A Family-Centered Approach as Prevention for Substance Abuse

Feature Articles 2016/Jan-Feb Counselor Magazine
www.counselormagazine.com/detailpageoverride.aspx?pageid=1729&id=6442456200#sthash.YkoUe4yo.dpuf

For centuries we have known the impact of alcoholism and drug addiction on children and families. Today parental substance abuse commonly involves alcohol and other drugs, as well as mental health problems, poverty, and violence. Addiction often runs in families, from generation to generation, the adult addict being the child or grandchild of an alcoholic or addict and likely to not have experienced nurturing or a healthy family. We are all well aware that addiction affects every member of the family. Children of alcoholics are more likely than other children to develop addiction due to environmental and genetic factors (NACOA, n.d.), and having parents active in their addiction during a child's development can have long-term impact. Although children may be predisposed by their family environment and genetics, they are not predestined to become alcoholics or addicts. Prevention strategies can make a difference.

Prevention programs aim to reduce the likelihood of new cases of a disorder by altering the underlying mechanisms implicated in the development and maintenance of the disorder. Prevention is distinct from—but complementary to—treatment in their common goal of reducing behavioral problems (Foster, Olchowski, & Webster-Stratton, 2007). The goal is to reduce the likelihood of developing a disorder in the future. Programs can be designed with the intended audience in mind: for everyone in the population; for those at greater risk; and for those already involved with drugs or other problem behaviors. Programs can also be geared for more than one of these audiences (NIDA, 2003).

Program Makeup

Methods of prevention can be classified along four levels: universal, selective, indicated, and multilevel (Battistich, Solomon, Watson, & Schaps, 1997; NIDA, 2003). Universal prevention programs, often referred to as "primary preventions," aim to prevent the onset of a disorder such as alcoholism or drug use. Delaying onset is important because it reduces the likelihood of addiction by reducing its duration. Selective prevention, or "secondary prevention," attempts to reduce the prevalence of drug abuse by early identification and aggressive treatment. Indicated preventions intervene with individuals displaying symptoms but not meeting full criteria for drug abuse. Finally, prevention programs that contain more than one prevention level are called multilevel or "tiered" preventions (Battistich et al., 1997).

Nearly all prevention programs include instructional and informational elements. Multilevel preventions also provide emotional support. Positive parent outcomes in universal prevention programs have included reductions in poor parenting behaviors such as rejection of the child, authoritarian parenting strategies, and physical punishment as well as increased use of positive parent management strategies, including greater use of praise and effective discipline as well as targeting alcohol and drug abuse (Niccols, 2009).

In a well-researched article previously published in *Counselor*, Ford, Savas, Drymon, Ramsey, and Patterson (2014) make a case for the importance of prevention. Their solutions document programs that are held in school and community settings. They cite Cuijpers (2002) and Botvin (2000) that such programs have been found to be "somewhat ineffective over longer periods of time" (Ford, Savas, Drymon, Ramsey, & Patterson, 2014). Furthermore, they cite Fisher and Harrison (2013, p. 321) that prevention efforts that solely offered information "did increase knowledge of participants but had no effect on attitudes and drug use." Clearly such efforts are too late in a child's life and are not centered where a child's attitudes are formed: the family.

Family-Centered Programs as Prevention

It is generally agreed that prevention programs that target the whole family are most efficacious (UNODC, 2013). When family programs were compared with other prevention approaches, they were found to be the second most effective approach after in-home family support, and approximately fifteen times more effective than programs that provided youth only with information and self-esteem, and approximately three times more effective than life or social skills training (Hawkins, Kosterman, Catalano, Hill, & Abbott, 2008; Cheng et al., 2007; Hiscock et al., 2008). Moreover the effect of family skills training programs was sustained over time (Cheng et al., 2007; Miller-Heyl, MacPhee, & Fritz, 1998). The long-term results of family-skills training programs in children show delayed initiation of substance abuse, improved youth resistance to peer pressure to use alcohol, reduced affiliation with antisocial peers, improved problem-solving, and reduced levels of problem behaviors such as delinquency. In parents, positive results include sustained improvement in family and child management skills such as setting standards, monitoring of behavior, and consistent discipline (Ialongo, Poduska, Werthamer, & Kellam, 2001).

