A Multisite Program Evaluation of Families and Schools Together (FAST): Continued Evidence of a Successful Multifamily Community-Based Prevention Program

Mary Crozier, Laurie Rokutani, Jill L. Russett, Emilie Godwin, and George E. Banks

Abstract

Strong school and family ties have long shown success in influencing positive child development and lasting academic success. While a multitude of programs exist to help facilitate the school–family connection, one program in particular, Families and Schools Together, or FAST, stands out as an effective prevention program that is suitable for a number of diverse populations. This article adds to the growing body of literature on the effectiveness of FAST. This study of the implementation and evaluation of the Kids FAST and FAST-WORKS programs over multiple years in a large metropolitan area of Virginia was conducted using existing data collected from individual program sites over the course of 35 months (Spring 2005 to Winter 2007), analyzed in aggregate using quantitative methods as prescribed in the FAST evaluation protocol. Few FAST program site results are analyzed in aggregate, even though this method is encouraged by the FAST developers. Thus, previous evaluation of individual program sites yielded mixed results. Analyzed in aggregate, families graduating from multiple sites of FAST programs were shown to make significant gains on most measures. These results indicate positive outcomes and can provide insight for program improvements as well as support for continuing to use the FAST program in the Virginia Beach City Public Schools and in similar sites. Limitations of this study and suggestions for future research are discussed.

Key Words: Families and Schools Together, FAST, family, systems, theory, prevention, community partnerships, evaluations, collaboration, evaluations, parents, education, programs, risks, social capital, quantitative, aggregate

Introduction and Background

Developed in 1988 by Dr. Lynn McDonald, the FAST program was designed as a preventive program for at-risk children aimed at improving family functioning, thereby strengthening child resiliency. Today, FAST is offered to both intervention and prevention populations with its blend of "family therapy principles, delinquency and substance abuse prevention strategies, psychiatric techniques, family systems theory, and group dynamics" (Sass, 1999, p. 2). As a universal prevention program that targets the family and school domains, FAST uses developmentally sound approaches to help bolster family functioning and reduce risk factors such as school failure, violence, delinquency, substance abuse, and family stress (Terrion, 2006). Fast is a multisession group for families of elementary school children to increase parental skills and family well-being with the objective of preventing risks (Substance Abuse and Mental Health Services Administration [SAMHSA], 2008). FAST has been credited with meeting the needs of all socioeconomic, racial, or geographical groups making it a successful universal program (FAST, n.d. a). In addition, different FAST curricula have been developed to meet the needs of specific target populations including: Baby FAST, Pre-K FAST, Kids FAST, Middle School FAST, and Teen FAST.

As a parent education process, FAST consists of numerous components and activities designed through the logic model to meet its ambitious goals. The components, which add rigor and effectiveness, include the selection procedure, structured group education and activities for multiple families, assessments, and follow up via FASTWORKS. The primary program goals are to enhance family functioning, prevent school failure, prevent substance abuse in parents and children, and reduce stress in parents and children (FAST, n.d. b; McDonald & Ziege, 2003). McDonald understood that resilient families with skillful communication strategies and social support were less vulnerable to risk factors such as school failure, substance abuse, delinquency, and violence (FAST, n.d. a). Research by Hawkins, Catalano, and Miller (1992) supports the premise of FAST. It has been demonstrated that by increasing protective factors, such as family management practices, parent to child and parent to parent bonding, connections with community agencies, and commitment to school, behaviors in children such as substance abuse and school underachievement or dropout can be mitigated (FAST, n.d. b). A qualitative review of FAST

identified three key variables which build social capital in FAST families thereby enhancing protective factors in children: bonding among family members and between the family and school, bridging between FAST parents and social agencies, and bonding as seen in increased family empowerment and cohesion (Terrion, 2006).

FAST also aligns with other traditional parent education models. Research on effective parent education programs supports the inclusion of parents and children (Redding, 2001 as cited in DiCamillo, 2001). FAST achieves this inclusion by offering focused interactive activities led by school and agency collaborators to address social, academic, developmental, and health topics (DiCamillo, 2001). Additionally, FAST uses change strategies from the community development and therapeutic family intervention literature to promote growth in participants (McDonald et al., 1997). Currently, FAST has a strong rating as an effective prevention program under the SAMHSA Center for Substance Abuse Prevention's National Registry of Evidence-based Programs and Practices. According to this registry, FAST received a score of 3.7 out of 4.0 on the Quality of Research ratings and an overall rating of 4.0 (on a 0.0-4.0 scale) for Readiness for Dissemination (SAMHSA, 2009). FAST has been replicated in 38 states in both urban and rural settings and in over 600 school communities of diverse ethnic and socioeconomic status (Kratochwill, McDonald, Levin, Bear-Tibbetts, & Demaray, 2004).

