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EXECUTIVE SUMMARY

The Family Strengthening Initiative was a two-year effort which involved the cooperation of the thirty-two funded project sites, the Center for Substance Abuse Prevention (CSAP) staff, the Center for Mental Health Services (CMHS) staff, and the Program Coordinating Center (PCC). The primary goals of the Initiative were to determine:

1. What factors contribute to the selection of the best evidenced-based model for specific populations;
2. What factors influence decisions in adopting, adapting, and implementing a family intervention model tailored for the target population; and
3. Do adapted family interventions reduce substance use and improve family functioning when culturally modified and replicated by community-based systems of care that intervene with the target population.

The first two goals of the Initiative were reached through the assessment of study sites with the Customer Satisfaction Feedback Questionnaire and the Phase I: Decision-Making Process Reporting Tool. A full description of the findings in support of the first two goals can be found in the Phase I final report and the Batch reports submitted earlier in the project. However, a synopsis of the results is presented below. The hypothesis guiding the Phase I study is that organizations that demonstrate a higher capacity to assess their agencies' strengths and challenges are more likely to promote consensus-based decision making, and thus to select a model appropriate to their organizational capacity and the target population.

The first facet of the evaluation served to ascertain the implementing agencies' strengths and challenges, resource availability and adequacy, staff strengths and experiences, and the various needs of the agencies and communities. The second section of the instrument assessed the process by which study sites solicited input from stakeholders, the evaluators and other key persons.

The findings from Phase I suggest that the majority of respondent sites scored themselves in the "moderate" range when assessing their organizational strengths and challenges. Most often the study sites indicated that they had experience delivering the services within the targeted community, had strong partnerships with other agencies in their community, and had used data from a needs assessment in order to clearly identify a target population and its presenting issues. Two areas that were identified least often as strengths for these sites were the "availability of adequate resources" and having "staff members with the necessary skills" to deliver the services. From these data, we can surmise that this was an established cohort of providers that had been working collaboratively to meet the needs of a well-defined population within the local community, but with fiscal and staffing resources that were perceived as inadequate to the study sites' missions.



Moreover, the majority of sites noted they had selected programs that seemed most appropriate for their respective target populations. In some cases, the selected program focused on a specific ethnic group. In other cases, implementation materials had been translated into Spanish or another language or were appropriate to the reading level of participants. In still other instances, study sites indicated that the program had been selected at least in part because participants' schedules could accommodate the number of classroom sessions. In sum, the evaluation findings of Phase I suggest that sites did not merely solicit input from the community about what would be the most appropriate intervention model, but carefully considered those suggestions during the decision-making process.

In this final report, the third goal is addressed in addition to the reporting of outcomes of the Initiative. A pretest/posttest study design employing a comprehensive survey which contained scales to assess substance use, family functioning, and demographics served as the primary instrument to evaluate the efficacy of the evidence based model programs.

Methods

This second Family Strengthening wave consisted of 32 funded study sites which included twenty states, the District of Columbia, and the commonwealth of Puerto Rico. The study sites proposed to serve various target populations to include Hispanics, African Americans, Native Americans, Asian/Pacific Islander, Caucasians, and other multi-ethnic groups. Additionally, all of the sites were funded through cooperative agreements spanning a two-year period from 2000 through 2002. At the end of the two year period, there was a total sample size of 995 families that were included in the analyses, but a total of 1,015 families served.

Throughout the project, the focus of the PCC efforts has been on data collection (both electronically and hard copies), data entry, and data cleaning. Despite the proactive efforts of the PCC staff to troubleshoot and minimize data collection problems, a thorough review of all received data revealed major data collection problems. Steps taken to resolve this problem are discussed in this report.

Data Analysis

The data analysis plan consisted of four areas that included evaluation of the psychometric properties of the cross-site instrument through reliability and factor analysis, examination of pretest and posttest means through analysis of variance (ANOVA), assessing the effectiveness in reducing substance use through the use of logistic regression, and exploration of sociodemographic characteristics through the use of analysis of covariance (ANCOVA).

The first phase examined the psychometric properties of the instrument, to include internal consistency reliability and factor analysis. Because the internal consistency reliability for the GPRA items was previously established in the first cohort of Family Strengthening grantees and subsequently for an earlier CSAP request for this cohort of grantees, they were excluded in this analysis. Cronbach's alpha was used to examine the internal consistency reliability and demonstrate the extent to which the items for the family core measures are focused on the construct of measurement. Upon the review of the initial reliability coefficients, additional analyses were conducted for the scales that did not show adequate coefficients to determine



whether the dimensionality of the constructs was yielding the true reliabilities. If the reliability coefficients were not adequate, exploratory factor analyses were conducted to determine if each of the constructs truly were unidimensional.

For the next phase, separate analyses were conducted to evaluate whether there was significant improvement in family functioning for each of the nine model programs. Family functioning included the domains of family resilience, family conflict, family cohesion, and family attachment. Repeated measures analysis of variance (ANOVA) was used to assess the difference in means from pretest to posttest for program participants. Next, logistic regression to determine the odds of substance use was originally a component of the analysis plan. However, after the determination of low prevalence of substance use at pretest and posttest and an initial run of the logistic regression with no significant results, the decision was made that to continue to run more analyses on these items would not be an effective use of time and resources. This culminated in no reporting of logistic regression results. The research question related to identifying the sociodemographic characteristics of participants most impacted by each program were examined using analysis of covariance (ANCOVA). The dependent variable was the posttest scores, the pretest scores served as the covariate, and the demographic variables (gender, race, education, age, and employment status) the independent variables.

Results

Subsumed within this report are the results of the first and second phases of the analyses as well as a discussion of these results presented by model program. The results of the reliability analysis support that the family resilience and family cohesion scales were suitably constructed and were adequate for the purpose of the study with sufficient coefficient alpha. Further, we see that both family conflict and family attachment scales exhibited low reliability when all their respective items were included in the reliability analysis. After factor analysis, three factors were extracted from family conflict and two factors from family attachment. Examination of the extracted subscales for family conflict and family attachment resulted in larger coefficient alpha that indicates a closer estimate of the true reliability for the multidimensional scales.

Some of the key results of this study are improved family functioning in the measured domains of family resilience, family cohesion, family conflict and family attachment. Three of the nine model programs had significant improvement from pretest to posttest on all four of the family functioning domains. There were five other programs that had significant improvement on two of the four domains and one program that had no significant results on any of the domains of family functioning.

Examination of the explained variance had diverse results. Based on program staff classification, only one program demonstrated a magnitude of improvement that was either moderate or substantial for all for domains of family functioning. Five other programs had either moderate or substantial improvements on two domains of family functioning. One culturally relevant program had the largest improvement for family resilience and also had a substantial improvement in family attachment.



Overall, except for one model program, the other eight did have either moderate or substantial improvements. Six of the model programs showed substantial or moderate improvement in family conflict and family cohesion had moderate improvement for two model programs. Finally, three model programs demonstrated substantial or moderate improvements in family attachment again with one culturally relevant program having the largest improvement.

Encouragingly, we not only observed the significant magnitude of the improvements of these programs but also observed a consistently positive trend of these programs. This is evidenced by eight (89%) of nine model programs improving family resilience.

Based on the ANCOVA, results were significant for three of the five sociodemographic characteristics. Specifically, gender, race and age all demonstrated significant results whereas education and employment status was not significant. Moreover, we see that females did significantly better than males in the domain of family resilience and Native Hawaiian or other Pacific Islander did not significantly improve as did the other race categories. Finally, with respect to age, of the five categories the age group 14-25 years had significant improvement and the age group 45-55 improved the least.

Policy Implications

This section of the report offers key recommendations for social scientists, family researchers, and policy makers to address the emerging trends related to program dissemination, prevention and fiscal consciousness.

In particular, in an effort to foster effective interventions and treatments, policies regarding provision of service must support the use of these evidence based model programs. The results of this initiative illustrate that these model programs do significantly improve family functioning in both areas of risk and protective factors. The findings from this study also support the use of family focused prevention programs. The most costly policies are ones that fund reactive services more readily than preventive ones.

Future Considerations

Several factors that may be considered in future studies are presented in the final section of the report. These include further empirical support for the theoretical framework with the use of a more rigorous study design (e.g., the use of control/comparison groups), replication using culturally relevant programs, further investigation of distinct subscales, and exploration of data collection methodology that could avoid missing data.



INTRODUCTION

Adolescent substance use is a topic of important public health concern because of its prevalence and associated negative consequences (Chassin et al., 2003). Moreover, there is a body of literature on the epidemiology of adolescent substance use that has documented the extent of the problem and its deleterious consequences (Carnegie Council on Adolescent Development, 1995; Center for Substance Abuse Prevention, 1997; Dryfoos, 1997; Johnston, Bachman, & O'Malley, 1997, Murray & Perry, 1985). Specifically, adolescent substance use problems are typically accompanied by a number of related symptoms and risky behaviours. Most notably, adolescents who are substance users are highly likely to show polydrug use (Chassin et al., 2003). Kandel, Yamaguchi, and Chen (1992), reported that adolescent substance use begins with the use of so-called “gateway” drugs (alcohol and nicotine), followed by marijuana and subsequently by other illegal drugs. Also, substance using or substance dependent adolescents are characterized by functional impairment in numerous domains. They tend to exhibit poorer academic achievement and higher rates of academic failure relative to youths who are not substance users (Moss, Kirisci, Gordon & Tarter, 1994; Tarter, Mezzich, Hsieh, & Parks, 1995). Adolescents who are substance users are also more likely to associate with deviant peer groups, to engage in delinquent behaviours (Blackson et al., 1999; Hawkins, Catalano, & Miller, 1992), and to experience frequent negative interactions with their parents (Kuperman et al., 2001; Mezzich et al., 1997).

Given the importance of adolescent substance use as a major public health concern, there have been national epidemiological studies such as the National Survey on Drug Use and Health (NSDUH) (formerly known as the National Household Survey on Drug Abuse [NHSDA]), which provides estimates of prevalence, incidence, demographic and correlates of drug use (Office of Applied Studies (OAS), 2002). According to the 2001 NHSDA, almost 5 million youths aged 12 to 17 (21 percent) had used an illicit drug in the past year, and over 8 million youths (34 percent) had used alcohol at least once in the past year. Furthermore, demographic correlates such as gender differences have been documented in substance use prevalence studies, such that girls use fewer types of drugs and use them with less frequency than do boys (Johnson et al., 2000). For example, data showed that 12th grade males reported substantially higher prevalence rates (at least 1.5 times as much as females) in the annual use of heroin, LSD, steroids, and smokeless tobacco, as well as in the daily use of marijuana and alcohol. In contrast, in the younger grades, Johnston et al., (2000) found that males and females showed similar rates for many drugs.

Although there are other demographic correlates such as ethnicity and socioeconomic status, risk factors for adolescent substance use have also been identified on multiple levels (Hawkins et al., 1992). Given the heterogeneity of substance use, it is unlikely that any one factor or etiological pathway could explain its development, but there have been findings in the literature that parenting and socialization do have an impact on youth substance use. For example, Stice and Barrera (1995) found that low levels of parental social support and discipline prospectively predicted increases in adolescent substance use over time. Likewise, low levels of parental



monitoring have been shown to prospectively predict the onset both of substance use and of heavy drinking in adolescence (Reifman, et al., 1998; Steinberg, Fletcher, & Darling, 1994). Additionally, high levels of family conflict (Webb & Baer, 1995) have been associated with higher levels of adolescent substance use. On the other hand, parenting that combines high levels of nurturance with consistent discipline has been associated with a lowered risk of adolescent substance use (Hawkins, et al., 1992).

Not only is adolescent substance use related to general parenting styles and family climate, but data suggest that adolescent substance use may also be related to parents' specific socialization about the use of substances (Chassin, et al., 2003). More specifically, Chassin et al. (2003) states that parents set not only general rules and expectations for adolescent behaviour, but also rules and policies about the use of alcohol, tobacco and other drugs.

Available data suggest that parent socialization, either in the form of general parenting and parent-adolescent relationships, or in the form of specific attempts to deter substance use, may influence the development of adolescent substance use behaviour (Chassin, Curran, Hussong, & Colder, 1996; Dishion, Patterson, & Reid, 1988).

There is a substantial body of literature establishing that effective parenting reduces problem behaviours in youth. Specifically, the literature indicates the potential public health benefits of validated family focused interventions (Mrazek & Haggerty, 1994) and the benefits of its widespread implementation. At the core of the family focused interventions is training parents and caregivers in child management strategies derived from a theoretical framework. Through the use of play and activities, parents are encouraged and guided to increase their positive interactions with the child as well as to reinforce appropriate behaviours. Currently, all family interventions now include explicit training for parents in positive parenting strategies and effective discipline, however, earlier proponents attempted to change children's behaviours through only the use of positive strategies such as praise and rewards. Through clinical experience, researchers concluded that the sole use of positive strategies were not sufficient for children with serious behaviour problems. The addition of effective use of brief punishment such as time out or loss of privileges evolved as a successful means to changing behaviour.

Although the primary component of family interventions is child management strategies, research has demonstrated that other factors such as marital conflict, poverty, parental depression, and single parent status all influence a parent's ability to parent which in turn influences the child's behaviour. This led to a number of components being added to the parent skills training. Subsequently, several studies have since shown the efficacy of these added components. For example, Gries et al. (1982) demonstrated that a parent enhancement component where parents received additional training related to personal and marital and extrafamilial relationships added to the effectiveness of child management trainings. Further, Dadds, Schwartz, and Sanders (1987) added to the findings through their study that demonstrated that couples who were high or low in marital discord showed similar gains in child management, but couples high in marital discord had greater difficulty in maintaining the gains unless additional partner support training was received. These findings suggest that couples can benefit



from child management training even when there is high marital discord provided that couples are offered assistance with their marital difficulties.

As with highly discordant couples, single parents, especially low income and socially isolated mothers have also been shown to benefit from supplemental interventions to parent training. For example, Pfiffner et al. (1990) showed that offering single parents social problem solving skills training focusing on problems other than child management adds to the effect of child management training. Collectively, these studies demonstrate that by enhancing parents' ability to cope with other stresses in their lives, they are then able to increase the efficacy of their parenting skills.

Procedures for Establishing Skill Sets

Confirmed by research, the use of role playing and modeling has been an important part of behavioural interventions and has been demonstrated to be more efficacious than the sole use of didactic methods. A comparison by Knapp and Deluty (1989) of two family interventions with identical length and similar content that differed in the teaching strategies was used. In one intervention, readings and discussions of the information were used whereas in the other intervention, modeling and role playing were employed. They found that the modeling and role playing intervention was more effective especially with lower socioeconomic status parents. Another key component of behavioural family interventions is educating parents in the principles of behaviour and not just the specific strategies. There are studies that have evaluated the added impact of educating parents on the behavioural principles of the strategies used. For example, Glogower and Sloop (1977) and McMahon, Forehand, and Griest (1981) found that parents who received the underlying principles of behaviour were more successful in assisting their children in improve their behaviour as opposed to parents who only received guidance in child management strategies. Ultimately, when parents understand the rationale behind the strategies, they become more effective at generalizing the acquired skills to new situations.

Finally, it is not sufficient to demonstrate that the parents who enroll in a program are more likely to espouse the philosophy of the program, but changes in the family environment must be shown on outcomes that have important long term consequences for the families. This CSAP and CMHS sponsored initiative represents an initial step in examining the outcomes of family focused interventions on diverse populations on substance use/abuse and family functioning.

The above mentioned information provides compelling reasons for implementing and rigorously evaluating evidence based, family focused model programs. To this end, the Center for Substance Abuse Prevention(CSAP) in partnership with the Center for Mental Health Services (CMHS) has established cooperative agreements to support the "Parenting and Family Strengthening Initiative" in efforts to move research to practice. The primary goals of the Initiative are to: 1) determine what factors contribute to the selection of the best evidenced-based model for specific populations, 2) determine what factors influence decisions in adopting, adapting, and implementing a family intervention model tailored for the target population, and 3) assess whether adapted family interventions reduce substance use and improve family functioning when culturally modified and replicated by community-based systems of care that



intervene with the target population. A concomitant mechanism to attaining these goals has been the formation of a Program Coordinating Center (PCC) that serves to provide assistance with program management, study design, training, and data coordination in support of the study sites. Specifically, the PCC has coordinated training, developed data collection instruments, collected data, and conducted analyses. These efforts have culminated in this final report. Subsumed in this report are the major components of how the PCC managed the program, our evaluation of the model programs implemented, and the key findings. Particularly, the section on program management covers the execution of the four conferences as a requirement of the grant, the dissemination of information to the grantees to assist in their decision-making processes, the development and management of the data collection instruments and the data, and how the program was staffed. Additionally, the research and evaluation section of the report includes the theoretical framework which has dual foci, the methodology of the program, the results of the analyses that were data driven, a discussion of the results, the limitations of study, and conclusions and recommendations. This report provides information that will add to the body of literature on family focused interventions to prevent substance use.



SECTION I: GRANTEE PROJECT DESCRIPTIONS

The Family Strengthening Initiative funded thirty-two project sites. The sites were selected based on their response to a SAMHSA/CSAP grant announcement issued in February 2000. The basis for the selections was the applicants’ capacity to deliver family services. Sites were supported to select a culturally-appropriate, family-focused program that was best matched to their target population.

The sites had the opportunity to implement one of thirty-five Model Family Programs for Substance Abuse and Delinquency Prevention identified by the Center for Substance Abuse Prevention. The programs are outlined in the publication, “Strengthening America’s Families-Model Family Programs for Substance Abuse and Delinquency Prevention”. The booklet was prepared under grant no. 1UDISP08737, awarded by the CSAP and grant no. 95-JN-FX-K01, awarded by the office of Juvenile Justice and Delinquency Programs (OJJDP). The selection list was grouped into Exemplary I, Exemplary II, Model and Promising Programs. The programs were also identified as “Selected”, “Indicated” or “Universal” (see Appendix 6 for an explanation of model program identifiers and geographic locations of the study sites). Table 1.1 outlines the frequency of program selection.

Table 1.1: Intervention Programs Selected by CSAP Phase II Grantees

Number of Grantees*	Program Name	Program Category
16	Strengthening Multi Ethnic Families and Communities (SMEFAC)	Selected/Promising
5	Parenting Wisely (PW) Adolescents	Indicated/Exemplary II
3	Strengthening Families Program (SFP)	Selected/Exemplary I
3	Strengthening Families Program 10-14 (SFP 10-14)	Universal/Exemplary II
1	Effective Black Parenting (EBP)	Selected/Model
1	The Incredible Years (IY)	Selected/Exemplary I
3	Nurturing Program for Parents and Children 5-11 Years (NPP)	Selected/Model
1	Dare To Be You (DTBY)	Universal/Model
1	Brief Strategic Family Therapy (BSFT)	Indicated/Exemplary II

*Total Grantees = 32 (not 34). Note: Two sites implemented two different programs.



The specific programs selected, by site, are outlined in Table 1.2.

Table 1.2: Site Program Selections

Grantees	Location	Program Model
9021 Lt. Joseph P. Kennedy Institute	Washington, DC	Strengthening Multi Ethnic Families & Communities
9030 Public Health Seattle & King County	Seattle, WA	Strengthening Multi Ethnic Families & Communities
9037 Amherst H. Wilder Foundation	St. Paul, MN	Strengthening Multi Ethnic Families & Communities
9055 Yakima Valley Farm Workers Clinic	Toppenish, WA	The Incredible Years
9058 Family Service, Inc.	Lawrence, MA	Strengthening Multi Ethnic Families & Communities
9078 Eagle Ridge Institute	Oklahoma City, OK	Nurturing Parenting Program
9024 University of Maryland College Park	College Park, MD	Effective Black Parenting/ on site training PD
9033 Port Gamble S'Klallam Tribe	Kingston, WA	Strengthening Multi Ethnic Families & Communities
9043 Mental Health Assoc of New York City	New York City, NY	Strengthening Multi Ethnic Families & Communities
9057 Family Health Centers of San Diego	San Diego, CA	Strengthening Families Program
9064 Phoenix Children's Hospital	Phoenix, AZ	Strengthening Multi Ethnic Families & Communities
9079 Family Self-Help Center	Joplin, MO	Strengthening Families Program
9082 Board of Regents of UW Systems	Madison, WI	Strengthening Families & Youth 10-14
9099 The Center For Success and Independence, Inc.	Houston, TX	Strengthening Multi Ethnic Families & Communities
9104 Luz Social Services	Tucson, AZ	Strengthening Multi Ethnic Families & Communities
9115 Racine Council on Alcohol & Other Drug Abuse, Inc.	Racine, WI	Parenting Wisely & Strengthening Families Program 10-14
9133 Denver Area Youth Services	Denver, CO	Strengthening Families Program
9148 Mental Health Association of South Central	Wichita, KS	Parenting Wisely



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9159 Pacific Clinics Asian Pacific Family Center	El Monto, CA	Strengthening Multi-Ethnic Families & Communities
9095 Cook Inlet Tribal Council, Inc.	Anchorage, AK	Parenting Wisely
9103 Keys for Networking Inc.	Topeka, KS	Parenting Wisely & Strengthening Multi Ethnic Families & Communities/PD 3/19-3/23 St. Louis
9106 Employee and Family Resources	Des Moines, IA	Parenting Wisely
9129 Solano County Administrator's Office	Fairfield, CA	The Nurturing Parenting Program
9147 Cleveland State University	Cleveland, OH	Nurturning Parenting Program
9151 Julian Dykman Andrus Memorial, Inc	Yonkers, NY	Strengthening Families Program for Parents & Youth 10-14
9161 Maui Economic Opportunities, Inc.	Wailuku, HI	Strengthening Multi Ethnic Families & Communities
9162 Arkansas Children Hospital Research Institute	Little Rock, AR	Dare to be You
9165 Taos Pueblo Central Management Systems	Taos, NM	Strengthening Multi Ethnic Families & Communities
9182 Cambodian Mutual Assistance Association, Inc.	Lowell, MA	Strengthening Multi Ethnic Families & Communities
9163 Mental Health Corp. of Denver	Denver, CO	Brief Strategic Family Therapy
9295 Little Wound School-The Takini Network	Rapid City, SD	Strengthening Multi-Ethnic Families & Communities
9201 Sowing the Seeds of Hope	Arecibo, PR	Strengthening Multi-Ethnic Families & Communities

Model program descriptions are located at Appendix .1.



SECTION II: CONFERENCES / WORKSHOPS

This study included four conferences/workshops designed to assist the study sites with program orientation, model program selection, and training, as well as to provide the study participants with program results. To accomplish these goals, CSAP/CMHS required the PCC to conduct a New Grantee Readiness Workshop (orientation and training), a Model Showcase (model programs orientation and selection), a Model Program Training Workshop (model program selection and training) and a Findings Symposium (program results). The Findings Symposium was later identified as the Learning Community Workshop and included information and attendees from Cohorts 1, 2 and 3.

New Grantee Workshop

The Family Strengthening Program New Grantee Workshop was held November 13-15, 2000 at the Radisson Barcelo' Hotel in Washington, DC. The Workshop was attended by 130 people. The primary goal of the workshop was to ensure the 32 Cohort II grantees were aware of their responsibilities to CSAP/CMHS and the requirements of the Guidance For Applicants. The second goal of the workshop was to acquaint conference participants with the structure, personnel, and organizational resources of CSAP/CMHS and the PCC. The workshop also provided an interactive forum for the exchange of ideas and experiences and promoted regional and national networking and communication among the family strengthening community.

The National Center for the Advancement of Prevention (NCAP) played an active role at the workshop. NCAP provided "Getting to Outcomes" training for all grantees during several break-out sessions. The goal of the NCAP training was to help participants acquire sufficient understanding and skills to conduct an assessment of their organization's readiness for selecting and implementing science-based Family Strengthening Programs.

PCC staff developed and administered an overall conference evaluation to elicit feedback to allow the PCC to revise and improve upon strategies to meet the future logistical needs of conference participants (Appendix 2). In developing the evaluation tool, both quantitative and qualitative approaches were used to elicit views and assessments, and to enable evaluation findings that are both summative and formative in nature. The first three questions of the evaluation were devoted to characteristics of the grantees' and their organization as well as the targeted population for the program. The next two questions comprised of quantitative items addressing participant's ratings of the program sessions. The next section addressed participants' ratings of eight "non-workshop" elements of the three-day event. Respondents were able to make written comments in each section of the instrument. The last question of the evaluation encouraged respondents to provide any additional information or address topics not included on the instrument. The findings of the evaluation were as follows:

Demographic Characteristics of Conference Participants

Table 2.1. illustrates the number of participants by affiliation. Each grantee site was encouraged to bring additional program staff members.



Table 2.1. Conference Participants

(N=130)		
Affiliation	N	%
Grantees	66	50.8
CSAP Staff and Presenters	14	10.8
CMHS Staff and Presenters	11	8.4
NCAP GTO Trainers	16	12.3
McFarland & Associates Staff	12	9.2
Presenters and Luncheon Panelists	9	6.9
Keynote Speaker	1	0.8
Contractors	1	0.8
<i>Total</i>	<i>130</i>	<i>100</i>

Table 2.2 reflects site representation at the workshop.



