

A Family-Centered Program to Break the Cycle of Addiction

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Abstract

Celebrating Families!TM (CF!) is a manualized family-centered program focused on the goal of breaking the cycle of generational substance use disorders (SUDs). It is one of the few evidence-based family-focused practices listed on Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices. Compared to another evidence-based program, Strengthening Families, CF! showed significant impact on family organization, positive parenting, parent involvement, and alcohol and drug use reduction. CF! is shown to be successful in unifying families from family dependency courts and as a prevention program for SUDs when offered by community social service agencies. A preliminary efficacy study illustrates changes within participating families consistent with the goal. The study's purpose was to test the hypothesis that a family skills program such as CF! changed behavior by reducing risk factors and increasing protective factors. Data from 20 cycles of the program revealed that parents ($N = 263$), referred from family drug court, expressed significant behavior changes toward their children in ways that increased protective factors after the 16-week program, and youth ($N = 106$) showed better understanding of SUDs. Results suggest that this family skills program can be an intervention program for families at-risk for perpetuating the cycle of addiction, as well as prevention of family violence, abuse, and neglect. Agencies that serve families at risk can use the program to prevent costly foster care placements and SUDs by providing such programs.

Keywords

family skills program, addiction, prevention, substance use disorder

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Addiction often runs in families, from generation to generation, the adult addict being the child or grandchild of an addict. Addiction is a developmental disease that usually begins in adolescence or even childhood, when the brain continues to undergo changes (National Institute of Drug Abuse [NIDA], 2007). Recent research by Abbott, Rohac, Bottom, Patadia, and Huffman (2017) found evidence that prenatal alcohol exposure in mice induced neurobiological damage extending to the third generation. Having parents active in their addiction during a child's development can have long-term impacts. For example, children whose parents

are dealing with substance use disorders (SUDs) are four times more likely than other children to

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develop addiction. An estimated 50% to 80% of child welfare cases involve parental SUDs (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009; Young, Boles, & Otero, 2007). Children involved in the child welfare system who have parents with an SUD are more likely to experience lengthier stays in out-of-home placement, recurrent involvement with child welfare services, and lower rates of family reunification (Brook & McDonald, 2007; U.S. Department of Health and Human Services [USDHHS], 2009).

Although children may be predisposed by their family environment and genetics, they are not predestined to become alcoholics or addicts. Brody, Beach, Philbert, Chen, and Murry (2009) analyzed the DNA of 11-year-olds enrolled in a prevention program, finding some youths carried a genetic variation known to be associated with impulsivity, low self-control, binge drinking, and substance use. The youth who received only minimal supportive parenting used at rates three times more than youth whose parents attended a prevention program. "In families that were characterized by strong relationships between children and their parents, the effect of the genetic risk was essentially zero," said University of Georgia Institute for Behavioral Research director Steven Beach. The results emphasized "the important role of parents, caregivers, and family-centered prevention programs in promoting healthy development during adolescence, especially when children have a biological makeup that may pose a challenge" (Brody et al., 2009). Clearly it is more efficacious to prevent SUDs than to treat them. Prevention strategies can be successful and what better place to start than within the high-risk family.

Risk and Protective Factors

Scientists have identified risk and protective factors that predict prevention of adolescent and adult SUDs (Child Welfare League of America [CWLA], 2014; NIDA, 2007). Risk factors include stressful conditions, events, or circumstances that increase a family's chances for poor outcomes. Children are more likely to experience risk when there is

(a) a lack of mutual attachment and nurturing by parents or caregivers; (b) ineffective parenting; (c) a chaotic home environment, including poverty; and (d) a caregiver who abuses substances, suffers from mental illness, or engages in criminal behavior. Furthermore, the more risks a child is exposed to, the more likely the child will abuse drugs. Focusing on the risk path, research-based prevention programs can intervene early in a child's development to reduce risks long before problem behaviors develop. Having a family history of substance abuse is particularly potent. These experiences can impede bonding to the family and threaten feelings of security that children need for healthy development (CWLA, 2014).