The purpose of this article is to examine the most efficacious elements of family-centered programs as preventive for drug and alcohol abuse and to present a successful, multilevel model program. Researchers can now compare program elements to gold standards; that is, those that lead in the field of prevention, that are most respected, and that give the best chance for prevention. Two publications meet that standard: The Guide to Implementing Family Skills Training Programs for Drug Abuse Prevention (UNODC, 2009) and Applying Preventive Principles to Drug Abuse Prevention Programs (NIDA, 2003). To that end we will address population risk and protective factors, the generally agreed upon essential elements of a successful, family-centered, evidence-based prevention program, and compare the multilevel program, Celebrating Families! to those standards.

Prevention Research

According to NIDA (2007), the following key aspects of an effectual approach to intervention are:

- Addiction is a complex disease that is influenced by a tangle of factors involving genes, environment, and age of first use.
- Addiction is a developmental disease that usually begins in adolescence or even childhood when the brain continues to undergo changes.
- Prevention and early intervention work best to reduce the incidence of substance abuse. The developmental years might also present opportunities for resiliency and for receptivity to intervention that can alter the course of addiction. We already know many of the risk factors that lead to drug abuse and addiction: mental illness, physical or sexual abuse, aggressive behavior, academic problems, poor social skills, and poor parent-child relations. This knowledge, combined with better understanding of the motivational processes at work in the young brain, can be applied to prevent drug abuse from starting or to intervene early to stop it when warning signs emerge.
- Family-centered programs work by strengthening powerful protective factors, thereby reducing the probability of risks.

Prevention science has made great progress in recent years. Since the early 1990s there has been a growing movement in health, education, and other behavioral service fields toward the delivery of services and practices whose impact on positive outcomes are grounded in science and research. The movement is defined by the term “evidence-based” that is assigned to practices, programs or interventions (UNODC, 2013). According to the Evidence-Based Practice Institute,

Evidence-based practice (EBP) is the use of systematic decision-making processes or provision of services which have been shown through available scientific evidence to consistently improve measureable client outcomes. Instead of tradition, gut reaction or single observations as the basis for making decisions, EBP relies on data collected through experimental research and accounts for individual client characteristics and clinician expertise (2012).

The Role of Risk and Protective Factors

Scientists have identified risk and protective factors that predict prevention of adolescent and adult drug and alcohol abuse and have identified prevention principles and prevention program delivery that has withstood testing in various populations and at various ages and stages. The basic principles of neuroscience indicate that early preventive intervention will be more efficient and produce more favorable outcomes than remediations later in life (Harvard, 2007). Over twenty 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).

Critical or sensitive periods in development may heighten the importance of risk or protective factors. For example, mutual attachment and bonding between parents and children usually occurs in infancy and early childhood. If it fails to occur during those developmental stages, it is unlikely that a strong positive attachment will develop later in the child's life (NIDA, 2003). A recent trend is for prevention programs to intervene in families with younger children than in the past. NIDA has revised its drug abuse prevention literature to include prevention starting in infancy instead of its previous start point at preschool age (2003). A growing body of literature suggests that developmental stage is an important consideration for which protective factors are most salient or most responsive. Recent evidence of neurological and cognitive factors is concentrated on infancy and early childhood. Many social and behavioral theories state that family protective factors are particularly important during early and middle childhood. Community-level factors reflected by the stability of children's living situations are important during those periods. The availability of economic resources and opportunities are most salient for adolescent and young adult populations (Children’s Bureau, 2014). For young children already exhibiting serious risk factors, delaying intervention until adolescence will likely make it more difficult to overcome risks. By adolescence, children's attitudes and behaviors are well established and not easily changed.

What are Risk and Protective Factors?

The risk of becoming a drug abuser involves the relationship among the number and type of risk factors and protective factors. Many factors have been identified that help differentiate those more likely to abuse drugs from those less vulnerable to drug abuse. Factors associated with greatest potential for drug abuse are called "risk" factors, while those associated with reduced potential for abuse are called "protective" factors. A risk factor for one person may not be for another.

Risk and protective factors can affect children in a developmental risk trajectory or path. This path captures how risks become evident at different stages of a child's life. For example, early risks, such as out-of-control aggressive behavior, may be seen in a very young child. If not addressed through positive parental actions, this behavior can lead to additional risks when the child enters school. Aggressive behavior in school can lead to rejection by peers, punishment by teachers and academic failure. If not addressed through preventive interventions, these risks can lead to the most immediate behaviors that put a child at risk for drug abuse, such as skipping school and associating with peers who abuse drugs. In focusing on the risk path, research-based prevention programs can intervene early in a child's development to strengthen protective factors and reduce risks long before problems behaviors develop (NIDA, 2014a).

