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KANSAS FAMILY INITIATIVE PILOT PROJECT: MULTI-YEAR EVALUATION PLAN

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KANSAS PARENT NETWORK AND TRAINING:

MULTI-YEAR EVALUATION PLAN

The Kansas National Guard, through its Community Outreach Program, has developed a program focused upon the prevention, not the treatment, of adolescent alcohol abuse. Funded by the Office of The Secretary of Defense, the Kansas Pilot Community Outreach Program is unique among funded pilot programs in its focus upon parent training, risk reduction, and building community based prevention programs. The Kansas project consists of three components:

1. Training of Trainers Drug awareness training consists of sixteen hours of training that all National Guard personnel and spouses are encouraged to attend. Once training is completed, the participants become certified trainers who conduct workshops in their communities using *Preparing for the Drug Free Years* curriculum.

2. Parent-Family Skills Training Parent training consists of five two-hour training sessions (forty-five hours for Effective Black Parenting) using *Preparing for the Drug Free Years* curriculum. Training informs parents about risk factors, developing a family position on drugs, managing family conflicts, and strengthening family bonds. One session, conducted with children present, informs participants how to say no to drugs.

3. Parent Network/Parent Organization Technical assistance and training are provided to help build Parent Networks. Services include how to work with volunteers, how to assist in network building, and prevention theory.

The RAND Corporation is charged with evaluating pilot projects and will focus upon the following:

* Information about participants and program, including when the programs operate, who participates (number, demographics), program design and implementation details.

* Program evaluation, including who conducted the evaluation, what was evaluated (program implementation issues), how it was evaluated (what was measured and how), what was the result (changes in drug use, attitudes, etc.), and costs of the program.

The purpose of this report is to outline an evaluation plan designed to measure implementation and results of the Kansas Parent Network and Training Program. This plan includes and is based on a literature review of evaluations of other parent training and substance abuse prevention programs. The evaluation of any program must start with an assessment of the basis for the program's theory. Does the program make sense given what is known about the problem? Valid judgment about the program must begin with and cannot proceed without "construct validity." Once construct validity has been examined, the plan will describe data collection procedures and will identify how the different components of the program will be measured.

Literature Review

As with all complex social problems, many different approaches are taken to solve or ameliorate substance abuse. And, as with other social problems, preventing substance abuse is essential. Primary prevention describes efforts to prevent, delay, or reduce the occurrence of substance use and abuse. Primary prevention includes education and activities that prevent drug use, abuse, or dependency. Secondary prevention focuses upon individuals who exhibit high-risk behavior for alcohol and drug use. Risk reduction is a focus of primary and also secondary prevention. Many studies indicate that prevention aimed at helping school-age children develop refusal skills or social skills resistance training may work. However, parents must also be involved. When informed parents support and apply drug education training provided by schools or other prevention programs, the prevention effort is strengthened. Programs that teach parents to "parent for prevention" focus on improving family relationships and parenting skills. These programs have shown success in altering parental behavior as well as some behaviors in children that may be precursors to substance involvement.[1]

Inclusion of family members in prevention and treatment of adolescent drug abuse adds to

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[1]Gonet, M. M. (1994). *Counseling the adolescent substance abuser*. Thousand Oaks: Sage.

the complexity of the intervention but is recognized as an important program component.[2] Recent research suggests there are several paths through which families influence adolescent drug use. While peers exert strong influence on adolescent drug use, families furnish important controls. A child who is less involved with family is at risk for increased drug use and also for an increase in the number of drug-using peers. Thus, involvement with family provides a direct form of control over adolescent behavior and is important for preventing involvement with peers who would provide opportunities and reinforcement for drug-using behavior. Higher levels of attachment to family also reduce adolescents' association with drug-using peers, providing another source of control. Because families and family relations influence peer associations, "families can affect not only immediate drug use, but also the development of behaviors and associations conducive to drug use."[3]

While a number of family factors influence drug use, parental use is probably the most significant factor. It affects the adolescent in terms of model behavior and family interactional styles.[4] Parents need to be aware that their use of drugs and alcohol can have a negative affect upon their children, and children living with a chemically addicted adult are at greatest risk for drug use.

