RPP Strategy Proposal Process

When considering how much detail to include, please keep in mind reviewers may not be familiar with your region.

Please cite your work.

Technical review items	
Proposed Strategy:	Active Parenting of Teens: Families in Action
Proposed Strategy Cost:	$2,420.30
Proposed Strategy Timeframe:	6 weeks: third week of the month September 2019 – February 2020
Proposed Strategy Persons Responsible:	Joe Smith, Programs Coordinator, Anytown Teen Center

1. Which RPP goal(s) does this strategy address? (see RPP Guidance Document, page 4) **Check all that apply:**	
☐	Goal 1: Increase state, regional and community capacity to prevent underage and binge drinking, prescription drug misuse, and marijuana use by implementing a targeted regional approach.
☒	Goal 2: Reduce underage and binge drinking among persons aged 12 to 20.
☒	Goal 3: Reduce prescription drug misuse and abuse among persons aged 12 to 25.
☒	Goal 4: Reduce marijuana use among persons aged 12 to 25.

2. Which risk and/or protective factor(s) does this strategy address?

- Law and norms favorable toward alcohol and drug use
  - The state has recently passed legislation to make a retail marijuana market legal, but it will not be enacted until July 2022 (AnystateLeg.gov/Act123).
  - Statewide surveys of parents of young Anystaters and Anystaters ages 18-25 show a decrease in both population groups' perception of harm of alcohol use and marijuana use, as well as moderate increases of use of both substances over the past 4 years (Parent Survey 2014-2018, Young Adult Survey 2015-2019).
  - Prescription drug misuse has dropped significantly according to Youth Risk Behavior Survey and National Survey on Drug Use and Health surveys over the past 5 years, and perception of harm of misusing prescription opioids has remained high (YRBS, NSDUH).
- Opportunities for engagement within school and community
  - Students report having low connectedness to family and community and low self-esteem (YRBS, Anytown Middle and High Sample Surveys).
  - All Anytown youth ages 11-19 are eligible to participate in Anytown Teen Center's after school and weekend resources. The teen center is mission driven with an emphasis on serving the town's low socio-economic status (SES) students.
- Availability and access to alcohol
  - Anytown is located in Anycounty.
    Anycounty is the county with the highest number of craft brewers and distillers in the state (anystatenews.com).

3. Why are you proposing this strategy?

The promising evidence-base of this strategy combined with its use in Anytown Teen Center makes it a better fit for our community than other family curricula listed on the RPP Menu.

The specific goals of *Active Parenting of Teens: Families in Action* for ages 11-14 are to:
1) increase youths' positive attachment to their families and their schools
2) increase their positive peer relations
3) **promote unfavorable attitudes toward the use of ATOD**s
4) increase self-esteem.

The goals for parents participating in the program are very similar:
1) increase positive attachment to their families
2) increase positive involvement in their children's schools
3) p**romote unfavorable attitudes toward the use of ATODs by minors**
(https://www.crimesolutions.gov/ProgramDetails.aspx?ID=261)

Families in Action goal #3 for parents and teens relate to the RPP goals #2-#4: "Reduce underage and binge drinking among persons aged 12-20." "Reduce prescription drug misuse and abuse among persons aged 12-25." and "Reduce marijuana use among persons aged 12-25."

This strategy aligns with our region's planning documents as a strategy supporting relationships-level activities to reduce underage substance use and other substance misuse or abuse. It is an expansion for our organization to begin a sub-grant relationship with the Anytown Teen Center. We will need to revise our planning documents if this strategy is approved to include Families in Action information and Anytown Teen Center information.

4. Please provide results of the assessment you have done to determine your region's needs, current resources, and readiness for the proposed strategy. This includes your responses to the utility and feasibility checks in the resources section below, #1. For an example of a successful proposal response, see the "Example Completed Submission" document.

Needs: See attached tables for youth and adult substance use trends (YRBS, NSDUH) for alcohol, prescription drugs, and marijuana. After a period of use reduction, Anytown's most recent assessment shows non-significant increases in substance use for alcohol and marijuana for both youth and adults, thus indicating our areas of highest concern.

Utility Check
Need & Readiness: Families in Action is identified for a rural and/or frontier geographic location, which is a similar setting to Anytown's geography with a population of 4,245 people (2010 Census). Review of the Families in Action materials do not give concern that there is a conflict with Anytown's culture, available settings for the program, or population characteristics. A focus group with Anytown Teen and Parent past-year participants was held in 2017 to determine if the materials, last updated in 2012, were appropriate to the times. The focus group indicated some materials could be refreshed but overall the programming suited their use.
Resources: Anytown Teen Center lost the resources to provide Families in Action in their last fiscal year and are seeking community support for re-implementing the curriculum in their current fiscal year. The Families in Action implementation materials will need to be purchased but are available

through the curriculum developer. TA is available for free, and **Anytown Teen Center Staff are trained in this curriculum**.

Feasibility Check
Need & Readiness: According to the statewide Parent Survey, Anycounty parents have ranked very highly compared to the average for parents statewide interested in speaking to their kids about substance use but not feeling equipped to on their own. Taking other factors into account (ex. scheduling, recruitment strategy, incentives), this data point indicates the community is ready for this curriculum.
Resources: In past years the curriculum was a part of Anytown Teen Center's offerings, however they do not have funding to offer the program (funding ended in previous fiscal year). Families in Action is in line with the mission, vision, and culture of the implementing organization, and is a priority of the implementing organization.

