenting skills (Fisher et al, 2007). Family may also bestow protective factors through encouraging and promoting protection and resilience (Velleman et al, 2005). Therefore, risk and protective factors for substance misuse are mediated by the family. It is interesting to note that while risk factors for substance misuse have been identified, and in a family context, these do not appear to have been developed into demarcated criteria for referral. The most specified referral criteria stipulated by the programme itself relates to age of participating children and this was not adhered to. There is no evidence of a shared understanding or agreement of the features of the families to be targeted in the referral process. This may be due to the fact that SFP authors do not provide guidelines or training around referral criteria.

There is also pressure on centres to recruit to ensure that programmes run in the area. It has been recognised that the multiple risk factors identified in relation to substance misuse are largely the same factors for other problem behaviours such as delinquency or school failure (Morgan, 2001). It may be suggested that a common risk factor approach is the starting point for developing specific shared referral criteria between the various agencies involved in the participant selection process. However, evidence suggests that the more targeted and tailored the intervention to the participant group in the context of the expected outcome the more successful it is likely to be (Kreuter et al, 2000; Kreuter et al, 2003). This identifies the tension between the focus on substance misuse versus a focus on risk factors implicated in substance misuse and other problem behaviours. Nevertheless, there is a need for a shared understanding to be developed amongst the agencies contributing to the programme with clearly defined eligibility criteria for participant selection of families and clearly delineated processes for referral. This would facilitate

consistency across centres in the way referral to the programme was undertaken, as differences were identified that could compromise equity of access to family support across the region.

Deviation from Planned Implementation

Deviations from the planned implementation of the programme were identified in the referral and participant selection process as described above and also in programme delivery. These changes are not necessarily negative and the programme authors themselves acknowledge that adaptation is essential to programme success (SFP, 2008). It is interesting to note that while the SFP 12-16 has been adapted for an Irish audience, 'Americanisms' were identified as a reason for necessary changes in this application. The programme authors carried out research on the impact of adaptations and found that they did not improve outcomes but they did improve recruitment and retention (Kumpfer et al, 2002). Programme changes were both actively planned prior to sessions, often in consultation with site co-ordinators and facilitators and reactively managed in response to situations in the sessions themselves. Again both scenarios are envisaged by the programme authors (SFP, 2008). While the SF programme recognises the need for local SFP providers to adapt the programme to local need, the degree to which programmes are adapted may compromise programme fidelity. Although facilitators initially stated that changes were minor, some changes, such as delivering 50-60% of programme content, may be considered significant.

The variation across centres similarly can be considered to reflect local need, but how much is open to question. The provision of training and the structured nature of the programme do not guarantee that programme delivery is the same across all centres and there could be quite significant differences. Evidence of this can be seen in the varied use of time-out which suggests that there is a lack of agreed understanding of the purpose and function of time-out across the centres, an area that requires further clarification in future programme implementation.

Expectations of Programme Success

As programme inputs, such as target group, were not agreed and shared by the providers, site co-ordinators, steering committee members, facilitators and referral agencies, this resulted in a lack of agreed, expected programme outcomes. Difficulties have been identified previously in the definition and measurement of outcomes in the context of evaluating parenting support interventions due to the broad range of what may constitute an outcome in this context (Moran et al, 2004). This is complicated by the fact that families involved in a specific intervention may also be using other support services (Lyons et al, 2001) which was the case for participants in the SFP. Moran et al, (2004) argue that the most effective interventions clearly state not only their theoretical basis but also the 'precise mechanism of change' they are expecting

This means having not just a general idea of overarching aims, but a clearly articulated set of concrete, measurable objectives. The expected sequence between inputs by the service and outcomes for user needs to be considered and precisely documented (Moran et al, 2004, p117).

This was lacking in the implementation of the SFP and so what constituted success varied as expectations of outcomes of programme implementation varied between SFP providers and family participants. That careful consideration should be given to how success is measured in the evaluation of family support interventions is identified by Bruner (2006). However, when expectations vary, this further complicates the situation.

The issues are complex. If success is constructed around a risk-factor approach then reductions in risk factors would constitute success whether or not a reduction in substance misuse had been achieved. The assumption being that a reduction in risk factors is on the pathway towards impacting on substance misuse. The difficulty arises in that a

reduction in risk factors does not necessarily result in a reduction in substance misuse but may, as recognised by Morgan (2001), impact on, for example, delinquency which is itself a risk factor for substance misuse (United Nations, 2000). The difficulty, apart from the complexity, is that it appears that the various SFP providers focused on different points in this trajectory with resultant variations in expectations of what constitutes success.

