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ORIGINAL ARTICLE

Promotion of Civic Engagement with the Family Leadership Training Institute

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Highlights

- Family Leadership Training Institute had large short-term effects on civic literacy and engagement.
- Results mapping interviews with graduates found sustained levels of civic engagement.
- 63% of graduates directed at least some of their activities to marginalized populations.
- 81–90% of community activities aligned with public health priorities.

Abstract In this efficacy study, both quantitative and qualitative data were used to gauge the effects of the Family Leadership Training Institute (FLTI) on civic knowledge and empowerment, civic engagement, and community health. The sample of 847 FLTI participants and 166 comparison adults completed pretest and posttest surveys. Medium to very large short-term effects were observed in civic literacy, empowerment, and engagement. Results mapping interviews were conducted with a stratified random sample of FLTI graduates (n = 52) to assess long-term (M = 2.73 years) program impact. Most FLTI graduates (86%) sustained meaningful, sometimes transformative, levels of civic engagement after program completion. This engagement involved multiple forms of leadership, most often advocacy, program implementation, and media campaigns; 63% of graduates directed at least some of their activities to marginalized populations. Content analyses of graduates' civic (capstone) projects and results mapping story maps indicated that 81–90% of community activities aligned with public health priorities. Thus, one promising means to promote community health is to empower families to develop leadership skills, become engaged in civic life, and forge connections with diverse constituents.

Keywords Family leadership · Civic engagement · Intervention · Community health · Community organizing · Results mapping · Social capital · Social determinants of health

Introduction

A community's well-being depends critically upon its citizens' active engagement in civic life (Foster-Fishman et al., 2006; Potter, Schooley & Vermulen, 2015). For example, community-based organizations promote members' self-efficacy and civic skills as well as build the collaborative synergy among diverse citizens that is necessary for community change (Butterfoss & Kegler, 2009). In doing so, individual wellness and health behaviors are enhanced and structural barriers to good health are mitigated (Bloemraad & Terriquez, 2016). The civic health of a community is represented in actions such as voting, volunteering, being a leader in an organization, contacting public officials, and working with neighbors to solve community problems (Potter et al., 2015; Stukas & Dunlap, 2002). Writ large, such actions reflect the density and strength of meaningful connections with the broader community, including organizations, government officials,

For information about the Family Leadership Training Institute: http://fltiofcolorado.colostate.edu/

For information about the National Parent Leadership Institute: http://www.nationalpli.org/

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and causes (Neal & Christens, 2014). Thus, one potentially fruitful means to promote community health is to empower citizens to become engaged in civic life, to forge connections with diverse constituents, to address health and social inequities through systems change (Prilleltensky, 2001), and to develop leadership skills. Family leaders are especially powerful advocates for addressing disparities in children's health, social, and educational outcomes (Henderson, Kressley & Frankel, 2016). In this article, we report on the Family Leadership Training Institute's (FLTI) impact on these aspects of civic and community health.

In subsequent sections, an argument is advanced that empowering families to undertake leadership roles enhances communities' social capital (Van De Valk & Constas, 2011), especially when endeavors attend to inequities in opportunities for children and families. The research question is focused on whether an intervention that empowers family and community leaders with leadership skills and encourages civic engagement, as with FLTI, promotes community health by means of personal efficacy, building networks, fostering a commitment to collective well-being, and advocating for programs and policies related to health (Bloemraad & Terriquez, 2016; Douglas, Grills, Villanueva & Subica, 2016). Action theory (Brandtstädter & Rothermund, 2002) frames this efficacy study given that civic engagement is defined by *activities* that are focused on problem solving and assistance to others, whether alone or collaboratively, to effect change in communities (Zukin, Keeter, Andolina, Jenkins & Delli Carpini, 2006). As well, empowerment theory of community organizing (Douglas et al., 2016; Maton, 2008) is used to explain how individuals' mastery of leadership skills can be applied to community initiatives that involve identifying needs, building relationships, and increasing awareness of community concerns.

Leadership and the Development of Communities' Social Capital

A community's quality of life is linked inextricably to its social capital (Prewitt, Mackie & Habermann, 2014; Szreter & Woolcock, 2003). Typically, social capital is defined in terms of features of social organization such as connectedness to neighbors and family, norms of reciprocity, and relationships with government or groups unlike one's own (Kawachi, Kennedy & Glass, 1999; Prewitt et al., 2014). From a community cultural wealth framework, networks of people and community resources provide support for navigating systems (Yosso, 2005), which in this study was assessed with results mapping. Conceptualizations of social capital also have incorporated aspects of civic engagement, including political participation and involvement in civic organizations (Prewitt et al., 2014), likely because social capital connotes resources that are available for collective action (Kawachi et al., 1999).

Empowerment theories in community psychology (e.g., Douglas et al., 2016; Maton, 2008) focus on individuals' and groups' sense of agency as catalysts of collective action that promote community's social capital and health. As Maton (2008) noted, when citizens, especially from marginalized or oppressed groups, are empowered, their development and well-being are enhanced; they become involved in collective action, to the community's betterment; and they are more likely to mobilize for social change. These bottom-up, community-level approaches to empowerment (Douglas et al., 2016) often begin with citizens developing self-efficacy and skills in community organizing, which by means of *radiating influence* (Maton, 2008) can initiate local program development, influence public discussions, and develop state and national policies to promote well-being and social justice (Douglas et al., 2016; Neal & Christens, 2014).

Common to theories of community empowerment are a supportive relational environment and transformational leadership (Maton, 2008). The relational environment refers to multiple types of mutual assistance that enhance community well-being (Neal & Christens, 2014). Coalitions among organizations are one aspect of the relational environment: They are a conduit for consensus building, and they facilitate capacity building to address community problems (Butterfoss & Kegler, 2009). Community capacity building is considered a core competency of community psychology (Wolfe, 2014), as is community leadership, to which we now turn.

A suite of leadership skills is required to develop community social capital and effect systems change (Maton, 2008). A comprehensive literature review on skills associated with effective community coalitions (Foster-Fishman, Berkowitz, Lounsbury, Jacobson & Allen, 2001) identified multiple competencies: for example, sets realistic goals and develops a shared vision, understands the focal problem and how to address it, is an effective communicator, is skilled in group dynamics and conflict resolution, promotes power sharing, values diversity, and is well-versed in policy and community change. These competencies also define best practices in community psychology (see Wolfe, 2014), many of which are taught in FLTI (National Parent Leadership Institute (NPLI), 2016). Research also indicates that social capital is enhanced when leaders empower collaborations and civic engagement (Prewitt et al., 2014), although so far evaluation designs have not been rigorous enough to conclude that a causal relation exists between participation in leadership development programs and increased social capital (Van De Valk & Constas, 2011).

