ABSTRACT

A SUBSTANCE ABUSE PREVENTION PROGRAM FOR FAMILIES

WITH PRE-ADOLESCENT CHILDREN

By

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May 2010

The purpose of this thesis was to develop a multi-component curriculum to address adolescent substance abuse by educating parents about contributing risk and protective factors, providing a supportive environment where parents can explore ways in which these factors operate in their own families, and by acting as a laboratory where parents and families can learn and experiment with skills meant to decrease risk factors and increase protective factors among their pre-adolescent children.

The intervention utilizes a variety of therapeutic approaches within three group types: family therapy, psychoeducation, and multi-family. The curriculum is intended for integration into tiered or universal programs. A facilitator's guidebook and presentation materials form the core curriculum content.

A SUBSTANCE ABUSE PREVENTION PROGRAM FOR FAMILIES WITH PRE-ADOLESCENT CHILDREN

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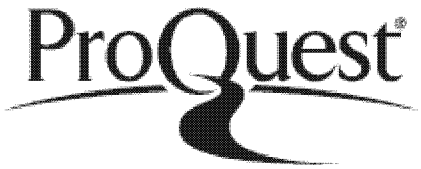

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CHAPTER 1

INTRODUCTION

Alcohol and other drug (AOD) use and abuse among adolescents can have tremendous personal and societal consequences, both immediate and long-term. Pathways to, or away from, AOD arise from a complex mix of biological, psychological, and societal factors. This curriculum was created as a multi-component intervention that emphasizes parent training integrated with family psycho-education and long-term multi-family support.

Curriculum Rationale

Research has shown that parental interaction is one of the strongest predictors of adolescent behavior (Oxford, Harachi, Catalano, & Abbott, 2001). Children who grow up in homes with a lack of mutual attachment, ineffective parenting, or a chaotic environment are far more likely to abuse substances than those in homes where there is a strong mutual bond, parental monitoring and involvement, and supportive parenting with clear and enforced limits (National Institute on Drug Abuse [NIDA], 2003). Research has also shown that youth are most vulnerable during transitional periods, such as entering puberty and moving from elementary to middle school (NIDA, 2003). The goal of this curriculum is to reduce risk factors and strengthen protective factors within families during the years prior to the high-risk transition period and to equip parents and

primary care givers with the skills necessary to deal effectively with their children once these transitions occur.

Purpose of the Curriculum

The purpose of this curriculum is to educate parents about risk and protective factors contributing to adolescent substance use and abuse, to provide a supportive environment where parents can explore ways in which these factors operate in their own families, and to act as a laboratory where families can learn and experiment with skills meant to decrease risk factors and increase protective factors among their pre-adolescent children.

Definition of Terms

Abuse: The American Psychiatric Association (2000) classifies alcohol and other drug abuse as a pattern of use related to adverse effects based on one or more of the following criteria: (1) recurrent use resulting in a failure to fulfill role obligations; (2) continued use in hazardous situations; (3) recurrent use-related legal problems; and/or (4) continued use despite adverse social or interpersonal consequences.

Adolescent: For the purpose of this project, an adolescent is defined as an individual between the ages 12 and 19.

AOD (alcohol and other drugs): This is a term used by government-funded research agencies, such as the National Institute on Alcohol and Alcoholism (2003) that refers to all forms of consumable alcohol and all forms of drugs that create or contribute to an altered state of being. The term "AOD" will be used here interchangeably with the terms "use" and "abuse."

Family: This refers to two or more generations of people living together in supportive roles.

Pre-adolescent: For the purpose of this project, a pre-adolescent is defined as an individual between the ages of 6 and 11 who has not yet reached puberty.

Risk and protective factors: These refer to biopsychosocial features associated with greater potential alcohol and other drug abuse are considered "risk" factors, while features associated with reduced potential abuse are considered "protective" factors (NIDA, 2003).

Importance of Curriculum to Social Work

This curriculum continues a long-standing relationship between social work and substance abuse treatment. It approaches treatment from a systems perspective by looking at how the adolescent is affected by the family and by how the family operates in the environment. Moreover, the curriculum works from a strengths perspective by drawing from the belief that individuals and families have the ability to improve their environment by expanding and improving upon the knowledge and skills they already possess. By putting this curriculum into practice, social workers would be focusing prevention efforts during a crucial period in the lives of children, and in the process, would have the opportunity to break the cycle of substance use and abuse.

CHAPTER 2

LITERATURE REVIEW

This literature review explores the need to address adolescent substance use and abuse through parent education and skills building by looking at the extent of the problem among adolescents in the United States; by summarizing contributing biopsychosocial and cultural risk and protective factors in the context of the individual, the family, and the community; and by exploring the attributes of evidence-based parent education and skills building programs.

Epidemiology

The National Survey on Drug Use and Health Administration (Substance Abuse and Mental Health Services Administration; 2008) reported a significant decline in "past month" drug use among adolescents 12-17 years of age. Rates of overall illicit drug use in 2002 were 11.6%, which dropped to 9.5% in 2007. In particular, past month marijuana use had declined from 8.2% to 6.7% within the same 5-year period; however, the decline was fairly rapid and had leveled off between 2005 and 2007.

The above data are averaged across ages 12 thru 17 (SAMHSA, 2008). More relevant data show the sharp increase in percentages as age increases. For instance, past month marijuana use among eighth graders in 2008 was 5.8% while the same measurement for 12th graders was 19.4% and the percentage of daily use among 12th graders (5.4) was roughly the same as eighth grade monthly use (NIDA, 2008). Alcohol

use revealed a similar trend: the average for past month drinking among the age group 12-20 was 27.9%. However, 15 and 16 year olds (29.0%) were almost twice as likely to have drunk in the past month as 14 and 15 year olds (14.7%), who were more than 4 times as likely to have drunk in the past month than 12 and 13 year olds (3.5%). Notably, more than 80% of drinkers in this age bracket reported drinking either in their own home or in the home of someone else (SAMHSA, 2008).

In terms of onset of use, the National Survey on Drug Use and Health (SAMHSA, 2005) reported that 6.5% of males and 2.4% of females began alcohol use prior to age 12; 38.6% of males and 28.7% of females began alcohol use between ages 15 and17; and 9.3% and 18.8% of males and females respectively began alcohol use after age 21. Clearly, a significant majority begin use in their mid-teens.

Risk and Protective Factors

Early Onset

Most adolescents who experiment with substances do not develop abuse or dependence issues; however, there is strong evidence that even single use is risky. The National Institute on Drug Abuse (Martin, 2003) reported that prior marijuana use is closely associated with the opportunity to use other drugs, such as cocaine, methamphetamine, and hallucinogens. Among those given the chance to use cocaine, for example, those who had already used marijuana were 15 times more likely to use cocaine, whereas among those who have never used marijuana, fewer than 10% initiated cocaine use (Martin, 2003).

Fergusson, Horwood, and Beutrais (2003) reported that those adolescents who use Cannabis more than 100 times are 5 to 8 times more likely to leave school prematurely,

3.3 times less likely to enter college, and 4.5 times less likely to obtain a college degree. Furthermore, a SAMHSA (2005) survey revealed that 32% of past year alcohol abuse disorder cases were adults who had begun drinking before age 14, while only 6.6% had begun drinking after age 18. These data reveal that the earlier adolescents initiate use, the higher their risk of developing a substance use disorder when they transition into early adulthood; therefore, while initiating use may always be considered a risk, helping adolescents to prolong initiation can be considered a protective factor.

In the field of Chemical Dependency Treatment, the *Diagnostic and Statistical Manual-IV (DSM-IV)* (American Psychiatric Association [APA], 2000) criteria, once met, are generally enough for insurance companies and government funding sources to justify treatment for, in this case, *DSM-IV* numeric code, 305.20--Cannabis Abuse. Most adolescent users, however, fall short of the *DSM-IV* criteria, and despite the overwhelming evidence that this population has a high potential for harmful consequences following even a single exposure, they often go untreated until the criteria are met. "Diagnosis," according to Tarter (2002), "is primarily a labeling process. [A] limitation is that diagnostic criteria are not conceptualized within a developmental framework. Hence, applicability of the DSM-IV system for adolescents is dubious" (p. 176). The risk factors listed above suggest that, although creating a set of diagnostic criteria specifically for adolescents may not be warranted, a paradigm shift in criteria for justification of intervention and treatment toward a category of "high potential risk for abuse" could greatly curb the personal and societal costs associated with long-term substance use and abuse.

While most adolescents do not progress beyond experimentation and occasional use, those who do tend to escalate quite rapidly into abuse. Research has shown that these individuals most likely experienced "a combination of high levels of risk factors with low levels of protective factors. These adolescents were characterized by high stress, low parental support, and low academic tolerance" (NIDA, 2000, p. 11).

Biological Factors

There are numerous biological stressors that increase an individual's risk of developing a substance use disorder compared to the general population. These are primarily genetic loading and cognitive development. Geneticists have recently linked a number of specific genes to AOD abuse and dependence (Dick & Agrawal, 2008). Prior to genetic testing, however, there were a number of studies that revealed a strong correlation between heredity and AOD. In a discussion on the genetic complexity of alcoholism, for instance, the National Institute on Alcohol Abuse and Alcoholism (NIAAA; 2003) describes a twin study that revealed identical twins as being twice as likely as fraternal twins, who share on average 50% of their genes, to resemble one another in terms of alcoholism. Longitudinal adoption studies have revealed similar genetic factors, however, while research suggests that 50-60% of risk for AOD abuse and dependence is genetically determined, the remainder is social and environmental (Dick & Agrawal, 2008) and perhaps much more complex than genetic factors.

According to Tarter (2002) executive cognitive functions, intellectual capacity and formal operational thinking develop along with brain maturation, which continues developing up to 25 years of age. Deficient in adolescent cognition is the ability to

integrate and synthesize information required to select the best option or to rationalize decision-making and foresee the potential consequences of behaviors.

While these functions are underdeveloped in all adolescents there is a certain amount of variability that can be measured as early as infancy. Response to stimuli and ability to maintain focus are considered early determinants of the behavioral regulation and control system and the attention regulation and control system (Zucker, Donovan, Masten, Mattson, & Moss, 2007). These systems are essential for learning, reflecting, considering alternative options, and making decisions based on potential outcomes while inhibiting urges and impulses. When these systems function poorly, either for organic reasons or because they are not nurtured in their environment, the potential for substance use and abuse greatly increases.

