The Strengthening Families Programme (SFP) 10-14 and Substance Misuse in Barnsley: The Perspectives of Facilitators and Families

The aim of this study was to evaluate the Strengthening Families Programme for young people aged ten to 14 and their parents (SFP 10-14) in Barnsley, a northern English city, based on the experience of facilitators and families who had participated in the programme. A mixed methods design blending both quantitative and qualitative data was used in the study carried out in two phases over a nine-month period in 2005. Quantitative data were collected through: the SFP 10-14 Parent/Caregiver Survey Questionnaire, the SFP 10-14 Young Persons’ Survey Questionnaire and the Strengths and Difficulties Questionnaire. Questionnaire data were compared at the beginning of the SFP 10-14 programmes (weeks 1–2) and at the end of the programmes (week 7). In addition, two focus group meetings were held with families who had undertaken the SFP 10-14 programme; and three focus group meetings were conducted with facilitators of SFP 10-14 programmes. Once quantitative and qualitative data had been analysed separately, a synthesis of the main findings from both approaches was then completed. Following the programmes, parents reported significant changes in communication limit setting, emotional management, prosocial behaviour and drugs/alcohol use. Total difficulties scores were also significantly different pre- and post SFP 10-14 programmes. For the young people, communication, and emotional management were improved and their drugs/alcohol use was less. Their total difficulties scores were also significantly different. Qualitative evidence indicated that families who participated in the study found the SFP 10-14 useful in preventing young people’s alcohol and drug use in terms

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of: learning more about alcohol and drugs, using knowledge and skills to reduce behaviours that might lead to alcohol and drug use and, for young people, dealing with peer pressure that might lead to drug and alcohol use. Parents/caregivers and young people reported that the SFP 10-14 had played a part in improving family functioning through strengthening the family unit. The findings from this exploratory study suggest that the SFP 10-14 may be a useful primary prevention intervention in helping to prevent drug and alcohol misuse in young people. Copyright © 2009 John Wiley & Sons, Ltd.

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Numerous studies in Europe report high rates of alcohol use among young people. The European School Project on Alcohol and Drugs reported that the UK had among the highest rates of drunkenness and binge drinking and alcohol consumption in Europe (Hibbell et al., 1999). Three quarters of participants in the study said that they had one episode of drunkenness, while nearly one third had 20 or more episodes in their lives or ten 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. These findings are consistent with the trends of the last decade in the UK: 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 by young people with a shift to alcopops/designer drinks (Alcohol Concern, 2005).

Young people may suffer significant adverse consequences, either directly related to their drug and alcohol use and/or as a result of their lifestyle, influenced by their substance misuse. Commonly reported psychosocial consequences include arguments with families and friends, financial difficulties and problems at school. Intoxication and drunkenness more than dependence are linked with problems such as violence, crime and accidents (Ramsey and Partridge, 1999). The UK studies of white heterosexual populations of young people suggest a positive association between drinking and risky sexual activity and sexually transmitted diseases (Mensch and Kandel, 1992). Young people with comorbidity of mental health problems and substance misuse report higher rates of family problems, antisocial behaviour, truancy and failure at school (Kandel et al., 1999). Young people with this pattern of problems are at enhanced risk of suicide, now a major cause of death among young males (Appleby et al., 1999; Hawton et al., 1999).

The alcohol and drug problems of individuals also affect their children and families. These effects have been well documented (Hurcom et al., 2000; Kroll and Taylor, 2003; Orford and Harwin,
1982; Velleman, 2000) and the phenomenon is a universal one (Eurocare, 1998; Orford, 1990; Orford et al., 1998). Velleman and Templeton (2002) have estimated that there may be about eight million family members (spouses, children, parents, siblings) living with the negative consequences of someone else’s drug or alcohol misuse. However, despite this growing evidence of the importance of family in all aspects of substance use and misuse, interventions (including prevention) have tended to focus on substance misusers with little attention paid to family members (Copello and Orford, 2002; Orford et al., 2005).