If this proposal is accepted, our organization will sub-grant to Anytown Teen Center. The sub-grant will ensure they have the technical (staff time) and financial (curriculum materials) means to implement the strategy with fidelity.

5a. What is the evidence base for the proposed strategy?	
SELECT FROM BELOW AND PROVIDE SUPPORTING DOCUMENTS AND INFORMATION. ATTACHMENTS MAY BE ADDED ON THE SUBMISSION FORM:	
☒	A. Included in Federal registries of evidence-based interventions as effective or promising (See resources for links, #2). Please provide links to the website or documents that describe the evidence-base of your requested strategy below: **Please see attached: OJJDP & legacy NREPP Profiles.**
☐	B. Reported (with positive effects on the primary targeted outcome) in peer-reviewed journals (See resources for guiding questions, #3). Please provide links to the relevant articles below:
☐	C. Supported by sources of information (other than Federal registries or peer-reviewed journals) and the consensus judgment of informed experts (see resources for guidelines, #4). Please explain how your proposal meets each of the guidelines described in Resource #4:
5b. Are you planning to make any modifications to the strategy for implementation in your region? If yes, please describe.	
☐	Yes Modification description
☒	No

6. How does your region plan to evaluate and sustain the proposed strategy (include an evaluation plan)? What are your plans to sustain or build the resources necessary to implement the strategy with fidelity (staff, stakeholder, physical, etc.)?
The Families in Action curriculum offers an evaluation plan including pre and posttests that we will use with fidelity. Our region proposes to run the program with Anytown Teen Center as a pilot for this year. If the program is a good fit, we will develop a step-down funding model with the Teen Center to build their capacity to offer the programming on their own.

Please allow 10 business days for the review of your information; members of the EBPW may reach out for clarification.

Resources:

1. Utility and Feasibility Checks:

   Utility Checks

   - Is the intervention appropriate for the population identified in the community needs assessment and community logic model? Has the intervention been implemented successfully with the same or a similar population? Are the population differences likely to compromise the results?
   - Is the intervention delivered in a setting similar to the one planned by the community? In what ways is the context different? Are the differences likely to compromise the intervention's effectiveness?
   - Is the intervention culturally appropriate? Did members of the culturally identified group participate in developing it? Were intervention materials adapted to the culturally identified group?
   - Are implementation materials (e.g., manuals, procedures) available to guide intervention implementation? Are training and technical assistance available to support implementation? Are monitoring or evaluation tools available to help track implementation quality?

   Feasibility Checks

   - Is the intervention culturally feasible, given the values of the community?
   - Is the intervention politically feasible, given the local power structure and priorities of the implementing organization? Does the intervention match the mission, vision, and culture of the implementing organization?
   - Is the intervention administratively feasible, given the policies and procedures of the implementing organization?
   - Is the intervention technically feasible, given staff capabilities, time commitments, and program resources?
   - Is the intervention financially feasible, given the estimated costs of implementation (including costs for purchase of implementation materials and specialized training or technical assistance)?

2. Federal Registries:
   - Evidence-Based Practices Resource Center: https://www.samhsa.gov/ebp-resource-center;
   - OJJDP Model Programs Guide: https://www.ojjdp.gov/mpg/;
   - Exemplary and Promising Safe, Disciplined and Drug-Free Schools Programs Sponsored by the U.S. Department of Education: https://www.lions-quest.org/wp-content/uploads/2015/11/exemplary01.pdf;
   - Guide to Clinical Preventive Services Sponsored by the Agency for Healthcare Research and Quality [AHRQ]: https://www.ahrq.gov/research/findings/evidence-based-reports/index.html;
   - Guide to Community Preventive Services Sponsored by the Centers for Disease Control and Prevention [CDC]: https://www.thecommunityguide.org/

3. Key elements addressed in most peer-reviewed journal articles with guiding questions for using peer-reviewed journals:
    - A defined conceptual model that includes definitions and measures of intermediate and long-term outcomes. Does the article describe the theory or provide a conceptual model of the intervention and link the theory or model to expectations about the way the program should work? Does the article describe the connection of the theory or the conceptual model to the intervention approach, activities, and expected outcomes in sufficient detail to guide your decision?
    - Background on the intervention evaluated. How closely does the problem targeted by the intervention match the identified needs of your community? Does the article adequately describe the proposed mechanism of change of the intervention? Are the structure and content of the intervention described in enough detail? Is the context or setting of the intervention described to an extent that allows you to make an informed decision concerning how well it might work in the communities targeted?
    - A well-described study population that includes baseline or "pre–intervention" measurement of the study population and comparison or control groups included in the study. Does the article describe in detail the characteristics of the study population and the comparison or control groups used? How well does the study population match your local target group?
    - Overall quality of study design and data collection methods. Does the article describe how the study design rules out competing explanations for the findings? Are issues related to missing data and attrition addressed and satisfactorily resolved? Did the study methodology use a combination of strategies to measure the same outcome using different sources (e.g., child, parent, teacher, archival)?
    - Analytical plan and presentation of the findings. Does the article specify how the analytical plan addresses the main questions posed in the study? Do the analyses take into account the key characteristics of the study's methodology? Does the article report and clearly describe findings and outcomes? Are the findings consistent with the theory or conceptual model and the study's hypotheses? Are findings reported for all outcomes specified?
    - A summary and discussion of the findings. Does the discussion draw inferences and conclusions that are clearly related to the data and findings reported?

