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Strengthening Families Programme 10-14

Review: February 2018

Note on provider involvement: This provider has agreed to EIF's terms of reference, and the assessment has been conducted and published with the full cooperation of the programme provider.

Strengthening Families Programme 10–14 is a parenting and family strengthening programme for families with children aged between 10 and 14. It can be implemented as a universal programme or targeted at high-risk adolescents.

Strengthening Families Programme 10–14 is based on the biopsychosocial model and other empirically based family risk and protective factor models. As such, the programme targets the enhancements of family protective processes and aims to reduce family risk.

The programme consists of seven weekly sessions lasting two hours each. During the programme, families learn how to communicate effectively as well as specific skills such as parental limit setting and child resistance to peer pressure.

Evidence rating: **3**

Cost rating: **1**

EIF Programme Assessment

Strengthening Families Programme 10-14 has evidence of a **short-term positive impact** on child outcomes from at least one rigorous evaluation.

Evidence rating: **3**

What does the evidence rating mean?

Level 3 indicates **evidence of efficacy**. This means the programme can be described as evidence-based: it has evidence from at least one rigorously conducted RCT or QED demonstrating a statistically significant positive impact on at least one child outcome.

This programme does not receive a rating of 4 as it has not yet replicated its results in another rigorously conducted study, where at least one study indicates long-term impacts, and at least one uses measures independent of study participants.

Cost rating

A rating of 1 indicates that a programme has a low cost to set up and deliver, compared with other interventions reviewed by EIF. This is equivalent to an estimated unit cost of less than£100.

Cost rating: **1**

Child outcomes

According to the best available evidence for this programme's impact, it can achieve the following positive outcomes for children:

Supporting children's mental health and wellbeing

Reduced rate of increase in internalising symptoms

Based on study 1d

Improvement on the Anxiety-Depression index from the Child Behaviour Checklist (self-report)

Long-term Between 1 and 6 years later

Preventing risky sexual behaviour & teen pregnancy

Reduced substance use during sex

Based on study 1e

5.6-percentage point reduction in proportion of participants who have used substances during sex (measured using a self-report measure)

Improvement index: **+2**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 52% and worse outcomes than 48% of their peers, if they had received the intervention.

Long-term 10 years later

Reduced number of sexual partners in past year

Based on study 1e

7.3-percentage point reduction in proportion of participants who have had more than one sexual partner in the past year (measured using a self-report measure)

Improvement index: **+1**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 51% and worse outcomes than 49% of their peers, if they had received the intervention.

Long-term 10 years later

Reduced sexually transmitted diseases

Based on study 1e

2.5-percentage point reduction in proportion of participants who have had sexually transmitted diseases (measured using a self-report measure)

Improvement index: **+15**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 65% and worse outcomes than 35% of their peers, if they had received the intervention.

Long-term 10 years later

Enhancing school achievement & employment

Improved academic success

Based on study 1c

Improvement on a 9-point scale of grades received at school (child and parent report)

Long-term 6 years later

Preventing crime, violence and antisocial behaviour

Reduced aggression and hostility

Based on study 1b

0.48-point improvement on the Observer Index of Aggressive and Hostile Behavior (consists of subscales from the Iowa Family Interaction Rating Scales - expert observation of behaviour)

Improvement index: **+13**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 63% and worse outcomes than 37% of their peers, if they had received the intervention.

Long-term 4 years later

Reduced aggressive and destructive conduct

Based on study 1b

0.22-point improvement on the Adolescent Report of Aggressive and Hostile Behaviours in Interactions (self-report)

Improvement index: **+14**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 64% and worse outcomes than 36% of their peers, if they had received the intervention.

Long-term 4 years later

Preventing substance abuse

Reduced alcohol initiation

Based on study 1a

0.23-point improvement on the alcohol initiation index (self-report)

Improvement index: **+10**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 60% and worse outcomes than 40% of their peers, if they had received the intervention.

Long-term A year later

Based on study 1a

0.65-point improvement on the alcohol initiation index (self-report)

Improvement index: **+15**

This means we would expect the average participant in the comparison group who did not receive the intervention (ie, someone for whom 50% of their peers have better outcomes and 50% have worse outcomes), to improve to the point where they would have better outcomes than 65% and worse outcomes than 35% of their peers, if they had received the intervention.

Long-term 2 years later

Reduced monthly polysubstance use

Based on study 1d

Improvement on a polysubstance use scale of past month use of alcohol, cigarettes, and other substances

Long-term Between 1 and 6 years later

Key programme characteristics

Who is it for?