Conclusion & Recommendations

Conclusion

The Strengthening Families Programme engenders a very positive and enthusiastic response from participants, both those involved in the provision of the programme and families participating in it. As Velleman (2009) notes, the programme inputs are predicted to strengthen family processes and structures, positively impacting on young people's values, self esteem, relationships and behaviour as well as preventing substance use. Preventing substance use is one of the topic areas covered in a single session within the 14 week programme.

The findings of this research indicate that it may be more appropriate to position the SFP as a more general prevention programme, of which substance use is an integral component, as opposed to a specific substance use prevention programme with the concurrent expectations of impact.

If considered as a more general programme it has some resonance with The National Drugs Strategy 2009-2016 (Department of Community, Rural and Gaeltacht Affairs, 2009) which describes the prevention of problem drug use as a highly complex concept that seeks to increase the awareness and understanding of people of the consequences of problem drug use and to delay the onset of first use (p28). In this context families welcomed the substance use module in the programme, engaged with it and were better informed as a result of it. However, as a substance misuse prevention programme, the impact is less clear.

Recommendations

Recommendation 1:

Develop a coherent shared agenda between all agencies participating in the programme.

A lack of a shared vision for the programme across the participating agencies compromised the coherence of this pilot project. Without such a shared vision there is a lack of synergy and there is unlikely to be a consistent perception as to the desired outcomes, as well as an agreement as to what constitutes success.

Recommendation 2:

Source alternative funding agencies to contribute in order to secure sustainable financial support for the programme.

It was widely acknowledged that funding the programme was a very significant financial commitment for any one agency. Given that the benefits of the programme may include reduced contact in the long term with a number of agencies, and given that SFP has been valued for its multi-agency focus, the cost of future programmes should be shared between agencies. This will have an additional benefit in broadening the focus of the outcomes. In line with this, and as the programme is one of life skills and is not drug and alcohol specific, future funding for SFP should come from a multiplicity of organisations and government departments and not be dependent on RDTFs.

Recommendation 3:

Develop a realistic timeframe from multi-agency buy-in to programme's delivery and completion with more preparation time before programme roll-out.

The required time for programme preparation and participant selection should not be under-estimated and the impact of public holidays on this process should be taken into account. The families' attendance was impacted by considerations such as school and public holidays. It is important that future programmes be scheduled to fit in with school terms in order to facilitate participation.

Recommendation 4:

Develop a protocol which stipulates the roles and responsibilities of referral agents.

Referral agents were inconsistent in the level of their participation in terms of steering committee involvement and ongoing support of participants throughout the programme. Although training was suggested for referral agents, many considered this to be unrealistic due to time constraints. A protocol would provide a framework for referral agencies' participation and make explicit their responsibilities as well as enhancing a shared understanding of the programme and its implementation processes.

Recommendation 5:

Review the work load of the site co-ordinators and steering committee with a view to reallocating work.

The site co-ordinators' responsibility for the establishment and implementation of the programme was wide-ranging and onerous. It was considered a particularly heavy workload as site co-ordinators also had their other professional duties to carry out. The fact that so much responsibility rests with one individual can leave a 14-week programme vulnerable if something untoward happened to that individual. The site co-ordinators experienced different levels of support from the steering committees and different steering committees were reported to play a more or less active role in the organisation and delivery of the programme. A review of the work loads and a pre-planned reallocation of the tasks would benefit the viability of the programme.

Recommendation 6:

The programme would be more usefully targeted towards families with younger children and the age band should be adhered to.

A widely expressed view during the interviews was that the age group targeted by SFP 12-16 was not the most opportune one for this programme in the west of Ireland. The distance between the ages of 12 years and 16 years was considered so wide as to make pitching the discussions at an appropriate level difficult. The older end of this age spectrum was considered very hard to engage within the SFP format whereas it was thought that much greater benefits could be achieved if the programme was directed towards younger children. Some steering committees adhered rigidly to the age criteria which they considered represented the correct interpretation of the SFP guidelines, while some interpreted the same guidelines differently and, yet others, chose to adapt the guidelines to accommodate local demand. This inconsistency resulted in inequitable provision within the region, which would be negated if the age criteria were adhered to.

Recommendation 7:

Training for facilitators should be refocused.

Many of the facilitators felt that the training, whilst interesting, spent too much time on the background detail of the SFP and its development rather than focusing on practical skills required in order to facilitate the sessions. Facilitators discussed using pre-existing skills without which, they would have been ill-equipped to deliver the programme effectively.

It is recommended that all future SFP facilitators be trained in the area of facilitation skills and that the SFP authors further develop their implementation manual to include a framework to deal with operational issues that may arise.

The background of the page is a solid light green color. Overlaid on this background are several large, stylized leaf shapes in a slightly darker shade of green. These leaves are arranged in a way that they appear to be part of a larger plant, with some overlapping others. The leaves have smooth, rounded edges and prominent veins.

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35

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