Parents—especially those from marginalized groups—often are underutilized in the development of communities' social capital (Henderson et al., 2016; Pancer, 2015). This oversight is counterproductive given that parents possess expertise on families' needs and the community resources necessary for solving problems, and have a vested stake in policies and programs that benefit their families (Shepard & Rose, 1995). Strategies that capitalize on families' insights and skills while building trusting, collaborative relationships have proven effective in educational reforms (e.g., site-based management; Comer, 2003) and in community change (e.g., Promise Neighborhoods; Geller, Doykos, Craven, Bess & Nation, 2014). Consistent with the view that families can be effective change agents, this study evaluated FLTI's impact on civic and community health.

Social Capital is Essential to Community Health

Many of the issues that compromise community health are rooted in social structures (Stukas & Dunlap, 2002). For instance, cross-national research finds that decreases in social capital, especially social cohesion—the *bonding* facet of social capital in Szreter and Woolcock's (2003) lexicon, are associated with poorer health and an array of social problems (Pancer, 2015). Similarly, a national survey of 167,259 adults found that lower trust, reciprocity, and membership in community groups were related to poorer health, even after controlling for proximal causes such as low income and smoking (Kawachi et al., 1999). Social capital may exert an influence on health through multiple pathways (see Kawachi et al., 1999), including more rapid diffusion of health information, health-related social norms, or social control (Eriksson, Dahlgren & Emmelin, 2009).

This connection between social capital and community health has prompted calls for concerted efforts to promote civic engagement and individuals' sense of social responsibility (Pancer, 2015). The priority placed on civic engagement is reflected in the 10 essential public health services, which include "mobilize community partnerships and action to identify and solve health problems" (Centers for Disease Control and Prevention (CDC), 2014). Lasker and Weiss (2003) argued that the first priority is community leadership, to catalyze individuals' involvement and collaboration. Community-based organizations (CBOs) may have a vital role in empowering citizens, especially those who are marginalized, in advocating for health-related programs and policies (Bloemraad & Terriquez, 2016). CBOs may be especially important to the *linking* facet of social capital: It comprises relationships among people across formal power gradients, and is a key to community well-being (Szreter & Woolcock, 2003). And in heterogeneous communities, the *bridging* facet of social capital—mutuality between people who are unalike—also needs to be a focus of efforts to promote community health to avoid exacerbating social inequalities (Eriksson et al., 2009; Lasker & Weiss, 2003).

Action Theory and Empowerment Models Applied to Leadership Development

Theories related to goal pursuit, such as action theory (e.g., Brandtstädter & Rothermund, 2002) and empowerment models (Cattaneo & Chapman, 2010), provide insights as to what skills leadership trainees need to acquire to advocate for vital, healthy communities. In particular, this framework accounts for persistence in goal pursuit while adjusting to obstacles to goal attainment, both of which are important to exerting social power in the service of community well-being (Cattaneo & Chapman, 2010). Action theory focuses on individuals' personal goals and the means of attaining them, whereas empowerment theory of community organizing (Douglas et al., 2016; Maton, 2008) is concerned not just with self-efficacy, knowledge of power, and social connections, but also with citizens' efforts to effect change in system-level decisions that affect their well-being.

Action theory and empowerment models have in common features that pertain to competencies FLTI fosters. Foremost among them is a recognition that people can exert influence in a variety of ways, and these actions are in relation to personally meaningful goals. Furthermore, power often is embedded in social relations, not necessarily by means of dominance but through mutual interactions, including those with systems (Cattaneo & Chapman, 2010). Thus, FLTI participants are encouraged to identify civic issues and community problems about which they are passionate, and learn how to recruit collaborators in taking action. Feelings of competence are essential to persistence in the face of obstacles to goal attainment; thus, FLTI nurtures self-efficacy, especially by gaining confidence in public speaking. The knowledge component of Cattaneo and Chapman's (2010) empowerment model includes information about how to exert influence, and reflection on the impact of actions related to goals. In FLTI, this is manifest in content related to problem-solving and conflict-resolution skills. Finally, these frameworks recognize that inherent in social contexts are opportunities as well as constraints on taking action, which in the FLTI curriculum are incorporated into modules on community mapping of assets, awareness of local institutions' structures and priorities, and social and demographic trends affecting communities.

Not infrequently, actions initially fail to achieve the desired outcome. Action theory identifies two

complementary, sometimes antagonistic, processes that are evoked when such setbacks occur: assimilative and accommodative modes (Brandtstädter & Rothermund, 2002). Assimilative processes involve persistent, corrective actions to circumvent obstacles; these may include marshalling additional resources or attempting different strategies. This adaptive flexibility entails maintenance of a focus on long-term goals but adaptability when barriers are encountered. In contrast, accommodative processes involve reframing the goal, by minimizing its importance or rescaling ambitions. These processes are relevant to civic engagement in two ways. First, leaders are more likely to persist in the assimilative mode when the importance of a goal is high and belief in the goal's attainability is strong. Second, frustration that kindles the accommodative mode often is attributable to unfamiliarity with the range of effective actions, entrapment in barren projects, or premature disengagement from goals. The FLTI curriculum aims to prevent accommodative processes by devoting multiple sessions to how state and community governance works, and how to effect change in these systems.

The social context of empowerment also is a core component of the FLTI program, given that several curriculum modules focus on marginalized groups, and disparities in health and resources. Cattaneo and Chapman (2010) note that power is not equally distributed in society, and that marginalized groups in particular have fewer opportunities to gain power. For example, in terms of civic engagement, middle-class, White populations are more likely to vote, volunteer, and contact elected officials (Christens, Speer & Peterson, 2011). Thus, empowerment programs typically recruit disenfranchised groups (Brady, Schlozman & Verba, 2015), promote awareness of power dynamics, and then help participants to develop and exercise control without infringing on the rights of others (Cattaneo & Chapman, 2010). When empowerment programs are effective, diverse citizens are more engaged and communities are healthier (Bloemraad & Terriquez, 2016), a cadre of cultural brokers may be created (Ishimaru et al., 2016), and more equitable family policies result (Henderson et al., 2016).

Interventions to Promote Family Leadership and Civic Engagement

Family leadership programs are a nascent approach to fostering civic engagement, yet rigorous evaluations of them are uncommon. Ayón and Lee (2009) used a mixed-methods design to assess the impact of a program to train neighborhood leaders, and found that leadership skills increased significantly, and graduates continued to be engaged in their communities. Evaluations of the Parent Leadership Training Institute (PLTI) and kindred programs typically find a significant increase in civic knowledge and engagement (Henderson et al., 2016), although few assess graduates beyond an immediate posttest. An offshoot of PLTI was evaluated with a mixed-methods design; participants increased in leadership and communication skills as well as various indicators of civic engagement (Cunningham, Kreider & Ocón, 2012). Several parent leadership programs have been tailored to family school relations, but their evaluations relied on case studies (e.g., Bolívar & Chrispeels, 2011; Warren, Hong, Rubin & Uy, 2009). None of the preceding evaluation studies included a comparison group, and only the Ayón and Lee (2009) evaluation assessed longer term outcomes. Thus, strengths of the current evaluation of FLTI are that a comparison group is included, and program impact was assessed up to 5 years after graduation.