Table 2.2. Grantee Representatives

(N=66)			
Grant Number	State	<i>Organization</i>	N
9095	AK	Cook Inlet Tribal Council, Inc.	3
9162	AR	Arkansas Children’s Hospital Research Institute	3
9104	AZ	Luz Social Services, Inc.	3
9064	AZ	Phoenix Children’s Hospital	3
9159	CA	Asian Pacific Family Center	1
9057	CA	Family Health Centers of San Diego	1
9129	CA	Solano County Administrator’s Office	2
9163	CO	Mental Health Corporation of Denver	2
9133	CO	Denver Area Youth Services	2
9021	DC	Lt. Joseph F. Kennedy Institute	2
9161	HI	Maui Economic Opportunities, Inc.	1
9106	IA	Employee and Family Resolutions	2
9103	KS	Keys for Networking	4
9148	KS	Mental Health Association of South Central Kansas, Inc.	2
9058	MA	Family Services, Inc.	1
9182	MA	Cambodian Mutual Assistance Association of Greater Lowell, Inc.	1
9024	MD	University of Maryland, College Park	2
9037	MN	Amherst H. Wilder Foundation	2
9079	MO	Family Self-Help Center	2
9165	NM	Taos Pueblo Indian Tribe	2
9043	NY	Mental Health Association of NYC, Inc.	1
9151	NY	Julian Dykman Andrus Memorial, Inc.	3
9147	OH	Cleveland State University	3
9078	OK	Eagle Ridge Institute	2
9201	PR	Sowing Seeds of Hope	2
9295	SD	The Takini Network/Little Wound School	2
9099	TX	Center for Success and Independence, Inc.	3
9033	WA	Port Gamble S’Klallam	2
9055	WA	Yakima Valley Farm Workers Clinic	1
9030	WA	Public Health Seattle/King County	2
9115	WI	Racine Council on Alcohol and Other Drug Abuse	2
9082	WI	Board of Regents of UW System	2

Question one asked respondents to identify their position. The results are presented in the Figure 2a below. The largest sector of respondents by profession was project directors with 37.9%, closely followed by administrators with 29.3%. Eight respondents identified themselves as evaluators and 5 respondents identified themselves as practitioners. Six people identified themselves in the categories of researcher. Responses for “other” included such positions as grant writer, educator, and program specialist.

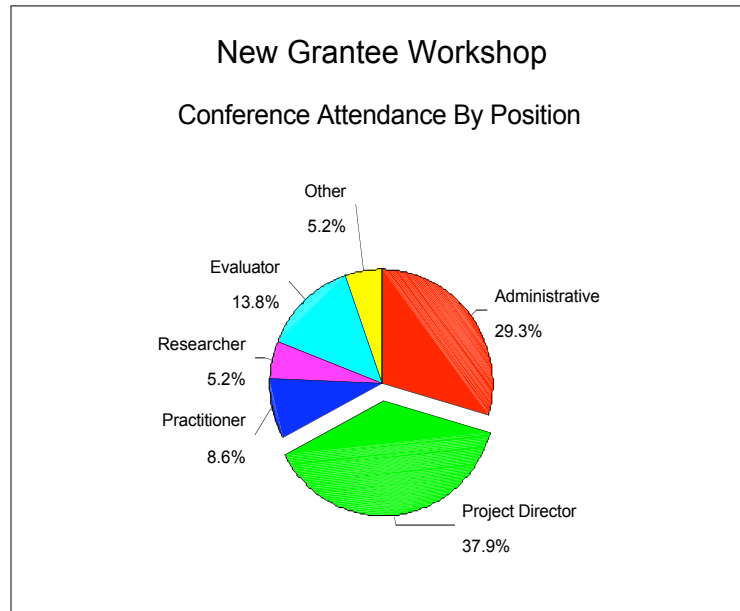


Figure 2a. Conference Attendance By Position

A sample of the written comments is listed below:

- Provide the agenda for grantees ahead of time, even if only a rough draft is available. This will help assist grantees with travel arrangements as well as encourage them to bring more than one representative to the conference.
- Continue to distribute relevant and useful printed materials in the resource notebook.
- Have more sessions involving input from Cohort 1. Possible topics of discussion include lessons learned, barriers encountered as well as solutions for overcoming them.
- Schedule more relevant discussions during the morning sessions. Afternoon sessions received a lower response rate as well as session occurring on the third day of the conference.
- Begin the conference on a Tuesday allowing for travel on Monday. Start the conference at 8 am on the first day and end earlier the third day allowing for individuals who have to travel to get an earlier start the third day of the conference without having to miss sessions.
- Provide a follow-up conference at the end of the grant period to address suggestions and concerns of the grantees.

The PCC experienced no significant logistical issues. Some planning issues such as hotel selection, menu selection and workshop agenda format received extensive attention. At times the expended time was excessive when one considers the decision to be made. Such activity increases the cost of the project and causes frustration among the planning committee members.



Overall, the conference received favorable ratings. Grantees felt well informed and were eager to begin the program implementation process.

Model Showcase

The Family Strengthening Model Showcase was held January 30-February 1, 2001, at the Radisson Hotel in New Orleans, Louisiana. The primary goals of the Family Strengthening Model Showcase were to 1) introduce the 32 grantees to model programs in the field of parenting and family strengthening, 2) familiarize grantees and others working in family strengthening with the elements associated with successful program design, implementation, and evaluation, and 3) inform participants of the types and scope of training and technical assistance available through CSAP/CMHS. Secondary goals of the conference were to provide an interactive forum for the exchange of ideas and experiences in the field and to promote regional and national networking and communication among the family strengthening grantees.

Based on grantee feedback from the New Grantee Workshop, daily networking time was built in for grantees to establish contact with each other and their Project Officers. A follow-up “Getting to Outcomes” training took place on the first day of the Showcase. The presentation allowed grantees the opportunity to ask any outstanding questions of facilitators regarding community collaboration, program selection, program implementation, and evaluation.

Thirteen model programs were showcased at the conference. Program Developers presented the model programs in six 2-hour overview sessions. Each model was presented twice, allowing grantees the opportunity to review two models each day. The 13 models are summarized in Table 2.3, organized by workshop sessions.



Table 2.3. CSAP/CMHS's Family Strengthening Program Matrix

FAMILY MODEL PROGRAMS	Parents with Children Age			Parent & Child Focused Session Activities	Parent Focused Session Activities	Home Visit Session Activities	Therapy Sessions	Program Used with Ethnic Groups	Curriculum Materials	Published Outcome Date	Available Outcome Instrument Tools	Spanish Materials	Other Language Materials
	0-5	6-10	11-18										
TUESDAY, JANUARY 30, 2001 OVERVIEW SESSIONS I & II													
Creating Lasting Family Connections			√	√				CA, AA	√	√	√		
The NICASA Parent Project	√	√	√		√			H, AA, CA	√	√		√	
Strengthening Families Program		√		√				AA, API, H, CA, H, R	√	√	√	√	
Effective Black Parenting	√	√	√		√			AA	√	√			
WEDNESDAY, JANUARY 31, 2001 OVERVIEW SESSIONS III & IV													
Strengthening Multi-Ethnic Families and Communities	√	√	√		√			AA, API, H, NA, AA, H, API	√	√	√	√	V, C, K, R
DARE to Be You	√			√				AA, API, H	√	√	√	√	
Brief Strategic Family Therapy	√	√	√	√		√	√	AA, API, H		√			
Nurturing Parenting Program	√	√	√	√		√	√	AA, H, API	√	√			
Strengthening Families Program for Parents & Youth 10-14			√	√				AA, CA, H	√	√	√		Videotapes for Non-English families
THURSDAY, FEBRUARY 1, 2001 OVERVIEW SESSIONS V & VI													
Parenting Wisely		√	√		√	√		INA	√	√	√		
Nurturing Program for Families in Substance Abuse Treatment & Recovery	√	√	√		√		√	INA	√	√			
Multisystemic Therapy Program			√	√		√	√	CA, AA, H		√	√		
Families and Schools Together (FAST)	√	√	√	√				H, AA, NA		√	√	√	V, G, FC
This matrix is based on information collected from the Program Developers as of Oct. 2000. Ethnic Codes: AA=African American, API=Asian/Pacific Islander, H=Hispanic, NA/AI=Native American/American Indian, R=Russian, CA=Caucasian, C=Cambodian, FC=French Canadian, G=German, K=Korean, R=Russian, V=Vietnamese, INA=Information not available													

An overall conference evaluation and a program model session evaluation were administered. The overall conference evaluation (Appendix 3) consisted of three major parts. Part I was comprised of demographic items, Part II addressed the general sessions, and Part III addressed conference logistics. The program model overview evaluation (Appendix 3) consisted of two major parts. Part I was identical to Part I of the overall conference evaluation, Part II required the respondent to comment on each model program presentation attended.

One hundred and twenty-seven individuals attended the conference. Table 2.4. illustrates the number of participants by affiliation. Each grantee site was encouraged to bring additional program staff members.



Table 2.4. Conference Participants

(N=127)		
Affiliation	N	%
Grantees	88	69.3
CSAP Staff	8	6.3
CMHS Staff	1	0.8
NCAP GTO Facilitators	3	2.4
McFarland & Associates Staff	8	6.3
White House Representative	1	0.8
Program Developers*	15	11.8
Guest	3	2.4
<i>Total</i>	<i>127</i>	<i>100.0</i>

*Two of the program model overviews had two individuals to help assist with their presentation, therefore there were 15 program developers present instead of 13.



Table 2.5 represent grantee conference attendance by study site.

Table 2.5. Grantee Representatives

(N=88)			
Grant Number	State	Organization	N
9095	AK	Cook Inlet Tribal Council, Inc.	2
9162	AR	Arkansas Children's Hospital Research Institute	3
9104	AZ	Luz Social Services, Inc.	3
9064	AZ	Phoenix Children's Hospital	3
9159	CA	Asian Pacific Family Center	3
9057	CA	Family Health Centers of San Diego	2
9129	CA	Solano County Administrator's Office	3
9163	CO	Mental Health Corporation of Denver	3
9133	CO	Denver Area Youth Services	2
9021	DC	Lt. Joseph F. Kennedy Institute	2
9161	HI	Maui Economic Opportunities, Inc.	2
9106	IA	Employee and Family Resolutions	2
9103	KS	Keys for Networking	3
9148	KS	Mental Health Association of South Central Kansas, Inc.	4
9058	MA	Family Services, Inc.	2
9182	MA	Cambodian Mutual Assistance Association of Greater Lowell, Inc.	3
9024	MD	University of Maryland, College Park	2
9037	MN	Amherst H. Wilder Foundation	4
9079	MO	Family Self-Help Center	4
9165	NM	Taos Pueblo Indian Tribe	2
9043	NY	Mental Health Association of NYC, Inc.	2
9151	NY	Julian Dykman Andrus Memorial, Inc.	4
9147	OH	Cleveland State University	3
9078	OK	Eagle Ridge Institute	3
9201	PR	Sowing Seeds of Hope	3
9295	SD	The Takini Network/Little Wound School	2
9099	TX	Center for Success and Independence, Inc.	3
9033	WA	Port Gamble S'Klallam	4
9055	WA	Yakima Valley Farm Workers Clinic	2
9030	WA	Public Health Seattle/King County	2
9115	WI	Racine Council on Alcohol and Other Drug Abuse	4
9082	WI	Board of Regents of UW System	2

The overall conference evaluation was completed by 36 of the 88 grantee attendees, a 40.9% response rate. The following demographic information was collected:



Question one of the overall conference evaluation asked respondents to identify their position. Findings are presented in Figure 2b. As with the New Grantee Workshop, the largest group of respondents by profession, was Project Directors with 36.1%, followed by Administrators with 22.2%. Eight respondents identified themselves as Practitioners or Researchers. Only one person identified his/herself as an Evaluator and two people identified themselves as Volunteers. Four people identified themselves in the category “Other,” which included Department Director, Project Developer, and two Project Coordinators.

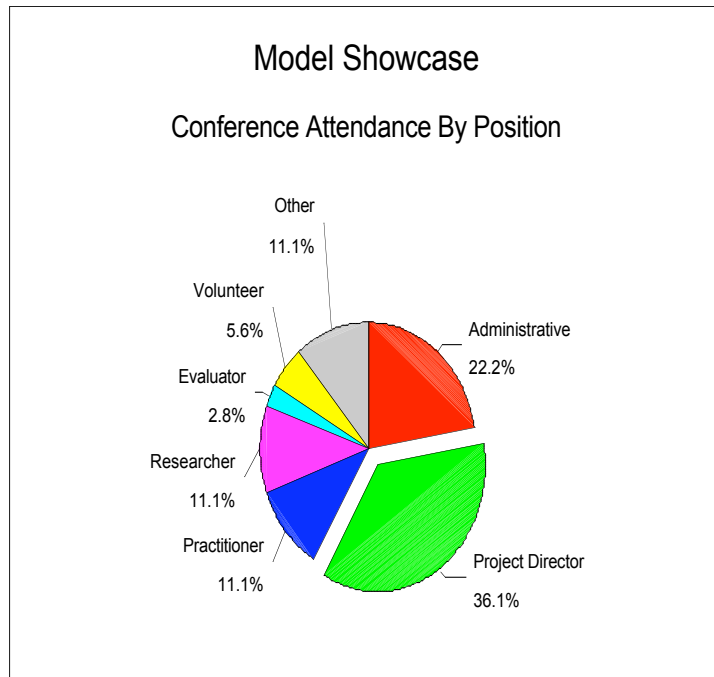


Figure 2b. Conference Attendance By Position

On Tuesday, January 30, 2001, there were four general sessions available for attendance by all grantees. Table 2.6. reflect the respondents “usefulness” of each session.

Table 2.6. Tuesday Conference Sessions

(N=36)*								
Event	Very Useful		Useful		Not Useful		Did Not Attend	
	N	%	N	%	N	%	N	%
Opening Plenary Session (N=34)	5	14.7	22	64.7	6	17.6	1	2.9
GTO-Technical Assistance (N=29)	9	31.0	16	55.2	0	0.0	4	13.8
Roundtables (N=34)	8	23.5	21	61.8	1	2.9	4	11.8
Grantee Networking Reception (N=31)	5	16.1	11	35.5	6	19.4	9	29.0

*The percentages in this table are row percentages and do not include missing data.



All conference sessions were viewed as very useful or useful by at least 72% of respondents attending the sessions. Space was also provided for additional comments by respondents regarding the conference sessions listed above. Twelve individuals provided comments. Four of the responses addressed issues concerning the roundtables. Two of these responses stated that the roundtables were great. The remaining two responses suggested the roundtables to be held during breaks and the roundtables would be better utilized if all participants were able to ask individual questions as well as listen to all of the answers. Three of the respondents addressed the Getting To Outcomes (GTO) sessions. One respondent viewed the GTO sessions as excellent whereas the other two respondents wanted a more in depth discussion rather than just following a handout. One respondent was unsatisfied with the length of the session, wanting it to be shorter and therefore allowing for attendance at more than one GTO session. Two respondents addressed the networking reception. One respondent felt it was very helpful and the other respondent suggested the session should have occurred earlier in the day. The remaining responses were varied and addressed issues such as room acoustics and conference logistics.

Three general sessions were held on Wednesday. These sessions were evaluated according to their usefulness. The results are in Table 2.7.

Table 2.7. Wednesday Conference Sessions

(N=36)*								
Event	Very Useful		Useful		Not Useful		Did Not Attend	
	N	%	N	%	N	%	N	%
Plenary Session (N=33)	3	9.1	21	63.6	8	24.2	1	3.0
Roundtables (N=34)	7	20.6	22	64.7	2	5.9	3	8.8
Cluster Meetings (N=26)	3	11.5	12	46.2	5	19.2	5	19.2

*The percentages in this table are row percentages and do not include missing data.

The majority of respondents found the sessions to be useful. Very few respondents indicated the sessions to be very useful or not useful. Additional space was again available for comment. Only six respondents filled out this portion of the questionnaire, a 16.7% response rate.

On Thursday there were three general sessions available for attendance. These sessions were also evaluated for their usefulness with the results in Table 2.8.

Table 2.8. Thursday Conference Sessions

(N=36)*								
Event	Very Useful		Useful		Not Useful		Did Not Attend	
	N	%	N	%	N	%	N	%
Plenary Session (N=33)	4	12.1	19	57.6	9	27.3	1	3.0
Roundtables (N=30)	6	20.0	16	53.3	2	6.7	6	20.0
Closing Plenary Session (N=25)	4	16.0	9	36.0	2	8.0	10	40.0

*The percentages in this table are row percentages and do not include missing data.



A look at respondents' attendance at the program model overviews is presented in Table 2.9 below.

Table 2.9. Program Model Overview Attendance

(N=342)*					
Program Model Overview		AM		PM	
		N	%	N	%
TUESDAY, JANUARY 30, 2001 OVERVIEW SESSIONS I & II					
Creating Lasting Family Connections	(N=33)	17	51.5	16	48.5
The NICASA Parent Project	(N=27)	17	63.0	10	37.0
Strengthening Families Program	(N=83)	60	72.3	23	27.7
Effective Black Parenting	(N=11)	4	36.4	7	63.6
WEDNESDAY, JANUARY 31, 2001 OVERVIEW SESSIONS III & IV					
Strengthening Multi-Ethnic Families and Communities	(N=38)	18	47.4	20	52.6
DARE to Be You	(N=13)	5	38.5	8	61.5
Brief Strategic Family Therapy	(N=7)	6	85.7	1	14.3
Nurturing Parenting Program	(N=45)	25	55.6	20	44.4
Strengthening Families Program for Parents & Youth 10-14	(N=18)	2	11.1	16	88.9
THURSDAY, FEBRUARY 1, 2001 OVERVIEW SESSION V & VI					
Parenting Wisely	(N=28)	22	78.6	6	21.4
Nurturing Program for Families in Substance Abuse Treatment & Recovery	(N=20)	8	40.0	12	60.0
Multisystemic Therapy Program	(N=19)	11	57.9	8	42.1
Families and Schools Together (FAST)	(N=33)	23	69.7	10	30.3
Total	(N=342)	<i>218</i>	<i>58.1</i>	<i>157</i>	<i>41.9</i>

* The percentages in this table are row percentages and do not include missing data.

As shown in the table above, the most frequently attended model program overview was Strengthening Families Program, with 22% of the total program model overview attendance. Strengthening Families Program had the largest attendance for both the morning and afternoon sessions. Nurturing Parenting Program was the second most frequently attended program with attendance by 45 of the respondents, a 12% attendance rate. The Nurturing Parenting Program tied with Strengthening Multi-Ethnic Families and Communities for the second most popular afternoon session with attendance by 20 respondents each.

Question eight of the program model overview evaluation asked respondents to comment on the degree of new ideas and information gained from the program presentations. Table 2.10 illustrates the frequency of responses for all program model overviews.



Table 2.10: Response To “New Ideas and Information”

(N=388)*										
Program Model Overview	Strongly Agree		Agree		Not Sure		Disagree		Strongly Disagree	
	N	%	N	%	N	%	N	%	N	%
Creating Lasting Family Connections (N=35)	7	20.0	22	62.9	5	14.3	0	0.0	1	2.9
The NICASA Parent Project (N=27)	5	18.5	16	59.3	1	3.7	5	18.5	0	0.0
Strengthening Families Program (N=87)	21	24.1	57	65.5	3	3.4	4	4.6	2	2.3
Effective Black Parenting (N=11)	3	27.3	8	72.7	0	0.0	0	0.0	0	0.0
Strengthening Multi-Ethnic Families and Communities (N=39)	15	38.5	21	53.8	1	2.6	2	5.1	0	0.0
DARE to Be You (N=13)	4	30.8	8	61.5	1	7.7	0	0.0	0	0.0
Brief Strategic Family Therapy (N=7)	2	28.6	4	57.1	0	0.0	0	0.0	1	14.3
Nurturing Parenting Program (N=48)	18	37.5	26	54.2	0	0.0	4	8.3	0	0.0
Strengthening Families Program for Parents & Youth 10-14 (N=17)	2	11.8	13	76.5	2	11.8	0	0.0	0	0.0
Parenting Wisely (N=30)	12	40.0	16	53.3	1	3.3	0	0.0	1	3.3
Nurturing Program for Families in Substance Abuse Treatment & Recovery (N=20)	4	20.0	13	65.0	1	5.0	1	5.0	1	5.0
Multisystemic Therapy Program (N=19)	5	26.3	11	57.9	1	5.3	2	10.5	0	0.0
Families and Schools Together (FAST) (N=35)	10	28.6	25	71.4	0	0.0	0	0.0	0	0.0
Total	108	27.8	240	61.9	16	4.1	18	4.6	6	1.5

* The percentages in this table are row percentages and do not include missing data.

The majority of respondents strongly agreed or agreed that each of the model overviews provided ideas and information that were new to them.

The program model overviews were received well and provided ideas and information that were new to the grantees. The majority of respondents felt they would be able to adapt the program to fit the needs of their specific program and target population. The respondents were also satisfied with the materials and content of the presentations. Many respondents thought it would have been helpful if the Program Developers had made program materials available for review at the conference (manuals, evaluation tools, etc). Written suggestions by respondents suggested that each Program Developer should be given an outline of topics to discuss in the sessions. This would make each of the program model overviews similar and ensure that participants are gaining the knowledge required for program selection and implementation. Respondents indicated that the two-hour program model overview sessions were too long. They recommended incorporating a break in the two-hour sessions or shortening the sessions and perhaps allowing participants to attend more than 6 program model overview sessions. One last suggestion by respondents to improve upon the content of the program model overviews was to include grantees from Cohort I in the discussions/presentations

Overall, the conference received favorable ratings and provided participants with the knowledge necessary to select a family strengthening program for their target population. The PCC experienced no significant logistical issues.



Model Program Training

The Family Strengthening Model Training was held at The Handlery Hotel in San Diego, California, May 8-11, 2001. The primary goals of the Family Strengthening Model Training were to 1) provide grantees with the opportunity to be trained in their selected model, 2) familiarize grantees and others working in family strengthening with the elements associated with successful implementation and evaluation, and 3) inform participants of adapting and maintaining fidelity to the core components to the program. Secondary goals of the conference were to provide an interactive forum for addressing concerns and policy questions as well as exchange of ideas and experiences in the field and communication among the family strengthening community.

There were five programs presented at the training (Table 2.11). Program Developers trained for approximately three and a half hours in the morning with a lunch break and resumed for an additional three hours in the afternoon. Each participant attended, depending on the model selected, 2 to 4 days of training.

PCC staff developed and administered an overall conference evaluation to elicit feedback on the training sessions and the conference components and arrangements (Appendix 4). The first section of the evaluation was devoted to characteristics of the grantees’ and their organization as well as the model program attended. The next section was comprised of quantitative and qualitative items addressing participant’s assessment of the training sessions. The final section addressed participants’ ratings of six “non-workshop” elements of the event. Each question was followed by adequate space inviting respondents to write open-ended comments they wished to make in addition to the structured items. The last question of the evaluation encouraged respondents to provide any additional comments on the conference arrangements.

Table 2.11. Model Program Attendance

(N=79)		
Model Program	N	%
DARE to BE You	4	5.1
Strengthening Families Program	8	10.1
Strengthening Families Program for Parents and Youth 10-14	12	15.2
Strengthening Multi-Ethnic Families & Communities	44	55.7
Nurturing Parenting Program	11	13.9

Question one asked respondents to identify their position. The results are presented in Figure 2c. The largest sector of respondents by profession was the program coordinators with 27.8%, followed by project directors with 20.3%. Fourteen respondents identified themselves as practitioners and 3 respondents identified themselves as evaluators. Six people identified themselves as administrators and fifteen as “other.” Responses for “other” included case managers and community liaison specialist.

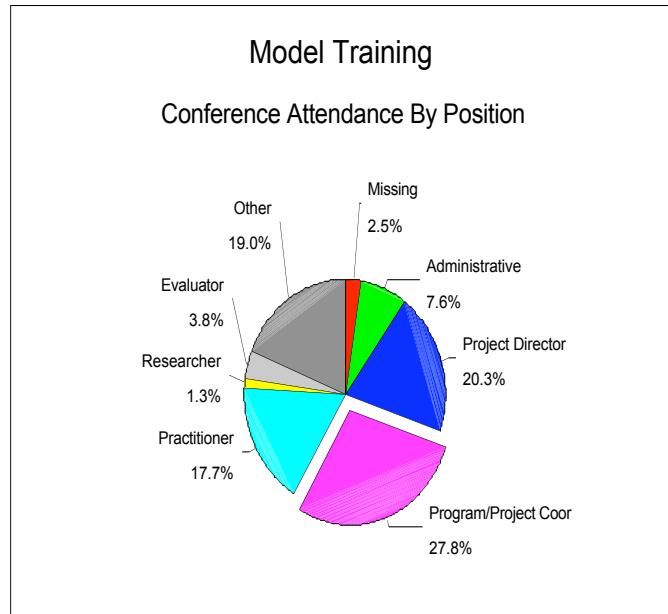


Figure 2c. Conference Attendance By Position

Learning Community Workshop (Findings Symposium)

The Family Strengthening Program Learning Community Workshop was held June 24-26, at the Hyatt Regency Tech Center, Denver, CO. The Workshop was attended by 140 people. The primary goals of the workshop were to disseminate findings for several CSAP projects (Cohorts 1, 2 & 3 and Project Youth Connect) and to provide additional information in the areas of model program implementation, local program issues and funding sources. The keynote speaker for the Workshop was Beverly Watts Davis, Director, Center for Substance Abuse Prevention. The specific Workshop topics of presentation are listed in Table 2.12.



