



Family Involvement and Participation

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Overview

The 1997–99 statewide evaluation of the Prevention and Intervention Services Program (PISP) includes an emphasis on the identification of program practices that are consistent with research knowledge in several targeted areas. One of these areas is family involvement with PISP and its services. The theoretical structure that guides program services identifies family factors as providing both significant protection against the development of problem behavior, as well as serving as a source of potential increased risk. The basis for this rationale and additional supporting data from the research literature are reviewed in this paper. Another impetus for this paper comes from the critical role of family participation identified in the published accounts of various initiatives, including previous evaluations of PISP. Finally, this paper reflects the experiences of intervention specialists who have been successful in involving parents.

This combination of theory, research findings, and practical experience suggests the need for a reconsideration of the importance of family participation in PISP. This includes reflection on the difficulties and barriers associated with engaging families in services with their children and the particular issues associated with substance abuse and confidentiality. The paper concludes with several suggestions for enhancing family participation in PISP.

Theoretical Rationale

The research literature has much to say about the role of families in adolescent development. This section will explore what the research has to say about both the positive and negative influences of the family.

Social Development Model

The social development model provides the rationale for multiple state and federal efforts to prevent and reduce adolescent substance abuse and related problem behaviors such as violence, school dropout, and delinquency. Years of accumulated research studies have demonstrated that such adolescent problem behaviors tend to occur together, and their development and occurrence are associated with a series of interconnected risk factors (Hawkins, Catalano, and Miller, 1992; Hawkins and Weis, 1995). The effects of these risk

factors may be countered by the presence of protective factors or resiliency characteristics, which tend to guard against the development of problem behaviors (Developmental Research and Programs, 1993). Prevention and intervention activities guided by this model aim to reduce risk factors and enhance protective factors.

Several critical risk factors for substance abuse are associated with the family. Those identified specifically for the development of alcohol and other drug problems are (1) family alcohol and other drug behavior and attitudes, (2) poor and inconsistent family management practices, (3) family conflict, and (4) low bonding to the family (Hawkins et al., 1992). These four general factors exert multiple and interrelated influences on the development and progression of adolescent substance abuse. Catalano, Kasterman, Haggertu, Hawkins, and Spoth (1998) summarized these influences, indicating that in addition to any genetic effects associated with parental addiction, family modeling of alcohol and other drug use shapes children's expectations about use and its effects. Children's perceptions of parental tolerance of substance use by young people provides a permissive environment for its initiation. Parental use is also closely associated with family conflict and poor parental functioning—including abuse and neglect (U.S. Department of Health and Human Services, 1999). The families at greatest risk for children developing substance use problems are socially isolated, have limited coping and financial resources, and exercise poor child rearing skills (Wright and Wright, 1994). The presence of weak parent-child bonds and family conflict contribute to and are exacerbated by unclear expectations and poor monitoring of behavior, poor communication of rules, and inconsistent responses to both good and unwanted behaviors (Catalano et al., 1998).

However, families also play a particularly strong role in the development and realization of protective factors that can shield children from the impacts of risk factors associated with the individual, school, and community. Families allow adolescents to establish critical positive relationships with important adults, and families are initially responsible for establishing and enforcing clear standards and healthy beliefs (Developmental Research and Programs, 1993). Wright and Wright (1994) identified other family protective factors, including competent and self-confident mothers, the presence of at least one caring parent, and social support from a close sibling or involvement in team sports. Family protective factors are thought to be most important as children enter middle school and begin to align themselves more strongly with peers (Catalano et al., 1998; Hoffmann, 1994). Recent research suggests that parents continue to have an important influence on substance use and abuse into late adolescence. Parental supervision and oversight of older teenagers

indirectly affect their risk of engaging in problem behaviors through continued impact on the influence and choice of peers (National Center on Addiction and Substance Abuse, 1996). Hoffmann confirmed that family relationships, in the form of bonding and attachment, influence the peer associations of older adolescents and their use of illegal drugs.

Family Risk and Protective Factors

The original identification and discussion of risk and protective factors noted that although multiple factors have been identified and associated with substance abuse, the manner in which these factors interact with one another is less clear. The research reports identifying the various associations of risk factors with problem behavior also reveal that all risk factors are not equal, and some have stronger associations and are more predictive of the development of problem behavior than others (Hawkins et al., 1992). It is apparent that as the number of risk factors increases, so does the likelihood and severity of substance abuse (Dusenbury, Khuri, and Millman, 1992).

Snyder (1992) noted the complexity of the influence of risk factors, pointing out that “contextual factors, parent factors, and adolescent factors overlap to produce stress, create problems, and present risk to the whole family” (p. 22). As described by McCubbin, McCubbin, Thompson, and Sae-Young Han (1999), risks for problem behavior within a family emerge from two quite different sources. First, they come from what the individual family members bring to the processes and the dynamics of the family system, which includes the child, parents, siblings, and other residents of the home. Second, family risks emerge from what the family unit itself creates as a group. In the same way, family resiliency is felt to be distinctive from individual resiliency, in that family systems possess the capacity to adapt in response to pressures to change. These adaptations may be functional or dysfunctional. Having a difficult child may lead to a failure of parental supervision, a withdrawal from exercising the parenting function, and dislike of the child (Wright and Wright, 1994). Families may contribute to the development of adolescent problems and may take no action to interrupt their progression (Snyder).

Bonding, Family Relationships, and Parental Substance Abuse

Newcomb and Earlywine (1996) posited a complex and interactive model of substance use and abuse. The formation of close relationships—that is, bonding—is one factor, but the capacity for such bonds varies greatly among individuals. The research also suggests that

the significance of bonds with the family are different for males and females and are applicable largely only to females. Thus it is most productive to examine the effects of multiple dimensions of parental influence, including the quality and warmth of the relationship and parental control and behavior management. Adolescents need their parents to support and advocate for them and to establish appropriate expectations and boundaries for behavior (Robertson, 1997).

Among the elements identified as family risk and protective factors, family cohesion and bonding seem to have a mostly indirect influence over alcohol and other drug use by adolescents. The strength or weakness of the parent-child relationship impacts use through its role in a child's choice of friends, a child's commitment to school, and the extent of parental monitoring of behaviors. Low or poor bonding may add another risk factor, but having higher levels of strong family connections do not necessarily function as a consistent protective factor (Forgays, 1998). Family relationships also affect responsiveness to risk factors: parental modeling of abusive substance use and tolerance for substance use by his or her adolescent child are likely to have the greatest influence on that youth when the parent-child relationship is a close one. Biglan and Metzler (1998) concluded that parental use of alcohol or other drugs is one of two major family aspects associated with the occurrence of a variety of problem behaviors for both sons and daughters.