4. When selecting interventions based on other sources of supporting information, **all four of the following guidelines should be met*:**
    - Guideline 1: The intervention is based on a theory of change that is documented in a clear logic or conceptual model;
    - Guideline 2: The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature;
    - Guideline 3: The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; and
    - Guideline 4: The intervention is reviewed and deemed appropriate by a panel of informed prevention experts (RPP's Evidence-Based Programs Workgroup) that includes: well-

qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review, local prevention practitioners, and key community leaders as appropriate (e.g., officials from law enforcement and education sectors or elders within indigenous cultures).

**Guideline 4 is to be determined after submission of Strategy Proposal to the Evidence Based Practices Workgroup, not before.*

Anytown Epidemiological Profile

Adapted from SAMHSA Prevention Fellowship Program Training 7/25-26/2016

Background

Anytown has a population of 4,245 people. Twenty-eight percent of the population is under age 18, 8% are age 18-24, 21% are age 25-44, 25% are age 45-64, and 18% are age 65 and older. Anytown residents identify as White (88%), Hispanic/Latino (10%), African-American (1%), and American Indian (1%). The median household income is $30,100 compared to the state's median of $47,000 (factfinder.census.gov). Approximately 17% of Anytown residents live below the poverty line as compared to 8% in the state. Seventy-five percent of the population is a high school graduate or higher, and 12% has a bachelor's degree or higher. Sixty-one percent of the population age 16 and older is in the labor force (factfinder.census.gov).

Anytown is located in Anycounty. Anycounty is the county with the highest number of craft brewers and distillers in the state (anystatenews.com). The state has also recently passed legislation to make a retail marijuana market legal, but it will not be enacted until July 2022 (AnystateLeg.gov/Act123).

Alcohol Use

Youth reporting past 30-day use of alcohol

	Anytown				State			
	2011	2013	2015	2017	2011	2013	2015	2017
9th Grade-Number	27	26	24	26	16,503	13,619	12,022	10,987
9th Grade-Percent	41%	39%	33%	39%	37%	30%	28%	24%
12th Grade-Number	35	35	31	33	16,465	15,947	15,244	16,390
12th Grade-Percent	72%	71%	67%	69%	54%	52%	48%	48%

Youth reporting binge drinking (having 5 or more drinks in a row on one occasion) in the past two weeks

	Anytown				State			
	2011	2013	2015	2017	2011	2013	2015	2017
9th Grade-Number	16	13	11	17	9,432	7,548	6,871	5,937
9th Grade-Percent	24%	19%	15%	26%	20%	16%	15%	13%
12th Grade-Number	28	27	19	22	10,618	10,566	10,307	10,302
12th Grade-Percent	55%	54%	40%	49%	34%	33%	32%	30%

Adults reporting binge drinking (having 5 or more drinks in a row on one occasion) in the past 30 days

	Anytown				State			
	2017	2013	2015	2017	2011	2013	2015	2017
Ages 18-24	38%	37%	35%	40%	32%	27%	19%	29%
Ages 25-34	36%	35%	33%	35%	31%	26%	23%	26%
Ages 35-44	26%	26%	24%	27%	21%	22%	19%	28%
Ages 45-54	20%	20%	19%	21%	16%	17%	12%	20%
Ages 55+	9%	11%	10%	10%	7%	7%	7%	10%

Alcohol Consequences

Alcohol-related motor vehicle (ARMV) fatalities

	Anytown				State			
	2014	2015	2016	2017	2014	2015	2016	2017
Number	0	0	1	1	197	166	190	163
Rate per 100,000	0.0	0.0	19.5	19.5	3.8	3.2	3.7	3.1

Driving while intoxicated (DWI) arrests

	Anytown				State			
	2014	2015	2016	2017	2014	2015	2016	2017
Number	63	65	86	89 63	30,072	41,951	36,989	34,216
Rate per 100,000	1,228.5	1,282.6	1,676.7	1,7407.7	712.2	802.0	711.7	655.4

Cirrhosis deaths*

	Anytown				State			
	2014	2015	2016	2017	2014	2015	2016	2017
Number	0	0	3	0	320	323	380	378
Rate per 100,000	0.0	0.0	58.5	0.0	6.1	6.2	7.3	7.3

*It is estimated that 40% of liver cirrhosis deaths are alcohol-related

Drug Use

Youth reporting past 30-day marijuana use

	Anytown				State			
	2011	2013	2015	2017	2011	2013	2015	2017
9th Grade-Percent	18%	17%	16%	18%	10%	12%	10%	16%
12th Grade-Percent	19%	18%	16%	18%	20%	19%	18%	20%

Youth reporting past 12-month prescription drug abuse (taken only to get high)

	Anytown				State			
	2011	2013	2015	2017	2011	2013	2015	2017
9th Grade-Number	6	6	7	7	4,114	3,374	3,295	4,123
9th Grade-Percent	9%	9%	9%	9%	9%	7%	8%	9%
12th Grade-Number	3	3	4	5	2,105	2,831	3,138	3,152
12th Grade-Percent	6%	6%	7%	7%	7%	9%	10%	10%