Prevention programs that focus upon eliminating, reducing, or mitigating risk for drug abuse focus most upon precursors to drug abuse. Because adolescent drug abuse is correlated with other problems (delinquency, teenage pregnancy, school misbehavior and drop out), risk-focused programs can help prevent other problems as well. Risk factors can be divided into contextual factors (societal and cultural) and individual-interpersonal factors (families, schools, peers) and are summarized in Table 1. Drug abuse is more likely to occur when risk factors are present from several areas, so viable prevention models should include simultaneous attention to

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[2]Lewis, R.A., Piercy, F. P., Sprenkle, D. H., & Trepper, T. S. (1991). The Purdue Brief Family Therapy Model for adolescent substance abusers. In T. Todd & M. Selekman (Eds.), *Family approaches with adolescent substance abusers* (pp. 29-48). Boston: Allyn & Bacon.

[3]Hoffman, J. P. (1993). Exploring the direct and indirect family effects on adolescent drug use. *The Journal of Drug Issues*, 23(3), 535-557.

[4]Gonet, M. M. (1994). *Counseling the adolescent substance abuser*. Thousand Oaks: Sage.

Table 1

RISK FACTORS ASSOCIATED WITH ADOLESCENT SUBSTANCE ABUSE[5]

Risk Factors:

Community	• Availability of drugs and alcohol • Lax community laws and norms regarding drug use • High mobility and transience • Low neighborhood attachment and high community disorganization • Extreme economic and social deprivation
Family	• Family history of substance abuse • Family management problems • Family conflict • Low bonding to family
School	• Early and persistent antisocial behavior • Academic failure in elementary school • Lack of commitment to school
Individual & Peer	• Alienation and rebelliousness • Friends who abuse drugs and alcohol • Favorable attitude toward substance abuse • Early use of drugs and alcohol

[5] Development Research and Programs, Inc. *Communities that Care: Risk-Focused Prevention Using the Social Development Strategy, An Approach to Reducing Adolescent Problems Behaviors* (Seattle, WA: DRP, Inc., no date). This list is slightly modified.

a number of risk factors. Since it may be impossible to alter certain risk factors directly (e.g., family history of alcohol abuse), prevention efforts attempt to moderate the effects of those risk factors.

Parent training can improve family interaction and reduce various child problem behaviors.[6] The parent training model has also been studied as a tool in drug abuse prevention and treatment. Results suggest that models or programs that work in prevention of substance abuse among adolescents include early intervention and parent involvement among other components.[7]

To summarize, research has identified factors that can help identify adolescents most at risk for drug abuse. Research also suggests that prevention efforts must simultaneously attend to several risk factors. Children who are less involved with their family are at risk for increased drug use and for an increase in the number of drug-using peers. Involvement with family provides a direct form of control over adolescent behavior and is important for preventing involvement with peers who would provide opportunities and reinforcement for drug-using behavior. Higher levels of attachment to family also reduce adolescents' association with drug-using peers, providing another source of control. Intervention strategies that involve parents and provide parent training are more likely to be effective in prevention of substance abuse among adolescents. Parents can be taught to "parent for prevention" by improving their parenting skills and improving family relationships. The literature review confirms that there is a basis for programs that focus upon providing parent training, changing parent and child attitudes toward substance abuse, improving family control, and building parent networks to provide ongoing support and to improve community resistance to substance abuse.