A recent Cochrane Collaboration Systematic Review reported on the effectiveness of the primary prevention of alcohol misuse in young people, and the 56 studies included in the systematic review reported a range of different prevention interventions over the short, medium and longer term (Foxcroft et al., 2003). Over the longer term, the results of the systematic review pointed to the potential value of the SFP-10-14 (Spoth et al., 2001) as an effective intervention for the primary prevention of alcohol misuse. The Number Needed to Treat for the SFP 10-14 over four years for three alcohol initiation behaviours (ever used alcohol, ever used alcohol without permission and ever been drunk) was nine young people (for all three outcomes). This indicates that for every nine young people receiving SFP 10-14, there will be one fewer person reporting that they have ever used alcohol, used alcohol without permission, or ever been drunk.

The reported effectiveness of the SFP 10-14 as a primary prevention programme has led several practitioners to experiment with its use in a number of UK settings. For example, Marsh and Male (2003) anecdotally reported 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 (CAMHS) in Barnsley. Whilst anecdotal reports of implementation of the SFP in the UK have been favourable, a more systematic approach to evaluation of the SFP was needed. Thus, the main aim of the study was to formally evaluate the use of the SFP 10-14 in the UK based on the experience of facilitators and families in Barnsley.

Methods

Design and Setting

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 nine-month period in 2005. The quantitative component of the study had a before and after intervention design. The School of
Health and Social Care Research Ethics Committee, Oxford Brookes University and Barnsley Local Research Ethics Committee approved the study.

According to the 2001 Census, Barnsley is one of the most extensive metropolitan areas in the UK with strong contrasts between rural and Pennine countryside (about two thirds of the borough is green belt and 9% is National Park land) and urban industrial areas, including the main town of Barnsley and other smaller towns and former mining villages. It has a population of 218,100 of whom 99.09 per cent of the resident population belong to the White ethnic group. Barnsley is ranked 28 (where the most deprived authority is ranked 1) out of 354 local authorities on the Index of Multiple Deprivation (National Statistics Online, 2008).

A survey conducted by Sheffield Hallam University on behalf of Barnsley’s Drug Action Team found that the borough did not have a drug misuse problem out of proportion with its size and socio-economic profile (www.barnsley.gov.uk/council/newslines/newsline1938.asp). Fifteen hundred heroin users were identified, but were said to be aging, with very few teenage users being known to services. However, a significant cannabis culture was identified. Far more crime was associated with alcohol misuse rather than class A drug use.

**The SFP 10-14**

Kumpfer and associates at the University of Utah originally developed the SFP in 1983 as part of a three-year prevention research project funded by the National Institute on Drug Abuse (Kumpfer et al., 1989). The original SFP was designed to reduce vulnerability to drug misuse in six- to 12-year-old children of methadone maintenance patients attending a clinic in Salt Lake City. By studying how the drug problems of parents affected their children, the researchers established that disorganised stress in the household often resulted in a lack of consistent parenting (Kumpfer et al., 1985). Parents spent relatively little time with their children, particularly ‘quality time’ enjoying activities. Stigma and fear of exposure lead to social isolation of the family and the children. The result was an impoverished social environment that lacked adult support. Family dysfunction took its toll on the children in the form of emotional stress, low self-esteem, under achievement at school, conflict at home and avoidance of intimate relationships.

The SFP 10-14 was the result of a major revision of the original SFP. In 1992, the Social and Behavioral Research Center for Rural Health at Iowa State University received a grant from the National Institute of Mental Health to test the SFP in schools with a general population of rural families with young adolescent children. The outcome was a substantial revision of the original SFP (Molgaard et al., 2000).
The SFP 10-14 curriculum consists of weekly sessions lasting two to three hours. For about an hour, parallel groups of children and parents from four to 14 families develop their understanding and skills led by two parent and two child group facilitators. In a second hour, parents and children come together in family units to practice the principles they have learned. The remaining time is spent in logistics, meals and enjoyable family activities. One two-three hour session is scheduled per week, for seven consecutive weeks. The programme is highly structured with detailed manuals, videos and activities whilst at the same time being highly interactive (Molgaard and Spoth, 2001).

Between 2000 and 2002, two key local health care workers worked as job sharing parent training coordinators for a health action zone (HAZ) parent project based within the local CAMHS in Barnsley. Following positively evaluated parenting training work with children aged three to eight with conduct disorder within the HAZ project, it was noted there was a perceived gap in services for families with young teenagers. The two key workers identified the SFP 10-14 as a favoured programme for this age group and they visited Iowa State University in the US to see the programme in action, and receive training in the delivery of the programme (Marsh and Male, 2003).