The best available evidence for this programme relates to the following age-groups:

- Preadolescents
- Adolescents

How is it delivered?

The best available evidence for this programme relates to implementation through these delivery models:

- Group

Where is it delivered?

The best available evidence for this programme relates to its implementation in these settings:

- Secondary school

The programme may also be delivered in these settings:

- Secondary school
- Community centre
- Out-patient health setting

How is it targeted?

The best available evidence for this programme relates to its implementation as:

- Universal

Where has it been implemented?

Argentina, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, South Africa, United Kingdom, United States

UK provision

This programme has been implemented in the UK.

UK evaluation

This programme's best evidence does not include evaluation conducted in the UK.

Spotlight sets

EIF includes this programme in the following Spotlight sets:

- parenting programmes with violence reduction outcomes

About the programme

What happens during delivery?

How is it delivered?

Strengthening Families Programme 10–14 is delivered by three trained facilitators (one lead practitioner and two co-practitioners) to family groups of between eight and 12 families. The programme consists of seven weekly sessions lasting two hours each.

What happens during the intervention?

- During the first hour, the parents and children attend separate sessions on a related family skill (e.g. family communication or peer-refusal skills for substance misuse).
- These sessions make use of an instructional video that provides the basis for a group discussion and practice activities.
- During the second hour, the parents and children are reunited to review and practise skills and competencies together.

What are the implementation requirements?

Who can deliver it?

- The facilitators who deliver this programme are a lead facilitator with NFQ-6 level qualifications and two co-facilitators with NFQ-5 level qualifications.

What are the training requirements?

Three days' training by certified master trainers is required. Booster training of practitioners is recommended.

How are the practitioners supervised?

- It is recommended that facilitators are supervised by one host-agency supervisor (qualified to NFQ-6 level), who is also a certified facilitator.

What are the systems for maintaining fidelity?

- A certification training where the research is presented, activities are modeled, and practice sessions are encouraged.
- A comprehensive manual with detailed lesson plans.
- Fidelity observations throughout the seven weeks of programming.

Is there a licensing requirement?

There is no licence required to run this programme.

How does it work? (Theory of Change)

How does it work?

- Young people's behavioural problems and substance misuse is linked to risk and protective factors within the family system. Key risks include poor family communication and ineffective parenting strategies. Key protective processes include improved family problem solving skills and strengthened family bonds.
- Parents and young people learn strategies for identifying and reducing the risks within their family system, while at the same time increasing the protective factors. These strategies include more effective parenting practices (including limit setting) and communication.
- In the short term, parenting practices, family communication and young people's attitudes improve.
- In the longer term, young people are less likely to be involved in substance misuse or antisocial behaviour and are more likely to do better in school.

Intended outcomes

Supporting children's mental health and wellbeing Enhancing school achievement & employment Preventing crime, violence and antisocial behaviour Preventing substance abuse Preventing risky sexual behaviour & teen pregnancy

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About the evidence

The most rigorous evidence for Strengthening Families Programme 10–14 is from an RCT which was conducted in the United States. This is a rigorously conducted (level 3) study, which has identified a statistically significant positive impact on a number of child outcomes. A programme receives the same rating as its most robust study, and so this programme receives a level 3 overall.

While this programme has robust evidence from the United States suggesting positive impact, the findings from recent European trials have been more equivocal, showing less positive results. However, these more recent trials have not been as methodologically robust as the US evidence, therefore we cannot draw strong conclusions from them. Please see reference list for details of all trials identified. The study contributing towards the rating tested the 'Iowa Strengthening Families Programme', which Strengthening Families 10–14 was formerly known as. It is based on the same seven-session model.

Study 1a

Citation: Spoth et al. (1999)

Design: RCT

Country: United States

Sample: 446 families of children in 6th grade (average age 11 years) at baseline

Timing: 1 year follow-up and 2 year follow-up

Child outcomes:

- Reduced alcohol initiation
- Reduced alcohol initiation

Other outcomes:

- None measured

Study rating: 3

Spoth, R., Redmond, C. & Lepper, H. (1999). Alcohol initiation outcomes of universal family-focused preventive interventions: One- and two-year follow-ups of a controlled study. Journal of Studies on Alcohol, 13, 103-111

Study design and sample

This study is a rigorously conducted RCT, involving random assignment of 22 schools to the Iowa Strengthening Families Program (ISFP) (11 schools), a rural population application of the Strengthening Families Program, or a minimal contact control condition (11 schools). 11 additional schools were assigned to a second intervention condition, which is not described in detail here. Stratified randomisation was used to ensure balance across the groups on school size and the proportion of lower income students.