Family Management and Behavioral Monitoring

The second of the two generalizations Biglan and Metzler (1998) offered about the roles played by parents in the development of problem behavior concern family management practices. Research reports have repeatedly found that poor parenting practices contribute to child and adolescent problem behaviors and their progression (Dishion, Andrews, Kavanagh, and Soberman, 1996). Biglan and Metzler asserted that three identified kinds of parenting practices influence the development of such behaviors: monitoring, effective discipline, and positive involvement. Of these, monitoring is the practice most consistently identified for preventing problem behaviors. Both younger and older adolescents whose parents monitor their activities have been found to be significantly less likely to be involved with problem behaviors (Biglan and Metzler). Effective discipline is a correlate of monitoring, with the latter providing the indication of a need for such parental correction. As in the case of bonding and relationships, poor parental monitoring and poor limit setting affect the initiation of problem behavior both directly and indirectly: they are related to adolescents' association with a deviant peer group, and these associations in turn influence

further problem behaviors that make the deviant group attractive and possible (Dishion and McMahon, 1998).

While acknowledging roles for poor parent-child relationships and family conflict and the development of adolescent substance abuse, Dishion, Fuzhong, Spracklen, Brown, and Haas (1998) also gave priority to the part played by behavioral oversight. They have asserted that “parental monitoring is the key factor in accounting for the young adolescents’ drift into a deviant peer group as well as early involvement with substance use” (p. 261). They reported that research on parenting practices has found that parental monitoring affects children’s safety, influences the development of problem behaviors and substance abuse, and impacts academic achievement. In addition to its importance as a critical protective factor for children in high-risk environments, parental monitoring has the advantage of being teachable—parents can learn to change their monitoring behaviors with appropriate training.

Dishion, Fuzhong, et al. (1998) identified several interrelated aspects of the monitoring process, including the emotional dimensions of relationship quality and behavioral activities such as limit setting, positive reinforcement, and problem solving. Monitoring is therefore conceptualized as encompassing much more than oversight functions. It also incorporates the key protective factors of bonding and the communication and enforcement of clear standards. Conversely, family disorganization and poor parental supervision are part of the cluster of family risk factors relevant to parental monitoring. Dishion and McMahon (1998) reported that these risk factors consistently are the best predictors of adolescent problem behavior—even more predictive than the several individual and school risk factors associated with the early initiation of problem behaviors. Wright and Wright (1994) reported repeated research findings that “inadequate supervision is a key variable in predicting delinquency” (p. 195). These findings should not be interpreted as support for intrusive oversight or overinvolvement in supervision by parents. Dishion, Fuzhong, et al. recommended moderate levels of monitoring as most conducive to positive adolescent development.

Dishion, Kavanagh, and Keisner (1998) identified schools as a primary influence on adolescent problem behavior, providing a training ground for these behaviors and a place to meet deviant peers. Low levels of parental monitoring after school poses a particular risk (Dishion, Kavanagh, et al.). School-based prevention programming is also likely to be ineffective when children live with adult role models who tolerate or encourage preadolescent drinking and escalating use with age (Stevens, Mott, and Youells, 1996).

Indeed, parental monitoring becomes increasingly important with a child's transition to adolescence. Monitoring allows parents to exert influence over a child's selections of friends and activities and to express disapproval and impose sanctions for antisocial and delinquent behavior (Wright and Wright, 1994).

In addition to its influence on a youth's association with deviant peers, parental monitoring and peer groups are affected by the community context (Dishion, Kavanagh, et al., 1998). Wright and Wright (1994) pointed out that although families are the social institution foremost in its effects on the child, interactions within the family invariably occur in a broader setting. The community and its characteristics, workplaces, churches, and schools also are of developmental importance. Not only are child rearing skills not a given for all parents, their exercise may be adversely affected by living conditions, economic problems, and adolescent dysfunction.

Integrating Family Factors

Several studies and reviews have concluded that both the qualitative and practical aspects of family interaction are closely linked as risk and protective factors. Dishion and McMahon (1998) noted that "specific parenting practices and the quality of the relationship are dynamically related" (p. 229). Waldron and Slesnick (1998) characterized these family factors as being "interdependent and bi-directional" (p. 271). Family factors have direct effects resulting from modeling and opportunities for use, as well as indirect effects from poor parental control and a stressed family relationship. Bonding facilitates more effective monitoring and discipline rather than exerting a direct impact on problem development or its prevention (Biglan and Metzler, 1998). Dishion, Kavanagh, et al. (1998) agreed, noting that a positive parent-child relationship is essential for parents to effectively supervise a teenager. Thus, although single-parent households are identified as a risk factor, their influence is primarily through household structure, economics, and parenting behaviors (Southwien and Van Eenwyk, 1995).

Dishion and McMahon (1998) posited a "parenting triad," connecting motivation, parental monitoring, and behavior management and setting these on a common foundation formed by the parent-child relationship. They found that the quality of this relationship influences the child's social development and that a positive relationship enhances a parent's motivation to use appropriate behavior management and effective monitoring. At the same time, the monitoring of activities is needed for the establishment and maintenance of such a positive parent-child relationship, and behavioral problems can potentially threaten and

erode this relationship. Snyder and Ooms (1992) emphasized that the family is always significant for the child: “Even when family members are detached or abusive, they are important in the adolescent’s experience and cannot be ignored or discounted” (p. 18).

Interventions Promoting Family Involvement

Spoth, Redmond, and Lepper (1999) maintained that developmentally appropriate interventions directed toward family-based risk and protective factors can significantly impact the development of adolescent substance abuse. Such a claim draws on the strong theoretical and practical support for the effectiveness of general, family-based intervention strategies directed toward the prevention of the early initiation of alcohol use and misuse and early intervention with high-risk youth (Boyd, 1999). Dishion et al. (1996) compared results from both teen-focused and parent-focused interventions and found the latter to be much the preferred strategy. Placing the emphasis on parents minimizes the negatives associated with interventions that only involve the adolescent, and interventions that include the family are more likely to produce positive outcomes. Both families and schools are considered developmentally appropriate locales for intervention with early adolescents, and schools continue to play a role throughout adolescence (Hawkins and Weis, 1985). The school setting of PISP takes advantage of this role.

Research on family-focused interventions for adolescent problem behaviors has found that these interventions should be targeted to the level of need. Higher risk children respond better to more intensive parenting interventions, including parent training and family-focused support or treatment (Dishion, Kavanagh, et al., 1998). Dishion, Kavanagh, et al. characterized this process as involving “multiple gates,” beginning with general community informational activities (uniform prevention) and moving to increasingly focused interventions for those families and youth identified as having the most needs. More intensive and targeted interventions are expected to have more pronounced effects on changing adolescent behavior. The most common interventions for families include training in communication, problem solving, assertiveness, and anger management, as well as strategies to increase involvement in positive family activities. Programs also often stress improved access to and use of resources in the community and school to address other family needs and problems (Waldron and Slesnick, 1998).