Zucker et al. (2007) describe a prominent theory that suggests a strong link between behavioral, emotional, and cognitive dysregulation and the early emergence of substance use disorders. "The dysregulation is identifiable as 'difficult' temperament in infancy and early childhood and an array of behavioral and neuropsychological deficits in adolescents" (p. 4). These problems not only increase potential initial substance use, but also, once initiated dysregulation potentially affects the amount and frequency of use because the adolescent is unable to discern what constitutes appropriate use.

Psychological Factors

While there are biological changes experienced by developing youth, the majority of developmental changes are psychological and social. This section will look at psychiatric and psychological traits and disorders that co-occur with AOD. As Deas and

Thomas (2002) point out, for a disorder to be a risk factor for AOD its onset must precede the AOD problem.

A number of psychological traits have been consistently related to AOD use and abuse in both adolescents and adults: "a personality pattern of high novelty seeking, low harm avoidance, and high reward dependence. This constellation of traits was first implicated in alcoholism risk in adults, but has also been shown to apply to adolescents" (Deas & Thomas, 2002, p. 117). High aggressivity has also shown to be a trait correlated with both initiation and continuation of AOD use. Both teacher- and self-rated aggressivity at age 9 were predictive of AOD disorders at age 21 (Deas & Thomas, 2002).

The disorders most frequently co-occurring with a Substance Use Disorder (SUD) are mood disorders, conduct disorders, and Attention Deficit/Hyperactivity Disorder (ADHD). In 2007, 2.0 million youth ages 12 to 17 reportedly had a major depressive episode in the past year. Among those, 35.5% reported using an illicit substance—more than twice the rate (17.2%) of adolescents who did not have a major depressive episode (SAMHSA, 2008). Rate comparisons are similar for alcohol and tobacco use. Of youth with major depressive episode, 38.9% reportedly sought treatment by either talking with a mental health or medical professional or through medication or both. What is not revealed is whether depressed teens who are also using substances are more or less likely to seek treatment. In a study of inpatient adolescents, 73% of those who used alcohol and other drugs (AOD) met diagnostic criteria for depression. In 80% of those adolescents, depressive symptoms predated AOD use and abuse (Deas & Thomas, 2002).

Adolescent AOD abusers also have a significant likelihood of developing a co-occurring anxiety disorder. Studies have shown that 60% of adolescents seeking treatment for AOD met the criteria for social anxiety disorder and that the latter predated the former by 2 years (Deas & Thomas, 2002). The relationship between PTSD and AOD disorders has been extensively studied as well. Findings have indicated that adolescent substance abusers are 6 to 12 times more likely to have experienced physical abuse and 18 to 21 times more likely to have experienced sexual abuse (Deas & Thomas, 2002).

The Adverse Childhood Experiences (ACES) study used a sample of 17,421 Health Management Organization members to look at the relationship between childhood trauma and health problems later in life. The survey measured three categories of abuse: recurrent physical abuse; recurrent severe emotional abuse; and contact sexual abuse; and five categories of household dysfunction: growing up in a household where someone was in prison; where the mother was treated violently; with an alcoholic or drug user; where someone was chronically depressed, mentally ill or suicidal; and where at least one biological parent was lost to the patient during childhood, regardless of cause. The participants were assigned points based on exposure, for example: 0 for no exposure, 4 for exposure to any 4 categories et cetera. (Felitti et al., 1998).

Felitti et al.'s (1998) study found that 22% of participants had been sexually abused as children and that the categories were generally clustered, so having experienced one ACE as a child increased the likelihood of experiencing multiple ACEs, and as the ACE score increases, the likelihood of developing organic disease or emotional disorders greatly increases. For example: a person with an ACE score of 4 is

260% more likely to have Chronic Obstructive Pulmonary Disease than a person with an ACE score of 0. A person with an ACE score of 4 is also 460% more likely to suffer with depression than a person with an ACE score of 0 (Felitti et al., 1998). So there is an extremely strong correlation between adverse childhood experiences and mental and physical health problems throughout the lifespan, and this phenomenon is cyclical in that the outcomes of these ACEs will become the ACEs the next generation will experience. Consequently, both the ACEs themselves and their outcomes are high-risk settings for AOD use and abuse (Felitti et al., 1998).

Rates of substance abuse for non-medicated ADHD among adolescents are 75% while rates among those medicated are 25% (Biederman, 2003). Based on this comparison, treating ADHD with medication greatly reduces the risk of developing SUD; nonetheless, rates of SUD among adolescents treated for ADHD remain higher than rates among those without ADHD. There is much debate as to whether ADHD itself increases the likelihood of AOD abuse or if the consequences of ADHD, such as lowered self-esteem or lack of coping mechanisms, may be contributing factors (Deas & Thomas, 2002). The numbers show, however, that having ADHD puts an adolescent at increased risk for developing SUD.

Social Factors

Many of the developmental tasks that take place during pre-adolescence are strongly connected with the social world. Attachment, speech, impulse control, reading, writing, ability to bond with peers, and ability to understand and navigate cultural cues and norms have become embedded by age 10 (Zucker et al., 2007). By this age youth have constructed a sense of self (Graber &Brooks-Gunn, 1999) based largely on the

degree to which the above tasks have been accomplished and how the social structure around them have responded. This construct of self will factor largely in determining the ability to cope with the difficult transition into adolescence.

Family is generally the social system most influential to the construct of self, and perhaps the most crucial domain when determining the extent of substance abuse risk for an individual. Ineffective parenting, chaotic home environment, lack of clear and enforced boundaries, and parents who themselves abuse substances or have a relaxed attitude toward substance use are all factors that increase potential risk. On the other hand, parents who are actively involved in the lives of their children and are meeting their financial, emotional, cognitive, and social needs while also communicating clear and enforced boundaries are factors that decrease potential risk. Much of the research in this area has focused on the concept that mutual attachment is determined by the health of the family environment and that attachment is the single greatest predictor of risk or protection where the family is concerned (Kumpfer & Alvarado, 2003; NIDA, 2008; Oxford et al., 2001).

Attachment theory emphasizes parents' ability to perceive the emotional needs motivating a child's behavior, interpret the needs accurately and respond in a loving way. Beginning in infancy and progressing through early childhood, mental representations of the care-giving relationship are formed and "thought to influence expectations and expectancies in relationships, including parent-child relationships in the next generation" (Suchman, Pajulo, DeCoste, & Mayes, 2006, p. 211).

Oxford et al. (2001) discussed control theory as it relates to the effects of family dynamics on the individual. During the elementary school years, parents exert direct

control over their children as the primary authority figures. However, during the transition from childhood to adolescence, direct control diminishes as adolescents seek appropriate levels of independence and autonomy. The authors posited that, while adolescents become primarily influenced by peers, the residual effects of parenting continue to play a major role in their decision making. "Family attachment, which informs indirect control, is . . . an important predictor of delinquency, drug use, [and] alcohol use" (p. 601).

Peers play an important role in determining the degree of risk and protection from substance use for a number of reasons. Transition from childhood to adolescents is marked by the physical changes that develop with puberty, which youth must incorporate into their construction of self based on the responses from those around them regarding these adult-like changes. "Developmental transitions, especially the pubertal transition, may be a time for particular vulnerability for youth" (Graber & Brooks-Gunn, 1999, p. S76). Generally pubertal development results in increased autonomy negotiated between youth and parents. The transition is also marked by entrance into a new school environment resulting in added autonomy coupled with a more diverse peer group pool. As youth become increasingly influenced by peer interactions, parent-child relations become strained and parents can be pulled toward giving in to their child's struggle for more autonomy by decreasing monitoring (Graber & Brook-Gunn, 1999).

In their study of pre-adolescent predictors of substance initiation, Oxford et al. (2001) found that peer influence is a strong predictor of substance use, but that family-based direct and indirect social control mediates deviant peer association. Typically peer

influence is proximal because most substance use by adolescents takes place in the peer environment.

Parental rules, parental monitoring, and child attachment had the greatest negative impact on substance initiation and indirectly impacted initiation through antisocial peer involvement. "Importantly, prosocial family processes have an enduring effect, as shown by the longitudinal nature of this analysis: family management practices and attachment contributed to both peer selection and substance initiation a year later" (Oxford et al., 2001, p. 611).

Family protective factors are well summarized by Kumpfer and Alvarado (2003): "The major protective family factors for improving adolescent health behaviors include positive parent-child relationships, positive discipline methods, monitoring and supervision, and the communication of pro-social and healthy family values and expectations" (p. 458). The challenge is to create effective interventions that address a broad range of family risk and protective factors.

Cultural Factors

In modern western society substances, especially alcohol, are ubiquitous, inexpensive, and widely accepted, which contribute greatly to children's beliefs and expectancies toward substances and their use. Fifty-eight percent of adolescents 12-17 report that it is easy to obtain Cannabis (Tarter, 2002), which creates an assumption of normativity, as does legalization in a number of U.S. states.

The alcohol industry spends more than $1.6 billion on radio, television, print media, and billboards (Bonnie & O'Connell, 2004). These advertisements regularly

expose adolescents to messages about alcohol through strategic advertisement placement in media to which teens are likely to watch, read, and listen.

> For example, in 2003, teens saw twice as many advertisements for beer, more than 3 times as many advertisements for alcopops (sweet flavored alcoholic drinks) and 50% more advertisements for spirits in magazines, on a per-capita basis, than did adults less than or equal to 35 years of age. (Zucker et al., 2007, p. 12).

A review of G-rated animated films found episodes of alcohol and tobacco use in 50% of the 50 films totaling 27 minutes, but none of them portrayed the negative health consequences of alcohol use (Zucker et al., 2007). A study of G-Rated television shows aired in primetime revealed that 38% modeled alcohol use, yet only 23% of those mentioned or portrayed negative consequences (Christenson, Henriksen, & Roberts, 2000). These figures sharply expose the gap between a strongly media-driven cultural acceptability of alcohol use and an accurate understanding of the potential consequences. Media shape culture, culture shapes families, families shape the next generation through the construction of self. By 6.5 to 7.5 years of age the majority of children can demonstrate the representation of alcohol by identifying alcohol labels in photographs and by explaining the differences between clusters of alcohol bottles compared with other bottles (Zucker et al., 2007).