Adults reporting past 30-day marijuana use

	Anytown				State			
	2011	2013	2015	2017	2011	2013	2015	2017
Ages 18-25	16%	16%	15%	17%	15%	14%	14%	20%
Ages 26+	5%	6%	10%	7%	4%	5%	5%	8%

Adults reporting past 12-month prescription drug abuse

	Anytown				State			
	2011	2013	2015	2017	2011	2013	2015	2017
Ages 18-25	12%	12%	11%	9%	11%	11%	11%	9%
Ages 26+	8%	8%	4%	2%	3%	3%	3%	2%

*Two-year averages reported

Drug Consequences

Drug-related deaths

	Anytown				State			
	2011	2013	2015	2017	2011	2013	2015	2017
Number	0	0	0	1	58	54	57	75
Rate per 100,000	0.0	0.0	0.0	19.5	1.1	1.1	1.1	1.5

Narcotics arrests involving marijuana

	Anytown				State			
	2011	2013	2015	2017	2011	2013	2015	2017
Number	1	2	9	7	11,114	11,317	11,489	11,749

Active Parenting of Teens: Families in Action

Date of Review: February 2010

Active Parenting of Teens: Families in Action is a school- and community-based intervention for middle school-aged youth designed to increase protective factors that prevent and reduce alcohol, tobacco, and other drug use; irresponsible sexual behavior; and violence. Family, school, and peer bonding are important objectives. The program includes a parent and teen component. The parent component uses the curriculum from Active Parenting of Teens. This curriculum is based on Adlerian parenting theory, which advocates mutual respect among family members, parental guidance, and use of an authoritative (or democratic) style of parental leadership that facilitates behavioral correction. A teen component was developed to complement the parent component.

Active Parenting of Teens: Families in Action uses a family systems approach in which families attend sessions and learn skills. Each of the sessions includes time during which parents and youth meet in separate groups and time during which all family members meet together. Modules address parent-child communication, positive behavior management, interpersonal relationships for adolescents, ways for families to have fun together, enhancement of the adolescent's self-esteem, and factors that promote school success. Youth are taught about the negative social and physical effects of substance use, they learn general life skills and social resistance skills, and they are provided opportunities to practice these skills. Parents are taught skills to help reinforce their teen's skills training. During the portion of each session involving the youth and parents together, they participate in a family enrichment activity and receive a homework assignment to complete before the next session.

The program is offered in six weekly 2-hour sessions. Typical groups consist of 5 to 12 families. Sessions use videos, group discussion, and role-plays, plus high-energy activities for the teens. Two leaders are needed, one for the parent portion and one for the teen portion, with one of the two leaders also leading the parents and teens combined.

Descriptive Information

Areas of Interest	Mental health promotion Substance abuse prevention
Outcomes	1: Positive attachment to family, school, and peers 2: Participation in counseling 3: Attitudes toward alcohol use 4: Self-esteem
Outcome Categories	Alcohol Family/relationships Mental health
Ages	6-12 (Childhood) 13-17 (Adolescent) 26-55 (Adult)
Genders	Male Female
Races/Ethnicities	Data were not reported/available.
Settings	Home School Other community settings
Geographic Locations	Rural and/or frontier
Implementation History	Active Parenting of Teens: Families in Action was developed by Active Parenting Publishers in conjunction with Ausable Valley Mental Health Services of Tawas City, Michigan, with a 3-year grant from the Center for Substance Abuse Prevention. The program uses the Active Parenting of Teens (2nd Edition) curriculum as its

	basis. Following the evaluation of the Active Parenting of Teens curriculum, the full Active Parenting of Teens: Families in Action curriculum--including the teen component--was published in 2000. Over 100,000 parents and teens have participated in the program at an estimated 1,500 sites. The program has been used in the United States and in the Bahamas, Bermuda and Cayman Islands (United Kingdom), Canada, Kuwait, Sint Maarten (Netherlands Antilles), and Singapore.
NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: No Evaluated in comparative effectiveness research studies: No
Adaptations	The program has been translated into Arabic, Chinese, Japanese, Korean, Spanish, and Swedish. An audiotape version of the Parent's Guide, as well as activities and group exercises, have been developed for use with parents who have poor reading skills or visual impairment.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the applicant.
IOM Prevention Categories	Universal

