

## Implementation of the Strengthening Families Program (SFP) 10-14 in Barnsley: The Perspectives of Facilitators and Families

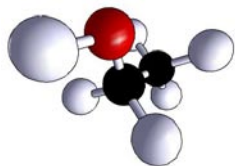
### Introduction

Numerous studies in Europe report high rates of alcohol use among young people. A recent European study on alcohol and drugs use by young people reported that the UK had among the highest rates of drunkenness and binge drinking and alcohol consumption in Europe. Research participants reported that 75% had had one episode of drunkenness, while nearly one third had 20 or more episodes in their lives or 10 or more episodes in the last year. Half had been intoxicated in the last month and a quarter intoxicated at least three times in the same period. The trends of the last decade are: more young people are drinking regularly (at least once a week); weekly drinkers are drinking more; regular young drinkers are drinking more alcohol per session; there are changes in the types of alcohol consumed (alcopops/designer drinks).

The alcohol and drug problems of individuals also affect their children and families. These effects have been well documented and the phenomenon is a universal one. It has been estimated that there may be about 8 million family members (spouses, children, parents, siblings) living with the negative consequences of someone else's drug or alcohol misuse.

The Strengthening Families Programme 10-14 (SFP10-14) was originally developed by Kumpfer and associates at the University of Utah, as a 14-session family skills training programme designed to increase resilience and reduce risk factors for alcohol and substance misuse, depression, violence and aggression, delinquency and school failure in high risk children and their substance misusing parents. The SFP10-14 resulted from a major revision of the original Strengthening Families Programme. The modified SFP10-14 has been evaluated for primary prevention effectiveness with young people and their parents living in disadvantaged areas in Iowa, U.S.A.

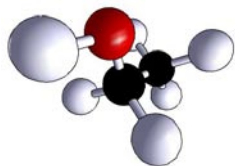
A recent Cochrane Collaboration Systematic Review, commissioned by the World Health Organisation and the UK AERC, reported that the SFP10-14 was an effective and promising prevention intervention. The number needed to treat (NNT) was 9 for preventing drinking and drunkenness initiation four years later. Importantly, the effectiveness of the SFP10-14 seemed to increase over time, rather than decay, as with other prevention programmes.



The reported effectiveness of the SFP10-14 as a primary prevention programme has led to its uptake in a number of therapeutic settings in the UK. For example, positive perceptions of the SFP 10-14 by both families and group leaders of an SFP 10-14 programme being run in a Child and Adolescent Mental Health Service in Barnsley have been reported. Similar findings in relation to the SFP10-14 run by the Kinara Family Resource Centre in Greenwich have also been noted. An exploratory trial of adapted SFP10-14 materials and approach in the UK context is currently being conducted in the School of Health and Social Care, Oxford Brookes University. Whilst initial anecdotal reports of implementation of the SFP in the UK are valuable a more systematic approach to evaluation of the SFP is needed.

A mixed methods design blending both quantitative and qualitative data was used in the study. The study was carried out in two phases over a 9-month period in 2005. Approximately 70 families have completed the SFP10-14 in the Barnsley area. A purposive sample of 10 families who met the inclusion/exclusion criteria for the study was selected. Two tape-recorded, focus group interviews lasting approximately 60 minutes were undertaken with the parents/caregivers and young people. Interviews focussed on the parent's/caregiver's and young people's experience of the SFP10-14 materials and approach. In addition, a purposive sample of 15 facilitators (approximately 30 facilitators had been involved in SFP10-14 programmes in the Barnsley area) was selected to reflect variation in facilitator backgrounds (i.e. number of agencies involved with, number of groups facilitated, occupational background). Three tape-recorded, focus group interviews lasting approximately 60 minutes were undertaken with the facilitators. Interviews focussed on their experiences of the SFP10-14 materials and approach. Audiotapes of all interviews were transcribed and a content analysis of transcriptions undertaken. Participants' responses were coded and categorised according to the theme(s) evident in what they said.

Quantitative data relating to the demographic characteristics of the participants in the study was collected i.e. parents'/caregivers'/young peoples': gender, age, presenting problems; facilitators': gender, age, occupational background, SFP10-14s completed). In addition, data was collected through: the SFP10-14 Parent/Caregiver Survey questionnaire (PCSQ); The SFP10-14 Young Persons' Survey questionnaire (YPSQ); The Strengths and Difficulties Questionnaire (SDQ). Descriptive

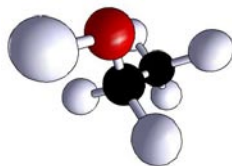


statistics for all questionnaire data were calculated. Total scores and subscale scores were calculated for all questionnaire data. Scores at the beginning of the programmes (weeks 1-2) and scores at the end of the programmes (week 7) were compared using the Wilcoxon signed ranks test ( $\alpha=0.05$ ). Once quantitative and qualitative data had been analysed separately, a synthesis of the main findings from both approaches was then performed.

