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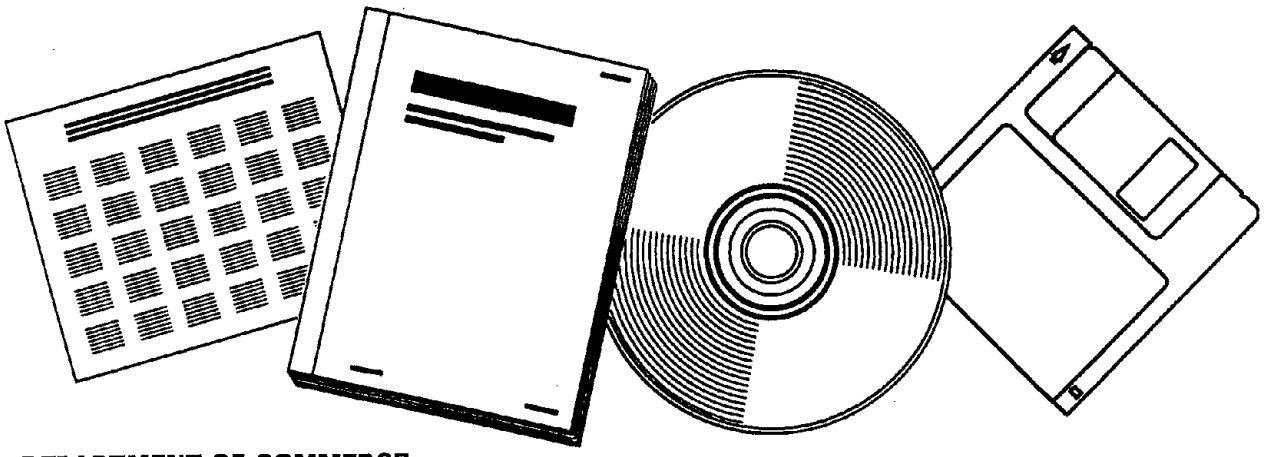
DRUG ABUSE PREVENTION FOR AT-RISK GROUPS

1997



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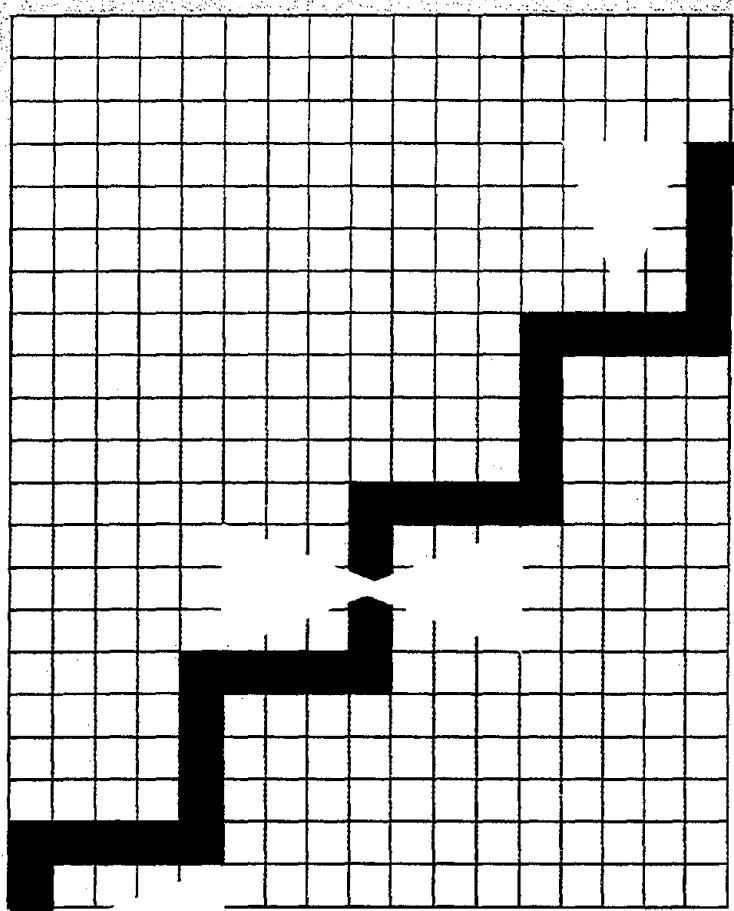
Drug Abuse Prevention for At-Risk Groups



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HOW TO USE THE DRUG ABUSE PREVENTION RESEARCH DISSEMINATION AND APPLICATIONS MATERIALS

Despite the best efforts of the Federal, State, and local governments, drug abuse continues to pose serious threats to the health, and social and economic stability of American communities. The causes of and factors associated with drug abuse are complex and vary across different segments of the population. To be effective, prevention programs must address not only the drug abuse behavior itself but also the relevant cultural, ethnic, regional, and other environmental and biopsychosocial aspects of the population segments being targeted for the prevention efforts. Therefore, it is important to match the program with the population it is to serve and the local community context within which it is to be implemented. The challenge for prevention practitioners is to select, modify, or design prevention strategies that will meet the needs of their constituencies, whether they comprise a whole community or specific segments within a community.

The Drug Abuse Prevention Research Dissemination and Applications (RDA) materials, of which this resource manual is a part, are designed to help practitioners plan and implement more effective prevention programs based on evidence from research about what works. These materials provide practitioners with the information they need to prepare their communities for prevention programming and to select and implement drug abuse prevention strategies that effectively address the needs of their local communities. These materials are intended for use by prevention practitioners who vary in their training and experience in the field but who are interested in developing prevention programs in their communities. The target audience for these documents includes prevention program administrators, prevention specialists, community volunteers, community activists, parents, teachers, counselors, and other individuals who have an interest in drug abuse and its prevention.

The set of materials contains seven documents. Four pieces comprise a core set of materials that are packaged and distributed together and that provide the foundations needed to begin planning effective prevention programs. The remaining three manuals, of which this is one, can be ordered separately. They provide more detailed information on how to implement specific prevention strategies. The four components of the core set of materials are:

- A *brochure* describes the contents of this set of RDA materials and provides information about how prevention practitioners can obtain these materials.

- *Drug Abuse Prevention: What Works* is a handbook that provides an overview of the theory and research on which these materials are based. It includes a definition of prevention, descriptions of drug abuse risk and protective factors, and a discussion of the key features of three prevention strategies—universal, selective,

and indicated—that have proven effective. The handbook also explains how prevention efforts can be strengthened by using knowledge gained through research.

- *Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools* is a resource manual that introduces the concept of community readiness for drug abuse prevention programming. The manual defines community readiness and provides a rationale for assessing a community's readiness prior to the planning or implementation of drug abuse prevention activities. It then identifies seven factors for assessing a community's readiness and offers strategies for increasing readiness factors found to be deficient.

- *Drug Abuse Prevention and Community Readiness: Training Facilitator's Manual* is a 9-hour, modular training curriculum, designed for use by training facilitators in introducing prevention practitioners and community members to the basic theory of drug abuse prevention and the three prevention strategies. The facilitator's manual also provides them with the skills to assess and increase the readiness of a community to launch a prevention effort. The curriculum includes talking points for lectures, instructions for conducting discussions and exercises, and overheads and handouts.

These four core components are intended to be used together as a set. Three stand-alone documents provide more intensive guidance on implementing the three prevention models introduced in the core set of materials. Each manual provides more detailed information about the strategy, including a rationale for its use, and a description of a research-based program model that illustrates the strategy. Information is provided on the key elements of the program, issues that need to be addressed to implement the program successfully, and resources that practitioners can access for more information about the program. These models have been selected because National Institute on Drug Abuse (NIDA) research indicates that these programs have been effective in preventing adolescent drug abuse. The following are the three stand-alone resource manuals:

- *Drug Abuse Prevention for the General Population* discusses the history and key features of universal prevention programs. The Project STAR Program—a communitywide program designed to teach adolescents the skills necessary to counteract the psychosocial influences that increase the likelihood of substance abuse—is described as an illustration of a universal prevention strategy.

- *Drug Abuse Prevention for At-Risk Groups* discusses the history and key features of selective prevention programs. The Strengthening Families Program—a family-

focused program targeting children ages 6 to 10 whose parents are substance abusers—is described as an illustration of a selective prevention strategy.

- *Drug Abuse Prevention for At-Risk Individuals* discusses the history and key features of indicated prevention programs. The Reconnecting Youth Program—a school-based program targeting 9th- through 12th-grade students who are at risk for dropping out of school, substance abuse, and suicidal behavior—is described as an illustration of an indicated prevention strategy.

These examples of universal, selective, and indicated prevention illustrate how different communities have implemented these approaches effectively and show how the models can be varied in different settings. Their inclusion in these materials does *not* imply an endorsement by NIDA. More information on these program models can be found in a video prepared by NIDA titled *Coming Together on Prevention*, which is available from the National Clearinghouse for Alcohol and Drug Information (NCADI). (See appendix A.) If prevention practitioners determine that one or more of these case examples might be appropriate for their communities, they can use the relevant resource manual as a supplement to the RDA core package. The stand-alone resource manuals are not included as part of the RDA core package and have to be ordered separately. Figure 1 shows how a practitioner might use the documents in this set of RDA materials. Appendix A provides information on how to order the RDA core package, the stand-alone manuals, the video, and other materials on the three programs.

These RDA materials are not intended to be an all-inclusive discourse on drug abuse prevention and programming. The programs presented as illustrations of the three prevention strategies all target children or adolescents. This selection is purposeful because this population has been the major thrust of policy, research, and program efforts. This does not imply that there are no effective drug abuse prevention efforts targeting adults, only that this topic is beyond the scope of these materials.

Throughout this manual and the other documents in the drug abuse prevention RDA materials, *substance abuse* is used to refer to illicit drug and alcohol abuse and to the use of tobacco products. Readers unfamiliar with the substance abuse and prevention terms used throughout this manual are referred to the Center for Substance Abuse Prevention (CSAP) *Prevention Primer: An Encyclopedia of Alcohol, Tobacco, and Other Drug Prevention Terms* referenced in appendix A.

Purpose of This Resource Manual

The purpose of this resource manual, *Drug Abuse Prevention for At-Risk Groups*, is to provide the reader with an increased understanding of the concept of selective prevention of drug abuse. Selective prevention strategies target specific subgroups of the general population who are

at risk for substance abuse to deter the onset of substance abuse. This manual describes the key features of selective prevention strategies, briefly describes some examples of successful selective prevention programs implemented in different settings, and presents a detailed description of the Strengthening Families Program (SFP)—a family-focused selective prevention program that targets 6- to 10-year-old children whose parents are substance abusers. This manual is intended for use by prevention practitioners who are interested in learning more about selective prevention strategies and potentially implementing such a program or programs in their local communities.

The primary objectives of this resource manual are to:

- Provide an overview of the key features of selective prevention;
- Demonstrate that selective prevention strategies work by presenting a summary of some of the research on selective prevention programs;
- Motivate the reader to consider initiating and/or participating in selective prevention efforts;
- Provide guidance to the reader who may be considering implementing a selective prevention program; and
- Describe the SFP, which is one example of a selective, family-focused prevention program.

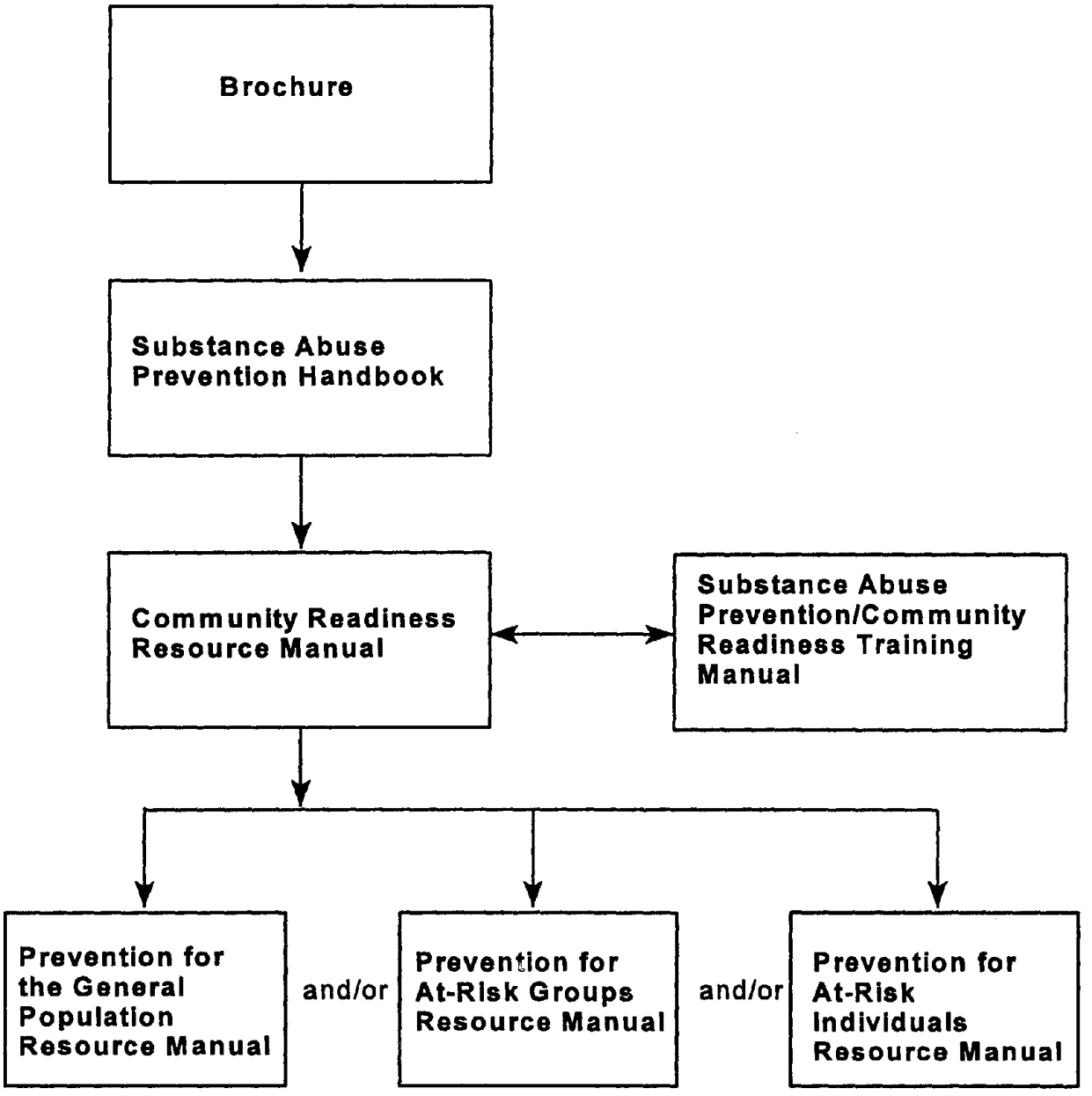
Specifically, this manual presents an overview of relevant literature on the research-based theory of selective prevention programming, including a summary of the history and key features of selective prevention programs. A brief review of the most current research on selective prevention is included, along with discussions of some examples of successful selective prevention programs.

Finally, this manual presents a detailed discussion of the SFP selective prevention approach. The discussion addresses the rationale for the inclusion of the SFP in this set of RDA materials, the key elements of the SFP model, significant research findings about the program, the approach to the implementation of this program, and issues and other points to consider in the implementation of the SFP model. Information also is included on resources such as SFP program materials, training resources, and other technical assistance resources that are available for the reader who wishes to implement the SFP model in his or her community.

Figure 1

Substance Abuse Prevention

Research Dissemination and Applications Materials



INTRODUCTION TO SELECTIVE PREVENTION

This chapter presents the conceptual basis for selective prevention and describes the role of selective approaches in drug abuse prevention. It then describes how to identify target groups that are appropriate for selective prevention programs. The key features of selective prevention programs are presented along with a rationale for why communities would consider selective prevention. The chapter next presents an overview of some relevant research on selective prevention programs. The chapter ends with an overview of a family-based selective prevention program model, the Strengthening Families Program (SFP). The SFP is described in more detail in the remaining chapters.

Two Conceptual Models of Prevention

Traditionally, prevention efforts have been conceptualized within a public health model in which prevention strategies to combat substance abuse have been organized along a continuum of primary, secondary, and tertiary prevention (Commission on Chronic Illness 1957; CSAP 1991).

- The goal of *primary prevention* is to protect individuals who have not yet begun to use substances to decrease the incidence of new users.

- The goal of *secondary prevention* (also called early intervention) is to intervene with persons who are in the early stages of substance abuse or who exhibit problem behaviors associated with substance abuse to reduce and/or eliminate the use.

- The goal of *tertiary prevention* (treatment) is to end substance dependency and addiction and/or ameliorate the negative effects of substance abuse through treatment and rehabilitation.

In response to criticism of the public health model, the Institute of Medicine (IOM 1994) proposed a new framework for classifying prevention, based on Gordon's (1987, pp. 20-26) operational classification of disease prevention. The IOM model divides the continuum of care into three parts: prevention, treatment, and maintenance. The prevention category is further divided into three classifications—universal, selective, and indicated prevention interventions, which replace the confusing concepts of primary, secondary, and tertiary prevention. Universal prevention strategies are those that address the entire population (national, local community, school, neighborhood) with messages and programs aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs. Selective prevention strategies target subsets of the total population that are deemed to be at risk for substance abuse by virtue of their membership in a particular population segment—for example, children of adult alcoholics, school dropouts, or students who are failing academically. Indicated prevention strategies are designed to prevent the

onset of substance abuse in specific individuals who do not yet meet DSM-III-R or DSM-IV criteria for addiction but who are showing early danger signs—such as falling grades and use of alcohol and other gateway drugs.

These three types of prevention do not correspond at all with the public health model of primary, secondary, and tertiary prevention. The overall aim of these strategies is to reduce the number of new cases of substance abuse as defined by DSM-III-R or DSM-IV. In addition, these interventions are designed to reduce the duration of the early signs of substance abuse and halt the severity and intensity of the progression of abuse.

For more information on these three prevention approaches, the reader is referred to *Drug Abuse Prevention: What Works* available through NCADI (see appendix A).

Selective Prevention Intervention Strategies

Selective prevention refers to strategies that target specific subgroups of the general population that are believed to be at greater risk than others. It targets the entire subgroup regardless of the degree of risk of any individual within the group. One individual in the subgroup may not be at personal risk for substance abuse, whereas another individual in this same subgroup may be abusing substances. The selective prevention program is presented to the entire subgroup because the subgroup as a whole is at higher risk for abuse than the general population. An individual's personal risk is not specifically assessed or identified and is based solely on a presumption given his or her membership in the at-risk subgroup.

The purpose of selective prevention is to deter the onset of substance abuse by strengthening the protective factors (such as self-esteem, problemsolving ability) of members of these at-risk subgroups and helping them learn how to deal effectively with risk factors (such as a genetic predisposition to drug abuse problems or association with people who abuse drugs). The subgroups targeted for selective prevention may be defined on the basis of the following types of risk factors:

- Demographic risk factors such as age, gender, socioeconomic status, and place of residence;
- Psychosocial risk factors such as family dysfunction and substance abuse, lack of school bonding, and academic failure;
- Biological and genetic risk factors such as a genetic predisposition for substance abuse; and

- Environmental risk factors such as disorganized communities with norms that support drug abuse.

Selective prevention programs are generally more costly to operate per participant than universal prevention programs because they target a wider range of risk factors over a longer period of time than do universal programs. Selective prevention programs focus on the school, family, and/or community and generally are operated in schools or community service agencies. The Strengthening Families Program described in detail in this resource manual, is an example of a selective prevention program focused on the family.

Identification of Subgroups for Selective Prevention

As the prevention field has matured, more sophisticated methods have been developed to identify the subgroups of the general population that are at risk for substance abuse. The research methods that are now used to identify the appropriate recipients for selective prevention programs consider not just demographic risk factors within the population but psychosocial, environmental, and biological and genetic risk factors for substance abuse as well.

Demographic Risk Factors

Demographic risk factors that can be used to identify at-risk groups include:

- Age;
- Gender;
- Race/ethnicity;
- Socioeconomic status;
- Employment;
- Income;
- Education;
- Location of residence; and
- Population density of community of residence.

Survey research studies are often used as the basis for the selection of demographic risk factors. However, because each area of the country differs with respect to the types of substances that are abused and in the local cultural and socioeconomic climate, general conclusions derived from national surveys of substance abuse may not match local survey data. Therefore, when designing a selective prevention program, practitioners may need to consult their county and State substance abuse agencies for local statistics on who uses what drugs. This information is essential for determining whom to target for selective prevention programs.

Today, many selective prevention programs target youth and adults who are at risk only on the basis of demographic risk factors. For example, because of the common belief that ethnic youth are at greater risk for drug abuse (which is generally not true), many selective prevention programs have been developed for them. However, prevention practitioners must be sure that local statistics truly indicate that the group of individuals targeted for the prevention effort are at higher risk for substance abuse and why. The major risk factor for ethnic youth may actually be an at-risk neighborhood with high rates of crime and substance abuse.

Psychosocial Risk Factors

Psychosocial risk factors used to identify at-risk groups are categorized according to the area of the risk, that is, within the individual, peer group, family, school, or community. Research suggests that psychosocial factors provide significant hazards for substance abuse (Smart and Fejer 1972; Brook et al. 1986; Hansen et al. 1987; Kandel 1980; Newcomb et al. 1986; Barnes and Welte 1986; Kandel and Andrews 1987; Brook et al. 1988; Needle et al. 1986; Estrada et al. 1982; Patterson et al. 1989, 1992; Dielman et al. 1989a; Wahler et al. 1979).

Psychosocial risk factors include:

- Family disruption and/or dysfunction due to death, parental divorce, and parental incarceration;
- High levels of family stress due to low income, unemployment, and lack of extended family or support system;
- Family substance abuse and parental emotional disturbance;
- Lack of support for positive school values and attitudes;
- Dysfunction within the school environment such as high rates of substance abuse and pro-use norms;
- Low teacher and student morale;

Environmental Risk Factors

Environmental risk factors include:

- A school climate that provides little encouragement and support to students;
- Community values and attitudes that are tolerant of substance abuse;
- Community dysfunction such as high rates of drug-related crime, high rates of drug abuse, and drug-infested housing projects;
- Lack of active community institutions; and
- Lack of community support resources.

Biological and Genetic Risk Factors

Biological and genetic risk factors offer additional means for identifying subgroups of the population that are at increased risk for substance abuse. These factors include:

- Fetal damage in utero due to drug exposure that can lead to biological problems such as mental retardation, hyperactivity, and attention deficit disorder;
- Genetically inherited vulnerabilities for alcohol and drug abuse found among children whose parents or first-degree relatives are substance abusers, have mental health problems such as depression, or have antisocial behavior problems (Conger and Rueter, in press). In general, research suggests that these children can inherit one or more of many genes from parents that can cause:
  - A reaction to alcohol and drugs making them more pleasurable to use;
  - Difficult temperament;
  - Hyperactivity;
  - Depression;
  - Pain sensitivity;

— Thrill-seeking; and

— Neurological problems.

Research has shown that children of parents who abuse drugs or other substances have a higher probability of becoming substance abusers themselves. This increased vulnerability may possibly be because of biological factors or because these children live with drug-abusing parents. It appears, however, that there may be a purely genetic basis for some part of the vulnerability of some persons to alcohol and drugs (Pickens and Svikis 1986). In general, research suggests that children can inherit a vulnerability to substance abuse.

