

FAMILY SKILLS TRAINING PROGRAMS FOR FAMILY DRUG COURT

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VALUE STATEMENT

It is of vital importance to find effective interventions for family drug courts (FDCs) to prevent the recurrence of child abuse. With just more than half of FDCs providing family-based services, this article describes a family skills training program for FDCs and child welfare practitioners.

ABSTRACT

Family drug courts (FDCs) operate as alternatives to traditional drug courts in that they work to balance the rights and needs of both parents and children when the adults are affected by substance use disorders (SUDs). Approximately 12.3 percent of children live with at least one parent who is dependent on alcohol or needs treatment for drug abuse (Lipari and Struther 2017). A model family skills training program illustrates a FDC intervention. The program engages all family members in learning healthy living skills, addressing child maltreatment, family violence, and SUDs. Simply put, the goals of both FDCs and family skills training programs are to reduce child maltreatment by treating the parents' SUDs and keeping families together. Although there is an urgent need, only just over half of FDCs provide family-based services (Children and Family Futures 2016). The purpose of this article is to describe an effective family skills training program for FDCs and child welfare practitioners that will meet the need for family-centered interventions.

KEYWORDS

Family drug courts, family drug court intervention, substance use disorder, family training programs, child abuse, family reunification

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INTRODUCTION

Family drug courts (FDCs) are specialized courts within the justice system which handle cases of child abuse and neglect that involve substance use by a child's caregivers (Brook, Akin, Lloyd, and Yan 2015). These courts are also called family treatment courts, family treatment drug courts, or family dependency treatment courts. FDCs operate as alternatives to traditional dependency courts because they work to balance the rights and needs of both parents and children. FDCs were created to help keep families together and to address the poor outcomes of family reunification programs that left many children in foster care instead of being raised in stable, permanent homes.

The overall goals of FDCs are to reduce child maltreatment by treating parents' underlying substance use disorders (SUDs) and by reunifying families. FDCs were developed by communities in the mid-1990s to respond to the estimated high percentage (60-80 percent) of substantiated child abuse and neglect cases that involved substance use by caregivers (Children and Family Futures 2016). Within the child welfare system, parents with SUDs are least likely to successfully reunify with their children. In addition, their children often stay in the foster care system longer (Gregoire and Schultz 2001). FDCs have been shown to produce positive outcomes, including: (1) significantly higher rates of parental participation in substance abuse treatment, (2) longer stays in treatment, (3) higher rates of family reunifications, (4) less time spent in foster care for children, and (5) less recurrence of maltreatment (Boles, Young, Moore, and DiPierro-Beard 2007; Green, Rockhill, and Furrer 2007).

Furthermore, efforts that focused services on children demonstrated improved family bonding and attachment, as well as improved school outcomes (Lieberman, Ghosh Ippen, and Van Horn 2006). Clearly, a family affected by a SUD in a parent is a family that needs intense intervention to break the cycle of addiction. Family-centered intervention has been shown to be superior to intervention centered only on the individual with the addiction (Rodi et al. 2015). Family therapy has gained increased acceptance, with the defining characteristic being the simultaneous involvement of more than one member of the family (United Nations International Drug Control Programme 1995). Federally published guidelines suggest that, to meet the needs of parents and their children, FDCs should bring together substance abuse treatment providers with mental health, social service, and other family-serving agencies to meet the needs of parents and their children (Children and Family Futures 2015).

However, in a 2010 needs assessment, Children and Family Futures (2016) found that, although "services to children" was one of the most urgent technical assistance needs of FDCs, just over half (55.8 percent) indicated that they provided family-centered treatment or family-based services. And, just 51.2 percent indicated that they provided children's services (Rodi et al. 2015). Subsequently, efforts to meet the needs of families impacted by SUDs have produced a number of family-centered programs. Family skills training programs may result in decreased child abuse, decreased time children spend in foster care, substance abuse intervention for parents, and prevention of additional cycles of addiction for children.

One such program, *Celebrating Families!*[™] (CF!), is presented here. FDC and child welfare practitioners may find such programs to be worth consideration for their FDC.