Thus, families, and society as a whole, need to take a proactive approach to counteracting AOD exposure by reducing risk factors and strengthening protective factors, primarily within families. As Kumpfer and Alvarado (2003) suggest, "many of the precursors of serious adolescent problems can be reduced or eliminated through early intervention to improve parenting and family systems dynamics from pre-birth to adolescence" (p. 458).

Family-Focused Interventions

This section utilizes the core elements (NIDA, 2003) and principles of effective family-focused interventions (Kumpfer & Alvarado, 2003) as organizational tools to explore the content and outcomes of implemented programs.

Evaluation Strategy

The 3 core domains of intervention programs are structure, content, and delivery and evaluation. Within the context of structure are program type, format, audience, and setting. There are four program types: universal, selective, indicated, and tiered. Format involves number of sessions and division of participants: parent, child, family etc.

Content can be further broken down into information dissemination, skills development, methods, and services. Furthermore, delivery is made up of program selection and feature implementation (NIDA, 2003), as well as recruitment and retention. An example may be, an agency wishing to implement a program in an after-school setting to an audience of high-risk families in a number of elementary schools that funnel into a middle school found to have a high rate of substance abuse by developing parenting skills and providing family therapy.

Kumpfer and Alvarado (2003) have derived a set of principles they believe practitioners can use as a checklist for selecting, adapting, or creating new family-focused programs:

1. Multi-component programs impact risk and protective factors more than single-component interventions.

2. Strengths-based family-focused interventions reach families with problematic relationships better than either parent- or child-focused strategies.

3. Effective programs include components that address family relations, communication, and parental monitoring.

4. The effects interventions have on family dynamics will be long lasting if cognitive, affective, and behavioral changes are realized.

5. Length of intervention should be significantly increased for families with greater risk factors and fewer protective factors.

6. Interventions should be age appropriate and graduated as families mature.

7. Risk and protective factors should be addressed at developmentally appropriate times for effectiveness and to maintain motivation.

8. Early life-cycle interventions are more effective for parents with high levels of dysfunction.

9. Culturally competent interventions aid in recruitment and retention and outcomes.

10. Incentives, such as food, child care, transportation, and rewards for task completion, aid in recruitment and retention.

11. Effectiveness of an intervention is strongly tied to the efficacy of the trainer.

12. Interactive, multi-faceted, client-centered programs are more effective than didactic lecturing.

13. Developing a collaborative, client centered process that empowers clients and builds relationships reduces parent resistance and drop out (Kumpfer & Alvarado, 2003).

Programs

Three widely disseminated and tested evidence-based programs will be explored: Preparing for the Drug Free Years (PDFY; Haggerty, Kosterman, Catalano & Hawkins,

1999); Families and Schools Together (FAST; MacDonald & Frey, 1999); and Strengthening Families Program: for Parents and Youth 10-14 (SFP 10-14; Molgaard, Spoth, & Redmond, 2000; NIDA, 2003).

The PDFY is a universal parent training program targeting parents of 8-14 year-old pre-adolescents. The program was developed out of a comprehensive literature review on risk and protective factors regarding adolescent substance abuse and guided by the social development model (Haggerty, et al., 1999). It has been disseminated across 30 U.S. states and Canada, reaching over 120,000 families (Vimpani, 2005). The curriculum format consists of five 2-hour sessions or 10 1-hour sessions, depending on setting. Schools and community centers are the usual setting; however, the program has been provided in the workplace during lunch hour (Haggerty et al., 1999).

The PDFY is a single component program with the exception of one session that involves both parents and children. Sessions are formatted using interactive, multi-faceted methods. Content takes an interactive, client-centered approach to introducing participants to AOD problems related to adolescents by presenting risk and protective factors and uses strengths-based cognitive behavioral techniques to teach skills related to positive family relations, communication, and parental monitoring. Workshops are led by community members who attend a 3-day training.

The program has been widely disseminated using schools, broadcast media (including a 1-hour television special), public service announcements, churches, and community centers. The initial campaign in the Seattle area drew nearly 2,500 parents to the workshops (Haggerty et al., 1999).

In terms of recruitment and retention, Haggerty et al.'s (1999) initial campaign retained 69% of participants from session 1 to completion. Testing found high ratings among participants in terms of exercises, materials, processes and leaders. Testing also found a positive change in understanding and skills regarding family management, motivation to enforce family drug policy, constructive expression of anger, and collaborative involvement with children on family issues (Haggerty et al., 1999).

Longitudinal studies have revealed a significant decrease (33% less than control) in Cannabis use among adolescents 4 years after their parents completed PFDY (Mathias, 2002). A recent study has found a notable outcome regarding gender moderation and alcohol use among children of PDFY participants at age 22. The rate of alcohol abuse among PDFY men was higher than control group (29% to 25% respectively), yet the rate of alcohol abuse among PDFY women was substantially lower than control group (6% to 16% respectively). Discussion among the researchers has focused on pro-social skills as the main determinant for this outcome, finding that psychosocial interventions may have greater impact on women than on men (Mason et al., 2009). However, there is evidence that fostering a stronger mutual attachment may have been equally influential. For example, Ma and Huebner's (2008) study on adolescent life satisfaction (LS) found that attachment to parents has a stronger effect on peer attachment relationships with girls than it does with boys.

> For girls, the quality of their attachment relationships with parents generalizes to the quality of their relationships with peers. In this vein, the impact of a secure attachment with parents is substantial, facilitating the development of an internal working model of others, such as peers, as trustworthy and available. (p. 186)

Using Kumpfer and Alvarado's (2003) criteria for programs listed above PDFY can be considered a strong, best-practice approach to Adolescent AOD intervention. The

program fits most of the criteria; however, it is a single- rather than multi-component program; facilitator training may not be as rigorous as other models, and, therefore, fidelity to content and presentation may have suffered; and retention rates were low: 69%. The researchers agree that adding a component for youth and incorporating incentives for retention would have increased program efficacy (Haggerty et al., 1999).

Families and Schools Together (FAST) is a universal/indicated, multi-component program targeting at-risk youth ages 3-14 and their families. The overall goal of the program is to help at-risk youth succeed in school, home and community, and thus avoid delinquency, violence, addiction and dropout (McDonald & Frey, 1999). The program has been implemented in 450 schools in 31 states and 5 countries. The FAST program relies on school professionals to identify "high-risk" youth based on classroom or playground behavior, socioeconomic status, mental health issues, known trauma being experienced in the family. The program is flexible in that it allows schools to create criteria for participation. For example, some schools have opted to take only self-referrals while others have treated families with particular issues, like bullying or truancy, in targeted groups. The FAST process is formatted into an initial home visit attended by a FAST parent graduate who invites the family to participate with up to 11 other families, 8-10 weekly 2.5 hour sessions, and a monthly multi-family group that meets for 2 years (McDonald & Frey, 1999). Training is intensive and hierarchical: FAST team trainers endure a year-long certification process that includes observing multifamily sessions, completing 1 week of classes at the national training center, and train a team under direct supervision of the program founder. Once certified, the team trainer works with

community members and parent graduates to facilitate multifamily groups (McDonald & Frey, 1999).

Curriculum content (McDonald & Frey, 1999) is highly interactive, opening with 15 minutes of FAST hello and FAST song, followed by 45 minutes of family table time where parents are in charge of activities which include a family meal and a structured activity drawn from a comprehensive, evidence-based list such as feelings charades, making a family flag, and song sharing. Next is 1 hour of mutual support where parents and children split into peer groups. Parents discuss parenting-related issues and learn cognitive behavioral skills while also building a support network. Children participate in age appropriate activities. Next are 15 minutes of one-on-one communication time between parents and children where parents practice communication techniques they've learned during the session. Learned parenting skills are age appropriate, such as play therapy for elementary school children and topics chosen by the youth group for middle school children. Lastly, is the closing tradition, which consists of thanking hosts, making announcements, and a silent circle (meant to build multifamily cohesion). The final component is FASTWORKS, the multifamily aftercare group that meets monthly for 2 years. The agenda is flexible and includes reinforcement of skills, process, and problem solving, as well as activities or topics chosen by a collaborative team of trained graduate parents (McDonald & Frey, 1999).

In terms of delivery, one study conducted at 8 FAST schools showed retention rates of 90%, due to incentives embedded into the curriculum, and received at least partial pre- and post-test information from 100% of participants. The study also showed that, while each of the 8 schools varied in feel, enthusiasm, and intensity, fidelity to

program structure and content was high. (Kratochwill, McDonald, Levin, Scalia, & Coover, 2009). The FAST program has been implemented in diverse populations: in 1999 51% of participants nationally were Caucasian, 25% were Latina/o, 23% were African American, and 2% were Asian and American Indian. Pre- and post-tests revealed a reduction in incidence of conduct disorder, anxiety, and attention span problems (McDonald & Frey, 1999). A 1-year follow up of the eight FAST schools study revealed a reduction in externalizing behaviors as well as improved overall family functioning (Kratochwill et al., 2009).

Using Kumpfer and Alvarado's (2003) criteria for programs listed above FAST appears to be a well developed program that adheres to best-practice principles. Similar to PFDY, the FAST program meets many of the criteria: however the program does not address specific skills and practices related directly to substance abuse. Also, while FAST does use interactive multi-faceted components, it seems to avoid didactic learning altogether.

The Strengthening Families Program was designed for parents and youth from 10-14 years of age (SFP 10-14) as a universal and selective multi-component program targeting families with children in this age group. The program is the result of a major revision of the original SFP, which targeted drug abusing parents with children 6-11 years of age. The revision was designed to meet the needs of a general population of families. The format has remained faithful to the original program, but has reduced from 14 to 7 sessions and has changed the target population from 6-11 to 10-14 (Molgaard et al, 2000; NIDA, 2002).