Key Features of Selective Prevention Programs

Selective prevention programs differ in content and form depending on the particular subgroup that is targeted for the prevention effort. However, the major determinant of whether a program is a selective prevention program is not the type of program but who receives the program. Therefore, regardless of their differences, selective prevention programs share certain common features or characteristics that define them as selective prevention efforts. The distinguishing features of selective prevention programs include the following:

- Programs target subgroups of the general population that are determined to be at risk for substance abuse;
- They are designed to delay or prevent substance abuse;
- Recipients of selective prevention are known to have specific risks for substance abuse and are recruited to participate in the prevention effort because of that group's risk profile;
- The degree of individual vulnerability or personal risk of members of the targeted subgroup generally is not assessed, but vulnerability is presumed on the basis of their membership in the at-risk group;
- Knowledge of specific risk factors within the target group allows program designers to address specific risk reduction objectives;
- Selective prevention programs generally run for a longer period of time and require more time and effort from participants than universal programs;
- Selective programs require skilled staff because they target multiproblem youth, families, and communities that are at risk for substance abuse;

- The programs may be more expensive per person than universal programs because they require more time and effort; and

- The program activities generally are more involved in the daily lives of the participants and attempt to change the participants in specific ways, for example, by increasing participants' communication skills.

Types of Selective Prevention Programs

Selective prevention programs include a variety of approaches that target at-risk groups. These programs include:

- Psychoeducational and skills training activities;

- Tutoring programs;

- Youth leadership programs; and

- Cultural competency training activities for youth.

Generally, selective prevention programs are operated as *pull-out* programs in schools or in community agencies, that is, students are pulled out of the classroom or general group at specific times to participate in the programs. Some programs targeting at-risk youth are operated within public housing communities and in low-income neighborhoods.

One example of a school-based selective prevention program is the *Seattle Social Development Project* (Hawkins et al. 1987). This program, designed for low-income elementary school children in 1st- through 6th-grades and their caregivers, is intended to prevent school failure, substance abuse, and delinquency among these at-risk children. This program incorporates three psychoeducational skills training components—a teacher training component, a cognitive and social skills training component for children, and a parenting education and training component. These components are implemented on differing schedules.

The teacher training component for mainstream classroom teachers is designed to change the teaching methods of the classroom teachers by providing them with a package of instructional techniques that emphasize proactive classroom management, interactive teaching, and cooperative learning. This component also includes direct observation and provision of feedback by project staff and school principals to the teachers on the use of the project teaching techniques.

The student skills training component, for children in the 1st- and 6th-grades, consists of cognitive and social skills training in which 1st-grade students are provided training that focuses

on the development of communication, decisionmaking, negotiation, and conflict resolution skills. The 6th-grade students are provided training that emphasizes the development of refusal skills.

Finally, the parenting education and training component for the parents and adult caregivers of the 1st-, 2nd-, and 3rd-grade children focuses on the parents learning to observe and pinpoint the desirable and undesirable behaviors of their children, develop appropriate behavioral expectations for the children, and provide consistent and contingent positive reinforcement for desirable behavior and moderate negative consequences for undesirable behavior. In addition, this program component seeks to improve parent-child communication and involvement by teaching parents how to help their children develop reading and math skills.

At the end of grade 6, the results of the project showed that:

- Both the low-income boys and girls who were exposed to the prevention program developed greater attachment and commitment to school and had higher levels of classroom participation than a comparable group of children who were not exposed to the program.

- The girls who participated in the program initiated use of alcohol, tobacco, and marijuana at lower rates than the girls who did not receive the program.

- When compared with sixth grade boys who did not participate in the program, the boys who received the program showed higher levels of social skills, better academic skills, and higher scores on standardized achievement tests.

- Program participants also showed a lower incidence of involvement with antisocial peers and lower rates of initiation of delinquent behavior.

These results indicate that this school-based selective prevention program was effective in changing the opportunity, skill, and reinforcement structure of regular classrooms and families as a means for achieving positive effects with low-income students who were at risk for academic failure, delinquency, and substance abuse.

Another example of a selective prevention program for at-risk families is the Strengthening Families Program highlighted in this manual. This multicomponent selective prevention program is specifically designed to address the needs of children whose parent(s) abuses substances. A more detailed discussion of this program, including descriptions of each of its key elements, is presented in the following chapters of this resource manual.

Why Consider Selective Prevention?

The purpose of selective prevention programs is to deter the onset of drug and other substance abuse by providing the members of at-risk subgroups of the general population with the information and skills necessary to reduce their vulnerability. Selective prevention programs can cost more per person to operate than do universal programs and may require more specially trained staff to administer. However, they are likely to be more efficient and effective than universal programs with at-risk populations because they target known risk factors for substance abuse and related problems. Therefore, selective prevention strategies should be considered because:

- Selective strategies are specifically designed to target subgroups of the general population that are at-risk for substance abuse.
- The goal of selective prevention is to intervene with the targeted groups before substance abuse and related problems develop.
- Research indicates that at-risk groups require prevention programs that are specifically designed to address their needs.
- The prevention effort is intended to mitigate problems associated with risk factors for the entire subgroup regardless of the risk status of any individual member of the group.
- It is not feasible to assess the individual risk status of members of the subgroup deemed to be at risk.
- Because specific behavior change is the objective of selective prevention, the prevention effort focuses on the protective factors (such as optimism, insight, self-esteem, and problemsolving skills) that serve to support the desired behavior.

Much is known about the kinds of factors that place people at risk for substance abuse and about the kinds of factors that are believed to provide protection against such abuse. Therefore, selective prevention approaches are more likely to be effective for at-risk groups when they specifically target these risk and protective factors. For example, selective prevention programs are effective because they focus directly on the vulnerable subgroups by reducing risk factors and increasing protective factors.

Research on Selective Prevention Approaches

Research confirming the effectiveness of selective prevention programs is limited, in part because the prevention field only recently has begun to target programs to at-risk subgroups of the general population. Much of the research that has been done has entailed primarily process evaluations documenting program implementation. In general, selective prevention approaches that have been rigorously evaluated have shown positive effects (Goplerud 1991; Lorion and Ross 1992). Selective prevention programs that focus on skills training are capable of improving youths' performance in school, family, and peer-group settings. If the programs are operated over a long enough period, they also can reduce depression and increase self-esteem. Parents, teachers, and youth report improvements in:

- Academic performance;
- Social relationships;
- Family relationships; and
- Life skills (such as problemsolving, planning, and decisionmaking).

Although there have been few long-term followup studies of selective prevention programs, those that have been conducted for preschool programs have shown long-term positive benefits of participation (Berrueta-Cement et al. 1984; Casto and Mastropieri 1986; Hubbel 1983).

Selective prevention programs for families appear to be more effective than the approaches that focus only on the youth or the parent (Mitchell et al., in press). In recent years there has been a shift from focusing prevention activities primarily on children to focusing on improving the parenting skills of parents and, more recently, to recognizing the importance of changing the total family environment. Recently developed skills training programs for families are comprehensive and include the following kinds of services:

- Structured parent training;
- Children's social skills training;
- Family relationship enhancement or family skills training; and
- Family support services (for example, case management, home-visiting, food and nutrition services, transportation, supportive counseling, and crisis intervention).

Examples of structured family-based prevention approaches include the Strengthening Families Program (Kumpfer et al. 1989a, pp. 108-125; 1989b, pp. 194-200; 1989c), the Nurturing Program, and the Family Effectiveness Program (Szapocznik et al. 1989).

Selective prevention programs, if well designed and correctly implemented, have great potential for having lasting effects on at-risk groups. For a program to have a measurable impact, it is essential that the risk factors that define the participants match those addressed by the program design. If the correct match is found between the risk factors of the target subgroup and the prevention program elements and activities, positive benefits will accrue to the program participants. Although this is an appropriate first step, there is need now to confirm the effectiveness of these kinds of approaches for drug abuse prevention.

The Strengthening Families Program: An Example of Selective Prevention

The example of the Strengthening Families Program is included in this resource manual as an illustration of a selective prevention program. The SFP targets children of a major risk group—children of parents who are substance abusers; it is a family-based prevention program. These children generally live in multiproblem families and are vulnerable to substance abuse because of biological and environmental risk factors. The SFP has been implemented and evaluated in a number of sites, including community agencies and schools, and has been found to be effective as a selective prevention approach. The SFP also has been modified for use with various at-risk ethnic groups, and evaluation results have shown the program to be effective across such groups.

The SFP was selected as an example of selective prevention for inclusion in this resource manual for a number of reasons:

- It is a selective prevention program that has been successfully implemented in a variety of settings and with diverse populations.
- It has been demonstrated to be effective in reducing family environmental risk factors as well as behavioral and psychological problems associated with substance abuse.
- It includes many of the key features that are characteristic of selective prevention programs.
- The effectiveness of the program has been established from extensive research and long-term evaluation.

The SFP is an important selective substance abuse prevention program, but it is presented here only for purposes of illustration. It is presented to show how a selective prevention effort can be implemented and to inform prevention practitioners of the kinds of issues and barriers they may encounter in their attempts to implement selective prevention programs in their communities. The following chapter provides a more detailed discussion of the SFP. Although the SFP is an effective research-based prevention program, the reader is reminded that inclusion of this program in this manual does not imply an endorsement by NIDA.

INTRODUCTION TO THE STRENGTHENING FAMILIES PROGRAM

Research suggests that children whose parents abuse drug and other substances are a subgroup highly vulnerable to becoming substance abusers (Kumpfer 1987). For this reason, targeting prevention efforts to this subgroup can make a difference in the lives of these children. This chapter provides a detailed description of the Strengthening Families Program, a prevention program that targets the children of substance abusers. This chapter presents a brief overview of the history of the SFP and describes the program's components. A discussion then follows of the cultural considerations involved in the use of the SFP with diverse population groups. Finally, research findings on the effects of the SFP, including a 5-year follow-up study, are presented.

History of the Strengthening Families Program

The SFP was developed by researchers at the University of Utah in response to requests from parents enrolled in a methadone treatment program. These parents wanted to improve their parenting skills to help their children avoid substance abuse. The development of the SFP began in 1983 as a 3-year prevention research project that was funded by the National Institute on Drug Abuse. The program has been tested in a variety of diverse settings, including urban and rural areas.

The Strengthening Families Program is an example of a family-based selective prevention program that was developed specifically for children of substance abusers who are at risk for substance abuse. It also has been used with at-risk youth who already exhibit behavioral and/or emotional risk factors for drug and other substance abuse. The SFP has been modified for use with different ethnic groups, and it has been implemented in community centers, mental health centers, churches, public housing communities, and drug treatment agencies and hospitals.

The Theoretical Basis of the SFP

The theoretical basis of the SFP model assumes that family environment is an important factor in deterring use of alcohol and/or other drugs among youth. Family climate and parenting factors are often the major determinants of children's self-esteem, with high self-esteem being highly correlated with positive school bonding. Family environment is an important factor that influences even a child's choice of friends. Therefore, improving parent-child relationships should be a major goal of a prevention program.

The SFP assumes that to reduce risk factors among children of substance abusers, it is necessary to improve the family environment and the parents' abilities to provide appropriate opportunities for their children to receive rewards for positive attitudes and behaviors. Because of the large number of family relationship problems that can be found in homes where parents abuse substances, the program developers determined that to make more lasting changes, more was needed than short parenting classes. They believed that a more effective training program

would allow staff trainers an opportunity to model appropriate parenting skills and responses to the behavior of their children and then to coach the parents to imitate those responses.

In addition, the program developers believed that the children needed to acquire skills in effective communication, coping, making friends, and self-control. The developers wanted to teach the children these skills, as well as provide models for the children to follow to reinforce their learning of these new skills. Hence, the intent was to design and test a family-based prevention program that combined three separate but interrelated program components.

Goals and Objectives of the SFP

The SFP program is designed to reduce family environmental risk factors and improve protective factors with the ultimate goal of increasing the resiliency of youth 6 to 10 years of age who are at risk for substance abuse. (There is also a 7-session version of the program for junior high school youth ages 11 to 14.) Specifically, the major goals and objectives of the SFP are:

- To increase parenting skills by:
  - Increasing positive attention and praise;
  - Increasing parents' levels of empathy for their children;
  - Increasing parents' use of effective discipline;
  - Decreasing parent's use of physical punishment; and
  - Decreasing parent's use or demonstrating use of substances.
- To increase children's skills by:
  - Increasing their communication skills;
  - Increasing their skills to resist peer pressure to use substances or engage in other inappropriate behaviors;
  - Increasing recognition of feelings;
  - Increasing knowledge about alcohol and drugs;
  - Increasing skills for coping with anger and criticism;

- — Increasing compliance with parental requests;
- — Increasing their self-esteem;
- — Decreasing aggressive and other problem behaviors; and
- — Reducing intentions to use in the future and the actual use of substances.

- To improve family relationships by:
  - — Decreasing family conflict;
  - — Improving family communications;
  - — Increasing parent-child time together; and
  - — Increasing planning and organization skills.

The SFP Program Approach

SFP participants meet for 2 to 3 hours weekly for 14 weeks. There are three components to the weekly meetings:

- Parent skills training;
- Children's skills training; and
- Family skills training.

The SFP is presented in two versions, each targeting two different at-risk populations:

- A program for elementary school-age children (ages 6 to 10) of substance abusers and their families, and
- A parallel 7-session program (called SPFII) for at-risk junior high school students (ages 11 to 14) and their families.

The 7-session version of the program for junior high school students was created as part of a research project in 19 counties in Iowa that was funded by NIDA and the National Institute on Mental Health (NIMH). The results evaluating the effectiveness of this version of the project

are not yet available. However, more information about this project is available from Kumpfer and colleagues (Kumpfer et al. 1996) or by contacting the program developer (see appendix A).

In weekly sessions over 14 consecutive weeks, parents and their children attend separate, 1-hour group sessions—parent training sessions for the parents, and children's training sessions for the children—followed by a 1-hour family training session, which children and parents attend together. Announcements before groups begin, breaks between groups, and meals afterwards can add up to 1 additional hour, for a total of 2 to 3 hours per session. The rationale for this order of presentation is to provide opportunities for the parents and children to learn their respective skills in their individual groups but then come together to practice those skills within the context of the family.

The family skills training component involves parents and their children working together to learn and practice new behaviors. This learning strategy is used because, when dealing with at-risk or dysfunctional families, the developers of SFP found that the appropriate behaviors become easier to incorporate into the interpersonal relationships of the family members when the service providers demonstrate appropriate behaviors and then participants practice the behaviors. In this way, parents can be acknowledged immediately for improvements in their parenting, and that acknowledgement increases their confidence and effectiveness in parenting. In addition, the parents are more likely to complete home practice assignments if they first have practiced the relevant behavior and received feedback during the program training sessions.

The three components of the SFP can be used in different ways depending on the needs of the families and the implementing agency's staff resources. For example, in the original program format, the youth and parents attended their own sessions separately for the first hour and then met with individual family therapists for the second hour. However, in other areas of the country, small multifamily groups (from four to six families) have been used successfully for the family skills training component.

To increase the recruitment and retention of SFP participants, a variety of incentives also has been developed by the sites implementing the program. These incentives have included:

- Meals and snacks;
- Transportation;
- Rewards for attendance and participation, such as tickets for sporting, cultural, and educational events; family social activities; household items; and children's Christmas gifts;
- Nursery or child care for siblings;

- Adolescent recreational activities; and
- Support and tutoring groups for older siblings.

SFP Cultural Modifications

Since its initial development as a program for substance-abusing parents and their children, SFP has been modified for use with African-American families; Asian, Pacific Island, and Hawaiian families; families of low socioeconomic status, regardless of race or ethnicity; and families of 11- to 14-year-old children who are at-risk. This latter version (SPFII) of the program is currently being evaluated. The adaptation for Hispanic/Latino families also currently is being evaluated.

When adapting the program to meet the needs of culturally diverse populations, the program developers considered the following points:

- Program trainers should be matched to the program participants as closely as possible in terms of their ethnicity and cultural background.
- Trainers should have the major responsibility to change or otherwise modify the language and examples used during the training sessions to be appropriate to the local culture because it is difficult to develop training manuals with examples and language that are locally appropriate for a wide range of different cultural groups.
- Role plays, case scenarios, and other types of exercises should be culturally relevant for the program participants. For example, role playing a situation where a father comes home drunk and late for a dinner prepared by the mother may not be relevant for single mothers.
- Prevention exercises and activities should be personalized and tailored to accommodate the specific cultural characteristics and needs of the groups targeted by the prevention effort.

SFP Program Effectiveness: Research Findings

The SFP was specifically designed to reduce the family environmental risk factors associated with substance abuse because little can be done to change genetic or biological risk factors. The focus of the program is on strengthening protective factors associated with non-substance abuse through the creation of an enduring improvement in family relationships, parenting effectiveness, and family climate.

The SFP has been extensively evaluated and has shown positive outcomes with substance-abusing families in general, and with low-income, rural and urban African-American families, urban Hispanic/Latino families (currently being evaluated), and rural and urban Asian and Pacific Island families in particular. The positive program results are consistent across the different sites implementing the program.

The primary outcomes of the program were reductions in family conflict and improvements in family communication and organization as well as reductions in youth conduct disorders, aggressiveness, and emotional problems such as depression as measured by a standardized diagnostic instrument for children, the Child Behavior Checklist (CBCL). One factor that has been found to be critical to program success is the recruitment and retention of the appropriate at-risk groups of children and parents into the program.

Results of evaluations of replications of SFP have shown that the program is effective in reducing:

- Family environmental risk factors;
- Behavioral and psychological risk factors for substance abuse among the children;
- Tobacco and alcohol use in children who had initiated use; and
- Intentions to use tobacco, alcohol and other drugs in the future.

The parents participating in the SFP who were substance abusers showed:

- Dramatic reduction in depression;
- Reduced substance abuse; and
- Improved parenting skills.

A 5-year followup study at several sites found that parents reported the SFP made a dramatic difference in their children's behavior, improved the parent-child relationship and communication, and reduced family conflict (Harrison 1994).

Original SFP Research Findings

When the SFP was begun in 1983, it was conducted with clients participating in an outpatient community mental health and drug-free and methadone treatment program. The family

program was conducted at community centers as a means to avoid the possible stigma of a program associated with substance abuse.

An extensive array of data collection instruments was used to measure program effects with information collected from multiple sources, including parents, children, and teachers. Analysis of preprogram data revealed that children of substance-abusing parents (from 71 families in treatment) had a significantly higher incidence of behavioral, academic, social, and emotional problems than a comparison group of children from 47 families who did not receive the program (DeMarsh and Kumpfer 1986).

Research findings also showed that the parent training curriculum significantly improved parenting skills and parenting self-efficacy, the children's skills program improved children's social skills, and the family skills training program improved family relationships and the family environment. In addition, when all three classes were coordinated and run simultaneously, the children's responses to risk and protective factors improved. Use of tobacco and alcohol in the older children who were already using substances decreased (DeMarsh and Kumpfer 1986), and parents also reduced their substance abuse and improved in their effectiveness as parents (DeMarsh and Kumpfer 1986).

Research on the program demonstrated that the combined force of all three program components was most effective in reducing the children's risk status in three program-targeted areas: (1) children's problem behaviors, emotional status, and social skills; (2) parents' parenting skills; and (3) family environment and family functioning (e.g., improved family communication, clarity of family rules, nonconflictual sibling relationships, and decreased family conflict and social isolation).

In general, the pattern of results suggested that each program component was effective in reducing risk the factors most directly targeted by that component. For example, the behavioral parenting component of the 14 sessions improved the parents' ability to reduce negative, acting-out behaviors in their children and to improve compliance with parent requests. However, the parent training component alone did not improve the children's social skills (communication, problemsolving, peer resistance, and goal-setting). These skills were significantly improved when the children's skills training component was added. Family environment and functioning variables actually deteriorated when only the parent training component was implemented. However, when the family relationship enhancement component was added to create the total SFP, the parent and child relationships improved significantly.

These promising results of the SFP have been replicated in eight locations with at-risk ethnic minority populations. For example, the program was replicated with:

- African-American low-income mothers in rural Alabama;

- African-American substance abusers in Detroit;
- Low-income Hispanic/Latino families in public housing communities in Denver;
- Asian/Pacific Islander and Hispanic/Latino families in three counties in Utah; and
- Asian/Pacific Island families in Hawaii.

The results of the Alabama, Detroit, and Utah studies with multiethnic, urban, and rural populations have supported the general positive findings of the original program research. These results are summarized below.

Rural African-American Families

The SFP was implemented by the Cahaba Mental Health Center in Selma, Alabama. African-American mothers who had substance abuse problems were recruited from among mental health center clients, public housing projects, and special education classes and through informal contacts with leaders within the African American community. Sixty-two families began the program, and 51 families completed at least 12 of the 14 sessions. Significant reductions in substance abuse were found for the mothers who had high substance abuse as measured by a composite alcohol- and drug-abuse score for a 30-day period. Other significant improvements included significant reductions in family conflict in the high-substance-abuse families, which is illustrated in Figure 2.

Before the program was implemented, the children of the mothers who were heavy substance abusers had significantly higher scores than the children of low-substance-abuse mothers on a variety of measures, such as depression, obsessive-compulsive disorders, somatic complaints, social withdrawal, aggression, delinquency, and hyperactivity. For these children, significant improvements were seen in all areas except communication after completion of the program. Figures 3 and 4 respectively show the reductions in depression and externalization (i.e., agression, delinquent behaviors and hyperactivity) among the children of the mothers who were heavy substance abusers. Children of low-substance-abuse mothers improved only on the measures of obsessive-compulsive behavior, aggression, and delinquency. These were the same measures on which they had scored relatively high before the program was implemented. These results suggested that the SFP was effective in reducing problem behaviors the children exhibited before the program began. The results also suggested that the SFP is equally effective with children of less well-educated mothers (who did not complete high school) as with children of better educated mothers (who completed high school).

