INTERVENTION PROGRAMS FOR CHILDREN OF SUBSTANCE ABUSING PARENTS: REALIST REVIEW AND PROGRAM EVALUATION STUDY

by

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Abstract

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Substance abuse is a pervasive issue affecting Canadian families, and a substantial number of children are impacted by alcohol or drug abusing parents. Children exposed to parental substance misuse are at increased risk for negative psychological, emotional, developmental, and behavioural outcomes, and a substantial proportion will go on to experience substance use issues later in life. Early intervention is key to providing support for these children and ultimately disrupting the family cycle of addiction. However, few family-based programs for children of substance abusing families are reported in the literature and information on program theory is lacking. A 2-study dissertation was conducted in order to address these gaps. First, a realist review study was undertaken to systematically review existing evaluations of family-based interventions aimed at improving psychosocial outcomes for children of substance abusing parents. A systematic search of academic and grey literature uncovered over 30 documents spanning 7 different intervention programs. Data were extracted on contexts, mechanisms, and outcomes for each program. Four demi-regularities, or patterns of program functioning, were found to account for the effectiveness of programs included in this review: 1) opportunities for positive parent-child interactions, 2) supportive peer-to-peer relationships, 3) the power of knowledge, and 4) engaging hard to reach families using strategies that are responsive to socio-economic needs and matching services to client lived experience. Second, a program evaluation

of the Renascent Children's Program was conducted in order to determine effective implementation and program outcomes for participating children and parents. A repeated measures, mixed methods design was used with 19 families (26 parents and 26 children) who enrolled in the program over a 16 month period. Results indicate that the Children's Program yields significant improvements in child emotional and depressive symptoms, child conduct behaviours, parenting skills, parent emotion regulation, family functioning, and family communication. High levels of implementation fidelity were also found. These two dissertation studies shed light on theoretical process of family-based interventions for children of substance abusing parents and provide preliminary evidence of effectiveness of the Children's Program.

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INTRODUCTION

Substance abuse is a serious concern in Canada, and its impact can extend far beyond the individual substance user. Children and family members often experience adverse outcomes as a result of parental substance abuse (Francis, 2010; Johnson & Leff, 1999). There is a need for evidence-based family intervention programs that target this population (Emshoff & Price, 1999). The current study seeks to address significant gaps in the literature, namely the lack of a comprehensive and explicit theoretical framework for family-based interventions for children of substance abusing parents (COSAPs) and the limited evaluation research on COSAP interventions. To address these research gaps, a two-study dissertation project was undertaken. Study 1 systematically reviewed and synthesized existing research on family-based COSAP interventions using a realist approach. Study 2 evaluated the implementation of the Renascent Children's Program and measured outcomes for families participating in this intervention. A mixed-methods approach using questionnaire, interview, and administrative data was adopted.

Background

Consumption of alcohol and illicit drugs is common among Canadian adults. According to the Canadian Alcohol and Drug Use Monitoring Survey, 79% of Canadians aged 15 and older reported consuming alcohol within the past year, 25% of whom also reported engaging in heavy drinking at least once a month (Health Canada, 2011). Heavy drinking is defined as five or more drinks per occasion for men, and four or more drinks per occasion for women (Health Canada, 2011). Illicit drug use is estimated at approximately 9.4% of the Canadian population (Health Canada, 2011). Prevalence of substance use (both alcohol and drugs) problems in Canada is estimated to be 11% (Veldhuizen, Urbanoski, & Cairney, 2007).

Substance use is often conceptualized along a continuum ranging from non-problematic social use to substance abuse to more severe dependence (Rinaldi, Steindler, Wilford, & Goodwin, 1988; Straussner, 2011). In clinical practice, the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) defines substance use disorders as existing along a continuum of severity, and no longer distinguishes between abuse and dependence as separate diagnoses (American Psychiatric Association, 2013). Most research literature on COSAPs, however, refer to addiction and substance abuse in the context of childhood exposure to parental alcohol or drug use, rather than in diagnostic terms. Accordingly, studies typically focus on the impact of parental substance use on children rather than measurement of substance use severity. Distinctions are often, but not always, reported between parental alcohol, drug, and poly-substance use.