This mixed-methods evaluation of FLTI had three primary objectives. First, FLTI was expected to have significant effects on civic literacy and efficacy, consistent with an empowerment model's focus on knowledge and confidence as core processes (Cattaneo & Chapman, 2010). Second, FLTI was expected to enhance satisfaction with social networks and sense of belonging in the community, given that core features of social capital are social connectedness and reciprocity in social relations. Third, FLTI was intended to have long-term effects on graduates' civic engagement and collective action, consistent with an empowerment model's emphasis on goal-oriented actions to solve problems and assist others. The evaluation was especially attentive to how graduates' endeavors contributed to community health.

Method

Participants

Intervention Group

Participants (N = 847) were recruited from 12 sites in Colorado: four were in an ethnically diverse urban area, three were in counties around small cities, and five were rural counties. Recruitment was by means of public service announcements, social media, flyers sent home from local schools, referrals from community leaders, and word of mouth. Participants identified a number of reasons for enrolling in FLTI, primary among them wanting to (a) learn specific skills that FLTI was offering (32.7%), (b) get more involved in the community (36.5%), and (c) improve the health and well-being of the family and/or community (19.8%). Demographic data collected at baseline show this to be a diverse sample in terms of age (14–

87), ethnicity, socioeconomic status, and family structure (Table 1).

A subsample of FLTI graduates participated in results mapping interviews to gauge the program's long-term impact. Selection criteria included having graduated from FLTI at least a year before the interview (M = 2.73 years), and sufficient oral English to understand and respond to interview questions; three graduates did not meet the latter criterion. A random sample of FLTI graduates, stratified by site and cohort, was selected (n = 73). Of these, 20 could not be contacted and so replacements were drawn at random from the same site and cohort. Eight participants declined to participate due to time constraints, 13 could not be contacted, and 52 were interviewed. Demographics for the results mapping participants were similar to the full FLTI sample at baseline (Table 1).

Comparison Group

A comparison group was recruited from two of the sites involved in the FLTI intervention as well as one site outside of the state. Recruitment was primarily through local schools as well as word of mouth. In all, 166 volunteers completed surveys on the same schedule as intervention participants. Demographically, they were similar to the intervention group in age, education level, parent status, and number of children. However, significant differences ($p < .05$) were observed in terms of sex (FLTI group = 81.4% female; comparison group = 63.3% female), employment, and ethnicity (Table 1).

Table 1 Participant demographics, by group

Demographic	Results		
	FLTI (n = 847)	Mapping (n = 52)	Comparison (n = 166)
Age	40.26	41.52	43.97
Education			
High school degree (%)	19.1	23.8	26.3
GED (%)	12.9	4.8	11.4
College degree (%)	21.0	23.8	22.2
Graduate degree (%)	11.1	19.0	13.8
Employment			
Full time (%)	43.9	38.3	55.9
Part time (%)	20.8	19.0	17.6
Median income	$30,800	$28,018	$29,800
Marital status			
Single (%)	21.3	14.3	10.6
Married (%)	58.2	61.9	56.5
Separated/divorced (%)	19.4	19.0	24.7
Ethnicity			
Black (%)	11.7	7.8	17.2
Latino (%)	44.3	19.0	17.2
White (%)	36.3	58.9	37.3
Is a parent (%)	73	77	84
Number of children	2.26	1.93	2.15
Family member with special need (%)	32.1	34.6	34.4

The Results Mapping group is a subset of the FLTI intervention group who graduated at least a year prior to being interviewed.

Family Leadership Training Institute

FLTI is based on the Parent Leadership Training Institute; details of the curriculum are found on the National Parent Leadership Institute's (2016) website. FLTI's goal is to increase participants' civic engagement through leadership and civic skills development, civic education, and networking with community leaders. Phase 1 establishes awareness and activation of personal leadership skills, including public speaking, conflict resolution, and self-actualization. Phase 2 features 10 weeks of civic engagement modules customized for the local governance structure, with a focus on skills and knowledge necessary for systems change. Both phases attend to family functions, child development, and assets and needs of children and families. FLTI develops a sense of community through a full-day retreat and weekly 4-hour meetings over 20 sessions. Shared mealtime and on-site childcare are provided. The manualized curriculum, involving mastery of sequential competencies and weekly homework, includes a variety of experiential activities related to community and team building, peer learning, mock debates and role plays, community mapping, public speaking, field trips to the state capitol, and guest panelists of community leaders and activists.

The capstone of the FLTI program is a community-based civic project designed to address some societal (i.e., community, health, or educational) issue. Participants explore these issues in the context of how to identify a problem and conduct a needs assessment, learn from elected officials and community leaders, and develop a strategy to address the problem. Such problem-based learning is a potent pedagogical approach because it engages learners in critical thinking, entails research to find and assess resources for effective solutions, and nurtures expertise in problem solving and communication (Connor-Greene, 2006). Support for developing the civic project is provided throughout the program by examining social trends and data sources, and coaching by the facilitation team. Participants develop an advocacy outline to guide their project to implementation, which often is driven by a personal experience of social or health inequity. Throughout the program, participants present a synopsis of their project in oral and written form to practice leadership and civic skills. Ideally, participants will have developed fully their community projects but few will have had time to implement them by the program's conclusion.

A team of four local facilitators delivers the course content; all receive training and credentialing according to NPLI standards. They must live in the local community and reflect the cultural tapestry thereof. The facilitators must be skilled in group dynamics and adult learning theory, and recognize the value of family leaders as change agents. FLTI encourages sustainability of the program by recruiting graduates to become facilitators. The facilitators are supported in the weekly operations of the course by a local site coordinator, who must have strong ties to multiple sectors of the community.

Measures of Program Impact

The outcome measures used to assess FLTI's impact were developed in conjunction with the PLTI's evaluation at other national sites (Frankel, Kressley & Henderson, 2014). The national evaluation reported changes on individual items but in this study, the items formed reliable scales. Cronbach's alpha coefficients are given for this sample. The first four multi-item scales described below were significantly intercorrelated, $r = .31–.47$, $p < .001$, but not so strongly as to warrant compositing them into a single measure.

Civic Literacy and Empowerment

This scale ($\alpha = .92$) includes 10 items that focus on knowledge about how to solve community problems, rated from 1 (*none of the time*) to 4 (*all of the time*). Example items include, "When problems arise within my community, I do something about them" and "I understand how public policy affects my community."

Civic Knowledge

Five yes (1) or no (0) items ($\alpha = .80$) were asked in relation to understanding of how state laws and budgets are made as well as knowledge of local representatives (see Table 3). Mean scores on this scale could range from 0 to 1.

Current Skills and Activities

This scale ($\alpha = .86$) is the mean of 13 items on involvement in activities to effect community change (see Table 3), each rated from 1 (*never*) to 5 (*daily*), with zero indicating "I don't know what this is" and "I don't know how to do this." Many of these items have been used elsewhere as core indicators of community engagement (Keeter, Zukin, Andolina & Jenkins, 2002). Given FLTI's focus on family functioning and needs, a single item asked about participants' confidence in their knowledge of the stages of child development, rated from 1 (*I don't know what you're talking about*) to 4 (*Very confident*).