Protective factors are conditions or attributes of individuals, families, communities, or the larger society that promote well-being and reduce the risk for negative outcomes. A body of evidence suggests that protective factors "buffer" the effects of risk exposure and may help individuals and families negotiate difficult circumstances and fare better in school, work, and life. Self-regulation skills, relational skills, and problem-solving skills are related to positive outcomes, such as resiliency, having supportive friends, positive academic performance, improved cognitive functioning, and better social skills (CWLA, 2014). Increasing the strength of protective factors is an effective prevention and intervention strategy to offset risk exposure and promote enduring gains (NIDA, 2014; Zweben et al., 2015). Families can serve as a protective factor when there is (a) a strong bond between children and caregivers; (b) parental involvement in a child's life (e.g., monitoring children's activities and peers); (c) supportive parenting that meets financial, emotional, cognitive, and social needs; (d) consistent enforcement of discipline and clear rules; (e) adoption of conventional norms about drug use; and (f) participation with community institutions and organizations. Family-centered programs work by strengthening powerful protective factors, thereby reducing the probability of risks (United Nations Office of Drugs and Crime [UNODC], 2009).

Family Skills Training Programs

Over 20 years of research demonstrates that prevention interventions designed and tested to reduce risk and enhance protective factors can help children at every step along their developmental path, from early childhood into young adulthood (NIDA, 2007). Moreover, critical periods in development may heighten the importance of risk and protective factors. For young children already exhibiting serious risk factors, delaying intervention until adolescence will likely make it more difficult to overcome risks. Therefore, a program that involves the whole family is preferable to one that targets individuals in one-on-one intervention. Two program designs have emerged: parent education programs and family skills programs.

Family skills training programs differ from parent education programs in that they focus on life skills for parents and children. Parent education programs are often shorter in duration (less than 8 hours in total), whereas family skills training programs typically consist of a minimum of four to eight sessions of 2 to 3 hours each. Moreover, parent education programs have not been found to be as effective as family skills training programs (Stomshak, Dishion, Light, & Yasui, 2005; UNODC, 2009; Webster-Stratton, Reid, & Hammond, 2001; Wills, McNamara, Vaccaro, & Hirky, 1996). A research review (Spoth, Redmond, Trudeau, & Shin, 2002) concluded that the most effective family skills training programs include (a) active parental involvement, (b) a focus on the development of social skills and responsibility among children and adolescents, and (c) specifically addressing issues related to substance abuse. Effective programs also involve youth in family activities and strengthening family bonds.

Family skills training programs generally combine (a) training of parents to strengthen their parenting skills, (b) training of children in personal and social skills, and (c) family 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, & Griffin, 1999; Spoth, Guyull, & Day, 2002; Spoth, Redmond, Shin, & Azevedo, 2004; Spoth et al., 2002).

A Model Program

Celebrating Families!TM (CF!; Tisch & Sibley, 2004) was originally developed for families in dependency drug courts (also called family treatment courts) where one or both parents have a serious problem with SUDs and are at high risk for domestic violence, child abuse, and neglect. It was created to (a) prevent children's future addiction, (b) facilitate healing from substance abuse, and (c) help unify families legally separated as a result of substance and child abuse. The original program was part of a SAMHSA grant providing services and evaluation in Santa Clara County, California. The program has grown to over 100 sites in the United States and Canada. It has been replicated in multiple settings, including schools, community-based sites, dependency drug courts, behavioral health and child welfare organizations, and substance treatment facilities. It is one of only a few programs listed on the SAMHSA's National Registry of Evidence-Based Programs and Practices (National Registry of Evidence-Based Programs and Practices [NREPP], 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. The CF! program uses a multifamily, skill-building model to engage every member of the family, with the goal of breaking the cycle of chemical dependency. A Spanish version, ¡Celebrando Familias!, is as effective in Hispanic communities as the English version is with English speakers (Coleman, 2006; Sparks, Tisch, & Gardner, 2013). In 2007, the LutraGroup conducted a direct comparison of CF! to the successful program Strengthening Families (Kumpfer, Molgaard, & Spoth, 1996). The results indicated CF! had a significant impact on family organization, positive parenting, and drug use reduction (LutraGroup, 2007). The logic model in Figure 1 documents short-term and long-term goals.