Figure 2
Alabama Research Results: Family Conflict

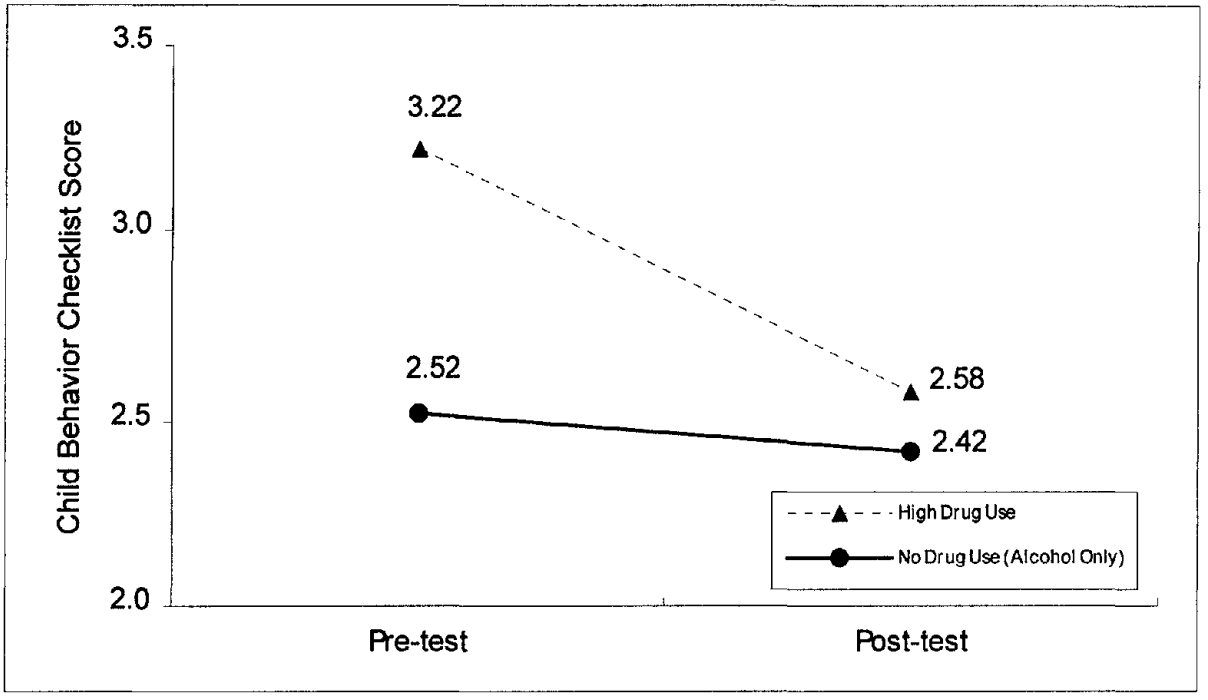


Figure 3
Alabama Research Results: Children's Depression

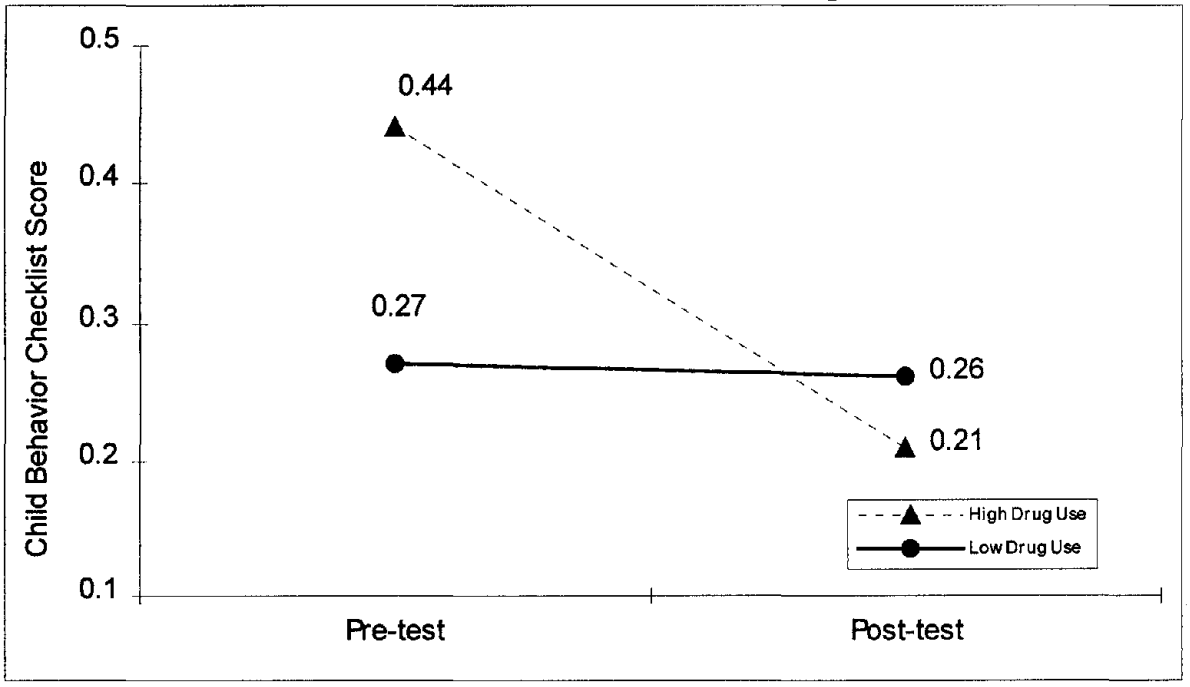
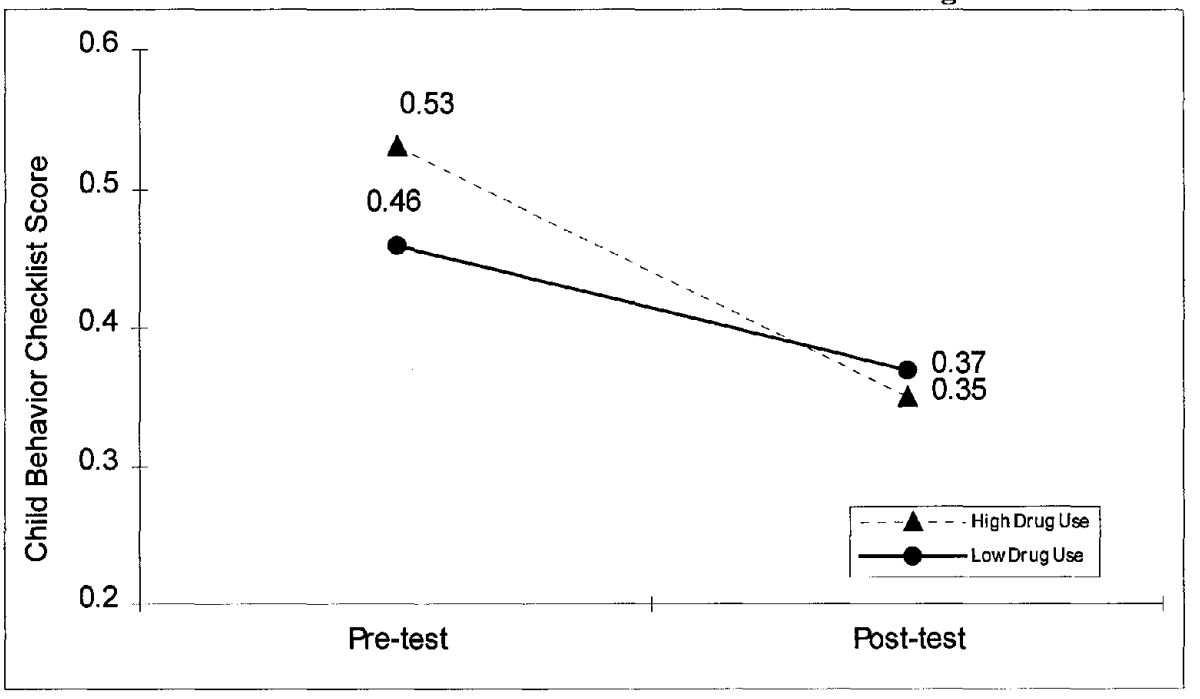


Figure 4
Alabama Research Results: Children's Externalizing



Urban African-American Families

The African-American parent version of the SFP developed for use in rural Alabama was modified for use with urban African-American parents in Michigan (Aktan 1995). By the end of the second year of program implementation, 51 families had completed the family program. The results showed that the SFP had a significant positive impact on the participating children and the parents (Aktan et al. 1996).

Parents reported decreased substance abuse, depression, use of corporal punishment and increased perceptions of competence as parents. Based on parents' reports, children's problem behaviors, including delinquency, aggression, and hyperactivity, decreased dramatically. These improvements were significant among the children of the high-drug-using parents for a variety of problems, including school problems, depression, communication problems, obsessive-compulsive disorders, and social withdrawal.

In addition, program results revealed significantly improved family relationships, improved family organization, reduced family conflict, and increased family cohesion. The researchers suggested that this increase in family cohesion, which was not found in Alabama, may have occurred because the *Safe Haven* program put an emphasis on reuniting mothers and fathers as a

total family. These families reported spending more time together. They also reported that the frequency of parent-and-child activities increased.

Hispanic/Latino and Asian Families

The Utah State Division of Substance Abuse was funded by the Center for Substance Abuse Prevention (CSAP) to implement a quasi-experimental pretest, posttest, and 3-month followup study to compare the effectiveness of the 14-session SFP with a shorter 11-session version of the program (Communities Empowering Parents Program). The 11-session version does not include the family skills training component. The study was implemented in three counties in Utah through eight agencies that formed a partnership, including two agencies serving primarily ethnic families: the Asian Association of Utah and Centro de la Familia. A total of 421 parents and 703 at-risk youth ages 6 to 13 years were recruited to attend one of the two programs. Program materials for both programs and the evaluation instrument battery were translated into Spanish, Vietnamese, Tongan, Korean,and Chinese for this project.

On the pretest, the study found that 57 percent of the youths had behavioral and academic problems. Attendance and completion of the program were high, averaging 85 percent across the three county sites; however, only 203 parents and 448 youth completed the postprogram evaluation battery. The lower posttest completion rates can be explained partially because this was a demonstration project, not a research project; therefore, there was less emphasis on data collection. Also, some participating agencies did not stress data collection with their staff, hence, two of the agencies had poor data-collection rates. Participants were not reimbursed for their time to complete the posttest; reimbursement increases completion rates.

The analysis of the preprogram and postprogram changes in scores suggested improvements in family environment, parenting behaviors, and children's behaviors and emotional status. Results for the 11-session comparison program without the family skills component were less impressive.

Five-Year Followup Study

A 5-year followup study of SFP participants by an independent evaluator included 87 families (Harrison 1994). The purpose of the study was to assess the long-term effects of the SFP on families that had previously completed the program in three counties in Utah. The results of the study provided evidence of the long-term positive impact of the program on the families. For example, a majority of the families were still using the skills they had learned in the program. The following table presents a summary of the kinds of program effects that were reported by the parents 5 years after their participation in the SFP.

FIVE-YEAR FOLLOWUP STUDY FINDINGS

- 99% of parents believed they were giving their children clear directions.
- 97% of parents reported improvements in the quality of the time they spent with their children.
- 97% of parents were catching their children being good.
- 95% of parents used reasonable consequences for their children's behavior.
- 94% of families enjoyed each other more.
- 85% of families scheduled family play-time on a regular basis.
- 84% of parents improved their problemsolving interactions with their children.
- 78% of parents reported decreases in family problems.
- 75% of parents reported decreased levels of stress and conflict.
- 68% of families were still using family meetings at least once per month, and 37% conducted them weekly.
- 67% of parents reported family talking together more.
- 65% of parents reported showing positive feelings.
- 62% of parents reported increased amounts of family fun.

The results of the evaluations of the SFP have consistently demonstrated positive effects concerning decreases in family-based risk, increases in family-based protective factors, and improvements in children's behaviors on standardized measures.

This chapter has provided an overview of the Strengthening Families Program, including the history of the program, the approach of this prevention program model, and a discussion of the research findings on the effectiveness of the program with diverse cultural groups. The following chapter presents a detailed discussion of the key elements of the SFP.

KEY ELEMENTS OF THE STRENGTHENING FAMILIES PROGRAM

The Strengthening Families Program is a selective prevention program for family change in that it involves not just the parents or just the children, but the entire family in the prevention effort. To reduce substance abuse risk factors and increase protective factors among children of substance abusers, the SFP was designed to improve the family environment. The SFP focuses on improving the abilities of substance-abusing parents to nurture and provide appropriate learning opportunities for their children through a psychoeducational learning approach. This chapter provides a brief description of the program manuals that form the basis of the program and are used to guide the skills development training sessions. The chapter then presents a detailed discussion of the three key programmatic elements of the SFP, including a description of the contents and process of the training. The chapter ends with a brief discussion of issues addressed by the developers in the evaluation of the SFP.

The SFP consists of three key programmatic elements:

- A Parent Skills Training Program;
- A Children's Skills Training Program; and
- A Family Skills Training Program.

Parents meet weekly for 1 hour in the Parent Skills Training Program while the children meet in a separate Children's Skills Training Program. Following these meetings, parents and children meet together for 1 more hour in the Family Skills Training Program. In addition to the 2 hours spent in these meetings, there may be snacks and announcements before the parents' and children's meetings begin, a break before the Family Skills Training begins, and a meal afterwards. Consequently, the total time in the program each week ranges from 2 to 3 hours, with 2 hours spent in groups.

SFP Program Manuals

A set of seven program manuals guides the implementation of these three program elements. Five manuals are curriculum manuals and program participant handbooks designed to be used in each of the three training programs. These include:

- *Parent Skills Training Manual* for the trainer;
- *Parent Handbook*;
- *Children's Skills Training Manual* for the trainer;

- *Children's Handbook*; and
- *Family Skills Training Manual* for the trainer.

Each of these will be described briefly as appropriate below. The remaining two manuals are designed to be used to implement and to evaluate the effects of the SFP. These are:

- *Program Implementation Manual*; and
- Program Evaluation materials.

The issues addressed in the SFP Implementation Manual have been incorporated into the discussion of the implementation of the program in the next chapter of this resource manual. In addition, all program handbooks and manuals were modified to be culturally appropriate for urban African-American families (12-sessions with video tapes for all parenting sessions) and for rural white families (7-session junior high school version with video tapes). See appendix A for further information about obtaining these manuals.

It has been found that SFP participants value having their own manuals of homework assignments and readings because many of the families do not have books available in their homes. However, some agencies have found it useful to provide the homework and reading assignments at each session to avoid the likelihood that program participants will lose their manuals.

Parent Skills Training Component

This section describes the content of the Parent Skills Training component of the SFP. The contents of the training curriculum are described, and there is a discussion of the methods by which the training is delivered. The format for each of the 14 parent training sessions is specified in the parent skills training trainer's manual. An example of a lesson plan from the parent skills training curriculum is presented in appendix B. This example is taken from *Lesson 3: Rewards* of the training manual.

Usually, each training session begins with a review of homework assignments and the concepts that were taught the previous week. New parenting concepts are reviewed, and new homework is assigned. Two staff trainers are recommended for each training session. The optimum number of participants for the parenting groups should range from six to eight sets of parents or from eight to 12 individual participants, depending on the number of single-parent or two-parent families participating in the program.

The skills training content is presented through a variety of methods including:

- Lectures;
- Demonstrations;
- Discussions;
- Role plays;
- Homework assignments;
- Practice exercises;
- Peer group support;
- Games;
- Supervised practice; and
- Video presentations.

Delivery of program training activities may differ somewhat depending on the individual training styles and capabilities of the trainers. In the initial implementation of the SFP, trainers adhered closely to the specified training delivery methods. However, in general practice, trainers often modify the program to fit the local population and the strengths of the trainers. Different trainers and participants may feel more comfortable with some methods; therefore, a variety of methods is provided to accommodate these preferences.

Parent Skills Curriculum

The Parent Skills Training component consists of the following content presented over the course of the 14 program weeks. Each week focuses on one of the 14 topics below, in the order in which they are listed.

- *Introduction and Group Building*. This is the opening session of the SFP during which the parents are welcomed to, and provided an overview of the program. Each training session in the program is reviewed and a course outline is distributed to the group members. Issues such as participant attrition, barriers to attendance, and rewards for attendance are discussed. Group-building exercises are presented as well as a short lecture on learning theory.

- *Developmental Expectancies and Stress Management*. The parents and staff discuss realistic expectations for the children in terms of developmental expectancies. Stress and anger management also is covered in this session.

- *Rewards*. The issue of rewarding children for their good behavior is addressed in this session. Rewards are differentiated from bribery. *Attends*, or paying attention to children only when they engage in good behavior, and social rewards, such as smiles and hugs, are discussed. The *catch them being good* philosophy is emphasized. This philosophy underscores the practice of parents looking for good behavior to reward in their children rather than looking for bad behavior to punish.

- *Goals and Objectives*. This session includes a short lecture on the topic of normal child development. Most of the session is spent on goal setting, defining good behavior, establishing behavioral goals and objectives for both parents and children, and making positive statements to children.

- *Differential Attention/Charts and Spinners*. The parents are taught the skill of differential attention, that is, attending to the desired behaviors of their children and ignoring unwanted behaviors. They are taught the secret rules of success that the children learn in the Children's Skills Training session. The skills of learning to reward a child are addressed including rewarding positive behaviors immediately, telling the child what behavior is likee, being consistent, being genuine, and making sure the reward is something the child likes/wants. Parents also are taught how to appropriately ignore undesirable child behaviors. The session ends with the parents making chore charts and spinners to track their children's behavior and progress toward rewards for good behavior.

- *Communication I*. Parents are taught listening and speaking roles, *I messages*, and roadblocks to communication. Extensive time is spent role playing these skills. Parents also are instructed to practice these skills at home with their children.

- *Communication II*. This session reinforces concepts that were discussed in the previous session. Group members role play significant issues with each other.

- *Alcohol, Drugs, and Families*. This session was designed for parents who are in alcohol and drug treatment. This session introduces the parents' role in prevention of problem behaviors in their children. Awareness of parental impact on children also is discussed. A video about children who are vulnerable or at risk is used to reinforce the concepts taught during this session.

- *Problemsolving, Giving Directions.* Parents are taught basic problemsolving skills, which their children also are learning. Making requests and giving directions also are covered in this session.

- *Limit Setting I.* During this session, parents are taught the behavior management skills of overcorrection (repeated practice of desirable behavior) and timeout (removing a disruptive child from the opportunity to receive positive reinforcement for the disruptive behavior), and good behavior cues are discussed. The previously learned skill of differential attention also is reinforced during this session.

- *Limit Setting II.* The behavior management skills discussed in the previous session are reviewed, and the issue of punishment is covered extensively. Problemsolving around a child's problem behavior, in terms of which behavior management strategies to use, is an exercise used to reinforce concepts covered in this session.

- *Limit Setting III.* Parents continue to problemsolve a variety of problems, including those supplied in the handbook and others that may be relevant to the individual needs of group members.

- *Development/Implementation of Behavior Programs.* Steps involved in implementing a behavior management program are reviewed. This includes discussion of issues such as identifying problem behaviors, behaviors parents would like their children to perform, and writing behavioral goal statements. The group then helps develop the first week of a behavior program for one or more of the participants. Parents rehearse the words they will use to introduce the behavior program to their children and receive feedback from other parents in the group.

- *Generalization and Maintenance.* A lecture on how to survive excuses or arguments and not give in is presented to parents. Parents are taught to decrease the use of extrinsic kinds of rewards, such as toys and candy, and to look for naturally occurring rewards, such as the good feeling that comes with accomplishing a difficult task. Parents also are taught to maintain the behavioral changes that have been made. This termination session also focuses on the progress made by group members. Participants often are encouraged to meet monthly as an ongoing support group.

Parent Skills Training Manual and *Parent Handbook*

This skills training manual for trainers includes all the group lectures, discussions, readings, group exercises, and homework forms for use in the parent skills training sessions. The time required to complete each section of the sessions is included in the manual, as well as

materials needed for each activity. The manuals have cartoons and pictures to make the activities more interesting and easy to use. The *Parent Handbook* contains the worksheets, activity sheets, and contracts and plans that are introduced by the program trainers in the *Parent Skills Training Manual.*

Children's Skills Training Program

This section describes the content of the Children's Skills Training component of the SFP. The contents of the training curriculum are described, and there is a discussion of the methods by which training is delivered. The format for each of the 14 children's training sessions is provided in the children's skills training curriculum. An example of a lesson plan from this curriculum is presented in appendix C. This example is taken from *Lesson 5: How To Say "NO" To Stay Out of Trouble* of the training manual.

Training Delivery

The children divide into three groups of 3- to 5-year-olds, 6- to 10-year-olds, and 11- to 14-year-olds or the best natural breaks based on the children's ages. Because the program has a strong emphasis on the family unit, all siblings who want to participate can, as long as they meet the age guidelines for the various groups. The optimum number of participants for each children's group is six or seven children. Therefore, because the children's skills training sessions usually have many more than six or seven children participating, after a general welcome the children divide into smaller, more manageable size groups. Ideally, there should be two trainers per group. Child care for children younger than 3 years of age is a necessary service to offer participants and should be made available.

The format for each session is specified in the curriculum. Generally, each children's session begins with a review of homework and the previous week's concepts. Children are taught the new material through a variety of methods, including:

- Exercises;
- Games;
- Coloring and workbook activities;
- Role plays;
- Puppet shows; and
- Discussions.

A review of new material is conducted, and new homework is assigned. Children who follow the group rules, which are explained in the first session, may be rewarded with small prizes from a grab bag filled with school supplies such as pencils, crayons, erasers, and colored pens. For the children's groups, it is important to have a space where the children can sit on the floor on pillows or in small chairs. Decorating the space with children's artwork and displaying the group rules helps to make the children feel more comfortable.

Program Curriculum

The Children's Skills Training curriculum consists of the following content. Each week focuses on one of the 14 topics below, in the order in which they are listed.

- *Hello and Rules.* This opening session welcomes children to the group through the use of games and songs. The children are provided a rationale for why the group has been established, and the remainder of the session is devoted to developing and discussing group rules.

- *Social Skills I.* The children review the group rules and incentives for session participation, as well as the names of the other participants in the group. Conversational skills, specifically listening, are discussed. The children then can play some suggested games, color illustrated conversation skills workbook pages, or role play to reinforce the concept of social skills.

- *Social Skills II.* Listening skills are reviewed and speaking skills, such as the use of eye contact, appropriate distance, and appropriate voice volume, are discussed. The children are taught appropriate ways to interrupt others. Praise and complimenting others also are stressed. Role plays, coloring activities, and a puppet show are used to reinforce speaking skills.

- *Creating Good Behavior, Secret Rules of Success.* Identifying children's likes and dislikes regarding the members of their families is the focus of this session. Goal statements are developed, and the children are taught the "Secret Rules of Success," the same principles their parent(s) are learning in the parents' group. The children then role play relevant situations where they can use the success rules.

- *How To Say "NO" To Stay Out of Trouble.* Through discussion, games, stories, and role plays, the children are taught four basic steps to stay out of trouble.

- *Communication I: Speaking and Listening.* Following a review of the social skills that were learned during the second and third sessions, "family talks" are discussed. The children also are taught additional speaking and listening skills such

as the use of "I feel" messages, saying one thing at a time, not talking for others, showing interest, accepting others' views, asking questions, and not jumping to conclusions. Holding "family meetings" is the assigned homework for the next few sessions.

- *Communication II: Preparation for Family Meetings.* "Rules for Family Talks" and speaking and listening rules are reviewed. Puppets and role plays are used to illustrate the concept of telling a friend when you need help.

- *Alcohol and Drugs.* The children are taught the effects and consequences of alcohol and drug abuse through the use of stories, lecture, and discussion.

- *Problemsolving.* Seven steps to solving problems are presented in this session. The children role play several examples to reinforce the concept of problemsolving.

- *Introduction to Parents' Game.* The children are taught the skills of giving good (effective) and bad (ineffective) directions through the use of discussion and demonstration.

- *Coping Skills I: Recognizing Feelings.* Through the use of songs, discussion, games, and worksheets, the children are taught how to recognize feelings in themselves and others, how people may have similar or different feelings about the same situations, and what to do about those feelings.

- *Coping Skills II: Dealing With Criticism.* This session focuses on how to give and receive criticism. Role plays are used to illustrate the concept.

- *Coping Skills III: Coping With Anger.* The children discuss things that make them angry, coping with anger, and controlling and expressing anger. Problemsolving skills are reviewed in relation to dealing with anger. The children then role play the new skills.

- *Graduation, Resources for Help, and Review.* The children are taught about resources that can help them if they have problems and their parent(s) are unavailable to help. Problemsolving skills are emphasized, as are staying safe and staying out of trouble (reviewed from session five). The children then review the content of all 14 sessions. Graduation certificates are awarded for completion of the children's skills training group.

Children's Skills Training Manual and *Children's Handbook*

The *Children's Skills Training Manual* for trainers includes all the group discussion, group exercises, and homework assignments the trainers will need to conduct the children's skills training sessions. The time required to complete each section of the sessions is included in the manual, as well as materials needed for each activity. The *Children's Handbook* contains the worksheets, activity sheets, and stories introduced by the trainers from the *Children's Skills Training Manual* and allows for skills practice within the home environment. These manuals also contain cartoons and pictures to maintain the interest of the children.