Civic Engagement

This scale ($\alpha = .72$) encompasses six activities such as attending board meetings, making presentations, using the media, and contacting elected officials, each answered yes or no. In addition, respondents indicated whether they voted—78% of FLTI participants and 81% of the comparison group said yes at pretest—and how many hours per week they volunteered in the community (range = 0–50); 34.2% of FLTI participants and 43.7% of comparison participants did not volunteer.

Support Satisfaction

Two intervention cohorts completed the Social Network Questionnaire's 8-item, yes/no measure of satisfaction with support; for example, wanting more people in their network or in whom to confide. Alpha reliabilities exceed .80 ($\alpha = .81$ in the current sample); support satisfaction correlates with self-efficacy and mental health indices across ethnic groups (MacPhee, Fritz & Miller-Heyl, 1996).

Connectedness to Community

Two intervention cohorts also completed the 10-item Social Connectedness Scale (Lee & Robbins, 1995). The items, rated from 1 (*disagree strongly*) to 6 (*agree strongly*), assess sense of belonging to one's community (e.g., "I don't feel I participate with anyone or any group," reversed) and feelings of respect (e.g., "In my community, my opinion is taken seriously"). The scale has high internal consistency ($\alpha = .86$ in this study) and good factorial validity.

Civic Projects

We evaluated participants' projects for the years 2009–2017 in two ways. First, the focus of each civic project was coded using directed content analysis (Hsieh & Shannon, 2005). This type of content analysis is informed by previous work that identifies key variables, in the present case health-related topics that were core objectives of The Colorado Health Foundation (a program funder). Each topic aligns with the broader essential public health activity to mobilize community partnerships and action (CDC, 2014). Interrater reliability for two coders was high, $\kappa = .92$. Second, the results mapping interviews with FLTI graduates included questions that focused on progress made in implementing the project and how they assessed outcomes.

Results Mapping

Results mapping (Kibel, 1999) was used to assess the extent to which participation in the FLTI program had an enduring effect on families and communities. Results mapping is well suited for programs that engage in transformation and prevention, in that it focuses on client narratives about actions taken over time to benefit others (Kibel, 1999). Interviews focused on leadership topics similar to those suggested by Frankel et al. (2014). Process evaluation questions concerned aspects of the curriculum that left a lasting impression. The corpus of interviews focused on eliciting detailed narratives about how knowledge and skills gained in FLTI were used, in the form of "who did what (actor), for whom (recipient), with what result?" Related to action theory, graduates also described what happened when they encountered roadblocks or failures.

Contributions to community health were captured in two ways. First, graduates described how FLTI might have an impact on public health. Second, initiatives in each map (narrative) were coded for their relevance to public health priorities and whether the initiatives served marginalized populations, defined as groups who are denied full involvement in social, political, and economic activities, or groups who differ from perceived norms (David, 2014).

Trained interviewers administered the interview protocol. Recorded interviews were coded in accordance with guidelines described in Kibel (1999). Specifically, narratives were coded for instigation of change (e.g., advocacy), which typically was done by participants; implementation of change, which in 11.6% of instances was done by another entity; and being the recipient or beneficiary of the action. For example, in Map 1, Participant 126 (see Appendix 1) received action points for speaking to his children's PTA about the school's use of sugary snacks, and advocating for use of locally purchased healthy snacks; the PTA received points for being a recipient of this advocacy. Map 2 would involve a *handoff* such that the PTA, with support from the school principal, then implemented the change that benefited the school's 350 students. The second element in such sequences of actions was assigned a *leverage multiplier* of 0.50 instead of 1.00 because the ultimate action was one step removed from the graduate's instigation of change, or because the action could not be attributed to FLTI's impact.

Story points also were determined by potential impact, based on Kibel's (1999) 7-level hierarchy. This hierarchy reflects (a) actively applying knowledge as opposed to passively absorbing information, (b) being an independent change agent who demonstrates enduring mastery of FLTI precepts, (c) achieving "milestone" activities that involved follow through and leadership, and (d) having a multiplier effect such that multiple individuals and groups are affected by the agent's activities. Thus, Action and Recipient points were both derived from the level of leadership growth and involvement or impact; each was multiplied by the number of people involved, categorized from 1 (*one person*) to 10 (*10,001 + people*), and by the leverage multiplier (i.e., whether the action could be attributed to the graduate's involvement in FLTI or a handoff to another entity was involved). *Story scores* were the sum of Action and Recipient points across all maps (i.e., individual action-recipient narratives), including the civic project. Typically, only activities conducted in the role of a volunteer contribute to Action and Recipient points. However, 19 participants (36%) reported that they transferred skills learned in FLTI directly into their professional lives, to the benefit of clients or the broader community. These maps were included in the story scores, but not narratives involving other professionals as initiators of actions, to represent more accurately the long-term effects of FLTI on participants.

Results mapping yields numerical scores in terms of overall story scores as well as maximum level attained, but no standard has been proposed to indicate meaningful change. We turned to Grove, Kibel and Haas's (2005) EvaluLEAD framework for guidance given that it describes three types of outcomes in leadership development programs. First, *episodic results* involve knowledge gains (e.g., facts and opinions) that can be assessed with pretest and posttest surveys; these would be at Level 2 in the results mapping metric. Second, *developmental results* are small successes in the service of a larger goal that depend in part on available opportunities and one's motivation to change, which would be at Levels 3 and 4 in the results mapping metric. Developmental results are similar to Foster-Fishman et al.'s (2006) description of leveraging change, or actions necessary to have a lasting impact on collective action in community systems. Finally, *transformative results* indicate shifts in life status of individuals or a community resulting from program participation; for example, marked alterations in vision or perspective, career shifts, changes in organizational direction, and policy changes, all of which would be at Levels 5–7.

As a check on the EvaluLEAD framework's applicability to FLTI, we asked eight FLTI leaders with extensive experience in the program to identify the lowest results mapping level indicative of meaningful change. All stated in some way that meaningful change meant taking action that involved leadership, initiative, problem solving, and/

or proactive communication. The experts' consensus was that Level 3 is the minimum standard for meaningful impact of FLTI; this level entails the provision or receipt of short-term service such as regular tutoring, training, education, or leading support groups. To put these levels into context, see Appendix 1 for exemplars of low-, medium-, and high-impact story scores.

Related to action theory, Participant 515′s frustrated attempts to instigate community change (see Appendix 1) illustrate Brandtstädter and Rothermund's (2002) description of accommodative processes: stuck in unfruitful projects, difficulties generating alternative solutions, limited institutional resources, and premature detachment from goals. Conversely, Participant 126 used multiple strategies to effect change when obstacles were encountered, which illustrates the concept of adaptive flexibility.