Table 2.12 Learning Communities Workshop Presentations

Learning Community Workshop Topics	
<i>PCC Outcomes / Cohort I</i>	<i>Julian Dykman Andrus Memorial, Inc.</i>
<i>Content Analysis Of Cohort I Outcomes</i>	<i>Housing and Urban Development (HUD)</i>
<i>Cohort I Study Site Outcomes</i>	<i>Top Ten Insider Tips To Raising Money</i>
<i>Cohort I Study Site Outcomes</i>	<i>Tips for Sustainability for Non-Profits</i>
<i>PCC Project Youth Connect Outcomes</i>	<i>PCC Cohort III Preliminary Data Review</i>
<i>PCC Outcomes / Cohort II</i>	<i>Racine Council On Alcoholism: 21ST</i>
<i>Cohort II Study Site Outcomes</i>	<i>Century Lighted Schoolhouse Program and</i>
<i>Use of Technology In Survey</i>	<i>SIG Grants</i>
<i>Administration</i>	<i>Partnering With University Cooperative</i>
<i>Parenting Wisely: The CD</i>	<i>Extension</i>
<i>Program Dissemination</i>	<i>Julian Dykman Andrus Memorial, Inc.</i>
<i>Fund Raising 101: Doing Things Right</i>	<i>Housing and Urban Development (HUD)</i>
<i>With Individual Donors</i>	<i>Program Adaptations for Families of</i>
<i>Top Ten Insider Tips To Raising Money</i>	<i>Children With Severe Emotional</i>
<i>Tips for Sustainability for Non-Profits</i>	<i>Disturbance</i>
<i>PCC Cohort III Preliminary Data Review</i>	<i>Lessons Learned In Planning,</i>
<i>PCC Outcomes / Cohort I</i>	<i>Implementing, Researching and Building A</i>
<i>Content Analysis Of Cohort I Outcomes</i>	<i>Community-Wide Family Strengthening</i>
<i>Cohort I Study Site Outcomes</i>	<i>Best Practice Effort</i>
<i>Cohort I Study Site Outcomes</i>	<i>Structured Group Mentoring (SGM)</i>
<i>PCC Project Youth Connect Outcomes</i>	<i>Mentor/Mentee Relationship: A Panel</i>
<i>PCC Outcomes / Cohort II</i>	<i>Discussion</i>
<i>Cohort II Study Site Outcomes</i>	<i>Cultural Competence Mentoring</i>
<i>Use of Technology In Survey</i>	<i>Strategies for Local Data Analysis</i>
<i>Administration</i>	<i>Overcoming Difficulties With High Risk</i>
<i>Parenting Wisely: The CD</i>	<i>Population</i>
<i>Program Dissemination</i>	<i>Building Capacity For Parenting Services</i>
<i>Fund Raising 101: Doing Things Right</i>	<i>in Substance Abuse Treatment</i>
<i>With Individual Donors</i>	<i>State, Federal And Other Funding Sources</i>
<i>Racine Council On Alcoholism: 21ST</i>	<i>Presentation on Publication Policy</i>
<i>Century Lighted Schoolhouse Program and</i>	<i>NREPP</i>
<i>SIG Grants</i>	
<i>Partnering With University Cooperative</i>	
<i>Extension</i>	

The workshop also provided an interactive forum for the exchange of ideas and experiences and promoted regional and national networking and communication among family strengthening and mentoring communities. Findings for Cohort 2 are presented in Section IV of this report. The Workshop agenda and Participants List is at Appendix 5. A workshop Evaluation Form was



distributed to the participants two weeks after the event, however, only 17 participants completed the form (12%).

The conferences/workshops met the goals of assisting study sites with program orientation, model program selection, training and providing the study participants with program results. CSAP/CMHS and the PCC staff were able to gain valuable incite on conference logistics from the conference evaluations. The overall format of the conferences/workshops proved to be successful.



SECTION III: TECHNICAL ASSISTANCE/INFORMATION DISSEMINATION

In an effort to prepare the study sites to select the “best fit” parenting program for implementation the PCC disseminated three separate batches of information containing family strengthening information materials. As part of the cooperative agreement and achievement of program goals for the Parenting and Family Strengthening Initiative, each grantee was required to provide feedback on the content and usefulness of different information materials (booklets, pamphlets, brochures, literature reviews, manuals, monographs, and reports). Feedback on each batch was provided via a Customer Satisfaction Feedback Questionnaire. Two phase reports were completed with the purpose of documenting the grantees process for program selection and to allow grantees to look at their organizational capacity to implement the selected model program. The process by which grantees reviewed the materials sent to them was also assessed in order to gain insight into how the dissemination process increases grantees’ awareness of family-based prevention programs.

Batch and Phase reports were completed and forwarded to CSAP under separate cover.

Batch 1

Batch one provided grantees with a basic awareness of model programs. Grantees were asked to review the information presented and complete the accompanying questionnaire. The information was mailed on October 24, 2000 with a response date of November 5, 2000. Included in the mailing were the following:

- *Parenting is Prevention: Parents Can and Do Make a Difference in Their Children’s Lives. HHS Publication No. (SMA) 3224-FY98. Reprinted 1999. Special Advertising Section, Reader’s Digest Supplement.*
- *Kumpfer, KL and Alvarado, R, (1998), “Effective Family Strengthening Interventions,” U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, November Juvenile Justice Bulletin.*
- *Taylor, TK and Biglan, A, (1998), “Behavioral Family Interventions for Improving Child-rearing: A Review of the Literature for Clinicians and Policy Makers,” Clinical Child and Family Psychology Review, Vol. 1, No. 1, 41-60.*
- *“Preventing Substance Abuse Among Children and Adolescents: Family -Centered Approaches, Practitioner’s Guide, Prevention Enhancement Protocols System (PEPS),” Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, May 1998.*
- *Drug Abuse Prevention Through Family Interventions: NIDA Monograph #177.*
- *CSAP/CMHS’s Family Strengthening Program Matrix*



- *Materials Order Form*
- *Customer Satisfaction Questionnaire*

Grantees were asked to select ten Model Programs for review and possible implementation. Grantees' responses to the included information was expected to help CSAP design more useful products on science based prevention. A 94% response rate was achieved for Batch 1.

The results of the Batch 1 analysis indicated that grantees were satisfied with the information presented. Order of review of materials was found not to depend upon which was on top, but rather on the relevancy of the title and length of the material. The title of the material was found to be the most important factor in determining the order of review. Items that were visually appealing were more likely to be viewed first or second. This study found that grantees viewed CSAP/SAMHSA sources to be trustworthier than Internet sites.

Batch 2

Once grantees had established a basic awareness of model programs and assessed their organization's readiness to implement a program, they requested more detailed information on ten of the programs that seemed most relevant to their organizational mission and target audiences. The assessment of this phase of the grant was completed in the Batch 2 evaluation.

The second batch of information was mailed on November 15, 2000 with a response date of November 25, 2000. Included in this mailing were the following:

- *(10) Two page program descriptions*
- *Materials Order Form*
- *Customer Satisfaction Questionnaire*

Grantees were asked to narrow their Model Program selections from ten to four. A 100% response rate was achieved for Batch 2.

The results of the Batch 2 analysis indicated that CSAP is meeting the needs of the grantees in providing the training materials and that the grantees are generally satisfied with the service CSAP is providing. Still to be assessed, however, is the role and finding of the Batch 2 results within the overall model of knowledge and dissemination; that is, does the reported usefulness and relevance of the materials contribute to the grantee organizations' readiness to implement an evidence-based family strengthening prevention program?

Batch 3

Finally, participants were to request 10-page pamphlets on the four evidence-based practices that seemed most germane to their organizations' missions. The manner in which these materials were read and processed by participants was assessed in the Batch 3 evaluation.



The final batch of information was mailed on December 18, 2000 with a response date of December 28, 2000. Included in this mailing were the following:

- *(4) 10 Page Program Descriptions*
- *Associated Research Articles for the 4 selections*
- *Customer Satisfaction Questionnaire*

A 100% response rate was achieved for Batch 3.

The results of the Batch 3 analysis indicated that 96.8%, of the grantees were either satisfied or very satisfied with the quality of information that they received in the Batch 3 mailing. Eleven percent of the respondents cited the cost for training and program implementation as a factor in their model selection. Grantees suggested that future studies should allow more time to review the materials and complete the questionnaire, 41%. Suggestions to rectify this included, limiting the amount of information sent, send information earlier and in a timely manner, and contacting grantees via email to verify receipt of information. The majority (96.8%) of grantees probably or definitely will share the information in the Batch 3 mailing with those involved in the consensus-building process.

Final Model Program Selection

On January 31, 2001, grantees were given the Final Model Program Selection Form (Appendix 6) while attending the Model Showcase in New Orleans, LA. The document served several functions most important of which was to determine which Program Developers to invite to the Model Training. Additionally, the form provided the PCC with information about grantee Internet access and updated e-mail addresses for two primary points of contact. All Final Model Program Selection forms were received by March 19, 2001. Many sites commented that there was a short amount of time between the Model Showcase and final model selection deadline. The time needed to thoroughly review and disseminate information gathered at the Model Showcase to community stakeholders for the collaborative decision-making process took longer than anticipated.

Figure 3a identifies the model programs selected by Cohort II grantees. An overwhelming majority of the sites, 50%, opted to implement the Strengthening Multi-Ethnic Families & Communities program. Twelve and a half percent of the sites selected the Parenting Wisely program. The remaining programs selected were Strengthening Families (9.3%), Strengthening Families for Parents and Youth 10-14 (9.3%), Nurturing Parenting Program (9.3%) along with Effective Black Parenting, Incredible Years, Dare to Be You, and Brief Strategic Family Therapy which were each selected by only one site. Two sites elected to implement more than one model program at the same time: 1) Grant # 9103, Keys for Networking, Inc. selected both Parenting Wisely and Strengthening Multi-Ethnic Families & Communities; 2) Grant # 9115, Racine Council on Alcohol & Other Drug Abuse, Inc. selected to implement Parenting Wisely, Strengthening Families for Parents and Youth 10-14, and FAST.

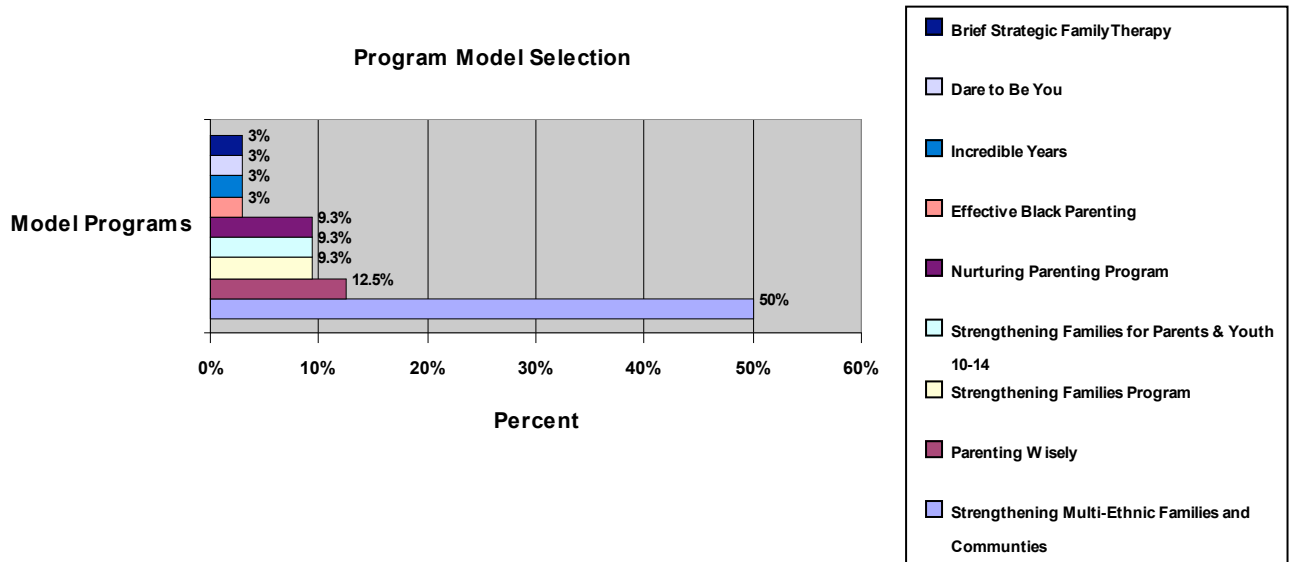


Figure 3a. Program Model Selection

Phase I & II

At the end of the above sequence (i.e., general information/self-assessment/detailed information), practitioners selected the evidence-based model they believed to be the most appropriate for the target population and most feasible for their organization to implement. Grantees completed Phase I Process Evaluation forms that focused on the various factors contributing to their selection of a particular model program for implementation. The objective of the Phase I evaluation was to more fully understand the process by which grantees ultimately decided upon a family strengthening intervention. This evaluation intended to address the following key questions:

- A. *How did agencies assess their organizational capacity?*
- B. *Through what processes did agencies go to select a model for implementation?*
- C. *Which evidence-based models were selected most frequently and why?*

It was believed that as practitioners' awareness of model programs increased, their organization's readiness to implement the programs would also increase. As a consequence of improved readiness, the members of the organization would be more capable of selecting appropriate prevention models and of implementing them successfully.¹

¹ "Success" would be defined by improved client-level outcomes, such as a decrease in youth substance use or a delayed age of first use among the target population.



The Phase I Tool was disseminated on February 23, 2001 with a return date of April 30, 2001. A 100% response rate was achieved for Phase I. The PCC website was an excellent tool for the Phase I data collection process. A seventy-two percent response rate was received via the website and a three percent response rate via electronic mail, the remaining 25 % sent the form to the PCC in a hard copy form.

Analysis of the Phase I data suggested the majority of respondent agencies scored in the “moderate” range when assessing their organizational strengths and challenges. Most often the agencies indicated that they had experience delivering the services in the community, had strong partnerships with other agencies in their community, and that they had used data from a needs assessment in order to clearly identify a target population and its presenting issues. Two areas that were identified least often as strengths for these organizations were the “availability of adequate resources” and having “staff members with the necessary skills” to deliver the services. From these data we can surmise that this was an established cohort of providers that had been working collaboratively to meet the needs of a well-defined population within the local community, but with fiscal and staffing resources that were perceived as inadequate to the agencies’ missions.

The majority of agencies noted that they had selected programs that seemed most appropriate for their respective target populations. In some cases, the selected program focused on a specific ethnic group. Others made their selections based on materials being available in the language of their population, or materials were appropriate to the reading level of their target population. In still other instances, respondents indicated that the program had been selected at least in part because participants’ schedules could accommodate the number of classroom sessions. In sum, the evaluation findings suggest that grantees did not merely solicit input from the community about what would be the most appropriate intervention model, but carefully considered those suggestions during the decision-making process.

Overall the evaluation of the Phase I Process data suggests that service providers can, and did, mostly operate within a collaborative framework in order to implement interventions that the community at large believes to be the most beneficial to its members.

Phase II: Evaluation Planning and Preparation provided all grantees the opportunity to fully document their program in three worksheets. The tool was disseminated on April 20, 2001 with a return date of August 30, 2001. A 100% response rate was achieved for Phase II.

The process evaluation for Phase II required grantees to complete three separate worksheets (see Table 3.1). Worksheet 1, entitled “Program Description,” asked grantees to provide a comprehensive description of the community context in which the agency was operating, and to describe the specific characteristics of the population that was targeted for the intervention. Worksheet 2, titled “Implementation-Related Evaluation Objectives and Questions,” focused on the process by which the agency intended to implement the evidence-based program it had selected. This second evaluation form required respondents to list the implementation objectives



that their agency had identified. For each objective, the grantee had to identify the evaluation question(s) as well as the data source(s) through which the agency could determine if the implementation objectives were met. Finally, Worksheet 3, “Outcome-Related Evaluation Objectives and Questions”, focused on the program’s effectiveness. This worksheet had respondents develop outcome goals and identify the sources of data by which they could assess if the goals were met. An example of each worksheet is at Appendix 7.

Table 3.1. Phase II: Evaluation Planning and Preparation

Worksheet 1: Program Description	Worksheet 2: Implementation-Related Evaluation Objectives and Questions	Worksheet 3: Outcome-Related Evaluation Objectives and Questions
<ul style="list-style-type: none"> • Statement of Need • Expected Effects • Activities • Resources • Context 	<ul style="list-style-type: none"> • Description of project goals and objectives • Development of concrete and measurable benchmarks for project implementation 	<p>Lists the five CSAP required Core Client Outcomes</p> <ul style="list-style-type: none"> • Age of first use • Substance abuse rates • Expectation to use • Attitudes about use • Perceived harmfulness of use

A majority of the 32 agencies chose a model prevention program based on the substance abuse risk factors faced by their target populations. In several cases, however, the data suggest that agencies focused on matching other aspects of the models with their communities, such as ensuring that the prevention program was culturally competent. With only a few exceptions, the Worksheet 2 data suggest that grantees were relatively certain about what constituted a process objective and measure, and, as importantly, how to assess if those objectives were met. Although there were expressions alluding to lack of consistency across respondents, there was not an overt general tendency to confuse process and outcome measures. In Worksheet 3, most of the grantees were able to identify outcome objectives and measures although there were, as expected, variations in the degree of attainment of program outcomes across grantees.

Based on reports by the study sites, the family strengthening model programs were chosen because they had the capacity to address the substance abuse risk factors of their target population. However, other factors, particularly the cultural appropriateness of the intervention, also appeared to play a significant role in the selection of the programs.

Most grantees completed the materials on-line through the website or utilized e-mail while some sites sent completed materials to the PCC through mail or fax. For those sites that completed only hard copies of the materials, data entry was required in order to create an electronic version for analysis.



Data Management

Data management was obviously a critical area of the cross-site study. Many hours were expended ensuring data was being collected, forwarded to the PCC, and prepared for analyses.

Data Coding

The PCC developed and assigned a list of codes that corresponded to each of the items on the instrument. The coding of quantitative data entailed assigning unique codes (variable) to the survey instrument. For example, the first GPRA question asks where the respondent (has) lived most of the time in the last thirty days. This item was coded as “living1a”. The codebook was embedded into the actual instrument to facilitate data entry at the study site (Appendix 8). A codebook was established for each model program implemented. The first three sections of the four section codebooks were identical. Section four was unique to the model program being implemented. This coding process of pre-established common variables was intended to facilitate a uniform and consistent data entry process at the project site level.

Database Development and Dissemination

Upon completing a working draft of the codebook, the PCC created a database using the statistical software program SPSS. This process entailed creating a separate database for each model program. During its design, the database codes were programmed only with the permissible values for each variable unless the item required an open-ended response.

On May 25, 2001, staff mailed comprehensive outcome evaluation packets to project sites. Each packet contained a compact disc (CD) with the SPSS database, a program specific codebook, and the appropriate GPRA/Common Core Measure instrument based on the grantee’s model program. Hard copies of the GPRA/Common Core Measures were also included in the packet. Outline below are contents of the packets disseminated:

Evaluation Packets

The Family Strengthening Program Questionnaire for Adults was model specific and comprised of four parts:

- A. Demographics
- B. GPRA
- C. Common Core Measures
- D. Family Model Core Measures

The Family Strengthening Program Questionnaire for Youth was not model specific and was comprised of three parts:

- A. Demographics
- B. GPRA
- C. Common Core Measures



In December 2001, the codebooks and SPSS data files were revised to reflect variable changes and additions. The variables in question were included in the survey instruments, but were inadvertently omitted from the SPSS files. Grantees were sent the revised materials and asked to re-submit data previously sent to the PCC reflecting the changes. By tracking the inaccuracies early on, PCC Staff was able to work with each site to specify the missing data and correct the procedure for future data submissions. The following variables were added to the revised SPSS data files:

ADULT Questionnaire:

1. **othrlang** (Specify other language, Part A: Question 5)
2. **aged** (used speed or uppers, Part B: Questions 11)
3. **agee** (used inhalants, Part B: Questions 12).

YOUTH Questionnaire:

In Part C the last four questions on the last page of the document pertaining to Attitudes Toward Youth Drug Use

1. **yattit1**
2. **yattit2**
3. **yattit3**
4. **yattit4**

Data Submission Protocol

A data submission protocol was developed and distributed to the study sites. The Protocol was sent to each site's Project Director and Evaluator ensuring that key players in the evaluation portion of the project were informed of the requirements for submission of pre and post-test data to the PCC. Each site was sent an ADULT Data Submission Form (Appendix 9) that was to accompany all data files submitted to the PCC. The form was designed to monitor the submission of data and ask the grantees to indicate the cycle of data being submitted, the language the program questionnaire was administered, and whether the data is pre-test data or post-test data. A comments section was included to allow grantees to notify the PCC of any special circumstance or concerns for the particular data file being submitted.



Adult Data Collection

The initial cycle tracking process consisted of each site was asked to submit information about the total number of cycles to be implemented according to the project plan. The estimated Adult sample size for each cycle was also obtained through the Cycle Form (Appendix 10) The purpose of gathering this information was to have a long-term picture of the start and end dates of each cycle as well as the pre-test, post-test, and follow-up test administration dates. This information was vital in determining when to expect each site's pre and post-test data. Grantees were given a two-week window of time to submit data to the PCC after each pre-test and post-test administration. A tracking chart of each site's pre and post-test administration date by cycle was created. PCC staff referred to this chart weekly to determine which sites need to submit their data. The Program Evaluator's of these sites were contacted by phone and e-mailed to determine the exact date the data would be submitted. This information was documented in the evaluation notes section of the Grantee Master Database. If the data was not received by that date, the Project Director and Project Evaluator were sent reminder e-mails. Once data was received, it was placed into pre-established folders designated by grant number.

Each site determined how many cycles to implement according to specific programmatic goals. As can be seen in Figure 3b, sites selected to implement two to six cycles. Only three sites (9%) decided to conduct pilot groups. Most grantees planned to collect data on participant families in 2, 3, or 4 cycles.

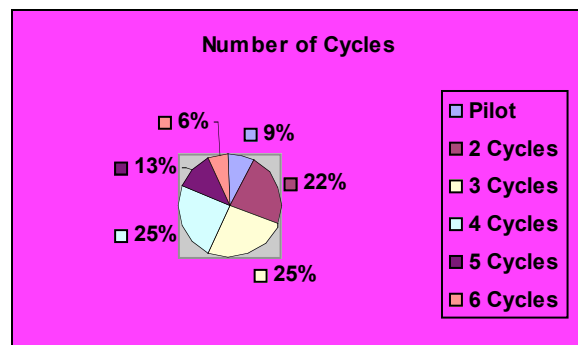


Figure 3b. Sites' Cycle Selection

The expected sample sizes for each cycle were also submitted to the PCC. Grantees were contacted if sample size projections were lower than the CSAP requirement of 30 families per site. Study site data was documented in the Grantee Master Database by date received and sample size (Figure 3c.). Due to the small amount of youth data received analyses were not completed.



	Adult	Youth
Pilot		
Pre-Test Received Date:	<input type="text"/>	<input type="text"/>
Start Date:	<input type="text"/>	<input type="text"/>
Pre-Admin Date:	<input type="text"/>	<input type="text"/>
End Date:	<input type="text"/>	<input type="text"/>
Post Admin Date:	<input type="text"/>	<input type="text"/>
Projected Pre-Sample Size:	<input type="text"/>	<input type="text"/>
Actual Pre-Sample Size:	<input type="text"/>	<input type="text"/>
Post Test Received Date:	<input type="text"/>	<input type="text"/>
Projected Post-Sample Size:	<input type="text"/>	<input type="text"/>
Actual Post-Sample Size:	<input type="text"/>	<input type="text"/>
Follow-Up Admin Date:	<input type="text"/>	<input type="text"/>
Follow-Up Received Date:	<input type="text"/>	<input type="text"/>
Follow-Up Sample Size:	<input type="text"/>	<input type="text"/>

Figure 3c. Grantee Master Database Cycle Information

As study sites began to collect data, problems surfaced concerning the survey instruments. The most common complaints from the sites concerned the survey instrument’s length (too many questions), the appropriateness of GPRA measures, and confusion about the “race” selections.

Complaints concerning the instrument’s length and the GPRA were taken into advisement. The issue of the “race” section was due to the same response options being used for the race and ethnicity questions. The questions were stated as follows:

What is your race?

- ① Black/African American
- ② Asian American
- ③ American Indian/Native American
- ④ Native Hawaiian or other Pacific Islander
- ⑤ Alaskan Native
- ⑥ White/Caucasian
- ⑦ Other (specify) _____



What do you consider your PRIMARY ethnicity?

- ① Black/African American
- ② Asian American
- ③ American Indian/Native American
- ④ Native Hawaiian or other Pacific Islander
- ⑤ Alaskan Native
- ⑥ White/Caucasian
- ⑦ Other (specify) _____

With the response categories the same for both questions, sites reported that participants were confused about the distinction between the two. Revision of the Primary and Secondary race and ethnicity questions was recommended for future instruments. It was suggested that future instruments follow the standard used in the U.S. Census instrument.

Several study sites administered translated instruments to their participants (Spanish, Chinese, Hmong and at least one Native American language). The Chinese, Hmong and Native American translations presented their own problems. For example, sites were unable to translate certain words, phrases and/or meanings into those languages. Due to the translations, sites were informed that all entered data must be translated into English before submission to the PCC.

Other sites reported participants found portions of the instruments intrusive (sensitive questions, culturally inappropriate, etc.). In response to these issues, CSAP granted exceptions to the four sites outlined in Table 3.2 below.



Table 3.2: Cohort II Special Cases

Grant #	Grant Name	Reason for exception
9165	Taos Pueblo Central Management Systems	Target population is Native American and the site did not believe that the questions were appropriate for their participants. The site used a modified version of an Adult and Youth Program Questionnaire that was used by a Cohort I site in New Mexico. The Program Questionnaire includes some GPRA measures that have been modified. The site's data will need to be analyzed separately from the Cross-Site data.
9159	Pacific Clinics Asian Pacific Family Center	The site was granted an exception from Part D: Family Model Core Measures of the Adult Program Questionnaire. In lieu of Part D, they are using the pre/post test from Marilyn Steele's Strengthening Multi-Ethnic Families Program.
9082	Board of Regents of UW Systems	The target population is Hmong and the site did not believe that some questions in the Adult Program Questionnaire were appropriate for their participants. Additionally, there were terms in the questions that could not be translated to the Hmong language. Several of the GPRA measures were not asked as well as select Common Core and Family Model Core Measures.
9021	Lt. Joseph P. Kennedy Institute	The site is only administering Part A: Demographics and Part B: GPRA of the Adult and Youth Program Questionnaire. They were granted an exception for the Common Core and Family Model Core Measures.

Although the PCC went through great lengths to ensure a smooth and accurate flow of data from the study sites, those efforts met with only moderate success.