This study was conducted in the USA, with a sample of 446 families of 6-graders. The average age of the young people in the sample was 11.3 years. Among ISFP and control group families who completed the pretest, there was an average of 3.1 children and in just over half of the families (52%), the target child was a girl. Representative of the study region, 86% of the families were dual-parent families. Nearly all study parents completed high school (98% of mothers and 95% of fathers), and more than half (54% of mothers and 49% of fathers) reported some post-high-school education. Average ages of study parents were 37.2 years for mothers and 39.4 years for fathers; nearly all (98%) were white.

Measures

- The likelihood that the young adolescent would refuse a peer alcohol offer, and general resistance to peer pressure, were measured at post-test and 1.5 years follow-up using the Young Adolescent Substance Refusal and Substance Resistance Measure (parent report and child self-report).
- Parenting behaviours directly targeted by the intervention were measured at post-test and 1.5 years follow-up using the intervention targeted parenting behaviors measure (parent-report).
- Alcohol initiation was measured at 1 and 2 year follow up using self-reported frequencies of alcohol use behaviours. The sum of these were used to create the Alcohol Initiation Index (child self-report).

Findings

This study identified statistically significant positive impact on a number of child outcomes. This includes lower Alcohol Initiation Index scores at both 1 and 2 year follow-up.

Note: Findings listed in this ‘About the evidence' section are based on measures judged to be valid and reliable. We have included a number of findings from across the follow-up time period, reflecting a range of outcome areas.

Study 1b

Citation: Spoth et al. (2000)

Design: RCT

Country: United States

Sample: 446 families of children in 6th grade at baseline

Timing: 4 year follow-up

Child outcomes:

- Reduced aggression and hostility
- Reduced aggressive and destructive conduct

Other outcomes:

- None measured

Study rating: 3

Spoth, R. L., Redmond, C., & Shin, C. (2000). Reducing adolescents' aggressive and hostile behaviors. Archives of Pediatric and Adolescent Medicine, 154, 1248-1257

Spoth et al., 2000 describe additional outcomes from study 1a above. In this case, several outcomes were measured, including:

- At 4-year follow up, aggressive and hostile behaviour was measured using the Observer Index of Aggressive and Hostile behavior, which consists of subscales from the Iowa Family Interaction Rating Scales (expert observation of behaviour).
- At 4-year follow up, adolescent aggressive and hostile behaviours in parent-adolescent interactions were measured using the parent-adolescent report of aggressive and hostile behaviours, based on the self-report portion of the Iowa Youth and Family Rating Scales on Perceptions of Hostility/Warmth (parent-report and child self-report).

This study identified statistically significant positive impact on a number of child outcomes. This includes reduced aggression and hostility and reduced aggressive and destructive conduct.

Study 1c

Citation: Spoth et al. (2008)

Design: RCT

Country: United States

Sample: 446 families of children in 6th grade at baseline

Timing: 6-year follow-up

Child outcomes:

- Improved academic success

Other outcomes:

- None measured

Study rating: 3

Spoth, R., Randall, G. K., & Shin, C. (2008). Increasing school success through partnership-based family competency training: Experimental study of long-term outcomes. School Psychology Quarterly, 23(1), 70.

Spoth et al., 2008 describe additional outcomes from study 1a above. In this case, several outcomes were measured, including:

- At 6-year follow up, academic success was measured by asking mother, father and students to report which grades the student typically gets in school (parent report and child self-report).

This study identified statistically significant positive impact on a child outcome. This was improved academic success.

Study 1d

Citation: Trudeau et al. (2007)

Design: RCT

Country: United States

Sample: 446 families of children in 6th grade at baseline

Timing: 1–6 year follow-up (change over time)

Child outcomes:

- Reduced rate of increase in internalising symptoms
- Reduced monthly polysubstance use

Other outcomes:

- None measured

Study rating: 3

Trudeau, L., Spoth, R., Randall, G. K., & Azevedo, K. (2007). Longitudinal effects of a universal family-focused intervention on growth patterns of adolescent internalizing symptoms and polysubstance use: Gender comparisons. Journal of Youth and Adolescence, 36, 725-740

Trudeau et al., 2007 describe additional outcomes from study 1a above. In this case, several outcomes were measured, including:

- At 1–6 year follow-up (change over time), internalising symptoms were measured using the Anxiety- Depression Index from the Child Behavior Checklist—Youth Self Report (child self-report).
- At 1–6 year follow-up (change over time), poly-substance use was measured through self-report questions which were summed to create a scale from ‘‘0’’ (no past month use) to ‘‘6’’ (past month use of all substance categories) (child self-report).