A review of the reports that describe effective and model parenting and family programs revealed no single best family intervention program—just the conclusion that involving families improves outcomes for adolescents (Kumpfer, Molgaard, and Spoth, 1996;

Waldron and Slesnick, 1998). Prinz and Miller (1996) concluded, "The consistent relationships found between social interactions within the family and severe antisocial behaviors in childhood clearly emphasize the importance of parental involvement in intervention" (p. 161). Snyder and Ooms (1992) were even more emphatic, maintaining that "treatment of adolescent problems that does not include the family is unlikely to be successful in the long run" (p. 1). Kumpfer et al. identified the common characteristics of effective programs. Such programs are comprehensive and family focused, provide long-term interventions with sufficient intensity to affect risk and protective factors, are targeted to needs, and are developmentally and culturally appropriate. These programs are initiated as early as possible and are delivered by well-trained, competent personnel.

Intensive Interventions—Treatment and Family Counseling

Joanning, Frank, William, and Mullen (1992) compared the effectiveness of three models of substance abuse treatment for adolescents: family systems therapy, adolescent group therapy, and family drug education. Family systems therapy provided the most intensive intervention for the entire family, adolescent group therapy primarily involved only the adolescent being treated, and family drug education involved the least intensive interactions with the therapist. Family systems therapy appeared to be more effective at stopping adolescent substance abuse than family drug education, and both were more effective than adolescent group therapy. Participating youth were least likely to complete adolescent group therapy. A separate study examined the effects of using functional family therapy after institutional treatment in a transition program for delinquent youth (Alexander, 1992). The family-focused program significantly reduced recidivism compared to other reentry support programs.

Although no parents in the interventions reviewed by Joanning et al. (1992) identified any significant changes in family interaction, the adolescents perceived improvements in family communication as a result of all three interventions. Thus Joanning et al. concluded that "apparently simply being in treatment left the youth feeling they were in closer contact with their parents" (p. 355). Controlled studies of behavioral family therapy have revealed that family therapy models lead to greater reductions in adolescent substance use than approaches that are not family based (Waldron and Slesnick, 1998). Dishion, Kavanagh, et al. (1998) posited that such intensive and targeted interventions may set off a self-sustaining cycle of behavioral change within the family.

Strategic functional family interventions can improve both family functioning and reduce a child's substance abuse (Biglan and Metzler, 1998). Parents may support and facilitate intervention in their child's substance abuse even if they themselves are abusers. According to Snyder (1992), the risks posed by parental substance use are "most effectively addressed with the parents themselves involved in the treatment" (p. 31). Snyder argued that parents should be included at the very beginning of any intervention and that to not do so poses the risk of further alienating the youth from the family. She acknowledged that this early initiation of family engagement may not be possible when the intervention is a crisis response or when the family has explicitly refused involvement. In these circumstances, involvement should follow as soon as possible, and the adolescent should be encouraged to bring reluctant family members in to help solve problems. In Snyder's view, participation of the family does not violate the therapeutic relationship but helps solve problems.

Parent Training and Family Education

Despite the evidence that parent training is an effective strategy for improving parenting skills and family communication and reducing problem behavior, interventions that target parenting practices are underdeveloped substance abuse prevention and intervention strategies. Dishion, Kavanagh, et al. (1998) cited a recent study which reported that only 40 percent of families with delinquent children received any intervention directed to parenting practices. Spoth et al. (1999) also found few reports of family-focused programs designed to reduce the misuse of alcohol and other drugs.

Spoth et al. (1999) conducted a two-year follow-up study of parents and adolescent youth who were participants in a seven-week training series to improve family functioning. The sessions included skill building training for parents, the youth, and for the family as a whole. At the end of the follow-up period, participating youth had reduced rates of substance use compared to the control group. Spoth et al. found that these reductions also applied to youth whose families completed fewer than half the sessions. The researchers attributed this outcome to the effects the program may have had on reducing peer pressure in the small schools that were part of the study. This finding suggests that effective family-focused interventions can impact even those who do not attend by changing the school and community climates.

Dishion, Kavanagh, et al. (1998) reported that, to some degree, one approach or aspect of parental oversight is as effective as any other. Targeting parental monitoring for

intervention is preferable due to the evidence supporting its correlation with adolescent problem behaviors and substance use and the findings that this relationship holds across different ethnic groups and community characteristics. Training in parenting skills can also be effective, and parents can learn and apply improved practices that can positively impact adolescent substance use and other problem behaviors (Biglan and Metzler, 1998; Catalano et al., 1998; Spoth et al., 1999).

Other Family-Focused Interventions

Other risk factors for problem behavior can also be the focus of family interventions. Prinz and Miller (1996) noted that successful interventions with multiproblem families depend on finding ways to resolve other problems and barriers, including poverty and unemployment, a lack of child care, and transportation problems. An intervention program can address the problem of limited access to community resources, but it is more difficult to change community risk factors such as neighborhood crime or to intervene effectively in difficulties with employers or problems with school personnel (Waldron and Slesnick, 1998).

Schools may be offering activities and programs outside of the student assistance program that are consistent with the aims of improving parental involvement and parenting behavior, and these offerings may already include parent training. A training program does not need to be particularly complex or systematic to be effective. Dishion, Kavanagh, et al. (1998) reported on studies showing that schools can improve parental monitoring and support the academic and social success of at-risk adolescents by simply raising parental awareness of attendance, homework, and classroom behaviors. The researchers concluded that communication between the school and parents is a key element for enabling parents' potential to improve a child's behavior.

Bogenschneider and Stone (1997) reported on the successful use of newsletters with developmentally targeted and locally specific information. These newsletters followed a proven model for improving parenting among families with younger children and were also effective in increasing the knowledge of high-risk families with older children. School-prompted parent-child activities offer another ready opportunity to provide parenting skills information (Biglan and Metzler, 1998).

Strategies that include parents, schools, and the general community have been among the most successful substance abuse prevention and early intervention approaches (Jansen,

Glynn, and Howard, 1996). Community resources also play an important supportive role in the more intensive approaches typical for higher risk youth. Communities can support family involvement by facilitating parental monitoring through well-supervised recreational activities for children of all ages. Communities can also supplement parental oversight by increasing police monitoring of known problem areas. The *multiple gating* model (Dishion, Kavanagh, et al., 1998) suggests that intervention strategies begin with the community and school context through the establishment of norms and the dissemination of information. School and community policy changes and actions that support zero tolerance for adolescent tobacco use are another potential part of the mix.

Prinz and Miller (1996) suggested broadening the focus of adolescent substance abuse treatment to encompass the promotion of a variety of life skills for both children and parents and the examination of how other community agencies can participate in an intervention. In situations where parents are reluctant or resistant, an intervention should involve those who are more willing to participate and who are also relevant to addressing the adolescent's needs (Dishion, Kavanagh, et al., 1998). These persons may be grandparents, a coach or activity director, or even an older sibling. Community resources might offer mentoring programs, which provide another person to act as a friend and change agent for families.