Data Cleaning/Quality Control

Data cleaning is an important aspect of quality assurance. The cleaning task was divided into three components: 1) logic checks, 2) spot checking, and 3) frequency tables for aberrant data points. Prior to the data analysis, the PCC staff reviewed the collected data for quality assurance purposes. In December 2001, the state of Cohort II data available for analysis was as follows:

- a. There were a total of 32 Cohort II program grantees.
- b. 14 grantee programs did not submit any Cohort II data.
- c. 18 of the 32 grantees submitted some or all the required data.
- d. 3 grantees had matching pre-test and post-test data for adult prevention programs, although only 2 of the 3 (9104 and 9133) provided pre-test and post-test data with enough cases for any analysis to be conducted.
- e. 2 grantees had matching pre-test and post-test data for youth prevention programs, although only 1 of the 2 (9104) provided pre-test and post-test data in the requisite SPSS data format for any analysis to be conducted. One grantee submitted data in



Microsoft Excel format but did not provide column header (variable names) information to permit preliminary data analysis.

- f. Overall, only 1 grantee out of the 32 Cohort II grantees submitted some or all required data for both youth and adults, for both the pre-test and post-test phases of their program (9104).

Despite the concerted efforts of the PCC staff to troubleshoot and minimize data collection problems, a thorough review of all received data revealed two major data collection problems. They were a lack of compliance at the site level with the strict instructions to not manipulate the variable names and values and the inability to use the SPSS data file as originally constructed. (The pre- and post-assessments were entered as separate cases rather than the continuation of a single case.).

Solution to Data Submission Issues

The problems outlined above severely limited the PCC staff's ability to conduct cross-site analyses. The PCC Project Director decided to have the staff to re-enter the collected data. The sites were required to forward copies of their completed survey instruments to the PCC. In October 2002, a revised SPSS data file was constructed. Several variables were added to the new file. The PCC developed and assigned a list of codes for the pre- and post-variables *separately*. Each row in the SPSS file represented one unique respondent, with his/her pre-intervention data being immediately followed in the data file by the respective post- and, where applicable, 6-month follow-up data. Initially, one master SPSS file was created that included Parts A-C of the site questionnaires. Because Part D was program specific, and given that the sites could have collected data from any one of nine programs, separate "master" files were subsequently created for each of the nine model programs implemented. The intent was to enter each site's data separately and then merge the files with those sites that collected identical programmatic data. Subsequent analyses could be undertaken at the both the national level (Parts A-C) and the program-specific level (Parts A-D). Data entry for any information collected by the site supplementary to Parts A-D was the responsibility of the sites.

Thirty-one study sites (97%) submitted their hard data. One site had destroyed their instruments. Three of the 31 sites sent hard data that were translated into another language. The PCC relied of those sites' previously forwarded electronic data to determine if their content were useable. All received data was entered into the master database by April 2003.

Participant Confidentiality

Project study sites were encouraged to utilize a unique identifier for each participant in their program. This served as a method to maintain participants' confidentiality as well as to match their instruments pre and post-test in preparation for analysis. The PCC insured that all data reported for public dissemination was aggregated in a way that maintained the confidentiality of the participants.



Monitoring sites

The PCC was the driving force that bridged the gap between scientific based research and program implementation for the SAMHSA/CSAP. The PCC staff monitored all phases of the dissemination plan as well as ensured receipt of all required documents for this project as it related to program implementation and evaluation. The PCC coordinated with 32 grantees from Alaska, Arkansas, Arizona, California, Colorado, Washington DC, Hawaii, Iowa, Kansas, Maryland, Massachusetts, Minnesota, Missouri, New Mexico, New York, Oklahoma, Ohio, Puerto Rico, South Dakota, Texas, Washington State and Wisconsin.

The PCC developed a Master Grantee Database with contact information, model chosen, target population, languages used, and other critical data. This database was an essential component for aiding the PCC in its efforts to monitor grantees' progress. The PCC collected information from the grantees by sending out fact sheets for the grantees to complete and return. The information was maintained in an on-line database, updated as necessary and tracking charts were generated for daily, weekly and monthly status reports. Each site was also provided with a significant events timeline (Table 3.3). The timeline informed grantees of all the materials to be disseminated by the PCC and permitted the PCC to monitor receipt of materials.



Table 3.3: Timeline

• PROJECT TIMELINE		
TASKS I.D	DESCRIPTION	MONTH OF COMPLETION
I.1	New Grantee Workshop Radisson Barcelo, Washington, DC	November 13-15, 2000
I.2	Family Strengthening Information Materials - Batch 2 distributed at the New Grantee Workshop	November 15, 2000
I.3	Customer Satisfaction Feedback Questionnaire for Batch 2 due back to the Program Coordinating Center	November 25, 2000
I.4	Mailing of Family Strengthening Informational Materials -Batch 3	December 18, 2000
I.5	Customer Satisfaction Feedback Questionnaire for Batch 3 due back to the Program Coordinating Center	December 28, 2000
I.6	Models Showcase New Orleans, LA	January 30, 2000- February 1, 2001
I.7	Mailing of Phase I Materials documenting the Decision – Making Process	February 23, 2001
I.8	Final Model Program Selection	March 2, 2001
I.9	Model Program Training Workshop <i>San Diego, CA</i>	May 8-11, 2001
II.1 II.1 a	Mailing of Required GPRA Measures for pre/post evaluations. Also to be posted on website (csap-pcc.com)	May 25, 2001
II.1 b	Mailing of Required Common Core Measures for pre/post evaluations. Also to be posted on website (csap-pcc.com)	
II.2	Grantees Begin Program Implementation	June 2001
II.3	Phase I Material due back to the Program Coordinating Center	April 30, 2001
II.4	Mailing of Phase II Materials which documents Evaluation Planning and Preparation	April 20, 2001
II.5	Phase II Materials due back to the Program Coordinating Center	August 30, 2001



The PCC implemented the following strategies to facilitate monitoring the Cohort II grantees' progress:

- *Telephone contact.* Regular communication was maintained through the use of telephone calls. This proved to be an effective way to encourage dialogue, strengthen the PCC relationship with the grantees, and receive feedback concerning progress or milestones.
- *Established Listserv/Email.* The PCC utilized email to contact grantees regarding deadlines, upcoming workshops and other programmatic issues. In addition to the listserv, the PCC website enabled staff to disseminate posted forms for grantees to complete and submit electronically.
- *Use of Facsimile.* When the PCC required a quick turn around that needed immediate completion, the use of facsimile served to facilitate this process, for example, registering for conferences.

Study Site Assistance (TA)

Initial TA efforts centered on assessing the grantees' technological proficiency. Given much of the work was conducted through the use of network computers, the PCC collected data from grantees by sending out fact sheets for the grantees to fill out and return. Grantees completed a survey outlining their hardware, software, and staff capabilities. Based on the assessment, we found some grantees were not technically proficient; therefore the PCC provided TA on an "as needed" basis. Our approach to the sites included establishing:

- *Clear Expectations.* PCC staff contacted project directors for each grantee site and discussed the proposed objectives. Early contact was important, especially for grantees without access to the PCC website or no cross-site experience. We clearly articulated the purposes, procedures and program and policy benefits related to the cross-site study. During the second year of the project we focused our TA efforts on assessing issues requiring clarification concerning cross-site instruments. We compiled a "Most Frequently Asked Questions" document and placed it on the PCC website along with answers to the questions (Appendix 11).
- *Communications.* Accessible and rapid transmission of information and ideas was essential to effective collaboration. The PCC created listserv e-mail addresses for enrollment of all family strengthening grantees as a means of providing technical assistance as well as to engaging continuous forms of open communication. The mode of communication with sites was through e-mail and telephone. E-mail was especially convenient to use with grantees located in a different time zones. The combined usage of e-mail and telephone led to a greater degree of responsiveness from sites. Documents were easily transmitted to sites through the use of e-mail attachments. Grantees also preferred to send materials to the PCC via e-mail. This proved especially useful in the submission of pre and post-test data by sites to the PCC.



- *Conduct site Visits.* The sites visits served a two-fold purpose. They offered the PCC an opportunity to hold face-to-face meetings to establish relationship with respective staff (i.e., site coordinators, research staff, etc.), and also offered an opportunity for on-site technical assistance.

On balance, The PCC efforts helped to thrust the Cohort into full force by providing corrective or supportive action when necessary (e.g., technical assistance). This was accomplished through implementing successful and improved strategies, which linked the monitoring capability described with the technical assistance capability. Secondly, the strategies provided a powerful mechanism for quality control and team building within the cross-site study.



SECTION IV: STAFFING

The Program Coordinating Center experienced several staff changes during the three-year study. Project staffing is a critical element in any study and frequent changes can have a negative impact on project success. Fortunately, the changes experienced by the PCC did not have a detrimental effect on the overall study outcome, however, the changes did create some program delays and unnecessary stress for the staff.

Our most critical personnel changes were at the Researcher/Statistician position. Three different employees held the position. With each change, time was expended in orientating the replacement to the study goals and design. Additionally, the changes created some confusion for the study sites. They were forced to build a new relationship with each change.

The changes seen in the Site Coordinator positions were not as harmful to the study. The Coordinators worked as a team and thus the departure of one member did not have a great impact on the study sites.

Most of the personnel changes were due to the incumbent finding a new position considered to be superior to their position with McFarland. None of the departures were for cause.

The initial staff members are reflected in Table 4.1 below.

Table 4.1: Initial PCC Staff

Position	Employee	Status
Project Director	Eddie C. McCormick	100% Time
Research Associate	Resa Matthew	50% Time
Researcher/Statistician	William Lee	50% Time
Research Analyst	Kathleen DeSnyder	50% Time
Site Coordinator	Evren Esen	50% Time
Site Coordinator	Chanda McNeal	50% Time
Admin Assistant	Todd Elliott	100% Time
Information Manager	Cassandra Thomas	50% Time
Logistics Coordinator	Paulette Wiggins	10% Time

The PCC started experiencing staff changes in June 2001. Todd Elliott and Kathleen DeSnyder terminated their employment with McFarland in June 2001. Mr. Elliott found a more desirable position with a local community agency. Ms DeSnyder found a more desirable position with the City of Alexandria, VA. On June 27, 2001, McFarland entered into a 90 day Consulting Agreement with Ms DeSnyder allowing her to complete the vital aspects of her function with McFarland. It was decided to not replace Ms. DeSnyder due to the shifting requirements of Cohort II's data analysis and the abilities of other staff members. Mr. Elliott was replaced by Ms



Debra Jones in October 2001. Ms. Cassandra Thomas terminated her employment with McFarland effective August 2001. Ms. Thomas found a more desirable position. Ms. Thomas was replaced by Ms Jin Zhang. Finally, Dr. William Lee terminated his employment effective October 31, 2001, due to personal issues. Dr. Lee held a key role as our Researcher/Statistician. His departure created a delay in the completion of the Phase I & II reports. Additionally, his guidance to staff and grantees was missed. In November 2001, a Consulting Agreement was entered with Jacob Andoh, M.S, M.P.H., C.P.M. His role was to assist the PCC with the research and data analysis responsibilities.

Effective November 2001, the staff was as reflected in Table 4.2 below.

Table 4.2: PCC Staff as of November 2001

Position	Employee	Status
Project Director	Eddie C. McCormick	100% Time
Research Associate	Resa Matthew	50% Time
Researcher/Statistician	Jacob Andoh	As Needed
Site Coordinator	Evren Esen	50% Time
Site Coordinator	Chanda McNeal	50% Time
Admin Assistant	Debra Jones	100% Time
Information Manager	Jin Zhang	50% Time
Logistics Coordinator	Paulette Wiggins	10% Time

In January 2002, a decision was made to hire George Yacoubian, Ph.D., to serve as our Director of Research, while retaining the services of Mr. Andoh to assist with data analysis and report writing.

As we approached the final months of the Cohort 2 study period, funding became an issue. The funding for Cohort 2 (\$270,000.00 per year) was insufficient to support the ideal staff. Additionally, staff members were aware of their impending lay-off with the conclusion of the study.

In January 2002 Ms Zhang resigned her position and Ms Esen resigned in May 2002. Both cited their need for more secure positions as their reason for leaving McFarland. Ms Esen's position was not filled. Her site responsibilities were shared with the remaining staff. Ms Zhang was retained as a consultant. Table 4.3 represents the staff as of June 2002.



Table 4.3: PCC Staff as of June 2002

Position	Employee	Status
Project Director	Eddie C. McCormick	100% Time
Research Associate	Resa Matthew	50% Time
Director of Research	George Yacoubian	75% Time
Researcher/Statistician	Jacob Andoh	As Needed
Site Coordinator	Chanda McNeal	50% Time
Admin Assistant	Debra Jones	100% Time
Information Manager	Jin Zhang	As Needed
Logistics Coordinator	Paulette Wiggins	10% Time

Several staffing modifications were made during this no-cost extension period. As funding dwindled down, the Project Director provided “in-kind” services. Resa Matthew assumed a Research Associate role with the project. She proved herself to be highly capable in the new role. Ms. Matthew is a doctoral student in the Department of Family Studies at the University of Maryland. She completed her course work in May 2003. Her services to the project were also moved to “in kind”. Dr. George Yacoubian left McFarland after a year of service. He cited “a better opportunity for professional growth” as his reason. Ms Jones left the project in May 2003. Her position was scheduled for termination in September 2003. Mr. Jacob Andoh remained with the project as consultant and in August 2003, the PCC retained the services of Min Qi Wang, Ph.D., to assist with the analyses of the Cohort 2 data. The services of Paulette Wiggins were no longer required following the Findings Workshop in June 2003. The final staff is listed in Table 4.4 below.

Table 4.4 Final PCC Staff

Position	Employee	Status
Project Director	Eddie C. McCormick	In-Kind Contribution
Research Associate	Resa Matthew	In-Kind Contribution
Site Coordinator	Chanda McNeal	50% Time
Research Analyst	Jacob Andoh	As Needed
Statistician	Min Qi Wang, Ph.D.	As Needed
Information Manager	Jin Zhang	As needed

The funding of Coordinating Centers is problematic. Seldom is the funding sufficient to attract and retain a quality staff. Within a contractor’s organization, staff is either divided among several projects to provide for full time employment or staff is hired as part-time. Dividing staff among several projects does not allow for project commitment while hiring on a part-time basis makes it difficult to retain quality people.

In a study of this nature, it is important to ensure that all site coordinators have an understanding of research and evaluation processes. Such knowledge will enhance their ability to fully assist the study sites.



SECTION V: OUTCOME EVALUATION

The current study used national, multi-site data to identify which aspects, if any, of family functioning are predictive of substance use and to determine the efficacy of the model programs implemented. To this end, key research questions were developed and are as follows: 1) Do the Family Strengthening programs improve family functioning (i.e., resilience, cohesion, conflict, and attachment)? 2) Are the family strengthening programs effective in preventing and/or reducing substance abuse? 3) What are the key sociodemographic characteristics that are most impacted by the model programs? A cross-site survey assessed parents pre-intervention to establish baseline and post-intervention to assess the proximal impact of the parenting intervention provided. Four main indicators of family functioning (i.e., family resilience, family conflict, family cohesion, and family attachment) were used based on parent assessments. Additionally, thirty day substance use indicators were used for alcohol, legal and illegal drugs.

Theoretical Framework

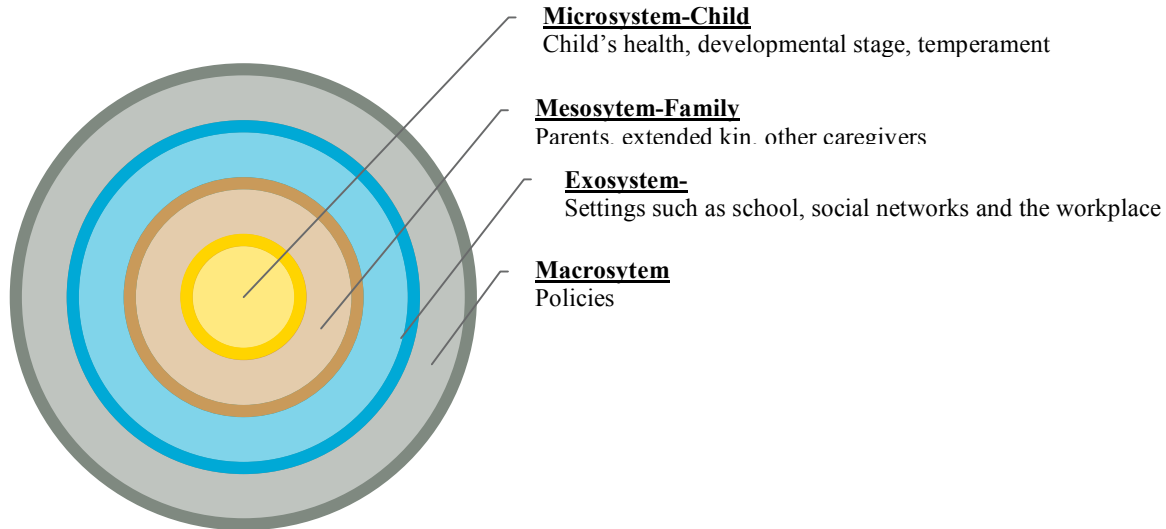
In order to understand more comprehensively family functioning and its correlation with youth development, strong theoretical frameworks are needed to guide efforts to translate research into practice. This section discusses a risk and protective theoretical perspective grounded in an ecological systems model of human development.

The ecological systems model of human development provides a basis for understanding the parent/caregiver and child relationship within families embedded in a complex social environment with diverse expectations (Bronfenbrenner, 1979). Specifically, the ecological systems theory expands our understanding of the child beyond the individual's psychological development to a view that positions the child with the context of relationships and interactions with others (Fine, 1992; Kraus, 1998; Worden, 1999). An ecological systems perspective on human development recognizes the mutual interactive relationships between the child, the parents, and the social environment (see Figure 4.1), which includes culture. The concept of mutual interdependence of these systems first proposed by Bronfenbrenner (1979), is a way of viewing the child as a “dynamic and evolving being that interacts with, and thereby restructures, the many environments with which he/she comes into contact” (Gardiner, Mutter, & Kosmitzki, 1998). The family, as a developmental niche, is also an open system that interacts across its boundary with its surrounding contexts. Additionally, Germain and Gitterman (1987), state with reference to the ecological systems perspective that “neither the people served, nor their environment, can be fully understood except in relationship to each other” (p. 493).



Figure 4.1.

Theoretical Framework: Ecological Systems Model of Human Development



Moreover, the idea of reciprocal influences between parent and child has been elaborated on in the publications of Erikson Institute (Garbarino et al., 1989), which stress the mutual influences between the children and their physical, social, and cultural contexts (Webb, 1996; 2001).

Integrated within the ecological systems model is the prominent risk and protective factors perspective to guide efforts in preventing problems before they commence. First, one of the most successful prevention models in the last two decades has been the epidemiological risk-focused model used to prevent heart and lung disease (Hawkins, Catalano, & Miller, 1992). Proponents have argued that human development, like heart disease, is influenced by multiple risk processes, and that taking steps to reduce or eliminate these risks holds promise for preventing youth problem behaviours as well (Bronfenbrenner, 1986; Hawkins, Catalano, & Miller, 1992; Segal, 1983). Second, the model that has gained prominence is the resiliency or protective process approach which suggests that focus must move beyond risk to include conditions that facilitate positive development. Even with glaring disadvantages and the most adverse conditions, it is unusual for more than a third (Werner, 1992) to a half of children (Rutter, 1985) to succumb to serious disabilities or persistent disorders. This resiliency exhibited by many children suggests that it is important to focus on those circumstances and characteristics of children that foster health promoting behaviours and competence (Bogenschneider, 1996).

Both the risk and protective models serve as a framework to guide efforts and both models have some validity, yet in isolation, neither model fully captures the reality of diverse populations. There is a need to integrate these two related, but unique perspectives with the ecological



systems of human development model. When merged, the ecological systems model suggests that it is necessary to identify both risk and protective processes at several levels of the human ecology, including the individual, family, school, and community systems. The combined ecological and risk/protective theories can serve as a comprehensive framework for not only understanding human development, but for designing, implementing, and evaluating prevention and intervention programs. The integrated ecological risk/protective theory holds that human development is molded by a myriad of processes and these processes needs to be identified at multiple levels of the human ecology and at different stages of the life course. Although no single model can capture the complexity of youth development, the ecological risk/protective theory does contribute a rich, comprehensive approach. More specifically, in examining youth development, the risk factor approach identifies those processes that can mitigate youth development, whereas the protective approach identifies processes that can maximize the likelihood of positive youth development. With this in mind, prevention efforts can focus on enhancing protective factors to help youth negotiate a risky environment, but also work simultaneously to reduce the number of risks to which youth are exposed. To this end, the ecological risk/protective theory serves to promote positive youth and family development.

Methods

Procedure

The data source for the current study was the Family Strengthening Initiative funded by the Center for Substance Abuse Prevention (CSAP) and the Center for Mental Health Services (CMHS). The design of the study was that of a pretest/posttest without any follow-up assessments. The data were obtained from a total of thirty-two funded study sites that implemented evidenced-based model programs. The break down of model programs implemented is found in Table 5.1.

Table 5.1: No. of Sites that Selected a Model Program

Model Program Selected	No. of Sites	No. in Cross-site	Sample Size (N)
Strengthening Multi-Ethnic Families & Communities	16 sites	14 sites	602
Parenting Wisely	5 sites	4 sites	78
Strengthening Families Program	3 sites	3 sites	78
Nurturing Parenting Program	3 sites	3 sites	68
Strengthening Families Program for Parents & Youth 10-14	3 sites	2 sites	26
Effective Black Parenting	1 site	1 site	33
Dare to Be You	1 site	1 site	48
The Incredible Years	1 site	1 site	36
Brief Strategic Family Therapy	1 site	1 site	26
Total (*N does not equal 32 - 2 sites implemented 2 programs)	34*	30	995



Table 5.1 demonstrates that the Strengthening Multi-Ethnic Families and Communities Program was the most popular with a total of 16 study sites implementing it followed by the Parenting Wisely program. The data from three study sites were not included in the cross site analysis (see Table 5.2) because they were study sites that were given permission by their GPO to change the instrument to the extent that it no longer matched the cross site instrument.

Table 5.2: Cohort II Special Cases

Grant #	Grant Name	Reason for exception
9165 Cannot be include in cross-site analysis, no individual analysis	Taos Pueblo Central Management Systems	Target population is Native American and the site did not believe that the questions were appropriate for their participants. The site used a modified version of an Adult and Youth Program Questionnaire that was used by a Cohort I site in New Mexico. The Program Questionnaire includes some GPRA measures that have been modified. The site's data will need to be analyzed separately from the Cross-Site data.
9159 Can be included Parts A, B, and C, individual analysis for these parts	Pacific Clinics Asian Pacific Family Center	The site was granted an exception from Part D: Family Model Core Measures of the Adult Program Questionnaire. In lieu of Part D, they are using the pre/post test from Marilyn Steele's Strengthening Multi-Ethnic Families Program.
9082 Cannot be included in cross-site analysis, no individual analysis	Board of Regents of UW Systems	The target population is Hmong and the site did not believe that some questions in the Adult Program Questionnaire were appropriate for their participants. Additionally, there were terms in the questions that could not be translated to the Hmong language. Several of the GPRA measures were not asked as well as select Common Core and Family Model Core Measures.
9021 Can be included for the cross-site Parts A and B, individual analysis of these parts	Lt. Joseph P. Kennedy Institute	The site is only administering Part A: Demographics and Part B: GPRA of the Adult and Youth Program Questionnaire. They were granted an exception for the Common Core and Family Model Core Measures.

Each study site assessed parents pre-intervention to establish baseline and post-intervention to assess the proximal impact of the intervention. The study sites were not required to have a follow-up data collection point. Only one parent from each household was assessed even if both parents attended the program sessions. The parent who provided the majority of the caregiving served as the index parent.



To address the research questions, data were collected using the cross-site instrument developed by CSAP and PCC staff. All thirty-two study sites utilized a longitudinal, pre-post test design with very few sites having a control or comparison group. Study sites used either one-on-one administration or group administration of the cross site instrument.

For the purposes of this study, family functioning, 30 day substance use, attitudes toward drug use, and perception of harm were measured by self reports of parents participating in the program.

Measures

The items within each of the core family constructs were based on already existing scales, but were modified for the purposes of this cross-site study (see Table 5.3).

Table 5.3: Core Family Measures

Name of Scale	Origination	Modified By	No. of Items
Family Strengths/Resilience	Adapted from Success By Six Family Strength Assessment, 1997	Karol Kumpfer	12 items
Family Conflict	Adapted from Moos, 1974	Karol Kumpfer, Hawkins, et al	13 items
Family Relations/Cohesion	Gorman-Smith, et al		6 items
Family Attachment	Not Available	Kumpfer, Hawkins, et al.	5 items

The items assessing the constructs of family resilience, family conflict, and family cohesion were modified by CSAP staff and adapted for the current Family Strengthening Initiative as part of the core measures contained within the cross-site instrument.

The response choices for the family resilience items were 5 point Likert type scales ranging from no strength, almost no strength, some strength, considerable strength, to amazing strength. The family conflict and family cohesion items had a 4 point Likert type scale which included true, somewhat true, somewhat false, and false. Finally, the family attachment scale had responses of yes, no, don't know and does not apply.

Missing Data

Although it is difficult to avoid some form of missing data problems, the challenge with the Family Strengthening data was that it was fraught with missing data. PCC staff explored several methods of addressing the issue raised by missing data that affect the generalizability of the results. To this end, PCC staff defined the missing data process as the following. Our missing data process was any systematic event external to the participant, or action on the part of the participant, that leads to missing data. For example, data collection or data entry errors were considered external to the participant and the refusal to answer was considered an action on the part of the participant. The effects of some missing data processes were known and directly



accommodated for during data cleaning. But others, particularly those based on actions by the participants, were rarely known. When the missing data processes were unknown, PCC staff attempted to identify any patterns of missing data that would characterize the missing data process.