Participants

The SFP 10-14 programme was introduced in the Barnsley area by two parent training coordinators working within a HAZ parent project based in the local CAMHS. After initial piloting of the programme, other services became involved such as the education service behaviour support team, the youth offending team and the intensive prevention team. Approximately 70 families completed the SFP 10-14 in the Barnsley area between 2002 and 2005.

The eligibility criteria for families asked to participate in the research were:

- at least one young person aged ten to 14 years;
- completed SFP 10-14 between 2002 and 2005;
- both parents/caregivers and young people willing to participate in the study and sign a consent form;
- able to read and write English;
- not hospitalised (but may be receiving medical or mental health care).

We approached all 70 families who had undertaken the SFP 10-14 in Barnsley and 58 (83%) agreed to take part. All 70 families met the eligibility criteria for the study. We were unable to trace seven of the families who chose not to take part in the study and the other five families did not respond to requests for information. It is
possible that these seven families may have been significantly different to those who took part in the study. However, when we discussed the families who did not take part in the study with referring professionals, the overall impression was that the demographic characteristics and problems on referral were similar to families who took part in the study.

A purposive sample of ten of these families who met the inclusion/exclusion criteria for the study was selected to undertake two focus groups with five families \((n = 10)\) in each group. Potential participants were invited to take part in the research through a letter from SFP 10-14 facilitators. They were also provided with written information about the study and were given an opportunity to ask questions about the research. Written consent was obtained from both parents and young people participating in the study. The inclusion criteria for the focus groups were:

(i) both parents/caregivers and young people should consent to participate in the study;  
(ii) where appropriate, the agreement of relevant responsible clinicians should be obtained for participants to participate in the study;  
(iii) participants undertook the SFP 10-14 between 2002 and 2005;  
(iii) participants were able to undertake focus group interviews.

A purposive sample of 15 facilitators (approximately 30 facilitators had been involved in SFP 10-14 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). Potential participants were invited to take part in the study and were provided with written information and an opportunity to ask questions about the research. Written consent was obtained from all facilitators.

**Instruments**

Data relating to the demographic characteristics of the participants in the study were collected alongside data from three self-report questionnaires.

**PCSQ**

The SFP 10-14 Parent/Caregiver Survey Questionnaire (PCSQ) is a structured 20 item self-report instrument used by facilitators to evaluate the SFP 10-14 (Molgaard and Spoth, 2001). Participants are asked to rate their behaviour against each item of the questionnaire at the beginning of the programme (weeks 1 or 2 of the programme) and following completion of the programme (week 7). The measurement scale consists of a four-point Likert scale where ‘A little of the time’ is scored 1 and ‘Most of the time’ is scored 4.
YPSQ
The SFP 10-14 Young Persons’ Survey Questionnaire (YPSQ) is a structured 15 item self-report instrument used by facilitators to evaluate the SFP 10-14 (Molgaard and Spoth, 2001). Participants are asked to rate their behaviour against each item of the questionnaire at the beginning of the programme (weeks 1 or 2) and following completion of the programme (week 7). The measurement scale consists of a four-point Likert scale where ‘A little of the time’ is scored 1 and ‘Most of the time’ is scored 4.

SDQ
The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire about three- to 16-year olds (Glazebrook et al., 2003; Goodman, 1997, 2001; Goodman et al., 1998; Goodman and Scott, 1999; Mathai et al., 2002; Muris et al., 2003; Smejde et al., 1999). It consists of 25 items measuring psychological attributes on five subscales: emotional symptoms (5 items), conduct problems (5 items), hyperactivity/inattention (5 items), peer relationship problems (5 items) and prosocial behaviour (5 items). The SDQ is completed by parents and young people at the beginning of the programme (weeks 1 or 2) and following completion of the programme (week 7). The measurement scale of the SDQ is a three-point Likert scale ‘Somewhat true’, ‘Not true’ and ‘Certainly true’. SDQ scores are sometimes classified into ‘normal’, ‘borderline’ and ‘abnormal’ categories. An ‘abnormal’ score on the total difficulties score can be used to identify potential likelihood of development of mental health disorders.