Family Skills Training Program

This section describes the content of the Family Skills Training component of the SFP in which parents and children work together on family skills development. The contents of the training curriculum are described, along with a discussion of the methods by which training is delivered. The format for this component of the 14 training sessions is provided in the *Family Skills Training Manual*. An example of a lesson plan from the family skills training curriculum is presented in appendix D. This example is taken from *Lesson 2: Child's Game* of the training manual.

Training Delivery

The Family Skills Training program follows the format used for the parents' and children's groups, and each session lasts 1 hour. Depending on the number of participants, the family group may be divided into two smaller groups with two staff trainers each, or the group may remain intact as one large group with four trainers. If, for example, there are only four families in the group, then each trainer can work with one family individually.

The format for each session is specified in the training curriculum and ranges from didactic to experiential with practical exercises. This program component requires the use of meeting space that is equipped with age-appropriate toys and play equipment for the children. The trainers generally bring children's toys for the Child's Game sessions as well as a clean blanket or rug for parents, children and trainers to sit on on the floor for the Child's Game. There should be at least two trainers per group to help families practice.

The Family Skills Training component is presented in three phases in each family group meeting:

- The Child's Game;
- The Communication Game; and

- The Parents' Game.

The Child's Game

In Phase One, the Child's Game, parents learn how to increase understanding and empathy for their children. They are taught the skills of therapeutic play with their children. The trainer models appropriate behavior for parents to teach them how to observe and understand the behaviors and emotions of their children, an important insight for substance-abusing parents. These sessions are designed to help parents develop empathy for their children while learning to enjoy them. In turn, this nonpunitive environment helps children learn to express the feelings that they often suppress in trying to cope with their stressful alcohol-and/or drug-abusing parent(s).

Most parents who participate in the SFP want to learn how to get their children to comply with their commands. Therefore, the Child's Game is used to improve parent-child relationships. In the Child's Game sessions, parents are asked to play with their children in a positive and less punitive manner. The children decide what they want to do, that is, what toys or games they want to play with, and their parents are asked not to direct or control the activity. Parents are taught to repeat the expressed feelings and behaviors of the children in the manner of a sports announcer. This strategy is designed to ensure that the parents pay attention to their children. These sessions help parents learn to respond more positively to their children's behavior. These sessions resemble play therapy, with parents learning how to be the therapist. The Child's Game sessions are videotaped to allow parents an opportunity to observe their behavior and receive feedback for improvement.

The Communication Game

During Phase Two, the Communication Game, elements of the *Family Relationship Enhancement* program (Guerney 1977) are introduced. In these sessions, parents practice imitating appropriate parenting behavior modeled by the trainer. The trainer in turn provides immediate feedback and reinforcement of the desired behavior to the parents.

The Parents' Game

In Phase Three, the Parents' Game, parents learn to start introducing controls and restrictions on the play of their children. The SFP developers believe that it is important to increase parent understanding of and empathy for children before helping parents learn behavior-control techniques. The parents practice applying appropriate limit-setting on their children's behavior and rewarding their children's good behaviors.

Program Curriculum

The Family Skills Training curriculum consists of the following content. Each week focuses on one of the 14 topics below, in the order in which they are listed.

- *Introduction and Group Building*. The purpose of this beginning session is to present the rationale for the parent training program, present the format and mechanics of the family skills training, and explain the Child's Game and differential attention.

- *Child's Game I*. The purpose of this session is to provide parents with an idea of the problems they are having with parent-child communication. Parents may not realize the scope of the problems. Training for the Child's Game should begin in this session.

- *Child's Game II: Rewards*. Parents and children continue to practice the Child's Game while trainers review parents' attending skills (skills in listening to their children and responding with their observations on what the children are doing).

- *Child's Game III: Goals and Objectives*. The parents and children continue to practice the Child's Game.

- *Child's Game IV: Differential Attention/Charts and Spinners*. The families make charts and spinners. In addition, they continue to practice the Child's Game.

- *Communication I: Speaking, Listening, and Coaching*. The purpose of Communication I and II (below) sessions is to present and discuss reasons for practicing communication skills, review the rules and roles of communication skills, and practice the skills. Families practice with group members who are not of their family. Families begin to practice the family meetings to be conducted at home on a weekly basis.

- *Communication II: Family Meetings*. Families are trained using videos in how to conduct weekly family meetings at home. They are encouraged to practice communication skills, and they are instructed to begin practicing family meetings at home.

- *Communication III: Learning from Parents-Parents' Discussion*. Families continue to practice communication skills, but in this session, they discuss drug and alcohol issues. Parents receive feedback on communication skills practiced at home, and their participation in family meetings at home is rewarded.

- *Parents' Game I: Problemsolving, Giving Directions.* Instructions for the Parents' Game, giving effective commands and requests, and using timeouts are introduced. The importance of consistency is stressed. Parents practice giving effective commands to their children.

- *Parents' Game II: Consequences for Non-compliance.* The families continue to practice the Parents' Game and work together as a family to set rules for the consequences for noncompliance.

- *Parents' Game III: Commands and Timeout.* Parents and children are shown effective commands, and timeout procedures are explained.

- *Parents' Game IV: Parent and Child Interaction on Commands and Consequences.* Families continue to practice the Parents' Game while receiving feedback from the trainer. Parent and child interaction on commands and consequences are covered.

- *Development/Implementation of Family Meetings and Behavior Change Programs.* The families participate in the development and implementation of a child's behavior change program as well as family program (i.e., plans for family meetings and family fun times) to use as a guide after the program is completed.

- *Graduation Party.* This last session is a graduation party for all program participants. Participants are encouraged to plan the party, and certificates of completion may be awarded.

Family Skills Training Manual

The *Family Skills Training Manual* is designed for use by the trainers who conducts the family sessions. The manual includes material for both parents and children, including material for group discussions, group exercises, and homework assignments for the family training sessions. The time required to complete each section of the sessions is included in the manual, as well as a list of all materials required for each session.

SFP Program Evaluation

Because the original development of the SFP was undertaken as a NIDA-funded drug abuse prevention research project, the developers incorporated a comprehensive process and outcome evaluation component into its design and implementation. Although it is important that agencies evaluate the effects of the prevention programs within their respective communities, it may not be possible to undertake an evaluation as extensive as that conducted by the SFP researchers.

Therefore, to guide agencies in a more practical approach, key components of an evaluation of the SFP address the following issues:

- The specific goals of the program for the intended population, that is, what the program implementors anticipate to be the outcome of the program for the targeted risk group;
- The strategies by which the program goals will be achieved;
- The indicators or risk factors that the program is intended to affect;
- The design or plan by which the evaluation will be conducted;
- The instruments that will be used to collect information to measure the effects of the program;
- The plan for how the information will be collected and by whom; and
- The methods that will be used to analyze and interpret the information that is collected.

If these kinds of issues are specifically and objectively addressed in an evaluation of an agency's implementation of the SFP, the agency will be able to determine whether, how, and to what extent the program has affected the population to whom it was targeted. Standardized pretest, posttest, and followup instruments have been developed to measure SFP goals and objectives. For more information on the types of instruments that have been used in previous evaluations of the SFP and/or asistance in evaluating SFP, the reader can contact the researchers listed in appendix A. In addition, the reader is referred to the NIDA Program Evaluation RDA package, *How Good Is Your Drug Treatment Program?* (see appendix A). Although that manual focuses on the evaluation of drug abuse treatment programs, the concepts and models presented in it can be applied to prevention programs as well.

This chapter has provided a detailed discussion of the key program elements of the SFP, including descriptions of the training content and delivery methods for each element and the training manuals that are used to guide program delivery and evaluation. The following chapter presents information that prevention practitioners can use to implement the SFP.

IMPLEMENTATION OF THE SFP: "PUTTING IT ALL TOGETHER"

This chapter presents a discussion of issues related to the implementation of the SFP. Specifically, this chapter discusses SFP staffing, including the qualifications and responsibilities of program staff and staff training and supervision. This chapter also addresses issues related to the recruitment and retention of families for the program and issues related to the conduct of the skills training sessions, including group process issues. Also provided is a discussion of ethical considerations, including confidentiality, that are involved in working with at-risk, multiproblem families. Finally, the chapter presents specific suggestions and recommendations for successful implementation of the SFP.

Program Implementation

The Strengthening Families Program works best when it is incorporated as part of a comprehensive family services program that includes case workers who help with recruitment, have the resources to meet the basic needs of most at-risk families, and provide emotional support and referrals to legal and medical treatment services. The SFP also works well when offered in conjunction with the aftercare component of an alcohol or drug abuse treatment program. It has been implemented in conjunction with self-help groups. Parents who come early or stay after Alcoholics Anonymous (AA), Narcotics Anonymous (NA) or Cocaine Anonymous (CA) meetings to attend Parent Skills Training groups or Family Skills Training groups can have their children participate in the Children's Skills Training groups while they attend their meetings. SFP has been used in conjunction with parent support groups, and sometimes the parents in the SFP form their own parent support group at the end of the program.

The SFP is designed to be presented in 14 consecutive weekly sessions, each lasting from 2 to 3 hours. Parents and children meet together at the beginning of each session for general welcome and announcements. Some programs provide a snack for families during the general welcome, while the families are arriving. Following the general welcome, parents and children separate into their respective groups and work for 1 hour. Next, parents and children are brought back together and work in the Family Skills Training portion of the program for 1 hour. Depending on the number of participants, the family group may be divided into smaller groups or may remain together. Generally, two family groups are formed with two trainers in each. After the second hour, participants may meet for a sit-down dinner and, when possible, a speaker, a film, or other entertainment related to substance abuse prevention.

SFP Program Component Sequencing

Although original research on the SFP showed that all three program components were effective in improving risk factors for substance abuse, the separate program components can be conducted independently. Research has been conducted on the effects of implementing the parent training alone, the parent training in combination with the children's training, and all three

components combined. The SFP has been independently tested for effectiveness with positive results when the family skills training component has been omitted. Some schools have had teachers conduct the program using only the parent skills training component, and the effects have been beneficial for the children (Millard 1988).

If all three program components cannot be included in the implementation, it is acceptable to conduct only one or two of them. However, research indicated that the best results are obtained when all three components are conducted together. It is not yet known whether the children's skills training component alone is effective (Kumpfer et al. 1996). Therefore, the SFP developers cannot recommend the implementation of only the children's program component.

SFP Program Modifications

Some agencies have modified the format or the ordering of the activities within a session. For example, presentation of the program components in reverse order has been used in an inpatient hospital setting prior to group meetings of AA, NA, and CA. During these presentations of the program, the family group sessions were conducted before the parents' and the children's individual training groups met. The children's group sessions were extended to 2 hours to accommodate short parent training group sessions followed by the AA, NA, or CA meetings.

Alternative formats have been successfully used in individuals program participants' homes, treatment clinics, inpatient treatment facilities, schools, and child care centers. The parent skills training program also can be taught by teachers in afterschool programs. Other combinations and modifications are possible to fit the needs of agencies as well as the needs of program participants.

A 32-session children's skills training curriculum has been conducted in conjunction with a half-day summer recreation and cultural enhancement program. Encouraging parents to attend these half-day outings at least monthly has been a successful approach used in some agencies. Parent and child support groups, combined with periodic *booster* sessions (opportunities to repeat the program or to take additional training), also are recommended to maintain the gains achieved through the program.

The group size and location of the program site also are important factors to consider when implementing the SFP. Because the parents' and children's training sessions are conducted concurrently, it is helpful to have two separate rooms for the sessions. A large-group room for the family sessions also is necessary, one large enough to hold from eight to 46 people. If only one large room is available, it is recommended that the room be divided temporarily for the parents' and children's sessions by the use of a curtain or other divider that can be removed later for the family training session.

SFP Program Implementation Sites

The most convenient sites that have been used for the SFP are family support centers in public housing communities. These were used in the Denver Hispanic/Latino SFP site and other cooperative family programs involving housing authorities. In these cases, the parents and youth had to walk only to another unit in their building or housing complex.

Other convenient program locations include free or low-cost facilities such as community centers, churches, and schools. For example, because rural families in Iowa are so isolated, some had to travel up to 15 miles to attend the program. However, use of local schools allowed this to be the maximum distance the families were required to travel. One advantage of conducting the program in schools is that it increases the involvement of school personnel and enhances communication between the parents and the school.

SFP Program Group Sizes

The SFP developers originally projected that the optimal group size would be eight to 12 families. Experience from the Iowa SFP project, however, suggests that groups with as few as five families (12 to 15 individuals) and as large as 14 families (46 individuals) can be effective. A group as large as 14 families requires well-trained, effective, and well-organized facilitators. The smaller groups provided a more intimate and supportive atmosphere in which personal relationships among parents, children and group leaders flourished. In rural areas, some locations had only two to three families; these groups had to be combined with families from other areas, thus adding to the required distance for travel to the sessions.

A crucial element in the practical logistics of any large-scale implementation of the program is the use of local arrangers. These may be parents who are trained and paid to help with logistical duties such as securing and monitoring child care services, making arrangements for building access, and helping secure equipment for the training sessions. The degree of responsibility and motivation of local arrangers can make a big difference in how smoothly the program runs.

Program Staff, Qualifications, and Responsibilities

Staff positions that are important to the effective implementation of the SFP include:

- Program Director;
- Program Coordinator; and
- Program Trainers (or Group Leaders).

The Program Director

The Program Director is usually responsible for hiring staff; managing the program budget, payroll, and personnel; and coordinating program implementation and modification. This position frequently has been held by a doctoral-level psychologist with experience in family and group counseling. However, the SFP has been successfully implemented by Program Directors who have fewer and/or different credentials. It is helpful, however, to have a Program Director who has clinical experience working with drug or alcohol abusers.

The Program Coordinator

The Program Coordinator must have considerable human relations and organization skills because of the many different program aspects that must be organized and coordinated. The Program Coordinator, who is almost always full time and frequently has assistants, ensures that the kinds of program functions listed in the chart are carried out efficiently and effectively. Some of these functions will probably be shared or involve the Program Director as well.

The Program Trainers

The Program Trainers, or group leaders, are the most important resource of the SFP program. They are the staff who are responsible for implementing the SFP (that is, for conducting the skills training sessions). Program trainers must maintain the important balance between the needs of individual group members and the needs of the group as a whole and between the problems of the children and those of their parents. They must be sensitive to the feelings of the families and still maintain order and a sense of responsibility for imparting the skills of the program. Characteristics of successful SFT trainers are listed in the chart below.

There are no established minimum qualifications to be a SFP trainer. Because the SFP involves teaching families skills involving both behavioral and cognitive changes, trainers who are knowledgeable in behavioral training, communication training, social skills training, and/or cognitive therapy or family therapy have a great advantage in conducting these programs. At least an undergraduate degree, with theory and practicum courses in psychology, sociology, social work, anthropology, education, family studies, or health education, is useful.

The staff conducting the sessions need to be able to understand why skills training is useful in correcting deficits in family members and that skills training is successful in changing behaviors. Staff need to understand the connection between reducing risk and strenghtening protective factors by improving family dynamics, parenting skills, and children's life or social skills. They also need to understand the relationship of parenting to later substance abuse in youth. It is sometimes best to hire trainers with at least a bachelor's degree and preferably a master's degree and/or experience in working with families or children in skills training because

FUNCTIONS OF THE SFP PROGRAM COORDINATOR

- Appropriate families are recruited, and referrals are made for participants who have basic physical and social needs (e.g., food, clothing, legal and medical services, housing, and vocational training or job services).
- A method is created to reduce program attrition, such as making phone calls, sending meeting reminder notices, and publishing a newsletter.
- Persons responsible for the program sites (e.g., churches, schools, community and treatment centers) have scheduled the times for the groups.
- Staff are hired, trained in agency policies and procedures and the SFP, and supervised.
- All trainers are available and prepared for the sessions.
- The meeting facility is open and clean, and the group rooms are organized with chairs, tables, and appropriate materials for the groups.
- The food is delivered and prepared for the family training sessions.
- Volunteers arrive to take care of children not participating in the program.
- Van drivers pick up families and conduct tutoring, skills training, or recreational sessions with young teens too old for the SFP.
- Videos are made for the Parent Game and Child's Game sessions.
- Rewards for children and/or parents (e.g., coupons for dinners, sports events, and cultural or educational events) are available for trainers to distribute.
- Program materials (e.g., newsprint, videos, overheads, name tags, project supplies, children's toys) are onsite for use in the program.

understanding certain psychosocial concepts in the program takes a range of interpersonal insight and academic preparation. School teachers or recreation specialists have a useful background in working with children, but they also should have experience in skills training and competency building activities to conduct SFP sessions.

CHARACTERISTICS OF SUCCESSFUL SFP TRAINERS
• A commitment to the importance of working with the whole family and to substance abuse prevention with this at-risk population.
• Skills in running a group; not lecturing but involving the participants.
• An understanding of the dynamics of substance abuse and substance abuse treatment.
• A comfortable style of leading and involving a group.
• Flexibility in delivering training and the ability to complete the materials during the sessions.
• Warmth, genuineness, and empathy for the children and their parents.
• Experience with children.
• Reliability and commitment to the program.

Trainer Preparation

The program works best with at least four staff trainers to conduct the SFP group sessions: a trainer and cotrainer for each parent skills training group and another trainer and cotrainer for each children's skills training group. This means that each SFP session is implemented by at least four trainers. It may be necessary to use more trainers to handle concurrent children's groups if children are of different ages. For instance, if three different age groups of children (e.g, 3- to 5-year olds, 6- to 10-year olds, and 11- to 14-year olds) are conducted simultaneously, up to eight trainers could be necessary.

Trainers should be prepared for each skills training session. They should be familiar with the content of the material for each session by reading the entire manual prior to the initial session and then by becoming familiar with the content of the training material for each group session. They also should discuss implementation issues with their cotrainer prior to each session.

The trainers are encouraged not to read from the training manuals during the training sessions but rather to present the material in a well-thought-out, professional manner. The program does not need to be implemented word-for-word. Examples of what to say are included in the manual. Trainers should personalize the delivery of the training material to fit their own style, local language, and community culture.

At the end of each training session, trainers should allow adequate time to complete session evaluation forms and to chart the progress of each individual parent, each child, and the entire

family. Trainers should complete their evaluation forms independently of each other prior to discussing issues related to group process. For the group evaluation, trainers should discuss the progress of the group and address any specific problem situations.

Staff Selection Criteria

Often the criteria used to select trainers, for example, their qualifications and characteristics, are based on the requirements of the target population. Matching the trainer's race or ethnicity to that of the program participants is useful for improving the trust and communication between parents and the trainer. For instance, when the SFP developers conducted the program with parents who were receiving drug abuse treatment, the trainers were staff members of drug abuse treatment programs who received special training in conducting the parent and child components of the SFP. When the program was used with African-American families, African-American staff of community crisis and counseling centers from the local neighborhoods were used.

Staff Recruitment and Retention

Locating and hiring the best staff to conduct the program is critical to the success of the SFP. Harrison's (1994) long-term SFP followup study found that the quality of the trainers contributed to program success. Program participants reported that they learned more when the trainers were skilled, well prepared, and genuinely warm and interested in the participants. To identify and hire the best staff, sufficient time should be given to advertising for and interviewing applicants. Appropriate advertising for program staff trainers, and solicitation of referrals, for example from community agencies and schools, are crucial. Aktan (1995) has published procedures as well as criteria that can be used for the selection of staff for the SFP.

Staff turnover is detrimental to a smoothly functioning program. Therefore, staff should be hired who will work well together and be likely to remain with the program. Hiring part-time hourly staff has been found to be effective in maintaining staff over a long period. Providing regular positive feedback to staff also improves staff retention.

Perhaps the most crucial part of retention is for participants to have a positive relationship with the group leaders (Harrison 1994). Selection of trainers with positive characteristics that make them well liked by participants (e.g., warmth, empathy, competence, non-drug using, and local or indigenous staff) will enhance attendance and program effectiveness. An essential part of trainers' training must focus on their ability to be supportive and personable with participants. When a family misses a session, it is helpful for the trainer, as well as other program members, to call and indicate that the family was missed, talk about the session content, and encourage the family to attend the next session. The offer of assistance with transportation or other needs, if possible, also may be helpful.

Program Trainers are responsible for conducting the skills training sessions of the SFP. These staff can be full- or part-time employees of mental health or youth services agencies who work part time in the SFP. They also might be hourly staff who are hired from within or outside of the agency. It is important to have backup trainers when regular staff are unavailable to attend a session. For this reason, it is recommended that a larger number of trainers than necessary be trained to ensure that an adequate number of backup trainers will be available.

Although trainers do not necessarily have to be parents or former substance abusers, often it is helpful for them to have experience working with children in the appropriate age range or experience in understanding the lives of substance abusers. The trainers who work with the children's groups generally have additional experience working with children or youth in church groups, recreational programs, youth groups, or schools. They need to enjoy being expressive and having fun. In addition, it is helpful if trainers are from the same communities or have lived in environments similar to that of the SFP participants so that they can better understand the needs and circumstances of the SFP parents and children. Matching the race or ethnicity of trainers and participants helps make the program more culturally relevant and trainers more credible.

Use of Parents as Staff in the Program

Some programs have hired former program participants who have been successful in using the skills they have learned and have the interest and capabilities to become trainers. Parents have been involved in the program as trainers or aides at some sites. They usually serve as cotrainers or program assistants to the Program Coordinator to help with logistics. Parents who have completed the SFP can be effective in these roles. In many ways, they can relate better to the program participants, especially around issues of alcohol and drug abuse and the consequences of such abuse on the family. If an agency is conducting the SFP on an ongoing basis, it may consider identifying parents who have the potential to be trainers or program aides. Because they have already participated in the program, these parents will be able to relate their own personal experiences concerning the benefits of the program to new participants. They also may be helpful as recruiters for new groups.

Staff Training

Experience from numerous SFP projects has confirmed that it is advantageous to conduct training for program trainers. The SFP is a complex program to administer, but the performance of trainers can be greatly enhanced if they are given training by experienced individuals who have implemented the program. The SFP can be implemented without formal training. The program manuals provide comprehensive instructions for trainers to implement the program, as well as homework exercises, stories, presentation methods, materials, and suggested time allotments for

each activity. However, training by experienced trainers is recommended because specific issues about implementation strategies can be presented and questions about implementation barriers can be addressed.

During the training, new SFP staff group leaders have important opportunities:

- To develop a feel for the program;
- To get feedback on how to improve their delivery of the program elements;
- To experience all the program sessions; and
- To discuss and role play possible implementation problems and their solutions.

Potential problems or misunderstandings in program delivery can be addressed and resolved during the staff training. In addition, training by experienced SFP implementers allows program planners to observe and learn the particular strengths and weaknesses of each staff member. This information can be used to make assignments of teams to work together by balancing strengths and weaknesses within the teams of group coleaders. This information also can be used to provide more intensive followup training and supervision to trainers who have some weaknesses in delivery style or ways of relating to participants.

Training Length, Content, and Methods

A minimum of 3 training days is recommended for the SFP staff training. One day of training on each program component is the minimum recommended. However, 1½ to 2 days per program component is ideal. Many agencies cannot afford to have staff in training for this length of time; therefore, only parts of all 14 sessions are conducted in a 1-day session for each component, for a total training time of 3 days. This training can be conducted over 3 to 6 consecutive days or spread over 3 weekends.

It is preferable to have between 14 and 28 trainees in a training session because the training is interactive and experiential. There should be enough participants to plan and deliver all of six sessions or parts of all 14 sessions. An agency that is planning to implement the SFP should train at least two sets of SFP group leaders to allow for substitutions at times when the primary trainers may be unavailable.

The training should include the provision of background information on the goals and objectives of the SFP, as well as information on previous SFP research results. This information can help prospective group leaders understand why improving family dynamics reduces later substance abuse, delinquency, and other negative youth outcomes. Training also can include

discussion of the program rationale for addressing risk and protective factors through skills training and the link between these factors and substance abuse.