FAMILY-CENTERED PROGRAMS

Family-centered programs are categorized as either parent education programs or family skills training programs. Family education programs rely on information presentation and sessions are typically

less than a total of eight hours. Parent education programs have not been found to be as effective as family skills training programs (Stormshak, Dishion, Light, and Yasui 2005; United Nations International Drug Control Programme 1995; Webster-Stratton, Reid, and Hammond 2001). Fisher and Harrison (2013) state that prevention efforts that solely offered information “did increase knowledge of participants but had no effect on attitudes and drug use” (p. 321).

On the other hand, family skills training programs consist of more and longer sessions and typically are more comprehensive. In a research review, Spoth, Redmond, Treadeu, and Shin (2002) concluded that the most effective family skills training programs: (1) include active parental involvement and parenting skills, (2) focus on the development of social skills and responsibility among children and adolescents, and (3) specifically address issues related to substance abuse. Effective programs also involve youth in family activities and strengthen family bonds in practice sessions. Thus, a typical session will see parents and children attending their own training groups and, at the end, coming together as a whole family for a family activity (Scheier, Botvin, Diaz, and Griffin 1999; Spoth, Redmond, Shin, and Azevedo 2004; Spoth, Guyull, and Day 2002).

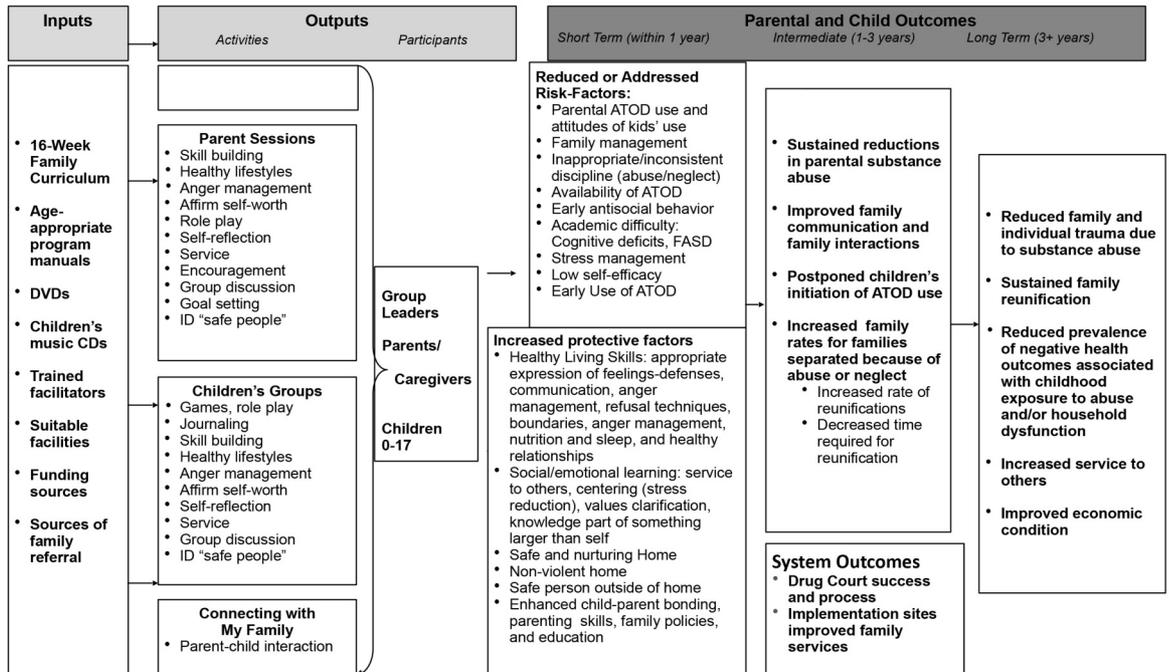
A MODEL FAMILY-SKILLS PROGRAM

The following is a description of a model family skills intervention program including topics covered, logistics, limitations, and costs of the program weighed against societal costs when children are put into foster care instead of being part of a stable home of origin.