This study identified statistically significant positive impact on a number of child outcomes. This includes lower rate of increase across time on internalising symptoms and lower overall level and a lower rate of increase in monthly polysubstance.

Study 1e

Citation: Spoth et al. (2014)

Design: RCT

Country: United States

Sample: 446 families of children in 6th grade at baseline

Timing: 10 year follow-up

Child outcomes:

- Reduced substance use during sex
- Reduced number of sexual partners in past year
- Reduced sexually transmitted diseases

Other outcomes:

- None measured

Study rating: 3

Spoth, R., Clair, S., & Trudeau, L. (2014). Universal family-focused intervention with young adolescents: Effects on health-risking sexual behaviors and STDs among young adults. Prevention Science 15 (Supplement 1), S47-S58

Spoth et al., 2014 describe additional outcomes from study 1a above. In this case, several outcomes were measured, including:

- At 10 year follow-up, health risking sexual behaviours were measured by asking young adults self-report questions relating to:
  - Number of sexual partners in past year (young adult self-report)
  - Condom use in past year (young adult self-report)
  - Substance use and sex (young adult self-report)
  - Lifetime sexually transmitted diseases (young adult self-report)

This study identified statistically significant positive impact on a number of child outcomes. This includes reduced health-risking sexual behaviours (indirect effects) (lower rates of substance use during sex and lower past year number of partners) and lower lifetime sexually transmitted diseases.

Other studies

The following studies were identified for this programme but did not count towards the programme's overall evidence rating. A programme receives the same rating as its most robust study or studies.

Baldus C, Thomsen M, Sack PM, et al. (2016) Evaluation of a German version of the Strengthening Families Programme 10-14: a randomised controlled trial. Eur J Public Health - **This reference refers to a**