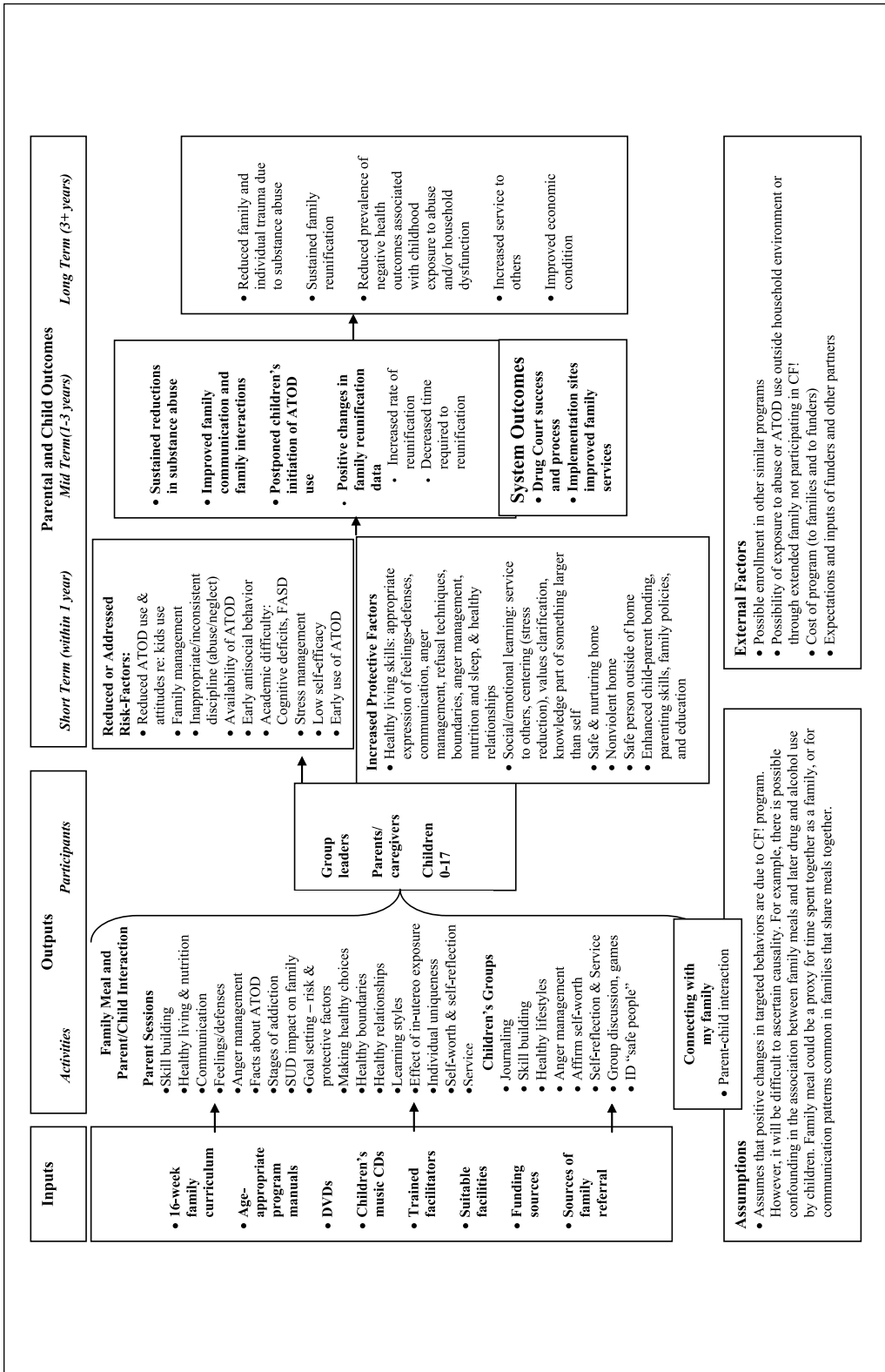


Figure 1. Logic Model.