Training on group process is important and should address such issues as how to deal with participants who do not become involved in the group activities, are disruptive, or dominate group discussions. Information and individual coaching on staff presentation style are helpful. Program staff should be trained on the effective use of strategies to deal with parents or children for whom a referral for additional help or counseling is indicated. In addition, program trainers should be able to manage such program logistics as room setup, snacks, and activity details.

Staff also should be trained on the policies and procedures of their agency. Those related to the implementation of the SFP can be included in a separate SFP policies and procedures manual that later can be used for training new program staff. Training about legal issues, such as confidentiality and child abuse reporting, also is important.

After an initial introduction to the SFP that lasts from ½ to 1 day, the trainees should be given an opportunity to study the SFP materials and present selected session activities from the program. It is helpful to have trainees interact with and present activities with the trainers with whom they will be working. Therefore, it is recommended that the decision should be made beforehand of who will work together in conducting the SFP components.

After the SFP trainees have selected one or two sessions or partial sessions to deliver for practice, the other trainees should play the part of group participants. For example, they might role play concerns that they may have about methods to handle inappropriate behaviors that family members might exhibit in the group. These concerns and how to handle them are discussed at the end of each session by the trainees. Practice sessions by the trainees should be conducted with coleaders before they actually present the SFP training.

Regularly scheduled booster training sessions for all staff also are recommended. These periodic booster sessions help enhance the trainers' skills and provide opportunities to share what has been learned in prior training sessions. Observations of the staff and critiquing videos made during training sessions will help improve training delivery. The agency staff responsible for overseeing implementation of the SFP, that is, the Program Coordinator, should observe each group leader at least once during each series of SFP groups and provide feedback. Trainers also can share tips for improving skills training sessions at staff meetings.

Staff Supervision

Onsite practice and followup supervision have been found to be helpful for group leaders in implementing the SFP. Videos of the leaders can be made and reviewed by local site supervisors or other program implementers to provide feedback on ways to improve the program

delivery. Additional consultation and technical assistance are available from the SFP developers. Training videos used in staff training sessions are available from previous program developers or implementors. Facilitators for the staff training can be hired through previous SFP research sites. For information on the above plus program materials and training, see appendix A.

Recruitment and Retention of Families

One major barrier in implementing the SFP has been the recruitment and retention of families into the program. Unless the agency implementing the program has a large pool of clients to participate in the program, recruitment becomes a major activity because parents with multiple problems, including substance abuse, often may say that they will attend the program but never show up. It is a good idea to expect only about one-third to one-half of the participants who signed up for the program to actually arrive for the first session. Some sites have made recruitment a major responsibility of a single staff member. In addition, dropout from the program can be significant in the first three sessions. However, once a core group is established, the trainers can expect a stable group. In fact, many participants will not want the program to end in 14 weeks once they are a part of the group.

In the beginning phase of the program, it is important to inform the families of incentives available for program participation, which may include:

- Free meals or snacks;
- Child care;
- Transportation;
- Program graduation gifts;
- Parties;
- Family outings;
- Clothing and food banks; and
- Support with referrals for legal, medical, housing, and financial assistance.

Flyers and posters, distributed to parents and children at schools or churches, can help increase local awareness of the program. Articles in local newspapers or school papers can help as well. Perhaps the most important recruitment tool is personal contacts with friends or neighbors.

One means for using positive peer pressure for recruiting additional parents would be to identify natural leaders in the parents' group and enlist their support to bring three or four families into the program. These recruiters possibly might be offered incentives for their assistance. School administrators and teachers of prospective child participants also can help to recruit families by talking up the program and encouraging attendance.

Community Agency Referrals

Most agencies recruit about twice as many families as are needed for the first session. An important first step in recruitment is linking with other community family-serving agencies to enlist their support and assistance with recruitment. Schools, local churches, drug treatment agencies, housing authorities, mental health centers, youth and social service agencies, the Cooperative Extension Service (CES), and Indian tribal councils are examples of appropriate groups that have been significant supporters of SFP and other family programs. The more supportive the local leaders, the more successful the SFP will be in reaching and attracting appropriate families for the program.

Barriers to Attendance and Retention

Although recruiting at-risk families is not easy, once the word gets around about the benefits of the program and staff are seen as trustworthy, parents generally become eager to participate. Having children involved has been found to increase retention of families because the children make sure that their parents continue to participate so that they can participate. Family skills training programs involving children at every session have lower dropout rates than programs involving parents only (Kumpfer et al. 1996).

Potential barriers to parental or family involvement in the SFP should be addressed in the design and implementation of the program. Common barriers to attendance include (Kumpfer 1991):

- Lack of transportation;
- Lack of child care;
- Required time commitment;
- Lack of interest in parent training;
- Lack of program ownership, that is, feeling that the program is especially for program participants;

- Cultural differences between providers and parents; and
- Lack of trust in or fear of the program staff.

The SFP has been designed to provide solutions to many of these barriers. Usually the program is free to participants. Transportation, child care, and meals should be provided to encourage program participation.

Research indicates that lack of time is a primary reason parents give for declining to participate in multiple-session programs (Spoth and Redmond, in press). Parents who are substance abusers and who are unemployed have the time, but often they have many stresses and crises in their lives. Therefore, it is important to explore with them in the first session how they can get to the sessions on time and not miss meetings. Working parents often are reluctant to leave their children one more evening during a busy week. This issue can be addressed by providing child care or structured groups for siblings not involved in the program. In addition, the fear of removal of their children based on reports by protective service staff must be addressed with parents. Some parents will be fearful that their parenting styles are not adequate and will be exposed. Discussing these fears with parents and providing reasonable assurances should be done during recruitment.

Trust in the program can be enhanced through the use of incentives and referrals for support of basic needs such as for housing and social services. An essential aspect of all SFP implementations is offering enough incentives to make program attendance attractive to both children and their parents. Basic support to needy families sends a message that the program staff really care about helping participants. Incentives, such as free coupons for food or video rentals and a monetary gift at the conclusion of the program, may need to be limited in a locally sponsored program. However, even a small local grant or the enlistment of support from local businesses might provide incentives to help make the program appealing to prospective participants. Arranging to have the local police department, service clubs, or churches sponsor families is another way SFP sites have increased their ability to provide incentives.

In the program marketing phase, it is important to let families know about all incentives (e.g., free meals or snacks, child care, transportation, graduation gifts, parties, family outings, clothing and food banks, support with referrals for legal, medical, housing, and financial aid). Flyers and posters distributed to parents and youth at schools or church can help increase local awareness of the program. Articles in local newspapers or school papers can help as well. Perhaps the most important recruitment tool is personal contacts with friends or neighbors.

The most effective way to enhance retention is to have an interesting program that meets the needs of families and involves them in relevant, meaningful activities. One means of helping parents and children feel committed to the program is to involve them in the practical aspects of

the program, such as bringing snacks and helping with attendance or room setup. For example, in the Iowa SFP, small groups of families signed up at the first session to bring snacks for the entire group on a specific evening. In addition, most activities in the family session were designed to encourage personal interaction between trainers and an individual family, as well as between small groups of families. These activities can help a family less well-connected in the group develop a sense of belonging to the group and, as a result, enjoy coming to subsequent sessions.

Issues That May Arise

There are several issues and obstacles that may be encountered in the delivery of the SFP that are important to the effective implementation of the SFP. These issues are related to:

- Participants' reading and conceptual skills;
- Participants' crises and knowing when to refer;
- Disruptions; and
- Intoxicated participants.

Participants' Reading and Conceptual Skills

One important adaptation of the SFP for families at risk who have limited education has been to reduce the reading and conceptual levels of the program materials to approximately a third-grade equivalent and to make exercises more culturally relevant. Trainers should ensure that the material presented is on a conceptual level that participants can understand.

It is important to know the reading level of program participants. In the parents' group, higher functioning adults can be instructed to read ahead in the workbooks. They will probably need less instruction for homework assignments and may be more likely to follow through with the assignments. Parents with lower reading skills should have homework assignments carefully explained to them to ensure that they understand well enough to be able to complete the assignments. In addition, trainers should be aware of parents' conceptual levels, carefully reading over workbook sheets as needed to see whether parents understand what they are required to do, as well as understand the ideas presented in the material. Having parents repeat instructions or explain what they will be doing during the week is also a helpful check on their comprehension.

In the event it is discovered that a parent is unable to read or has a comprehension problem, attention should not be drawn to that fact, but the trainer should privately offer to repeat the assignment until the parent can remember it. It is important that the trainer not embarrass the parent or act surprised or upset. People who have not had the opportunity to learn to read or who

have a learning disability are not uncommon in these types of programs, and they usually respond very well to the private assistance offered by the trainer.

In the children's group, children will probably be at various reading and comprehension levels. It is important to review all workbook pages, even with children who appear to have high reading levels. It also is important to have children repeat instructions to assess their level of understanding of what is expected of them. Reading the scripts for the puppet shows, stories, and workbook pages are excellent ways to gain group participation, increase the interest level of the children, and enhance their self-esteem. Ways also should be found to involve the children who have lower reading levels in the group exercises.

Participants' Crises and Knowing When to Refer

Working with parents who are substance abusers and their children requires sensitivity and flexibility. It is not uncommon for parents and/or children to come to group sessions in crisis. Crises may include family fights just before coming to the group, arrests of family members, or participants coming to the group under the influence of alcohol or other drugs. These problems should not be ignored. Ignoring the problems that participants bring with them can be counterproductive for group process and affect the entire group, not just the person with the crisis. Therefore, it is important for trainers to be flexible and meet the needs of the participants first, adapting the curriculum to them or at least processing the dynamics first. Discussing rewards and incentive programs when a parent is experiencing a crisis will not have much meaning to participants. In other words, start where the participants are! Material should not be presented that the members are obviously not ready to handle.

It is important for trainers to be familiar with local and community resources so that they can make appropriate referral for ancillary services such as individual, group, or family counseling, medical services, and social services for participants who need them. It also is critical that trainers not offer advice or assistance for problems they are not trained to handle; instead they should refer the family to appropriate agencies. In addition, it is important to coordinate services with schools, counselors, and parents. It is important to determine whether participants are receiving other services. The trainers should be sure that all appropriate release of information forms are signed prior to a family's participation in the program.

Disruptions

Disruptions should be handled in a respectful but firm manner. Guidelines governing disruptions should be discussed when the group norms are established and then followed. Disruptions can be mild, such as family members interrupting each other in the group or a belligerent parent talking out of turn. Disruptions also can be serious, such as when an intoxicated parent physically attacks one of his or her children.

In the case of a mild disruption by a parent, it should be handled with tact. The parent should be reminded that the spirit of the group is to consult and discuss problems and that the norms the group has established do not allow for his or her behavior. If possible, trainers should discuss the disruption in private with the individual, not in front of the other group members or in front of children. If the disruption is caused by one or more of the children, it should be handled in the same manner. Trainers should remind the children of the group norms and the consequences of their disruption. Trainers should try to maintain a positive attitude and discuss the group norms in terms of positive consequences and rewards for good behavior and not negative consequences for bad behavior.

Serious disruptions, such as those involving physical violence, should be handled carefully. Before the first session begins, trainers should consider the likelihood of serious disruptions, given the population of the participants, and discuss what the agency recommends as a course of action. There should be a policy regarding contacting a law enforcement agency or hospital if physical violence or firearms are involved. These policies should be clear to all trainers and participants before the program begins.

Participants Who Are Under the Influence of Alcohol or Other Drugs

Even in the best programs there is the possibility that a parent or even a child will come to a session under the influence of drugs or alcohol. If this is suspected, either by a trainer or another participant, the issue should be addressed. The person should be taken aside and asked whether her or she is intoxicated or under the influence of drugs and asked to leave the session if the explanation indicates that he or she is under the influence. A substance abuse policy should be established and shared with the participants beforehand. If the possibility of an intoxicated member coming to the group is addressed as part of the norms established for the group, it will be easier to convince the person that they should not attend the session when using drugs. This discussion may be left to the discretion of the trainers, but a policy should be formulated before the program begins.

Some points to consider regarding this issue are whether the abuse is noticeable, whether it will affect the group dynamics, and whether the good being done by the group sessions will outweigh the damage of the abuse for the individual and the group. These are not easy situations to evaluate. If a family's participation in the SFP is court mandated, the court may have placed certain restrictions on the family or individual family members. If the agency is contracting with the court to provide the program, the decision must be made whether to inform the court of any drug or alcohol abuse, or the court may have mandated such reporting as part of its contract with the agency. This also should be considered in light of the agency policies and individual experience.

Managing the Group Process

To manage the group process and involve participants in the SFP training process, there are a number of strategies for effective group facilitation. These strategies involve:

- Group trainer (also called group leader) issues;
- Group participant issues; and
- Group process issues.

Group Trainer Issues

As indicated earlier, SFP trainers are the most important resource of the SFP. What trainers do in the training sessions and the manner in which they conduct the sessions will be critical to the overall success of the program. Therefore, several issues related to the behavior of the trainers that will have an impact on the training group process are identified below. These issues are related to the importance of balancing free discussion with the completion of the SFP exercises and encouraging the participation of the group members.

Behavior of Trainers

Program trainers should be friendly and personable. They should learn and use the parents' names as soon as possible, at least by the end of the first session. Stick-on name tags can be used for this purpose. Trainers should greet all family members by their names when they arrive and warmly welcome them into the program. Saying goodbye and thanking participants for coming to the session also are helpful. Remembering any special things participants have shared or asking them about personal stressors, crises, or family successes will show that the trainer cares about them.

Trainers should behave in a relaxed manner. They should always be well prepared by having thoroughly reviewed the session materials before each session. This preparation will help them act more naturally during the sessions. If trainers conduct a session as a team, they should be sure to meet before the session begins to coordinate their responsibilities for each aspect of the session. In addition, they should meet before the program to reconfirm how each will run the sessions, the session logistics and share any new information about the families that other trainers should know.

Group Participant Issues

Training group participants bring their own sets of issues to the group process that must be addressed. These issues include their personal characteristics and problems, denial of the effects of their substance abuse, and problems in their capacity to trust others.

Personal Issues

Some shy and hard-to-engage parents may be uncomfortable with the demands for personal disclosure and intimacy in the parenting group. Therefore, trainers should be sensitive to personal boundaries and not demand more from participants than they are either able or willing to give. Demands for personal disclosure can scare some participants away from the program. Some participants may feel uncomfortable if they do not understand how to complete homework assignments and group exercises. Some parents may be overly responsive to the chance to talk about their problems and take too much of the group's time. Therefore, trainers will need to find the right balance between the need to present the training materials and the personal needs of the parents to discuss their particular problems. For some parents there will not be enough time for personal sharing and disclosure, whereas for others there will be too much time for sharing. The trainers should occasionally include humorous and fun activities in the parenting program to lighten the mood and make the group enjoyable.

Parent Denial

On many occasions that the SFP has been replicated, the program developers have found that many parents will minimize the degree of impact their alcohol and drug abuse has on their children. In other words, they are in denial. Many parents believe that their children should do as they say and not as they do. Parents even have become argumentative and left the sessions when the issue of their substance abuse and its impact on their children has been discussed. In fact, some parents believe that if they give their children alcohol or drugs at home, the children will not use them with their friends at parties later. Research has shown that youth who are allowed to use alcohol at home between the 5th and 7th grades are the youth who have the highest alcohol use rates by ninth grade (Dielman et al. 1989b). Trainers must be sensitive to the group dynamic during such sessions and whenever this issue is raised.

Trust

Trainers must develop a trusting relationship with SFP participants, and they should invest a significant amount of time in getting to know and engage the families. It is important to develop a trusting relationship with parents because many are fearful of State intervention and the loss of their children because of the parents' substance abuse. The trainers can help ease these fears by showing how participation in the SFP can help the parents improve their parenting skills.

Group Process Issues

To facilitate the group process and enhance the involvement of program participants in SFP training activities, the following are strategies that have been suggested by the SFP developers for effective group facilitation.

Balancing Free Discussion With Completion of Exercises

It is not always an easy task to maintain an appropriate balance between the desire of program participants to socialize and the need to complete the training exercises. For example, if family crises are taking too much of the group's time to allow parents or children to learn the skills they need to learn, the effectiveness of the program will be compromised. It is important that the training exercises be completed.

However, there will be occasions when discussion will be difficult to contain. Sometimes the discussion may be of an intensely personal or emotional nature, and it would be inappropriate and/or insensitive for the trainers to interrupt. The purpose of the program is not to rigidly plan every minute of the hour with assignments but to encourage group problemsolving and allow for individual differences. However, the trainers may need to restrain a parent or child who insists on monopolizing the discussion and repeatedly uses the time to enumerate his or her problems. In these instances, trainers may need to explain that the exercises are important and that group members should try to complete them. It is the trainer's assessment of the circumstances that will help maintain the necessary balance between individual and group needs, and trainers' ability to do this effectively is vital.

Encouraging Participation

Trainers can help group members who are shy or feel that they do not have much to offer by drawing them out directly by name. However, the shy participants should not be put on the spot. If it is clear that some participants, either children or parents, do not want to speak in groups, they should not be forced to do so. It has been found that some participants feel that they are not as well educated as the other members or that they do not have a good command of English. These participants may be embarrassed by their accents or nonstandard use of English. The trainers must be especially sensitive to these issues. However, not all group members must participate in the group to learn the information. For example, in a study of single, low-income African-American mothers, it was found that the mothers who participated little still learned as much as the mothers who participated a great deal (DeMarsh and Kumpfer 1986). It was clear that these mothers were listening carefully even though they did not say much.

Personal Examples

It is important for trainers to demonstrate that they understand the difficulties of being a parent. Therefore, trainers should feel free to share personal examples from their own family situations as a means to illustrate different parenting or child behavior situations or behavior management techniques. It also is useful to make participants feel that no parents, including the trainers, are perfect. It often helps to have personal testimonials about the effectiveness of the parenting skills, child social skills, and family relationship skills that are being taught in the program. If trainers are not parents or have never raised a child, they should use examples from their childhood, babysitting experiences, or relatives or friends. However, these personal examples should not include the names of the persons in the situations being described.

Personal Acknowledgments

Trainers should make particular effort to acknowledge good responses and thank participants for volunteering responses during the training exercises. The SFP is based on the principle of "Catch Them Being Good" applied to parents as well as children. However, if a particular response is not exactly what the trainer is looking for or is not entirely to the point, the trainer should try put a positive slant on the response and should not make the participant feel embarrassed or feel as if the person did not know the right answer. All responses can be useful and illustrate a point.

Group Norms

Norms or rules by which the group will operate should be clearly established in the first session of the SFP. Participants should help generate the norms to increase the chances that the norms will be followed. However, trainers should include norms that they think are important for good group functioning and not rely solely on the norms generated by parents and children. Some examples of group norms include:

- Starting and ending the sessions on time;
- Respecting others by not interrupting them;
- Not talking about certain agreed on subjects; and
- No actual or threatened aggressive behavior, either verbal or physical.

Using the Parent and Child Workbooks

The parent and children's workbooks can be helpful resources to reinforce concepts discussed in group sessions. Depending on participants' reading comprehension level, parents and children should be encouraged to read their books both before and after the sessions. Children should be encouraged to color their books and feel ownership of them. Parents should be encouraged to read the books and, if possible, come to the group sessions prepared with questions. Participants should bring their books with them to group sessions each week. If they do not, the trainers should use incentives to increase the chances that they will. If incentives are ineffective, the trainers may consider keeping the books and bringing them to each session for the parents and children to work in during the group. Trainers should emphasize to participants that the books belong to participants, that they should take care of them, and that they should use them.

Homework Assignments

Assigning homework to participants presents a unique challenge to trainers. Without tangible incentives for the parents and children, few assignments will likely be completed. But a scheduled followup at the beginning of each session to review the homework assigned from the previous week will encourage participants to complete the assignments.

To increase the likelihood that homework is completed, trainers may can several strategies. First, when assigning the homework, trainers should ensure that parents and children understand the importance of the assignment. If participants think it is just busy work, they will be less likely even to remember the assignment. In addtion, it is helpful to have participants repeat what they will be doing in the homework to ensure that they understand the assignment.

Second, if participants believe that the trainers think the assignments will be useful and are important, they will be more likely to complete them. Trainers, therefore, should be enthusiastic about the assignments.

Third, trainers should institute incentive programs for homework completion. Having group members help design the incentive programs will provide ownership for the programs and will increase assignment completion. Finally, trainers who acknowledge participants who complete their assignments at the beginning of each group session will likely have more success than trainers who do not.

Making the Program Enjoyable

Participants will be more likely to return and participate actively if they feel that the program is interesting, tailored to their needs, and fun. There are numerous examples from the trainer's personal parenting or family life experiences that can be used as anecdotes in the

program. A fun-loving and relaxed presentation style helps to make the group more relaxed and learn better. Humor has an important place in the SFP training sessions. The use of funny anecdotes and laughing at appropriate jokes that participants make during the sessions will make the program more enjoyable. Parents and children will be more likely to return to a program where they believe that they will have fun.

Trainers should maintain a positive climate in the group that does not exclude any family. For example, during the family dinner the trainers should ensure that no family sits alone with no one to talk to. The trainers should ensure that values of all families are respected during the group discussions. For instance, if a member indicates that something he or she has learned in the program does not match his or her family's values or ways of doing things, the trainer would assure the individual that he or she is not expected to do all of the things recommended in the program but can take from the group whatever can be used.

To increase the sense of belonging and togetherness of the SFP group, many programs develop special rituals to close each family session. Many use a large closing circle that involves special words and a group hug. A number of groups have developed their own closing songs and T-shirts to wear to the group meetings. In addition, some SFP sites have included extra family games and activities after the program. For example, if the program is conducted on Saturday mornings, the families can have lunch together and participate in family games. Some programs have extra evening activities, such as dances or family parties. If the sessions are held on a Friday night, the session can end with an alcohol-free, multifamily party with traditional dancing and singing.

Ethical Considerations

During program sessions, certain disclosures may be made by participants that will require ethical decisions on the part of the trainers. These disclosures may be related to such considerations as:

- "Don't talk" issues and family secrets, and
- Confidentiality.

"Don't Talk" Issues and Family Secrets

All families have some issues that are not discussed, often by unspoken mutual agreement. This is especially true of families where substance and/or other abuse occurs. For this reason, agencies implementing the SFP should be particularly alert to signs of child physical and/or sexual abuse (Kumpfer and Bayes 1995).

It is ethical practice to inform children and parents at the beginning of the program that if they disclose information that child physical or sexual abuse is occurring in the family, trainers have a legal responsibility to report any suspected or confirmed cases to the appropriate authorities within the agency as well as to the child protective services system. This disclosure is a statement that advises individual parents of the legal responsibility of the trainers to report suspected child abuse. If abuse is detected, each agency using the SFP should follow the reporting requirements of its State as well as the agency's policies.

Confidentiality

The confidentiality of information shared in the group sessions must be stressed in the program from the first session. Trainers should be thoroughly familiar with Federal and State laws governing confidentiality, as well as the confidentiality policies and regulations of their agencies. However, participants should be reminded of the confidentiality requirements as well. For example, participants might be told that they should not discuss with anyone outside the group any personal information that was shared by other group members during a session. These reminders can occur at the end of each training session, during the reminders for homework, and during the session closing activity.

Confidentiality and keeping the information within the group also should be stressed because family secrets also may involve drug abuse and/or drug distribution. In such cases, it is within the discretion of trainers how to proceed, but they should be aware of the consequences for the individual and the goals of the training sessions of disclosing confidential information.