The format consists of three components: a behavioral parent training program, a children's skills training program, and a family skills training program. Eight to 13 families participate in seven weekly 2-hour sessions plus four booster sessions, generally set in a school, church, or community center. The first hour addresses children and parent skills training, and then families and trainers reconvene for an hour of family skills training. Attendance is incentivized through the use of childcare services, transportation, etc. Trainers are generally teachers, social workers, counselors, ministers and parents who have strong presentation and organization skills, and who can be flexible and creative within the confines of the standardized program. There is also a 450 page trainer's manual and a 2-day training (Molgaard et al., 2000).

The content of each section centers on typical family situations presented in the context of risk and protective factors. For example: "Age-appropriate parental expectations, positive parent-child affect, empathy with parents" (Molgaard et al., 2000, p. 3) as protective factors, compared to "Harsh and inappropriate discipline, poor child parent relationships" (Molgaard et al., 2000, p. 3) as factors of risk. Information is disseminated to parents through didactic presentations, role-play, group discussions and skills-building activities. Video tapes are used in every parent session to maintain program fidelity and to provide visual demonstrations of positive family interactions. Youth session content corresponds to parent sessions, but delivery is developmentally appropriate. Time is used doing skills-building activities, which are presented in an engaging interface. Videos are also used in a few youth sessions. Family sessions bring youth and parents together to practice skills learned in separate groups via activities such as communication exercises and family poster making. Booster sessions reinforce skills

learned in primary sessions while also taking a broader look at topic content (Molgaard et al., 2000).

In regard to delivery, recruitment relies on local agencies, churches, schools and community groups to disseminate program brochures and video tapes. Outcomes attributed to SFP 11-14 were derived from the study of a previous version of the program: the Iowa Strengthening Families Program (ISFP), which measured results using pre-and post-tests and follow-up. Longitudinal data analysis reveal "significantly improved parenting behaviors directly targeted by the intervention" (Molgaard et al., 2000, p. 8), which has been correlated with positive outcomes related to substance use and use-related behavior among adolescents. At 48 months following program completion ISFP adolescents were 33% less likely to initiate alcohol use compared with control (Molgaard et al., 2000).

Using Kumpfer's and Alvarado's (2003) criteria for programs listed above SFP 11-14 can be considered a well-rounded intervention program that meets most, if not all of the criteria, which is reasonable since Dr. Kumpfer was among the original program architects. There are; however, a few major flaws with this version of the program: 1) there is very little AOD use and abuse education in any of the three components, 2) content is highly focused on family dynamics, but given the lack of AOD content, the age range for this type of focus should be closer to that of the original program version, 6-11 years of age, 3) there are no specific criteria for recruitment, and 4) assuming results from a previous program version will hold up following major revisions is unscientific: further evaluations should be implemented.

Conclusion

There is significant evidence that adolescent substance use problems in the United States are directly related to biopsychosocial and cultural risk and protective factors and that family is perhaps the single greatest factor in determining the extent of risk and protection for an individual. Family-focused multi-component intervention programs targeting pre-adolescents and their families have effectively reduced substance use problems among adolescents.

CHAPTER 3

METHODS

Rationale for Methods

Methods have been informed by the literature review. Program design was organized using the core domains: structure, content, delivery, and evaluation (NIDA, 2003). Program content was guided by the principles of effective family-focused interventions (Kumpfer & Alvarado, 2003) and informed by best practices revealed by the literature review.

Target Population

This curriculum targets families with pre-adolescent children determined to be at-risk for substance use and abuse based on a number of bio-psycho-social criteria. The curriculum aims to reduce risk factors and increase protective factors within family systems with the objective of reducing the incidence of adolescent substance use and abuse.

Module Format and Content

Program content will be presented in 12 weekly sessions, each 2 hours in length. The first four modules will be attended by parents only: these modules consist of education, skills building, and process discussion. The first two sessions inform parents of the prevalence and effects that substance use and abuse have on adolescents in U.S. society and the degree to which parents are determinants of risk and protective factors.

Sessions 3 and 4 focus on skills and techniques. Each session provides time to discuss and process educational content. The discussion portion employs motivational interviewing and cognitive behavioral therapeutic techniques to increase program efficacy. Participants will be encouraged to incorporate into their week the knowledge and skills learned in each session, the experiences and outcomes of which are discussed at the beginning of each following week. The final eight sessions are multifamily focused. The time will be split between activities that simulate the family interacting in its environment (i.e., meals, games, homework, and solution-focused process centered on family issues). There will also be an optional extension of the aftercare group where parents, or families, can gather to discuss successes and challenges and to sustain peer and facilitator support.

Curriculum Design

The curriculum will employ three evidence-based therapeutic approaches in order to increase efficacy at different stages of the program. Motivational interviewing will be used prior to and during the intake process and in early sessions in order to assess and promote readiness to change; cognitive behavioral therapy will be used during process-oriented sub-sessions; and solution-focused therapy will be used during aftercare groups and an individual family session, where both parents and children will be present.

Motivational Interviewing

Because this curriculum targets at-risk pre-adolescents and their families prior to the tangible problems that follow substance exposure and abuse, parents' commitment and buy-in may be challenging. Motivational interviewing is a therapeutic technique that has proven practical and effective in helping families increase motivation to change

(Miller & Rollnick, 2002). Initial interviews will take place with individual families, specifically with parents or primary caregivers of selected pre-adolescents, during the weeks prior to the start of the program. These interviews will employ many features of motivational interviewing, such as: (1) establishing rapport with the parents by empathizing with them regarding characteristics and situations that may be putting their child or children at risk, and by allying with them in the common objective of reducing substance abuse risk factors and strengthening protective factors; (2) providing information to help facilitate decision-making and commitment; (3) assessing parents' motivation to look at risk and protection in their family system and their willingness to make changes where necessary; and (4) assisting parents' in problem solving around whatever issues arise that may present barriers to treatment (Gance-Cleveland, 2005).

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) has been effective in treating people with a wide range of diagnoses, such as anxiety, depression, obsessive-compulsive disorder, and substance abuse, thus CBT is expected to work well in a group setting that presents a broad array of risk factors. The overarching goal of CBT is to investigate collaboratively and reveal thought processes that lead to behavioral patterns and to use structured techniques to facilitate change where needed. Using a strengths-based perspective in the context of working with parents and families of at-risk pre-adolescents, the CBT model encourages and reinforces positive thought processes and behaviors, while also revealing the cause and effect nature of negative thoughts and behaviors.

A core feature of CBT is its person-in-environment approach, which subsequently focuses session content around the tasks of everyday life. Skills will be taught and

practiced in group sessions before being translated into family environments (Verduyn, 2005). Thought processes and belief systems will be identified and explored using guided discovery and the pros and cons of associated behaviors and consequences will be discussed. Thoughts, beliefs, and parenting behaviors that appear to have a positive effect on pre-adolescents will be nurtured while those that contribute to or exacerbate risk will be addressed through skills building, behavior rehearsal, homework assignments, and progress tracking. The group will take a client-centered approach: the facilitator will encourage participants to offer their parenting experiences for group discussion, and will create and support a positive, collaborative environment.

Solution-Focused Therapy

The multi-family aftercare group will act as a problem-solving laboratory, providing support and feedback for families as they work toward behavioral changes. Solution-focused therapy provides a sensible platform for encouraging and reinforcing strategies learned in parent training sessions while also providing structure for engaging resistant pre-adolescents. Solution-focused therapy explores with families the exceptions to problems (Corcoran, 2002) by examining what has worked for the family in the past. There are a few solution-focused techniques that naturally occur in a dynamic group setting, such as empathy and normalizing (depathologizing behaviors). Other techniques, such as reframing and aligning with family goals, will help the facilitator keep the session focused on solutions rather than problems. Scaling questions will also be used to track family successes and challenges.

Corcoran (2002) provided a developmentally appropriate framework for engaging complainants (pre-adolescents seeking only to please their parents, which may be the

case for participants in the present curriculum) and visitors (pre-adolescents seeking only to change their parents, their school, etc.). The developmental stage of the target population is such that concrete rather than abstract thinking is typical; thus, recalling abstract exceptions will need to be a collaborative family effort, which is expected to strengthen family bonds due to the positive nature of finding exceptions to problems.

Evaluation Plan

The program should include a pre- and post-test in order to evaluate the efficacy of the curriculum content and delivery. The tests will evaluate participants' knowledge of substance use and abuse prevalence among adolescents; their beliefs and attitudes toward substance use in general; their level of knowledge regarding risk and protective factors; their level of perception of themselves as key determinants in terms of risk and protection; their beliefs, attitudes, and behaviors regarding parent-child communication, boundaries, monitoring, and rules and consequences; and, finally, their perceived level of efficacy regarding prevention of substance use and abuse by their children. Test content and format will be included within the curriculum. Satisfaction with curriculum content and delivery will also be assessed.

CHAPTER 4

CURRICULUM

The curriculum is composed of a Group Facilitator's Guidebook and a Participant's Workbook. The guidebook (Appendix A) provides general information on group type, format, delivery, and the theoretical basis for methods and content, as well as presenting information specific to individual sessions, such as learning objectives, content and materials. Brief instructions address facilitator efficacy and design methods. The participant's workbook (Appendix B) provides outlines of session content, group exercises and homework assignments.

Structure of Weekly Sessions

Sessions are designed to be focused and familiar. Group type and approach will change across the program components (family therapy, psychoeducation, multifamily), yet familiar patterns will be established through consistency of session format. Session content will be objective-driven, yet flexible enough to meet emergent group needs.

There are two 1-hour individual family therapy sessions scheduled for the first and last modules of the program. The objective of the first family session is to establish rapport, assess risk and protective factors within the family, and establish baseline patterns of family interaction and behavior. The objective of the final family session is to reflect on the family's experience in the program, reinforce family strengths, assess family goals, and provide closure.

The five 2-hour psycho-educational sessions are designed to provide parents with information, skills, and support toward the overarching objective of reducing risk and increasing protection against adolescent substance use.

The five 2-hour multi-family groups provide each family with a platform for practicing and discussing positive family interactions and through planned activities and group process and support. The overarching objective of the multi-family groups is to foster positive family bonding and cohesion, to reinforce skills building models, and to track the progress of individuals and families.

The Group Facilitator's Guidebook (Appendix A) provides a semi-scripted outline of each module, digital and printed copies of Powerpoint presentations for psychoeducational modules, and copies of activities and homework assignments found in the Participants Workbook. The Facilitator's Guidebook also provides content and method rationale. The Participant's Workbook (optional printing) can assist participants in using program content and skills applications, both during sessions and in their daily living.