PCC staff remained cognizant of the impact of missing data being detrimental not only through its potential hidden biases of the results but also in its practical impact on the sample size available for analyses. Particularly in survey research, missing data may eliminate so many cases that what was an adequate sample is reduced to an inadequate sample. In such situations, the prudent approach is to find a remedy for the missing data. Although finding a remedy is the most practical solution, few guidelines exist pertaining to the diagnosis and remedy for missing data. Although missing data can occur for many reasons and in many situations, PCC staff found it easiest to remedy missing data processes due to procedural factors such as errors in data entry or the use of invalid codes. This process was facilitated by the request for each study site to provide hard copies of their cross-site instruments. In situations where there was failure to complete the entire instrument, the PCC staff had little control over the missing data processes. Other missing data processes were less easily accommodated. These were most often related directly to the participant. One example was the refusal to respond to many of the GPRQ questions due to the sensitivity of the questions.

Approach for Remediating Missing Data

One of the simplest approaches for dealing with missing data is to include only those cases with complete data (listwise deletion). However, this approach is best suited for instances in which the extent of missing data is small, the sample is sufficiently large to allow for deletion of the cases with missing data, and the relationships in the data are so strong as to not be affected by any missing data process (Hair et al., 1998). As mentioned above, the dataset was fraught with missing data that this method of listwise deletion would have significantly reduced the sample size available for analyses.

Another remedy for handling missing data is through one of the many imputation methods. Our objective was to employ known relationships that were identified in the valid values of the sample to assist in estimating the missing values. However, in contemplating this method, PCC staff carefully considered the use of imputation because of its potential impact on the analysis. Of the many imputation methods, PCC staff deemed the method of estimating replacement values for the missing data most appropriate. More specifically, staff decided on mean substitution as the most viable method. Mean substitution replaces the missing values for a variable with the mean value of that variable based on all valid responses. The rationale for this approach is that the mean is the best single replacement value, which serves to keep more respondents in the study, gives higher power, and is less likely to generate bias (unlike listwise deletion).

The exact procedure employed for the data used a conservative estimate of 80% or more nonmissing values to create the mean value replacement. This approach was used for all of the family core measure constructs. For example, family resilience has twelve items which make up



the construct. If participants responded to ten items, the mean was imputed for the remaining two items not answered.

Data Preparation

Prior to conducting any inferential statistics to address specific research questions under consideration, the raw data underwent close examination. There are a few primary issues that are of some concern for this project. The first issue pertains to the distribution. Given that some variables (e.g., frequency of substance use) have the potential to display “floor” or “ceiling” effects, it was necessary to transform or recode such variables prior to statistical analysis. This was the case for the family functioning constructs. For example, all of the twelve items in the family resilience construct were recoded and eight of the thirteen items for family conflict were recoded. No recoding was necessary for family cohesion and family attachment. The recoding was necessary to ensure that the directionality of all scales were such that high values represent **negative** attitudes/behaviours, higher use of drugs and illegal substances, etc. Additionally, the responses for the family attachment scale included “don’t know” and “do not apply”. In the cases where the participants responded “don’t know,” it was recoded as a “no” response. The “do not apply” response was recoded as missing. The second and related issue was the need to combine information from various items (questions) to create a composite score suitable for subsequent analysis. Again, this was the situation for the family functioning constructs. For example, the family cohesion items were summed to create an overall or composite score for that construct.

Analysis Plan

The analysis plan consisted of four areas. The first area included evaluation of the psychometric properties of the cross-site instrument, and the subsequent three areas will address each of the three research questions. Specifically, the analyses to address the research questions will be comprised of analysis of variance (ANOVA), logistic regression, and analysis of covariance (ANCOVA).

After cleaning and preparing the dataset for analyses, the psychometric properties for the cross-site instrument were conducted². Specifically, internal consistency reliability will be established for the family core measures (Section C) of the instrument (see Appendix 8). The internal consistency reliability for the GPRA items was previously established in the first cohort of Family Strengthening grantees and subsequently for an earlier CSAP request for this cohort of grantees. The use of Cronbach’s alpha to examine the internal consistency reliability demonstrates the extent to which the items are focused on the construct of measurement. Upon the review of the reliability coefficients, program staff will then make the decision to conduct additional analyses to determine whether the dimensionality of the constructs are yielding the true reliabilities. To the knowledge of program staff, before now, there has been no examination of the reliability of the family core measures. Thus, if the reliability coefficients are not adequate, exploratory factor analyses will be conducted to determine if each of the constructs truly are unidimensional. In exploratory factor analysis, there usually are not precise expectations about the results of the analysis (e.g. concerning the number and nature of the

² All analyses for this study were conducted using SPSS 11.5.



factors which will be extracted). The technique is used to reveal hidden structure. If factor analyses reveal that a construct is multidimensional, the reliability analyses will again be conducted using the items that have high loadings on the same factor.

Research Questions and Their Concomitant Analytic Models

This section of the analysis plan delineates the key research questions and their associated analytic procedures. The original set of cross-site research study addresses the following questions about substance abuse and families: 1) Do the Family Strengthening programs improve family functioning (i.e., resilience, cohesion, conflict, and attachment)? 2) Are the family strengthening programs effective in preventing and/or reducing substance abuse? 3) What are the key sociodemographic characteristics that are most impacted by the model programs? Each of these questions will be addressed by model program. For example, separate analyses will be conducted to evaluate whether there was significant improvement in family functioning for Strengthening Multi-Ethnic Families and Communities, then Parenting Wisely then Nurturing Parenting Program, etc.

To address the first question regarding improvement of family functioning, repeated measures analysis of variance (ANOVA) will be used to assess the difference in means from pretest to posttest for program participants. Although there is the comparison of only two means, repeated measures ANOVA was selected as the best analytic procedure over t-tests because it will allow staff to also produce the eta squared³ (η^2) for each program. The second question assessing the effectiveness in reducing substance use will be addressed using logistic regression. The GPRA items used to measure substance use/abuse will be recoded into a binary variable of either use or nonuse and will serve as the dependent variable. The family functioning variables at pre-test and again at posttest will serve as the independent variables.

The research question related to identifying the sociodemographic characteristics of participants most impacted by each program will be examined using analysis of covariance (ANCOVA). The posttest scores will be the dependent variable, the pretest scores will serve as the covariate, and the demographic variables (gender, race, education, age, and employment status) the independent variables. Again, each of these analyses will be conducted separately and for each of the model programs.

³ Eta squared is a calculation for General Linear Models such as ANOVAs that provides the variability in the dependent variable that is explained or accounted for by the independent variable. For example, an $\eta^2=.203$ indicates that 20.3% of the variability of the dependent variable is explained by the independent variable.



Results

The results of the study are presented in the following manner. First, the psychometric properties for the instrument are presented based on internal consistency reliability and factor analysis. For the purposes of these analytic procedures, the Strengthening Multi-Ethnic Families and Communities program data set was used. This model program was the most frequently selected program (n= 16 study sites) among the thirty-two study sites, thus providing the largest sample size, a necessary component for these procedures. Second, the remainder of the results are presented by model program beginning with the Strengthening Multi-Ethnic Families and Communities. The data sets used were for the adult participants only. Although the use of the youth questionnaire was highly recommended, very few sites administered the questionnaire for reasons such as not enough funding or target audience was parents of young children.

Examination of the Psychometric Properties

This section presents an examination of the psychometric properties of the CSAP Family Strengthening cross-site instrument. According to basic psychometric theory (Himmelfarb, 1993), multiple item scales have the distinct advantage of yielding more reliable scores. Therefore, the intent was to develop an instrument to accurately measure substance use/abuse and family processes. Specifically, the CSAP Government Performance and Results Act (GPRA) items were employed to measure thirty day substance use and family constructs such as family strengths/resilience, family conflict, family cohesion, and family attachment were included to measure family processes.

Internal Consistency Assessment

Internal consistency is the extent to which tests or surveys assess the same characteristic, or quality. It is a measure of the precision of the measuring instruments used in a study. This type of reliability often helps researchers interpret data and predict the value of scores and the limits of the relationship among variables. Analyzing the internal consistency of the survey items dealing with a particular construct will reveal the extent to which items on the questionnaire focus on the notion that is being measured.

Coefficient alpha is an appropriate reliability estimator for composite measures containing multiple components. Multiple components may be homogeneous in the sense of measuring a single latent variable, or they may be heterogeneous in the sense of measuring two or more factors or latent variables (Osburn, 2000). It has been noted that internal consistency reliability coefficients, including coefficient alpha, based on a single administration of a test may overestimate reliability because such coefficients assign transient error due to differences in test administration, temporary changes in the participant, and so on to true-score variance (Guion, 1965; Schmidt and Hunter, 1996). Although it is true that coefficient alpha may sometimes be inflated for the reasons mentioned above, a potentially more serious problem is the tendency of coefficient alpha to underestimate the true reliability when the data are multidimensional. If the items conform to classical test theory assumptions, coefficient alpha is then a lower bound to the true reliability of a measure (Osburn, 2000).



Upon initial examination of the family scales in their entirety, reliability analysis resulted in the following coefficient alpha found in table 5.4.

Table 5.4: Reliability–Family Core Measures

<i>Scale</i>	<i>No. of items</i>	<i>Coefficient alpha</i>
Family Strengths and Resilience	12 items	alpha=.9287
Family Conflict	13 items	alpha=.6808
Family Relations and Cohesion	6 items	alpha=.8231
Family Attachment	5 items	alpha= .5879

Coefficient alpha indicates item homogeneity based on the scores of each scale. Alpha levels greater than .70 indicate modest reliability, which is acceptable for early stages of research. Alpha levels greater than .80 are considered adequate (Nunally & Bernstein, 1994). The exhibitors of good scores are the family strengths and resilience scale and the family relations and cohesion scale. The family attachment and family conflict scales show unacceptable alpha according to Nunally and Bernstein.

In the instances where the coefficient alpha was low, PCC staff sought to determine whether coefficient alpha underestimates the true reliability of those constructs of the cross site instrument. A related goal was to examine, through factor analysis, alternative internal consistency reliability estimates that may improve the estimate of reliability.

Factor Analysis

Prior to conducting any additional reliability analyses on the family scales, staff made the decision to use the factor analysis statistical procedure to detect any underlying factors. Factor analysis extracts factors one at a time which account for the patterns of correlations between the variables in the correlation matrix. The first factor that is extracted usually accounts for more variances of the correlation matrix.

The utility of factor analysis is an appropriate approach to estimate the coefficient alpha of the true reliability when the data are multidimensional. When the scales were examined in its entirety, the coefficient alpha for the two scales (family attachment and family conflict) were low ($\alpha=.5879$ and $\alpha=.6808$ respectively). Because family strengths and resilience and family relations and cohesion exhibited adequate reliability coefficients, they were excluded from the factor analysis. For the purposes of this report, factor analysis will consist of two main steps. The first step involves extracting the factors. This step yields a matrix (usually called the Factor Matrix) containing factor loadings. These are regression coefficients, showing the contribution of each factor to each variable. Unfortunately, it is usually not possible to interpret the factors at



this stage of the analysis. The next main step is called the factor rotation phase. During this step, the factors are transformed and if the factor analysis is successful, clear patterns of rotated factor loadings should emerge.

In our first run of the data, factor analysis using maximum likelihood extraction methods, was conducted on the family attachment and family conflict scales. The maximum likelihood analysis with varimax rotation resulted in three factors for family conflict and one factor for family attachment with eigenvalues greater than one. Communality is the proportion of variance of a particular item that is due to common factors (shared with other items). Communalities (see Tables 5.5 & 5.6) ranged from .243 to .779 for family conflict and .216 to .421 for family attachment.

Table 5.5. Communalities for Family Conflict

	Initial Extraction	Final Extractionl
Recode fconf1	.557	.610
Recode fconf2	.566	.612
Recode fconf3	.529	.570
Recode fconf4	.485	.524
Family members rarely become angry.	.356	.434
Family members hardly ever lose their tempers.	.368	.779
Recode fconf7	.415	.452
We really get along well with each other.	.253	.325
In our family, we believe you don't get anywhere by raising your voice.	.243	.319
Recode fconf10	.462	.434
Recode fconf11	.430	.357
If there's disagreement in our family, we try hard to smooth things over and keep the peach.	.267	.562
Recode fconf13	.331	.316

Extraction Method: Maximum Likelihood.

a One or more communalitiy estimates greater than 1 were encountered during iterations. The resulting solution should be interpreted with caution.



Table 5.6. Communalities for Family Attachment

	Initial Extraction	Final Extraction
Do you feel very close to your child in this program?	.295	.421
Do you share thoughts and feelings with your child?	.242	.355
Do you enjoy spending time with your child in this program?	.216	.303
Do you feel very close to your partner?	.261	.259
Do you discuss parenting ideas with your partner?	.267	.267

Extraction Method: Maximum Likelihood.

Because the first iteration of factor analysis resulted in only one factor for the family attachment scale, the decision was made to repeat factor analysis with a different approach. A second iteration of factor analysis was conducted where the criterion of an eigenvalue of 1 was abandoned and the data were forced to extract two factors. This method was conducted only for the family attachment scale. The communalities (see Table 5.7 below) then ranged from .216 to .639.

Table 5.7. Communalities for Family Attachment

	Initial Extraction	Final Extraction
Do you feel very close to your child in this program?	.295	.590
Do you share thoughts and feelings with your child?	.242	.338
Do you enjoy spending time with your child in this program?	.216	.308
Do you feel very close to your partner?	.261	.370
Do you discuss parenting ideas with your partner?	.267	.639

Extraction Method: Maximum Likelihood.

a One or more communality estimates greater than 1 were encountered during iterations. The resulting solution should be interpreted with caution.



Factor Loadings

The first factor in the family conflict scale accounted for 35.6% of the variance and the factor loadings for the family conflict scale (see Table 5.8) shows adequate loadings. Factor loadings are regression coefficients showing the contribution of each factor to each variable. Items 1-4, 7, 10-11, and 13 loaded very well on the first factor, whereas items 8, 9, and 12 are loaded on the second factor, and items 5-6 load on the third factor.

Table 5.8: Family Conflict Rotated Factor Matrix

	Factor		
	1	2	3
Recode fconf1	.764		
Recode fconf2	.757		
Recode fconf3	.742		
Recode fconf4	.699		
Family members rarely become angry.			.638
Family members hardly ever lose their tempers.			.874
Recode fconf7	.626		
We really get along well with each other.		.524	
In our family, we believe you don't get anywhere by raising your voice.		.520	
Recode fconf10	.658		
Recode fconf11	.595		
If there's disagreement in our family, we try hard to smooth things over and keep the peach.		.747	
Recode fconf13	.549		

Extraction Method: Maximum Likelihood. Rotation Method: Varimax with Kaiser Normalization.
a. Rotation converged in 4 iterations.

When we examined the factor structure, we found that the items that had adequate loadings on the first factor clustered on what we call “engaged in conflict”. The second factor appears to represent what we call “constructive conflict”. Finally, the items that clustered on the third factor seem to represent “avoidance of conflict”.

The results for the forced two factor analysis for the family attachment scale indicate that the first factor accounted for 45.6% of the variance. The first three items show high factor loadings (see Table 5.9) on the first factor and the last two items show high factor loadings on the second factor.



Table 5.9: Family Attachment Rotated Factor Matrix

	Factor	
	1	2
Do you feel very close to your child in this program?	.752	
Do you share thoughts and feelings with your child?	.531	
Do you enjoy spending time with your child in this program?	.524	
Do you feel very close to your partner?		.560
Do you discuss parenting ideas with your partner?		.779

Extraction Method: Maximum Likelihood. Rotation Method: Varimax with Kaiser Normalization.
a. Rotation converged in 3 iterations.

Based on the factor loadings for the family attachment scale, we can surmise that the two dimensions represented are attachment to the child as evidenced by items 1 through three, and attachment to the partner/spouse.

After exploratory factor analyses, reliability analysis based on the extracted factors were again conducted which revealed the following coefficient alpha in table 5.10.

Table 5.10: Coefficient alpha for Family Scales after Factor Analysis

Construct	No. of Items	Coefficient alpha
Family Strengths and Resilience	12 items	alpha=.9287
Family Conflict		
Factor 1	8 items	alpha=.8758
Factor 2	3 items	alpha=.6316
Factor 3	2 items	alpha=.7298
Family Relations and Cohesion	6 items	alpha=.8231
Family Attachment		
Factor 1	3 items	alpha=.6484
Factor 2	2 items	alpha=.6369

After the extraction of three factors for family conflict and the two factors for family attachment, we see an overall increase in their coefficient alpha, thus confirming that coefficient alpha is a lower bound estimate of the true reliability when the data are multidimensional.



General Linear Models Analytic Procedures

This section of the results addresses the first research question: Do the Family Strengthening programs improve family functioning (i.e., resilience, cohesion, conflict, and attachment)? Below, the results specific for each of the nine model programs are presented separately.

RESULTS SPECIFIC TO STRENGTHENING MULTI-ETHNIC FAMILIES & COMMUNITIES

The Strengthening Multi-Ethnic Families and Communities program was developed to target ethnic and culturally diverse parents of children aged 3-18 years of age. The specific aims of the program are to reduce drug/alcohol use, juvenile delinquency, gang involvement, and child abuse and domestic violence. The short term objectives of the program are to increase parent sense of competence, positive family interactions, parental involvement. For a more detailed description of the program, please refer to Appendix 1.

As mentioned above, this model program was the most popular and was selected for implementation by 16 of the 32 study sites, however, the results for 14 of the 16 sites are presented below. (Two sites made substantial changes to the cross-site instruments which did not allow for their inclusion in the analyses.) At baseline, 785 participants had completed the pre-test and at the end of the intervention, 602 participants completed the posttest.

For the SMEFC program, participants' average age was 38 years ($SD = 10.48$) with 78.9% of those participants being women. Forty-one percent of the participants identified as being Hispanic, 21.4% were Asian American, 12.1% were African Americans, and 10.9% were American Indian/Native American. Only 6.0% were Caucasian, 4.2% were Native Hawaiian/Pacific Islander, and 4.4% were from other racial or ethnic origins.

Other characteristics of the participants include an average of 11 years ($SD = 3.87$) of schooling with 30.4% of the respondents unemployed but looking for work, 27.0% employed full time, 15.9% specified other for employment, and 11.4% were employed part time. Other participants were either unemployed due to disability (6.9%) or unemployed due to retirement and volunteer work (8.1%). Additionally, 46.2% of respondents reported living in the city, 22.9% lived in a suburb/town, 11.7% lived on a reservation and 10.5% lived in a rural area. Family composition characteristics included the following: 33.9% of the families had two children under 18 years of age living at home, 20.1% only had one child, 18.6% had three children, and 18.6% had 4 or more children under 18 years of age living at home. Ninety percent of the participants reported being the biological relative of the child and of these, 74.2% were the biological mother, 16.9% were the biological father, and 6.9% were either an aunt or uncle. Of those respondents who were not a biological relative 33.9% were a step-parent, 18.6% were a partner to a biological parent, 15.3% were a foster parent, 8.5% were adoptive parents, and the remaining 20.4% were a surrogate parent, close non relative or designated other. Finally, 41.5% of the families used English as the primary language in the home, 28.3% used Spanish as the primary language in the home and 30.2% spoke another language in the home.



Table 5.11: Demographics for SMEFC

General Demographics		
No. of Participants	Pre-test: 785	Post-test: 602
Gender	78.9% Female	21.1% Male
Average Age	38 (SD=10.48)	
Average Education Completed	11 Years (SD=3.87)	
Race/Ethnic Group		
Hispanic	41%	
Asian American	21.4%	
African American	12.1%	
American Indian/Native American	10.9%	
Caucasian	6.0%	
Native Hawaiian/Pacific Islander	4.2%	
Other	4.4%	
Area of Residence		
City	46.2%	
Suburb/town	22.9%	
Reservation	11.7%	
Rural	10.5%	
Family Composition		
One Child Living at Home	20.1%	
Two Children Living at Home	33.9%	
Three Children Living at Home	18.6%	
Four or More Children Living at Home	18.6%	
Employment Status		
Full time	27.0%	
Part time	11.4%	
Unemployed	30.4%	
Disabled	6.9%	
Retired/Volunteer	8.1%	
Other	15.9%	
Biological Relationships w/Child(ren)		
Biological Relative	90%	
Biological Mother	74.2%	
Biological Father	16.9%	
Aunt/Uncle	6.9%	



Non-Biological Relationships w/Child(ren)	
Step Parent	33.9%
Partner to Biological Relative	18.6%
Foster Parent	15.3%
Adoptive Parent	8.5%
Surrogate Parent	20.4%

For the purposes of the multi-site evaluation, each study site was allowed to implement the data collection method that best suited their needs. This resulted in varying data collection methods across sites that implemented the SMEFC program. Specifically, 64.8% of the participants were administered the instrument in a group interview format where the adults were allowed to record their answers confidentially, 13.4% were administered the instrument in an individual interview where the adult recorded their answers confidentially, 11.1% were administered the instrument in an individual interview where the interviewer recorded their answers, 10.2% reported they were administered the instrument in the “other” format to include individual self administered.

Examination of Pretest and Posttest

One-way repeated measures ANOVA was used to examine the differences of means for participants on their pre and post-test scores for family resilience, family conflict, family cohesion, and family attachment separately. The one-way within subjects ANOVA was conducted with “time” being the factor and each of the family functioning scores being the dependent variable. The means and standard deviations for the family resilience scores are presented in Table 5.12. The results for the ANOVA indicated a significant change in family resilience from pre-test to post-test with $F(1, 592) = 83.5, p=.000, \eta^2=.12$.

Table 5.12: Means and Standard Deviations for Family Functioning Scores

Family Functioning	Pre-test Mean (Std. Deviation)	Post-test Mean (Std. Deviation)	N
<i>Family Resilience</i>	27.74 (9.692)	24.02 (9.117)	593
<i>Family Conflict</i>	27.66	24.66 (7.554)	602
<i>Family Relations & Cohesion</i>	9.46 (3.357)	8.58 (2.829)	599
<i>Family Attachment</i>	5.86 (1.240)	5.44 (.946)	493

The results for the ANOVA indicated a significant change in family conflict from pre-test to post-test with $F(1, 601) = 102.4, p=.000, \eta^2=.15$. See Table 5.13.

The family cohesion scores’ means and standard deviations are presented in Table 5.12. The results for the ANOVA indicated a significant change in family cohesion from pre-test to post-test with $F(1, 598) = 44.0, p=.000, \eta^2=.07$.



Finally, the means and standard deviations for the family attachment scores are presented in Table 5.12. The results for the ANOVA indicated a significant change in family attachment from pre-test to post-test with $F(1, 492) = 46.5, p = .000, \eta^2 = .09$.

Table 4.13. Repeated Measures ANOVA

Source	F	Sig.	Eta Squared
Family Resilience	83.530	.000	.124
Family Conflict	102.363	.000	.146
Family Cohesion	44.037	.000	.069
Family Attachment	46.523	.000	.086

a Computed using alpha = .05

Overall, these results suggest that the Strengthening Multi-Ethnic Families and Communities program seems to improve family functioning in the domains of family resilience, family conflict, family cohesion, and family attachment. More will follow in the discussion section of the report.

RESULTS SPECIFIC TO PARENTING WISELY

Through the innovative use of CD-ROM, the Parenting Wisely program is a highly interactive program designed for families at risk with children from early elementary to high school age. Parenting Wisely seeks to help families enhance relationships and decrease conflict through behaviour management and support. It enhances child adjustment and potentially reduces substance abuse juvenile delinquency, and other behaviour problems. Please see Appendix 1 for more details of the program.

Although five study sites selected the Parenting Wisely program for implementation, only four sites submitted their data. (Two of the five sites implemented Parenting Wisely in conjunction with another evidenced based model program.) At baseline, 117 participants had completed the pre-test and at the end of the intervention, 81 participants (77.9%) completed the posttest. Participants at baseline had an average of 38 years ($SD = 6.98$) with 87% of them being female. Further, the majority of the respondents (53%) identified as Caucasian, 20% were Alaskan Native, 12.2% were Black/African American, 8.7% were Hispanic, and 6.1% were Native American.

Other attributes of the Parenting Wisely participants include an average of 12 years ($SD = 2.37$) of schooling with 57.4% of the participants employed full or part-time, 19.1% unemployed and looking for work, 11.3% were unemployed but engaged in volunteer work or were disabled. Moreover, of those who responded, 73.9% lived in the city, 24.3% lived in the suburbs, and



1.8% lived in a rural area. The composition of the participating families were as follows: many of the families had two children (33.3%) under the age of 18 years, however, the same number of

families (20.2%) reported having either one or three children under the age of 18 years, and 25.5% of the families reported having four or more children in the home under the age of 18 years. Ninety-five percent of the participants reported being a biological relative of the child and of these individuals, 86.1% were the biological mother, 11.1% were the biological father, and 2.8% were an aunt or grandparent. Of those respondents who were not a biological relative, 50% were a step-parent, 33.3% were adoptive parents, and 16.7% were a partner to the biological parent. Lastly, related to family characteristics, 94.7% of the families used English as the primary language in the home while 5.3% spoke primarily Spanish in the home.

Table 5.14: Demographics for Parenting Wisely

General Demographics		
No. of Participants	Pre-test: 117	Post-test: 81
Gender	87% Female	13% Male
Average Age	38 (SD=6.98)	
Average Education Completed	12 Years (SD=2.37)	
Race/Ethnic Group		
Caucasian	53%	
Alaskan Native	20%	
African American	12.25%	
Hispanic	8.7%	
Native American	6.1%	
Area of Residence		
City	73.9%	
Suburb/town	24.3%	
Rural	1.8%	
Family Composition		
One Child Living at Home	20.2%	
Two Children Living at Home	33.3%	
Three Children Living at Home	20.3%	
Four or More Children Living at Home	25.5%	
Employment Status		
Full time/Part time	57.4%	
Unemployed	19.1%	
Disabled/ Retired/Volunteer	11.3%	
Biological Relationships w/Child(ren)		
Biological Relative	95%	
Biological Mother	86.1%	
Biological Father	11.1%	
Aunt/Grandparent	2.8%	
Non-Biological Relationships w/Child(ren)		
Step Parent	50%	
Partner to Biological Relative	16.7%	



Adoptive Parent	33.3%
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Related to the administration of the cross-site instrument, 44.5% of the participants completed it in a group interview format where each respondent was able to record their answers confidentially. An additional 49.1% participated in individual interviews that allowed them to record their answers confidentially, and 6.4% had individual interviews where the interviewer recorded their answers.