Evaluation of Program Components

The Kansas Family Initiative Pilot Project focuses upon substance abuse prevention

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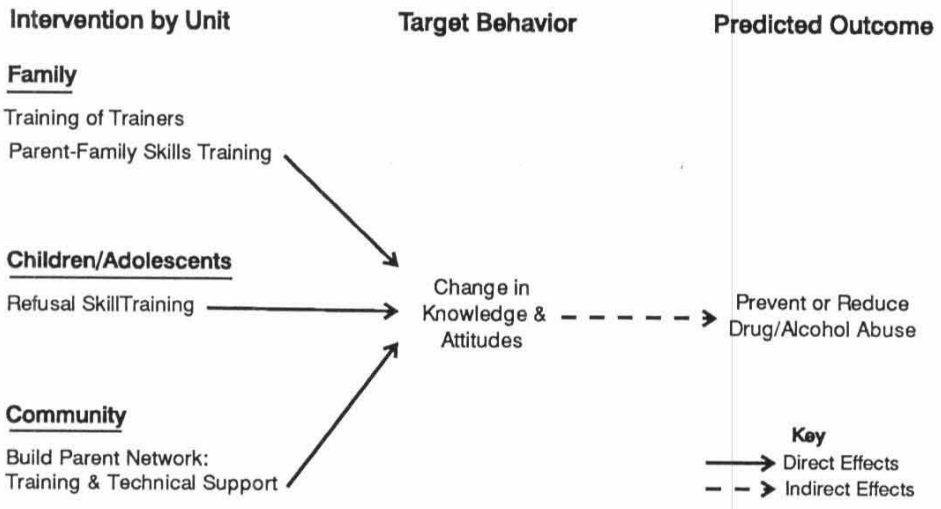
[6]Graziano, A. M. & Diament, D. M. (1992). Parent behavioral training: An examination of the paradigm. *Behavior Modification,* 16(1), 3-38.

[7]Dryfoos, J. G. (1991). Adolescents at risk: A summation of work in the field: Programs and policies. *Journal of Adolescent Health,* 12(8), 630-637.

among adolescents by teaching parents to "parent for prevention" and teaching their children refusal skills. Training addresses family risk factors (family history of substance abuse, family management problems, family conflict) and individual risk factors (attitude toward substance abuse, early use of drugs and alcohol). The project also provides technical assistance training to help build a Parent Network/Parent Organization to provide ongoing support to families. This component addresses community risk factors as well as family risk factors.

Figure 1 illustrates how the program targets parent training and community building, with direct and indirect effects upon child/adolescent risk factors. The program does not intervene directly upon peer risk factors. The evaluation process will focus upon those parts of the model where intervention occurs: training of trainers, parent-family skills training, child/adolescent refusal skill training, and parent network training and technical support. Evaluation of each of these components will include verification of implementation (implementation measures) and measures of knowledge gained, drug and alcohol use, and attitude changes (outcome measures).

Figure 1
Program Theory



Training of Trainers

To evaluate the implementation and outcome of Training of Trainers, information will be collected in three areas: participant demographics, attendance, and military affiliation; participants' knowledge of the subject area (content knowledge); and participants' ability to present the material learned as workshop leaders (content delivery).

1. *Participants*. To describe who was trained, the following information will be collected during registration or at each training session: those present, number of military participants, number of families represented, number of school-age children per family. To describe other military contributions, location of training will list any military site or equipment used. Use of drugs and alcohol by the family (parents, children) will be assessed using a brief questionnaire before, during, and after training when content knowledge is assessed.

2. *Content knowledge*. Pre- and posttests will assess participants' knowledge of the subject area before and after training.[8] The pre-posttest design gives confident answers when working with "novel outcome variables and short pretest-posttest time intervals."[9] This design assumes physical isolation; the behavior change must be due to the intervention and not other events. This means that, in the case of programs that train new information, comparison of responses made on pretests will show that participants did not have the knowledge prior to training. Posttests administered after training was completed verify that knowledge was gained. The pre-posttest design also assumes stable pretest trends. Pre- and posttests can be administered and behavior measured over a short time span, which eliminates or greatly reduces the chance that change was due to maturation and other events resulting from the passage of time. Pre-posttest designs are frequently used to assess knowledge gain because the response required is a new response (new knowledge) and thus novel.

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[8]Instruments developed by *Project Family* (University of Washington) or by DCCCA Center (Lawrence, KS) are available (pre- and posttests).

[9]Cook, T. D. & Campbell, D. T. (1979) *Quasi-experimentation: Design and analysis issues for field settings*. Chicago: Rand McNally College Publishing Co.