Check-In Activity

In order to support continuity across program components every session begins with a check-in activity. The central idea of the check-in is to foster a positive atmosphere and to give individuals and families a platform for acknowledging strengths and accomplishments.

Education

Educational format and content are concentrated into five parent-only sessions, then reinforced in multi-family groups where families can discuss and problem solve in a

supportive environment. Education is meant to provide foundational information and skill-building techniques. The participant's workbook will act as a bridge between the group setting and the home setting by integrating outlines of module content with exercises and activities to complete at home.

Exercises

In-group exercises are meant to supplement and reinforce education module content. The exercises vary in content and format and may ask members to engage with other group members or families. These exercises will take between 20 and 30 minutes.

Discussions

This curriculum is client-centered, and therefore, discussion-centered. Discussions lead or follow each exercise or homework component and group members are encouraged to engage with the material and with the facilitator during education modules, the latter of which allows all group members to model and practice healthy communication skills.

Homework

Group members are given weekly assignments designed to integrate the educational content into family life. Assignments range from writing and reflection to family activities. The time required for each assignment will vary depending on the nature of the assignment.

Family Activities

Family activities are part of each multi-family session. These activities are meant to strengthen family interaction and cohesion and to maintain participants' interest and

enthusiasm. Family activities will take between 15 minutes and 1 hour depending on the activity.

Content of Sessions

Session 1: Family Intake

The objective of the family intake session is to establish rapport with family members, to process paperwork, and to discuss program and family goals. This session also provides an opportunity to explore family level of motivation for treatment, to evaluate and problem solve around barriers to treatment, and to assess family interaction patterns.

Session 2: Introduction and Overview

The objective of this module is to familiarize parents with the structure, format and materials of the program and to introduce parents to the nature and prevalence of adolescent substance use and abuse, the short- and long-term impacts of early onset. The discussion portion of the session explores the concept of risk and protective factors.

Sessions 3 and 4: Identifying Risk and Protective Factors

The objective of these two modules is to inform parents about common risk and protective factors across a number of domains: individual, family, peer, school, and community (NCTSN, 2008). These sessions will be interactive and reflective. Once parents have a basic understanding of how and where AOD-related risk and protective factors operate they will be asked to objectively view their own families using the same domains.

Session 5: Building Strengths

The objective of this module is to explore ways to integrate strength-building strategies into daily life. This intervention focuses both on factors commonly associated with risk and protection and factors unique to individual families.

Session 6: Planning for the Next Step

The objective of this final education module is for parents to formulate goals and a plan for meeting them. This session represents a transition from education to multi-family group, providing a more natural setting to discuss the unique challenge of transitions and how that may affect the group and each of their families and to model healthy strategies for coping with transitions.

Sessions 7-11: Multi-family Group

Multi-family group is a platform for practicing and discussing positive family interactions through planned activities, group process and support. Sessions are structured yet allow flexibility in order to be sensitive to the needs of individuals, families, and the group as a whole.

Session 12: Family Exit

The objective of the family exit session is to reflect on the family's experience in the program, reinforce family strengths, assess family goals, and provide closure. The exit session also provides an opportunity to assess the need for further treatment and to address potential referrals.

CHAPTER 5

CONCLUSION

Research has shown that parental interaction is one of the strongest predictors of adolescent behavior (Oxford et al., 2001). Children who grow up in homes with a lack of mutual attachment, ineffective parenting, or a chaotic home environment are far more likely to abuse substances than those in homes where there is a strong mutual bond, parental monitoring and involvement, and supportive parenting with clear and enforced limits (NIDA, 2003). This curriculum is designed to educate parents about risk and protective factors contributing to adolescent substance use and abuse, to provide a supportive environment where parents can explore ways in which these factors operate in their own families, and to act as a laboratory where parents and families can learn and experiment with skills meant to decrease risk factors and increase protective factors among their pre-adolescent children.

Strengths and Weaknesses

The principles for selecting, adapting, or creating new programs (Kumpfer & Alvarado, 2003) are an appropriate structure for reviewing curriculum strengths and weaknesses. This is a multi-component, strengths-based, family-focused intervention that addresses family relations, communication and parental monitoring. The curriculum uses best-practice approaches aimed to create lasting cognitive, affective, and behavioral

changes. The program is not designed to stand alone as a selective intervention, but rather to be integrated into a tiered or universal application.

This curriculum is designed for use by, or used under the supervision of, skilled and experienced group facilitators. Module objectives are fixed, yet content is semi-scripted and flexible, allowing the facilitator to address group needs as they arise. Session content can be modified as time permits.

A strength of the curriculum is its focus on building family strengths, which can potentially produce many positive outcomes other than reducing incidents of adolescent substance abuse.

Another strength of the curriculum is that it requires implementation by skilled and experienced facilitators. The positive side of having skilled facilitators is consistent quality of program delivery. The semi-scripted nature of the facilitator's guidebook creates an appropriate training environment for social work interns or marriage and family therapist trainees.

Implications for Social Work

This curriculum continues a long-standing relationship between social work practice and substance abuse treatment. It approaches treatment from a systems perspective by looking at how the adolescent is effected by the family and by how the family operates in the environment. Moreover, the curriculum works from the strengths perspective by drawing from the belief that individuals and families have the ability to improve their environment by expanding and improving upon the knowledge and skills they already possess. By putting this curriculum into practice, social workers will be

focusing prevention efforts during a crucial period in the lives of children, and in the process, will have the opportunity to break the cycle of substance use and abuse.

The purpose of the curriculum is to reduce incidence of adolescent substance abuse by strengthening families. Setting and group member selection can be determined by the social worker based on needs.

Recommendations for Future Curriculum Development

Curriculum efficacy is strongly tied to the assessment and selection process, facilitator training, and the ability to integrate current best practice interventions into existing programs. Curricula that incorporate culturally appropriate values and norms is highly recommended. Further curriculum development could modify current content and structure in order to strengthen family protective factors in order to combat other outcomes, such as gang affiliation or truancy. The curriculum could also be expanded to include screening and assessment tools for practitioners or for parents.

APPENDICES

APPENDIX A

GROUP LEADER'S GUIDE

GROUP LEADER'S GUIDE

PRELIMINARY CONSIDERATIONS

Purpose of the Curriculum

This is a multi-component curriculum developed to address adolescent substance abuse by educating parents about contributing risk and protective factors, providing a supportive environment where parents can explore ways in which these factors operate in their own families, and by acting as a laboratory where parents and their families can learn and experiment with skills meant to decrease risk factors and increase protective factors among their pre-adolescent children.

Group Leadership

This curriculum is intended for group facilitators and educators experienced in working with substance abuse populations, preferably masters-level social workers, certified alcohol and other drug counselors, or equivalent. The curriculum is designed as a framework within which best practices and cultural considerations can be easily introduced and updated. Facilitators are expected to update statistical information whenever possible.

Format

Structure

Group type and approach will change across the program components (family therapy, psychoeducation, multifamily), yet familiar patterns will be established through consistency of session format. Session content will be objective-driven, yet flexible enough to meet emergent group needs.

There are two 1-hour individual family therapy sessions scheduled for the first and last modules of the program. The objective of the first family session is to establish rapport, assess risk and protective factors within the family, and establish baseline patterns of family interaction and behavior. The objective of the final family session is to

reflect on the family's experience in the program, reinforce family strengths, assess family goals, and provide closure.

The five 2-hour psycho-educational sessions are designed to provide parents with information, skills, and support toward the overarching objective of reducing risk and increasing protection against adolescent substance use.

The five 2-hour multi-family groups provide each family with a platform for practicing and discussing positive family interactions and through planned activities and group process and support. The overarching objective of the multi-family groups is to foster positive family bonding and cohesion, to reinforce skills building models, and to track the progress of individuals and families.

Audience

The curriculum is intended to treat parents and families with pre-adolescent children considered to be at high risk for substance use and abuse. A pre-adolescent can be defined as an individual between the ages of 6 and 11 who has not yet reached puberty.

Group size

Participation is optimal when group size is between 7 to 8, with an acceptable deviation of 2 (Yalom & Leszcz, 2005). Accepting 5-6 families into each cycle of the program will help keep the educational component close to an acceptable range. Capacity can be increased through co-leadership and simultaneous groups. The program can also be accelerated from 12 to 7 weeks by holding psychoeducation and multifamily groups in the same week.

Participant's Workbook

Content delivery of the Participant's Workbook can be flexible and budget-driven. It should consist of PowerPoint slide pages with rule lines for note taking, and it may contain session outlines from the Group Leader's Guide. Facilitators may also wish to create and add guided homework sheets.

Therapeutic Approaches

The curriculum employs three evidence-based therapeutic approaches in order to increase efficacy at different stages of the program. Motivational interviewing will be used prior to and during the intake process and in early sessions in order to assess and promote readiness to change; cognitive behavioral therapy will be used during process-oriented sub-sessions; and solution-focused therapy will be used during aftercare groups and an individual family session, where both parents and children will be present.

Motivational Interviewing

Because this curriculum targets at-risk pre-adolescents and their families prior to the tangible problems that follow AOD exposure and abuse, parents' commitment and buy-in may be challenging. Motivational interviewing (MI) is a therapeutic technique that has proven practical and effective in helping families increase motivation to change (Miller & Rollnick, 2002). Initial interviews will take place with individual families, specifically with parents or primary caregivers of selected pre-adolescents, during the weeks prior to the start of the program. These interviews will employ many features of MI, such as 1) establishing rapport with the parents by empathizing with them regarding characteristics and situations that may be putting their child or children at risk, and by allying with them in the common objective of reducing AOD risk factors and strengthening protective factors, 2) providing information to help facilitate decision-making and commitment, 3) assessing parents' motivation to look at risk and protection in their family system, and their willingness to make changes where necessary, and 4) assisting parents' in problem solving around whatever issues arise that may present barriers to treatment (Miller & Rollnick, 2002; Gance-Cleveland, 2005).