Coders were trained to criterion before data collection began, using Kibel's (1999) guidelines. Two trained coders independently scored 33% of the interview transcripts, $r = .92$ for the story score and $ICC = .82$ for the maximum level. Agreement was 100% for whether the maximum level met or exceeded the threshold of meaningful change (Level 3). Coders discussed discrepancies to consensus. Related to validity, the overall story score is reflective of the number of maps generated ($r = .82$) and the maximum level attained by participants ($r = .81$), $p < .0001$. Thus, higher story scores represent more extensive community engagement as well as sustained growth in leadership activities over time.

Perceptions of FLTI

The implementation evaluation at two sites included critical incident questions that asked participants ($n = 58$) about activities that "strengthened your understanding of the importance of civic engagement and leadership." In addition, an open-ended question on three cohorts' posttest asked graduates ($n = 384$), "How would you describe your FLTI experience?" Directed content analysis (Hsieh & Shannon, 2005), linked to curriculum modules, was used with both sets of responses ($\kappa = .81$). Finally, three posttest items asked graduates to rate their satisfaction with what they had learned from the FLTI curriculum.

Procedure

All procedures, including informed consent, were approved by the university's Institutional Review Board. Participants completed baseline and 20-week posttest surveys either as group-administered paper-and-pencil forms or, in later cohorts, by means of Survey Monkey. Interviews for results mapping were conducted in person or by phone, and were recorded for later coding.

Group Equivalence and Attrition

Preliminary analyses were conducted to determine group equivalence at baseline. The two groups were not equivalent on several demographic variables, as described previously, and on one of the seven baseline measures of program impact. Using t tests, a significant difference ($p < .001$) was observed on Civic Literacy and Empowerment (Table 2). Propensity score matching (Austin, 2011) was not used to equate the groups because nearest neighbor matches could not be made with sufficient precision (i.e., a caliper width equal to 0.2 of the pooled *SD* of the logit), and it would compromise statistical power. Repeated-measures ANOVAs showed that none of the demographic variables (i.e., gender, ethnicity, and employment) explained significant variance in treatment group effects on the outcomes in Table 2.

Attrition was similar in the intervention (19%) and comparison (21%) groups. Exit surveys with those who withdrew from the intervention group indicated that the majority left the program because of family commitments or stressors (38.1%), work commitments (32.4%), or illness (13.3%). Less frequent were complaints about the difficulty or relevance of the FLTI program (8.8%);

Table 2 Mean (*SD*) changes in civic engagement, by intervention group

Outcome	FLTI ($n = 847$)		Comparison ($n = 166$)		$F_{G \times T}$	η_p^2
	Time 1	Time 2	Time 1	Time 2		
Civic literacy & empowerment	2.09 (0.74)	2.81 (0.70)	2.90 (0.78)	2.80 (0.61)	268.82***	.210
Civic knowledge	0.29 (0.34)	0.86 (0.23)	0.36 (0.24)	0.36 (0.26)	429.01***	.322
Child development knowledge	3.55 (1.08)	4.24 (0.85)	3.78 (1.10)	3.82 (0.93)	101.48***	.158
Current skills & activities	2.04 (0.88)	2.77 (0.87)	1.94 (0.92)	1.75 (0.56)	170.93***	.164
Civic engagement	0.44 (0.29)	0.70 (0.25)	0.46 (0.33)	0.45 (0.27)	115.96***	.103
Volunteer hours per week	3.99 (7.21)	5.23 (7.31)	3.51 (6.81)	3.58 (7.14)	20.47***	.047

$F_{G \times T} = F$ value for Group by Time interaction effect. An effect size (η_p^2) of .01–.06 is considered small; .06–.14 is considered medium; and >.14 is considered large.

*$p < .05$; **$p < .01$; ***$p < .001$.

86.5% of dropouts rated the program as valuable or very valuable. Differential attrition was assessed by comparing participants who completed the posttest to those who had not. Univariate analyses were conducted on 10 demographic variables and the eight outcome variables measured at baseline. No significant differences were observed between those who completed posttests and those who did not.

Next, missing data were imputed using a multiple imputation strategy recommended by Schafer and Graham (2002). The fully conditional MCMC method was used to impute missing data for normally distributed dependent variables. It assumes an iterative approach that fits a single variable using all other variables in the model as predictors and then imputes missing data for the single variable being fit. The method continues for each variable in the model to the maximum number of iterations specified, which was 20 in this study.

Plan of Analysis

Repeated-measures ANOVAs, with group as the between-subjects factor, were used to assess program impact on the outcome measures between baseline and the follow-up. We focus on Time by Group interactions because these indicate differential changes in the intervention versus comparison groups over time. Preliminary analyses indicated that site differences were negligible ($\eta_p^2 < .04$), so multilevel modeling was not used.

Results

Change in Civic Empowerment, Knowledge, and Engagement

Short-term gains at program completion were statistically significant, with medium to very large effect sizes. Compared to no changes in the comparison group, FLTI graduates reported significantly greater (a) civic literacy, (b) knowledge of the policy-making process and ability to identify elected officials, and (c) confidence in how to address community issues (see Table 2). Participants showed a 4- to 10-fold decrease in having no knowledge of how state laws and state budgets are made, as well as who their local representatives are (see Table 3). Using McNemar's test, all of these changes on items in the Civic Knowledge scale were statistically significant. As well, confidence in knowledge of child development increased significantly; this differential change relative to the comparison group was a medium effect size (Table 2).

Turning to the FLTI objective related to participants becoming change agents in their communities, significant increases were observed on all outcome measures related to actions that are taken to advocate for an issue or policy, community organizing, and developing projects that address community needs. Specifically, significant increases were obtained on Current Skills and Activities as well as on Civic Engagement; both effect sizes were much larger than typical (Table 2). These scale scores can be disaggregated into specific core indicators of civic engagement (Keeter et al., 2002) such as those found in Table 3. Using McNemar's test, especially large increases were observed in (a) advocating for an issue or public policy, (b) problem-solving skills, (c) developing projects or programs to address community needs, and (d) using outcome data to assess program impact, all of which are addressed in depth by the FLTI curriculum. No changes in voting were found, likely because major elections were not held during the spring when the FLTI program was offered. However, participants did show a significant increase in volunteering in their communities (Table 2), a change relative to the comparison group that represents a small effect size.