The program, *CF!*, was created at the request of Judge Leonard Edwards II, Supervising Judge of the Santa Clara County, California, Juvenile Dependency Court (National Association for Children of Addiction 2017). *CF!* was developed for families in that drug court and other FDCs, where one or both parents had a serious problem with SUDs and domestic violence, child abuse, and neglect were present. It was created to prevent children’s future addiction, facilitate parents’ recovery from substance abuse, and help with reunification of families legally separated as a result of substance and child abuse. It required addressing the needs of the whole family and so, by definition, it was family-centered. The underlying philosophy of *CF!* is to reduce risk factors known to contribute to the generational cycle of addiction and child abuse and to increase protective factors (resilience) in all participants’ lives. Activities are multi-modal, recognizing that many participants have cognitive deficits. The model was piloted in Santa Clara County as part of a series of services funded by a Substance Abuse and Mental Health Services Administration (SAMHSA) grant in 1998. Over the years, the program received many formative evaluations from participants, group leaders, and outside evaluators. The manualized program has grown to over 100 sites in the United States and Canada as an effective alternative to placing children in foster care and preventing the cycle of addiction. *CF!* has been replicated in multiple settings, including schools, community-based sites, dependency drug courts, behavioral health and child welfare organizations, and substance treatment facilities.

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FIGURE 1
LOGIC MODEL



Assumptions

Assumes that positive changes in targeted behaviors are due to *CFI* program. However, it will be difficult to ascertain causality. For example, there is possible confounding in the association between family meals and later drug and alcohol use by children. Family meal could be a proxy for time spent together as a family, or for communication patterns common in families that share meals together.

External Factors

- Possible enrollment in other similar programs
- Possibility of exposure to abuse or ATOD use outside household environment or through extended family not participating in *CFI*
- Cost of program (to families and to funders)
- Expectations and inputs of funders and other partners

The logic model in Figure 1 documents short-term and long-term goals which coincide with the goals of FDCs. Consisting of sixteen sessions, each session begins with a healthy meal eaten in family groups with group leaders, is followed by ninety-minute, age-appropriate groups (parents and caregivers, children birth to age seventeen), and ends with a thirty-minute structured, related family activity. Families with infants/toddlers attend a family time focused on interaction with their young children for thirty minutes before the meal.

The curriculum includes information on brain chemistry, addiction, life skills, resilience, and asset development. It directly addresses issues of addiction in every session and incorporates recovery principles to anchor families in recovery and help children better understand addiction, anger management, problem solving and decision-making, family/domestic violence, refusal skills, goal setting, affirmations, learning disabilities and in-utero exposures (including fetal alcohol spectrum disorders), and limit and boundary setting.

LOGISTICS

Since 2017, Uplift Family Services' Addiction Prevention Services (APS) in San José (Santa Clara County), California, has provided over twenty-five cycles of *CF!* for families referred from family drug court. Their procedure is presented here as a model that has been successful after many evaluations.³ Participation, presented by the judge, is voluntary, but the parent referred from court has reunification with his or her children as an incentive to graduate from the program. Participants include the parent or parents and child or children from the dependency drug court, other children in the family, and other significant children's caregivers (e.g., mother/father, step-mother/father, foster parent, grandparents, other relatives). All family members are welcomed, as the program's goal is for the family system to become healthy by learning healthy living skills, thereby increasing protective factors and decreasing risk factors for children. Unrelated visitors, including social workers and probation officers, are allowed only for session 16-graduation.

Parents or caregivers participating in the twenty-five cycles at APS were between the ages of twenty to twenty-five, Hispanic, with an average of two and a third children. Groups are offered in English and Spanish. Average attendance in the program was eighty-seven percent for the sixteen weeks with an attrition rate of ten to fifteen percent, mostly due to homelessness. Referring court social workers were trained by the APS Program Director in program components and outcomes, appropriate referrals, and enrollment procedures. The process is:

- 1) The judge recommends the program to the person before him or her and encourages it as a consideration for family reunification. Several facilitators emphasized the importance of the judge at this stage. Anecdotally, they noted that a judge who gives at least a few minutes to the individual, asking about that person's life challenges while showing a caring attitude, improved incentive to change.
- 2) The court's social worker then makes the program referral. The referral consists of a confidential e-mail to the program with the family's contact information, number and ages of children, and information on domestic/family violence. No information on substance use is included. The program facilitator makes two contacts to the family: a letter and a call. The social worker is also alerted when the next *CF!* will be offered. In Santa Clara County, this is every two months.
- 3) Families come an hour early on the first night in order to meet staff, complete an intake, and review participation agreements, both verbally and in writing. Agreements include:
 - a) Consent for data to be included in evaluations (without identifying information)
 - b) Understanding that no more than three absences are allowed for graduation
 - c) Acknowledgement that children will not be released to anyone under the influence. Anyone under the influence of alcohol or other drugs will be asked to leave the session. However, the family is encouraged to remain, and the individual may return for the following session.