Literature detailing the program structure, operational framework, and real-world implications for the FAST program is in abundance (FAST, n.d. b; FAST, n.d. c; McDonald et al., 2006). In addition, a number of empirical studies have investigated outcomes for the implementation of FAST programs within individual schools. However, despite encouragement by FAST developers to analyze program effectiveness across program sites in aggregate, literature to date has continued to focus on independent school programs and has yielded mixed results. In order to evaluate efficacy across the multiple schools contained within a program site, the Virginia Beach (VB) FAST program has been analyzed in aggregate, and results are presented herein.

Theoretical Framework

The foundational theories upon which FAST is based include family stress and prevention theory and incorporate multifamily group models that promote family interaction as a preventive tool. However, while multifamily group psycho-educational models have long been a practiced prevention technique, FAST's incorporation of the school into the family process has shown profound results for children in both home and school environments. Empirical

evaluations of worldwide FAST implementation have consistently shown a 20 percent improvement in child behavior and functioning at home as well as in school (Coote, 2000). As such, FAST has effectively drawn from family systems theory which argues an inseparable overlap of distinct environments and provides an answer to the call for successful family–school collaboration models, particularly for at-risk children.

Family systems theory evolved in the social sciences from general systems theory in the general sciences wherein systems were explained to be interrelated components of a cohesive whole as opposed to independent self-regulating parts (Dowling & Osborne, 2003). The foundation of the theory understands relationships to be interrelated and interactive as opposed to consisting of linear cause and effect occurrences. Families, then, are conceived of as units in which all personal interactions both within and outside of the family work together as moderating influences on behavior and thinking. The inception of systemic thinking in psychology shifted assessment of families away from distinct interacting individuals toward a holistic view of the family unit in which all environments encompassing the family are considered to be influential. For school-aged children in the family, this systemic analysis called for the incorporation of the school environment and school-based behaviors and attitudes into the overall understanding of the family. Moreover, child behavior in the home could no longer be viewed as distinct from behavior in school.

As an evolving understanding of families as systems emerged, so too did an increasing awareness in education that parent involvement in schools increases the likelihood of student success. The connection between parent involvement and student achievement is now well established (Dunst, 2002; Griffith, 2000; McWilliam, Maxwell, & Sloper, 1999; Parent Involvement Task Force, 1999), and it illustrates the need for school programs that facilitate relationships between the schools and students' families. Moreover, Epstein (1995) outlines multiple benefits to increasing family–school collaboration, including "improving school programs and school climate, providing family services and support, increasing parents' skills and leadership, connecting families with others in the school and in the community, and helping teachers with their work" (p. 701).

Despite the clearly illustrated benefits to improving parental involvement in education, there remain many challenges to the implementation of programs that facilitate this in practice. A primary challenge to programs that facilitate collaboration between families and schools is the historically held beliefs of many educational institutions which assert that organizational separation facilitates stronger learning environments (Unger & Sussman, 1990). This view of separateness includes a need for distinct goals and standards for families and

schools. An entrenched component of this educational model is that interaction between families and schools is only facilitated by the school when there is significant trouble. However, when families enter a school environment for the first time in response to a crisis, they are often operating from a position of defensiveness as opposed to collaboration (Griffith, 2000). As a result, the relationship between parents and school personnel can become adversarial with disparate agendas, thereby reducing the likelihood that students will benefit from cohesive objectives and unified support.

An additional obstacle to effective school–family partnership is the failure of many schools to effectively invite marginalized families to participate in collaborative efforts. Research illustrates that affluent communities typically have more positive parental involvement than schools in economically depressed communities, unless the school has specific programs in place to encourage collaborative efforts (Epstein, 1995). Although schools may expect and encourage parental involvement, often parents in lower socioeconomic groups are only contacted as the result of student behavioral or academic problems. Further, the expectation of families to operate in a value system that may differ from their own can belie efforts at effective collaborative dialogue.