CF! sessions are provided weekly for 16 weeks, serving all members of the family. Each session consists of 2.5 hours beginning with a family meal with group leaders. Participants then break into subgroups of adults, teens, and children for a 90-minute instructional session on the following themes: (a) healthy living; (b) nutrition; (c) communication; (d) feelings and defenses; (e) anger management; (f) facts about alcohol, tobacco, and other drugs; (g) addiction as a disease; (h) the effects of addiction on the whole family; (i) goal setting; (j) making healthy choices; (k) healthy boundaries; (l) healthy friendships and relationships; (m) learning differences and the effects of in utero exposure to alcohol and drugs; and (n) individual uniqueness. Parents then reunite with their children for a 30-minute related family activity. When the 0-3 component was added in 2014-2015, families with infants/toddlers attended a Family Time focused on interaction with their young children for 30 minutes before the meal.

Methodology

Efficacy Study

The purpose of the study was to test the hypothesis that attendance at CF changed behavior by reducing risk factors and increasing protective factors, thereby enhancing family functioning and intervening in the cycle of addiction.

Research Design for Parents

A questionnaire was developed for parents/caregivers based on the protective factors discussed above, in the areas of self-regulation skills, problem solving, the bond between parent and child, supportive parenting, and consistent discipline and rules. The behaviors were taken from established principles strongly linked to SUD prevention (National Center on Addiction and Substance Abuse, 2012; NIDA, 2014). The questionnaire asked parents how often they engaged in a behavior. Parents answered on a 5-point Likert-type scale ranging

from every day, several times a week, about once a week, less than once a week, and never.

Sample. In fiscal years 2011-2015, there were 20 cycles of CF! offered by Addiction Prevention Services of Uplift Family Services to families referred from family court and choosing to participate. Twenty-four parents/caregivers plus their children were enrolled in each of the groups. Four hundred and eighty individuals were enrolled: 263 parents and caregivers and 217 children ages 4-17. The adults' mean age was 22.7 years. The attrition rate was approximately 10%-15%. Average attendance was 87% for the 16 weeks. The number of children per parent averaged 2.3, although some parents attended without their children due to difficulty of transporting children who were in foster care. Additional figures for the adults are summarized in Figure 2.

Ethical considerations. All participating parents signed a Consent to Participate in the Use of Outcomes and Evaluation Instruments form for them and their children under 12. Youth over 12 signed an identical form. The form stated that group results may be published in reports and journals, but 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 ensure that 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 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.

Procedures. The questionnaire was administered by the facilitators as a posttest, which included retrospective pretest recall, allowing parents to rate the weekly frequency of specific parenting practices before and after

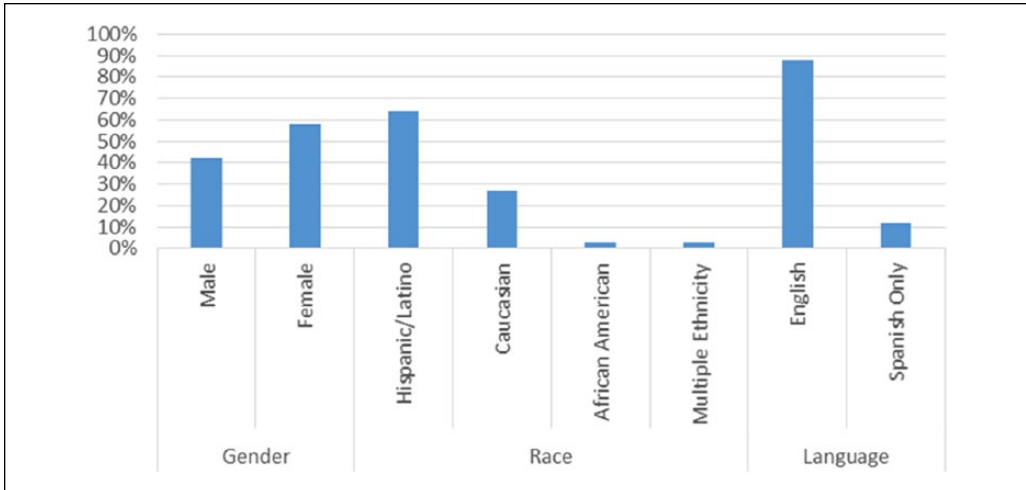


Figure 2. Figures for adult sample.

participating in CF!. At the 15th session, a total of 263 parents and caregivers completed evaluation instruments.