Anecdotally, those clients whose children do not live with them at the time, are homeless, or who have transportation problems may be most at risk for not completing the program.

- 4) Court social workers receive confidential e-mails weekly with attendance figures. At the conclusion of the program, they receive group leaders' observations and recommendations for the family and participants' evaluation forms, including program satisfaction. Anecdotally, those clients whose children do not live with them at the time, are homeless, or who have transportation problems may be most at risk for not completing the program. At APS, staff were helpful in finding resources to solve such problems.

To provide an effective program with fidelity, sites will need a large room with kitchen facilities for family activities plus several smaller group rooms (one for each age group). Sites should be easily accessible by public transportation. Ideal locations include family resource centers, schools, and churches with Sunday school classes and parish halls. Not effective are county/city court buildings or social services offices.

Staffing needs include coordinators (part-time), trained group leaders (two per group), and a licensed clinician with the ability to coordinate and make referrals for treatment to facilities and community services when appropriate. Coordinators also oversee reports from group leaders and conduct evaluations. Children's leaders need experience working with the age group they serve. All leaders need knowledge of addiction and its impact on families. It is important to balance program teams by gender, ethnicity, and recovery. It is very helpful to have at least one parent group leader who is in recovery.

Sustainable funding can be an obstacle. The program appears to be expensive at the outset. Costs can be reduced by using trainer interns/volunteers and in-kind donations of food and space. Funding sources have included contracts with the Departments of Social Services (families and children), Behavioral Health Services (alcohol and other drug treatment services), and Child Abuse Prevention, as well as Healthy Families Insurance, Medicaid, grants from SAMHSA, and local foundations.

COMPONENTS OF A SUCCESSFUL PROGRAM

In a 2001 article, Clark cited the principles of Lambert (1992) who concluded from extensive research that there are four common factors in successful drug court programs. All therapies, those targeted to individuals or are family-centered, seem to be more effective when they promote these common factors in their own unique ways.

The first factor involves the client's preexisting assets and challenges. Because *CF!* was written specifically for families in FDCs, it addresses the challenges that make it so hard for these families to succeed: their co-occurring substance use and mental health problems, learning differences, trauma, and toxic stress. Second are relationship factors: the connection between client and staff. Groups are conducted in an environment of respect and hope. Staff is there to help families graduate and to be reunited with their children. Staff are advocates for the families, asking how they can help in various areas such as with transportation and outside appointments. Third is hope and expectancy – the client's expectation that therapeutic work will lead to positive change. The staff's belief in the program and their impor-

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tance in it results in low staff turnover. Last are model and technique. *CF!* has been modified many times, using input from participants and staff.

EFFICACY STUDIES

The ability to link a specific component to a positive or negative outcome in the context of FDCs remains challenging. There are several methodological limitations such as a lack of rigorous study designs, small sample sizes, absence of comparison groups or use of inappropriate comparison groups, inclusion of only program graduates in the outcome data, and lack of appropriate statistical controls when calculating results (Brook et al. 2015; Gifford, Eldred, Vernerey, and Sloan 2014). The following is an attempt to gather the evidence for the inclusion of family skills-based programs, such as *CF!* in FDCs.

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In 2007, the Lutra Group conducted a direct comparison of *CF!* to *Strengthening Families* (Kumpfer 2009), another family-centered program. The results indicated that *CF!* had a significant impact on family organization, positive parenting, and drug use reduction with medium effect sizes from .15 to .70. They also found that *CF!* significantly impacted positive parent involvement, supervision of children, efficacy, and positive parenting styles with effect sizes from .18 to .60. The result was that *CF!* is one of only a few programs listed on the Substance Abuse and Mental Health Services Agency's National Registry of Evidence-Based Programs and Practices (2014) that engages all family members from infancy to adult in learning healthy living skills while addressing child maltreatment, family violence, and addiction/recovery issues. *CF!* is also listed on the California Evidence-Based Clearinghouse for Child Welfare.