The challenge of increasing family involvement in the schools is underscored by a need for understanding the goals of this collaboration. Christensen and Sheridan (2001) recommend that schools implementing collaborative programs must work toward four specific objectives in order to achieve a positive outcome for the school and the families involved. First, collaborative efforts must be student centered and focused on shared school–family goals of improving student academic, social, behavioral, and emotional skills. Next, rather than ascribing specific roles for families and schools, there should be a shared focus on both education and positive socialization. Additionally, collaborative interactions should be designed to enhance an optimum relationship between the family members and school personnel. Finally, approaches should be preventative in nature and focused on solutions to promote student learning and overall development. These objectives should be met for all students, and a focus on improving historically poor relationships between schools and marginalized families must be forefront on the school's partnership agenda (Christensen, 2004).

The FAST program's holistic, ecological view of the family and school as interrelated components of a larger system allows for comprehensive integration of the family–school partnership model into an educational setting. This program embraces the idea that collaborative efforts are an essential component of widespread academic success for all students by addressing historical challenges to partnership (FAST, 1998). First, the FAST philosophy rejects the theory of

success in education as being dependent upon a strong, independent educational institution. Moreover, the program welcomes families who may have traditionally been called to the school only for student behavioral or academic infractions by extending an invitation to participate in multifamily programs in the school building during times of non-crisis. The meetings are designed to create a sense of partnership among the families themselves as well as between each family and the school in order to share the objective of preventing student failure in academic, behavioral, social, and emotional realms. The role of educator is extended beyond the school and into the home, while the personal interactions between family and school personnel facilitate the sharing of caretaking duties historically assigned to the family. Finally, the foundational framework grounded in prevention theory allows for a solution-focused approach to addressing student, family, and school challenges as they arise.

FAST Program Description

Kids FAST (K-5) is a program for parents and their elementary age children. The program is designed to build protective factors for children and empower parents to be primary prevention agents for their children. Short-term outcomes include "improved family functioning, increased social support, increased parent involvement in school, improved parent–child relationships, expanded social relationships, and improved child behavior" (McDonald, Frank, & Price, 2007, p. 9). Long-term outcome goals are the prevention of substance abuse, child abuse and neglect, juvenile delinquency, mental health problems, school failure, and violence (McDonald et al., 2007).

The Kids FAST program is an interactive, voluntary, multifamily program that engages the whole family system. It consists of eight weekly evening sessions which last for two hours each and are typically held in a school. The program is facilitated by a trained team consisting of a school and community representative and includes the parent, other family members, and the child. FAST activities range from age appropriate lessons with music, to feeling charades, to creating a family flag, to dinners on and off site, to fun family play. A central component includes structured and unstructured playtime which include the parents and children (FAST, n.d. d)

The follow-up program, FASTWORKS (FAST, n.d. e), is a year-long structured program for families who have completed all eight sessions of Kids FAST. In this program, families meet on a monthly basis and continue doing so for up to two years or more. FASTWORKS is unique in that it is a parent-led program that meets in the school or community. One of the primary tenets of FASTWORKS is that during the meetings parents have one-on-one time with

their children. The goal of FASTWORKS is to empower parents to strengthen their families, to be their child's advocate, and to become leaders in the community and school. Through FASTWORKS, parents build an ongoing support network.

FAST Program Implementation: Virginia Beach FAST Initiative

This study consists of a series of Kids FAST programs conducted over a two-year time span in VB, Virginia. According to a 2006 estimate by the U.S. Census Bureau, the population of the city of VB is 435,619 (U.S. Census Bureau, 2006). As published on the VB City Public Schools (VBCPS) website, as of September 2007, the K-12 school census was reported as 34, 194 (Virginia Department of Education, 2008). There are 55 elementary schools serving the area (VBCPS, 2008).

The Kids FAST program began in VB in February 2005 in two elementary schools. At that point it was under the direction of a different national authority targeting at-risk families, and VB developed limited FAST programs administered in four at-risk elementary schools. When national changes occurred, FAST became a "universal" prevention program targeting all families of elementary school children. According to the Institute of Medicine,

> a *universal preventive measure* is a measure that is desirable for everybody in the eligible population. In this category fall all those measures that can be advocated confidently for the general public and for all members of specific eligible groups, such as pregnant women, children, or the elderly. (1994, pp. 20-21)

Virginia Beach began to include additional schools and programs. FAST has now been conducted in 10 elementary schools. Carolyn Decker, Program Coordinator for the VB FAST Programs, noted that

> any stigma that may have existed with the program being initially marketed for at-risk families began to disappear. It is nonexistent now. Lack of participation these days is generally due to conflicting schedules—kids' sports activities, etcetera. As families have begun to integrate as a FAST Family Group, all types of exchanges have taken place…demonstrations of preferred behaviors, ideas on handling stressful situations, acceptances of differences, whatever they may be—educational, economical, etcetera. It has all been positive (personal communication, March 26, 2008).