Examination of Pretest and Posttest

As part of the proposed analysis plan, one-way repeated measures ANOVA was used to examine the differences of pre and posttest means for the participants' scores on family resilience, family conflict, family cohesion, and family attachment. The one-way within subjects ANOVA was conducted with "time" being the factor and each of the family functioning pre and posttest scores being the dependent variables. The means and standard deviations for the family resilience scores are presented in Table 5.15. The results of the repeated measures ANOVA indicated a significant change in family resilience from pretest to posttest with $F(1, 77) = 21.479, p = .000$, eta squared $\eta^2 = .22$. The explained variance of 22% also appears to be similar to that of the other programs which is presented in table 5.16.

Table 5.15: Means and Standard Deviations for Family Functioning Scores

Family Functioning	Pre-test Mean (Std. Deviation)	Post-test Mean (Std. Deviation)	N
<i>Family Resilience</i>	29.8 (8.6)	25.9 (7.1)	78
<i>Family Conflict</i>	28.9 (8.7)	27.0 (8.8)	77
<i>Family Relations & Cohesion</i>	9.3 (2.9)	8.4 (2.9)	77
<i>Family Attachment</i>	6.1 (2.4)	5.3 (.742)	53

Table 5.15 also presents the means and standard deviations for the family conflict pretest and posttest scores. The results of the repeated measures ANOVA for family conflict were also significant (see Table 5.16) with $F(1, 76) = 9.087, p = .003$, eta squared $\eta^2 = .11$.

Table 5.16: Repeated Measures ANOVA

Source	F	Sig.	Eta Squared
Family Resilience	21.479	.000	.218
Family Conflict	9.087	.003	.107
Family Cohesion	9.087	.003	.107
Family Attachment	4.973	.030	.087

a Computed using alpha = .05



Interestingly, the results for family cohesion for the repeated measures ANOVA mirrored that of the family conflict results with $F(1, 76) = 9.087, p = .003, \eta^2 = .11$.

The means and standard deviations for family attachment scores can be found in table 5.15. The results for the ANOVA indicated a significant change in family attachment from pretest to posttest with a smaller sample size ($n=53$) than the other previous measures with $F(1, 52) = 4.973, p = .030, \eta^2 = .09$.

Overall, these results suggest that the Parenting Wisely program appears to significantly improve family functioning in all of the domains (family resilience, family conflict, family cohesion, and family attachment). With an adequate sample size, the variance for each of the domains was low except for family resilience.

RESULTS SPECIFIC TO NURTURING PARENTING PROGRAM

Designed as a family centered program to build nurturing skills, the Nurturing Parenting program strives to produce alternative approaches to abusive parenting and negative child rearing attitudes and practices. The goals of the program are to stop the generational cycle of child abuse by building nurturing parenting skills, reducing the rate of juvenile delinquency, reducing alcohol and drug abuse and preventing repeat pregnancies among teenagers. For a more detailed description of the program, please refer to Appendix 1.

A total of three study sites selected the Nurturing Parenting Program for implementation with ninety families participating at baseline. However, at the end of the intervention, sixty-eight participants completed the posttest. At baseline, the Nurturing Parenting Program had participants with an average age of 32 years ($SD = 10.3$) with 72.2% of those participant being female. Additionally, 39.8% of participants identified as Caucasian, 30.7% were Black/African American, 22.7% reported being Hispanic, and 4.5% were Asian American, Native American or “other”.

Other characteristics of the participants include an average of 12 years ($SD = 2.08$) of education with 26.8% of the participants working full time, 7.3% employed part-time, and 37.7% stated they were unemployed. Those who reported they were unemployed were looking for work (26.8%), disabled (8.5%), retired (1.2%), or engaged in volunteer work (1.2%). Moreover, 79.8% of respondents reported living in the city, 12.4% lived in a suburb/town, 2.2% lived in a rural area, and 5.6% lived in an “other” area. Family composition characteristics included the following: of the families with children under the age of eighteen, 27% had one child, 24.7% had two children, 22.5% had three children, and 21.3% had four or more children. Seventy-six percent of the participants reported being the biological relative of the focal child, and of these, 81.3% were the biological mother, 15.6% were the biological father, and 3.2% stated they were “other” relative. Of those respondents who were not a biological relative, 57.1% were a stepparent, 28.6% were an adoptive parent, and 14.3% were foster parents. Finally, English was the primary language spoken in the home reported by 85.5% of the participants and 12% speak



Spanish as the primary language in the home. Few respondents (2.4%) responded that they speak another language.



Table 5.17: Demographics of Nurturing Parenting Program

General Demographics		
No. of Participants	Pre-test: 90	Post-test: 68
Gender	72.2% Female	27.8% Male
Average Education Completed	12 Years (SD=2.08)	
Average Age	32 (SD=10.3)	
Race/Ethnic Group		
Caucasian	39.8%	
African American	30.7%	
Hispanic	22.7%	
Asian/Native American/Other	4.5%	
Area of Residence		
City	79.8%	
Suburb/town	12.4%	
Other	5.6%	
Rural	2.2%	
Family Composition		
One Child Living at Home	27%	
Two Children Living at Home	24.7%	
Three Children Living at Home	22.5%	
Four or More Children Living at Home	21.3%	
Employment Status		
Unemployed	37.7%	
Full time	26.8%	
Unemployed Looking For Work	26.8%	
Disabled/ Retired/Volunteer	10.9%	
Part time	7.3%	
Biological Relationships w/Child(ren)		
Biological Relative	76%	
Biological Mother	81.3%	
Biological Father	15.6%	
Other	3.2%	
Non-Biological Relationships w/Child(ren)		
Step Parent	57.1%	
Adoptive Parent	28.6%	
Foster Parent	14.3%	



These particular sites that implemented the Nurturing Parenting Program, administered the cross-site instrument to 53.3% of their participants in a group format where the respondents recorded their responses confidentially, 30% of the participants had one to one interviews where the interviewer recorded their responses, and 16.7% reported they were administered the instrument in one to one interviews that allowed them to record their answers confidentially.

Examination of Pretest and Posttest

The analysis plan included the use of one-way repeated measures ANOVA to examine the differences of pre and posttest means for the participants’ scores on family resilience, family conflict, family cohesion, and family attachment. Similar to the other programs, one-way within subjects ANOVA was conducted with “time” being the factor and each of the family functioning pre and posttest scores being the dependent variables. The means and standard deviations for the family resilience scores are presented in Table 5.18. With a sample size of 66, the results of the repeated measures ANOVA indicated a significant change in family resilience from pretest to posttest with $F(1, 65) = 11.409, p = .001, \eta^2 = .15$.

Table 5.18: Means and Standard Deviations for Family Functioning Scores

Family Functioning	Pre-test Mean (Std. Deviation)	Post-test Mean (Std. Deviation)	N
<i>Family Resilience</i>	29.3 (8.9)	26.5 (7.4)	66
<i>Family Conflict</i>	28.9 (9.6)	26.5 (8.7)	67
<i>Family Relations & Cohesion</i>	9.9 (3.3)	9.3 (3.5)	68
<i>Family Attachment</i>	6.0 (1.3)	5.8 (1.3)	44

Table 5.18 also presents the means and standard deviations for the family conflict pretest and posttest scores. The results of the repeated measures ANOVA for family conflict were also significant (see Table 5.19) with $F(1, 66) = 9.250, p = .003, \eta^2 = .12$.

Table 19: Repeated Measures ANOVA

Source	F	Sig.	Eta Squared
Family Resilience	11.409	.001	.149
Family Conflict	9.250	.003	.123
Family Cohesion	2.449	.122	.035
Family Attachment	2.051	.159	.046

a Computed using alpha = .05



However, with a similar sample size ($n=68$), the results for family cohesion for the repeated measures ANOVA did not produce significant results with $F(1, 67) = 2.449, p > .05, \eta^2 = .04$.

The means and standard deviations for family attachment scores can be found in table 5.18. As with family cohesion, the results for the family attachment ANOVA did not provide significant change in family attachment from pretest to posttest with $F(1, 43) = 2.051, p > .05, \eta^2 = .05$.

The results of the ANOVA suggest that the Nurturing Parenting Program appears to significantly improve family functioning in the domains of family resilience and family conflict.

RESULTS SPECIFIC TO STRENGTHENING FAMILIES PROGRAM

The Strengthening Families Program is a family skills training program designed to increase resilience and reduce risk factors for substance abuse, juvenile delinquency, violence and aggression, and school failure in high-risk children 6-12 years. A more detailed description of the program can be found in Appendix 1.

Three study sites selected the Strengthening Families Program for implementation with 108 families. At program exit, there were a total of seventy-eight pretest/posttest matches. At baseline, Strengthening Families Program had participants with an average age of 40 years ($SD = 11.4$) with 93.5% of the participants being female. Moreover, the majority of the participants (47.2%) identified as Hispanic, 39.6% were Caucasian, 10.4% were Black/African American, and 1.9% reported being Native American. Those who identified as Hispanic were primarily Mexican.

Other characteristics of the participants include an average of 11 years ($SD = 3.23$) of education with 25.9% of the participants working full time, 19.4% employed part-time, and 47.2% stated they were unemployed. Those who reported they were unemployed were looking for work, disabled, retired, or engaged in volunteer work. Moreover, 71.2% of respondents reported living in the city, 16.3% lived in a rural town, 10.6% lived in the suburbs, and two individuals (1.9%) reported living on a farm or ranch. Family composition characteristics included the following: of the families with children under the age of eighteen, 47.2% were families with two children, 18.9% were three children families, 12.32% had either one child or four children, and 9.4% had five or more children. Ninety percent of the participants reported being the biological relative of the focal child, and of these, 73.3% were the biological mother, 4% were the biological father, and 20.8% were grandparents. Those respondents who were not a biological relative were a foster parent, adoptive parent, or surrogate parent. Finally, Spanish is the primary language spoken in the home reported by 68.2% of the participants and 31.8% speak English as the primary language in the home.



Table 5.20: Demographics for Strengthening Families Program

General Demographics		
No. of Participants	Pre-test: 108	Post-test: 78
Gender	93.5% Female	6.5% Male
Average Education Completed	11 Years (SD=3.23)	
Average Age	40 (SD=11.4)	
Race/Ethnic Group		
Hispanic		47.2%
Caucasian		39.6%
African American		10.4%
Native American		1.9%
Area of Residence		
City		71.2%
Rural		16.3%
Suburb/town		10.6%
Farm/Ranch		1.9%
Family Composition		
Two Children Living at Home		47.2%
Three Children Living at Home		18.9%
One Child or Four Children Living at Home		12.32
Five or More Children Living at Home		9.4%
Employment Status		
Unemployed/Disabled/ Retired/Volunteer		47.2%
Full time		25.9%
Part time		19.4%
Biological Relationships w/Child(ren)		
Biological Relative		90%
Biological Mother		73.3%
Grandparent		20.8%
Biological Father		4%

The three sites that implemented the Strengthening Families Program administered the cross-site instrument to their participants in the following manner. Fifty-two percent administered on a one to one, individual interview where the interviewer recorded their answers, 37.4% were group interviews where the participant recorded their answers confidentially, and 10.3% were individual interviews where the respondent recorded their answers confidentially.



Examination of Pretest and Posttest

As planned, one-way repeated measures ANOVA was used to examine the differences of means for participants on their pre and post-test scores for family resilience, family conflict, family cohesion, and family attachment separately. The one-way within subjects ANOVA was conducted with “time” being the factor and each of the family functioning scores being the dependent variable. The means and standard deviations for the family resilience scores are presented in Table 5.21. The results for the ANOVA indicated a significant change in family resilience from pre-test to post-test with $F(1, 77) = 30.412, p = .000, \eta^2 = .28$.

Table 5.21: Means and Standard Deviations for Family Functioning Scores

Family Functioning	Pre-test Mean (Std. Deviation)	Post-test Mean (Std. Deviation)	N
<i>Family Resilience</i>	31.4 (7.2)	25.5 (7.3)	78
<i>Family Conflict</i>	29.5 (7.8)	27.3 (6.5)	78
<i>Family Relations & Cohesion</i>	9.0 (2.8)	8.2 (2.4)	77
<i>Family Attachment</i>	5.6 (.72)	5.3 (.52)	42

The means and standard deviations for the family conflict pretest and posttest scores can be found in Table 5.21. The results of the repeated measures ANOVA indicate a significant change in family conflict from pretest to posttest with $F(1, 77) = 5.355, p = .023, \eta^2 = .07$.

Table 5.22: Repeated Measures ANOVA

Source	F	Sig.	Eta Squared
Family Resilience	30.412	.000	.283
Family Conflict	5.355	.023	.065
Family Cohesion	5.626	.020	.069
Family Attachment	6.917	.012	.144

a Computed using alpha = .05

The means and standard deviations for family cohesion and family attachment scores can be found in table 5.21. Similar to the first two measures, the results for family cohesion for the repeated measures ANOVA was significant and demonstrated a low effect size (see Table 5.22) with $F(1, 76) = 5.626, p = .020, \eta^2 = .07$.

Like the other measures, the results for the ANOVA did have a significant change in family attachment from pretest to posttest with $F(1, 41) = 6.917, p = .012, \eta^2 = .14$.



In general, these results suggest that the Strengthening Families Program appears to significantly improve family functioning in all of the key domains (family resilience, family conflict, family cohesion, and family attachment). Also of interest is the variance of 28% for family resilience, which is the highest effect size for this domain of family functioning.

RESULTS SPECIFIC TO STRENGTHENING FAMILIES PROGRAM FOR PARENTS AND YOUTH 10-14

Adapted from the Strengthening Families Program, the ultimate goals of the Strengthening Families Program for Parents and Youth 10-14 are to reduce substance use and behaviour problems during adolescence. Additionally, objectives are to improve parents' skills in nurturing and child management and improve interpersonal and personal competencies among youth. Additional details of the program can be found in Appendix 1.

Three study sites selected the Strengthening Families Program for Parents and Youth 10-14 for implementation, but only two were included in the analyses. The third site targeted the Hmong population and did not believe that some questions in the instrument were appropriate for their participants. Specifically, several of the GPRM measures were not asked as well as the Common Core Measures. This resulted in items not comparable with the cross-site items in the study. Between the two sites included in the analysis, there were 65 families at the pretest and 42 families completed the posttest. For the family core measures, there were only a total of 26 pre and posttest matches.

At baseline, participants in the program had an average age of 37 years ($SD = 6.53$) with 89.2% of them being female. Additionally, 56.5% of the participants identified as being African American, 35.5% were Caucasian, 3.2% were Hispanic and Asian American, and 1.6% were American Indian/Native American.

Other characteristics of the program participants include an average of 12 years ($SD = 1.67$) of education and 56.6% of them either employed full-time or part-time. Nineteen point six percent were unemployed and looking for work while 17.3% reported unemployed due to disability or were only engaged in volunteer work. Further, the majority of the participants (92.9%) reported living in the city whereas 4.8% lived in the suburbs, and 2.4% lived in a rural area. Family composition characteristics included the following: 37.5% of the families had two children under the age of 18 living at home, 20.8% had only one child, 25% had three children, and 14.6% had four or more children under the age of 18 living at home. Families also reported that 93.8% were biological relatives of which 93.1% were either mother or father, and 6.8% were either a grandparent or older sibling. If respondents were not a biological relative, they were a partner to the biological parent. Finally, 93.8% of the families spoke English as the primary language in the home whereas only 6.3% spoke Spanish in the home.



Table 5.23: Demographics for SFP 10-14

General Demographics		
No. of Participants	Pre-test: 65	Post-test: 42
Gender	89.2% Female	10.8% Male
Average Education Completed	12 Years (SD=1.67)	
Average Age	37 (SD=6.53)	
Race/Ethnic Group		
Caucasian		35.5%
African American		56.5%
Hispanic		3.2%
Indian/Native American		1.6%
Area of Residence		
City		92.9%
Suburb/town		4.8%
Rural		2.4%
Family Composition		
One Child Living at Home		20.8%
Two Children Living at Home		37.5%
Three Children Living at Home		25%
Four or More Children Living at Home		14.6%
Employment Status		
Full time/Part time		56.6%
Unemployed Looking For Work		19.6%
Disabled/Volunteer		17.3%
Biological Relationships w/Child(ren)		
Biological Relative		93.8%
Biological Mother or Father		93.1%
Grandparent or Older Sibling		6.8%

For the purposes of the cross-site, 93.8% of the participants were administered the instrument in individual interviews where they were able to record their answers confidentially, 4.2% were administered the instrument in individual interviews where the interviewer recorded their answers, and 2.1% participated in group interviews where they recorded their answers confidentially.

Examination of Pretest and Posttest

Part of the proposed analysis plan included the use of one-way repeated measures ANOVA to examine the differences of pre and posttest means for the participants' scores on family resilience, family conflict, family cohesion, and family attachment. As with the other programs, one-way within subjects ANOVA was conducted with "time" being the factor and each of the family functioning pre and posttest scores being the dependent variables. The means and



standard deviations for the family resilience scores are presented in Table 5.24. With a sample size of 26, the results of the repeated measures ANOVA indicated a significant change in family resilience from pretest to posttest with $F(1, 25) = 4.780$, $p = .038$, eta squared $\eta^2 = .16$.

Table 5.24: Means and Standard Deviations for Family Functioning Scores

Family Functioning	Pre-test Mean (Std. Deviation)	Post-test Mean (Std. Deviation)	N
<i>Family Resilience</i>	29.5 (6.5)	26.7 (6.9)	26
<i>Family Conflict</i>	32.0 (7.6)	27.6 (7.9)	26
<i>Family Relations & Cohesion</i>	9.5 (2.9)	8.3 (2.7)	26
<i>Family Attachment</i>	5.5 (.89)	5.3 (.60)	16

Table 5.24 also presents the means and standard deviations for the family conflict pretest and posttest scores. The results of the repeated measures ANOVA for family conflict were also significant (see Table 5.25) with $F(1, 25) = 10.988$, $p = .003$, eta squared $\eta^2 = .31$.

Table 5.25: Repeated Measures ANOVA

Source	F	Sig.	Eta Squared
Family Resilience	4.780	.038	.161
Family Conflict	10.988	.003	.305
Family Cohesion	2.368	.136	.087
Family Attachment	.630	.440	.040

a Computed using alpha = .05

However, with the same sample size ($n=26$), the results for family cohesion for the repeated measures ANOVA did not produce significant results with $F(1, 25) = 2.368$, $p > .05$, eta squared $\eta^2 = .09$.

The means and standard deviations for family attachment scores can be found in table 5.24. The results for the ANOVA did not provide significant change in family attachment from pretest to posttest, but it is important to note that the results were produced with a smaller sample size ($n=16$) than the other previous measures with $F(1, 15) = .630$, $p = .440$, eta squared $\eta^2 = .04$.

The results of the ANOVA suggest that the Strengthening Families Program for Parents and Youth 10-14 appears to significantly improve family functioning in the domains of family resilience and family conflict. Notably, the variance for family conflict was 31% which is higher than the other family measures.



RESULTS SPECIFIC TO BRIEF STRATEGIC FAMILY THERAPY

Brief Strategic Family Therapy (BSFT) is a family based intervention targeting children and adolescents ages 8-17. The specific aims of the intervention are to prevent and treat behaviour problems by improving family interactions that are presumed to be directly to children's symptoms that lead to mitigating risk factors and enhancing protective factors for conduct problems and substance use. For a more detailed description of the program, please refer to Appendix 1.

One study site selected the BSFT program for implementation with forty-nine families participating at baseline. However, at the end of the intervention, only twenty six participants completed the posttest. At baseline, the BSFT program had participants with an average age of 37 years ($SD = 6.18$) with 77.6% of those participant being female. Additionally, 93.9% of participants identified as Hispanic, 4.1% were American Indian/Native American, and 2% reported being Caucasian.

Other characteristics of the participants include an average of 9 years ($SD = 4.12$) of education with 46.7% of the participants working full time, 15.6% employed part-time, and 26.6% stated they were unemployed. Those who reported they were unemployed were looking for work, disabled, retired, or engaged in volunteer work. Moreover, 97.9% of respondents reported living in the city and 2.1% lived in a suburb/town. Family composition characteristics included the following: of the families with children under the age of eighteen, the distribution was equal for three and four children families at 30.6% each, 20.4% had two children, 12.3% had five or more children, and 6.1% had only one child. Eighty-six percent of the participants reported being the biological relative of the focal child, and of these, 75.6% were the biological mother, 15.6% were the biological father, 6.6% stated they were "other" relative and 2.2% reported they were a grandparent. Of those respondents who were not a biological relative, only 4.1% were able to be discerned from the data. Finally, Spanish is the primary language spoken in the home reported by 82.6% of the participants and 17.4% speak English as the primary language in the home.



Table 5.26: Demographics for Brief Strategic Family Therapy

General Demographics		
No. of Participants	Pre-test: 49	Post-test: 26
Gender	77.6% Female	22.4% Male
Average Education Completed	9 Years (SD=4.12)	
Average Age	37 (SD=6.18)	
Race/Ethnic Group		
Caucasian		2%
Hispanic		93.9%
Indian/Native American		4.1
Area of Residence		
City		97.9%
Suburb/town		2.1%
Family Composition		
One Child Living at Home		6.1%
Two Children Living at Home		20.4%
Three Children Living at Home		30.6%
Four Children Living at Home		30.6%
Five or More Children Living at Home		12.3%
Employment Status		
Full time		46.7%
Part time		15.6%
Unemployed Looking For Work/Retired/Disabled/Volunteer		26.6%
Biological Relationships w/Child(ren)		
Biological Relative		86%
Biological Mother		75.6%
Biological Father		15.6%
Other Relative		6.6%
Grandparent		2.2%

This particular site that implemented the BSFT program, administered the cross-site instrument to 83.7% of their participants on a one to one basis where the respondent recorded their responses, 12.2% of the participants had one to one interviews where the interviewer recorded their responses, and 4.1% reported they were administered the instrument in an “other” format.

Examination of Pretest and Posttest

As proposed in the analysis plan, one-way repeated measures ANOVA was used to examine the differences of pre and posttest means for the participants’ scores on family resilience, family conflict, family cohesion, and family attachment. The one-way within subjects ANOVA was



conducted with “time” being the factor and each of the family functioning pre and posttest scores being the dependent variables. The means and standard deviations for the family resilience scores are presented in Table 5.27. Even with a fairly small sample size (n=26), the results of the repeated measures ANOVA indicated a significant change in family resilience from pretest to posttest with $F(1, 25) = 5.86, p = .023, \eta^2 = .19$. The variance of 19% also appears to rival that of the other programs which is presented in table 5.28.

Table 5.27: Means and Standard Deviations for Family Functioning Scores

Family Functioning	Pre-test Mean (Std. Deviation)	Post-test Mean (Std. Deviation)	N
<i>Family Resilience</i>	38.8 (10.8)	33.8 (10.3)	26
<i>Family Conflict</i>	30.2 (8.7)	26.4 (8.2)	25
<i>Family Relations & Cohesion</i>	10.9 (4.07)	9.7 (3.4)	25
<i>Family Attachment</i>	6.31 (1.066)	5.65 (.988)	20

Table 5.27 also presents the means and standard deviations for the family conflict pretest and posttest scores. The results of the repeated measures ANOVA were approaching significance (see Table 5.28) with a variance of 14%. Again, these results are from a small sample size (n=25) with $F(1, 24) = 4.02, p > .05, \eta^2 = .14$.

Table 5.28: Repeated Measures ANOVA

Source	F	Sig.	Eta Squared
Family Resilience	5.862	.023	.190
Family Conflict	4.017	.056	.143
Family Cohesion	4.183	.052	.148
Family Attachment	5.797	.026	.234

a Computed using alpha = .05

Similarly, the results for family cohesion for the repeated measures ANOVA approached significance (see Table 5.28) with $F(1, 24) = 4.18, p > .05, \eta^2 = .15$.

The means and standard deviations for family attachment scores can be found in table 5.27. The results for the ANOVA indicated a significant change in family attachment from pretest to posttest with a small sample size (n=20) with $F(1, 19) = 5.79, p = .026, \eta^2 = .23$.

In general, these results suggest that the Brief Strategic Family Therapy Program appears to significantly improve family functioning in the domains of family resilience and family attachment. However, even with very small sample sizes, the domains of family conflict and



family cohesion were approaching significance. It should also be noted that the variance for the Brief Strategic Family Therapy Program either rivaled or surpassed that of the other programs.

RESULTS SPECIFIC TO THE INCREDIBLE YEARS

The Incredible Years is an intervention/prevention program designed for caregivers of children ages 3-12. The program has both parent and child training components which aim to strengthen competencies by training caregivers in positive communication, limit setting and teaching children to problem solve, manage anger, and promote prosocial skills. For a more detailed description of the program, please refer to Appendix 1.

As with some of the other programs, one study site selected the Incredible Years program for implementation with thirty-six families. Surprisingly, at the end of each of the two cycles, thirty-six families completed the posttest. At baseline, the Incredible Years has participants with an average age of 37 years ($SD = 6.6$) with 80.6% of the participants being female. Moreover, the majority of the participants (86.1%) identified as Hispanic, 11.1% were Caucasian, and 2.8% reported being Black/African American. Of those who identified as Hispanic, 93.3% were Mexican and 3.3% were each Puerto Rican and Latin American.