Results of other independent efficacy studies have shown that *CF!* doubled the rate of family reunification while decreasing time for reunification for families in FDCs (Quittan 2004). Brook et al. (2015) evaluated reunification outcomes for children and families who participated in an FDC that incorporated the use of two evidence-based parenting programs: *Strengthening Families* and *CF!* in a sequential format with a sample of 241 children whose child welfare cases were adjudicated through the FDC and 418 matched comparison cases. Within a forty-five-month period, they found that families receiving these FDC family-centered services were more than twice as likely to reunify.

Brook and colleagues (2015) also found significantly increased positive growth for youth in knowledge and use of resources, coping skills, and ability to avoid interactions with the criminal justice system. Jrapko, Ward, Hazelton, and Foster (2003) reported that *CF!* changed adult behavior. For example, during the preceding thirty days, recovering clients had not used alcohol or illegal drugs and seventy-four percent had not used tobacco. Coleman (2006) studied results of the manualized program in English and Spanish and found the Spanish program (*¡Celebrando Familias!*) to be as effective in Hispanic communities as the English version was with English speakers (Sparks, Tisch, and Gardener 2013).

RETENTION OF SKILLS POST-GRADUATION

Cohen, Urbanski, and Greenberg (2018) conducted a prospective study of participants' retention of skills learned in *CF!* three to six months after graduation in the areas of parenting, emotional

functioning, family life, substance use, legal issues, and use of recovery support and treatment services. Twenty-two participants volunteered to be interviewed about their retention of principles learned in the program. The authors state that the gains from the program appear to have “staying power”. They reported positive outcomes in terms of relationships to their children, their self-image as a parent, pro-family behaviors, and self-care. They reported a high rate of attendance at Alcoholics Anonymous, Narcotics Anonymous, and similar self-help recovery groups indicating likelihood of continuing recovery from SUDs. The study was limited in that the subjects were self-selected. Those not interviewed may have had a different experience.

At the present time, family-skills training programs do not typically include after-graduation support. When asked for suggestions to make the programs better to serve their needs, participants cited their need for support after they learned the messages of the program and their families were reunited. They felt more likely to revert to former habits and behaviors without some form of on-going support. Participants also noted that it would be advantageous for them if the programs provided a way to stay in touch with friends who have also been through the program in a group setting.

CONCLUSION

Children who have experienced physical abuse are most at risk of re-experiencing it (Hindley, Ramchandani, and Jones 2006). Therefore, it is of vital importance to find effective interventions to prevent the recurrence of child physical abuse and break the cycle of violence. Family-skills training programs as part of FDCs are shown to be efficacious for families who are at high risk for domestic violence and child abuse, thus subjecting their children to the risk of out of home placement. As an illustration, one such intervention program, *CFI*, is designed specifically for families dealing with, or at high risk for, SUDs. Such family skills training programs fulfill the goals of FDCs by reducing child maltreatment by treating parents’ underlying SUDs. Thus, the cycle of addiction is broken, and families can be reunified, avoiding foster care.

Initial costs for implementation of family skills programs may present a barrier to FDCs. However, the lifetime economic cost for all new cases of abuse in one calendar year in the US has been estimated at \$124 billion (Fang, Brown, Florence, and Mercey 2012). Family skills training program as an FDC intervention is likely more cost-effective when contrasted to the costs of keeping children in foster care and the incarceration of a parent, along with the associated emotional costs.