Data Collection
Two tape-recorded, focus group interviews lasting approximately 60 minutes were undertaken with the ten parents/caregivers and young people. The focus groups were held at the sites where parents and young people had undertaken the SFP 10-14 (local schools). In addition, three tape-recorded, focus group interviews lasting approximately 60 minutes were undertaken with the 15 facilitators. These focus groups were conducted outside of the facilitators’ work settings (conference rooms in local hotels). Interviews focused on participants’ experiences of the SFP 10-14 materials and approach. Quantitative data were collected through: the SFP 10-14 PCSQ, the SFP 10-14 YPSQ, and the SDQ. These questionnaires were administered during weeks one to two and week seven of the programme.

Data Analysis
Audiotapes of focus group interviews were transcribed and a content analysis of transcriptions was undertaken. Content analysis
produces a relatively systematic and comprehensive summary of the data as a whole (Silverman, 2006). Participants’ responses were coded and categorised according to the theme(s) evident in what they said. For quantitative data, descriptive and inferential statistics for all questionnaire data were calculated using SPSS v10. 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 (α = 0.05). This is a statistical test used to see whether there is a significant difference between participants scores and is the non-parametric equivalent of the parametric paired t-test. Once quantitative and qualitative data had been analysed separately, a synthesis of the main findings from both approaches was then performed.

Results

As a rule, in relation to SFP 10-14, the term ‘family’ normally applies to a unit of one or two parent/caregivers and one young person. However, there are occasions when SFP 10-14 facilitators make exceptions to this rule and more than two parents and caregivers and more than one young person attends an SFP 10-14 programme. In this study two pairs of young people attended SFP 10-14 programmes with one or both parents. The numbers of parents/caregivers and young people attending the SFP 10-14 programmes are summarised in Figure 1. This figure shows the number of families contributing data and the data they provided. Of the families providing data, 47 (81%) were female parents/caregivers and 11 (19%) were male parents/caregivers. Forty-two (72%) parents/caregivers attended SFP 10-14 programmes without partners and eight (28%) with partners (i.e. 16 parents/caregivers). Fifty-four young people attended SFP 10-14 programmes (50 young people without siblings and two pairs of young people with siblings (i.e. 4 young people). There were 26 (48%) male young people and 28 (52%) female young people in the sample of families. The median age of the young people was 12 years with a semi-interquartile range of 1.5 years.

Twenty-three facilitators reported having undergone SFP 10-14 training in the Barnsley area and 17 of these had run SFP 10-14 programmes. The largest number of SFP 10-14 programmes facilitated by an individual was ten, with the majority of facilitators (58%) having completed between one and three programmes. Facilitators were employed by the following organisations/agencies: Health, social services, local education authority/schools or the voluntary sector.
At commencement of the programme, parents assessed the behaviour of the young person using the SDQ. In addition, the young people self-assessed their behaviour using the SDQ. The results of these assessments are summarised in Tables 1 and 2.

The behaviour of young people participating in the SFP 10-14 programmes was judged to be outside of normal range for the majority of young people. All young people in the sample were considered to have ‘hyperactivity’ and over 90 per cent were thought to have ‘conduct problems’ according to the young person’s SDQ self-report and the parent/caregivers’ SDQ report of the young person. Parents’ and young people’s assessments of behaviour were remarkably similar. Facilitators reported that young people who attended the SFP 10-14 programmes had a range of problems including: chronic school refusal, offending behaviour, non-compliance, bullying, low self-esteem, misuse of drugs and alcohol, self-harm, depression, anxiety and challenging behaviour.

‘All young people in the sample were considered to have “hyperactivity”’
When SDQ scores at the beginning of the SFP 10-14 programmes were compared with SDQ scores at the end of the SFP 10-14 programmes, the following changes were noted. According to scientific convention a $p$ value of less than 0.05 indicates a significant difference (in this case between before and after SDQ scores). For the parents/caregivers, the total difficulties scale and the emotional symptoms scale scores were significantly lower at the end of the course than at the beginning (Wicoxon $z = -2.538, p = 0.018$ and Wilcoxon $z = -2.578, p = 0.010$, respectively). There was no significant change for other subscales except to note that hyperactivity approached statistical significance (Wicoxon $z = -1.740, p = 0.082$). For the young people, the total difficulties scale was significantly lower at the end of the course than at the beginning (Wilcoxon $z = -2.022, p = 0.043$). However, there were no significant changes for the other subscales for young people’s SDQ responses.