From February 2005 to December 2007, 18 FAST cycles were conducted in VB elementary schools and completed over a span of 35 months. A total

of 251 families attended FAST, with a total of 165 families meeting FAST National's criteria of completing all eight weeks and officially graduating. On average there were 9.2 families per cycle who officially graduated per each of the 18 cycles. The FAST team consists of trained facilitators through collaborative partnerships with VB Mental Health Services and VBCPS. Data were available for 14 of the 18 program cycles.

Methodology

The FAST program has been rigorously evaluated since 1990 using an evaluation protocol originally developed by McDonald and Billingham (1988). The evaluation package includes standardized questionnaires with accepted validity and reliability and uses published norms for children and families. The measurements are administered using a pre- and post-assessment at home and in the school by both parents and teachers. The FAST evaluation package has been used in more than 300 schools and communities, and the improvements are predictable and consistent.

This study was conducted using existing data collected from individual program evaluation results from sites implemented over the course of 35 months and was analyzed in aggregate, using descriptive statistics and paired sample, t-tests. The evaluation protocol for the VBCPS was a non-experimental, single-group, pre-post design in compliance with FAST program evaluation standards. Participants were exposed to the FAST program taught by trained staff at VBCPS. The following instruments were utilized for this evaluation: Family Environment Scale, Social Relationships Questionnaire, Self-Efficacy Scale, Parental Involvement in Education Scale, Strength and Difficulties Questionnaire, Substance Use Questionnaire, Social Support Instrument, and Reciprocal Support with Other Parents (McDonald et al., 2007).

Family Environment Scale

The Family Relationship Index of the Family Environment Scale (FES) rates cohesion, conflict, and expressiveness on a 27-item scale (Moos & Moos, 1981).These scales measure the amount of support and commitment between family members. Higher scores indicate higher levels of family functioning and more effective communication whereas lower scores indicate family distress. Conversely, high scores on the conflict scale indicate distressed families. The FES uses standardized norms and scores and has acceptable levels of validity and reliability. The two month test-retest reliabilities, all in an acceptable range, vary from a low of .68 for independence to a high of .86 for cohesion. Test-retest reliabilities were also relatively high for the four month interval.

Social Relationships Questionnaire

Specifically designed for the FAST program, the Social Relationships Questionnaire (McDonald & Moberg, 2002) measures the relationship that parents have with their FAST child. It also measures social relationships with other people and community agencies. Eight questions measure the relationship that parents have with their FAST child, and 11 questions measure the relationship that parents have with other people and community agencies. Respondents are asked to score each item on a scale of 0 to 9, with higher scores corresponding to stronger relationships. Test-retest reliability (Cronbach's alpha) scores range from .88 for the Community Social Relationships scale to .94 for the Parent-Child Relationship scale.

Self-Efficacy Scale

The parents complete the Self-Efficacy Scale (Coleman & Karraker, 2000; Sherer et al., 1982) that measures self-efficacy expectations dependent upon the parent's past experiences and their tendencies to attribute success to skill rather than to chance. The questions in the Self-Efficacy Scale were adapted to measure the parent's general sense of personal effectiveness. A total of 10 items address the relationship between self-efficacy and general tasks. Six questions ask about social relationships and self-efficacy, which determine the parents' beliefs about their ability to establish and maintain friendships. Seven items were developed by Coleman and Karraker to measure the relationship between the parents' self-efficacy and their ability to support and nurture their children. Scores range from 1 to 5, where a 5 indicates the highest level of efficacy. Internal consistency, Cronbach alpha (persistence) = 0.64 (Bosscher & Smit, 1998), and Cronbach alpha (whole scale) = 0.86 (Sherer et al., 1982).

Parental Involvement in Education Scale

The Parental Involvement in Education Scale (Epstein & Salinas, 1993; Shumow, Vandell, & Kang, 1996) is widely used and measures the level of parents' involvement in their child's school. The eight questions look at parental school involvement, parent-initiated contact with teachers, and school-initiated contact with the parent. Reliability for each domain ranges from .70 to .76. Scores for the items range from 0 to 4 with higher scores indicating increased involvement.

Strength and Difficulties Questionnaire

The Strength and Difficulties Questionnaire (SDQ) is an instrument about children's behavior that is completed by parents and teachers (Goodman, 1997).