Outcomes

Outcome 1: Positive attachment to family, school, and peers	
Description of Measures	Students and parents completed a self-report survey that assessed the following: • Family cohesion, measured with the 9-item Cohesion subscale from the Family Environment Scale. This scale assesses the degree of commitment, help, and support family members provide one another. The scale has a true/false response option. The items were averaged to obtain one family cohesion score for the student and one for the parent. • Family fighting, measured with a 4-item scale developed for this study. A sample item is "How many times have you yelled at your child (parent)?" Scores were calculated separately for the student and the parent. • School attachment, measured with the 10-item Attachment to School subscale from the Effective School Battery. This subscale uses a 2-point response option and assesses whether respondents "like" or "don't like" the student's school, teachers, principal, counselors, and classes. The items were averaged to obtain one school attachment score for the student and one for the parent. • Participation in school activities, measured by asking respondents whether they are involved in different activities at the child's school (e.g., member of a club or team, attended a PTA meeting). Using a yes/no response format, students reported on their involvement in three school activities, and parents reported on five school activities. One average score was computed for the student and one for the parent. • Students' peer attachment (completed by students only), measured with a 15-item subset of the Inventory of Peer Attachment, which uses a true/false response scale to assess perceptions of friends' supportiveness. Items were averaged to obtain an overall peer attachment score.
Key Findings	In one study, short-term effects of program participation were examined by comparing pretest, posttest, and 10-week follow-up data, which were collected only for intervention participants. Long-term effects were examined by comparing the intervention and control groups at 1-year follow-up. A second study was conducted with a new cohort of students and parents 1 year later. Long-term effects were examined by comparing the intervention and control groups at 1-year follow-up. Findings from these studies included the following: • Family cohesion: In the first study, parents who participated in the intervention reported significantly greater family cohesion at posttest than they did at pretest ($p < .006$). This effect was not significant at the 10-week follow-up. In the second study, students who received the intervention reported greater family cohesion than students in the control group at 1-year follow-up ($p = .03$). • Family fighting: In the second study, students receiving the intervention reported less family fighting at the 1-year follow-up than students in the control group ($p = .002$). This effect was not significant for parents. • School attachment: In the first study, male students who received the intervention scored significantly higher than did male students in the control group on school attachment at 1-year follow-up ($p < .03$). This effect was not significant for female students. However, the second study found that students receiving the intervention reported greater school attachment at the 1-year follow-up than students in the control group ($p = .01$). No significant gender differences were found in this study. No significant differences for parents were found in either study. • Participation in school activities: In the first study, parents receiving the intervention reported

	more involvement in school activities at 1-year follow-up than did nonparticipating parents ($p < .002$). There were no significant differences for students. • Peer attachment: In the first study, students receiving the intervention reported significantly greater peer attachment at posttest than at pretest ($p < .04$). This effect was not significant at the 10-week follow-up. However, male students who received the intervention reported significantly greater peer attachment than male nonparticipants at 1-year follow-up ($p < .05$). This long-term program effect was not significant for female students.
Studies Measuring Outcome	Study 1, Study 2
Study Designs	Quasi-experimental
Quality of Research Rating	2.6 (0.0-4.0 scale)

Outcome 2: Participation in counseling	
Description of Measures	Participation in counseling was measured by a 3-item self-report scale developed for this study to assess whether the student or parent had talked with a psychologist, social worker, or school counselor. Responses were averaged to obtain one overall score for the student and one for the parent.
Key Findings	Students ($p < .004$) and parents ($p < .001$) who participated in the intervention reported more involvement in family counseling at 1-year follow-up compared with their counterparts in the control group, after controlling for baseline scores.
Studies Measuring Outcome	Study 1
Study Designs	Quasi-experimental
Quality of Research Rating	2.2 (0.0-4.0 scale)

Outcome 3: Attitudes toward alcohol use	
Description of Measures	To assess attitudes toward adolescent alcohol use, a 5-item alcohol attitudes scale was created by adapting items from the Parents scale in the Program Evaluation Handbook: Drug Abuse Education. The scale uses a 4-point response option ranging from "definitely yes" to "definitely no." Questions for students are phrased in terms of their friends (e.g., "Would you be upset if your friend took you to a party where alcohol was being used?"). Parents answered parallel items about their child's use of alcohol (e.g., "Would you be upset if your teenager got drunk on a special occasion like a graduation party or New Year's Eve?"). Students and parents were also asked, "What age do you think that it is O.K. to drink more than a sip of alcohol?"
Key Findings	In one study, short-term effects of program participation were examined by comparing pretest, posttest, and 10-week follow-up data, which were collected only for intervention participants. Long-term effects were examined by comparing the intervention and control groups at 1-year follow-up. A second study was conducted with a new cohort of students and parents 1 year later. Long-term effects were examined by comparing the intervention and control groups at 1-year follow-up. Findings from these studies included the following: • Opposition to adolescent alcohol use: In the first study, at 1-year follow-up, male students who received the intervention reported significantly more opposition to adolescent alcohol use than did male students in the control group ($p < .003$). These program effects were not significant among female students. In the second study, parent participants, as compared with parents in the control group, reported stronger opposition to adolescent alcohol use ($p = .04$). • Age at which it is "O.K." to drink alcohol: In the first study, the mean acceptable drinking age (in years) according to parents receiving the intervention increased from pretest to posttest (20.10 vs. 20.55; $p < .02$) and from pretest to 10-week follow-up (20.10 vs. 21.09; $p < .04$). At 1-year follow-up, the mean acceptable drinking age reported by male students receiving the intervention was higher than the age reported by male students in the control group (19.96 vs. 16.27; $p < .03$). No significant difference was seen among female students. In the second study, at 1-year follow-up, intervention group students reported a higher mean age than control group students (18.08 vs. 17.16; $p = .04$), and intervention group parents reported a higher mean age than control group parents (20.84 vs. 19.82; $p = .05$). No significant gender differences were found in this study.

Studies Measuring Outcome	Study 1, Study 2
Study Designs	Quasi-experimental
Quality of Research Rating	2.6 (0.0-4.0 scale)

Outcome 4: Self-esteem	
Description of Measures	Students' self-esteem was measured with the 16-item self-report Behavior subscale from the Piers-Harris Children's Self-Concept Scale. This subscale, which uses a yes/no response option, measures positive self-esteem regarding how well one is handling responsibilities at home and at school. Responses are averaged to obtain an overall self-esteem score.
Key Findings	Students who participated in the intervention reported greater self-esteem at 1-year follow-up compared with students in the control group (p = .003), after controlling for baseline scores.
Studies Measuring Outcome	Study 2
Study Designs	Quasi-experimental
Quality of Research Rating	2.7 (0.0-4.0 scale)

Study Populations

The studies reviewed for this intervention included the following populations, as reported by the study authors.