Of course, there are important limits on confidentiality. Such limits apply to life-threatening situations, including suspected or threatened suicide and homicide, as well as to instances of child abuse and neglect. Under these circumstances, it is imperative that SFP trainers have a well-thought-out plan for addressing such issues, both with the individuals involved as well as within the larger group context. For example, the trainers may choose, in the first group session, to specifically address those circumstances when the confidentiality of the group members may be breached.

Other Implementation Issues To Consider

The following issues are presented to provide the practitioner with suggestions and recommendations for implementing the SFP. This information, gleaned from the experiences of sites that have implemented the SFP, is intended to provide meaningful information on ways to implement the program. The following considerations are presented here to help the trainers plan their sessions and facilitate the management of routine logistical issues.

Announcements

Any general announcements should be made before parents and children go into their respective groups. Announcements also may be repeated in the family session. It is often helpful to distribute fliers with announcements indicating changes in meeting time or meeting place and other logistical issues.

Telephone Calls and Followup

Some families may need followup telephone contact or visits during the week between training sessions. The purpose of these calls and visits is to offer support, answer any questions participants may have concerning homework, and encourage participants to do the homework. Trainers should discuss the implementation of followup contacts prior to the first session and decide whether they will be available for contact outside of group sessions. Procedures for followup calls, as well as who will make the calls, should be decided before the first session. In most programs, one trainer is designated to call a family within 24 hours after the family has missed a group session. Some trainers have found it helpful to give their home telephone numbers to the children or parents in their groups to provide additional support.

Whatever trainers decide to do regarding followup contacts should be presented to parents and children during the general welcome of the first session and repeated as often as necessary. Parents and/or children who abuse the privilege of calling trainers during the week should be challenged about their behavior on an individual basis and according to agency or program policy.

Food and Snacks

Some agencies may choose to provide a snack prior to the beginning of each session. This helps to encourage punctuality and allows parents and children an opportunity to socialize with one another. In addition, many agencies also choose to provide dinner following each family session. This may be helpful in maintaining member attendance.

Supplies

Materials needed for each session are specified in the training manuals. It is strongly recommended that the materials that will be needed for the entire program should be acquired before the program begins. A list of the general materials that will be necessary to conduct the SFP is included in the resources section of this manual.

For children's training sessions, trainers may choose to copy pictures from the training workbooks and laminate them onto brightly colored construction paper. During family sessions, children should have access to a variety of toys and games. The best toys are those that allow the

children to express feelings, such as puppets, crayons, magazines, dolls, and cars. In addition, board games, children's handbooks, and old clothes for the children to play dress-up may be provided. To reduce the cost of purchasing toys for the Child's Game sessions, the trainers may solicit donations from the children of agency staff or friends. A large blanket or a carpet is useful to lay on the floor to define the area for the Child's Game sessions, as well as to provide a common sitting area.

Local grocery stores, fast food restaurants, or toy stores may be willing to donate gift certificates, prizes, and other incentives for group attendance, completion of homework assignments, and good behavior in the children's group. These are excellent resources that should not be overlooked.

In summary, this chapter has presented a discussion of the implementation of the SFP. An overview of the staff requirements for the SFP was provided, including discussion of their qualifications and program responsibilities. Discussion also was presented of the staff training needs and processes necessary for the implementation of the SFP. This chapter has addressed issues related to the recruitment and retention of at-risk families for the program, ethical considerations related to at-risk families, and issues and recommendations related to the establishment and maintenance of effective group process.

SUMMARY AND CONCLUSIONS

Selective prevention programs hold great promise for reducing the impact of problems associated with drug abuse in subgroups of the general population that are deemed to be at risk for such problems. This resource manual has presented a discussion of the use of selective prevention strategies for drug abuse prevention and provided a detailed discussion of the development, implementation, and evaluation of the Strengthening Families Program, a family-based selective prevention program for children of substance abusers. This program has been successfully implemented with different cultural groups throughout the United States. In addition, practical suggestions for enhancing the implementation of the SFP were presented, along with strategies for facilitating the SFP training group process.

It is hoped that this resource manual has increased the knowledge of prevention practitioners about selective prevention approaches and has increased their interest in implementing selective prevention programs such as the SFP. This manual has provided detailed and specific information about what is included in the contents of the program, how it can be implemented, and research-based alternative formats of the program that have been implemented. Each site where the SFP has been implemented has made modifications to the program to accommodate its particular resources, staff, and facilities and the characteristics of the populations targeted by the program. The SFP should be considered a starting point for the development of a research-based family program that can be used for parents who are substance abusers and their children.

For prevention practitioners who are interested in learning more about the SFP, a variety of resources are identified in the appendices of this manual. Appendix A lists resources, and appendixes B, C, and D provide sample lesson plans.

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APPENDIX A: RESOURCES

CONTACTS AND RESOURCES: RESEARCH-BASED PREVENTION MODELS FOR DRUG ABUSE

The following drug abuse prevention program models are highlighted in the *Drug Abuse Prevention RDA* set of materials. The name and address of the principal investigator conducting the research for each model is provided, followed by information on the availability of training manuals, formal training services, consultation, and technical assistance.

Project STAR, a communitywide prevention program:

Mary Ann Pentz, Ph.D.
Department of Preventive Medicine
University of Southern California
1540 Alcazar Avenue, Suite 207
Los Angeles, CA 90033
Phone: (213) 342-2582
Fax: (714) 494-7771

Manuals, training, and technical assistance services are available from the research group at the University of Southern California, as follows:

- School component—teacher and peer leader training, manuals, and parent-child workbook;
- Parent component—parent and school principal training, manuals, and parent-child workbook;
- Community organization component—training;
- Policy component—training;
- Media component—training; and
- Evaluation—evaluation instruments, services, and data collection training tape.

Training costs are $150 to $250 per person per day, from a minimum of $1,500 up to a maximum of $,2500 per day, depending on the nature of the presentation. Technical assistance costs are negotiated on a case-by-case basis. Further information about materials, training, or technical assistance also can be obtained by contacting:

Project I-STAR
5559 West 73rd Street
Indianapolis, IN 46268
Phone: (317) 291-6844

Strengthening Families, a family-focused prevention program for children of substance-abusing parents:

Karol L. Kumpfer, Ph.D.
Department of Health Education
HPERN-215
University of Utah
Salt Lake City, UT 84112
Phone: (801) 581-7718
Fax: (801) 581-5872

Manuals, training, and evaluation services and instruments are available from the program developers, evaluators, or implementors by contacting Dr. Kumpfer. A 3-day training costs $2,000 plus travel for a group of up to 16 participants.

Costs for program materials are:

Family Training Therapist Manual	$ 25
Parents' Skills Training Manual	25
Parent Handbook	25
Children's Skills Training Manual	25
Children's Handbook (6 to 12 years)	25
Implementation Manual	25
Evaluation Package	25
7-Manual Package Total:	$175
African-American Parent Handbook	25
8-Manual Package Total:	$200

Reconnecting Youth, a school-based prevention program for at-risk youth:

Leona L. Eggert, Ph.D., R.N.
Psychosocial and Community Health Department
P.O. Box 357263
University of Washington
Seattle, WA 98195
Phone: (206) 543-9455 or 543-6960
Fax: (206) 685-9551
e-mail: eggert@u.washington.edu

Consultation and technical assistance are available by contacting Dr. Eggert. Materials and training are also available. Program awareness can be gained in a day. Full-scale training requires 3 to 5 days and is limited to small groups. Prices for the training vary depending on the number of people to be trained. Rates are structured on an honorarium-plus-expenses basis. A curriculum and leaders' guide, *Reconnecting Youth: A Peer Group Approach to Building Life Skills*, is available for $139. For materials and training, contact:

Susan Dunker or Peter Brooks
National Educational Service
1252 Loesch Road
P.O. Box 8
Bloomington, IN 47402-0008
Phone: (812) 336-7700
Toll Free: (800) 733-6786
Fax: (812) 336-7790

CONTACTS AND RESOURCES: COMMUNITY READINESS FOR DRUG ABUSE PREVENTION

Eugene R. Oetting, Ph.D.
Scientific Director
Barbara Plested,
Research Associate
Tri-Ethnic Center for Prevention Research
Colorado State University
C79 Clark Building
Fort Collins, CO 80523
Phone: (800) 835-8091
Fax: (970) 491-0527

Abraham Wandersman, Ph.D.
Professor
Department of Psychology
University of South Carolina
Columbia, SC 29208
Phone: (803) 777-7671
Fax: (803) 777-0558

SOURCES OF INFORMATION ON COMMUNITY COALITIONS

The Anti-Drug Abuse Act of 1988 provided congressional authorization and funding for the Center for Substance Abuse Prevention (CSAP) to create more than 250 community partnerships nationwide (Davis 1991). Additional community substance abuse prevention coalitions and community action groups have been implemented by:

- State and local governments, for example, Rhode Island (Florin et al. 1992) and Oregon (Hawkins et al. 1992);

- National foundations, for example, Henry J. Kaiser Family Foundation (Tarlov et al. 1987) and Robert Wood Johnson Foundation Fighting Back and Join Together coalitions (Robert Wood Johnson Foundation 1989);

- Federal Public Health Service agencies, for example, the National Cancer Institute's COMMIT and ASSIST tobacco and cancer reduction programs (Best et al. 1988; Shopland 1989), the Planned Approach to Community Health (PATCH) health promotion program of the U.S. Centers for Disease Control and Prevention (Kreuter 1992), and the Weed and Seed Program of the Bureau of Justice Assistance; and

- Schools and universities, for example, the university coalitions sponsored by the Department of Education/Fund for the Improvement of Post-Secondary Education (DOE/FIPSE) and local school boards.

POTENTIAL FUNDING SOURCES

Federal Grants

Most Federal substance abuse funding is provided as either demonstration and evaluation grants or prevention research grants. These funding mechanisms require evaluations and data collection processes to determine the effectiveness of the programs. These are *not* service grants (See list of Federal Government agencies).

Potential Federal funding sources for *demonstration grants* include:

- Center for Substance Abuse Prevention (CSAP);
- Center for Substance Abuse Treatment (CSAT);
- Office of Juvenile Justice Delinquency Prevention (OJJDP);
- Bureau of Justice Assistance (BJA);
- U.S. Department of Housing and Urban Development (HUD); and

Potential Federal funding sources for *research grants* include:

- National Institute on Drug Abuse (NIDA);
- National Institute on Alcohol Abuse and Alcoholism (NIAAA); and
- National Institute of Mental Health (NIMH).

Other Grants

Service grants are available through individual State block grant mechanisms or through local county funding sources.

FEDERAL GOVERNMENT AGENCIES

Bureau of Justice Assistance (BJA)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 20531
Phone: (202) 514-6278

Implements national and multistate programs, offers training and technical assistance, establishes demonstration programs, and conducts research to reduce crime, enforce drug laws, and improve the functioning of the criminal justice system. Offers the following information clearinghouse:

Bureau of Justice Assistance Clearinghouse (BJAC): (800) 688-4252

Bureau of Justice Statistics (BJS)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 29531
Phone: (202) 307-0765

Focuses on drugs and crime data and covers law enforcement and crime rates. Offers the following information clearinghouses:

BJS Automated Information System
National Criminal Justice Reference Service (NCJRS)
Box 6000
Rockville, MD 20849-6000
Phone: (202) 307-6100

Offers drug- and crime-related information and materials. Fax-on-demand and Internet services also available.

BJS Clearinghouse
National Criminal Justice Reference Service (NCJRS)
Box 6000
Rockville, MD 20849-6000
Phone: (202) 307-6100

Distributes drug- and crime-related publications.

Center for Substance Abuse Prevention (CSAP)
U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Rockwall II, 5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-0365

Focuses attention and funding on the prevention of substance abuse. Offers the following hotline:

Drug-Free Workplace Helpline (DFWH): (800) 843-4971

Center for Substance Abuse Treatment (CSAT)
U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Rockwall II, 5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-5052

Focuses attention and funding on the development and assessment of treatment techniques and models. Offers the following hotline:

CSAT's National Drug Information and Treatment Referral Hotline: (800) 662-4357

Centers for Disease Control and Prevention
U.S. Department of Health and Human Services
1600 Clifton Road, N.E.
Atlanta, GA 30333
Phone: (404) 639-3311 or 3534

Researches and develops cures for diseases worldwide. Offers the following information clearinghouse:

CDC National AIDS Clearinghouse
P.O. Box 6003
Rockville, MD 20849-6003
Phone: (800) 458-5231

Offers information on AIDS-related resources and services. Publications are also available on substance abuse issues related to HIV.

Crime Prevention and Security Division
U.S. Department of Housing and Urban Development
451 Seventh Street, S.W.
Washington, DC 20410
Phone: (202) 708-1197

Awards drug elimination grants each year. Offers the following information clearinghouse:

> Drug Information and Strategies Clearinghouse
> P.O. Box 6424
> Rockville, MD 20849
> Phone: (800) 578-3472
>
> Distributes materials on substance abuse prevention in public housing.

U.S. Department of Housing and Urban Development (HUD)
451 Seventh Street, S.W.
Washington, DC 20410
Phone: (202) 708-0685

Focuses on all aspects of housing. Community programs target at-risk youth and work to improve neighborhoods.

Fund for the Improvement of Post-Secondary Education (FIPSE)
U.S. Department of Education
Seventh and D Streets, S.W.
Room 3100
Washington, DC 20202-5175
Phone: (202) 708-5750

Funds drug and violence prevention programs aimed at students enrolled in institutions of higher education. Program encourages colleges and universities to develop programs to prevent alcohol and other drug use for their students and staff.

U.S. Government Printing Office (GPO)
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954
Phone: (202) 783-3238
Fax: (202) 512-2250

Publishes and makes available numerous publications on many topics, including substance abuse. Many publications are available free of charge.

National Clearinghouse on Child Abuse and Neglect (NCCAN) Information
P.O. Box 1182
Washington, DC 20013-1182
Phone: (703) 385-7565
Phone: (800) 394-3366

Serves as a major resource center for the acquisition and dissemination of child abuse and neglect materials; free publications catalog on request.

National Clearinghouse for Alcohol and Drug Information (NCADI)
P.O. Box 2345
Rockville, MD 20847-2345
Phone: (800) 729-6686
TDD: (800) 487-4889

Houses and catalogs numerous publications on all aspects of substance abuse. Provides computerized literature searches and copies of publications, many free of charge.

National Institute of Justice (NIJ)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 20531
Phone: (202) 307-2942

Conducts research and sponsors the development of programs to prevent and reduce crime and improve the criminal justice system.

National Institute of Mental Health (NIMH)
U.S. Department of Health and Human Services
5600 Fishers Lane
Room 7C-02
Rockville, MD 20854
Phone: (301) 443-4513

Focuses on research in mental health and related issues.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)
U.S. Department of Health and Human Services
National Institutes of Health
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-3860

Focuses attention and funding on research on alcohol abuse and alcoholism and their treatment.

National Institute on Drug Abuse (NIDA)
U.S. Department of Health and Human Services
National Institutes of Health
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-6245

Contacts: William J. Bukoski, Ph.D.
Chief, Prevention Research Branch
Division of Epidemiology and Prevention Research
Room 9A-53
Phone: (301) 443-1514

Susan L. David, M.P.H.
Coordinator, Epidemiology and Prevention Research
Division of Epidemiology and Prevention Research
Room 9A-53
Phone: (301) 443-6543

Focuses attention and funding on research on substance abuse and its treatment and on the dissemination and application of this research.

National Technical Information Service (NTIS)
Order Desk
5285 Port Royal Road
Springfield, VA 22161
Phone: (703) 487-4650
Fax: (703) 321-8547
Fax Receipt Verification: (703) 487-4679
RUSH Service: (800) 553-NTIS (additional fee)

Makes available numerous publications on many topics, including substance abuse.

Office of Justice Programs (OJP)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 20531
Phone: (202) 307-5933

Operates many programs to prevent and treat substance abuse-related crime.

Office of Juvenile Justice Delinquency Prevention (OJJDP)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 20531
Phone: (202) 307-5911

Focuses on program development and research to prevent and treat delinquency in at-risk youth. Offers the following information clearinghouse:

> Juvenile Justice Clearinghouse
> National Criminal Justice Reference Service (NCJRS)
> Box 6000
> Rockville, MD 20849-6000
> Phone: (800) 638-8736
>
> Provides publications on juvenile crime and drug-related issues.

Office of National Drug Control Policy (ONDCP)
Executive Office of the President
Washington, DC 20500
Phone: (202) 467-9800

Is responsible for national drug control strategy; sets priorities for criminal justice, drug treatment, education, community action, and research. Offers the following information clearinghouse:

> Drugs and Crime Clearinghouse
> 160 Research Boulevard
> Rockville, MD 20850
> Phone: (800) 666-3332
>
> Distributes statistics and drug-related crime information.

Safe Drug-Free School Program
U.S. Department of Education
600 Independence Avenue, S.W.
Washington, DC 20202
Phone: (202) 260-3954

Funds drug and violence prevention programs that target school-age children. Training and publications are also available.

OTHER PREVENTION PROGRAMS AND ORGANIZATIONS

The following list of programs, organizations, and hotlines is provided for the reader seeking additional resources. Inclusion on this list should not be construed as an endorsement by NIDA.

Community Anti-Drug Coalition of America (CADCA)
901 North Pitt Street
Suite 300
Alexandria, VA 22314
Phone: (703) 706-0560
Fax: (703) 706-0565

A membership organization for community alcohol and other drug prevention coalitions, with a current membership of more than 3,500 coalition members. Provides training and technical assistance and publications and advocacy services and hosts a National Leadership Forum annually.

Narcotics Education
6830 Laurel Street, N.W.
Washington, DC 20012
Phone: (202) 722-6740
Phone: (800) 548-8700

Publishes pamphlets, books, teaching aids, posters, audiovisual aids, and prevention materials designed for classroom use on narcotics and other substance abuse.

National Center for the Advancement of Prevention
11140 Rockville Pike
Suite 600
Rockville, MD 20852
Phone: (301) 984-6500

Produces documents on a variety of prevention and community mobilization and readiness topics.

National Families in Action
2296 Henderson Mill Road, Suite 300
Atlanta, GA 30345
Phone: (404) 934-6364

Maintains a drug information center with more than 200,000 documents; publishes *Drug Abuse Update*, a quarterly journal containing abstracts of articles published in journals, academic articles, and newspapers on drug abuse and other drug issues.

Parents Resource Institute for Drug Education, Inc. (PRIDE)
3610 Dekalb Technology Parkway, Suite 105
Atlanta, GA 30303
Phone: (770) 458-9900
Phone: (800) 241-9746

Offers drug prevention consultant services to parent groups, school personnel, and youth groups. In addition, provides drug prevention technical assistance services, materials, and audio and visual aids.

Partnership for a Drug-Free America
405 Lexington Avenue
16th Floor
New York, NY 10174
Phone: (212) 922-1560

Conducts advertising and media campaigns to promote awareness of substance abuse issues.

Prevention First Inc.
2800 Montvale Drive
Springfield, IL 62704
Phone: (312) 793-7353

Produces a variety of print and audiovisual products on various prevention topics.

TARGET
National Northwest Federation of State High School Associations
11724 Plaza Circle
P.O. Box 20626
Kansas City, MO 64195
Phone: (816) 464-5400

Offers workshops, training seminars, and an information bank on substance use and prevention.

Toughlove International
P.O. Box 1069
Doylestown, PA 18901
Phone: (215) 348-7090
Phone: (800) 333-1069

National self-help group for parents, children, and communities, emphasizing cooperation, personal initiative, avoidance of blame, and action. Publishes a newsletter, brochures, and books. Holds workshops.

Hotlines

Al-Anon Family Group Headquarters
Phone: (800) 356-9996

Provides printed materials specifically aimed at helping families dealing with the problems of alcoholism. Available 9 a.m. to 4:30 p.m. EST.

Alcohol and Drug Hotline
Phone: (800) 821-4357
Phone: (801) 272-4357 in Utah

Provides referrals to local facilities where adolescents and adults can seek help. Operates 24 hours.

Child Help USA
Phone: (800) 422-4453

Provides crisis intervention and professional counseling on child abuse. Gives referrals to local social services groups offering counseling on child abuse. Operates 24 hours.

Covenant House Nineline
Phone: (800) 999-9999

Crisis line for youth, teens, and families. Locally based referrals throughout the United States. Help for youth and parents regarding drugs, abuse, homelessness, runaway children, and message relays. Operates 24 hours.

Depression, Awareness, Referral and Treatment (D/ART)
Phone: (800) 421-4211

Provides free brochures about the symptoms of depression, its debilitating effects on society, and information about where to get effective treatment. Operated by the National Institute on Mental Health. Operates 24 hours.

Grief Recovery Institute
Phone: (800) 445-4808

Provides counseling services on coping with loss. Available 9 a.m. to 5 p.m. PST.

National Mental Health Association (NMHA)
Phone: (800) 969-6642

Provides a recorded message for callers to request a pamphlet that includes general information about the organization, mental health, and warning signs of illness. Available 9 a.m. to 5 p.m. EST.

GENERAL PUBLICATIONS ON PREVENTION

The following publications are available from:

Join Together
441 Stuart Street, 6th Floor
Boston, MA 02116
Phone: (617) 437-1500
e-mail: jointogether.org

Alcohol and Drug Abuse in America: Policies for Prevention, 1995.
Recommendations on how communities can prevent alcohol and drug abuse.

Community Action Guide to Policies for Prevention, 1995.
Steps communities can take to strengthen prevention efforts.

How Do We Know We Are Making A Difference? 1996.
Eighty-six page substance abuse indicator's handbook to help communities assess substance abuse problems.

Substance Abuse Strategies in America's 20 Largest Cities, 1996.
Efforts against alcohol and drugs in 20 cities in the United States.

GOVERNMENT PUBLICATIONS

National Institute on Drug Abuse
Research Dissemination and Application Packages (NIDA RDA Packages)

NIDA RDA packages are available from the National Clearinghouse for Alcohol and Drug Information (NCADI), the National Technical Information Service (NTIS), and/or the U.S. Government Printing Office (GPO). (See list of Federal Government agencies.) NCADI, NTIS, and GPO publication numbers and costs are listed for each RDA package.

Drug Abuse Prevention Package (4 publications), NCADI Order No. PREVPK

This package is designed to help prevention practitioners plan and implement more effective prevention programs based on evidence from research about what works. The core package should be ordered and read first because it provides the information needed to prepare communities for prevention programming. Three stand-alone resource manuals then can be ordered. These manuals each provide information and guidance on implementing a specific prevention strategy introduced in the core package. The core package is available free of charge from NCADI (Order No. PREVPK) while supplies last.

- *Brochure*
- *Drug Abuse Prevention: What Works*
- *Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools*
- *Drug Abuse Prevention and Community Readiness Training Facilitator's Manual*

Drug Abuse Prevention Resource Manuals

These manuals are available free of charge from NCADI while supplies last.

- *Drug Abuse Prevention for the General Population*, NCADI Order No. BKD200
- *Drug Abuse Prevention for At-Risk Groups*, NCADI Order No. BKD201
- *Drug Abuse Prevention for At-Risk Individuals*, NCADI Order No. BKD202

How Good Is Your Drug Abuse Treatment Program Package (4 publications)

This package deals with treatment program evaluation; however, much of it is applicable to drug abuse prevention programming.

- NTIS #PB95-167268/BDL: $44.00 (domestic) + postage; $88.00 (foreign) + postage
- GPO #017-024-01554-7: $33.00 (foreign rate add 25-percent surcharge for special handling. If by airmail, an additional cost is added.)

Working With Families To Support Recovery Package (4 publications), NCADI Order No. FAMILYPK

This package is designed to disseminate research-based family therapy treatment approaches to the drug abuse field. It is available free of charge from NCADI while supplies last.