There are 25 items that address two subscales: strengths (prosocial behavior), and difficulties (emotional issues, conduct problems, peer relationships, and hyperactivity problems).

Scores for the prosocial and individual difficulties subscales can range from 0 to 10. A higher score for strengths corresponds to positive behavior. A lower score for difficulties corresponds to less difficult behavior. The total difficulties subscale is the sum of the individual difficulties subscales, and scores can range from 0 to 40, with a lower score indicating less difficult behavior. Five additional questions are used to assess the impact that the FAST child's difficulties have on his or her everyday life. A score of zero or one corresponds to no or very little impact, and a score of two or three indicates moderate or high impact on the child and family. Reliability, internal consistency, ranged from .61 to .82 and criterion validity was assessed and found to be acceptable.

Substance Use Questionnaire

The Substance Use Questionnaire asks parents about their use of various substances over the past 30 days (Center for Substance Abuse Prevention Government Performance and Results Act [CSAP GPRA], 2005). The four questions ask about consuming alcohol, intoxication, smoking cigarettes, and using marijuana. The scores range from "0 Days" to "All 30 Days."

Social Support Instrument

Four aspects of social support are measured by the 12-item Social Support Instrument (Sherbourne & Stewart, 1991) as follows: emotional support (expression of affect, empathetic understanding, and encouragement of expressions of feelings); tangible support (providing material aid or behavioral assistance); affectionate support (expression of love and affection); and total support (sum of emotional, tangible, and affectionate support scores). Scores on each item range from 0 to 3, and a higher score corresponds to stronger social support. Reliability of the scale as a whole is .97 (Cronbach's alpha) with individual subscales ranging from .91 to .96.

Reciprocal Support with Other Parents

The final measure, Reciprocal Support with Other Parents (McDonald & Moberg, 2002), includes six items that determine the level of support that parents may receive from or provide to other parents, such as help with babysitting, carpooling, sharing feelings, and getting together socially. Scores can range from 0 to 5, with a higher score corresponding to more support. Test-retest reliability (Cronbach's alpha) range from .90 for the Support Received scale to .91 for the Support Provided scale.

Participants in the FAST Program

During the data collection period, a total of 196 children and 187 parents participated in the VB FAST program. The average age of the children was 7.7 years and the average age of parents was 33.7 years. Both children and parents represented different racial groups. There were 1 to 7 children aged 18 and under in each household with an average of 2.4 children per family. Regarding marital status: 117 parents (67%) were married; 52 (30%) were separated, single, or divorced; six (3%) were members of an unmarried couple; and 12 did not answer that question. The annual family income of participants ranged from "less than $10,000" to "$100,000 or more" with a median family income range of $35,000 to $49,999. Tables 1 and 2 provide demographic profiles of the children and parents, respectively, who participated in the studied FAST cycles.

Table 1. Child Demographic Profile

Demographics	Number of Respondents	Percentage
Sex		
Female	101	56.7
Male	77	43.3
No response	18	3.2
Race/Ethnicity		
Caucasian	76	42.9
African American	65	36.7
Hispanic/Latino	11	6.2
Asian	1	.6
Native Hawaiian or Native Islander	3	1.7
Mixed race	18	10.2
Other	3	1.7
No response	10	
Age	Mean= 7.7	

Table 2. Parent Demographic Profile

Demographics	Number of Respondents	Percentage
	187	100
Sex		
Female	156	89.1
Male	19	10.9
No response	12	3.2
Race/Ethnicity		
Caucasian	87	49.7
African American	60	34.3
Hispanic/Latino	14	8.0
Asian	3	1.7
Native Hawaiian or Native Islander	2	1.1
Other	3	1.7
No response	12	
Age	Mean= 33.7	Range = 21-60
Education		
Elementary or some high school	14	8
High school diploma or GED	47	27
Attended a junior college or had some college education	69	39
College degree or higher	45	25
No Response	12	
Employment		
Employed - full-time	90	52
Employed - part-time	28	16
Unemployed and looking for work, not working outside the home, a student, or disabled	5	28
No response	15	

Note: These data refer to the parents who graduated from the program and completed the pre- and post-tests. For additional descriptions of FAST families, see Appendix A, Table 3, available from the authors or editor upon request.