Barriers to Family Involvement

Lack of participation by many of those parents who most need the benefits is a significant barrier to the effectiveness of all such family-based interventions (Biglan and Metzler, 1998; Dishion, Kavanagh, et al., 1998). Even the effective prevention program Parenting for the Drug-Free Years encountered major constraints to the involvement of those parents needing the most help (Catalano et al., 1998). Not surprisingly, many of the factors that are associated with high rates of nonparticipation also tend to be those that are risk factors for problem behavior. These factors include households stressed by lower income and educational levels, the presence of only a single parent, lower levels of social support, and higher levels of internal and external family conflicts (Biglan and Metzler).

Numerous reasons are responsible for these participation difficulties. The most commonly cited reasons are time and scheduling issues (Biglan and Metzler, 1998; Spoth et al., 1999). These are factors that affect both financially secure and low-income families (Prinz and Miller, 1996). Biglan and Metzler added that parents may also be influenced by previous events that led to stressful encounters with the school or other service providers,

perceptions that their child is not at risk and thus participation is unnecessary, and concerns about maintaining privacy and being the subject of assessment. Waldron and Slesnick (1998) noted the “significant challenge” of engaging families in treatment with an adolescent and found that this challenge is due to family conflicts, resistance to treatment, blaming the user, and a lack of recognition that there is a problem or need for change other than by the user.

Both parents and professionals may bring to their contacts with each other unhelpful attitudes, experiences, and beliefs as a result of previous experiences (Fine, 1992). Fine pointed out that the progressive development of adolescent problem behaviors often means that parents are tired and desperate and have accumulated frustrations with services and service providers by the time more intensive interventions are recommended or sought. Professional service providers may themselves have experienced unsuccessful relationships with families that led them to expect a lack of parent support.

Joanning et al. (1992) reported that a lack of family involvement in a comparison study of three treatment models often indicated a lack of understanding of the treatment process or a lack of investment in its outcomes. The model that used only adolescent therapy groups did not include parents beyond an initial orientation, but even in this case parents showed that they were not invested in the process. Parents refused to bring their children to the group sessions, challenged the treatment method, or refused to complete the assessments that were part of the research project. Problems with parental engagement and willingness to change also result when a crisis or mandate motivates interventions, such as might occur with a school disciplinary referral. These situations lead parents to focus on reducing a particular negative behavior to resolve the immediate crisis and not on changing parenting behaviors or overall family functioning (Prinz and Miller, 1996).

Peters and McMahon (1996) identified four areas that affect parental engagement. The first area concerns the assumption that the therapist’s or intervention specialist’s interpersonal relationship with the parent is important to the outcome of interactions with parents. Whereas experts in the chemical dependency field (see, for example, Anderson, 1993) often recommend confrontation, Peters and McMahon (1996) found that confronting and challenging families generates parental resistance to change—an outcome also noted by Dishion, Kavanagh, et al. (1998). Second, parents may have expectations about their role, beliefs about limited self-efficacy, contrary expectations for their child, and causal accounts for behaviors that do not reinforce the aims of therapy or facilitate change. Parents who believe that parenting skills cannot be changed and that any problem is a reflection of their

ability to parent have lower expectations and aspirations for a successful intervention and show limited engagement. Peters and McMahon also cited the pressures of other environmental, economic, and personal problems. Finally, time and scheduling conflicts identified previously are the most typical barriers to parental participation. Peters and McMahon expanded on these areas that affect parental engagement by pointing out potential problems created by the setting of the intervention and its mode of delivery—group or individual. Although groups may provide support and opportunities for learning, when participants have widely varied backgrounds, styles, and needs the group setting can impede participation for some parents.

Improving Parent Participation

Findings associated with improving parent participation in intensive family interventions suggest strategies that could be applicable to PISP. Dishion et al. (1996) found that parents of high-risk youth are responsive to participation requests for interventions that offer parenting resources. Anderson (1993) suggested that the ideal initial approach for school-based services seems to be a positive letter from the school principal that invites participation, followed by a personal telephone call. The Iowa Strengthening Families Program described by Kumpfer et al. (1996) suggested the following research-based strategies for recruiting and engaging parents: First, the school principal sends an endorsement letter to the parents; second, the school distributes program flyers and announcements; and third, a parent sends an introductory letter about the program and telephones to invite other parents to participate. Using these strategies and offering incentives such as prizes for attendance, the Iowa Strengthening Families Program obtained a 49 percent participation rate.

Szapocznik et al. (1988) used a more systematic and intensive stepped approach in their study on engaging hard-to-reach families in adolescent treatment interventions. Their *strategic structural-systems approach* began with initial calls and proceeded through repeated personal follow-ups designed to restructure the reasons for resistance (the control families received a single and limited follow-up phone call after the invitational letter). All but a few of the families showed up for treatment intake. Such combinations of motivational techniques have also been effectively utilized with Johnson Institute-style interventions (Garret, Landau-Stanton, Stanton, Stellato-Kabat, and Stellato-Kabat, 1996).

Anderson (1993) cited the advantages of linking interventions to school policies requiring parent attendance at conferences. Biglan and Metzler (1998) also supported the inclusion

of mandatory parent participation in some intervention activities for certain offenses. Although these may present issues concerning parent expectations for intervention outcomes, as noted by Prinz and Miller (1996), they do facilitate initial participation.

Getting families to follow through after an initial engagement also presents difficulties. Szapocznik et al. (1988) found that parents tended to drop out of the subsequent, brief family therapy sessions at the same rates regardless of the engagement procedure used. Szapocznik et al. concluded that family resistance, defined as a “tendency for the family system to protect its structural status quo,” is a repeated occurrence throughout the intervention process. Kumpfer et al. (1996) proposed that the most important element for the retention of parents who initiate participation is contact made by other group members when a parent is absent. Kumpfer et al. also suggested that offering a program that is interesting, relevant, meaningful, and meets family needs helps promote continued involvement in the intervention.

The nature of the intervention relationship with the family is important for both engagement and retention. Prinz and Miller (1996) stressed that this relationship should be built on informational exchange and that parents should give and receive. They characterized the relationship as a collaborative, and parents are expected to feel that their actions can make a difference. A supportive and motivating manner that includes the reframing of situations and actions is more likely to promote engagement. The optimal engagement approach is identified as a variation on motivational interviewing, a technique that offers parents a realistic assessment of risks and varied opportunities to build on their strengths (Dishion et al., 1996; Waldron and Slesnick, 1998). Prinz and Miller pointed out that any newly gained parenting skills are more likely to be used when the intervention builds on family competencies and ameliorates environmental obstacles and stressors. They suggested that programs be customized for each family through attention to the family’s strengths and needs for support and resources and that programs include options for alternative times, contact types, and delivery modes.