Study	Age	Gender	Race/Ethnicity
Study 1	6-12 (Childhood) 13-17 (Adolescent) 26-55 (Adult)	52.7% Female 47.3% Male	Data not reported/available
Study 2	6-12 (Childhood) 13-17 (Adolescent) 26-55 (Adult)	52% Male 48% Female	Data not reported/available

Quality of Research

The documents below were reviewed for Quality of Research. Other materials may be available. For more information, contact the developer (s).

Study 1

Pilgrim, C., Abbey, A., Hendrickson, P., & Lorenz, S. (1998). Implementation and impact of a family-based substance abuse prevention program in rural communities. Journal of Primary Prevention, 18(3), 341-361.

Study 2

Abbey, A., Pilgrim, C., Hendrickson, P., & Buresh, S. (2000). Evaluation of a family-based substance abuse prevention program targeted for the middle school years. Journal of Drug Education, 30(2), 213-228. PubMed

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating

1: Positive attachment to family, school, and peers	3.6	3.3	1.8	2.0	2.0	3.0	**2.6**
2: Participation in counseling	2.0	2.0	2.0	2.0	2.0	3.0	**2.2**
3: Attitudes toward alcohol use	3.8	3.3	1.8	2.0	2.0	2.8	**2.6**
4: Self-esteem	4.0	4.0	1.5	2.0	2.0	2.5	**2.7**

Study Strengths

The measures in both studies were appropriate to the goals and hypotheses for the program. In general, the studies used established measures with known psychometric properties. In addition, reliability estimates were presented for each measure, including those developed by the researchers, where applicable. The scales created by the researchers have face validity. The researchers attempted to compensate for initial differences found between participants and nonparticipants by conducting ANCOVAs, using as covariates the students' and parents' demographic characteristics and baseline outcome measures for which there were differences.

Study Weaknesses

Fidelity of implementation was not described in sufficient detail to demonstrate that the program was implemented as intended. The high attrition rate, though not uncommon in school-based intervention research, was considerable (greater than 20%) in both studies. These quasi-experimental studies compared volunteer families with families that elected not to participate, thus creating potential selection bias; in fact, a number of significant baseline differences were found, including socioeconomic status, which was lower among participants than nonparticipants. Because participants completed questionnaires more frequently than did nonparticipants, testing effects are also a potential confounding factor. The group sizes for the student intervention groups (all less than 50) raise serious questions about statistical power.

Readiness for Dissemination

The documents below were reviewed for Readiness for Dissemination. Other materials may be available. For more information, contact the developer(s).

Dissemination Materials

Active Parenting Publishers. (2002). Active Parenting Now & Active Parenting of Teens training video [DVD]. Atlanta, GA: Author.

Active Parenting Publishers. (2009). Training of trainers seminar. Atlanta, GA: Author.

Active Parenting Publishers. (n.d.). Active Parenting of Teens: Families in Action quality assurance protocol and handouts. Atlanta, GA: Author.

Active Parenting Publishers. (n.d.). Leader training workshop evaluation form. Atlanta, GA: Author.

Popkin, M. H. (2002). Leader training workshop participant's guide for Active Parenting Now and Active Parenting of Teens. Atlanta, GA: Active Parenting Publishers.

Popkin, M. H., & Hendrickson, P. (2002). Active Parenting of Teens: Families in Action for parents program kit. Atlanta, GA: Active Parenting Publishers.

Popkin, M. H., & Hendrickson, P. (2002). Active Parenting of Teens: Families in Action parents-only materials kit. Atlanta, GA: Active Parenting Publishers.

Popkin, M. H., & Hendrickson, P. (2002). Active Parenting of Teens: Families in Action teen edition program kit. Atlanta, GA: Active Parenting Publishers.

Program Web site, http://www.activeparenting.com

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
3.9	3.4	3.2	**3.5**

Dissemination Strengths

The materials provided to guide implementation are thorough, consistent, and well presented. Instructions for preparing to implement the program are detailed and logical, and guidance on recruiting appropriate program participants is excellent. The developer offers a variety of onsite trainings for leading the intervention with teens only, parents only, or parents and teens, and also offers train-the-trainer opportunities. Some trainings are also available in Spanish. A comprehensive set of fidelity tools, outcome measures, and data collection instruments support quality assurance.

Dissemination Weaknesses

The skills and qualifications needed to serve as a program leader are not fully described. There is no formalized curriculum for program leader training or the training of trainers; only an explanation of implementation materials is available. Quality assurance tools are not an integrated or emphasized component of implementation and training. No information is provided on how data collected should be used to improve program delivery.

Costs

The information below was provided by the developer and may have changed since the time of review. For detailed information on implementation costs (e.g., staffing, space, equipment, materials shipping and handling), contact the developer.