Results: Virginia Beach FAST Initiative

Outcome Data Reported by Parents

On the Family Relationship Index of the Family Environment Scale, parents reported statistically significant changes in cohesion ($p < .001$), expressiveness

($p < .01$), conflict ($p < .001$), and total relationship ($p < .001$; see Appendix A, Table 4, available from the authors upon request). All subscale scores span from zero to nine. Higher scores in cohesion, expressiveness, and total relationship suggest the presence of these protective factors in the family. Lower scores on the conflict subscale suggest a protective factor.

Parents rated how they felt about their self-efficacy or personal effectiveness in three areas. Nurturance efficacy, general efficacy, and social self-efficacy scores fall on a scale of 1 (low effectiveness) to 5 (high effectiveness). Their scores indicated a slight increase in social self-efficacy (+2.6%) and a significant increase in general efficacy ($p < .001$) and nurturance efficacy ($p < .001$; see Appendix A, Table 5, available upon request).

On the Social Relationships Questionnaire, parents reported the quality of their social relationships with 1 being poor and 10 being excellent quality. The parents reported significant increases in community social relationships ($p < .001$), relationship with FAST child ($p < .001$), and total social relationships ($p < .001$; see Appendix A, Table 6, available upon request).

On the Social Support Questionnaire, parent responses may range from 0 (never have support) to 3 (always have support). Parents reported significant increases in tangible support ($p < .001$), affectionate support ($p < .001$), emotional support ($p < .001$), and total support ($p < .001$; see Appendix A, Table 7, available upon request).

FAST provides opportunities for parents to support one another. Reciprocation is essential to building social support. Parents were asked about the support they received from and provided to other parents. Scores can range from 0 to 5, with higher levels meaning more support. The parents reported statistically significant increases in support provided to other parents ($p < .001$) and support received from other parents ($p < .001$; see Appendix A, Table 8, available upon request).

Parents reported on their children's strengths and difficulties. Subscales, including prosocial behaviors, emotional symptoms, conduct problems, peer problems, and hyperactivity range from 0 to 3. Total difficulties can range from 0 to 60 and the impact scores can range from 0 to 15. Parents reported a significant decrease in children's emotional symptoms ($p < .001$) and impact ($p < .01$; see Appendix A, Table 9, available upon request).

When parents were asked about their involvement and contact with the school in the past month, they reported statistically significant changes in parent–school involvement ($p < .001$), parent-to-school contact ($p < .001$), school-to-parent contact ($p < .001$), and total parent involvement ($p < .001$; see Appendix A, Table 10, available upon request). Responses can range from 0 (never) to 4r (six or more times).

Parents' Substance Use

Parents were asked four questions about how often in the past 30 days they used or did the following: smoked cigarettes, drank alcohol, were drunk from alcohol, and smoked marijuana or hashish. Response categories were: 0 = 0 days, 1 = 1-2 days, 2 = 3-5 days, 3 = 6-9 days, 4 = 10-19 days, 5 = 20-29 days, and 6 = all 30 days. In reviewing 30-day use rates, responses were largely unchanged except for cigarette use ($p < .05$; see Appendix A, Table 11, available upon request). Generally, parents reported very little use at the pre-test, leaving little room for reduction.

Special Presentation

Each FAST site decides on the topic of the special presentation, which can range from substance-related issues, to prevention of gang violence, to mental health issues, to yoga and other stress reducing techniques. Because the FAST program focus is on substance abuse prevention, the FAST evaluation assesses special presentations that focused on alcohol, tobacco, or other drug use (ATOD). In particular, the evaluation focuses on whether the presentation helped to increase parents' knowledge concerning substance-related topics. If the special presentation focuses on a topic unrelated to ATOD, parents do not complete these questions. The special presentation for this site focused on substance abuse through the avenue of family communication skills.

Information on knowledge-related change is collected using a retrospective pre- and post-test design. This fact means that parents are asked at the post-test to assess their level of knowledge as it was before the FAST session and as it was after the FAST session. Participants are asked to rate their understanding of the following, on a scale of "low" (1) to "high" (5): the impact of ATOD on the family; the ability to recognize a problem with addiction in a family member; where to get help for a problem with addiction; and the negative effects of alcohol/tobacco/other drugs on one's health.

Parents reported a slight gain in their knowledge of the impact of ATOD on the family (3%) and significant gains in their knowledge of where to get help for a problem with addiction ($p < .05$) and in their ability to recognize a problem with addiction ($p < .05$), as well as their knowledge of the negative effects of ATOD on one's health ($p < .05$; see Appendix A, Table 12, available upon request).