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) has been effective in treating people with a wide range of diagnoses, such as anxiety, depression, obsessive-compulsive disorder, and substance abuse, thus CBT will work well in a group setting that presents a broad array of

risk factors. The overarching goal of CBT is to collaboratively investigate and reveal thought processes that lead to behavioral patterns and to use structured techniques to facilitate change where needed. Using a strengths-based perspective in the context of working with parents and families of at-risk pre-adolescents, the CBT model encourages and reinforces positive thought processes and behaviors, while also revealing the cause and effect nature of negative thoughts and behaviors.

A core feature of CBT is its person-in-environment approach, which subsequently focuses session content around the tasks of daily life. Skills will be taught and practiced in group sessions before being translated into family environments (Verduyn, 2005). Thought processes and belief systems will be identified and explored using guided discovery and the pros and cons of associated behaviors and consequences will be discussed. Thoughts, beliefs, and parenting behaviors that appear to have a positive effect on pre-adolescents will be nurtured while those that contribute to or exacerbate risk will be addressed through skills building, behavior rehearsal, homework assignments, and progress tracking. The group will take a client-centered approach. The facilitator will encourage participants to offer their parenting experiences for group discussion, and will create and support a positive, collaborative environment.

Solution-Focused Therapy

The multi-family aftercare group will act as a problem-solving laboratory, providing support and feedback for families as they work toward behavioral changes. Solution-focused therapy provides a sensible platform for encouraging and reinforcing strategies learned in parent training sessions while also providing structure for engaging resistant pre-adolescents. Solution-focused therapy explores with families the exceptions to problems (Corcoran, 2002) by looking at what has worked for the family in the past. There are a few solution-focused techniques that naturally occur in a dynamic group setting, such as empathy and normalizing (depathologizing behaviors). Other techniques, such as reframing and aligning with family goals will help the facilitator keep the session focused on solutions rather than problems. Scaling questions will also be used to track family successes and challenges.

Corcoran (2002) provided a developmentally appropriate framework for engaging complainants (in this case, pre-adolescents seeking only to please their parents), and visitors (pre-adolescents seeking only to change their parents, their school, etc.). The developmental stage of the target population is such that concrete rather than abstract thinking is typical, thus recalling abstract exceptions will need to be a collaborative family effort, thus strengthening family bonds due to the positive nature of finding exceptions to problems.

Sessions

Check-In Activity

In order to support continuity across program components every session begins with a thematic check-in activity. The central idea of the check-in is to foster a positive atmosphere and to give individuals and families a platform for acknowledging strengths and accomplishments. The check-in theme asks parents and family members to describe a "family favorite". It could be a favorite experience, favorite characteristic, etc.

Education

Educational format and content are concentrated into five parent-only sessions, then reinforced in multi-family groups where families can discuss and problem solve in a supportive environment. Education is meant to provide foundational information and skill-building techniques. The participant's workbook will act as a bridge between group and home by integrating outlines of module content with exercises and activities to complete at home.

Exercises

In-group exercises are meant to supplement and reinforce education module content. The exercises vary in content and format and may ask members to engage with other group members or families. These exercises will take between 20 and 30 minutes.

Discussions

This curriculum is client-centered, and therefore, discussion-centered. Discussions lead or follow each exercise or homework component and group members are encouraged to engage with the material and with the facilitator during education modules, the latter of which allows all group members to model and practice healthy communication skills.

Homework

Group members are given weekly assignments designed to integrate education content into family life. Assignments range from writing and reflection to family activities. The time required for each assignment will vary depending on the nature of the assignment. Discussion time should be allotted at the beginning and near the end of each session to discuss homework assignments.

Family Activities

Family activities are part of each multi-family session. These activities are meant to strengthen family interaction and cohesion and to maintain interest and enthusiasm. Family activities will take between 15 minutes and 1 hour.

Breaks

Breaks provide group members with an opportunity to interact informally, which often leads to increased cohesiveness during group. Five- to 10- minute breaks are given near the middle of the session.

Materials

The Facilitator's Guidebook and the optional Participant's Workbook are the core materials for the program. Psychoeducation modules are presented on PowerPoint slides with corresponding prints in the guidebook and workbook option.

SESSION 1: Introduction to the group

The objective of this module is to familiarize parents with the structure, format and materials of the program, and to introduce parents to the nature and prevalence of adolescent substance use and abuse, the short- and long-term impacts of early onset. The discussion portion of the session explores the concept of risk and protective factors.

Opening Activity: Introductions

Objective: To help create an open, supportive environment where participants will be comfortable interacting with one another.

Procedure: Facilitator will begin introductions. Participants will be asked to tell the group their favorite thing about their family.

Discussion: Group Expectations

Objective: To set clear guidelines for the group.

Materials: Facilitator's Guidebook and Participant's Workbook.

Procedure: Create with participants a set of group agreements (rules and expectations) that will guide the group as it goes forward. Facilitator should ensure the discussion of topics such as confidentiality, mutual respect, attendance and punctuality, and assignment completion. Facilitator should create a list of agreements and distribute a typed copy at the next session.

Discussion: Materials

Objective: Familiarize participants with workbook structure and content.

Materials: Facilitator's Guidebook and Participant's Workbook.

Procedure: Discuss the various components of the Participant's Workbook. Answer any question that may arise about structure or content, and define important terms if needed.

Break

Refreshments may be considered during first session's break so group members will be comfortable interacting.

PowerPoint Presentation

Objective: Introduce parents to the nature and prevalence of adolescent substance use and abuse, the short- and long-term impacts of early onset.

Materials: Laptop, projector, and digital PowerPoint file for session 1.

Procedure: PowerPoints provide information intended to launch group discussions about content. Some material may be new and surprising to parents, which may require sensitivity.

Exercise: Checking Back In

Objective: Provide a structured process for participants to express thoughts and feelings about the content of the PowerPoint slide presentation.

Homework Assignment

Preview and discuss observational homework assignment: Family's relationship with AOD. What part do alcohol and other drugs play in our family and where do they show up? Encourage participants to take notes during the week and to bring the notes next session for discussion.

Close

Dismiss the group participants and thank them for their effort. Encourage them to peruse the workbook throughout the week, but remind them to bring their workbook to each visit.

SESSION 2: Identifying Risk and Protective Factors (Individuals and Families)

The objective of this module is to inform parents about common risk and protective factors contributing to adolescent substance abuse across individual and family domains.

Opening Activity

Objective: To continue building group cohesion by helping participants get to know each other better.

Procedure: Participants partner with someone next to them (other than their partner), trade favorite family holiday stories, then repeat what they heard to the group in the who-what-where-when-why format.

Homework Review

Objective: To discuss participants' experiences with the observational homework assignment.

Procedure: Facilitate discussion about the way people experience alcohol and other drugs in their daily lives. Look for ways to normalize individual experiences.

PowerPoint Presentation

Objective: Introduce parents to the nature of risk and protective factors contributing to adolescent alcohol and other drug abuse.

Materials: Laptop, projector, and digital PowerPoint file for session 2.

Procedure: PowerPoint slides provide information intended to launch group discussions about content. Some material may be new and surprising to parents, which may require sensitivity and process.

Homework Assignment

Preview and discuss the nature and implications of the homework assignment. Participants are asked to inventory the risk and protective factors in their family members and their family as a whole. Participants may find the personal nature of this assignment quite difficult; therefore, it may be helpful to normalize the balance of having both risk and protective factors in all families.

Close

SESSION 3: Identifying Risk and Protective Factors (peer, school, and community)

The objective of this module is to inform parents about common risk and protective factors contributing to adolescent substance abuse across peer, school, and community domains.

Opening Activity

Objective: To shift the focus toward more soothing content

Procedure: Participants discuss their favorite activity outside family.

Homework Review

Objective: To discuss participants' experiences with the risk and protection inventory assignment.

Procedure: Facilitate discussion about the risk and protective factors participants observed in themselves, their families, and their environment.

PowerPoint Presentation

Objective: Introduce parents to the nature of risk and protective factors contributing to adolescent alcohol and other drug abuse.

Materials: Laptop, projector, and digital PowerPoint file for session 3.

Procedure: PowerPoint slides provide information intended to launch group discussions about content. Some material may be new and surprising to parents, which may require sensitivity.

Homework Assignment

Preview and discuss the nature and implications of the homework assignment. Participants are asked to inventory the risk and protective factors within peer groups, schools, and communities.

Close

SESSION 4: Building Strengths

The objective of this module is to explore ways to integrate strength-building strategies into daily life. This intervention focuses both on factors commonly associated with risk and protection and factors unique to individual families.

Opening Activity

Objective: Put the family system into the spotlight.

Procedure: Participants discuss their favorite family activity.

Homework Review

Objective: To discuss participants' experiences with the risk and protection inventory assignment.

Procedure: Facilitate discussion about risk and protective factors participants observed in peers, school, and environment.

PowerPoint Presentation

Objective: Getting participants focused on the protective factors identified in sessions 2 and 3 by re-looking at generalizable strengths correlated with low incidence of AOD abuse (found in session 2 and 3 PowerPoints).

Materials: Laptop, projector, and digital Powerpoint file from sessions 2 and 3

Procedure: PowerPoint slides provide information intended to launch group discussions about content.

Homework Assignment

Preview and discuss the nature and implications of the homework assignment.

Participants are asked to objectively list and reflect upon risk and protective factors observed in the five domains of their own lives: individual, family, peer, school, community.

Close

SESSION 5: Planning for the Next Step

The objective of this final education module is for parents to formulate goals and a plan for meeting them. This session represents a transition from educational setting to multi-family group setting, providing a natural opportunity to discuss the unique challenge of transitions and how that may affect the group and each of their families and to model healthy strategies for coping with transitions.

Opening Activity

Objective: To help participants think about how their experience in the program is benefiting their family.

Procedure: Participants discuss one change they have seen in themselves or other family members since beginning the program. If participants have a difficult time seeing changes, they can use this opportunity to talk about the kinds of change they would like to see in their family.

Homework Review

Objective: To discuss participants' experiences with the risk and protection inventory assignment.

Procedure: Facilitate discussion about how the reflection portion of the risk/protection inventory process. Help participants to reframe risk factors and to celebrate protective factors in their lives.

Group Discussion/Activity

Objective: Help parents assess the results of their risk and protection inventory, generate discussion around goals and planning, and facilitate activity focused on developing individual family goals regarding AOD prevention.