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REFERENCES

- Boles, Sharon, Nancy Young, Toni Moore, and Sharon DiPirro-Beard. 2007. "The Sacramento Dependency Drug Court: Development and Outcomes." *Child Maltreatment* 12, no. 2 (May): 161-71. <https://doi.org/10.1177/1077559507300643>.
- Brook, Jody, Becci Akin, Margaret Lloyd, and Yueqi Yan. 2015. "Family Drug Court, Targeted Parent Training and Family Reunification: Did this Enhanced Service Strategy Make a Difference?" *Juvenile and Family Court Journal* 66, no. 2 (April): 35-52. <https://doi.org/10.1111/jfcj.12028>.
- Children and Family Futures. 2015. *Guidelines to States: Recommendations for Developing Family Drug Court Guidelines*. Rev. ed. Washington, DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. <http://www.cffutures.org/files/publications/FDC-Guidelines.pdf>.
- Children and Family Futures. 2016. *Model Programs Guide Literature Review: Family Drug Courts*. Washington, DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. https://www.ojjdp.gov/mpg/litreviews/Family_Drug_Courts.pdf.
- Clark, Michael. 2001. "Change-Focused Drug Courts: Examining the Critical Ingredients of Positive Behavior Change." *National Drug Court Institute Review* 3, no. 2 (Winter): 35-87. <https://www.ndci.org/wp-content/uploads/DCR%20III2.pdf>.
- Cohen, Edward, Lauren Urbanski, and Rivka Greenberg. 2018. *Interviews of Graduates of "Celebrating Families!"* Unpublished manuscript. San Jose, CA: San Jose State University.
- Coleman, Kent. 2006. *The Success Rate of Hispanic vs. Non-Hispanic Participants in "Celebrating Families!"* San Jose, CA: San Jose State University. http://www.celebratingfamilies.net/PDF/EvaluationReport_coleman.pdf.
- Fang, Xiangming, Derek S. Brown, Curtis S. Florence, and James A. Mercey. 2012. "The Economic Burden of Child Maltreatment in the United States and Implications for Prevention." *Child Abuse and Neglect* 36, no. 2 (February): 156-165. <https://doi.org/10.1016/j.chiabu.2011.10.006>.
- Fisher, Gary L., and Thomas C. Harrison. 2013. *Substance Abuse Information for School Counselors, Therapists, Social Workers, and Counselors*. 5th ed. Boston, MA: Pearson.
- Gifford, Elizabeth, Lindsay Eldred, Allison Vernerey, and Frank Sloan. 2014. "How Does Family Drug Treatment Court Participation Affect Child Welfare Outcomes?" *Child Abuse and Neglect* 38, no.10 (October): 1659-1670. <https://doi.org/10.1016/j.chiabu.2014.03.010>.
- Green, Beth, Anna Rockhill, and Carrie Furrer. 2007. "Does Substance Abuse Treatment Make a Difference for Child Welfare Case Outcomes? A Statewide Longitudinal Analysis." *Children and Youth Services Review* 29, no. 4: 460-473. <https://ideas.repec.org/a/eee/cysrev/v29y2007i4p460-473.html>.
- Gregoire, Kathryn, and Delray Schultz. 2001. "Substance-Abusing and Child Welfare Parents: Treatment and Child Placement Outcomes." *Child Welfare* 80, no. 4: 433-452. <https://pdfs.semanticscholar.org/1f20/eeee752a71243a072967459f0b01c9de7f3e.pdf>.
- Hindley, Nick, Paul Ramchandani, and David P.H. Jones. 2006. "Risk Factors for Recurrence of Maltreatment: A Systematic Review." *Archives of Disease in Childhood* 91, no. 9: 744-752. <https://doi.org/10.1136/adc.2005.085639>.
- Jrapko, Alicia, DeSondra Ward, Tracy Hazelton, and Thomas Foster. 2003. *Family Treatment Drug Court Head Start Program Annual Report 2002-2003*. Richmond, CA: The Center for Applied Local Research. www.celebratingfamilies.net/PDF/evaluationHeadStartAnnualReport.pdf.
- Lambert, Michael. 1992. "Psychotherapy Outcome Research: Implications for Integrative and Eclectic Therapists." In *Handbook of Psychotherapy Integration*, edited by J.C. Norcross and M.R. Goldfried. New York, NY: Basic Books.
- Lieberman, Alicia, Chandra Ghosh Ippen, and Patricia Van Horn. 2006. "Child-Parent Psychotherapy: 6-Month Follow-Up of a Randomized Controlled Trial." *Journal of the American Academy of Child and Adolescent Psychiatry* 45, no. 8 (August): 913-918. <https://doi.org/10.1097/01.chi.0000222784.03735.92>.