Outcome Data Reported by Teachers

On the Strengths and Difficulties Questionnaire, teachers reported significant improvements in students' prosocial behaviors ($p < .001$), but little or no

change in the difficulty scores (see Appendix A, Table 13, available upon request). The range of scores is the same as for parents.

Teachers were asked about the FAST parents' involvement and contact with the school in the last month. The scores range from 1 to 5, with higher numbers indicating a better relationship with the child's parent, more frequent contact with the parent, and a perception of greater parental involvement in school. Teachers reported no significant changes in relationship with parent, teacher contact with parent, or parent involvement in school (see Appendix A, Table 14, available upon request).

Discussion

The FAST evaluation protocol (McDonald et al., 1997) focuses on measuring change toward the FAST program goals in the following areas:

Goal: enhance family relationships
- family environment
- parental empowerment

Goal: reduce incidence of academic failure for the target child
- family participation in school
- behavior of student

Goal: prevent substance abuse by the child and family
- knowledge of alcohol, tobacco, and other drugs
- past 30 day use of alcohol, tobacco, and other drugs

Goal: stress reduction for families in the school community
- interpersonal relationships
- communal support
- program satisfaction

The results from the measures used in the FAST assessment protocol suggest that the FAST program at these locations, analyzed in aggregate, achieved the desired proximal objectives of assisting participants in making gains in improvement of family functioning, parental self-efficacy, and social connectedness, and parental knowledge of ATOD-related issues and substance use. However, results from the school-to-parent relationships and targeted children's behavior subscales were mixed.

As the results indicate, parents exhibited significant increases in the cohesion, expressiveness, conflict, and total relationship domains of the Family Environment Scale. Evaluation of individual program sites yielded mixed results, but analyzed in aggregate, it appears that families participating in FAST

made significant gains in each of the subscales for assessing family environment, especially in the conflict and total relationship domains. These results appear to meet the FAST goal of enhancing family relationships. In addition, parents made slight gains in social self-efficacy, but made significant gains in general efficacy and nurturance efficacy on the Self-Efficacy Scale. These results indicate that parents participating in these FAST programs made proximal progress toward developing a sense of empowerment, again, consistent with the FAST goal of enhancing family relationships.

The parents reported significant gains in community social relationships, relationship with FAST child, and total social relationships measures on the Parent Involvement in Education by Parents scale. This indicates that participation in FAST helped parents enhance their social connectedness and develop closer relationships to their children, at least while they were enrolled in FAST. Furthermore, participant parents appear to have made improvements in social support, which was evidenced by gains in several measures. Parents made significant gains in tangible support, affectionate support, emotional support, and total support. Thus, it appears that while parents attended FAST, they made improvements in these areas which, if maintained, can serve them in the future when faced with adversity, and they can also model this behavior for their children (McDonald et al., 2007). The parents reported significant increases in support provided to other parents and support received from other parents. These results further support the validity of the gains made in social support and social relationships and provide tangible evidence that these gains were put into action, thereby meeting the FAST goal to reduce the stress that parents and children experience from daily life situations.

Both parents and teachers observed improvements in some of the target children's behaviors. Parents reported a significant decrease in emotional symptoms and impact while teachers found significant improvements in prosocial behaviors ($p < .001$) but little or no change in the difficulty scores. However, no gains were reported by either parents or teachers in any of the subscales. Yet, on the scores that did not meet statistical significance, parental and teacher perceptions appeared to be similar. On the subscales that were different, it is possible that parents and teachers observe children in different settings and thus have differing opportunities in which to note change. For example, teachers reported a significant improvement in prosocial skills, but they also may have more opportunity to observe children in numerous social situations. Conversely, parents reported significant gains in emotional and impact scores. Thus, progress appears to have been made toward the FAST goal to prevent the target child from experiencing school failure, but continuous parental and teacher consultation is advised to establish mutual goals and define target behaviors in order to address these risk and protective factors.

When parents were asked about their involvement and contact with the school in the past month, they reported statistically significant gains in their school involvement, parent-to-school contact, school-to-parent contact, and total parent involvement. Teachers reported no gains in relationship with parent, teacher contact with parent, and parent involvement in school. However, the scales were different for parents and teachers, so it is difficult to make a direct comparison. In the relationship with parents and parent involvement in school, there appeared to be a ceiling effect, as the teachers' scores were near the top of the scale at pre-test, thus leaving little room for gains. Although it is a positive development that parents made significant gains, it is difficult to state with certainty that the results of these measures show progress toward the FAST goal to prevent the target child from experiencing school failure. Thus, it is difficult to make definitive statements as to the effectiveness of the FAST program regarding this goal, but it also signifies the need to ensure that teachers are familiar with the FAST program goals. Generally, the results of the FAST program are promising, but teacher awareness and involvement is critical and consistent with the FAST program fidelity protocols.