Item Description	Cost	Required by Program Developer
Program Kit	$489 each	Yes
Jump-Start Package (includes Program Kit plus 15 additional copies each of the Parent's Guide, Teen's Guide, and parent and teen completion certificates, as well as PowerPoint presentations for use with parents, teens, and parents and teens combined)	$799 each	No
Additional Parent's Guide	$14.95 per parent	Yes
Additional Teen's Guide	$11.95 per teen	Yes
Additional completion certificates	$6 for 15	No
Parent handouts	$24 per set (reproducible)	No
PowerPoint presentation	$49 each	No
2-day, on-site leader training	$165 per participant for groups of 12 or more, plus travel expenses	No
Technical assistance/consultation	Free	No
Quality assurance materials	Free	No

Additional Information

Quantity discounts are available for program guides.

Replications

Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.

Chen, M. (2006). Active Parenting Now and Active Parenting of Teens national field studies.

CSR, Incorporated. (1994). Center for Substance Abuse Prevention High Risk Youth Demonstration Grant Program. CSR cross-site evaluation: Families in Action.

Leonardson, G. (1991). Draft report on Active Parenting of Teens project. Watertown, SD: Northeastern Drug and Alcohol Prevention Resource Center.

Mullis, F. (1999). Active Parenting: An evaluation of two Adlerian parent education programs. Journal of Individual Psychology, 55(2), 225-232.

National Prevention Implementation Program. (1989). Parenting as prevention: Preventing alcohol and other drug use problems in the family. Prepared for the Office for Substance Abuse Prevention of the Alcohol, Drug Abuse, and Mental Health Administration, U.S. Department of Health and Human Services.

Popkin, M. H. (1989). Active Parenting: A video-based program. In M. Fine (Ed.), The second handbook on parent education: Contemporary perspectives (pp. 77-98). San Diego, CA: Academic Press.

Contacts

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- **http://www.activeparenting.com**

The NREPP review of this intervention was funded by the Center for Substance Abuse Prevention (CSAP).

Program Profile: Active Parenting of Teens: Families in Action

Evidence Rating: Promising - One study

Date: This profile was posted on *July 20, 2012*

Program Summary

A family-based alcohol, tobacco, and other-drug abuse prevention program that targets families with middle school children. The program is rated Promising. Participants reported greater family cohesion, school attachment, higher levels of self-esteem, and an older age for alcohol consumption than the control group. Also, program parents reported stronger attitudes against minor alcohol use. There was no significant difference between the control and treatment group on attitudes of tobacco use.

Program Description

Program Goals/Theory

Active Parenting of Teens: Families in Action is a family-based alcohol-, tobacco-, and other drug (ATOD) abuse–prevention program that targets families with children entering middle school. The specific goals of Active Parenting of Teens: Families in Action are to 1) increase youths' positive attachment to their families and their schools, 2) increase their positive peer relations, 3) promote unfavorable attitudes toward the use of ATODs, and 4) increase self-esteem. The goals for parents are very similar: 1) increase positive attachment to their families; 2) increase positive involvement in their children's schools; and 3) promote unfavorable attitudes toward the use of ATODs by minors.

The program is based on a social developmental model that emphasizes the contributions of family, school, and peers to adolescent development and proposes that if a youth bonds with prosocial individuals and social groups he or she is less likely to use ATODs. The program teaches a combination of general life skills and social resistance techniques and provides opportunities for youths to practice these skills. It also incorporates modules promoting self-esteem, since Active Parenting of Teens: Families in Action staff hypothesized that youths who feel good about themselves are more likely to feel that they can succeed in school and make friends.

Target Population

The program serves both parents and their children, specifically concentrating on families with children entering middle school or between the ages of 11 and 14. The program can be used with both males and females.

Program Activities

The Active Parenting of Teens: Families in Action program includes several components or modules, which promote youths' attachment to their family, school, and prosocial peers. These address a wide range of topics, including parent–child communication, positive behavior management, adolescent alcohol and tobacco use, interpersonal relationships for adolescents, school success, family fun activities, and enhancement of adolescent self-esteem.

The program is offered several times each year in middle and junior high schools as an afterschool activity. There are six 2½-hour sessions. Sessions are administered once a week for 6 weeks. Typically, the sessions are held in classrooms on weekday evenings, with groups ranging from 5 to 12 families. The core instructional component is the use of videotaped vignettes that show different families handling a variety of problems. There is also a parent handbook and an accompanying student handbook and curriculum.

Sessions 1 and 2 concentrate on positive thinking and on using positive, rather than negative, strategies to reach behavioral goals. The sessions also discuss normal adolescent development and emphasize maintaining self-esteem during this difficult period. Sessions 3 and 4 teach interpersonal communication skills and demonstrate the logical consequences of individual actions as part of a family management style. Youths are taught that their actions have

Program Snapshot

Age: 11 - 14

Gender: Both

Race/Ethnicity: Black, American Indians/Alaska Native, Asian/Pacific Islander, Hispanic, White

Geography: Rural

Setting (Delivery): School

Program Type: Family Therapy, Leadership and Youth Development, Alcohol and Drug Prevention

Targeted Population: Families

Current Program Status: Active

Listed by Other Directories: Model Programs Guide, National Registry of Evidence-based Programs and Practices

Program Developer:
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President
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consequences; parents are taught how to help their children make appropriate choices. Sessions 5 and 6 focus on applying the resistance skills and concepts from the first four sessions to the prevention of ATOD usage, early sexual activity, and violence. Every session is designed to teach children and parents separately and then bring them together for group activities. Skills are taught through role-playing activities and group discussion of how to handle different situation.