The PCSQ and YPSQ scores measured at the start and end of the SFP 10-14 programmes are summarised in Table 3. Again, a $p$ value less than 0.05 indicates a significant difference (in this case between before and after PCSQ and YPSQ scores). Parents’/caregivers’ scores for the PCSQ were highly significantly lower at the end of the SFP 10-14 programmes than at the beginning ($p < 0.001$ for all scales). The young people’s communication scores, emotional management scores and drugs/alcohol use scores were significantly lower at the end of the SFP 10-14 programmes than at the beginning as recorded on the YPSQ (Wilcoxon $z = -4.715$,
Table 3. Changes in parent/caregiver and young people’s SDQ subscale scores

<table>
<thead>
<tr>
<th>Scale</th>
<th>Parent/Caregiver (n = 16)</th>
<th>Young people (n = 16)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wilcoxon z</td>
<td>p</td>
</tr>
<tr>
<td>Total difficulties score</td>
<td>−2.538</td>
<td>0.018*</td>
</tr>
<tr>
<td>Emotional symptoms</td>
<td>−2.578</td>
<td>0.010*</td>
</tr>
<tr>
<td>Conduct problems</td>
<td>−1.570</td>
<td>0.129</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>−1.740</td>
<td>0.082</td>
</tr>
<tr>
<td>Peer problems</td>
<td>−0.356</td>
<td>0.722</td>
</tr>
<tr>
<td>Prosocial behaviour</td>
<td>−0.743</td>
<td>0.458</td>
</tr>
</tbody>
</table>

*p < 0.05.

Table 4. Changes in parent/caregiver and youth survey subscale scores

<table>
<thead>
<tr>
<th>Scale</th>
<th>PCSQ (n = 50)</th>
<th>YPSQ (n = 50)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wilcoxon z</td>
<td>p</td>
</tr>
<tr>
<td>Total difficulties score</td>
<td>−4.715</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Communication</td>
<td>−4.710</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Limit setting</td>
<td>−4.452</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Emotional management</td>
<td>−3.952</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Prosocial behaviour</td>
<td>−4.917</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Drugs/alcohol use</td>
<td>−3.812</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

* Not measured by YPSQ. PCSQ = Parent/Caregiver Survey Questionnaire; YPSQ = Young Persons’ Survey Questionnaire; NS = not significant.

*p < 0.001, Wilcoxon z = −3.490, p < 0.001 and Wilcoxon z = −2.723, p = 0.006, respectively* (Table 4). There was no significant change for young people’s scores on the limit setting subscale (Wilcoxon z = −1.934, p = 0.163), meaning that the young people did not think that there was any change in the frequency that their parents were setting limits for them (Table 4).

The families who completed the SFP 10-14 programmes identified four main areas where they thought that the programme was effective. Figure 2 represents a synthesis of the quantitative and qualitative findings regarding these four main areas.

Parents/caregivers and young people in this study reported improvements in their emotional health and well-being during the course of the programme in the focus groups they participated in. Several parents reported that they felt more able to control their emotions when interacting with the young person. One parent/caregiver commented: ‘I learned how to talk to him without shouting and to listen more without arguing’.

This and other comments reflected a general feeling expressed by parents/caregivers and young people that they were dealing with emotional issues more constructively. A number of parents/caregivers and young people said that they were dealing with stress...
Figure 2. Parent/caregivers’/young persons’ experience of the SFP 10-14
more effectively: ‘I learned how to deal with stressful situations in a different way’ (parent/caregiver). ‘I learned how to deal with stress, to talk things through sensibly and how to get out of tricky situations’ (young person).

Developing a repertoire of effective strategies and skills for dealing with difficult situations where emotions ran high was thought to be very valuable by parents.