When asked about their substance use, the parents noted 30-day use rates were largely unchanged except for cigarette use. Generally, parents reported very little use at the pre-test, leaving little room for reduction and thus revealing another ceiling effect. In response to a special presentation on substance use, parents found a slight gain in their knowledge of the impact of ATOD on the family and significant gains in their knowledge of where to get help for a problem with addiction, their ability to recognize a problem with addiction, and their knowledge of the negative effects of ATOD on one's health. Considering that these parents report very low ATOD use but appear to have made significant gains in knowledge of ATOD effects as well as how to identify and address ATOD problems, results strongly indicate that the probability of achieving and maintaining the FAST goal to prevent substance abuse by the child and family was enhanced.

The literature review yielded few FAST program site results that were analyzed in aggregate, even though this method is encouraged by FAST developers as it can produce more confidence in the results (McDonald et al., 2007). This has been true for the VB FAST program sites as sessions have been evaluated individually with mixed results, and even in those program sites that produce positive outcomes, the "*N*" (number of participants) was generally small (i.e., $N \leq 20$). While program outcomes and real-world implications have been detailed in existing literature, without aggregate analysis to support individual site findings, program effectiveness has not been holistically validated. Therefore, this study analyzed results in aggregate from multiple program sites,

conducted over a two-year period, thus adding validity to individual site results and supporting the efficacy of the FAST program and its utility for the VB community.

Limitations and Suggestions for Future Research

Although there were statistically significant gains made on most scales and subscales, this study was a non-experimental design and thus cannot make general claims to the effectiveness of the FAST program in VBCPS. For example, parents could have obtained knowledge from other resources, which could have contributed to the gains cited in this study. Furthermore, the measures were pre-program—post-program and not longitudinal, so no definitive statements can be made as to long-term retention of these gains. Also, the scales used to measure parent–school involvement were different for parents and teachers, so comparisons should be made with caution.

In addition, there were no data available that tracked family attendance at individual sessions, as it was collected in aggregate. Thus, it was difficult to attribute changes due to specific modules or activities or to assess the impact of absence from a particular module or activity. FAST is a model program (SAMHSA, 2009), and this research identified additional participant gains. It is recommended that future research address FAST participation and long-term behavioral changes.

In conclusion, although follow-up data were not available for this study to make statements regarding long-term impact, significant proximal gains were made on the standardized quantitative measures included in the FAST evaluation protocol. Furthermore, the FAST program is a model program (CSAP GPRA, 2005) and, therefore, if implemented with fidelity, should produce similar results as compared with the original FAST research and evaluations (SAMHSA, 2009).

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Mary Crozier is an assistant professor and the coordinator of the Substance Abuse Counseling Certificate at East Carolina University. She has worked in

several mental health and academic settings in Virginia and Canada since 1979. Her research interests include substance abuse prevention and behavioral addictions. She can be reached at crozierm@ecu.edu or East Carolina University, Department of Rehabilitations Studies, Substance Abuse and Clinical Counseling, Greenville, NC, 27858.

Laurie Rokutani is an Adjunct Instructor at the College of William and Mary and President and CEO of MoonShadow, LLC, which provides consultation, training, curriculum development, technical assistance, preservice and continuing education, workforce development (individual and organizational), and evaluation services in substance abuse and mental health. She has worked extensively with collaborative prevention programs focused on substance abuse.

Jill L. Russett is program coordinator for the Prevention of High Risk Drinking among College Students at the College of William and Mary's School of Education. Her research interests focus on the development of addictions practitioners, gender issues related to substance use, and enhancing quality programs for prevention efforts.

Emilie Godwin is the family services program coordinator at Virginia Commonwealth University—Health Systems, Department of Physical Medicine and Rehabilitation, Division of Neuropsychology. Her work is primarily with families who have a member with a traumatic brain injury. Areas of specialty work include assisting TBI families in school-based issues, psychoeducational family intervention following brain injury, and family counseling.

George E. Banks is an evaluator for the Office of Mental Health in the Virginia Department of Behavioral Health and Developmental Services. He also runs his own evaluation consulting firm, Positive Outcomes, specializing in conducting community needs assessments, human services program evaluation, and policy analysis.