Parental engagement may be further enhanced by participation in planning program activities, membership in an advisory group, and responsibility for contributing to program activities in some way (Fine, 1992; Kumpfer et al., 1996; Robertson, 1997). Dishion, Kavanagh, et al. (1998) maintained that the key to engaging high-risk parents is the close connection of family interventions to the school setting. The multiyear evaluation results of a project to reach and engage substance-abusing families supports this conclusion (Carlson, 1998). Parents were responsive to requests for their involvement when these requests came

through school-based services that were offered to their children, and these responses often led to interventions with the family as a whole, closer relationships with the school, and improvements in child and family functioning. These findings suggest that PISP may have an advantage in parental involvement over strictly community-based intervention approaches.

Alternative methods of delivery are a very promising consideration in resolving barriers to participation. Catalano et al. (1998) suggested delivering aspects of parent training through books, videos, home study materials, and even online through the Internet or the school's Web page. Professionals need not deliver parent training. Several communities use trained lay personnel from the community, many who are parents themselves. Training might even be home-based. Biglan and Metzler (1998) identified several other alternatives. School media materials, such as regular parent contacts or informational newsletters, can also provide an alternative means for contacting, informing, and engaging parents. Although these means do not provide the intense follow-through that would be needed to address serious and long-standing problems, they can function to improve parental motivation to respond to requests to act. Various screenings or assessments conducted for some other purpose may well serve to improve parental engagement in resolution of the problem behavior.

Family Involvement in PISP

PISP primarily serves students in middle and high schools, although some services are provided to elementary schools in some sites. Most of the youth who participate in the program are high-risk children and adolescents, but the extent of their involvement in substance abuse varies greatly. The program works with students who are initiating use, who have begun to abuse substances, and who are alcohol or other drug dependent. Students whose primary issue is the substance abuse of a family member or close associate also are recipients of program services, and PISP provides support for students who are trying to continue to be drug free. In recognition of the interdependence of many problem behaviors, program staff also are involved in violence prevention and intervention and assist students with other problems associated with alcohol and other drug use and their correlates. This diversity of use patterns and the multiplicity of problem behaviors necessarily require a range of program services and referrals. Not surprisingly, parents' participation in the program is similarly diverse and generally related to the nature of their children's program involvement.

Reported Parental Involvement

RMC Research collects statewide data from all the school sites that provide student assistance services through PISP. Data are compiled on the number and characteristics of students served, the types of services delivered, and student outcomes. These data include information about contacts with parents and an assessment of the extent of parent participation. The most recent data available are for the 1997–98 school year, during which the program served a total of 19,625 students. Of these students, 42 percent were in high schools, 38 percent were in middle schools, 11 percent were in elementary schools, and 9 percent were in other school settings—generally alternative schools.

Parents were identified as the source of referral for 15 percent of the students as a whole, and this proportion was considerably higher (28 percent) for participants in elementary grades. The majority of the students lived in a two-parent household: 39 percent lived with both parents and 20 percent resided with a parent and stepparent. One-third of the students lived in a single-parent household and the remaining 8 percent had some other living situation. For over half of the program’s participants (52 percent), some type of family issue was noted as one of several potential reasons for referral. These students included 42 percent who were referred due to “home problems” and 30 percent whose referral reasons included substance use by a family member.

The data reporting form provided several options for recording family contacts and parental program participation. Forty-eight percent of the students’ families were reported as having been contacted by the intervention specialist. Middle school students were only slightly more likely to have their parents contacted than high school students (51 percent versus 48 percent), and both had higher contact levels than those in elementary school (44 percent). The annual report (Deck and D’Ambrosio, 1998) explained this difference as due to older students being more likely to have substance abuse issues or other issues requiring family involvement. For approximately half of the students whose parents were contacted, the delivery of information was the most common type of service provided (reported for 81 percent). About half (49 percent) of the contacted families had an in-person meeting or participated in an extended telephone consultation with the intervention specialist. Few of these families (11 percent each) participated in family counseling or received intervention and support focused on the intervention with the child. Just 8 percent received prevention and education, identified as helping families with behavioral control, limit setting, and parenting skills.

At the end of the 1997–98 school year, intervention specialists provided an assessment of the level of parent participation for each student. The data indicate some contact with 62 percent of the parents, a higher percentage than reported for family contacts. This difference may be due to reporting parent contacts made by others as well as those initiated by the intervention specialist: school administrators and counselors often have responsibility for parental contact when they are the source of referrals, especially if the referrals are part of some disciplinary action. In 17 percent of the cases parents declined to participate, another possible reason for the discrepancy between the two accounts of family involvement. The end-of-year data reveal that parental participation was most often modest when it did occur: 48 percent of parents who participated were rated as having minimal participation, 16 percent had moderate participation, and 19 percent participated fully. There is no set standard with which to interpret the meaning of these levels of participation. Interview data suggest that minimal participation would be considered the receipt of written information about the general program and provision of a signature allowing student participation.

The indications from these data are that most parents have very little involvement with the program and that this involvement is most often passive. From half to about 60 percent of the families had some contact from the program, and in close to 20 percent of these contacts parents declined to participate in the program. The most typical way in which parents were involved was as recipients of one or more generic informational telephone calls or letters that may or may not have required a signature granting approval to proceed. Only about one-quarter of the students' families were involved beyond this minimal level, participating in activities such as meetings or telephone consultations. There was very little parent participation in more substantive contacts with the program. Only 4 to 15 percent of parents actually received one or more program services designed to support student progress or improve family functioning.

Policies and Practice

Several additional sources of information have contributed to an understanding of actual program policies and practices in regard to family notification and participation across the different sites. Intervention specialists and coordinators at five selected program sites provided information about family involvement during intensive interviews conducted as part of the 1998–99 evaluation of PISP. In spring 1999 all coordinators were asked in a written survey to respond to questions about program policies and practice specifically for this position paper: responses were received from nine sites throughout the state. Five

intervention specialists identified by coordinators as particularly knowledgeable about family involvement took part in telephone interviews covering similar topics.

Policies for Parental Involvement

All sites do encourage and seek out some parent participation in the program. This begins—and often ends—with a letter or telephone call providing general information about a given student’s recommended program participation, often accompanied or followed by a request for the parent to either approve (active permission) or disapprove (the absence of disapproval is considered passive permission) their child’s involvement. Although guided by the same federal and state laws, the policies governing this participation vary by site, school district, and sometimes by individual schools. These policies range from blanket contact and permission requirements at some locales to policies that depend on student circumstances and characteristics. The most common policies reported required parent notification and permission for certain types of participants and required selective notification and permission for other participants.