A pretest-intervention-posttest design is weaker when used without a control group. Control groups are not available in this project, so repeated tests will increase the strength of the evaluation research design.[10] A pretest (including drug/alcohol use questions) will be administered during registration or at a minimum one week before training. This would serve as baseline data. This test will be comprehensive in that it will contain questions about topics covered in all training sessions to provide a measure of knowledge before training. It will not be detailed, however, focusing on general knowledge, not course specific content. Subsequent session by session pretests will include relevant questions from the initial pretest as well as additional items. A posttest will be given at the end of each training session and during a follow-up telephone survey. A follow-up posttest similar to the initial comprehensive pretest will be administered during the registration process. The follow-up test will examine the longevity of knowledge gained during training.

Since different groups will be trained at different times, the effects of training will be replicated across groups and across time. Data will be collected for all participants, unless the number becomes too large. If numbers become too large to be practical or necessary for evaluation purposes, data will be analyzed for a randomly selected group of trainers. Twenty training sites will be randomly selected. An equal number of rural and urban sites would be included, and each site would have a minimum of ten participants. Thus, test data from a minimum of 200 trainers will be evaluated. Test data will be analyzed for change in attitudes and knowledge. Change in drug and alcohol use by these potential trainers will be compared across session to session by including one or two pretest questions regarding use and attitudes. Data will also be analyzed by rural and urban groups.

3. *Content delivery*. Once trainers have been trained, they conduct parent-family skills workshops. Senior trainers attend the first two training sessions given by new trainers. Workshop leaders will be asked to assess their general impressions after each workshop or

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[10]Schinke, S. P., Botvin, G. J., & Orlandi, M. A. (1991). *Substance abuse in children and adolescents: Evaluation and intervention.* Newbury Park, CA: Sage Publications, Inc.

training session using instruments provided by developers of *Project Family* (University of Washington). This assessment will provide data regarding what parts of the curriculum were presented. Senior trainers will evaluate content delivery of the curriculum (what was covered and how it was presented) using additional materials developed by *Project Family* (University of Washington). Senior trainers' observations will provide a reliability check for workshop leaders' assessment of what was presented during the session.

Table 2 summarizes how evaluation of this program component, Training of Trainers, will progress.

Table 2

Training of Trainers: Summary of Evaluation Process

TASK:		PLAN:	
1.	Site selection	1.	20 sites; equal number of rural and urban sites; minimum of ten participants per site.
2.	Describe participants, including attitudes/use of drugs & alcohol	2.	Collect demographic data during registration
3.	Assess knowledge (baseline)	3.	Collect pretest data during registration
4.	Train	4.	Collect implementation data from trainers, senior trainers.
5.	Assess knowledge gained	5.	Collect pre- and posttest data from participants before and after each training session.
6.	Assess longevity of knowledge gained	6.	Collect follow-up posttest data several weeks after training.

Parent-Family Skills Training

Using the curriculum, *Preparing for the Drug Free Years,* parent-family skills training will be conducted during five two-hour workshop sessions. Data will be collected from all who participate in training, unless the number becomes larger than is practical or necessary for evaluation purposes. In that case, twenty training sites or groups will be randomly selected for evaluation. Groups will contain a minimum of ten participants, and half will be located in urban counties and half will be located in rural counties. Thus, a minimum of 200 randomly selected participants will be evaluated.

Control groups are not available in this project, so repeated tests will increase the strength of the evaluation research design. A brief, comprehensive pretest (baseline), which will include questions regarding drug/alcohol use and attitudes, will be administered during registration or at a minimum of one week before training. Pretests focusing on topics to be taught will be administered at the beginning of each workshop session. Posttests will be given at the end of each workshop training session to measure knowledge gained. During a follow-up telephone survey, a posttest similar to the initial comprehensive pretest will be administered to test the longevity of knowledge gained during training. Since different groups will be trained at different times, the effects of training are replicated across groups and across time.