Evaluation Outcomes

Study 1

Family Measures

Abbey and colleagues (2000) report findings from the 1-year follow-up survey. Students who participated in the Active Parenting of Teens: Families in Action program reported having significantly greater family cohesion and significantly lower levels of family fighting than students in the comparison group. However, there were no significant differences between the treatment and control groups on measures of family communication.

School Attachment and Self-Esteem

Students that participated in the program reported greater school attachment and higher levels of self-esteem than students in the comparison group.

Peer Support

There were no significant differences on measures of peer support.

Attitudes Toward Alcohol Use

Treatment group students reported that it was okay to consume alcohol at an age that was significantly older than the age that students in the comparison group reported. Specifically, treatment group students believed that it was acceptable to drink more than a sip of alcohol at age 18 where the comparison group students reported that it was acceptable to drink more than a sip of alcohol at age 17.

Attitudes Toward Tobacco Use

There were no significant differences between the treatment group and control group on measures of students' attitudes toward tobacco use.

Parents Results

Parents participating in the program reported significantly stronger attitudes in opposition to alcohol use by minors. Parents in the program also reported that alcohol should not be consumed until an age (about 21 years) that was significantly older than the age that parents in the comparison group reported (about 20 years).

However, no significant program effects were found for parents on measures of school attachment, family cohesion, family fighting, family attachment, and attitudes toward tobacco use.

Evaluation Methodology

Study 1

Abbey and colleagues (2000) used a quasi-experimental design with nonequivalent comparison groups to evaluate the effectiveness of the Active Parenting of Teens: Families in Action program at preventing alcohol, tobacco, and other drug use (ATOD). Four schools in a rural county of northeastern Michigan were used in the evaluation. Almost the entire population in the county was white (96 percent), and 21 percent of the families were below the poverty line.

A baseline survey was administered in fall of the school year to all students; the same survey was administered 1 year later as a follow-up. Participation in Active Parenting of Teens: Families in Action was completely voluntary. Those families who participated in the program served as the treatment group, and those families who did not participate acted as the comparison group. The treatment group had 37 students and 38 parents; the comparison group had 268 students and 134 parents. Parents were mailed a survey with a stamped-and-addressed return envelope to send back to the research team. Treatment students were not significantly different from students in the comparison group. However, treatment parents had significantly lower scores at baseline on attitudes toward tobacco, age at which parents considered it acceptable for their children to drink, and family cohesion. They also reported higher levels of family fighting. That is, the baseline difference favored the comparison group, as the treatment group parents reported more lenient attitudes toward substance use and higher levels of family fighting.

There were several multi-item scales used to measure student and parent attitudes and behavior. Family measures included family cohesion, communication, and fighting. Family cohesion was measured with a nine-item subscale from the

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Family Environment Scale. Family cohesion assessed the degree of commitment, help, and support that family members provided one another, with higher scores reflecting greater cohesion. Family communication and family fighting were measured with a nine-item scale and a four-item scale, respectively, created by the research team. Example questions included "How many times have you discussed your feelings with your parent (child)?" and "How many times have you yelled at your child (parent)?" School attachment was measured with a 10-item subscale from the Effective School Battery. Attitudes toward ATOD use (rather than actual use) were measured with a seven-item scale that was adapted from previously existing scales. Students and parents both were asked about their attitudes toward ATOD use by minors.

Peer support and self-esteem were measured only for students. Perceptions of friends' supportiveness were measured with a 15-item subset of the Inventory of Peer Attachment. Self-esteem was measured with the 16-item behavior subscale from the Piers–Harris Children's Self-Concept Scale. All survey items and scales used had high Cronbach coefficient alphas and are considered reliable.

One-way analyses of variance (ANOVAs) were used to determine the significant differences between program participants (treatment group) and nonparticipants (comparison group). Baseline differences were accounted for in all of the analyses by treating baseline scores and demographics as covariates.

Cost

Supplies for the program can be purchased through the Active Parenting™ Publishers Web site: http://www.activeparenting.com/shop.

Implementation Information

Information on Active Parenting training opportunities is available on the Active Parenting™ Publishers Web site: http://www.activeparenting.com/training. Leader Training Workshops, Online Leader Training Workshops, and Training of Trainers Workshop are available for anyone interested in implementing the program.

Evidence-Base (Studies Reviewed)

These sources were used in the development of the program profile:

Study 1

Abbey, Antonia, Colleen Pilgrim, Peggy Hendrickson, and Sue Buresh. 2000. "Evaluation of a Family-Based Substance Abuse Prevention Program Targeted for the Middle School Years." *Journal of Drug Education* 30(2): 213–28.

Additional References

These sources were used in the development of the program profile:

Active Parenting™ Publishers Web site. 2012. http://www.activeparenting.com/

Mullis, Fran. 1999. "Active Parenting: An Evaluation of Two Adlerian Parent Education Programs." *The Journal of Individual Psychology* 55(2):225–32.

Pilgrim, Colleen, Antonia Abbey, Peggy Hendrickson, and Sue Lorenz. 1998. "Implementation and Impact of a Family-Based Substance Abuse Prevention Program in Rural Communities." *Journal of Primary Prevention* 18(3):341–61. (This study was reviewed but did not meet CrimeSolutions.gov criteria for inclusion in the overall program rating.)

Popkin, Michael H. 1989. "Active Parenting: A Video-Based Program." In Martin J. Fine (ed.). *The Second Handbook on Parent Education: Contemporary Perspectives*. New York, NY: Academic Press Inc.