Changes on the primary outcomes were not due to just a few graduates benefiting from FLTI. To illustrate this, we first partitioned the entire sample into quintiles, based on the mean of pretest scores for civic literacy,

Table 3 Change in percent of FLTI group reporting no knowledge of civic processes and skills

	Pretest	Posttest	χ^2 (n = 710)
Civic Knowledge			
Know how state budgets are made	85.5	17.2	388.85***
Know how state laws are made	64.1	6.1	335.23***
Know who your city government rep is	67.2	12.8	312.36***
Know who your state representative is	68.5	17.5	287.11***
Know who your state senator is	66.8	17.8	273.17***
Current Skills and Activities			
Advocating for an issue or policy	26.5	6.9	115.42***
Public speaking	7.2	2.8	15.79***
Community organizing	12.6	4.4	36.10***
Problem solving	6.3	1.8	21.84***
Consensus building	26.6	7.5	98.12***
Review or analyze budgets	10.1	3.8	25.81***
Volunteer in a community organization	6.6	2.1	21.84***
Participate on a board	10.9	6.8	11.70**
Call on or involve the media	15.1	7.9	25.25***
Engage in policy development	19.5	8.6	42.84***
Assess community assets	19.5	6.7	39.19***
Develop projects for community needs	17.9	4.3	71.68***
Use outcome data to assess outcomes	22.4	6.5	78.57***

*$p < .05$; **$p < .01$; ***$p < .001$.

skills, and engagement. We computed an average gain score for these outcomes as the percent of the maximum possible change. As illustrated in Fig. 1, FLTI graduates showed gains regardless of their pretest score, although a monotonic decrease in gain scores was evident as the pretest score approached ceiling. Within each quintile, treatment effects were evident, with the smallest group difference being observed in the highest (fifth) quintile, $t(205) = 6.51$, $p < .0001$, Cohen's $d = .69$.

We conducted exploratory analyses to determine whether any of eight baseline demographic variables, plus volunteer hours, moderated program impact as assessed by gain scores on the four measures in Table 2 of civic knowledge and engagement. With the Bonferroni correction for multiple tests, p was set at .001. Two correlations met this criterion: Participants who reported doing more volunteer work at baseline showed smaller gains on the measures of Current Skills and Activities, $r = -.14$, and Civic Engagement, $r = -.11$. However, both were small effect sizes.

Given that both critical incident reports and results mapping interviews indicated social networking and connectedness to the community to be important benefits of FLTI, we included measures of these two outcomes for the latest two cohorts of the intervention group. A small but significant increase from 28.73% to 36.25% was observed in support satisfaction, paired $t(195) = 3.93$, $p < .001$, Cohen's $d = .28$. Similarly, a small but significant increase in social connectedness was obtained, pretest $M = 4.73$ ($SD = .79$) to posttest $M = 4.95$ ($SD = .72$), paired $t(184) = 4.05$, $p < .001$, Cohen's $d = .29$.

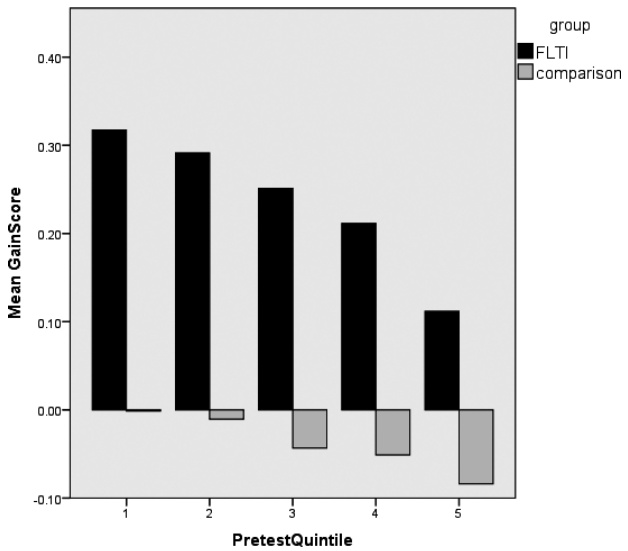

Fig. 1 Mean pretest/posttest gain score in civic literacy, skills, and engagement, by pretest quintile and intervention group.

Civic Projects and Public Health

Content analysis of 738 civic project proposals revealed that 90% were consistent with at least one of The Colorado Health Foundation's objectives (Table 4). Health coverage (e.g., for uninsured families) and health care were uncommon foci as compared to community needs related to healthy living (e.g., activity programs for children; community gardens) and preventive health. Child development and prosocial development were promoted in civic projects that focused on, for example, increased access to early childhood education, school mentoring, restorative justice with youth, and father involvement in children's lives.

In the results mapping interviews, graduates discussed their progress in implementing civic projects: 59.6% completed their project, and 48.1% of projects were still active. When asked to describe obstacles or setbacks to project completion, 21% of graduates said "none." Others identified pragmatic issues such as limited time (35.4%), funding (12.5%), or expertise (12.5%). Several themes mirrored action theory's assimilative processes. For instance, 23% said they encountered competing interests or community priorities that necessitated collaboration or changing direction. Also, 37.5% experienced limited support for their proposal when more social capital was needed, as when a city council's initial response to a community fund-raising proposal was that "we were just a bunch of gabby women selling cupcakes." Parenthetically, the city council was persuaded to support the fundraiser, and one council member became a speaker at an FLTI session. Finally, 12.5% talked about the importance of idealism, but this passion needed to be leavened with pragmatism when addressing community problems.

We coded graduates' story maps for their relevance to public health using the same content themes that were applied to the civic projects. The public health foci of the story maps were similar to the foci of the projects (Table 4), with the exception of preventive health, which

Table 4 Public health foci of civic projects and graduates' community initiatives

Public health focus (%)	Civic projects ($n = 738$)[a]	Community initiatives ($n = 329$)[b]
Health coverage	1.76	0.71
Health care	6.64	8.51
Preventive health	30.49	13.98
Healthy living	16.12	14.28
Child development	34.01	26.75
Prosocial development	17.76	13.98
At least one public health focus	90.00	80.80

[a] n is smaller than the number who completed surveys because civic projects could be done in groups.
[b] Sample size represents the total number of maps (individual initiatives) generated by the 52 FLTI graduates who were interviewed.

was much less common in the story maps, $\chi^2(1, N = 1067) = 33.58$, $p < .0001$. Story maps also were coded with respect to whether the action was meant to benefit a marginalized group; 63.5% of graduates described at least one such activity.

One results mapping question asked graduates to describe how FLTI contributed to public health. The 72 meaning units cohered into six themes, not including two respondents who did not believe FLTI was germane to public health. A direct connection was evident in descriptions of projects that promoted health (30% of meaning units), especially mental health, as well as knowing how to navigate systems (12%); e.g., "If you recognize something is wrong, you provide resources and you point people in the right direction." Many graduates described a connection between empowerment, or advocacy, and community health (32%), as articulated by this community leader: "If we had not empowered the community members to use their voice, to show up for the conversation, there's no way for us to know what needs to be funded. . . . They understand why people are falling through the cracks." Another 14% of statements pertained to FLTI's promotion of social capital, by means of attention to social cohesion as well as civic engagement that ". . . promotes emotional and mental health because people feel less disconnected or like they belong." Finally, 10% concerned FLTI's focus on diversity and social justice; e.g., "You can understand other people's struggles and obstacles. It contributes to mental health."

Long-Term Effects: Results Mapping

Overall story scores ranged from 5.00 to 147.00 ($M = 69.71$, $SD = 42.30$), with the exception of one outlier's score—a graduate who became a policy analyst—equaling 227.00. With this outlier's score winsorized, the story scores approximated a normal distribution. Most graduates (86.5%) were involved in community activities that met or surpassed the threshold of meaningful program impact, or Level 3, and 35% of those interviewed reported transformative changes at Levels 5–7.