randomised control trial, conducted in Germany.
Foxcroft, D. R., Callen, H., Davies, E. L., & Okulicz-Kozaryn, K. (2016). Effectiveness of the strengthening families programme 10–14 in Poland: cluster randomized controlled trial. The European Journal of Public Health, 27(3), 494-500 - **This reference refers to a randomised control trial, conducted in Poland.**
Riesch, S. K., Brown, R. L., Anderson, L. S., Wang, K., Canty-Mitchell, J., & Johnson, D. L. (2012). Strengthening Families Program (10-14) effects on the family environment. Western journal of nursing research, 34(3), 340-376 - **This reference refers to a randomised control trial, conducted in the USA.**
Spoth, R. L., Redmond, C., Trudeau, L. & Shin, C.(2002). Longitudinal substance initiation outcomes for a universal preventive intervention combining family and school programs. Psychology of Addictive Behaviors, 2, 129-134 - **This reference refers to a randomised control trial, conducted in the USA.**
Spoth, R., Randall, G. K., Shin, C., & Redmond, C. (2005). Randomized study of combined universal family and school preventive interventions: patterns of long-term effects on initiation, regular use, and weekly drunkenness. Psychology of addictive behaviors, 19(4), 372 - **This reference refers to a randomised control trial, conducted in the USA.**
Trudeau, L., Spoth, R., Mason, W. A., Randall, G. K., Redmond, C., & Schainker, L. M. (2016). Effects of adolescent universal substance misuse preventive interventions on young adult depression symptoms: Mediational modeling. Journal Of Abnormal Child Psychology, 44(2), 257-268. (CaFaY) - **This reference refers to a randomised control trial, conducted in the USA.**
Coombes, L., Allen, D., & Foxcroft, D. (2012). An exploratory pilot study of the Strengthening Families programme 10-14 (UK). Drugs: Education, Prevention and Policy, 19 (5), 387-396 - **This reference refers to a mixed-methods study, conducted in the UK.**
Allen, D., Coombes, L., & Foxcroft, D. R. (2006). Cultural accommodation of the strengthening families programme 10–14: UK Phase I study. Health Education Research, 22(4), 547-560 - **This reference refers to a qualitative study, conducted in the UK.**
Spoth, R., Redmond, C., Shin, C., Greenberg, M., Clair, S., & Feinberg, M. (2007). Substance-use outcomes at 18 months past baseline: The PROSPER community–university partnership trial. American journal of preventive medicine, 32(5), 395-402 - **This reference refers to a randomised control trial, conducted in the USA.**
Spoth, R., Redmond, C., Shin, C., Greenberg, M. T., Feinberg, M. E., & Trudeau, L. (2017). PROSPER delivery of universal preventive interventions with young adolescents: Long-term effects on emerging adult substance misuse and associated risk behaviors. Psychological Medicine, 47(13), 2246-2259 - **This reference refers to a randomised control trial, conducted in the USA.**
Russell, M. A., Schlomer, G. L., Cleveland, H. H., Feinberg, M. E., Greenberg, M. T., Spoth, R. L., et al. (2017). PROSPER intervention effects on adolescents' alcohol misuse vary by GABRA2. Prevention Science - **This reference refers to a randomised control trial, conducted in the USA.**
Siennick, S. E., Widdowson, A. O., Woessner, M. K., Feinberg, M. E., & Spoth, R. L. (2017). Risk factors for substance use and adolescents' symptoms of depression. Journal Of Adolescent Health, 60(1), 50-56 - **This reference refers to a randomised control trial, conducted in the USA.**
Ragan, D. T. (2016). Peer beliefs and smoking in adolescence: A longitudinal social network analysis. The American Journal Of Drug And Alcohol Abuse, 42(2), 222-230 - **This reference refers to a randomised control trial, conducted in the USA.**
Schlomer, G. L., Cleveland, H. H., Vandenbergh, D. J., Feinberg, M. E., Neiderhiser, J. M., Greenberg, M. T., et al. (2015). Developmental differences in early adolescent aggression: A gene × environment × intervention analysis. Journal Of Youth And Adolescence, 44(3), 581-597 - **This reference refers to a randomised control trial, conducted in the USA.**
Rulison, K. L., Feinberg, M. E., Gest, S. D., & Osgood, D. W. (2015). Diffusion of intervention effects: The impact of a family-based substance use prevention program on friends of participants. Journal Of Adolescent Health, 57(4), 433-440 - **This reference refers to a quasi-experimental design, conducted in the USA.**
Spoth, R., Trudeau, L., Redmond, C., Shin, C., Greenberg, M. T., Feinberg, M. E., & Hyun, G. H. (2015). PROSPER partnership delivery system: Effects on adolescent conduct problem behavior outcomes through 6.5 years past baseline. Journal Of Adolescence, 45, 44-55 - **This reference refers to a randomised control trial, conducted in the USA.**
Crowley, D. M., Jones, D. E., Coffman, D. L., & Greenberg, M. T. (2014). Can we build an efficient response to the prescription drug abuse epidemic? Assessing the cost effectiveness of universal prevention in the PROSPER trial. Preventive Medicine, 62, 71-77 - **This reference refers to a cost-benefit analysis, conducted in the USA.**
Coombes, L., Allen, D., Marsh, M., & Foxcroft, D. (2009). The Strengthening Families Programme (SFP) 10?14 and substance misuse in Barnsley: the perspectives of facilitators and families. Child Abuse Review, 18(1), 41-59 - **This reference refers to a mixed-methods study, conducted in the UK.**
Coatsworth, J. D., Duncan, L. G., Nix, R. L., Greenberg, M. G., Gayles J. G., Bamberger, . . . Demi, M. A. (in press). Integrating mindful- ness with parent training: Effects of the Mindfulness-enhanced Strengthening Families Program. Developmental Psychology - **This reference refers to a randomised control trial, conducted in the USA.**

Guidebook

The EIF Guidebook provides information about early intervention programmes that have at least preliminary evidence of achieving positive outcomes for children. It provides information based on EIF's assessment of the strength of evidence for a programme's effectiveness, and on detail about programmes shared with us by those who design, run and deliver them.

The Guidebook serves an important starting point for commissioners to find out more about effective early interventions, and for programme providers to find out more about what good evidence of impact looks like and how it can be captured. As just one of our key resources for commissioners and practitioners, the Guidebook is an essential part of EIF's work to support the development of and investment in effective early intervention programmes.

Our assessment of the evidence for a programme's effectiveness can inform and support certain parts of a commissioning decision, but it is not a substitute for professional judgment. Evidence about what has worked in the past offers no guarantee that an approach will work in all circumstances. Crucially, the Guidebook is not a market comparison website: ratings and other information should not be interpreted as a specific recommendation, kite mark or endorsement for any programme.

How to read the Guidebook

EIF evidence standards

About the EIF Guidebook

EIF

The Early Intervention Foundation (EIF) is an independent charity and a member of the What Works network. We support the use of effective early intervention for children, young people and their families: identifying signals of risk, and responding with effective interventions to improve outcomes, reduce hardship and save the public money in the long term.

We work by generating evidence and knowledge of what works in our field, putting this information in the hands of commissioners, practitioners and policymakers, and supporting the adoption of the evidence in local areas and relevant sectors.

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