Additional characteristics of the participants include an average of 8 years ($SD = 3.43$) of education with 47.2% unemployed (looking for work, disabled, or a volunteer), 44.4% of the participants working full time, and 8.3% working part-time. Although the majority of the participants lived in the city (57.1%), a considerable amount reported living in a rural town (34.3%), and 2.9% reported living on a reservation. Composition of family characteristics include the following: 30.6% of the families had two children under the age of eighteen living at home, 22.2% had four children, 16.7% had one or three children under eighteen years of age, and 13.9% had five or more children in the home who was eighteen or under. Unexpectedly, 100% of the participants reported being the biological relative of the focal child with 82.4% reporting being the mother, 14.7% was the biological father and 2.9% being a grandparent. Finally, 83.3% of the families used Spanish as the primary language in the home and 16.7% reported English as being the primary language used in the home.



Table 5.29: Demographics for Incredible Years

General Demographics		
No. of Participants	Pre-test: 36	Post-test: 36
Gender	80.6% Female	19.4% Male
Average Education Completed	8 Years (SD=3.43)	
Average Age	37 (SD=6.6)	
Race/Ethnic Group		
Caucasian		11.1%
African American		2.8%
Hispanic		86.1%
Area of Residence		
City		57.1%
Reservation		2.9%
Rural		34.3%
Family Composition		
One Child or Three Children Living at Home		16.7%
Two Children Living at Home		30.6%
Four Children Living at Home		22.2%
Five or More Children Living at Home		13.9%
Employment Status		
Full time		44.4%
Unemployed Looking For Work/Disabled/Volunteer		47.2%
Part time		8.3%
Biological Relationships w/Child(ren)		
Biological Relative		100%
Biological Mother		82.4%
Biological Father		14.7%
Grandparent		2.9%

This study site primarily employed a group interview method of administering the cross-site instrument with 80.6% of the participants and an individual interview with the interviewer recording the answers with 16.7% of the respondents, and 2.8% had an individual interview where they recorded their responses.



Examination of Pretest and Posttest

Consistent with the analyses for the other programs, one-way repeated measures ANOVA was used to examine the differences of means for participants on their pre and post-test scores for family resilience, family conflict, family cohesion, and family attachment separately. The one-way within subjects ANOVA was conducted with “time” being the factor and each of the family functioning scores being the dependent variable. The means and standard deviations for the family resilience scores are presented in Table 5.30. The results for the ANOVA indicated a significant change in family resilience from pre-test to post-test with $F(1, 35) = 7.758, p = .009$, eta squared $\eta^2 = .18$.

Table 5.30: Means and Standard Deviations for Family Functioning Scores

Family Functioning	Pre-test Mean (Std. Deviation)	Post-test Mean (Std. Deviation)	N
<i>Family Resilience</i>	30.7 (8.4)	26.6 (7.4)	36
<i>Family Conflict</i>	31.3 (8.3)	28.1 (7.5)	35
<i>Family Relations & Cohesion</i>	9.1 (3.0)	8.8 (2.7)	34
<i>Family Attachment</i>	6.07 (1.2)	5.6 (.84)	24

The means and standard deviations for the family conflict pretest and posttest scores can be found in Table 5.30. The results of the repeated measures ANOVA indicate a significant change in family conflict from pretest to posttest with $F(1, 34) = 8.639, p = .006$, eta squared $\eta^2 = .20$.

Table 5.31: Repeated Measures ANOVA

Source	F	Sig.	Eta Squared
Family Resilience	7.758	.009	.181
Family Conflict	8.639	.006	.203
Family Cohesion	.760	.390	.023
Family Attachment	3.449	.076	.130

a Computed using alpha = .05

The means and standard deviations for family cohesion and family attachment scores can be found in table 5.30. Contrary to the first two measures, the results for family cohesion for the repeated measures ANOVA was not significant and also demonstrated a very low effect size (see Table 5.31) with $F(1, 33) = .760, p > .05$, eta squared $\eta^2 = .02$.

Similar to family cohesion, the results for the ANOVA did not indicate a significant change in family attachment from pretest to posttest with $F(1, 23) = 3.449, p > .05$, eta squared $\eta^2 = .13$.



In general, with small sample sizes, these results suggest that the Incredible Years Program appears to significantly improve family functioning in the domains of family resilience and family conflict. Also of interest is the variance of 20% for family conflict, which is the highest effect size for this domain of family functioning.

RESULTS SPECIFIC TO EFFECTIVE BLACK PARENTING

The Effective Black Parenting (EBP) program was designed to meet the needs of African American parents. Specifically, the program seeks to foster effective family communication, healthy African American identity, extended family values, and child growth and development. Additionally, it facilitates efforts to combat child abuse, substance abuse, juvenile delinquency, gang violence, and behaviour problems. Grounded in basic parenting strategies, the program targets all socioeconomic status levels, especially for parents with children 2-12 years. Further information on the program can be found in Appendix 1.

One study site selected the EBP program for implementation with thirty-four families participating at baseline. At the end of the intervention, all thirty-four participants completed the posttest. At baseline, the EBP program had participants with an average age of 31 years ($SD = 9.36$) with 97.1% of those participant being female. Additionally, this program was implemented with all (100%) African American participants.

Other characteristics of the participants include an average of 13 years ($SD = 1.54$) of education with 64.7% of the participants working full time and 35.3% employed part-time. Moreover, 100% of respondents reported living in the city. Family composition characteristics included the following: of the families with children under the age of eighteen 44.1% had two children, 20.6% had only one child, 17.6% had three children, and 17.6% had four or more children. All of the participants reported being the biological relative of the focal child, and of these, 93.9% were the biological mother, 3% were the biological father, and 3% reported they were a grandparent. Finally, as expected from the above mentioned characteristics, English is the primary language spoken in the home reported by all of the participants.



Table 5.32: Demographics for Effective Black Parenting

General Demographics		
No. of Participants	Pre-test: 34	Post-test: 34
Gender	97.1% Female	2.9% Male
Average Education Completed	13 Years (SD=1.54)	
Average Age	31 (SD=9.36)	
Family Composition		
One Child Living at Home	20.6%	
Two Children Living at Home	44.1%	
Three Children Living at Home	17.6%	
Four or More Children Living at Home	17.6%	
Employment Status		
Full time/Part time	64.7%	
Part time	35.3%	
Biological Relationships w/Child(ren)		
Biological Relative	100%	
Biological Mother	93.9%	
Biological Father	3%	
Grandparent	3%	

This particular site that implemented the EBP program, administered the cross-site instrument to all of their participants on a one to one, individual interview where the participant recorded their answers confidentially.

Examination of Pretest and Posttest

As proposed in the analysis plan, one-way repeated measures ANOVA was used to examine the differences of pre and posttest means for the participants' scores on family resilience, family conflict, family cohesion, and family attachment. The one-way within subjects ANOVA was conducted with "time" being the factor and each of the family functioning pre and posttest scores being the dependent variables. The means and standard deviations for the family resilience scores are presented in Table 5.33. Even with a fairly small sample size (n=33), the results of the repeated measures ANOVA indicated a significant change in family resilience from pretest to posttest with $F(1, 32) = 56.79, p = .000, \eta^2 = .64$. Also, the explained variance of 64% surpasses that of family resilience in any of the other programs (see table 5.34).

Table 5.33: Means and Standard Deviations for Family Functioning Scores

Family Functioning	Pre-test Mean (Std. Deviation)	Post-test Mean (Std. Deviation)	N
<i>Family Resilience</i>	37.2 (9.9)	23.3 (9.5)	33
<i>Family Conflict</i>	40.6 (7.2)	42.4 (6.6)	31
<i>Family Relations & Cohesion</i>	20.8 (3.7)	21.1 (2.5)	34



Family Attachment	7.3 (3.3)	5.3 (.659)	28
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Table 5.33 also presents the means and standard deviations for the family conflict pretest and posttest scores. The results of the repeated measures ANOVA were not significant (see Table 5.34) with a variance of only 7%. Again, these results are from a small sample size (n=31) with $F(1, 30) = 2.33, p > .05, \eta^2 = .07$.

Table 5.34: Repeated Measures ANOVA

Source	F	Sig.	Eta Squared
Family Resilience	56.790	.000	.640
Family Conflict	.110	.137	.072
Family Cohesion	4.183	.742	.003
Family Attachment	10.095	.004	.272

a Computed using alpha = .05

Similarly, the results for family cohesion for the repeated measures ANOVA were not significant (see Table XX) with $F(1, 324) = .110, p > .05, \eta^2 = .003$.

The means and standard deviations for family attachment scores can be found in table 5.33. The results for the ANOVA indicated a significant change in family attachment from pretest to posttest with a small sample size (n=28) with $F(1, 27) = 10.095, p = .004, \eta^2 = .27$.

In general, these results suggest that the EBP program appears to significantly improve were large in comparison to the other programs. It should also be noted that the direction of the means progressed in the opposite direction than anticipated. This may have been an artifact and warrants further attention.

RESULTS SPECIFIC TO DARE TO BE YOU

Designed to increase resiliency factors and reduce risk factors in families with young children, the Dare to Be You program targets 2-5 year old children and their families including extended family who fulfill caregiving roles. Outcomes for the program include reducing alcohol, tobacco, and other drug use. See Appendix 1 for more details of the program.

One study site selected the Dare to Be You program for implementation with fifty-five families. At the end of each of four cycles, there were forty-eight families that completed the posttest. At baseline, Dare to Be You had participants with an average age of 29 years ($SD = 6.3$) with 96.4% of the participants being female. Moreover, the majority of the participants (85.5%) identified as Caucasian, 9.1% were Black/African American, 3.6% were Hispanic, and 1.8% reported being “other”. Those who identified as Hispanic were of Mexican descent.

Other characteristics of the participants include an average of 12 years ($SD = 1.84$) of education with 47.3% of the participants working full time, 23.6% employed part-time, and 12.76% stated they were unemployed. Those who reported they were unemployed were looking for work,



disabled, or engaged in volunteer work. Moreover, 98.2% of respondents reported living in a rural town and one individual (1.8%) reported living on a farm or ranch. Family composition characteristics included the following: of the families with children under the age of eighteen, the distribution was equal for two and three children families at 36.4% each, 18.2% had one child, 9.1% had four or more children. Ninety-five percent of the participants reported being the biological relative of the focal child, and of these, 96.2% were the biological mother, 1.9% were the biological father or grandparents. Those respondents who were not a biological relative were a stepparent. Finally, English is the primary language spoken in the home reported by 98.2% of the participants and 1.8% speak Spanish as the primary language in the home.

Table 5.35: Demographics for Dare to Be You

General Demographics		
No. of Participants	Pre-test: 55	Post-test: 48
Gender	96.4% Female	3.6% Male
Average Education Completed	12 Years (SD=1.84)	
Average Age	29 (SD=6.3)	
Race/Ethnic Group		
Caucasian	85.5%	
African American	9.1%	
Hispanic	3.6%	
Other	1.8%	
Area of Residence		
Rural	98.2%	
Farm/Ranch	1.8%	
Family Composition		
One Child or Three Children Living at Home	18.2%	
Two Children Living at Home	36.4%	
Three Children Living at Home	36.4%	
Four or More Children Living at Home	9.1%	
Employment Status		
Full time	47.3%	
Unemployed Looking For Work/Disabled/Volunteer	12.76%	
Part time	23.6%	
Biological Relationships w/Child(ren)		
Biological Relative	95%	
Biological Mother	96.2%	
Biological Father or Grandparent	1.9	



This particular site administered the cross-site instrument to all of their participants on a one to one, individual interview where the interviewer recorded their answers.

Examination of Pretest and Posttest

One-way repeated measures ANOVA was used to examine the differences of means for participants on their pre and post-test scores for family resilience, family conflict, family cohesion, and family attachment separately. The one-way within subjects ANOVA was conducted with “time” being the factor and each of the family functioning scores being the dependent variable. The means and standard deviations for family resilience, family conflict, family cohesion, and family attachment scores are presented in Table 5.36. The results for the ANOVAs indicated no significant change in any of the family core measures from pre-test to post-test with little or no variance (see Table 5.37).

Table 5.36: Means and Standard Deviations for Family Functioning Scores

Family Functioning	Pre-test Mean (Std. Deviation)	Post-test Mean (Std. Deviation)	N
<i>Family Resilience</i>	24.9 (7.2)	23.6 (6.0)	48
<i>Family Conflict</i>	22.8 (8.3)	22.8 (7.9)	48
<i>Family Relations & Cohesion</i>	7.5 (2.0)	6.9 (1.7)	48
<i>Family Attachment</i>	5.3 (.60)	5.2 (.57)	28

Table 5.37: Repeated Measures ANOVA

Source	F	Sig.	Eta Squared
Family Resilience	3.207	.080	.064
Family Conflict	.001	.980	.000
Family Cohesion	2.274	.138	.046
Family Attachment	.325	.573	.021

a Computed using alpha = .05

In summary, the Dare to Be You program failed to produce any significant changes from pretest to posttest on any of the family core measures (family resilience, family conflict, family cohesion, and family attachment) as well as demonstrated little to no variance. Interestingly, the mean for the pretest scores for this program were lower than that of the other programs.



This next section of the results addresses the second research question: Are the family strengthening programs effective in preventing and/or reducing substance abuse? Below, the results specifically related to the GPRA items for 30 day substance use are presented separately.

Even though the analysis plan had proposed examining the effectiveness in reducing substance use through the use of logistic regression, all of the programs exhibited low prevalence in the reporting of thirty day substance use. This low prevalence was determined through the initial examination of the distribution of 30 day reported use. Once the low prevalence was established for each of the model programs, the decision was made to still run the logistic regression model for the Strengthening Multi-Ethnic Families and Communities which yielded no significant results. The distribution of the 30 day substance use items are presented below which demonstrates the low prevalence phenomenon. For the purpose of not being repetitive for all nine model programs, the distribution for the substance use items are presented for only one model program.

RESULTS SPECIFIC TO STRENGTHENING MULTI-ETHNIC FAMILIES & COMMUNITIES

Figure 5a. Reported 30 Day Alcohol Use

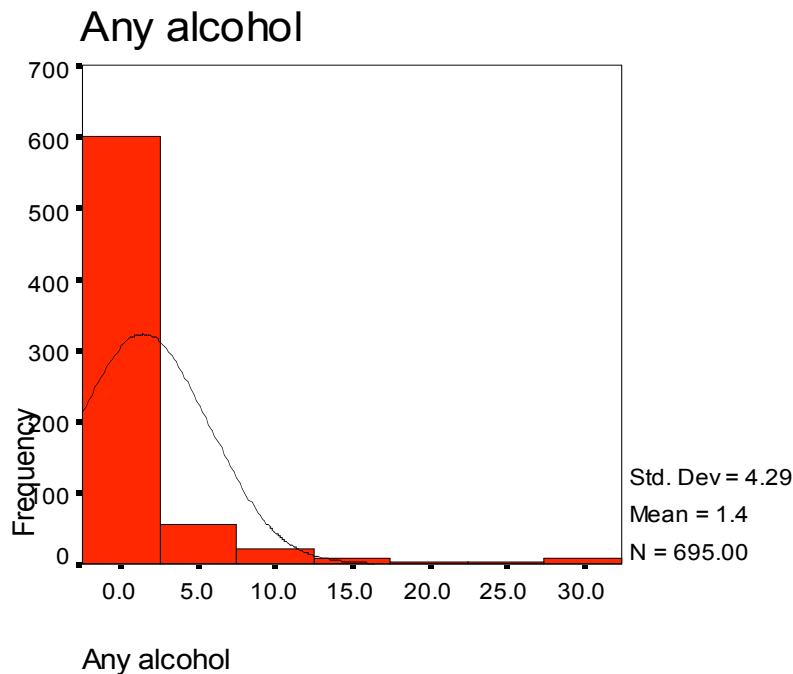




Figure 5b. Reported 30 Day Use of Binge Drinking

Alcohol to intoxication (5+ drinks in one setting)