Story scores were subdivided into four categories: service points, village building points, networking points, and self-determination points. The most common types of service points[1] were (a) initiated a community-wide fund-raising effort on behalf of a cause (15% of graduates), (b) implemented a support or service program lasting at least 6 months (50%), (c) became an FLTI facilitator (27%), and (d) started a nonprofit organization (14%). Village building and networking involve similar processes but the former pertains to actions taken and the latter concerns benefits to recipients. Examples of village building included (a) joined a community board (25%); (b) spoke at a meeting of the city council, county commissioners, or school board (25%); (c) advocated for a policy initiative with elected state officials (14%); and (d) conducted a media campaign to disseminate information about a community need, issue, or service (21%). In some instances, a sequence of village building and networking involved a handoff such that a graduate would advocate for an action to an entity with power, such as city council, who then would enact change affecting the populace. For example, one graduate advocated to the school board that home visitors be hired to serve low-income neighborhoods, and the school board then implemented a Neighborhood Navigators program. Finally, self-determination maps involved the graduate as both actor and recipient, typically related to personal growth or seeking resources to improve family well-being. Almost half (45%) of graduates described some form of change or activity, attributable to FLTI, that benefitted the self, including greater professional development, attaining more education, or being empowered to leave a poor relationship.

We examined several possible explanations for variations in graduates' maximum level attained and overall story scores. First, no mean differences were observed in relation to site, $p > .38$. Second, earlier graduates might have more opportunities to accumulate community activities, but time since graduation was not associated with either maximum level attained or the overall story score, $p > .63$. Third, FLTI participants are not required to implement their civic projects, yet doing so might jumpstart their community engagement. However, the difference in the overall story score, favoring those who did complete the project, was minimal once points awarded for completion of the civic project were excluded, $d = .23$, $p = .41$. Finally, the pretest measures of weekly volunteer hours, $r = .41$, and Civic Engagement, $r = .44$, were significantly related to the overall story score, $p < .05$, but none of the other pretest variables or gain scores approached significance.

Were there any defining characteristics of the seven graduates for whom FLTI did not have a meaningful impact; that is, a maximum Level of 2 and story scores below 20? These graduates' comments about obstacles encountered in completing their projects and engaging in civic activities revealed four impediments to taking action: They did not get the help needed, including community connections, to complete civic activities ($n = 3$); they were too busy with work or family obligations ($n = 4$); they already had extensive experience in the nonprofit world ($n = 3$); and although they gained self-confidence, they were more comfortable being consumers of information as opposed to taking action ($n = 3$).

[1] Note that the types of service and village building are similar to many of the Civic Skills and Activities survey items (see Table 3).

Participant Satisfaction

In the critical incident narratives and results mapping responses, participants consistently identified six key features of FLTI that left an enduring impression on them. These were the development of personal and professional networks (46.5%) as well as civic skills (44.2%) and community involvement (46.5%), with the Day at the Capitol being the activity that was most often mentioned (36.5%). Other insights noted multiple times related to communication skills (50%) and policy making (50%).

Graduates' perceptions of FLTI were strongly favorable. First, a single survey item asked, "FLTI has helped me to improve the well-being of my family and community;" $M = 5.75$ where six is "strongly agree." Second, the mean on two general satisfaction items exceeded 3.75 where four is "strongly agree." Last, content codes of graduates' brief descriptions of their FLTI experience revealed seven themes that were endorsed by at least 15%: (a) general superlatives such as "life changing," "enlightening," "inspiring," and "phenomenal" (48.1%); (b) civic skills and involvement (34.6%); (c) networking or social bonding (31.9%); (d) confidence gained (29.6%); (e) leadership skills (17.3%); (f) communication skills (16.2%); and (g) FLTI curriculum and facilitation (34.2%). Seven of the 384 respondents indicated that the time commitment was onerous; no other drawback received more than three mentions.

Discussion

In this efficacy trial, the Family Leadership Training Institute was found to have a substantial impact on civic knowledge, confidence, and engagement; effects related to civic engagement endured for as much as 5 years. These effects were consonant with FLTI's grounding in empowerment frameworks (Cattaneo & Chapman, 2010; Maton, 2008) and alignment with action theory (Brandtstädter & Rothermund, 2002). This is the only evaluation so far of a family leadership program to include a comparison group and assess long-term outcomes. Thus, a case can be made that participation in FLTI—which emphasizes empowerment, leadership development, civic engagement, and collective well-being—does contribute to greater social capital (Van De Valk & Constas, 2011) as well as community health (Bloemraad & Terriquez, 2016).

Effects of FLTI on Civic Engagement

When making decisions regarding policies that affect children and families, legislators often consider economic implications yet rarely take into account a family perspective or evidence from research conducted with families (Bogenschneider, 2014). However, family centered programs produce intended outcomes more effectively and efficiently (Dunst, Trivette & Hamby, 2007). Some government programs have made greater efforts to include family leaders in policy decisions, as with revisions to the Title V Maternal and Child Health (MCH) Service Block Grant that provides incentives to programs that involve families in decision making. An evaluation of state MCH and Children with Special Health Care Needs programs found that a key barrier to inclusion of family leaders, especially across diverse backgrounds, was a lack of effective recruitment strategies (Association of Maternal and Child Health Programs, 2016). Thus, despite a growing recognition that involving families in policy and programmatic decisions is beneficial, policymakers, and interventionists generally are remiss in recruiting capable, knowledgeable family leaders.

FLTI begins to address this problem, given that the curriculum provides in-depth training in family leadership skills; experiential learning related to civic engagement; and information about community needs, assets, and health disparities. Notably, FLTI is not a direct-service program so much as an intensive educational experience to empower graduates to effect systems changes regardless of specific community need or locale (Henderson et al., 2016)—the radiating influence of empowered graduates (Maton, 2008). For example, in results mapping interviews, multiple graduates reported that they had since moved to other communities yet were still successful at building social capital and employing their leadership skills across different contexts.

What might account for FLTI's effectiveness? Graduates highlighted several processes that are imbued in action theory (Brandtstädter & Rothermund, 2002) and empowerment models of community change (Maton, 2008), key among them an integration of idealism with pragmatism. Graduates talked about the importance of finding a passion that one is willing to advocate for, which in part accounts for the various manifestations of civic engagement, especially on behalf of children and marginalized groups. This commitment to a cause may predate enrollment in FLTI given that the only pretest variables associated with results mapping story scores were involvement in volunteer work and other forms of civic engagement. Yet family and community leaders often encounter obstacles to goal attainment, as was the case with their civic projects, and so the FLTI curriculum prepares them with a toolbox of knowledge and problem-solving strategies. Skills that were identified consistently across surveys and qualitative data included effective communication, how government works and how to

influence policies, and the importance of recruiting collaborators (Cattaneo & Chapman, 2010) and building a support system (Maton, 2008). Related to the latter outcome, significant increases were also observed in support satisfaction and connectedness to the community.