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- Lipari, Rachel, and Struther Van Horn. 2017. "Children Living with Parents Who have a Substance Use Disorder." *The CBHSQ Report* (SAMHSA), August 24, 2017. https://www.samhsa.gov/data/sites/default/files/report_3223/ShortReport-3223.html.
- Lutra Group. 2007. *Final Outcome Evaluation May 2007: Report for Lucile Packard Foundation for Children's Health*. https://www.celebratingfamilies.net/PDF/FinalOutcomeEvaluation_LutraGroup.pdf.
- National Association for Children of Addiction. 2017. "Celebrating Families!: Homepage." Last modified in 2017. <http://www.celebratingfamilies.net>.
- National Registry of Evidence-Based Programs and Practice. 2014. "Substance Abuse Prevention Interventions." Washington, DC: Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention (OJJDP).
- Quittan, Giorgio. 2004. "An Evaluation of the Impact of the *Celebrating Families!* Program and Family Drug Treatment Court on Parents Receiving Family Reunification Services." Master's thesis, San Jose University, College of Social Work. www.celebratingfamilies.net/evaluation_reports.htm.
- Rodi, Michael, Colleen Killian, Phillip Breitenbucher, Nancy Young, Sharon Amatetti, Russ Bermejo, and Erin Hall. 2015. "New Approaches for Working with Children and Families Involved in Family Treatment Drug Courts: Findings from the Children Affected by Methamphetamine Program." *Child Welfare* 9, no. 4: 205-232. <https://www.ncbi.nlm.nih.gov/pubmed/26827483>.
- Scheier, Lawrence, Gilbert Botvin, Tara Diaz, and K.W. Griffin. 1999. "Social Skills, Competence, and Drug Refusal Efficacy as Predictive of Alcohol Use." *Journal of Drug Education* 29, no. 3 (September): 251-257. <https://doi.org/10.2190/M3CT-WWJM-5JAQ-WP15>.
- Sparks, Shirley, Rosemary Tisch, and Mary Gardner. 2013. "Family-Centered Interventions for Substance Abuse in Hispanic Communities." *Journal of Ethnicity in Substance Abuse* 12, no. 1 (March): 68-81. <https://doi.org/10.1080/15332640.2013.759785>.
- Spoth, Richard, Cleve Redmond, Chungyeol Shin, and Kari Azevedo. 2004. "Brief Family Intervention Effects on Adolescent Substance Initiation: School-Level Growth Curve Analyses 6 Years Following Baseline." *Journal of Consult Clinical Psychology* 72, no. 3 (June): 535-542. <http://dx.doi.org/10.1037/0022-006X.72.3.535>.
- Spoth, Richard, Cleve Redmond, Linda Trudeau, and Chungyeol Shin. 2002. "Longitudinal Substance Initiation Outcomes for a Universal Preventive Intervention Combining Family and School Programs." *Psychology of Addictive Behavior* 16, no. 2 (June): 129-134. <https://doi.org/10.1037//0893-164X.16.2.129>.
- Spoth, Richard, Max Guyull, and Susan Day. 2002. "Universal Family-Focused Interventions in Alcohol-Use Disorder Prevention: Cost Effectiveness and Cost Benefit Analyses of Two Interventions." *Journal of Studies of Alcohol* 63, no. 2 (March): 219-228. <https://doi.org/10.15288/jsa.2002.63.219>.
- Stormshak, Elizabeth, Thomas Dishion, John Light, and Miwa Yasui. 2005. "Implementing Family-Centered Interventions Within the Public Middle School: Linking Service Delivery to Change in Student Problem Behavior." *Journal of Abnormal Child Psychology* 33, no. 6 (December): 723-733. <https://doi.org/10.1007/s10802-005-7650-6>.
- United Nations International Drug Control Programme. 1995. "The Social Impact of Drug Abuse." Paper presented at the World Summit for Social Development, Copenhagen, Denmark, March 6-12, 1995. https://www.unodc.org/pdf/technical_series_1995-03-01_1.pdf.
- Webster-Stratton, Carolyn, Jamila Reid, and Mary Hammond. 2001. "Preventing Conduct Problems, Promoting Social Competence: A Parent and Teacher Training Partnership in Head Start." *Journal of Clinical Child Psychology* 30, no. 3 (September): 282-302. http://dx.doi.org/10.1207/S15374424JCCP3003_2.
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IRB STATEMENT

All participating parents signed a Consent to participate in the Use of Outcomes and Evaluations Instruments for themselves and their children under twelve. Youth over twelve signed an identical form. The form stated that group results may be published in reports and journals but that no participant or family member would be identified. The informed consent was approved by agency managers at Uplift Family Services, which has an internal procedure to insure the informed consent for participation in treatment, as well as for the use of data collected for research, meet all federal guidelines for the protection of human subjects. In addition, for purposes of this research, the authors had no access to client identifiers. The agency (Uplift) prepared a deidentified dataset for these analyses, without client names, identification numbers, addresses or any other identifying information that could be matched to an actual person.

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