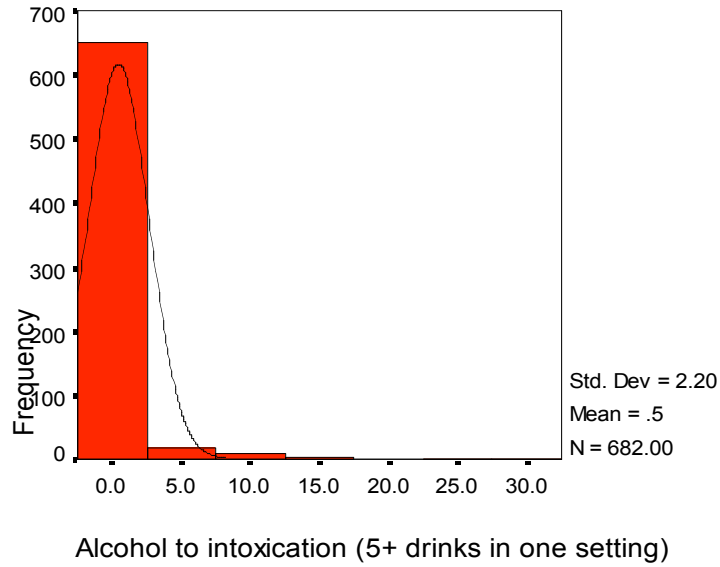


Figure 5c. Reported 30 Day Use of Illegal Drugs

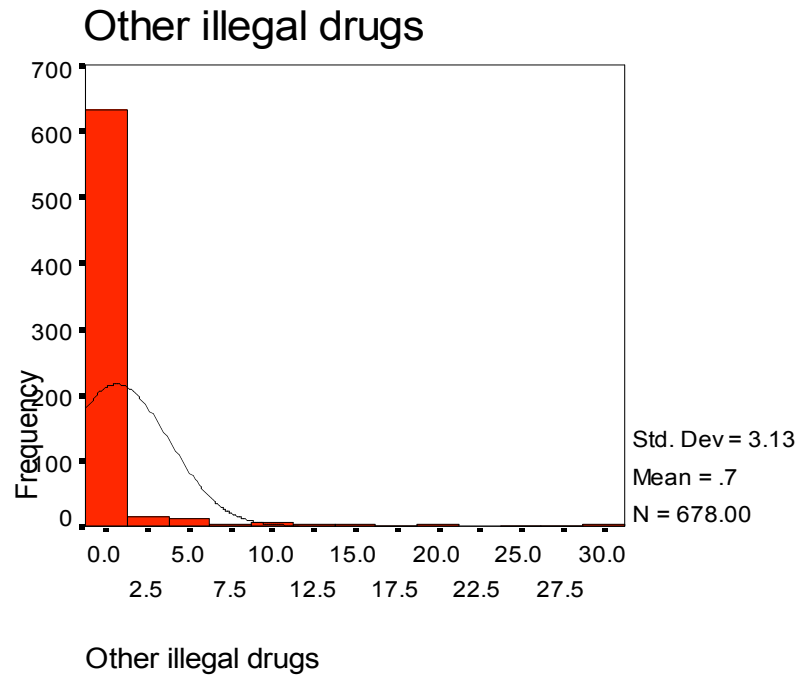


Figure 5d Reported 30 Day Use of Cocaine/Crack

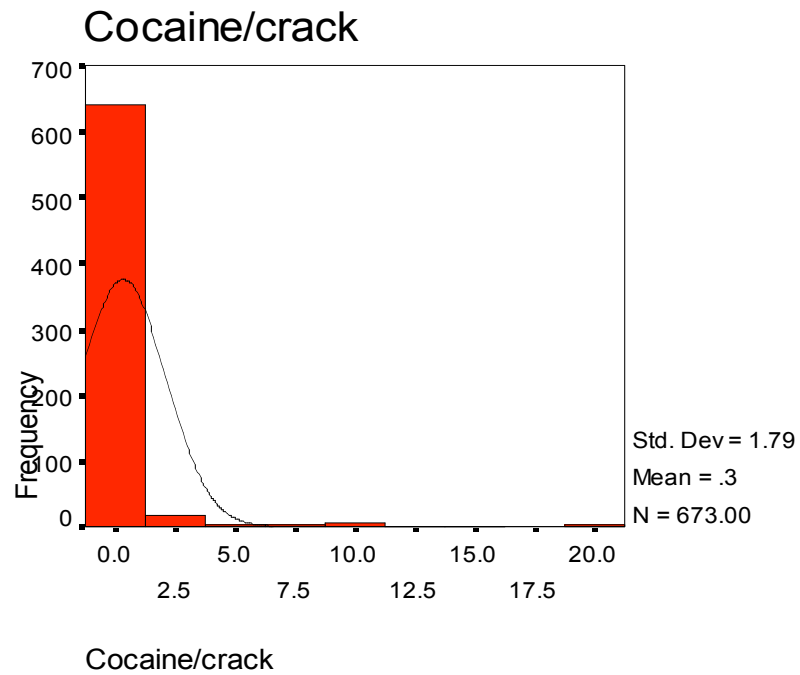




Figure 5e. Reported 30 Day Use of Marijuana

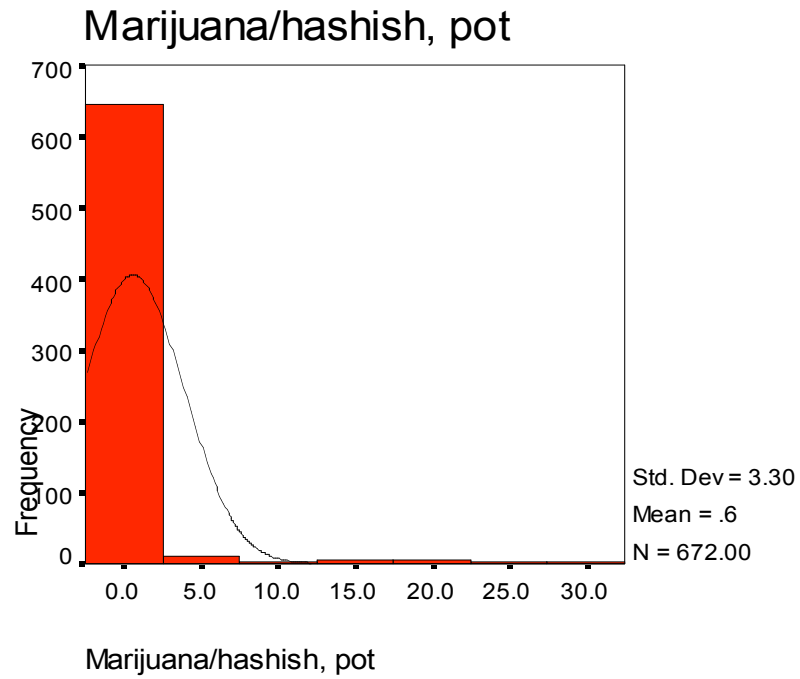


Figure 5f. Reported 30 Day Use of Heroin

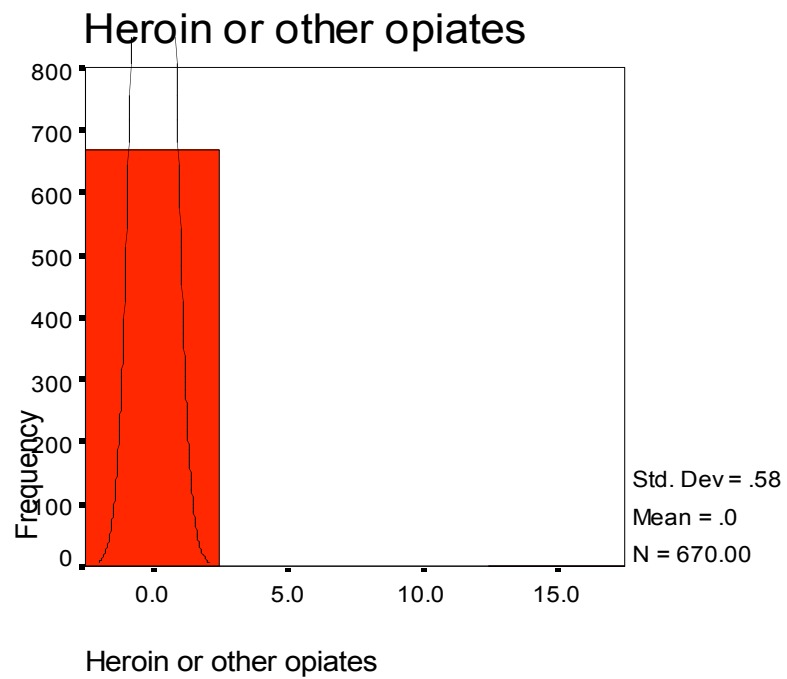




Figure 5g. Reported 30 Day Use of Nonprescription Methadone

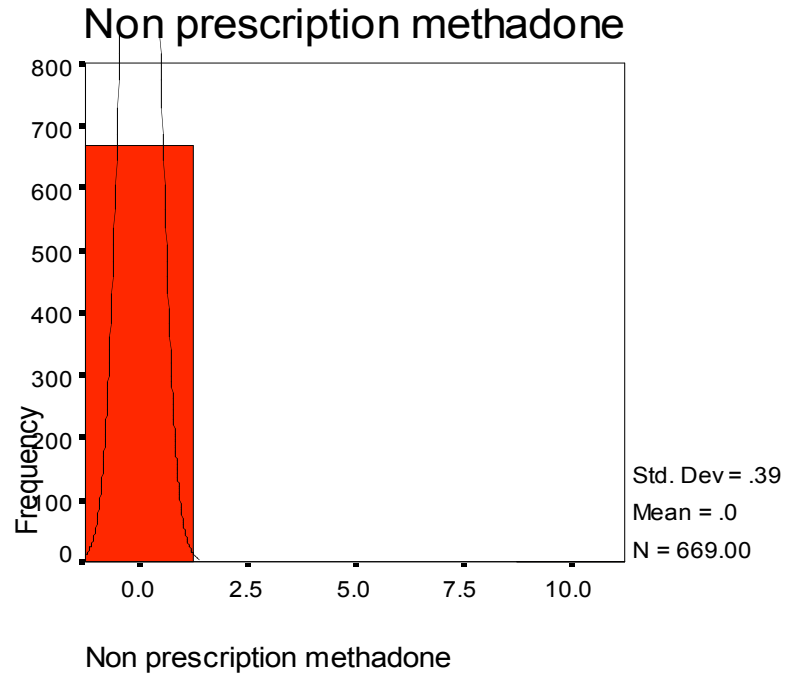


Figure 5h. Reported 30 Day Use of PCP, Other Hallucinogens, LSD

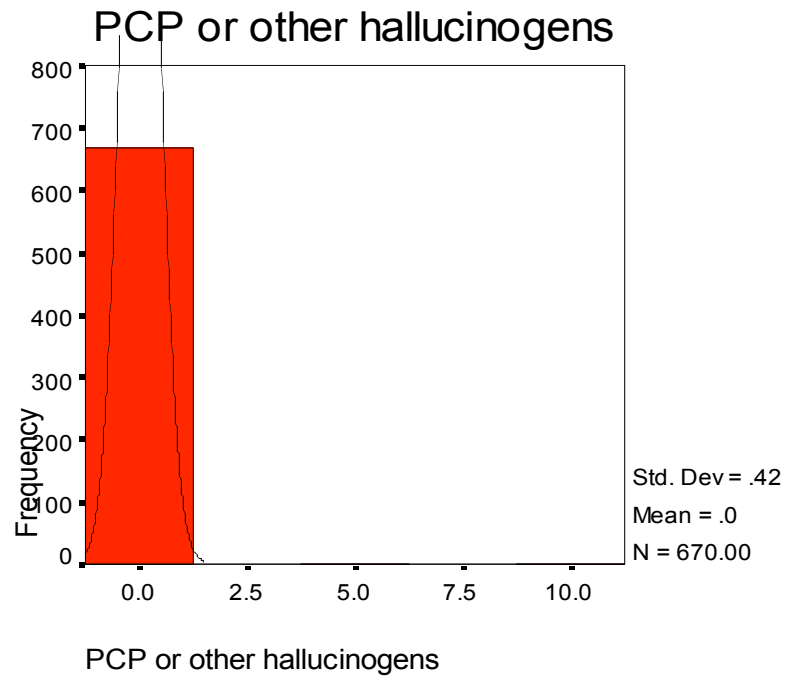




Figure 5i. Reported 30 Day Use of Methamphetamines, Other Amphetamines, Uppers

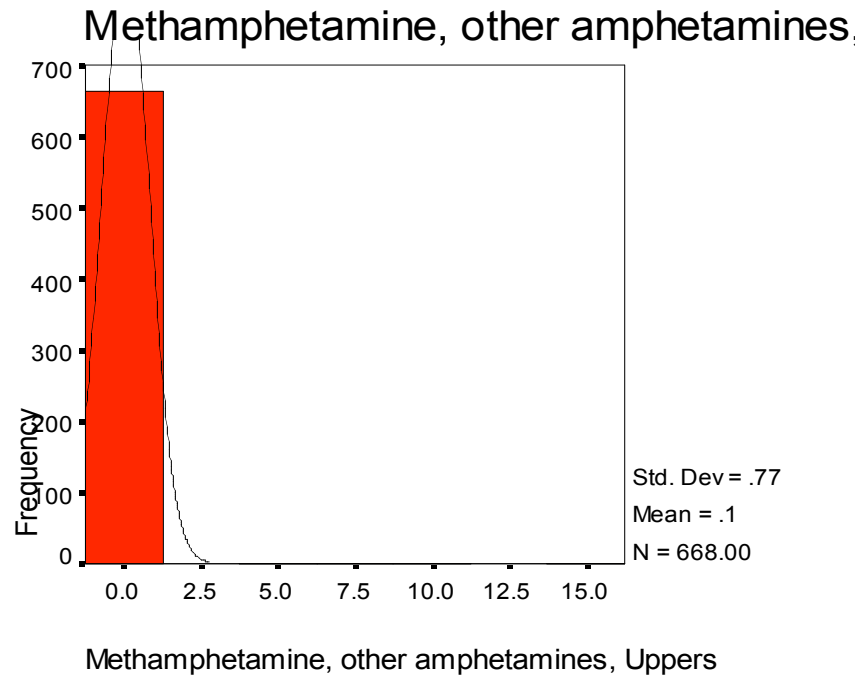


Figure 5j. Reported 30 Day Use of Benzodiazepines, Barbiturates, Tranquilizers

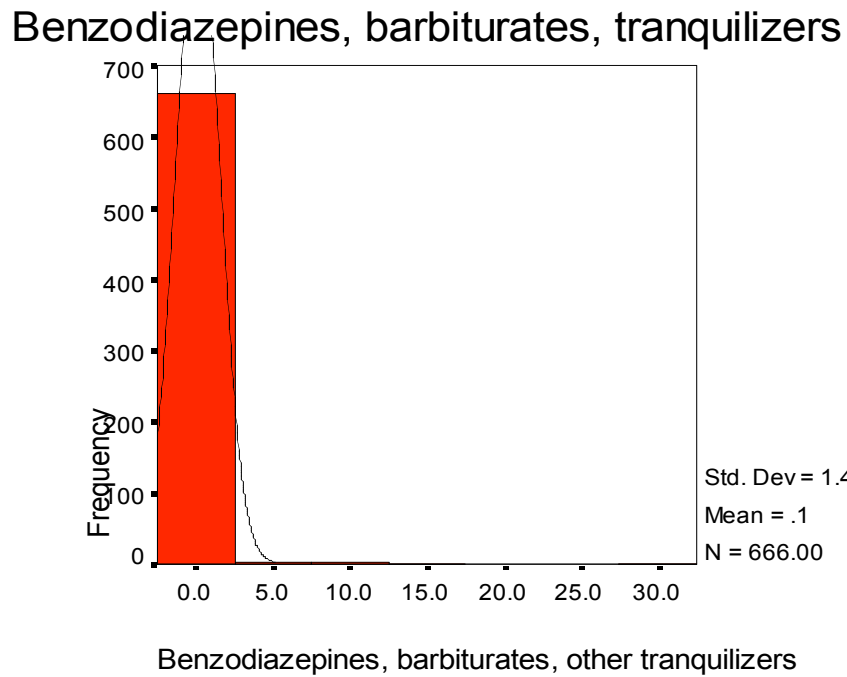
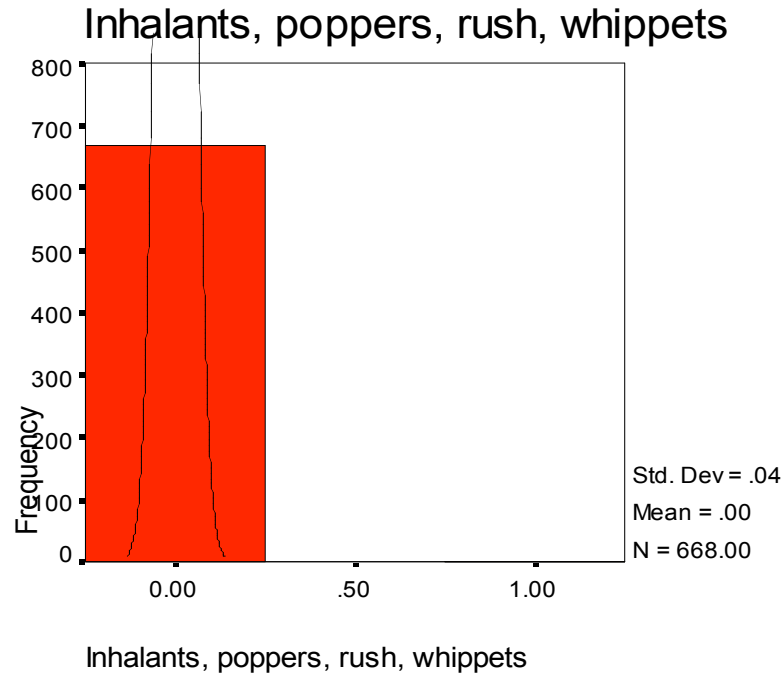




Figure 5k. Reported 30 Use of Inhalants, Poppers, Rush, Whippets



Univariate Analysis of Covariance

This next section of the results addresses the final research question: What are the key sociodemographic characteristics that are most impacted by the model programs? Below, the results for each of the demographic characteristics are presented separately. The Strengthening Multi-Ethnic Families and Communities data set was used for this set of analyses because of the large sample size which lend to the probability of larger between group variance.⁴

The ANCOVA model was utilized to examine the differences in outcome between certain demographic factors. The ANCOVA *F* test evaluated whether the means on the dependent variable, adjusted for differences on the covariate (i.e., the pretest scores), differ across levels of a factor. If a significant demographic factor has more than two levels, follow up tests were conducted to determine where there were differences on the adjusted means groups.

A one-way analysis of covariance was conducted for each of the demographic variable of interest (i.e., gender, race, education, employment status, and age). For the first run, the independent variable gender, included two levels: male and female. The dependent variable was the posttest score on family resilience and the covariate was the pretest scores on family resilience. The ANCOVA was significant, $F(1, 586) = 9.812$, $MSE = 65.457$, $p = .002$.

Table 5.38. Descriptive Statistics for Gender

⁴ NOTE: The ANCOVA was conducted with the family resilience measure controlling for pretest scores. Due to time and funding limitations, other analyses were not conducted.



Dependent Variable: Sum of Post test Resilience Items

Gender	Mean	Std. Deviation	N
Male	25.91	9.447	120
Female	23.48	8.934	469
Total	23.98	9.086	589

Because the independent variable had only two levels, there was no need to conduct any post hoc comparisons. Through examination of the adjusted means (see Table 5.38), the females in the program significantly improved over the males.

Again, the ANCOVA was conducted with race as the independent variable with seven levels. The ANCOVA was significant, $F(1, 557) = 6.99$, $MSE = 63.747$, $p = .000$. Since the results were significant, follow up tests were conducted to evaluate pairwise differences among the adjusted means. The Bonferroni procedure was used to control for family wise errors across the multiple comparisons. There were significant adjusted means between the Native Hawaiian or other Pacific Islander group and all of the other racial groups. Based on the results, it is indicated that of all the racial groups, the Native Hawaiian or other Pacific Islander group of participants did not significantly improve in family resilience in comparison to all other racial groups (see Table 5.39).

Table 5.39. Adjusted Means for Race Categories

Dependent Variable: Sum of Post test Resilience Items

What is your race?	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Black/African American	24.605(a)	.905	22.828	26.382
Asian American	23.242(a)	.697	21.873	24.611
American Indian/Native American	23.749(a)	1.205	21.382	26.117
Native Hawaiian or other Pacific Islander	33.859(a)	1.889	30.149	37.569
White/Caucasian	25.277(a)	1.298	22.726	27.827
Other	28.064(a)	1.721	24.684	31.444
Hispanic	22.689(a)	.531	21.646	23.733

a Covariates appearing in the model are evaluated at the following values: Sum of Resilience Items on Pre-test = 27.70.

A third ANCOVA included education with five levels as the independent variable. The ANCOVA was not significant, $F(1, 569) = 2.017$, $MSE = 66.816$, $p = .091$ suggesting that there was no difference between the categories of education (see Table 5.40).

Table 5.40. Adjusted Means for Education Categories



Dependent Variable: Sum of Post test Resilience Items

Recoded education variable into a categorical variable	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
0-8th Grade	25.388(a)	.807	23.803	26.973
9-11th Grade	24.066(a)	.783	22.528	25.604
High School Graduate	24.331(a)	.623	23.107	25.555
Some College	22.549(a)	.850	20.878	24.219
College Graduate and Above	22.775(a)	.862	21.082	24.468

a Covariates appearing in the model are evaluated at the following values: Sum of Resilience Items on Pre-test = 27.71.

Similarly, the ANCOVA was conducted with employment status as the independent variable while still controlling for the pretest scores on resilience. As with education, the adjusted means for employment status (see Table 5.41) was nonsignificant, $F(1, 559) = 1.486$, $MSE = 62.124$, $p = .181$.

Table 5.41. Adjusted Means for Employment Status

Dependent Variable: Sum of Post test Resilience Items

Are you currently employed?	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Employed full time (35+ hours per week)	23.687(a)	.648	22.414	24.960
Employed part-time	25.080(a)	1.036	23.044	27.115
Unemployed- Looking for work	24.009(a)	.588	22.855	25.164
Unemployed- Disabled	24.248(a)	1.252	21.788	26.707
Unemployed- Volunteer work	19.918(a)	1.490	16.991	22.844
Unemployed- Retired	24.830(a)	1.815	21.266	28.394
Other	23.943(a)	.817	22.338	25.548

a Covariates appearing in the model are evaluated at the following values: Sum of Resilience Items on Pre-test = 27.83.

The final ANCOVA included the age at baseline recoded into five categories as the independent variable. The ANCOVA was significant, $F(1, 577) = 2.493$, $MSE = 66.355$, $p = .042$.

Table 5.42. Adjusted Means for Age at Baseline



Dependent Variable: Sum of Post test Resilience Items

Recoded Baseline Age	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
Ages 14-25	21.480(a)	1.132	19.258	23.703
Ages 25-35	23.597(a)	.586	22.445	24.749
Ages 35-45	24.121(a)	.569	23.004	25.239
Ages 45-55	25.628(a)	.803	24.051	27.205
Ages 55 and older	24.970(a)	1.491	22.042	27.899

a Covariates appearing in the model are evaluated at the following values: Sum of Resilience Items on Pre-test = 27.74.

Post hoc comparisons with adjusted means (see Table 5.42) indicate that participants in the age group 14-25 years did better and participants in the age group 45-55 did worse. The remaining age groups did not demonstrate significant differences.

Discussion

As indicated in the introduction, one of the primary goals of the Initiative was to determine the impact of the interventions on the target families in the study. The study made significant contributions to the body of literature on family focused interventions. It demonstrated that the Initiative is effective in improving the family functioning as measured by family resilience, family cohesion, family conflict, and family attachment. The Initiative provided additional

empirical evidence in supporting ecological systems theoretical framework that was adopted in this intervention project. The use of an ecological systems theoretical framework integrated with the risk and protective factor concept provides a unique perspective for examining family focused interventions. As Bronfenbrenner (1979) pointed out, effective interventions with children must involve the parents who define the environment in which children live and grow. The model assumes that support and education services provided to parents enhance their ability to nurture the healthy development of their children which will extend beyond direct program contact. Through this modality of intervention, risk factors are reduced and protective factors are enhanced for the individuals and the family unit. Additional contributions of the study are examination of the psychometric properties of the family core measures, which before now has not been conducted, determination the effectiveness of the program with the use of multiple sites, and assessment of which sociodemographic characteristics are impacted by the evidence based model programs. The following sections highlight the contributions as well as the limitations of the Family Strengthening Initiative.

Psychometric Properties

In general, the results of the reliability analysis support that the family resilience and family cohesion scales were suitably constructed and were adequate for the purpose of the study with sufficient coefficient alpha. Further, we see that both the family conflict and the family attachment scales exhibited low reliability when all the respective items were included in the reliability analysis. After factor analysis, three factors were extracted from family conflict and two factors from family attachment. When each of the two scales and the items which loaded on



each of the factors were examined individually through reliability analysis this resulted in a larger coefficient alpha that indicates a closer estimate of the true reliability for the multidimensional scales. We believe that it is important when future studies examine the psychometric properties of the family conflict and the family attachment scales.

For both the family conflict and the family attachment scales, staff recommends that further consideration be given to increasing the number of items within each dimension. For example, factor analysis for family attachment resulted in two dimensions in what appears to be attachment to the child as indicated by the first three items loading on the first factor and attachment to the spouse/partner for the last two items. However, there were only three items identified for one factor and two items for the other factor. Based on the psychometric theory, increasing the number of items with regards to the two dimensions will likely increase the reliability.

Family Functioning

There is empirical evidence that demonstrates both parents and children do benefit from family focused interventions. The principal reason is that the interventions changes parenting practices in that parents are provided the guidance that allows them to set clear limits, criticize less, and use praise more often. Likewise, parents also experience several benefits which include reduced stress, improved communication and improved conflict resolution (Taylor and Biglan, 1998).

Some of the benefits as evidenced by the results of this study are improved family functioning in the measured domains of family resilience, family cohesion, family conflict and family attachment. For example, we saw three of the nine model programs had significant improvement from pretest to posttest on all four of the family functioning domains. The Strengthening Multi-Ethnic Families and Communities program, Parenting Wisely, and Strengthening Families Program exhibited statistically significant ANOVA results. There were five other programs that had significant improvement on two of the four domains and one program that had no significant results on any of the domains of family functioning. Specifically, the Nurturing Parenting Program, Strengthening Families Program for Parents and Youth 10-14, and The Incredible Years all improved from pretest to posttest on family resilience and family conflict. The Brief Strategic Family Therapy and the Effective Black Parenting had significant improvements on family resilience and family attachment. Only Dare to Be You had no significant results on any of the family functioning domains.

Examination of the explained variance had diverse results. Program staff classified single digit eta squared results as marginal (e.g., .00 - .09), double digits from .10 - .19 as moderate, and .20 and higher as substantial. Only one program demonstrated a magnitude of improvement that was either moderate or substantial for all for domains. This program, Brief Strategic Family Therapy had substantial improvement in family attachment (.23) and moderate improvement on family resilience, family conflict, and family cohesion. The Incredible Years had either moderate or substantial improvement in three domains which were family conflict (substantial at .20) and family resilience and family attachment. Parenting Wisely had substantial (.22) improvement in family resilience and moderate improvement on family conflict and family cohesion. Five other programs had either moderate or substantial improvements on two domains of family



functioning. Nurturing Parenting Program had moderate improvements on family resilience and family conflict, Strengthening Families Program for Parents and Youth 10-14 had a substantial (.31) improvement in family conflict and a moderate improvement in family resilience. The Effective Black Parenting program had the largest improvement at .64 for family resilience and also had a substantial (.27) improvement in family attachment. In light of the health disparity and the differential problem behaviors among ethnic groups, these findings deserve special attention in future investigation. The Strengthening Families Program had substantial (.28) improvement in family resilience and moderate improvement in family attachment, and the Strengthening Multi-Ethnic Families and Communities program had moderate improvements in family resilience and family conflict. Dare to Be You had marginal or no improvements in the four domains.

Overall, except for one model program, the other eight did have either moderate or substantial improvements in family resilience with Effective Black Parenting exhibiting the largest magnitude of improvement. Six of the model programs showed substantial or moderate improvement in family conflict with the explained variance ranging from .31 (SFP 10-14) to .11 (SMEFC). Family cohesion had moderate improvement for two model programs. Finally, three model programs demonstrated substantial or moderate improvements in family attachment again with Effective Black Parenting having the largest improvement (.27).

Encouragingly, we not only observed the significant magnitude of the improvements of these programs but also the consistent trend of these programs. This is evidenced by eight (89%) of nine model programs improving family resilience which is a concept that extends our understanding of healthy family functioning. To date, the literature has focused on individual resilience, but this study takes on a family resilience perspective that recognizes parental strengths. This approach fundamentally changes the deficit-based notion that troubled families are damaged beyond repair, but have the potential to heal and grow. The improvement in these family processes is not surprising based on the ecological systems theoretical framework. Family functioning can be viewed from an ecological perspective in that its relationship has a broader sociocultural context. Specifically, problems are seen as resulting from an interaction of individual and family factors in their appropriate social contexts such as poverty or racism.

According to the ecological model, the four systems that may influence parenting behaviors are the individual, the family, the community, and the culture, which are systems that constantly interact with and influence one another. Moreover, risk and protective factors in one level may impact the other three levels. One can speculate that family functioning influences the nature and quality of parenting children and adolescents especially those at risk for problem behaviours and delinquency.

Substance Use

Interestingly, the participants in the family focused interventions demonstrated low prevalence for substance use. For each of the categories for both legal and illicit substances, there was either very little or no substance use. There may be some points for consideration related to very low or no use. First, there is the need to carefully consider the role of parent motivational factors



in enrolling in a program. Parents who are heavy users may not be inclined or motivated to enroll in a parenting program as this may not be a high priority. Prior research (Spoth & Redmond, 1995) has suggested that parents can be segmented on the basis of parenting program motivational factors and that one segment of parents appears to be disinclined to program involvement.

Second, one can speculate that the targeted families for the interventions are more “universal” in that these families represent the general population instead of high risk families. This is one potential explanation for the low prevalence of substance use.

A final consideration is to revise the GPRA items to be more reflective of the types of populations that are targeted for prevention programs. The current version of the GPRA items seems to be more appropriate for a treatment population in terms of assessing 30 day use of both legal and illegal substances. However, the items related to attitudes and beliefs and age of first use are appropriate and could be enhanced with items related to intent to use both legal and illegal substances.

Sociodemographic Characteristics

Based on the ANOVA results, family resilience was the only domain of family functioning to demonstrate significant improvement across eight of the nine model programs. (One program

had no significant improvement on any of the domains.) These results culminated in the decision to explore which sociodemographic characteristics were impacted in the domain of family resilience. More specifically, the family resilience posttest scores served as the dependent variable and the sociodemographic characteristics such as gender, age, employment status, and educational attainment served as the independent variables while controlling for the pretest scores on family resilience.

The ANCOVA results were significant for three of the five sociodemographic characteristics. Specifically, gender, race and age all demonstrated significant results whereas education and employment status was not significant. Moreover, we see that females did significantly better than males in the domain of family resilience and Native Hawaiian or other Pacific Islander did not significantly improve as did the other race categories. Finally, with respect to age, of the five categories the age group 12-25 had significant improvement and the age group 45-55 improved the least. These findings have implications for clinicians, program planners, and policy makers as they make decisions for targeting groups that may best be served while working under fiscal constraints.

Limitations to the Study

Use of a One-group Pretest-Posttest Design

Although this particular study design can examine an index change from the pretest to the posttest, there are several limitations with it. First, the study had no control group. Consequently, we could not attribute all improvements to the intervention alone. This design has failed to take into account several alternative explanations such as history, maturation, testing,



and statistical regression which are threats to internal validity. For example, an event (say, a local media campaign for promoting family relations) could occur between the pretest and the posttest and was not part of the intervention but contributed to the changes of variables in this study. Any such event could confound the intervention effect. It then becomes difficult to separate the effects of the event from the effects of the intervention. Second, both the parents/caregivers and the youth change over time and any changes that occur systematically over time may result in a change from pretest to posttest. This change could erroneously be attributed to the intervention and not to the effects of maturation. Next, the actual administration of the pretest may cause changes in behaviour by increasing awareness of substance use, parenting behaviours, or methods of communication. Thus, a change found at the posttest could be the result of taking the pretest rather than the intervention. Finally, with regression to the mean, if there is measurement error in the score of a participant who scores at the extreme, that score is likely to become less extreme when the measure is re-administered. Therefore, the overall change from pretest to posttest of the program participants could be due to statistical regression, not the intervention.

All of the above mentioned problems could have been eliminated by the use of an appropriate randomly assigned control or comparison group. Random assignment ensures that the participants in the intervention group and the control/comparison group must be equivalent because if the participants in the two groups differ before the intervention they will probably

differ after the intervention as well. Thus, if the intervention group is statistically significantly different from the control/comparison group on the dependent measures administered after the intervention, the difference between the two groups can be attributed to the effect of the intervention.

Use of Mean Substitution for Missing Data

After deliberation and examination of the data, PCC staff selected mean substitution as the remedy for dealing with missing data. This approach, although it is used extensively, also has some disadvantages. First, the actual distribution of values is distorted by substituting the mean for missing values. Additionally, it makes the variance estimates derived from the standard variance formulas invalid by understating the true variance in the data. Despite these disadvantages to the approach we employed, it still remains the best possible remedy based on the data. Though there is no way to validate it, it is hoped that these missing values were random and thus, did not post serious bias to the findings. Future investigation may consider adopting a data collection method that can avoid missing values.

Policy Considerations

We need more policies that require the use of empirically supported programs for families with at risk or high risk children and adolescents. As the issue of program dissemination and replication comes to the forefront, social scientists and family researchers are increasingly recognizing that influencing the spread of a cultural practice such as that of providing evidenced based interventions and treatment, requires that we must examine the larger social context for the families that we serve. In particular, in an effort to foster effective interventions and treatments, our policies regarding provision of service must support the use of these evidence based model



programs. The results of this initiative illustrate that these model programs do significantly improve family functioning in both areas of risk and protective factors. When integrated into an ecological systems theoretical framework, we can posit that significant improvement that affect the parents will also affect the children and communities as each of these ecological systems are interdependent.

Further, policies that place restrictions on how monies can and cannot be spent present obstacles for many interventions. For example, to engage parents in family focused interventions, it is often necessary to provide child care, incentives, and transportation or if services are being offered in the home, it is necessary to pay for staff time and transportation needs. Anecdotal data support the need for funding for programs to accommodate these ancillary services to decrease program attrition.

The findings from this study also support the use of family focused prevention programs. The most costly policies are ones that fund reactive services more readily than preventive ones. For example, if a parent seeks assistance in parenting a child with behavioural problems, they may not receive those services. But if the same parent used corporal punishment in frustration, more reactive services come into play such as removing the child from the home or punishing the parent. Such strategies frequently fail to reduce the original problem and may even worsen it.

Future considerations

Although this study has made some significant contributions to the body of literature, there are a few factors that may be considered in future studies. First, our data appear to be consistent with our ecological model. The use of the ecological theory may need further empirical support with the use of a control/comparison group. Second, the largest improvement for family resilience was observed in this study and needs to be replicated using culturally relevant programs. In addition, the interaction of individual and family factors in their appropriate social contexts such as poverty or racism needs to be considered. Third, several interesting and distinctive subscales from family attachment and family conflict that were observed in the study may need to be replicated with an adequate number of items. The reliability of these scales could be further established. Fourth, future investigations could explore data collection methodology that can validate data and avoid missing values. This could eliminate the use of mean imputation dealing with missing values. The benefits of using web based technology with online validation, feedback, and controls could improve the data quality.



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