Research Design/Measures for Children and Teens

For data analysis, the age groups were collapsed into two: children ages 8-12 and teens ages 13-17. All were asked to rate their general knowledge of substance abuse and how their families are affected by it. Measures for the youth programs were limited to true-false statements about the effects of SUDs on them and their family members. The questions were taken from material taught in the program (e.g., “I can stop my parent from using if I just try hard enough;” true or false).

Results

Parents and Caregivers

Figure 3 shows the percent of respondents who reported how often they engaged in a behavior and if it was more, the same, or less often than before attending CF!. Use or increase of these skills ranged from a high of 95% for talking with their child(ren) to a low of 49% for eating together.

Children and Teens

Overall, both groups indicated a strong understanding of chemical dependency, how it affects the family, and how it affects them. As illustrated in Figure 4, of 13- to 17-year-olds, 90% felt the program helped them understand alcohol and drug addiction. Seventy percent of those teens felt the program led to a positive change. The children had 89% positive answers, which was more than the average for the teens, which was 78%. Spotty attendance may have been a factor for teens, or they may have been distracted or disinterested. Their less positive responses lead to the conclusion that the younger the better for intervention to be effective.

Discussion and Conclusions

The original focus for CF! was to provide an alternative for removal of children through family dependency court. Although family reunification and reduction of parental substance use are not documented in this study, they were tested in a study by Rodi et al. (2015), in which CF! was evaluated along with five other evidence-based programs with families involved with family drug courts. They found that “specifically, parents reduce substance use and extend their treatment

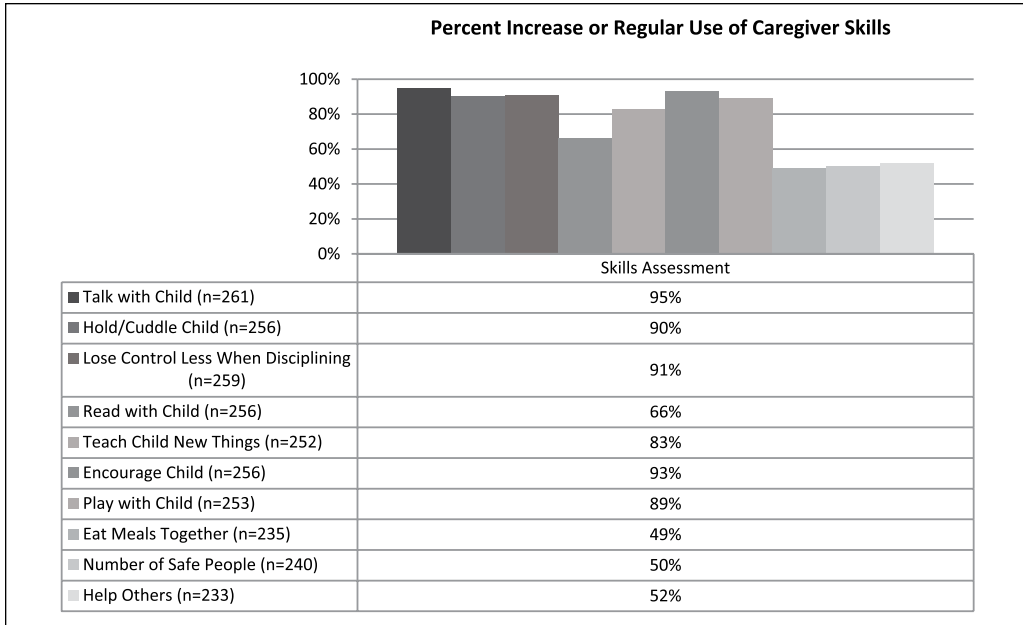


Figure 3. CF! Caregiver Skills Assessment.