Risk factors can influence drug abuse in several ways. They may be additive—the more risks a child is exposed to, the more likely the child will abuse drugs. Some risk factors are particularly potent, yet may not influence drug abuse unless certain conditions prevail. Having a family history of substance abuse, puts a child at risk for drug abuse. However, in an environment with no drug abusing peers and strong antidrug norms, that child is less likely to become a drug abuser. The presence of many protective factors can lessen the impact of a few risk factors. For example, strong protection—such as parental support and involvement—can reduce the influence of strong risks, such as having substance-abusing peers. An important goal of prevention, then, is to change the balance between risk and protective factors so that protective factors outweigh risk factors (NIDA, 2014a).

Risk Factors

Children's earliest interactions occur within the family and can be positive or negative. For this reason, factors that affect early development in the family are probably the most crucial. Children are more likely to experience risk when there is:
lack of mutual attachment and nurturing by parents or caregivers

- ineffective parenting
- a chaotic home environment
- lack of a significant relationship with a caring adult
- a caregiver who abuses substances, suffers from mental illness or engages in criminal behavior

These experiences, especially the abuse of drugs and other substances by parents and other caregivers, can impede bonding to the family and threaten feelings of security that children need for healthy development.

Protective Factors

Protective factors are conditions or attributes of individuals, families, communities, or the larger society that, when present, 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, importantly, may help individuals and families negotiate difficult circumstances and fare better in school, work, and life.

Focusing on protective factors offers a way to track child and adolescent development by increasing resilience in the short term and contributing to the development of skills, personal characteristics, knowledge, relationships, and opportunities that offset risk exposure and contribute to improved well-being and positive outcomes in the long term. In this sense, protective factors can be used as interim results to monitor for progress over time towards the desired impacts that may not be realized for many years (Children's Bureau, 2014).

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 (Children's Bureau, 2014).

Families can serve a protective function when there is:

- a strong bond between children and families
- parental involvement in a child's life
- supportive parenting that meets financial, emotional, cognitive, and social needs
- clear limits and consistent enforcement of discipline

Elements of Efficacious Family Skills Training Programs

Family skills training programs differ from parent education programs, which focus on providing parents with information about the use of substances in the absence of skills training for parents and children. Parent education programs are often shorter in duration (less than eight hours in total), whereas family skills training programs typically consist of a minimum of four to eight sessions of two to three hours each for universal programs. Moreover, parent education programs have not been found as effective as family skills training programs (Stormshak, Dishion, Light, & Yasui, 2005; Webster-Stratton, Reid, & Hammond, 2001; Willis, McNamara, Vaccaro, & Hirky, 1996; UNODC, 2009). A research review (Spoth, Redmond, Trudeau, & Shin, 2002) concluded that the most effective family skills training programs include active parental involvement, focus on the development of adolescents' social skills and responsibility among children and adolescents, and address issues related to substance abuse. Effective interventions also involve youth in family activities and strengthen family bonds.

Children learn personal, social, and communication skills, and at the end of each session families come together to practice new skills as a family unit. These programs improve family functioning, organization, communication, and interpersonal relationships and have been found to have multiple positive outcomes for children and adolescents including decreased alcohol and drug use, increased child attachment to school and academic performance, decreased child depression and aggression, increased child social competence and prosocial behavior and decreased family conflict. In addition these programs have been found to be cost-effective.

Family skills training programs generally combine training of parents to strengthen their parenting skills, training of children in personal and social skills, and 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 some practice time (Scheier, Botvin, Diaz, & Griffin, 1999; Spoth, Redmond, Shin, & Azevedo, 2004; Spoth, Guyull, & Day, 2002; Spoth et al., 2002).