Homework Assignment

Preview and discuss the nature and implications of the homework assignment. Participants are asked to develop a family policy on substance use. Ideally, all family members will participate in the policy design and all family members will agree to the policy. Families are asked to present their substance use policy at the first multifamily group meeting.

Close

SESSIONS 6-11: Multifamily Group

Multi-family group is a platform for practicing and discussing positive family interactions through planned activities, group process and support. Sessions are structured yet allow flexibility in order to be sensitive to the needs of individuals, families, and the group as a whole.

Opening Activities

Objective: The objective of multifamily opening activities is to help create family identity and bonding.

Procedure: Families discuss and agree upon particular favorites, for example, favorite family vacation, favorite family pet, favorite family story, etc.

Group Activities

Objective: Provide a platform for families work together on projects and activities designed to foster positive communication and strengthen family bonds.

Procedure: Activities range from creating a family mascot character, deciding upon a family theme song, developing a family flag or family cheer. Families share their creations with the entire group.

Community Sharing

Objective: Give individual families an opportunity to share a favorite food with the entire group. This activity can help create a family's sense of identity.

Procedure: Families are each chosen once to share a favorite snack food or dessert during the next group and to tell the group why the particular food is meaningful to the family. Depending on number of families, facilitator may decide to assign a family to the community sharing activity during the last education group, or to bring the snack food for the first multifamily group.

Close

APPENDIX B

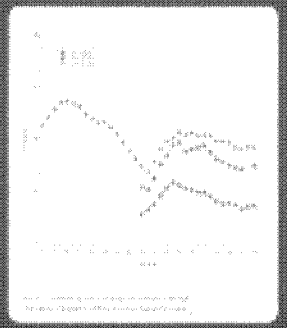
KEYNOTE SLIDE PACKET

A
Substance Abuse
Prevention Program
for Families with
Pre-Adolescent Children

#1: Epidemiology

(who is using what drug)

Trends in annual prevalence of drug use



Data reveal that alcohol and other drug use increases as age increases

- Past month Cannabis use among 8th graders was 5.8%
- Past month Cannabis use among 12th graders was 19.4 (NIDA, 2008)

Alcohol revealed similar trends...

* 15 and 16 year olds (25%) are twice as likely to have drank in the past month as 14 and 15 year olds (14.7)
* 14 and 15 year olds were more than 4 times as likely to have drank than 12 and 13 year olds (3.5%) (SAMHSA, 2006)

Onset of use...

* Before age 12: M=6.5%, F= 2.4%
* Between 15 and 17: M=38.6%, F=28.2%
* After age 21: M=9.3, F=18.8%
  * (NSDUH, 2005)

Early Onset

- Most adolescents who experiment with substances do not develop abuse or dependence issues. However...
- **Prior use is closely associated with the opportunity to use other drugs**

Early Onset

- Among those given the chance to use cocaine, for example, those who had already used marijuana were 15 times more likely to use cocaine, whereas among those who have never used marijuana, fewer than 10% initiated cocaine use (Martin, 2003).

Early Onset

Marijuana

* Adolescents who use Cannabis more than 100 times are:
  * 5 to 8 times more likely to leave school prematurely
  * 3.3 times less likely to enter college
  * 4.5 times less likely to obtain a college degree.

([illegible])

Early Onset

Alcohol

* 32% of past year alcohol abuse disorder cases were adults who had begun drinking before age 14, while only 6.6% had begun drinking after age 18.

([illegible])

- The earlier adolescents initiate use, the higher their risk of developing a substance use disorder as they transition into early adulthood

Therefore...

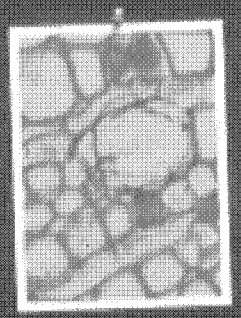
*helping adolescents to prolong initiation can be considered a protective factor

?

#2: Risk and Protective Factors

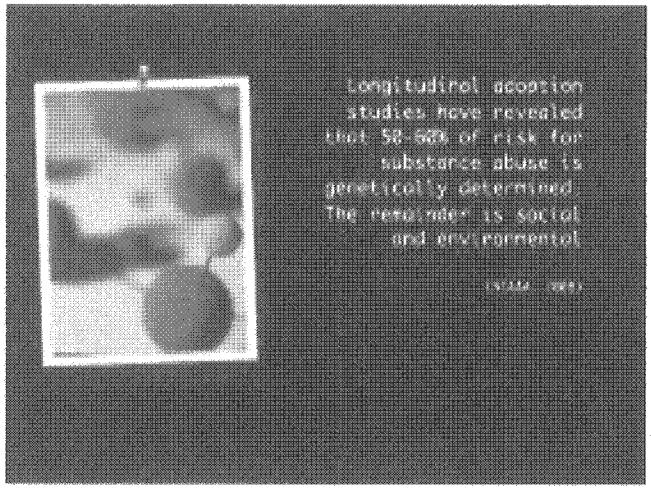
Individuals and Families...

Biological Factors



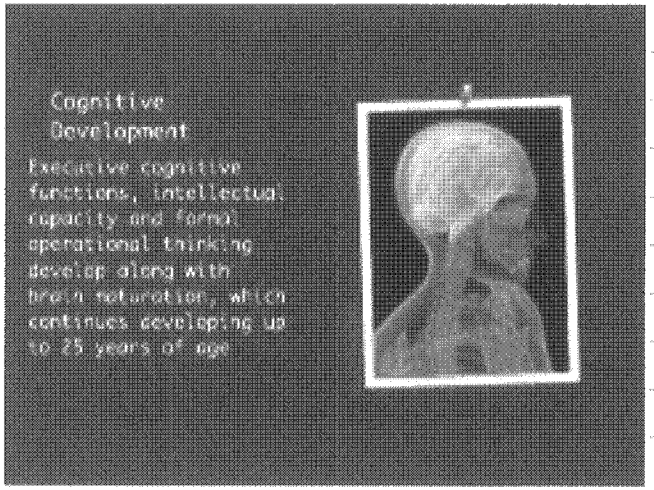
Genetic loading

Cognitive development



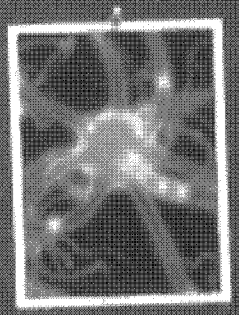
Longitudinal adoption studies have revealed that 50-60% of risk for substance abuse is genetically determined. The remainder is social and environmental

(Volk, 2006)



Cognitive Development

Executive cognitive functions, intellectual capacity and formal operational thinking develop along with brain maturation, which continues developing up to 25 years of age



Deficient in adolescent cognition is the ability to integrate and synthesize information required to select the best option or to rationalize decision-making and foresee the potential consequences of behaviors

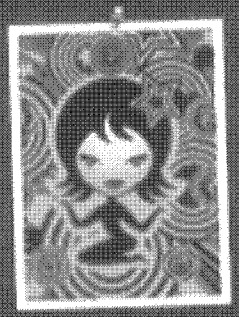
(Spear, 2013)

Psychological Factors

Mood disorders

ADHD

Trauma



Depression

* In 2007, 2.8 million youth ages 12 to 17 reportedly had a major depressive episode in the past year
* Among those, 35.5% reported using an illicit substance—more than twice the rate (17.2%) of adolescents who did not have a major depressive episode (SAMHSA, 2008)

Depression

* In a study of inpatient adolescents, 73% of those who used alcohol and other drugs (AOD) met diagnostic criteria for depression
* In 80% of those adolescents, depressive symptoms preceded AOD use and abuse (Kaminer & Tarter, 1992)

ADHD

(Attention Deficit Hyperactivity Disorder)

- Rates of substance abuse for non-medicated ADHD among adolescents are 75% while rates among those medicated are 25%
- Rates of SUD among adolescents treated for ADHD remain higher than rates among those without ADHD
- There is much debate as to whether ADHD itself increases the likelihood of AOD abuse or if the consequences of ADHD, such as lowered self-esteem or lack of coping mechanisms, may be contributing factors

Trauma

(Post Traumatic Stress Disorder)

- The Adverse Childhood Experiences (ACEs) study
  - A study to examine the biopsychosocial effects of adverse childhood experiences over the lifespan

ACEs Categories

*Abuse, By Category	Category Prevalence (%)
•Psychological	11%
•Physical	11%
•Sexual	22%
Household Dysfunction, by Category	
•Substance Abuse in family	26%
•Mental Illness in family	19%
•Domestic Violence	13%
•Imprisoned Household Member	3%
•Loss of parent	23%

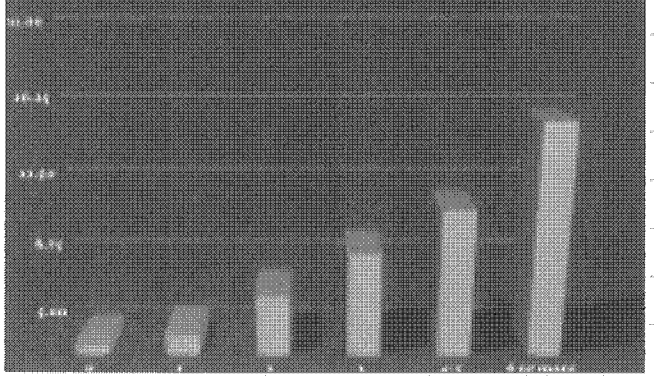
Adverse Childhood Experiences Score

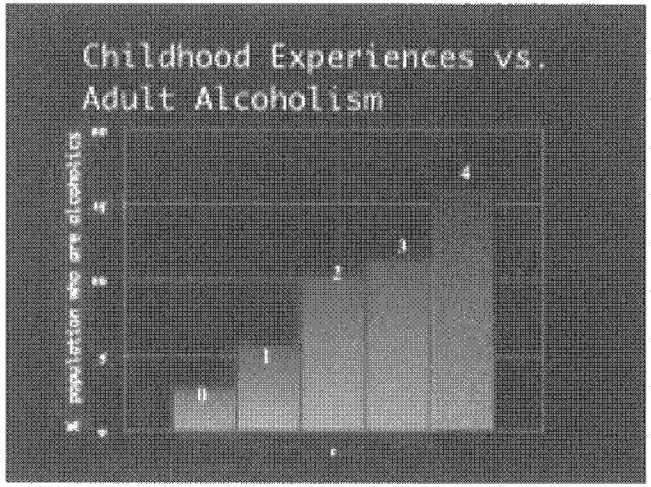
ACE score	Percentage of study population
0	45%
1	25%
2	13%
3	7%
4 +	7%