Several parents thought that better emotional management had led to improved relationships between them and their children. Some parents reported that they were expressing feelings of care and love more frequently and that this was helping to strengthen relationships. Some young people also said that they felt that emotional aspects of their relationships with parents had improved. ‘I tell my child my feelings now—I didn’t do this before’ (parent). ‘I have learned that my mum loves me and wants what’s best for me’ (young person).

Closely allied with expressing feelings was an improved sense of empathy between parents/caregivers and young people. Several parents/caregivers and young people said that they had developed better understanding of each other’s perspectives. ‘I learned that my parents love me and I love them and to understand how they work’ (young person).

Parents/caregivers and young people reported positive changes in young people’s behaviour. Many of these changes were attributed to development of consistently enforced family rules within a framework of well-balanced discipline. One parent reported that she was no longer: ‘. . . afraid or guilty in setting limits and stating consequences for behaviour’.

Some parents commented that it was hard to set limits and to remember to consistently maintain boundaries, but that it was an important way of expressing love and care for young people. One parent felt that it was an important component in demonstrating respect for family members. It was also identified that young people actually do need to have limits set. One parent/caregiver described setting limits as providing a form of security for the young person: ‘Because that is what I think—especially all that is going on out there at the moment. Kids need to know that there is security, you know’.

But, it wasn’t just parents who thought that effective behaviour management was helpful. Two young people who participated in the SFP 10-14 described how improved behavioural management had brought benefits to family relationships and functioning: ‘We use the points chart and I get to go to the swimming pool or to football for not losing my temper. I help my parents and understand what they are saying more’.

The problem of drugs and alcohol use was clearly a reality for some parents:
‘Well it was the strengthening families bit and obviously the drugs and alcohol stuff too. Y is 13 now and he has obviously seen some of that, but at the time it was the strengthening families thing. And I always thought we had quite a good relationship going and we did spend lots of time together just me and him, but our family was going through lots of changes obviously because his brother is off and about and doing his own thing and I just thought you know if that is changing then we need to find ways to deal with other things because he might be wanting to do things that his older brother were doing’.

In this study, both parents/caregivers and young people reported that the way that they were dealing with drug and alcohol use had changed significantly during the period of the SFP 10-14. One young person felt that their peer resistance skills were improved following the course: ‘Whenever anyone asks you to do something you don’t want to I know the process’.

Several parents/caregivers and young people reported that they felt that the programme had improved family functioning. Improvements in emotional health and well-being and better behaviour management were cited as reasons for progress in the area of family functioning. However, knowing the family’s strengths, receiving better positive and negative feedback, and working together as a team were also thought to be important by both parent/caregivers and young people. ‘We have family meetings now and we talk about what we are doing. We have less arguments’ (young person).

Discussion

Barnsley has been a pioneer in using the SFP 10-14 in the UK. It has been used by a wide range of public services to help families whose teenagers have developed a variety of psychosocial and behavioural problems. Data provided by the parents/caregivers, facilitators and the young people themselves in this study indicated that the young people suffered from emotional, behavioural and interpersonal difficulties. Some families were identified as being in ‘crisis’, ‘tearing themselves apart’ and with relationships between members of the family having broken down. Some parents/caregivers were feeling worthless and hopeless and failures in their roles of parents/caregivers. Some families were subject to parenting orders, exclusion (temporary and permanent) from school and involvement with the criminal justice system. Some young people were using drugs and alcohol. In addition, many of the families had experienced economic hardship and consequent problems of social exclusion. Against this background, the families became involved with the SFP 10-14, offered by a range of organisations and agencies in the Barnsley area.

Facilitators, parents/caregivers and young people faced a number of other barriers to their participation in the SFP 10-14. As reported,
time constraints and conflicts with other events and activities were felt to be significant problems (Spoth \textit{et al.}, 2002; Allen \textit{et al.}, 2007). Timing groups to meet the needs of families requires considerable flexibility on the part of programme facilitators (and the organisations and agencies that they work for), with most programmes taking part in the evening. Similarly, families vary in their willingness and ability to travel to venues where programmes are being held. This presents two challenges for facilitators: providing transport for families who want it (facilitators reported providing taxis, arranging lifts, using a minibus to bring families to programmes), or travelling to venues that are local to families, but not to the facilitators (this is a particular issue when there are a limited number of trained facilitators available). Whichever is the case, it is apparent that funding is needed to address transport issues.