Information collected in three areas (participant demographics and attendance, participants' knowledge of the subject area, and drug/alcohol) use will include the following:

1. *Participants and attendance*. Detailed description of participants will be collected during the registration process. This information will detail the number of youth participating in or indirectly affected by the program, their distribution by age, the number thought to be at risk, the number from military families, the number of low income, male, and minority. A description of parents will include age, education, employment status, income, risk factors, drug/alcohol use, marital status (see Appendix A). Using this information, a detailed description of types of families served and their history of drug/alcohol use will be provided. Attendance records kept by workshop leaders will document the number who completed the program and the number who left the program.

   Children will attend one workshop session to learn refusal skills. While parents are

completing workshop pre- and posttests, children will complete drug use questions (any use, frequency, attitudes toward drug use) taken from the DCCCA School Student Survey (Kansas). All materials available from *Project Family* (University of Washington) and DCCCA Center (Lawrence, KS) are included in Appendix B.

2. *Content knowledge*. Using instruments developed by *Project Family* (University of Washington) or DCCCA, pre- and posttests will assess participants' knowledge of the subject area. A comprehensive pretest (including drug/alcohol use questions) will be administered during registration or at a minimum one week before training (baseline data). At the beginning of each training session, a pretest will be administered (same procedure as described above). A posttest will be given at the end of each training session and the comprehensive posttest will be administered during a follow-up telephone survey. The follow-up test will examine the longevity of knowledge gained during training. Since different groups will be trained at different times, the effects of training will be replicated across groups and across time. Data will be analyzed for change in attitudes and knowledge. Change in drug and alcohol use will be compared from session to session and from registration through follow-up by including questions regarding parent and child use during the previous week. During follow-up telephone interviews, children who participated in refusal skill training will be interviewed regarding use of refusal skills, drug/alcohol use, and attitudes toward drug/alcohol use.

3. *Content delivery*. As described above, workshop leaders will assess their general impressions after each workshop or training session using instruments provided by developers of *Project Family* (University of Washington). This assessment will provide data regarding what parts of the curriculum were presented. Senior trainers will also evaluate content delivery of the curriculum (what was covered and how it was presented) using additional materials developed by *Project Family* (University of Washington). Workshop participant posttests include questions that rate each workshop for content and presentation.

Table 3

Parent-Family Skills Training: Summary of Evaluation Process

	TASK:	PLAN:
1.	Site selection	1. 20 sites; equal number of rural and urban sites; minimum of ten participants per site.
2.	Describe participants, including attitudes/use of drugs & alcohol	2. Collect demographic data during registration
3.	Assess knowledge (baseline)	3. Collect pretest data during registration
4.	Train	4. Collect implementation data from trainers, senior trainers. Collect attendance data.
5.	Assess knowledge gained	5. Collect pre- and posttest data from participants before and after each training session.
6.	Assess parent drug/alcohol use and attitudes	6. Collect data regarding use/ attitudes during session pretests.
7.	Assess child refusal skill.	7. Collect pre- and posttest data before and after training session.
8.	Assess child/adolescent drug/alcohol use and attitudes	8. Administer survey at beginning of training session.
9.	Assess longevity of knowledge gained (parent, child/adolescent)	9. Collect follow-up posttest data several weeks after training

Parent Network/Parent Organization

A manual has been designed to provide guidance through the steps of creating and maintaining a Parent Network. The Kansas National Guard will train personnel in forming and maintaining a Parent Network. These persons will provide assistance to those seeking help in forming and maintaining a network. The National Guard will also provide information about finding resource materials. Evaluation of this portion of the Kansas Family Initiative Pilot Project will include evaluation of outcomes and process evaluation.

Outcome Evaluation

1. *Description of Parent Network.* A Parent Network assessment form[11] has been designed to collect information about each network formed (name, location, description of area served, description of group served such as number of parent members and number of children impacted, purpose of formation, mission, goals, objectives, examples of activities, how it functions, number of meetings held). From this information, a description of what areas and populations reached can be provided. A description of Parent Networks goals, objectives, and activities can also be provided.
2. *Technical assistance provided: implementation and outcome.* Parent Networks organizers will be surveyed by telephone to determine whether they received the resource manual and/or technical assistance. Organizers will be invited to complete a process evaluation form (described below).
3. Outcome evaluation would compare networks in rural and urban settings.
4. A three, six, and twelve month follow-up would determine the durability of networks. The follow-up telephone survey would determine if Networks continued to function and how well they functioned. This would provide a measure of which Networks survive and how successful they were in completing the steps in Network building provided by the resource manual. From this information an objective measure or definition can be developed to describe when a network becomes self-sufficient (no longer needs National Guard assistance.