***Celebrating Families!* Model**

Celebrating Families! (Tisch & Sibley, 2004) was originally developed for families in dependency drug courts, where one or both parents are in early recovery and children have been removed due to abuse or neglect. It was created to prevent children's future addiction, facilitate healing from substance abuse, and help unify families legally separated as a result of substance and child abuse. The program has grown to fifty-three sites in twenty states in the United States and in Canada. It has been replicated in multiple settings, including schools, community-based sites, dependency drug courts, child welfare organizations, and treatment facilities. It is one of only a few programs listed on the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of Evidence-Based Programs and Practices (NREPP) that engages all family members from infancy to adult in learning healthy living skills while addressing child maltreatment, family violence, and addiction and recovery issues. The *Celebrating Families!* program uses a multifamily, skill-building model to engage every member of the family, with the goal of breaking the cycle of chemical dependency. *Celebrating Families!* has a Spanish version, *Celebrando Familias*, and it is as effective in Hispanic communities as the English version is with English speakers (Sparks, Tisch, & Gardener, 2013).

Family-centered programs can strengthen protective factors among young children by teaching parents better family communication skills, developmentally appropriate discipline styles, firm and consistent rule enforcement, and other family management skills. Parents also can be taught how to increase their emotional, social, cognitive, and material support, which includes, for example, meeting their children's financial, transportation, health care, and homework needs. Research confirms the benefit of parents taking a more active role in their children's lives, by talking with them about drugs, monitoring their activities, getting to know their friends, and understanding their problems and concerns, providing consistent rules and discipline, and being involved in their learning and education. The importance of the parent-child relationship continues through adolescence and beyond.

Conclusion

Recent research on universal, selective, indicated, and multilevel prevention programs for drug and alcohol abuse has led to conclusions about program elements that yield the best methods of prevention for all levels of risk. In general, the best programs incorporate information and support in multilevel, family-centered, evidence-based programs tailored to individuals from infancy to adult ages. The Celebrating Families! model successfully meets the essential elements to be an effective prevention program.

There are two tables related to this article.

References

Battistich, V., Solomon, D., Watson, M., & Schaps, E. (1997). Caring school communities. *Educational Psychology, 32*(3), 137–51.

Botvin, G. J. (2000). Preventing drug abuse in schools: Social and competence enhancement approaches targeting individual-level etiologic factors. *Addictive Behaviors, 25*(6), 887–97.

Cheng, S., Kondo, N., Aoki, Y., Kitamura, Y., Takeda, Y., & Yamagata, Z. (2007). The effectiveness of early intervention and the factors related to child behavioral problems at age two: A randomized controlled trial. *Early Human Development, 83*(10), 683–91.

Children's Bureau. (2014). *Promoting protective factors for in-risk families and youth: A brief for researchers.* Retrieved from http://www.dsgonline.com/acyf/PF_Research_Brief.pdf

Cuijpers, P. (2002). Effective ingredients of school-based drug prevention programs: A systematic review. *Addictive Behaviors, 27*(6), 1009–23.

Evidence-Based Practice Institute. (2012). *What is an evidence-based practice?* Retrieved from https://depts.washington.edu/pbhjp/evidence-based-practice-institute/what-evidence-based-practice

Fisher, G. L., & Harrison, T. C. (2012). *Substance abuse: Information for school counselors, social workers, therapists, and counselors* (5th ed.). Boston, MA: Pearson.

Ford, T., Savas, E., Drymon, C., Ramsey, A., and Patterson, D. (2014). Best approaches to substance abuse prevention. *Counselor, 15*(6), 46–53.