National Institute on Drug Abuse
Clinical Reports (NIDA Clinical Reports)

All NIDA Clinical Reports are available from NCADI. (See list of Federal Government agencies.) NCADI order numbers are listed for each clinical report.

Family Dynamics and Interventions, NCADI Order No. BKD147

Mental Health Assessment and Diagnosis of Substance Abusers, NCADI Order No. BKD 148

National Institute on Drug Abuse
Research Monographs

All NIDA Research Monographs are available from NCADI. (See list of Federal Government agencies.) NCADI order numbers are listed for each research monograph.

Drugs and Violence: Causes, Correlates, and Consequences. NIDA Research Monograph 103, NCADI Order No. M103

Drug Abuse Prevention Intervention Research: Methodological Issues. NIDA Research Monograph 107, NCADI Order No. M107

Methodological Issues in Epidemiological, Prevention, and Treatment Research on Drug-Exposed Women and Their Children. NIDA Research Monograph 117, NCADI Order No. M117

Advances in Data Analysis for Prevention Intervention Research. NIDA Research Monograph 142, NCADI Order No. M142

Adolescent Drug Abuse: Clinical Assessment and Therapeutic Interventions. NIDA Research Monograph 156, NCADI Order No. M156

National Institute on Drug Abuse
Videotapes for Prevention Practitioners

These videotapes are available from NCADI. (See list of Federal Government agencies.) Order numbers are provided for each tape.

Coming Together on Prevention, 1994, 27 minutes, NCADI Order No. VHS66, $8.50

Dual Diagnosis, 1993, NCADI Order No. VHS58, $8.50

Adolescent Treatment Approaches, 1991, NCADI Order No. VHS40, $8.50

National Institute on Drug Abuse
Other Publications

There are various other NIDA publications and products on various prevention and other related topics, some of which are listed below. For a full list, contact NCADI for a catalog. (See list of Federal Government agencies.) In addition, future products related to prevention will be announced through flyers and the *NIDA Notes* newsletter. Readers with access to computers can find out about new materials by calling up NIDA on its World Wide Web homepage at *http://www.nida.nih.gov/*

Drug Use Among Racial/Ethnic Minorities, NCADI Order No. BKD180

Monitoring the Future Survey—Prevalence of Various Drugs for 8th, 10th, and 12th Graders, 1994, NCADI Order No. CAP48

Center for Substance Abuse Prevention (CSAP)
Publications

CSAP has a wide range of prevention products addressing various prevention topics and targeted populations. These products include resource guides, manuals, pamphlets, posters, videotapes, and data reports. Target populations include educators, community leaders, families, health professionals, and youth. Publications are also available in Spanish. CSAP products are available from NCADI. (See list of Federal Government agencies.) For a full list, contact NCADI for a catalog. Publications cited in this *Drug Abuse Prevention RDA package* are given below. NCADI publication numbers are listed for each publication.

Communicating About Alcohol and Other Drugs: Strategies for Reaching Populations at Risk. CSAP Prevention Monograph 5. Rockville, MD: NCADI Pub. No. BK170, 1993

Conducting Focus Groups With Young Children Requires Special Consideration and Techniques. CSAT Technical Assistance Bulletin. Rockville, MD: NCADI Pub. No. MS501, 1991 (Reprint 1994)

Cultural Competence for Evaluators: A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working With Ethnic/Racial Communities. Center for Substance Abuse Prevention. DHHS Pub. No. (ADM)92-1884A. Rockville, MD, 1992

Handbook for Evaluating Drug and Alcohol Prevention Programs: Staff/Team Evaluation of Prevention Programs (STEPP). U.S. Department of Health and Human Services. DHHS Pub. No. (ADM)87-1512, Rockville, MD, 1987

Measurements in Prevention: A Manual on Selecting and Using Instruments To Evaluate Prevention Programs. CSAP Technical Assistance Report 8. Rockville, MD: NCADI Pub. No. BK213, 1993

Prevention Plus II: Tools for Creating and Sustaining a Drug-Free Community, Rockville, MD: NCADI Pub. No. BK159, 1991

Prevention Plus III: Assessing Alcohol and Other Drug Prevention Programs at the School and Community Level. Rockville, MD: NCADI Pub. No. BK18, 1991

Prevention Primer: An Encyclopedia of Alcohol, Tobacco, and Other Drug Prevention Terms. Rockville, MD: NCADI Pub. No. PHD627, 1994

You Can Manage Focus Groups Effectively for Maximum Impact. CSAP Technical Assistance Bulletin. Rockville, MD: NCADI Pub. No. MS495, 1991 (Reprint 1994)

Center for Substance Abuse Treatment (CSAT) Publications

CSAT has two series of publications, some of whose issues address topics of interest to substance abuse prevention professionals. Topics include dual diagnosis, assessment and treatment of adolescents, and so forth. The two series are called Technical Assistance Publications Series (TAPS) and Treatment Improvement Protocol Series (TIPS). CSAT publications are available from NCADI. (See list of Federal Government agencies.) For a full list, contact NCADI for a catalog.

Other Government Publications

The following publications are available from the agencies. (See list of Federal Government agencies.)

Supporting Substance-Abusing Families: A Technical Assistance Manual for the Head Start Management Team. Washington, DC: Department of Health and Human Services, Administration for Children and Families, Head Start Bureau, 1994

Working With Parents: Grades 9-12, Learning To Live Drug Free: A Curriculum Model for Prevention. Washington, DC: Department of Education, May 1990.

APPENDIX B:

PARENT SKILLS TRAINING PROGRAM MANUAL

EXAMPLE: LESSON 3, "REWARDS"

SESSION THREE: REWARDS

TIME, MEDIA, AND MATERIALS

OUTLINE OF PARENT TRAINING ACTIVITIES

10 MINUTES I. SHARE HOMEWORK

Before the class, tape up a sheet of newsprint for each member with the person's name written on top. As parents arrive, ask them to tape their homework to the bottom of the newprint. Did your child enjoy Child's Game?

Ask everyone to share one fun thing they did this week and in the past with their child. How did they know it was fun for the child?

40 MINUTES II. REWARDS

A. Lecture on Rewards:

Behavioral programs seem to be one of the best ways of changing children's behavior. There is a very simple reason for this: children work for things that bring pleasure (e.g., rewards, treats, presents, attention, etc.). Adults work the same way; a paycheck rewards time spent at a job or we may buy ourselves a present for losing 20 lbs. Children also avoid or change behaviors that result in punishment, being ignored, extra chores, etc.

Those things children work for are called "Rewards." Rewards are one of the most important ways parents have of controlling what their children do.

Rewards are used to increase behavior which you like your child to do. You can make the behavior occur more often by making sure it results in consequences your child enjoys. For example, a parent might be able to help his or her child spend more time practicing spelling words if the outcome of working is that the child gets to play a game with the parent. This arrangement will be effective if the child likes playing games with the parent. People are all different, and the rewards you can use will be different depending on what one child likes, another child may not like at all.

This "things people like" and will work to get are called "rewards." A reward is anything which maintains or increases a behavior.

(10 Minutes) B. Group Exercise: The Power of Rewards

Say, "Okay, now let's do a little exercise to show just how much power rewards do have in changing people's behavior."

(Operant Reinforcement Shaping Exercise- Use applause or smiling as a reward to change whatever behavior the group decides subjects should perform, e.g., stand in corner, etc.) Ask for a volunteer from the group. If no one volunteers, then have one of the staff be subject of the demonstration.

(5 Minutes) C. Lecture on Rewards continued:

Explain that reinforcing your child for a certain behavior is also showing love in a sense. The difference, however, is that the rewards are given CONTINGENT upon the behavior.

Contingent means:

YOU GIVE THE REWARD ONLY AFTER THE BEHAVIOR YOU LIKE OCCURS.

IF THE GOOD BEHAVIOR DOES NOT OCCUR, THEN DON'T GIVE THE REWARD!

A reward will increase or maintain the behavior it follows.

NEVER GIVE THE CHILD THE "REWARD" BEFORE HE OR SHE GIVES YOU THE BEHAVIOR YOU WANT---ONLY AFTER!

What do you say if parents say this is bribery?...

BRIBERY is: ---Illegal
---Unethical (A reward for doing something you shouldn't)

REWARD is: ---A Natural Event
---Follows Good Performance (Example: Paycheck)
---Not offered if the child doesn't mind the first time

(10 minutes) D. "Six Things to Remember About Catching Them Being Good"

Page 3-A Say, "As we are rewarding children, there are a few hints which make them more powerful. Let's go through these handouts." (See page 3-A)

Newsprint, Put major points on newsprint: 1) Reward a lot; 2) Reward right away; 3) Look at the child; 4) Tell your child what you liked; 5) Be excited; and 6) Pair reward with smiles and praise.

(15 minutes) E. "Attends" and Social Rewards

Discuss concept of "attends" and how we will be using it as a reward later when parent and kid groups are combined. Practice using "attends" appropriately by role play.

Video tape Player, tape Then use Forehand and Atkinson tapes or role play with group. Talk about other and social rewards.

---

5 MINUTES III. HOMEWORK

Page 3-B A. Ask everyone to complete the forms on "Things Your Child Likes" (page 3-B)

Page 3-C B. Also, have parents monitor each time they give their child a reward during their Child's Game which they will do 15 minutes daily. (Record on Worksheet 3-C "Record of Positive Social Rewards.")

Tell them that the child's game exercise will be more fully explained later in the sessions when parent and children groups are combined.

END OF SESSION THREE

SIX THINGS TO REMEMBER
ABOUT CATCHING THEM BEING GOOD

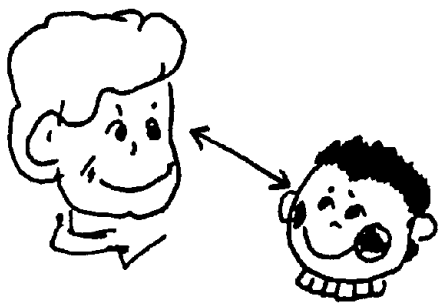
1. REWARD <u>A LOT</u>

   Whenever you see your child do something you like, reward him or her. (Few of us get enough strokes.)

2. REWARD <u>RIGHT AWAY</u>

   After the good behavior occurs. Waiting weakens the effect.

3. LOOK AT THE CHILD



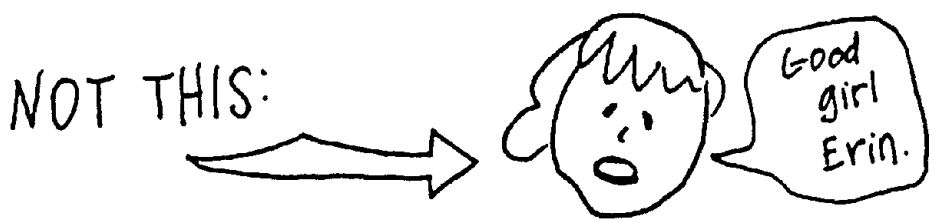
4. TELL YOUR CHILD WHAT YOU LIKED

   When you simply say "good girl" or "good boy" rather than "You did a good job on the dishes", your child doesn't know exactly what he or she did right--so tell your child specifically. The idea to get across is that they are loved and respected as a person; however, some of the things they do are more or less pleasing to you than other things they do.

5. BE EXCITED

   Listen to your tone of voice.

6. PAIR REWARD WITH <u>SMILES AND PRAISE.</u>



FILL IN THE SIX THINGS TO REMEMBER ABOUT REWARDS:

1. Reward _____
2. Reward _____
3. Look _____
4. Tell your child _____
5. Be _____
6. Reward with _____ & _____

SAMPLE PHRASES . . . . FOR GIVING REWARDS

I like the way you are working.
What neat _____.
WOW! NEAT! GREAT!
Keep up the good work.
Thank you very much.
That's quite an improvement!
Excellent work.
I'm very proud of the way you _____.
Marvelous.
Thank you for sitting down, being quiet, getting to work, etc.
You are on the right track now.
Ann is paying attention.
Jimmy is working quietly.
Good thinking!
I like the way you have settled down.

That's a good point; thanks for sharing.
Good try; keep it up.
Nifty!
Far Out!
Give me five.
Thank you for not interrupting.
You're a good helper.
How thoughtful of you to _____.
I like what you did.
What a good job!
I'm impressed with the way you _____.
You sure are growing up.
I like it when you _____.
That was a kind thing to do.
You are very considerate.
Thanks for doing what I asked.

Write what you could say:

_____ _____
_____ _____
_____ _____

FUN THINGS MY CHILD LIKES

Please sit down with your child and fill this page with things he or she likes. These may be things to do or get or praise, whatever sounds good to your child. (You may be surprised! . . .) Some ideas are listed on the next two pages.

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

13.

14.

15.

16.

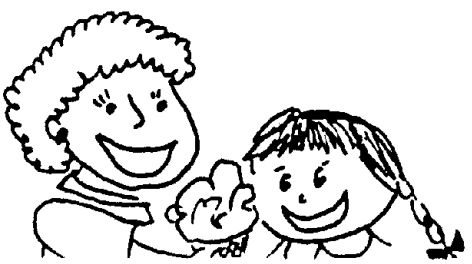
17.

18.

19.

20.

THANK YOU!



IDEA LIST -- REWARDS

SOCIAL REINFORCERS:

- hugging
- congratulating
- shaking hands
- touching or patting
- praising
- paying special attention to
- smiling
- applause
- recognition
- nodding
- winking
- tickling
- kissing

PRIVILEDGES, SPECIAL ACTIVITIES:

- free time
- extra turn in a game
- work puzzles
- dressing up in funny clothes
- build up, knock down blocks
- have parent wear a funny hat for 15 minutes
- pop balloons, paper bag
- water plants
- play with squirt gun
- roll wheeled toy
- sing a song
- read comic book
- string beads
- listen to a song
- go to museum, park, etc.
- 15 minute later bedtime
- dance with parent
- blow up a balloon, let it go
- play with typewriter
- pick story for parent to read
- cut with scissors
- show and tell
- pour water through funnel from one container to another
- parent does one of child's household chores
- help prepare dinner
- play jump-rope with parent
- throw a ball, bean bag
- to be turned around in swivel chair
- blow out match
- look in mirror
- be pulled in wagon
- listen to record or tape
- be swung around
- push adult around in swivel chair
- go to a movie
- be pushed on swing
- horsey-back ride
- operate a jack-in-the-box
- comb parent's hair
- solve codes or puzzles
- play musical instrument
- draw and color pictures
- have a party
- play short game (tic-tac-toe, etc)
- blow soap or gum bubbles
- have a bubble bath
- sit on parent's lap
- work on arts and crafts
- climb ladder
- listen to own voice on tape recorder
- have timed foot-races
- select the TV program
- jump from high place into parent's arms
- have shadow show
- take a picture with a camera

NON-FOOD OBJECTS OR
MATERIAL REWARDS:

Silly Putty
bookmarkers
jacks
jump rope
cards
toy watches
combs
pick-up sticks
birthday hats
games
yo-yo's
paints and brushes
bean bags
toys
badges
chalk
compasses
clay
beads
jumping beans
stamps
elastic bands
masks
flash cards
colored paper
marbles
stickers
fans
ribbons
story books
pencils with names
coloring books
pictures from magazines
toy musical instruments
pennies
miniature card
comics
cowboy hats
whistles
pencils and pens
blocks
puzzles
buttons
flashlight
bubble blowing set
crayons
striped straws
balloons
banks
model kits

FOOD AS REWARDS

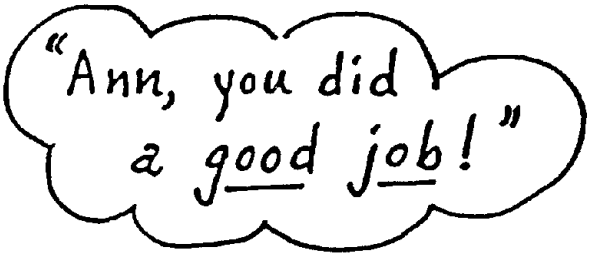
penny candy
jawbreakers
Smarties
milk
M & M's
chocolate creams
apples
raisins
sips of fruit juice or soda
gum
crackers
candy canes
lollipops
popcorn
candy kisses
doughnuts
lemon drops
nuts
sugar-coated cereals
ice cream
marshmallows
sugar cane
cake
candied apples
lemonade
Cracker Jacks
jelly beans
candy bars
candy corn
animal crackers
fruit
pretzels

RECORD OF POSITIVE "SOCIAL REWARDS"

Please mark a "1" for every positive thing you tell your child during this next week:

NAME	MON	TUES	WED	THURS	FRI	SAT	SUN	TOTALS
1.								
2.								
3.								
4.								
5.								
6.								

List on the back examples of the rewards you gave your child. For example:



Also, list the things your child did that you rewarded; for instance, Ann had just cleared the dishes from the table.

APPENDIX C:

CHILDREN'S SKILLS TRAINING PROGRAM MANUAL

EXAMPLE: LESSON 5, "HOW TO SAY 'NO' TO STAY OUT OF TROUBLE"

SESSION FIVE: HOW TO SAY "NO" TO STAY OUT OF TROUBLE

TIME, MEDIA AND MATERIALS — OUTLINE OF CHILDREN'S TRAINING ACTIVITIES (6-10 YRS.)

5 MINUTES I. REVIEW HOMEWORK

Review "secret rules of success." Ask children to give examples of times when they rewarded and ignored their parent's behavior. Also have children share what happened in the Child's Game with other members of the group.

10 MINUTES II. GAME: MAKE ME LAUGH

Have each child take a turn being in the "hot seat". The other children have 45 seconds to get that child to laugh. The person who can hold a straight face the longest (or ignore the other children) wins. The other children cannot touch or throw objects at the child in the "hot seat".

Discuss the following questions:

What did you have to do to try not to laugh? (Ignore, do not look at the other children, pretend they were not there, etc.)

It is hard to ignore others?

When would you want to ignore someone? (When they are trying to get you into trouble, teasing you, trying to make you mad, etc.)

40 MINUTES III. DISCUSSION: SAYING "NO" TO STAY OUT OF TROUBLE

Sometimes ignoring may not always work. Someone may ask you to do something you do not want to do. This could be a friend or a stranger. Have children give examples of things others may ask them to do (smoke, steal, lie, cheat, ride with a stranger, etc.). Today we are going to learn how to say "NO" to stay out of trouble.

There are four steps:

1. Stop what you are doing.
2. Think about what could happen.
3. Say "NO".
4. Look for something else to do.

TIME, MEDIA AND MATERIALS — OUTLINE OF CHILDREN'S TRAINING ACTIVITIES (6-10 YRS.)

Page 5-A

A. STOP what you are doing.

This step involves asking questions to find out what the other person is wanting you to do and naming the trouble (i.e. "That's stealing," "That's vandalism," "That's illegal," etc.) Once you stop what you are doing and realize that what others are asking you to do may be something that could get you into trouble, you can then move on to the next three steps.

Page 5-B

B. THINK about what could happen.

1. Discussion: Choices and consequences

We are all responsible for our own behaviors. We can make our own choices and we are responsible for the what will happen. What does "choices" mean? What are some examples of choices? What are some examples of things that might happen if you made the choices you just mentioned? Explain choices and consequences in relation to the following points:

a. We use our personal power to make choices.

b. Behind every choice we make, something either good or bad will happen.

c. Many times our choices are made based on what we think will happen.

d. Choices we make are either good or bad.

e. What could happen if...

1. you did not do your homework?
2. a person used drugs?
3. you stole some candy?
4. you swore at your mom?
5. you did not take a time-out quietly?
6. Have the group think of other choices they have made, and what happened.

2. Puppet Power: Choices and Consequences about Lying

Play act the following situation with the puppets highlighting the concept of making a choice and the good and bad things that might happen as a result.

Sandy sees Alvin drop a nickel from his pants pocket. Sandy races toward the nickel, picks it up and puts it in her pocket.

Sandy: "(singing) Boy-o-boy. I found a nickel, I found a nickel!"

Alvin: "Aren't you lucky! I have a nickel too (reaching in his pants to find his nickel) It's gone (begins to cry)."

Sandy: "Well don't look at me, this is my nickel; my mother gave it to me."

Leader: What did Sandy do? (she told a lie) How could she have used her personal power in a good way? What could she have done? (told the truth; given the nickel back to Alvin) Discuss with the children what could happen as a result of lying. How did Sandy use her personal power?

Repeat the same sequence this time with Sandy telling the truth. Ask the children to brainstorm what could happen when Sandy told the truth. How did Sandy use her personal power?

If time allows repeat the play acting with other topics relevant to the group. Some examples could include taking a quiet/noisy time-out, hitting others, treating others nicely, taking things without asking, etc.

Page 5-C

3. Read and discuss "Johnny Dare-Me"

a. What did Johnny's friend tell him to do?

b. What were Johnny's choices?

c. What would happen if he did that?

d. Why do you think Johnny listened to his friend even though he knew he would get into trouble?

e. Why do you think Johnny didn't scribble on the drawing the last time?

f. How do you think the friend felt about Johnny when he didn't scribble on the drawing?

g. How do you feel when you don't think anyone likes you?

h. How do you feel when one of your friends won't do something you want them to?

i. What can you do if your friends tell you to do something you don't want to do or you think is wrong to do?

Page 5-D

C. SAYING "NO"

Sometimes we have to say "No" to other kids and adults so we do not do things we really do not want to do. Saying "No" is not always easy.

1. Discuss.

   Have children brainstorm the verbal and non-verbal (body language) ways they say "No." Discuss ways to say "No" and not really mean it, ways to say "No" with conviction, "scared No", aggressive and assertive ways to say "No", etc. If someone wanted to touch you in a place you didn't want to be touched, what type of "No" should you use?

2. Role play

   Discuss times when it is and is not okay to say "No." Role play the following situations with the children.

   a. The kids in your class are hiding books and things from the teacher. They want you to join in.

   b. Some kids try to get you to throw rocks at the school windows.

TIME, MEDIA AND MATERIALS — OUTLINE OF CHILDREN'S TRAINING ACTIVITIES (6-10 YRS.)

c. Your mom asks you to baby sit your little brother at home. Your friend suggests you go along with him to a ball game.

d. A stranger asks you to go for a ride.

e. Some kids want you to smoke a cigarette with them. They call you a chicken when you say "NO."

f. Your brother suggests that you try some of your dad's whiskey.

Just after the invitation has been made to perform an unacceptable behavior, ask the children what they should do. Have the children practice saying "No" by shouting the word, changing the subject, or other variations they have come up with. Follow through on the above situations by modeling the desired behavior.

Page 5-E

D. LOOK for something else to do.

1. Change the subject. Suggest another activity. What could you suggest to the friend who wanted you to go to a baseball game? (have him help baby sit, watch a movie on TV, etc.)

2. Leave.

IV. OPTIONAL

Read and discuss "Copy Cat." Allow children to write their own stories.

---

5 MINUTES V. HOMEWORK

Have children share these steps with their parent(s) at home as well as practice them during the week. They could also color the four steps to say "NO".

END OF SESSION FIVE

what you are doing.