Parent involvement was frequently linked to student age. Participation by all students aged 13 or younger required parent permission (generally active permission) and students older than 14 were either able to participate without parent contact or by way of passive permission. It was fairly standard that parents were informed and permission for services was required when a student received a disciplinary referral to the program or when participation in services or some alternative was mandatory. For example, program participation was often offered as an alternative to suspension or some other punitive sanction. A school administrator or counselor was often responsible for making the initial contact in these cases, and parent approval might also have involved attendance at a meeting with the administrator. Parent involvement was also likely to be required when a student was to be referred for an assessment for treatment, which raised issues such as payment to an external agency, insurance coverage, and liability. Liability also was a factor that prompted sites to require parent notification because individuals who are not school personnel deliver PISP services. Some schools reportedly required parents to be notified when students missed class time due to program participation.

The specific content or focus of the intervention was often not stated directly in the letter or contact. For groups that deal with disciplinary issues, such as insight or anger management groups, the parent contact was more likely to provide an explanation of the purpose of the group. For other services, parents often received a list of possible discussion topics,

including alcohol and other drug use by the youth or family members, but these topics were not identified as the intervention focus. In these cases, the wording was intended to present the program activities nonspecifically and ambiguously. Such generalities were used to mask the content of groups dealing with topics such as family substance use or student experimentation and misuse. The purpose of the parent contact was not, therefore, to actually inform parents about the program and their child's participation. Rather, it seemed intended to fulfill some legal or policy obligation while obscuring the program's specific intervention focus.

Other factors guided whether or not parents were notified and asked to approve their child's participation, as well. These factors were not stated as formal policy but were consistently identified in the intervention specialists' accounts of how they handled parent participation. Parents might not have been contacted when a student indicated he or she would not participate if his or her parents were informed, when a parent was a substance abuser, and when the intervention specialist believed that a parent would actively refuse to let the student participate if contacted. These factors were not generally an issue when the student was referred for disciplinary reasons. Some schools required parent permission for students to take part in the program. Strict adherence to this rule was sometimes modified to provide at least some services to a student identified as having high needs.

The willingness of program staff to stretch or bend policies regarding parental notification and permission varied greatly among individual intervention specialists and across program sites. The intervention specialists balanced meeting students' needs for services, families' wishes, and program mandates to adhere to those wishes. As helping professionals, intervention specialists were extremely reluctant to take actions that might result in a student being denied services and made every effort to avoid situations that might result in parental refusal or the withdrawal of permission. When it appeared that a student's participation would be jeopardized if the parents were involved, the intervention specialists were strongly inclined to withhold parent contact if possible.

Such informal policies for not pursuing parent involvement apparently could supercede any of the other policy guidelines, including those requiring parents to be notified. This practice explains why the statistics on parent contact are not congruent with what appear to be the policies for parent involvement. These informal policies reflect how much the primary client of the program is defined by the intervention specialists as being the student, and the most important service aim is assisting students. Parent participation is largely

defined in terms of this priority, and assistance to the family as a unit is a very secondary concern.

Characteristics and Circumstances of Additional Contact

More personal and focused contacts with students' families generally occurred under three circumstances: First, some parents did follow up on the offer of additional contact with the intervention specialist, and this often resulted in an extended telephone call or an in-person meeting. These meetings were usually at the school, but some programs also conducted occasional home visits. These meetings sometimes provided brief information about ways to improve parenting practices and referral information, including pamphlets or contact numbers, for appropriate school- or community-based services. Again, in most cases these extended telephone calls or meetings did not result in any further parental contact or involvement with the program, although intervention specialists reported additional follow-up telephone calls with a minority of these families to check on their progress and offer support. Such parent-initiated involvement in the program seemed to account for the majority of the more intensive family contacts reported that were not required as a part of program activities.

Other types of involvement were initiated by the intervention specialists or school administrators or counselors. In some cases, families were contacted directly if their participation was necessary for service delivery, such as for assessment or treatment referrals or meetings associated with disciplinary actions. These meetings were often initiated by and included a school administrator or counselor. Lastly, parents were contacted if there was a safety issue, such as suicide risk or the need for mental health services that required intervention. In accord with the law, intervention specialists contacted Child Protective Services and parents if indications of sexual or physical abuse or neglect were present.

One intervention specialist described his approach to parent involvement as "selective," a characterization that largely indicated the inclusion of parents willing to work with him. He described these parents as having initiated contact themselves or having become involved due to the initiation of the student. This intervention specialist does not "make the first move unless it is a treatment referral." Thus an intervention specialist might initiate contact with the parent if a student wanted more parent involvement. Intervention specialists also reported contacting a parent if he or she felt this was indicated because of some problem or need that family participation might assist. Such optional family contacts were made with

caution, and the intervention specialists, who expressed considerable concern about the maintenance of student confidentiality, generally deferred to the students' acceptance of parent involvement before making contact. "My first duty is to the student," maintained one intervention specialist.

Intervention specialists tended to report most of their experiences with and views of family involvement and participation by referring to students who had alcohol or other drug problems requiring assessment or treatment. That is, they associated parent participation with this more seriously impacted segment of program participants—about 10 percent of the students served by PISP. Intervention specialists were most likely to maintain or attempt meaningful contact with the parents of those students. Most treatment programs—and notably those programs the intervention specialists considered the best—included some intervention with parents and the family system as well as with the adolescent. Thus the time intervention specialists spent with parents prior to treatment entry was followed by time spent in parent engagement during treatment. A parental component might also be included in aftercare services through these or other community-based agencies. PISP also offers school-based services for students in recovery or following treatment, but there is no indication that these services necessarily included any further parental involvement.

Parental participation beyond the receipt of letters or telephone calls was also likely for disciplinary referrals—accounting for 23 percent of the students in PISP. Intervention specialists cited students involved in the program as a result of disciplinary or mandatory referrals as examples of how the program seeks family contact. Disciplinary or mandatory referrals provided a negative incentive, or "hammer," for involvement. One intervention specialist compared different types of student involvement with the likelihood of parental involvement in this way:

If there's a hammer, it's easy to get the parents involved. If the kid really recognizes, wants to do something about it, those parents are pretty easy to get involved. It's the ones that are stuck in the middle, either they're completely denying there's a problem or maybe they're just giving it thought or don't think it's that big, they're minimizing.

Another intervention specialist characterized the greater ease of involving families when a crisis situation included school-related problems, such as disciplinary infractions, or health-related problems, such as substance abuse.

Conflicting and Complex Rationales

There was uniform agreement among those interviewed that parent involvement is a critical component of an effective substance abuse prevention and intervention program. Parents were seen as being particularly important for younger students. The view for older youth was that although they are developmentally able to make progress without family support, this support for change is the best approach for these youth as well. One intervention specialist, although agreeing that parents were more important for younger students, also had the experience of such parents being less involved with the program. In her view, "Older ones have a longer history of not being functional, so more people are ready to be mobilized to participate." The parents of older youth are more likely to be "so tired" that they are ready to ask, "Please help me."