### Findings

50 families (58 family members) attended SFP10-14 programmes in the Barnsley area between April 2002 and December 2004. 42 (84%) parents/caregivers attended without partners and 8 (16%) with partners. 47 (81%) female parents/caregivers and 11 (19%) male parents/caregivers attended programmes. 52 young people attended programmes (50 young people without siblings and 2 pairs of young people with siblings). There were 26 (50%) male young people and 26 (50%) female young people in the sample of families. The median age of the young people was 12 years with semi-interquartile range of 1.5 years. 23 facilitators reported having undergone SFP10-14 training in the Barnsley area. 17 of these facilitators have run SFP10-14 programmes. The largest number of SFP10-14 programmes facilitated by an individual was 10, with the majority of facilitators - 14 (58%) having completed between 1 and 3 programmes. Facilitators were employed by the following organisations/agencies: Health/Social services, LEA/Schools, Voluntary sector.

- There is evidence that families who participated in the study found the SFP10-14 useful in preventing young people's alcohol and drug use in terms of: learning more about alcohol and drugs, using knowledge and skills to reduce behaviours that might lead to alcohol and drug use and dealing with peer pressure
- The SFP10-14 was reported to have had a positive influence on the emotional health and well being of the participating families in terms of developing: better anger management skills, a more constructive approach to problem solving, more explicit demonstration of love and care, greater feelings of safety/security, increased respect for self and other people, improved self-esteem, greater empathy, better stress management and decreased feelings of being a failure
- There are indications that the SFP 10-14 contributed to changes in the behav-

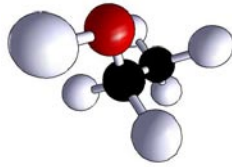


...our of the young people during the programme in terms of: knowing and learning the rules of behaviour, setting the boundaries of behaviour, using effective questioning techniques to monitor the young person's whereabouts, using a points chart to manage behaviour, dealing with peer pressure and learning how to keep out of trouble

- Parents/caregivers and young people reported that the SFP10-14 had played a part in improving family functioning through: strengthening the family unit, improving parent/caregiver communication, using a more consistent approach, increasing the repertoire for dealing with situations, developing better positive and negative feedback, working more together as a team, identifying family strengths, strengthening family bonds, receiving group support, working more closely with mum and dad, learning to listen more, learning to get along with each other better, helping parents/caregivers more, better understanding of what parents/caregivers/young people are saying, changing the code of behaviour and developing more interaction in family
- A number of messages emerged from the qualitative evaluations of the programmes: from the family's perspective it was important not to be seen as a "problem family" or as a "failure", the timing and place of programmes was crucial regarding family attendance, the programme had to be adequately funded (to provide sufficient facilitators, childcare support and incentives for participants), recruitment is enhanced through the use of pre-course literature and family briefing meetings, problems with literacy are a reality for many families, group dynamics are an important part of the programme and need to be addressed by facilitators

#### Implications

The findings from this study suggest that the SFP10-14 may be a useful primary prevention intervention in helping to prevent alcohol and drug use in the UK. This finding is interesting as the US programme and materials were predominantly used in the programmes focused on by the research. However, whilst facilitators and families in Barnsley reported that the US context to the programme was not an absolute barrier to using it, it was a relative distraction. They thought that there was clearly a need to produce a UK version of the programme. This study has reported



on the use of the SFP10-14 as a targeted intervention with high-risk families known to a young people's services service. Further studies of the use of the programme with high-risk families is needed, especially those from different minority ethnic backgrounds. Studies of the use of the SFP10-14 as a universal intervention are also required. Further studies of the efficacy of the SFP10-14 in the UK are needed using a culturally adapted version of the programme. Quantitative studies should be based on a randomised controlled trial design, with sample sizes based on power calculations, using valid and reliable instruments (especially in relation to substance misuse). Qualitative data should be collected to explore participants' perceptions of the adapted materials. Cost effectiveness of the SFP 10-14 in the UK should also be determined

Further information

This research was carried out by: Lindsey Coombes, Debby Allen and David Foxcroft at the School of Health and Social Care, Oxford Brookes University and Megan Marsh, Altogether Now Parenting Team, Barnsley.

Enquiries to:

Debby Allen:  
dallen@brookes.ac.uk

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