Foster, E. M., Olchowski, A. E., & Webster-Stratton, C. H. (2007). Is stacking intervention components cost-effective? An analysis of the incredible years program. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(11), 1414–24.
Harvard University. (2007). *The science of early childhood development: Closing the gap between what we know and what we do*. Retrieved from http://developingchild.harvard.edu/wp-content/uploads/2015/05/Science_Early_Childhood_Development.pdf
Hawkins, J. D., Kosterman, R., Catalano, R. F., Hill, K. G., & Abbott, R. D. (2008). Effects of social development intervention in childhood fifteen years later. *Archives of Pediatric and Adolescent Medicine, 162*(12), 1133–41.
Hiscock, H., Bayer, J. K., Price, A., Ukoumunne, O. C., Rogers, S., & Wake, M. (2008). Universal parenting programme to prevent early childhood behavioural problems. Cluster randomised trial. *BMJ, 336*(7639), 318–21.
Ialongo, N., Poduska, J., Werthamer, L, & Kellam, S. (2001). The distal impact of two first-grade preventive interventions on conduct problems and disorder in early adolescence. *Journal of Emotional and Behavioral Disorders, 9*(3), 146–60.
Miller-Heyl, J., MacPhee, D., & Fritz, J. J. (1998) Dare to be you: A family-support, early prevention program. *The Journal of Primary Prevention, 18*(3), 257–85.
National Association for Children of Alcoholics (NACOA). (n.d.) *Children of addicted parents: Important facts.* Retrieved from http://www.nacoa.net/pdfs/addicted.pdf
National Institute of Drug Abuse (NIDA). (2003). *Preventing drug use among children and adolescents: A research-based guide for parents, educators, and community leaders.* Retrieved from https://www.drugabuse.gov/sites/default/files/preventingdruguse.pdf
National Institute of Drug Abuse (NIDA). (2007). *Topics in brief: Drug abuse prevention.* Retrieved from http://www.drugabuse.gov/publications/finder/t/107/Prevention%20Research
National Institute on Drug Abuse (NIDA). (2014). *Drug facts: Lessons from prevention research.* Retrieved from http://www.drugabuse.gov/publications/drugfacts/lessons-prevention-research
Niccols, A. (2009). Immediate and short-term outcomes of the "COPEing with toddler behavior" parent group. *Journal of Child Psychology and Psychiatry, 50*(5), 617–26.
Scheier, L. M., Botvin, G. J., Diaz, T., & Griffin, K. W. (1999). Social skills, competence, and drug refusal efficacy as predictors of adolescent alcohol use. *Journal of Drug Education, 29*(3), 251–78.
Sparks, S. N., Tisch, R., & Gardner, M. (2013). Family-centered interventions for substance abuse in Hispanic communities. *Journal of Ethnicity in Substance Abuse, 12*(1), 68–81.
Spoth, R., Redmond, C., Shin, C., & Azevedo, K. (2004). Brief family intervention effects on adolescent substance initiation: School-level growth curve analyses six years following baseline. *Journal of Consulting and Clinical Psychology, 72*(3), 535–42.
Spoth, R. L., Guyull, M., & Day, S. X. (2002). Universal family-focused interventions in alcohol-use disorder prevention: Cost effectiveness and cost benefit analyses of two interventions. *Journal of Studies on Alcohol, 63*(2), 219–28.
Spoth, R. L., Redmond, C., Trudeau, L., & Shin, C. (2002). Longitudinal substance initiation outcomes for a universal preventive intervention combining family and school programs. *Psychology of Addictive Behaviors, 16*(2), 129–34.
Stormshak, E. A., Dishion, T. J., Light, J., & Yasui, M. (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*(6), 723–33.
Tisch, R., & Sibley, L. (2004). *Celebrating families!* Retrieved from http://nned.net/docs-general/CF_PREFACE.pdf
United Nations Office of Drugs and Crime (UNODC). (2009). *Guide to implementing family skills training programmes for drug abuse prevention.* Retrieved from https://www.unodc.org/documents/prevention/family-guidelines-E.pdf
United Nations Office of Drugs and Crime (UNODC). (2013). *Appendix II: Description of the methodology utilized for the collection, assessment and utilization of the scientific evidence.* Retrieved from https://www.unodc.org/documents/prevention/prevention_standards_appendix_02_methodology.pdf
Webster-Stratton, C., Reid, M. J., & Hammond, M. (2001). Preventing conduct problems, promoting social competence: A parent and teacher training partnership in Head Start. *Journal of Clinical Child Psychology, 30*(3), 282–302.
Wills, T. A., Vaccaro, D., McNamara, G., & Hirky, A. E. (1996). Escalated substance use: A longitudinal grouping analysis from early to middle adolescence. *Journal of Abnormal Psychology, 105*(2), 166–80.

Table 1

NIDA Prevention Principles and Comparison to *Celebrating Families!*™

Prevention programs should:

Principle 1 - enhance protective factors and reverse or reduce risk factors.	Outside evaluation indicates *Celebrating Families!(CF!)* increases protective factors and decreases risk factors (LutraGroup, 2007).
Principle 2 - address all forms of drug abuse	All ages (except 0-3) learn about: alcohol, tobacco and drug use (illegal and prescription), their impact on all aspects of individuals' lives, risks of early use and binge drinking, use during pregnancy, progression of the disease, brain chemistry, warning signs, intervention & recovery; impact of addiction on family.
Principle 3 - address the type of drug abuse problem in the local community	*CF!* encourages sites to adapt the curriculum to their community.
Principle 4 - be tailored to address risks specific to population.	*CF!* was developed for families affected by or at high risk for addiction. It includes safety planning, relapse and impact on children, and in-utereo exposure.
Principle 5 - enhance family bonding and relationships and include parenting skills; practice… and training in drug education and information.	Each age-group learns the same topic with a related Family Activity, providing everyone with similar terminology and skills. Parent/Caregiver sessions address: nurturing parenting; family rules; age-appropriate, consistent limits & consequences, monitoring and supervision; and praise/encouragement.
Principle 6 - be designed to intervene as early as infancy.	*CF!* serves families with children birth to 17. The 0-3 component specifically addresses attachment, bonding and early risk factors.
Principle 7 - target improving academic and social-emotional learning for elementary school children.	Children's groups teach skills of self-control: centering; anger management; using reducers and staying out of fights; social/emotional competency: communication, identification and appropriate expression of feelings; problem-solving, decision making, Saying NO to others, recognizing boundaries; academic support: helping participants become aware of learning styles and strategies; identification of the characteristics of a safe person.
Principle 8 - increase academic and social competence for middle or junior and high school students.	Pre-adolescents'/adolescents' groups teach: learning styles and strategies; social/emotional competency; healthy relationships; self-efficacy and assertiveness; drug resistance skills; and strengthening of personal commitments.

Principle 9 – aim at general populations at key transition points.	*CF!* has been used and found effective in school-based programs with non-identified families.
Principle 10 - combine two or more effective programs to be more effective than a single program alone.	*CF!* is often used in collaboration/partnership with other school and community based programs.
Principle 11 - present consistent, community-wide messages.	*CF!* training on alcohol, tobacco and other drugs; chemical dependency; and its impact on families is often used as training for community members and service-providers working with families.
Principle 12- ….retain core elements of original research-based intervention.	*CF!* offers training and a Fidelity process.
Principle 13 - … be long-term with repeated interventions.	A family is encouraged to return as children age and as parents' recovery is strengthened.
Principle 14 – … include teacher training …	Group Leader training is available.
Principle 15 - …employ interactive techniques.	All groups employ multi-modal learning. Skills are taught and practiced utilizing a specific method for individuals with learning differences.
Principle 16 - can be research-based and cost-effective.	*CF!* has been shown to double the reunification rate of families in Drug Court and to reduce time to reunification by 50% (Quittan, 2004).

Table 2
Principles of a Good Family Skills Training Program (UNODC 2009)
& Comparison to *Celebrating Families!*™

Principle 1: … should be based on theory about which causes of substance abuse would be addressed … and a theory of why the proposed interventions would be effective.	*Celebrating Families!*™ (*CF!)* theoretical basis is that substance abuse/addiction has both genetic and environmental components and addresses reducing risks and increasing protective factors.
Principle 2: … should be based on a Needs Assessment.	*CF!* encourages sites to utilize a family-based program that meets the needs of the population.
Principle 3: …should be matched to level of risk of target population.	*CF!* serves all members of the family and is a multi-level prevention program. Developed as an indicated program for families mandated to participate by dependency drug courts, *CF!* has been used in school settings and shown effective with non-identified families (general population) as a universal program.
Principle 4: should be matched to the age and level of development of children in the target population.	*CF!* consists of: (1) a Family Meal; (2) age-appropriate groups for children 0-17 and parents/caregivers; (3) a Family Activity or Family-Time (parent-child interaction time for children 0-3).
Principle 5: … should have adequate intensity and duration.	*CF!* consists of 16 sessions of 2.5 hours each. Curriculum is divided into four components: Developing Trust (Sessions 1-5), Addressing Addiction and ATOD (Sessions 6-8), Becoming a Safe Family (Sessions 9-13), Preparing for Graduation (Session 14-16).
Principle 6: … should use interactive activities and techniques, with groups of no more than 8-12 families.	*CF!* utilizes multi-modal techniques including skill development and role playing. All age-groups are facilitated by two leaders.
Principle 7: … should provide parents with skills … to strengthen positive family relationships, supervision and monitoring, and assist them in communicating family values and expectations. **A. Content and skills for parents** **Teach parents to be responsive.**	Outside evaluation found that *CF!* has a positive effect size: • family organization, cohesion, strengths and resilience; and communication • parent involvement, supervision, efficacy, and positive style (LutraGroup, 2007). Parent/caregiver group teaches skills of: affirming and encouraging children; reading; communication skills; identification and appropriate expression of feelings including anger management and keeping out of fights (especially with children); nurturing parenting.
Teach parents to provide structure.	*CF!* parent/caregiver group teaches skills of based, clear, consistent, age-appropriate limits and making and problem solving; protecting children; person's uniqueness; and importance of active