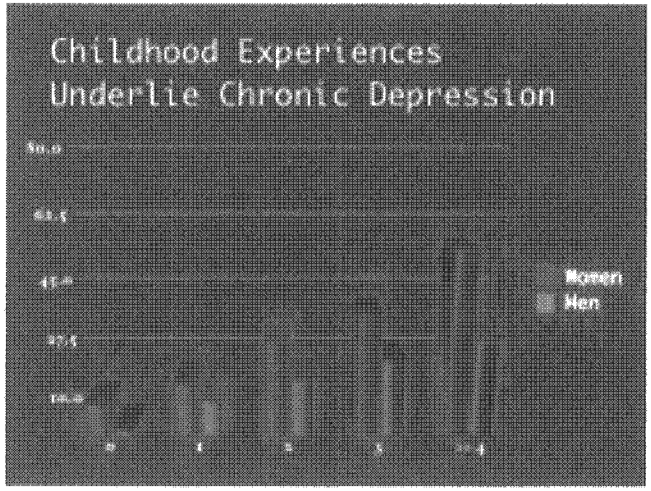
- More than half of the population have at least one ACE
- ACEs tend to cluster: if one ACE is found, the ACE Score is likely to range from 2.4 to 4

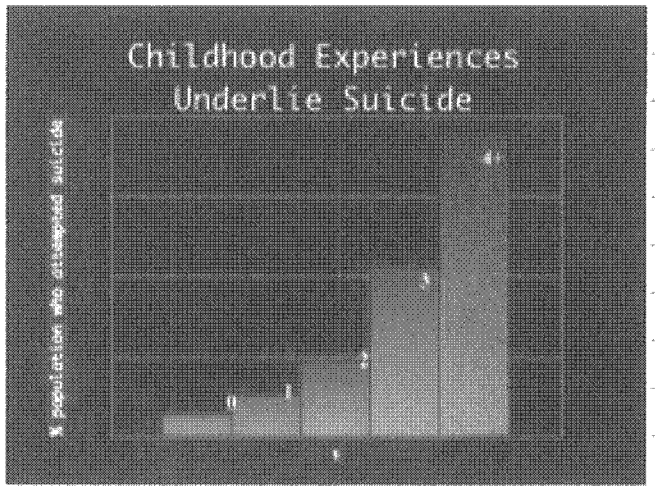
Effects of ACEs

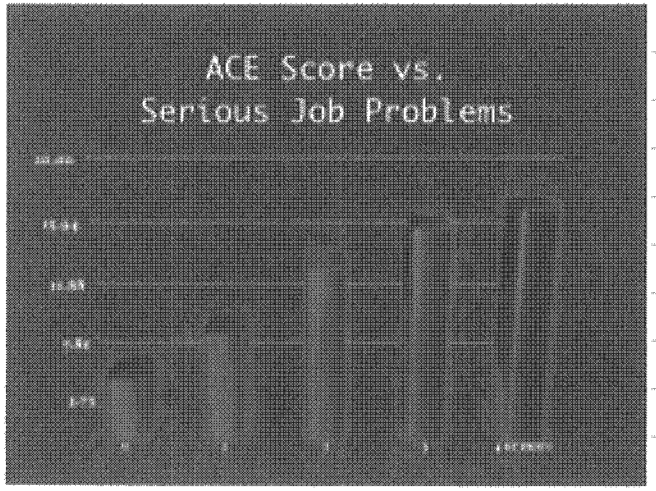
Adverse Childhood Experiences vs. Current Smoking




Childhood Experiences vs.
Adult Alcoholism


Childhood Experiences
Underlie Chronic Depression
Women
Men


Childhood Experiences
Underlie Suicide
4+
3
2
1
0


ACE Score vs.
Serious Job Problems

Social Factors

Social Development

Attachment Theory

Control Theory

Protective Factors

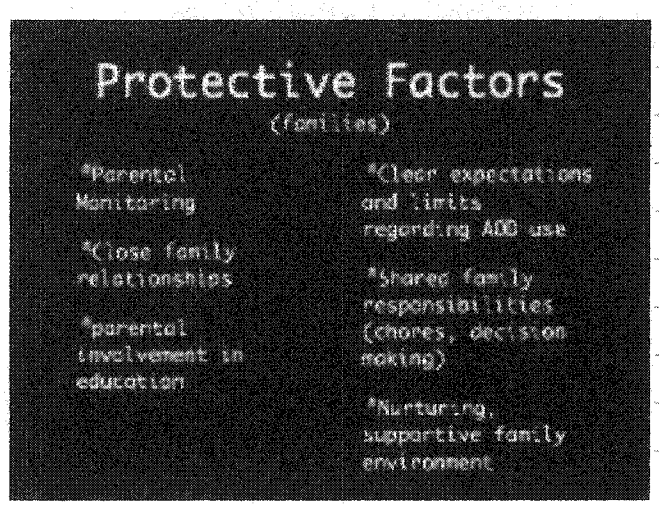
(individuals)

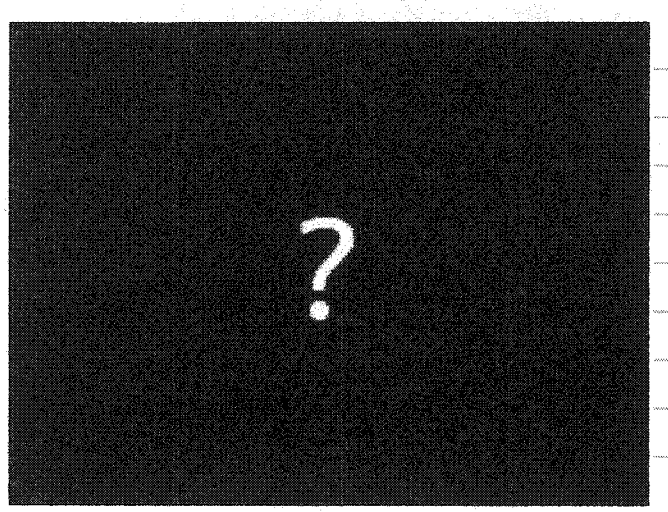
*Self control

*Positive relationships with adults

*Involvement in extracurricular activities

*Positive future plans


Protective Factors
(families)
*Parental Monitoring
*Close family relationships
*parental involvement in education
*Clear expectations and limits regarding ADD use
*Shared family responsibilities (chores, decision making)
*Nurturing, supportive family environment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#3: Risk and Protective Factors

peer, school, community...

Peers

- Risk Factors:
  - Substance Abuse
  - Ties to deviant peers/gangs
  - Inappropriate sexual activity
  - Poor academic achievement among peers
  - peers with poor individual protective factors

Peers

- Protective Factors:
  - Academic competence
  - Involvement in substance-free activities
  - Strong individual protective factors
  - Negative view of AOD use among peers

School

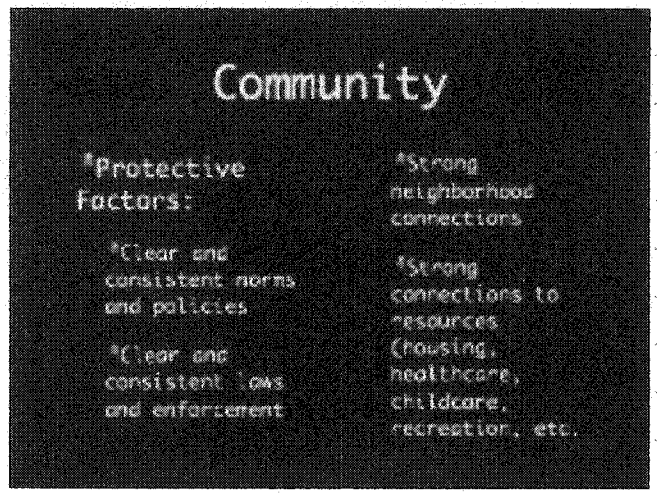
- Risk Factors:
  - Drug availability
  - Poor academic achievement within school
  - Lack of parent involvement
  - Lack of community involvement
  - Lack of school spirit

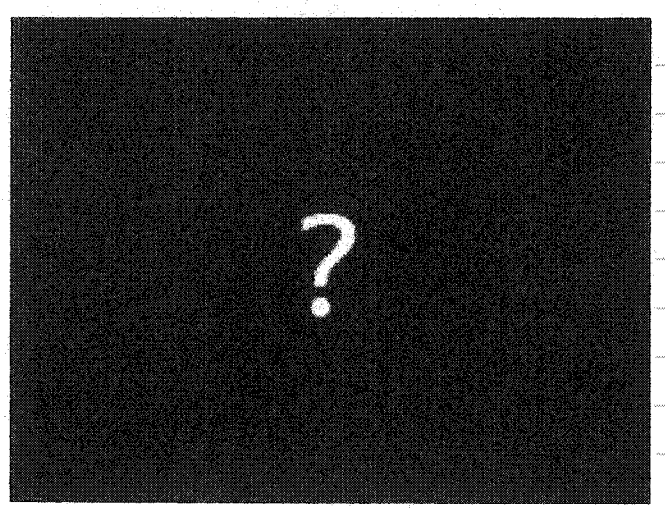
School

- Protective Factors:
  - Anti-ADD policies
  - Strong school spirit
  - Positive attitude towards school
  - Goal-setting, accountability, academic achievement

Community

- Risk Factors:
  - Poverty
  - ADD availability
  - Poor laws and enforcement
  - Unclear norms around ADD
  - Lack of community connection
  - Lack of youth monitoring
  - High unemployment


Community
*Protective factors:
*Clear and consistent norms and policies
*Clear and consistent laws and enforcement
*Strong neighborhood connections
*Strong connections to resources (housing, healthcare, childcare, recreation, etc.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