One impediment to community engagement for some graduates was a preference to consume information as opposed to engage in advocacy. This suggests that interventions such as FLTI might assess participants' resourcefulness or grit (Duckworth, Peterson, Matthews & Kelly, 2007) as a moderator of program impact. An alternative explanation is that these graduates did not gain sufficient confidence to advocate for an issue (Cattaneo & Chapman, 2010), or did not experience a personal transformation of the sort described in the PLTI's focus groups (Henderson et al., 2016). Even so, examples of accommodative processes—curtailing goal pursuit—were uncommon. Rather, results mapping interviews documented multiple instances of personal transformations in the form of self-determination maps, which typically resulted in enhanced confidence that may contribute to recruiting support and enhancing political influence (Henderson et al., 2016; Maton, 2008). This self-efficacy is an important ingredient of assimilative processes, which enables leaders to persist in the face of obstacles and setbacks (Brandtstädter & Rothermund, 2002).

Effects of FLTI on Community Health

Civic engagement is 1 of the 10 essential public health services (CDC, 2014), in large part because it is a constituent of the social capital that is foundational to community health (Pancer, 2015). Consistent with these priorities, most FLTI graduates' civic project proposals and later community activities focused on at least one public health priority, most frequently vulnerable populations such as children and marginalized groups. The fact that two-thirds of graduates engaged in activities on behalf of marginalized groups indicates that FLTI promotes the bridging facet of social capital, to the betterment of community well-being (Lasker & Weiss, 2003). The emphasis of civic activities on vulnerable populations is consistent with community psychology's values (Prilleltensky, 2001), especially the critical importance of advocating for families' well-being (Shepard & Rose, 1995), and mirrors FLTI's attention to societal power dynamics as well as social policies contributing to inequities that manifest in health disparities.

The linkage between social capital and community health also was evident in graduates' reflections on how FLTI might promote public health. Many interviewees prefaced their response with something akin to, "I had not thought about FLTI in that way," but then proceeded to discuss projects that promoted mental health and safety. Beyond the content of civic actions, perhaps more intriguing were insights about mechanisms that contribute to community well-being or cultural wealth. Among these were resources to help people navigate systems (Yosso, 2005); empowerment of families to identify community needs and assets (Shepard & Rose, 1995); promotion of social cohesion, or the bonding facet of social capital (Szreter & Woolcock, 2003); and work on behalf of equity, diversity, and social justice that ultimately makes communities healthier (Bloemraad & Terriquez, 2016; Douglas et al., 2016) and family policies more equitable (Henderson et al., 2016). These graduates' perspectives suggest that future evaluations of family leadership programs might consider assessing outcomes related to social capital, particularly openness to diversity.

Limitations and Applications

The strengths of this efficacy study notwithstanding, several limitations should be noted. First, we used a quasi-experimental design (QED) rather than random assignment to groups. Studies show that QEDs may overestimate program effects unless groups are carefully matched, especially on pretest measures of the outcome (Mihalic & Elliott, 2015). Offsetting this concern, stratification analyses (Austin, 2011) related to Fig. 1 do indicate robust intervention effects within each pretest quintile. Even so, a next step in evaluating programs such as FLTI should be to conduct randomized controlled trials of its impact. Second, although results mapping provided rich information about long-term effects on participants, especially how skills and knowledge translated into actions, supplemental survey data would be useful in tracking maintenance of leadership skills acquired during FLTI.

An agenda for future research on family leadership programs should include assessment of community-level effects, especially whether policies have been enacted that are attributable to family leaders' influence, and whether community health indicators—including health disparities—improve subsequent to implementation of programs that empower family leaders (e.g., Douglas et al., 2016; McAllister, Thomas, Wilson & Green, 2009). Also, one precept of NPLI (2016) is that parenting is a form of leadership. Thus, graduates of FLTI should be more capable parents in terms of effective communication, conflict resolution, family cohesion, and democratic rearing practices. However, this hypothesis remains unexamined. More broadly, FLTI graduates recognize that their leadership skills may extend beyond their own families to affect their communities, by means of advocating for policies that strengthen all families. Although much work remains to

be done to promote civic engagement and citizen's social responsibility (Pancer, 2015; Zukin et al., 2006), FLTI is a viable approach to enhancing community well-being and moving the needle on social determinants of health.

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Appendix 1

Low Impact (Levels 1–2)

Participant 515 lived in a rural county with a high rate of heroin abuse; deaths due to drug overdoses tripled in 10 years. This drug epidemic motivated him to learn how to speak out to address the issue, especially with the police, and so he agreed to enroll in FLTI when invited. He said that FLTI gave him confidence to speak in public, and to be more involved politically. As a result, he now votes regularly and pays more attention to political issues. He also repeatedly contacted law enforcement when he observed drug activity in his neighborhood, but the police did little to address the issue. His civic project was to bring police officers and youth together in a positive youth development program, but the project was not launched because of his work obligations and lack of support from volunteers. He repeatedly expressed frustration that local officials are not being more proactive in addressing drug abuse, but he has not yet taken the initiative to speak out through the media or to city council, nor has he sought resources to initiate his program. Thus, his highest actions were at Level 2, indicating that he received knowledge about how to advocate but has not yet effected change in the community. [Overall story score = 18.5]

Moderate Impact (Levels 3–4)

Participant 126 was motivated to enroll in FLTI to make the community more supportive of children. His civic project was meant to teach youth how to cook, and to encourage families to share mealtime, but the project was not initiated. After graduating FLTI, he noticed that changes to road signage were routing truckers through his residential neighborhood, thus endangering children who played along the street. He contacted the Department of Transportation (DOT), spoke to City Council, and organized neighbors to attend City Council meetings as well as to write letters to the local paper. As a result, City Council directed DOT to reroute trucks and increase traffic enforcement, which would represent a handoff or ripple effect. Participant 126 also advocated with local schools, with the help of PTAs, that they use locally purchased, healthy snacks for fundraisers rather than sugary snacks, an effort that was successful. He summarized FLTI's impact as making him a more active, involved citizen. His highest action—speaking to City Council—was at Milestone 4. [Overall story score = 61.5]

High Impact (Levels 5–7)

As a result of FLTI, participant 8611 got involved in various volunteer activities, including serving on her HOA board and volunteering in her son's classroom. The latter experience led her to join the PTA, later becoming its president and thus positioning her to advocate on behalf of all families in the school. She also formed a support group for mothers that eventually included 63 women; as it expanded, she created a board of directors for it and it achieved nonprofit status because of her initiative. This endeavor was a springboard for her to become a frequent facilitator of statewide conferences for parents of children with disabilities, with direct 1:1 interactions involving nearly 200 families. Her average Level was 3.88 and her highest action—her organization attaining nonprofit status—was at Milestone 6. [Overall story score = 141.0]