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[11] *Parent Network Resource Manual*, Kansas Family Initiative Pilot Project.

Process Evaluation

The process evaluation would be mailed to Network organizers and would ask question like:

Does the network address any of the family risk factors, i.e., family history of alcoholism, poor family management practices, and parental drug use and positive attitudes toward drug use?

What was the initial reason for forming the network? What is the current focus? How did the network evolve from the original reason to its present focus?

Who was the original target audience for network membership? Who is the current target audience? How did the target audience evolve from its original membership to its present membership?

Were barriers to successful network building identified and what was done to overcome barriers?

Was the manual used during planning for the first meeting? How was the first meeting planned?

Were "motivators" used to stimulate attendance, e.g., food, child care, transportation?

Were meeting ground rules established? Was the manual used during establishment of meeting ground rules?

When were mission, goals, objectives, and plans of action developed? Was the manual used during that process?

What skill-building curricula are used by network members? What other types of resources are used?

What was the source of resources used by the network during its formation? Is a different source used now? If yes, why?

How was the manual used? Which parts of the manual were used: facilitation skills, communication skills, decision making skills, suggested network activities, assessment survey?

What sections of the manual were particularly helpful? Give reasons why sections were used?

Data would be analyzed by rural and urban networks and by pre-existing networks vs. Guard

developed networks. Other types of analysis that could be considered if sufficient numbers exist within each group include groups using vs not using the manual or groups that addressed one, two, or three family risk factors.

It is recommended that a case study on the development of one or more networks be included in the evaluation.

COMPLIANCE WITH RAND EVALUATION

Table 5 lists the information requested by RAND for evaluation of all pilot programs. This table also summarizes what data the Kansas Family Initiative Pilot Project proposes to collect to provide information for each item requested by RAND. How those data will be collected is also described. As can be seen by the summarization provided in this table, the evaluation plan meets the needs of the RAND evaluation team.

Table 5
KANSAS FAMILY INITIATIVE PILOT PROJECT EVALUATION PLAN: COMPARISON OF RAND REQUIREMENTS AND KANSAS PLAN

PROGRAM COMPONENT: Training of Trainers and Parent-Family Skills Training

Rand Requirements	Kansas Evaluation Plan: Data and Source
I. Information about program	
A. General program schedule	A. Training schedules (AR*)
B. Mechanism for selection of participants (parent/youth) in program.	B. Participation procedures (AR)
C. Demographic information by age group, risk factors, military (AR) minority.	C. Participation registration information for parents and children families, low-income, male,
D. Number of participants who completed program, number who left program, number of hours spent in program (including hours spent in direct contact with military person).	D. Workshop attendance records (parent/child), records of who led workshops (AR)
E. Program design: is it based on a standard program, replicated at military/non-military sites, military's role, unique assets brought to program by the military.	E. Description of program, of implementation, military role, and military assets (AR).
II. Information about evaluation	
A. Outside agency employed	A. Describe IPPBR (EC*)
B. Evaluation timeline	B. Timeline described (EC)
C. Aspect of military's efforts evaluated and impact on military readiness.	C. Description of coordination with other agencies (AR); description of change in knowledge, attitudes, drug/alcohol use by Guard personnel who participated in training (EC).
D. Aspects of the program addressed Quality, suitability, participants' perceptions/attitudes toward program. (youth, parents, trainers)	D. Quality (evaluation of implementation), Suitability (literature review), Perception/attitudes (participants' assessment following each workshop training session and during follow-up survey) (EC)