Note. Regular use of skills is defined as a rating of “several times a week/everyday” or “more often.”

participation when their children are engaged in services. Children seem to be subject to less neglect and abuse, stays in out-of-home care are shorter, families are more stable, and family functioning appears to be improved when extending services to both children and their caregivers” (p. 230). Previous studies document positive changes on family reunification by family skills programs by Brook and McDonald (2007) and CF! specifically by Quittan (2004). The average stay for children in foster care in California is 8.5 months. In two California sites that provide CF!, the average is 4.8 months (Santa Clara County) and 5.4 months (Sacramento).

Having achieved success as a family skills program, the question arose: Could CF! be a prevention program? The purpose of the present study was to increase known protective factors in families (NIDA, 2007), thus preventing the cycle of addiction to perpetuate. The specific behaviors measured focused on parenting skills and family bonding and were taught in the program leading to the goals in the logic model (Figure 1). The range of increase or regular use of the behaviors was

95% for talking with your child to 49% for eating meals together. Many anecdotal comments from parents were of surprise that those behaviors were important, as they had not experienced them from their own parents. We conclude that CF! has been shown to increase behaviors identified as protective factors against perpetuating the cycle of addiction in families. Therefore, it may be used as a prevention program.

Limitations

This preliminary study is limited to parents’ awareness and frequency of behaviors that increase protective factors and are appropriate for their children and to children’s and teens’ understanding of the role of substances in their family’s lives. Risk factors were not measured, although given the population of parents who were referred by family drug court, there is a presumption of existing risk due to SUDs in the home and documented abuse or neglect. Limitations to this study also include the absence of a comparison group. Pre- and postsurveys would have been

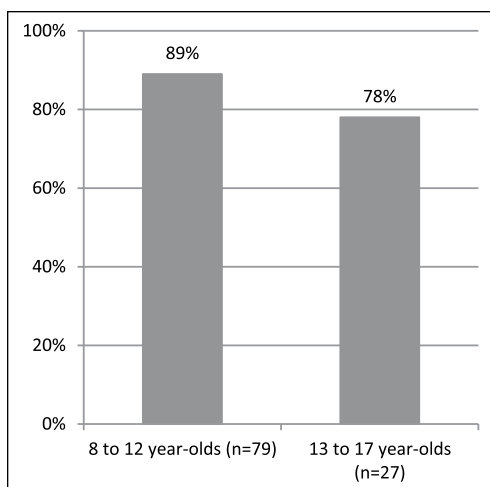


Figure 4. Percent of youth positive cognitive outcomes.

preferable to the retrospective method used. This method of retrospective pre- and posttest surveys was chosen since formal pretest surveys are infeasible with a population that, at the beginning of such mandated interventions, are not trusting of treatment providers nor of evaluation surveys. The use of retrospective recall was found to result in more valid and reliable response after trust with the program has been established (Kumpfer, Whiteside, Greene, & Allen, 2010). Trust had to be built during the 16 weeks of the program.

Implications for Practice

Agencies that serve families can reduce out-of-home placement of children and help families to prevent SUDs by providing family-skills training programs, such as CF!, for families affected by SUDs and those at risk. To be effective, leaders must possess skills taught in training sessions, including trauma-informed group leadership. Programs should emphasize strengthening protective factors such as healthy attachment between parents and children. Programs should also emphasize decreasing risk factors by educating parents about the importance of decreasing substance use, violence, and abuse in the home. A place to begin is family dependency courts and other courts in order to offer an alternative to incar-

ceration and child removal. However, any institution that serves families is appropriate, such as schools and community centers. Contraindications for community programs are the cost of providing a meal, staffing multiple age groups, and the need for facilitator training and manuals for this evidence-based program.

Future Research

Research is necessary to further understand the way protective factors affect the major outcomes of interest to practitioners and policy makers working to improve outcomes for populations at low as well as high risk. There is a need to conduct research that focuses on protective factors at different developmental periods. (The family becomes less influential than the peer group as a child ages.) Studies of protective factors with diverse populations are also needed. The program would be further strengthened by comparing the perceptions of parents to those of their own children. That is, does increasing protective factors in the parents correlate to changed behaviors and attitudes in their children? Finally, it would be useful to know if the intervention and prevention aspects of the program persisted for a generation by follow-up several years later with the sample population.

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Declaration of Conflicting Interests

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