Think about

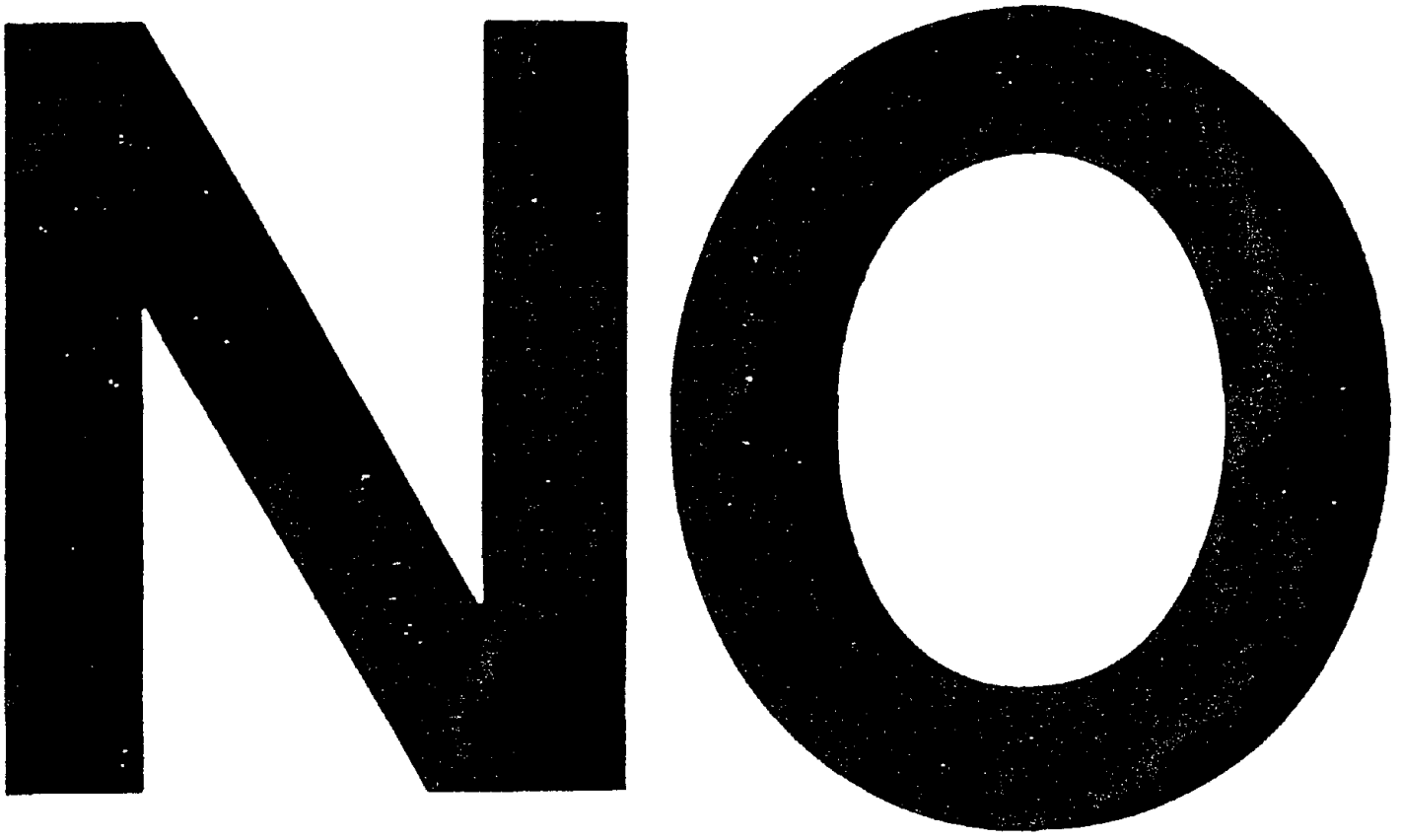
what could happen.

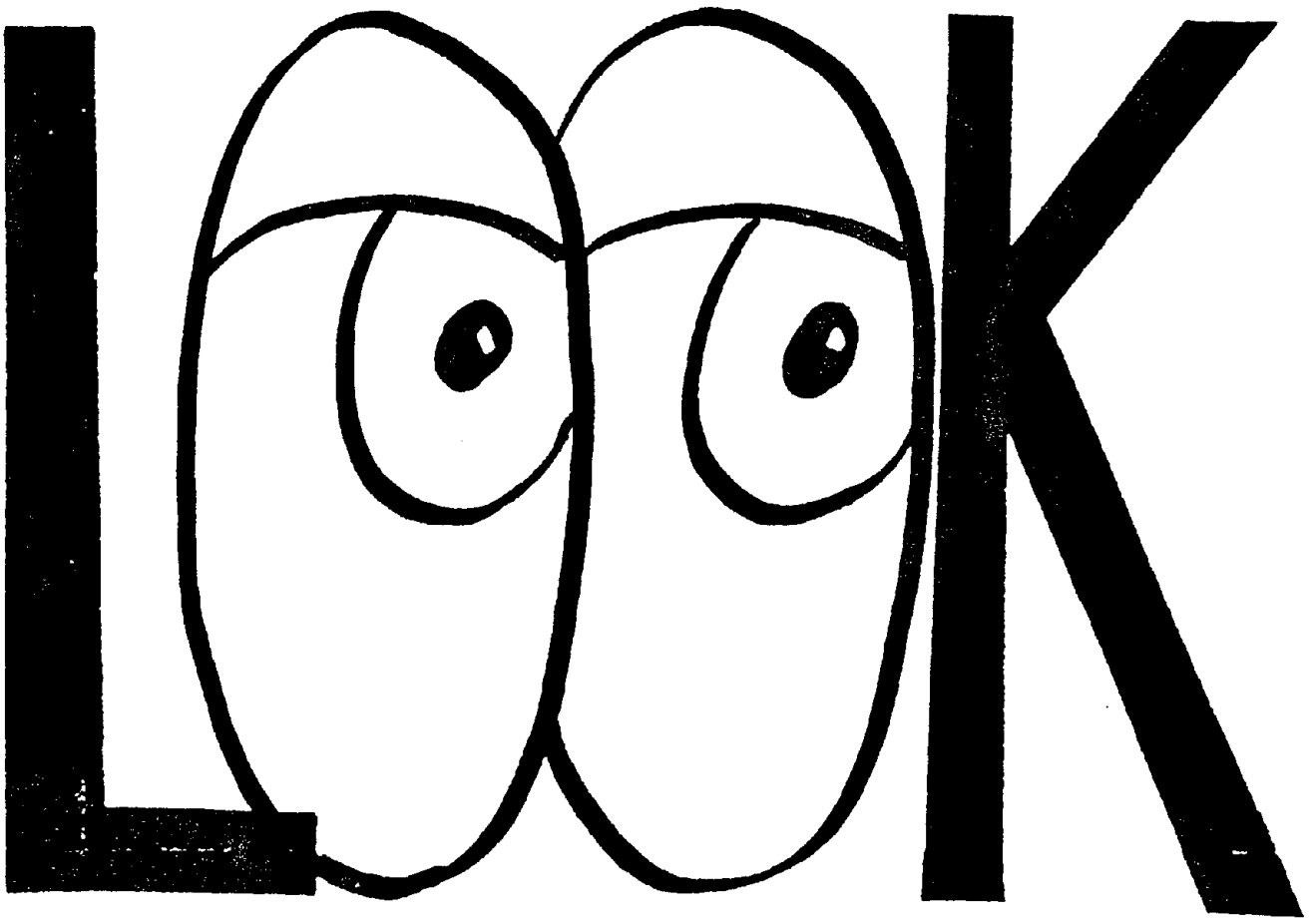
JOHNNY DARE-ME

This is a story about Johnny Dare-Me. He was seven years old. He lived in a house a lot like yours. Johnny had one friend with whom he did everything--but, you know what? Johnny was always getting into trouble. The first time I met Johnny was the first day of school. I found him running and pushing and knocking down the other kids coming to school. Johnny said his friend told him to do it. Johnny and I had a long talk about the kinds of things he could do at school and the kinds of things he couldn't do. He agreed not to run and push anymore because it isn't safe.

But, a little while later, I found him knocking down block buildings which belonged to other children. It turned out that he was dared to do it by his so-called friend. Another time, Johnny landed in the nurse's office after his friend dared him to drink some whiskey and it made him sick. Johnny kept getting into trouble, thanks to his friend, because he always did whatever his friend said.

Then, one day I heard someone tell Johnny to start thinking for himself and stop listening to his friend. Later that day, Johnny came to me and told me his friend had told him to go and scribble on someone else's drawing and he didn't do it.


NO



for something
else to do.

APPENDIX D:

FAMILY SKILLS TRAINING PROGRAM MANUAL

EXAMPLE: LESSON 2, "CHILD'S GAME"

SESSION TWO: CHILD'S GAME

TIME, MEDIA, AND MATERIALS

OUTLINE OF FAMILY TRAINING ACTIVITIES

PURPOSE AND TASKS OF SESSION TWO- CHILD'S GAME

The primary tasks of the second session are:

1. To provide the parent with a conceptualization of the presenting problem (s) in the context of the parent-child interaction.

2. The therapist also uses the child's behavior during the first treatment session as a means of demonstrating the effectiveness of the social learning procedures.

3. Training in Phase I--Child's Game of the program usually begins in the second session (if time available).

Child's Game Video

NOTE: Demonstration of Child's Game- The class instruction in how to do Child's Game can be done by live demonstration or showing the Child's Game video tape.

I. SETTING INSTRUCTION TO CHILD BY THERAPIST

A. Therapist models an appropriate setting instruction to the child.

Example: "(Name), your Mom (and/or Dad) and I are going to be talking over here. Here are some (toys, books, comics, games, etc.) for you to play with. We have a lot of work to do, so please don't interrupt us. If you do, we will ignore you." (Therapist then returns to parent and begins presentation.)

B. Therapist reinforces appropriate child behavior.

After a couple of minutes, therapists interrupts presentation to parent and says, "Since (name) has been reading/playing quietly, I am going to let him or her know we like that."

Therapist walks over to child and praises by saying, "Thanks for reading/playing by yourself over here. We like it when you do that." (Therapist then returns to parent and resumes presentation.)

C. Therapist prompts parent to reward child throughout session.

1. At first, the therapist should tell the parent exactly what to say and when to say it.

2. As the parent becomes more proficient, he/she should be encouraged to interrupt the therapist at appropriate intervals to reinforce the child's appropriate behavior.

3. The therapist should reinforce the parent for "interrupting" correctly within the session.

D. Therapist/parent ignore as required.

II. UNDERSTANDING THE PROBLEM(S)

A. Assessment information is used.

Figure 2.1

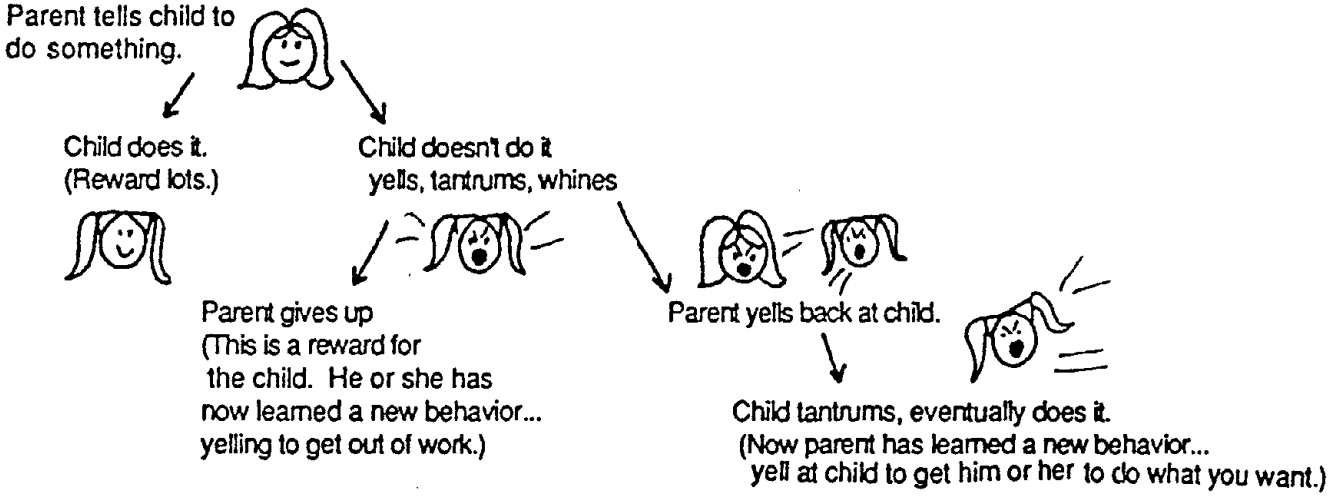
B. Situations are summarized in which noncompliance and problem behaviors occur. (Figure 2.1)

C. Coercive nature of parent-child interactions is examined and briefly explained.

Many children don't like their parents telling them what to do. To get parents to stop asking them to do things, children will either 1) do the thing asked of them, or 2) whine and cry until the parent tells them they don't have to do whatever it was they were supposed to do. The parent will either give in or start yelling back at the child. If the child then obeys the parent, the child in a way is rewarding the parent for yelling at him or her.

As a result, families where the parent(s) tells the child what to do much of the time are families where the child and parent may yell at each other a lot, also.

The following diagram shows how parents can be rewarded for yelling at their child after they first disobey them:



The more this happens, the more frequent and intense the interactions. Yelling by the parent and child is very unhealthy and makes it harder to get along with each other. Thus, in this system the child is rewarded for engaging in bad behaviors. The child learns more bad behaviors (like yelling) by watching the parents yelling and modeling other unwanted behaviors. There is truth to the sayings, "Do as I say, not as I do."

Another way bad behaviors increase is by rewarding them with a lot of attention when they occur. The parent might spend several minutes talking, trying to "understand" the child's anger, or reasoning with the child. Assuming that parental attention is a reward for the child, the parent has in effect spent several minutes rewarding the very behaviors (noncompliance and tantrums) he or she is trying to decrease. Thus, in any given situation, positive and/or negative reinforcement from the parent may be fostering the child's noncompliance.

III. CHILD'S GAME

A. Explain Attends:

Now that you have learned the Differential Attention rules, we will have you practice your differential attention and "attends" to the child in the Child's Game. Your (the parent) job is to tell the child what he or she is doing.

1. Two kinds of attends:

   a. Describing: Those that simply describe good behavior that you can see. For example, "You're stacking the blocks," or "Here comes the truck." Describe only the good behavior, not bad (such as, "You're throwing the truck at the window.")

   b. Emphasizing: The second kind is emphasizing good behaviors. For example, "You're talking in a nice voice." "You're playing quietly by yourself."

2. Keep watching.

   You need to keep watching what the child is doing. You don't need to stare at the child's face which may make them uncomfortable.

3. To do's.

   You can play with the child if they want to play with you, but do not try to get the child to play or do what you want him or her to do. You can hand the child toys or take a turn. If the child does not ask you to play with him or her, you can play yourself with a similar toy or game, or you can imitate his or her play. Remember to keep describing and emphasizing what your child is doing, not what you are doing. Also, try to be excited about what your child is doing and watch with interest.

4. No-No's during Child's Game

   During the Child's Game, the parent is not to ask any questions or make any commands. The child gets to decide what to play with and what to do. (A question can be used to direct the child. For example, "Wouldn't you rather play with this game?" really means, "I want you to play with this game.") Do not use the play session to teach.

5. Tracking feelings

   You can also describe the child's feelings (what you can see). For example: "You are smiling; you are happy now," or "You are frowning; you are unhappy." Try to "track" your child's feelings to different things. It is easier to get along with each other when you learn to tell how each other is feeling. Your child will spend time practicing this in the Children's Group.

B. Discuss Child's Game

Ask, "Do you have any questions about what you are to do during the Child's Game?" (Ask both parents and child.) Answer questions.

C. Demonstration: Therapist models attends with the co-therapist or parent.

Now I will show you how Child's Game is played. Would either of you (parent or co-therapist) be willing to play the child's part?

(Encourage parent to role play, but it too timid this first time, have co-therapist play child. This also gives the child a chance to observe what they should do.)

D. Demonstration: Therapist models attends with the child.

Now I will show you how we play Child's Game. Is it okay with you (child), that I pretend I am your Mom/Dad and we play Child's Game together? To start, you can choose any toy or game to play with and I will watch or play with you, as you want.

(Start Child's Game)

E. Parent/Child Practice of Attends

Now you (parent and child) should do what we have done. I will stay in the room and give you help about what to do or not to do. Also, I will tell you when you are playing the game well.

F. Parent/Child Practice without Feedback

IV. CURRICULUM FOR ADVANCED PARTICIPANTS: EMPATHY TRAINING

A. Therapist Note:

The Child's Game is designed essentially to help parents master their skills of attending to and rewarding their children's good behavior, and involving them in activities that foster family unity and attachment. It has been the therapists' observation that some participants are able to master these skills and meet the behavioral criteria for both phases of the Child's Game within the first practice session. To continue practicing these skills for three more sessions (as directed in the curriculum) has been observed to be aversive and degrading for these participants.

If you are working with a family who has demonstrated mastery of these skills before Session Six, the following exercises may be substituted. These exercises follow the same format of first having family members participate in the specified charade or role play (a different one is presented in Session Three, Four and Five), and then individually responding to four questions concerning the exercise:

1. An accurate description of the actual behaviors seen during the exercise

2. A description of body cues that may help describe the participant's feelings.

3. Interpret the feelings expressed by each person in the exercise and;

4. A discussion of what caused those feelings.

This procedure of having participants begin focusing on each other's overt behaviors, moving towards assessing and interpreting affect and feelings displayed, and attempting to develop a logically consistent causal explanation of those feelings and affect, is one recommended by Dr. Robert McMahon as a means to have advanced participants practice the skills of empathic decentering and perceptual role-taking.

The charades and role-plays are intended to be used in place of the Child's Game (once participants reach criteria for both phases of Child's Game) and will comprise the content for the second hour of the family session. Participants may reenact the charades with family members playing different roles, but therapists should not substitute or replace the charades or role-plays designated for the following three sessions. The charades and role-plays are presented under "Curriculum for Advanced Participants" in each of the next three sessions.

B. Homework for Advanced Participants

In addition to substituting charades for the Child's Game, advanced participants should also be assigned the following directions as a substitution to the homework at the end of the joint Family Life Training Session Three, Four and Five.

Labeled Verbal Rewards

Instead of having advanced parents (and those of older children) practice the Child's Game for 15 minutes daily, give them instructions to give the child a social reward at least three times a day when the parent sees the child perform a good behavior (e.g., "John, I like the way you played with your baby sister when she began crying" or "Thanks, Mary for helping your father wash the car.") These directions are presented again in each of the following three sessions under "Homework for Advanced Participants."

V. HOMEWORK

A. Remember we discussed the importance of your practicing your new skills at home for 10-15 minutes each day. You need to do this to learn these skills well and have some confidence you can do them. Play the Child's Game with your child for 15 minutes each day and record what happened on 2-E. Please call us if you have any questions about how to start or on what happened. Do you have any questions now? Record Child's Game on 2-C.

B. Location/Time

You need to find a room where you can be alone without interruption from the phone or other kids and friends. Have some of the child's games or toys out. You

may want to do Child's Game in the child's bedroom or living room. Don't have distractions like having the radio on. If you can, it is also a good idea to play Child's Game with other brothers and sisters who might get mad if you don't spend equal time with them.

Can you think now of a time during the day you can practice Child's Game? (Get specific commitment.) Also, where do you think you will do it?

C. Parent Instruction Handouts 2-C and 2-D and Parent Record Sheet 2-E:

There are some guidelines for you to follow on Parent Handout 2-D. These basically repeat the rules which we have just learned.

On the Parent Record Sheet, you should write down the time of day, activity, and child's response to each Child's Game you play. Bring this sheet back to discuss with your therapist at the next session.

D. Pep Talk:

This may be hard or uncomfortable at first, but with practice, it will come easier. One thing you will discover (as many parents have) is that Child's Game is an excellent way to be sure you spend at least 10-15 minutes of "quality time" with your children.

Giving children so much positive attention ensures that they enjoy their "special time". Since children like this special time, they often remind the parent that it is time to play Child's Game.

Many parents, particularly working or single parents, find Child's Game very helpful in ensuring that they take time to spend with their child alone. It is hard sometimes to find the time--but what can be more important than investing in your child's future? Many parents only spend a few minutes a day with a child and much of that time is spent telling the child what not to do. This leaves very little "quality time". If parents can increase the quality time even just a few minutes a day, the child's maturity and moral development increases by several years. Also, the child behaves better and the parent doesn't need to discipline as much.

END OF SESSION TWO

FIGURE 2.1

PROBLEM GUIDE SHEET

CHILD: INTERVIEWEE(S):			INTERVIEWER: DATE:		
Setting	What Happens	How Often	How Long	Parent Responses	Child Responses
Bedtime (a.m. and p.m.)					
Mealtime					
Bath time					
On phone					
Visiting Others					
Car					
Public places (stores,etc.)					
School					
Brothers & Sisters					
Friends					
Other parent/relative					
Disciplinary procedures					
Other					

PHASE I

There are two ways to decrease your child's bad behavior: (1) increase his or her good behavior; or (2) decrease his or her bad behavior. The goal of Phase I is on increasing good behaviors.

WHAT PHASE I SKILLS CAN DO

1. You can teach your child which behaviors you like, so that he or she can do them more. Punishing bad behavior only gives your child information about what not to do.

2. You can learn to watch your child's behavior closely and to notice good things that he or she does. You will find your child has many good behaviors, not just bad ones.

3. These skills can help you to relax and have fun playing with your child. This will help to make time you spend playing with your child "quality" time.

4. As your child begins to enjoy being with you more, he or she will try harder to please you by doing the things you like.

5. You can teach good behavior to your child by having them see you do the good behavior you want them to learn.

6. By increasing your child's good behaviors, there is less time for bad behaviors.

WHAT YOU WILL LEARN

1. You will learn to use your attention after good behavior. You will learn two types of positive attention: (1) describing your child's behavior (attends), and (2) praising or rewarding.

2. You will learn to ignore (withhold your attention) after bad behavior. Note that ignoring can be used only when the behavior is not harmful or destructive. Harmful behaviors will be talked about in Phase II.

3. You will learn how to use attention and ignoring the same way each time.

PRACTICING FOLLOWING AND ATTENDING (CHILD'S GAME)

RULES FOR CHILD'S GAME

1. Child's activity. Let your child choose what he or she wants to do. Do not bring anything new into his or her play. If your child changes activities, follow along, but do not change the activity yourself.

2. Follow. Watch with interest what your child is doing. A good way to describe this is "tail-gating" your child.

3. Attends. Describe with excitement what he or she is doing (these are attends). Attends may be viewed as a play-by-play account or telling your child what the child is doing.

4. Some play and imitation. Play with your child by handing him or her toys or taking a turn. Be careful not to begin directing the activity yourself. You also may play by copying his or her play. Your child's activity is to be the center of your attention, so describe his or her activity while working on your own.

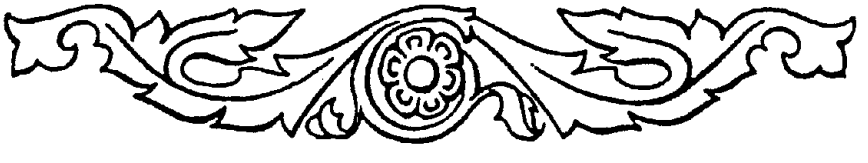
5. No questions or directions. Do not ask any questions or give any directions. These interrupt and/or direct your child's play.

6. No teaching. Do not use this time to teach your child or to test what he or she knows.

HOMEWORK

Play Child's Game with your child for 10-15 minutes each day. (It may be helpful to schedule a time so you don't forget.) Keep track of each Child's Game on the Parent Record Sheet.

This 10 to 15 minutes is for you to practice your attending skills. It also will be "quality" time for your child, since he or she will have your complete attention. Although Child's Game is a practice time, attending is a skill you can use throughout the day with your child.



PARENT RECORD SHEET

CHILD'S GAME			
Date	Number	Activity	Child's Response

*U.S. Government Printing Office: 1997 - 418-525/83577

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