Another difficulty faced by many families concerned siblings. Typically parents/caregivers attend the programme with one young person. But what happens to siblings—especially if they are very young—when the rest of the family is attending the programme? Many facilitators said that running a childcare group (‘crèche’) in parallel with the SFP 10-14 is an ideal solution to this problem. Indeed, where this has been possible, facilitators have reported that this has been very popular with those children attending this group and also with families who feel reassured that their other children are safe and engaging in worthwhile activity. However, such an arrangement is not without cost, both in terms of a facilitator of the childcare group (in spite of this some facilitators reported that there are individuals who are willing to provide support for no financial reward) and resources needed to run this group.

All of these difficulties present barriers to participation in the SFP 10-14 and unless these can be overcome, there is a risk that families in the greatest need will miss out (Drugs Prevention Initiative, 1998; Velleman, 2000). Furthermore, unless this happens, potential funders of initiatives to help families may be reluctant to support the SFP 10-14. The parents/caregivers, facilitators and young people identified convenient programme timings, provision of meals, help with transportation and childcare, and support with reading and writing as being important to access the programme. Voluntary participation and self-motivation (encouraged by incentives) were thought to be preferable to ‘orders’ and directives to participate.

Those families who overcame the barriers to participating in the SFP 10-14 and completed the programme (some with and others without booster sessions) identified four main areas where they thought that the programme was effective. These were: (1) Improving parents’/caregivers’ and young peoples’ emotional health and well-being, (2) changing young people’s behaviour, (3) helping prevent young people’s substance use and (4) improving family
functioning. Such findings are consistent with work undertaken in the US, where Spoth et al. (1999a, 999b) has reported that these and other changes have helped delay substance use or misuse.

Parents/caregivers and young people reported that the SFP 10-14 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 the family. Again, these findings are consistent with work undertaken in the US. In Project Family, it was reported that family functioning had improved communicating rules about substance use; managing the child’s anger; involving the child in family activities and decisions; and communicating understanding of the child as well as the parent’s wishes (Molgaard and Spoth, 2001; Redmond et al., 1999; Spoth et al., 1998). In turn, these led to generalised improvements in the parents’ management of the child and in the emotional quality of the parent-child relationship.

**Conclusions**

The SFP 10-14 is an evidence-based family intervention that has been shown to be effective as a long-term primary prevention for alcohol and drug misuse in the US. It has also been used in a number of settings in the UK, but most notably in Barnsley. The study reported here provides some evidence that both participating families and facilitators perceive the programme in its US form as useful and meaningful. However, evidence of quantitative changes to family functioning, emotional health and well-being, young person’s behaviour and substance use obtained during the study are difficult to interpret. Small and biased sample sizes, lack of a comparative control group, lack of valid and reliable outcome measures, lack of longer term follow-up data and limited generalisability of findings due to non-probability sampling method may all have been confounding factors. Whilst these are acknowledged as significant limitations of the study it should be noted that they are not uncommon problems in prevention studies and should not completely detract from findings that may mark the starting point in providing evidence for the SFP 10-14’s effectiveness in the UK.

The findings from this study suggest that the SFP 10-14 may be a useful primary prevention intervention in helping to prevent...
alcohol and drug use in the UK, supporting findings from Cochrane systematic reviews (Foxcroft et al. 2003; Gates et al. 2006). 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 such a UK version of the programme and materials.¹ This study has reported on the use of the SFP 10-14 as a targeted intervention with high-risk families known to a young people’s service. Further studies of the use of the programme with high-risk families is needed, especially those from different ethnic backgrounds. Studies of the use of the SFP 10-14 as a universal intervention are required. Further studies of the efficacy of the SFP 10-14 in the UK are needed using a culturally adapted version of the programme.² 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 also be collected to explore participants’ perceptions of the adapted materials. Data on the cost effectiveness of the SFP 10-14 in the UK are also required.

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References


¹ Adaptation of the US SFP 10-14 has been undertaken by Allen and colleagues in the School of Health and Social Care, Oxford Brookes University.

² An exploratory trial of the UK adapted SFP 10-14 has been completed by Allen and colleagues in the School of Health and Social Care, Oxford Brookes University (www.aerc.ork.uk).