These views produced the general aim to always involve the parent in PISP services, and this goal was often formally backed up by program, district, or school policies. Several intervention specialists reported observing improved progress when students had family support and students struggling or being more likely to fail when this support was lacking. One intervention specialist noted, "I don't think the kid can get any meaningful help if they don't have some family involvement." Another stated that those who have strong family participation "are going to have a much better chance—a monumentally better chance." Drawing on the risk and protective factors model, this intervention specialist continued, "If it's a kid who has supportive peer groups and supportive alternative activities, the more support from as many different avenues as possible will better the chance."

The intent to involve parents did not always fit the practice, however, and both the reported data and the interviews showed that parental involvement was very likely in certain circumstances and highly unlikely in others. The same intervention specialists who maintained the importance and benefits of family involvement also had ready arguments as to why parents should not be notified or fully informed. "I believe that all parents want to see their child succeed," claimed this intervention specialist, although he reported only routinely seeking contact with the parents of younger students. Thus while he stated that he has an "informal rule to always involve parents," he also reported that he does not do so if he thinks parental involvement would "jeopardize my relationship with the child." Another intervention specialist noted the importance of parental involvement in situations dealt with at the school that do not involve a community agency referral:

Certainly you want to be sure that the parent and I are advocates and we're on the same page . . . communicating the same thing. So in a sense it's the same approach with the parent as with the kid—education first—this is what's happening; this is what we need to know about it. And let the parent go home and almost practice those same skills with the kid that I work with.

However, this intervention specialist immediately qualified this statement, describing situations in which the parent would not be involved:

Depending upon how the kid comes in here, sometimes the parent may not necessarily even be notified. If it's something where the kid is coming in and you know they're either considering or just in the beginning stages of use; and you know that light bulb has gone off and they figure this isn't for me; and they just need to stop, just need to talk to somebody about it; and they're afraid about what mom or dad knows. Then I'm going to respect that.

This and other intervention specialists do not perceive the need for and value of parental participation to be uniform across all students served. Rather, parental participation is contingent on particular student and intervention circumstances. This intervention specialist concluded, "Once we cross over a certain line and that's not working anymore, then we'll get it stepped up a bit." That is, only when students show continuing problems and the intervention efforts are not working does this intervention specialist consider it necessary to engage the family. This decision principle was used by another intervention specialist in an explanation of how, after working with a youth for nearly a year and observing his use stop and start again, the intervention specialist "finally confronted him" with the need to do something. The intervention specialist said, "Then [the student] told his parents, but he was ready to. I wouldn't have done that to a kid who just came right in."

This intervention specialist recognized that this and other students "think their parents are going to kill them," a belief that did not match the intervention specialist's actual experiences with parents but that is an indication of students' mistrust. The intervention specialist continued, "The other thing is, kids don't want to let their parents down. They don't want to let their parents see them in a different light, burst that bubble for them." Another intervention specialist recounted similar experiences: "Students underestimate their parents sometimes, or they feel their parents are going to react a certain way when they might not." She described how families usually respond to her efforts to engage them

in the program as variable, indicating that some “haven’t been real happy or [have been] real resistant to services.” For the most part, however, this intervention specialist reported that “it’s been pretty good. They’re thankful to get some help. They didn’t know what to do or where to turn.”

One intervention specialist who described a program with passive parental permission also characterized the nature of parental contact and efforts to engage parents in programs that require a signature for services to proceed. (In terms of providing information to families, passive and active notification procedures do not seem to greatly differ.) The intervention specialist began this account with the statement “parent involvement is very important” and then described the exchange that occurs “if a parent calls me and says, ‘What’s this group thing my kid is in?’”:

The only parents who know for sure that their kids are involved in it are discipline kids. And they know this is one of the things that’s offered. But I let them know that we talk about a lot of things and alcohol and drug refusal skills and that kind of stuff is on the list somewhere. But I let them know it’s a place where the kid can come and talk about stuff, and if they want more information, I send them a parent packet. That parent packet has a questionnaire—“Are you seeing any of this stuff in your kid?” It has all of the tips and stuff. So hopefully the parents’ eyes will be open if they read it. I wonder how many of them read it?

Barriers and Issues Influencing Parental Participation

The impediments to satisfactory parental involvement occur largely in two areas: those that reside with the family and family circumstances and those that result from the role of the intervention specialist and the constraints associated with professional practice.

Intervention specialists and coordinators identified the issues in the first category along the same lines as described in the literature review. One intervention specialist suggested, “Some of it is apathy; some of it is minimization,” and concluded that “the lack of education is what it really boils down to—a lack of knowledge about the disease of addiction and what it potentially can do.” Additionally, intervention specialists recognized that parents want to believe the best about their child and may refuse to accept allegations to the contrary—especially if these allegations are not acknowledged by the child.

Intervention specialists also reported being aware that many parents have a history of

negative interactions and failed interventions with the school and other service providers that may take years to overcome.

The second type of difficulty with parent engagement stems from constraints on the intervention specialists. Primary among these is a lack of time. Intervention specialists reported wanting to do more in the way of personal family contacts, follow-up, and offering parent support groups and education, but their schedules are already busy with what they presently do with the students themselves. At most sites, intervention specialists also indicated that they cannot provide enough services to meet students' needs, let alone extend their time to better respond to parents. In addition, intervention specialists have had negative experiences with parent participation that affect their expectations and willingness to reach out. One intervention specialist recounted, "Parents will say they'll be involved and then not follow through." Others reported offering parent nights and other opportunities for parental skill building that were not attended, leading to the assertion that "parent nights don't work." Another major barrier to parent involvement is associated with requirements and promises of confidentiality between the students and the intervention specialists. Confidentiality within the group means confidentiality about the group and what it is trying to accomplish. This confidentiality requirement combines with the priority given to the relationship with the student over that of informing and engaging parents. The result is a disincentive for attempting more than perfunctory or reactive parent contact except when circumstances—such as a school disciplinary action or treatment referral—make this contact essential.

The frequent conflict between the intervention specialists' work hours and availability and the availability of the parents was among the most significant and practical factors interfering with parent contact. Not only do intervention specialists work primarily during the day when many parents are also at work, many intervention specialists move among several schools throughout the week. Thus there may be contact difficulties even for parents who do try to call. An intervention specialist may not be able to return the call for over a week when they are not available. Pagers help somewhat, but not all intervention specialists have them. Intervention specialists may also be difficult to reach because their office at the school, if indeed they have an office, does not have a telephone. Some intervention specialists reported that because they are not really considered part of the staff at their schools, they are not listed on staff rosters and not always known to the students assigned to answer the telephone. Interviews with and surveys of parents have suggested

that they may be as frustrated at the lack of their involvement as the intervention specialists.