Teach parents to become involved in their children's school and studies and community.	ahead and visible monitoring of children; routines and consistency, recognizing, clarifying, and family values; and strengthening family through family meals and family times. *CF!* parent/caregiver group teaches: importance of advocating for children in the school system, especially if they have learning differences or were exposed in-utereo; importance of regular medical check-ups and sharing family medical history; communication skills; and connection to resources.
<u>B. Content and skills for children</u>	*CF!* has specific groups for children 0-18 months, 2-3, 4-7, 8-10, pre-adolescent and adolescents.
To acquire motivation and orientation to the future, children should learn and practice: **To build their self-esteem,** **To acquire problem-solving skills,** **To care for themselves.**	*CF!*'s teaching style is strength-based, trauma-informed, and multi-modal providing an atmosphere of support and success, building the confidence of participants. Children's groups teach: centering and impulse-control; saying NO with role plays and practice; truth statements; boundaries; decision making, and problem solving; values clarification; automatic negative thoughts; the four components of a Healthy Living; nutrition and exercise.
<u>C. Content and skills related to children's relationships to other people: Children should:</u> **build social relationships,** **respect others,** **communicate effectively,** **resist peer pressure,** **develop new skills and interests through hobbies and out-of-school activities;** **read social contexts.**	*C*hildren's groups also specifically teach skills of: choosing safe and trustworthy friends, how to be a good friend, finding safe people; appropriate expression of feelings; recognizing and establishing boundaries, *Acts of Kindness* (doing something kind for another person); Communication: active listening and use of "I" messages; asking for help; anger management; keeping out of fights, avoiding conflicts; facts about ATOD, addiction, and its impact on individuals and families.
<u>D.Content and skills for families</u> **acquire communication skills, families should learn and practice how to:** **set limits and provide structure,** **maintain goals for the future of the family.**	In Family Activity: families practice communication skills including listening; set family chores and rules; develop a family Safety List/Plan and family goals; address developmental assets of service to others and

	sense of purpose; explore how ATOD affects families and their risk for addiction; organize a family night for when series ends; engage in activities related to healthy relationships. Parent/Caregivers determine age-appropriate attachment-based, consistent disciplinary methods-including "time-in's". Participants identify resources; clarify personal and family values.
Principle 8: . .should focus resources on recruiting and retaining families, including reaching them at important transition points.	*CF!* serves all age groups. Written for families with identified substance use disorders, impacted by child abuse and family violence, it has successfully been used in schools in high-risk communities (non-identified families).
Principle 9: . .should be chosen on the basis of its level of evidence of effectiveness.	Listed on SAMHSA's National Registry of Evidence-Based Programs & Practices (NREPP 2014). *CF!* was also listed as a preferred program by SAMHSA's Request for Children Affected by Methamphetamine in Families and is being implemented at 80+ U.S. sites. Evaluation studies indicate: *"9 of 10 parenting and family outcomes were statistically significantly increased - usually not possible in research"* (Lutra Group, 2007). • *CF!* significantly reduced time to reunification to 6-12 months while increasing reunification rates to 73%, from national rate of 33% • *CF!* significantly increased family communication, cohesion, strengths and resilience; skills of listening, appropriate expression of feelings, anger management, problem solving, empathy and choosing healthy relationships; and parent involvement, supervision, efficacy, and style (Quittan 2004, Brook, 2013).
Principle 10: …should be adapted to meet the cultural and socio-economic needs of the target population through a well-resourced, careful and systematic process. .	*CF!* has been successful with various ethnic groups in the US. • *CF! has been shown to be as effective as a family-centered intervention for Spanish-speaking participants as for White participants (Sparks, Tisch & Gardener, 2013).* • *Keys to Healthy Families* (predecessor program to *CF)!*¸ was successfully implemented in Russia.

Principle 11: … should provide adequate training and ongoing support for carefully selected staff.	Training and implementation support is available through National Association for Children of Alcoholics. Implementation materials were ranked by NREPP evaluators at 4.0 (of 4.0) and Training & Support Services at 3.8.
Principle 12: … should include strong and systematic monitoring and evaluation components.	*CF!* evaluation Instruments and Fidelity Forms are available through NACoA.