*AR = Project administration records; EC = Evaluation consultants

Rand Requirements (cont.)	Kansas Evaluation Plan: Data and Source (cont.)
E. Research design Employed control group Employed random assignment Collected baseline data Collected data immediately after intervention Collected follow-up data	E. Pre-Posttest with repeated measures No: suitable control groups not available Not applicable (no control group) Yes: repeated pretest measures Yes: posttest measures Yes: follow-up posttest measures
F. Mechanisms used to collect data	F. Surveys of parents and students, knowledge acquisition pre-posttests, follow-up interviews.
G. Data collected on drug use	G. Surveys regarding parent/child attitudes toward and use of drugs/alcohol.
H. Other outcome measures used	H. Knowledge gained as a result of training.
III. Information about program costs	
A. Direct dollar costs	A. Direct dollar costs, personnel hours invested by military, volunteers, others per family/children (AR)
B. Fixed costs	B. ?

PROGRAM COMPONENT: Parent Network

Rand Requirements	Kansas Evaluation Plan: Data and Source
I. Information about program	
A. General program schedule	A. Implementation & meeting schedules (AR)
B. Mechanism for selection of participants (parent/youth) in program.	B. Participation procedures (AR)
C. Demographic information by age group, risk factors, military (AR) minority.	C. Participation registration information families, low-income, male,
D. Number of participants who completed program, number who left program, number of hours spent in program (including hours spent in direct contact with military person).	D. Workshop attendance records, records of who led workshops (AR); Network durability (survey)
E. Program design: is it based on a standard program, replicated at military/non-military sites, military's role, unique assets	E. Description of program, of implementation, military role, and military assets (AR).

brought to program by the military.

Rand Requirements (cont.)	Kansas Evaluation Plan: Data and Source (cont.)
II. Information about evaluation	
A. Outside agency employed	A. Describe IPPBR (EC)
B. Evaluation timeline	B. Timeline described (EC)
C. Aspect of military's efforts evaluated and impact on military readiness.	C. Description of coordination with other agencies (AR)
D. Aspects of the program addressed Quality, suitability, participants' perceptions/attitudes toward program. (youth, parents, trainers)	D. Quality (evaluation of implementation), Suitability (literature review), Perception/attitudes (consumers' assessment of manual & technical assistance received)(EC)
E. Research design:	
Employed control group	E. No: suitable control groups not available
Employed random assignment	Not applicable (no control group)
Collected baseline data	Yes: number of Parent Networks existing prior to intervention and after intervention
Collected data immediately after intervention	
Collected follow-up data	Survey. Case study
F. Mechanisms used to collect data	F. Surveys of consumer's use and assessment of manual and technical assistance; case study
G. Data collected on drug use	G.
H. Other outcome measures used	H. Survey
III. Information about program costs	
A. Direct dollar costs	A. Direct dollar costs, personnel hours invested by military, volunteers, others (AR)
B. Fixed costs	B.

APPENDIX A

PARENT-FAMILY SKILLS TRAINING:
PARTICIPANT DEMOGRAPHICS

PARTICIPANT DEMOGRAPHICS

A. Descriptive information collected during registration process

1. Participants by family
    a. Number of parents participating per family
    b. Number of children per family (sex, age, and race of each)
    c. Number of children living with parents (per family)
    d. Identify which child(ren) will be participating in training (PDFY training only)
    e. Other adults living with family
2. Drug/alcohol use by family
    a. History of use (frequency, type, etc.) by
        1. Parent(s)
        2. Child(ren)
        3. Others living with family or sharing custody
    b. Outside influences or usage by
        3. Parents' friends
        4. Child(ren)'s friends
        5. Child(ren)'s friends' parents
    c. Arrests related to drug/alcohol use (number, when)
        1. Parents
        2. Child(ren)
3. Adult participants' demographics
    a. Age
    b. Education
    c. Employed
    d. Earnings
    e. Identify those on welfare, inmates, or those working with SRS regarding children, other "risk" factors
    f. Race
    g. Marital status
    h. Previous participation in parent training programs or drug abuse prevention programs
    i. Use of "formal" family meetings (if yes, how often, topics covered)
    j. Connection with military, if any