Strategies for Improving Engagement

Despite the barriers to parental involvement, intervention specialists and coordinators recognize that current levels of parent involvement and participation are inadequate. One intervention specialist described “tending to respond to the squeaky wheel.” He recognized that this tendency to involve parents only when they initiated contact was not optimal and acknowledged that rather than following up with families, he assumed that there were no problems if he was not contacted. Another intervention specialist noted, “We don’t do a very good job with families . . . we don’t say often enough, ‘This kid is not going to get through this without the family doing the work.’” In practice, the approaches used to involve parents closely resemble those recommended by the research on effective engagement. The initial letter is often signed by a school administrator and is typically on school letterhead. For those parents with whom there is contact subsequent to this letter, even when this involves less than full disclosure, intervention specialists reported relating to parents in ways that are respectful, supportive, and nonjudgmental:

To be really supportive of them when they’re in a crisis is important because they’ll come back. They may not deal with it at that time, but they’ll remember that you were supportive instead of judgmental . . . They need to hear that it’s not your fault, you didn’t do it, there are things you can do. They need to hear some positive things.

Another intervention specialist discussed the need to approach parents not as an expert telling them what to do but with an attitude that says “How can I help you?” Another described this approach as being an advocate for the child and the parents, giving ideas and support.

Most of the coordinators and intervention specialists identified several steps taken or planned to improve the current levels of parent participation. Parents do have involvement opportunities built into some PISP programs that offer a parent session or gathering as a regularly scheduled part of specific groups. One intervention specialist characterized her efforts as trying to build a team with the child, parent, school, and outside agencies. Some schools have family therapist services that the intervention specialist can use as a school-based referral resource. Intervention specialists may send parents packets of informational

materials, either as part of a student's group participation or in response to a request. The intervention specialist may also have books or other materials to lend to parents either at the school or through the main PISP office.

A few sites also hold regularly scheduled parent information sessions or gatherings and sometimes offer access to parent support groups linked to PISP. Several sites reported on collaborative efforts with other organizations and activities for parents, including PTSA and community-based programs. These community-based offerings were seen as more acceptable to parents who have had negative school experiences. At least one of the sites is planning an increased focus on family engagement and participation in 1999–2000 over and above that associated with treatment as part of staff training.

Some engagement strategies are applied to all parents, not just those of students in the program. Some school districts offer formal parent training opportunities at the school, ranging from multiweek programs such as Parenting For the Drug-Free Years to one-time sessions on specific topics. Other schools offer monthly parent night programs or activities through the PTSA or community groups. Schools may have a lending library for parenting resources or a source for information through another program, such as a school family resource center. More generally, several districts use newsletters to provide all parents with information about alcohol and other drug use, community resources, and PISP offerings.

Integrating Research and Practice

The results of the literature review on parent involvement and the summary of program practice and philosophy show numerous overlaps and several important inconsistencies. In general, most PISP sites are doing an adequate if not exemplary job of parental involvement in the case of certain students and a poor or inadequate job in regard to many others. Many valid reasons contribute to this pattern, including legal requirements, school policies, and limits on intervention specialists' time and capacities. However, there are also compelling reasons to effect change.

1. The student's family should be an active part of PISP. The importance of this participation has its basis in solid research and in risk and protective factor theory. This precept is also accepted and acknowledged by program personnel. In practice, the program shows more adherence to concepts of the family as posing risk factors for the child than it does to the family as a significant source of protective factors.

2. Any involvement of the family is likely to be positive. The minimal involvement that characterizes much of the practice in PISP is better than not including the parents at all. Small improvements in program practice could lead to better parent participation and better student outcomes.
3. Families of all kinds, including those with problems and active substance abuse issues, can prove helpful for a child in the program. The practice of avoiding parent participation or obscuring the program focus with students whose parents are substance abusers denies these parents the opportunity to help their children change this family pattern.
4. PISP tends to follow a passive and reactive model for parental involvement rather than a proactive one that seeks out and encourages engagement and participation. This practice reinforces the belief that parents are not interested in more participation and becomes a self-fulfilling prophecy. Minimal efforts to engage parents result in few parents who are likely to respond. Although concerns about parent refusal to allow a student to participate are certainly justified and based on experience, countering indications reveal that most parents are interested in assisting their children. The presumption that parents would not be supportive should not guide program practice when parent support is so important to student improvement.
5. The parents of students who have serious substance abuse problems and who have experienced trouble with school authorities are the most likely to be more intensively involved in the program. These parents often have extra incentives for participation that have proven effective. Other students, most notably those in the early stages of substance use, are much less likely to have their parents involved. These are the youth for whom early intervention is most likely to be effective and who may be significantly impacted by parental actions.
6. Some parental contact is most likely for younger students, who are developmentally in the best position to respond to parental actions. However, this opportunity to impact parental behavior is weakly and inconsistently pursued. Most parents are not provided information about what they can do to alter emerging use unless they seek it out, and this information seldom includes a chance for training linked to the students' program participation.

7. Key family protective factors related to behavior management and oversight are teachable skills that most parents can acquire through brief, focused training. Present parent education offerings are not marketed to and often not attended by program families, nor are they routinely available or readily accessible at all schools.

Recommendations

Recognizing that intervention specialists' time and program resources are limited and in some cases shrinking, recommendations for action on these conclusions are deliberately modest. Nonetheless, much could be done with only slight shifts in program practice and philosophy. Continuing to operate with only minimal parental participation is neither necessary nor justified. If enacted, the following recommendations should make a meaningful difference to student outcomes.

1. PISP should expand the scope of routine parental notification and initial contact to cover all students involved in the program at all sites. This practice should be applied uniformly, regardless of student age or circumstances.
2. Contacts with parents and strategies to involve them in aspects of the program should be proactive in nature, routinely seeking parent participation and offering participation opportunities rather than responding only if a parent expresses an interest.
3. Such parent participation opportunities would be more readily available if the program improved its connections with other school and community services. PISP should make more deliberate efforts to link the parents of program participants with existing offerings by referral and through structured engagement strategies to improve utilization. Collaborative offerings and initiatives might also better fit these parents' needs.
4. The greatest focus for taking such actions to increase parental participation should begin with program participants in the elementary and middle schools. These students are developmentally the most likely to be affected by improved parent engagement. Current practices are often already in line with making initial contacts, and parents of children in these age groups are more likely to already have central and active roles in their children's lives.

5. Parent education on behavioral management and oversight to improve monitoring should be the primary offerings of these enhanced engagement efforts. These offerings may already be available in the community or through the school, are of documented value, need not be excessively demanding of parent or intervention specialist time to be effective, and provide the highest returns for what should be a modest investment of energy and resources.

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