Despite research tracking substance abuse in Canada at the individual level, there is a general lack of data on how family members might be affected. It is difficult to estimate the precise number of individuals who are impacted by a family member with addiction in Canada. The most recent version of the Canadian Addiction Survey reports that a third of Canadian adults indicated being harmed within the past year because of another person's drinking, and 10% reported family or marriage problems because of others' alcohol use (Health Canada, 2004). These self-report data likely underestimate the problem, however, due to shame and stigma associated with addiction. The sample was also limited to adults and thus the impact on children was not explored or reported.

American data estimate that 1 in 4 children under the age of 18 are exposed to alcohol abuse or dependence in the family (Slutske et al., 2008) and that between 8 and 11 million children are currently living with a parent who abuses drugs or alcohol (Emshoff & Price, 1999;

Lam & O'Farrell, 2011). While comparable data from Canada was not found, the Children's Aid Society (CAS) estimates that between 40-80% of the children who come in contact with child welfare services in Canada live in families with addiction problems (Ontario Association of Children's Aid Societies, 2010). Approximately 25,000 families in Ontario receive ongoing services from CAS every year (Ontario Association of Children's Aid Societies, 2010).

It is clear that many families are impacted by substance abuse. Family members carry considerable burden in supporting substance abusing relatives and often provide unacknowledged health and social support, suggesting that "the cost of substance misuse to families and societies is extensive and significant" (Coppello, Templeton, & Powell, 2010, p. 67). Children are particularly vulnerable when exposed to parental substance abuse. Decades of research have demonstrated that children of substance abusers are at increased risk for negative psychosocial and developmental outcomes, and a substantial proportion will go on to develop a substance use disorder themselves (Johnson & Leff, 1999; Straussner, 2011).

Negative Impacts of Parental Substance Abuse

The negative consequences for children living in a substance abusing household are well documented. Such children are at increased risk for a range of psychological, behavioural, cognitive, and social problems (Francis, 2010; Johnson & Leff, 1999; Lieberman, 2000). Children of substance abusers are also more likely to themselves engage in substance abuse later in life, as intergenerational transmission of addiction has been well documented in this population (Johnson & Leff, 1999).

Psychological Impacts

Studies comparing children from substance abusing families to those from non-substance abusing households have reported higher rates of depression, anxiety, and other psychiatric

diagnoses (Gruber & Taylor, 2006; Johnson & Leff, 1999; Ritter, Stewart, Bernet, Coe, & Brown, 2002). A recent review revealed that children exposed to parental drug abuse were more likely to have a psychiatric diagnosis of any kind, with major depression and anxiety being the most prevalent (Barnard & McKeganey, 2004). Research on alcohol abusing families reveals a similar pattern. Wilens and colleagues (2002) report that among children aged 6 – 18, those with at least one alcohol abusing parent had significantly higher rates of depression, phobia, and separation anxiety as compared to controls. Diaz and colleagues (2008) confirmed this finding, where children with a substance abusing parent were more likely to display depressive and anxious symptoms than controls.

Studies of young adults from alcoholic families also confirm higher rates of depression, phobia, and generalized anxiety (Sher, Walitzer, Wood, & Brent, 1991). A longitudinal study of children of alcohol abusing parents, followed from adolescence to young adulthood (N = 407, mean age at follow-up = 20 years), reported that they were at significantly elevated risk of depressive disorder and marginally elevated risk of anxiety disorders, as compared to controls (Chassin, Pitts, Delucia, & Todd, 1999).

Emotional and Behavioural Impacts

Increased risk of emotional and behavioural problems is often found in this population (Peleg-Oren & Teichman, 2006; Velleman & Templeton, 2007). For example, feelings of loneliness and social isolation are found to be prevalent among COSAPs, as are difficulty forming peer relationships (Bernard & McKeganey, 2004; Kelley et al., 2010; Kroll, 2004). Further, youth exposure to familial alcohol abuse was found to be related to low self-esteem, particularly in adolescent girls (Ritter et al., 2002).

Children from both alcoholic and drug abusing families were observed to display increased aggression and oppositional behaviours (Barnard & McKeganey, 2004). ADHD and conduct disorders are also frequently diagnosed in this population (Johnson & Leff, 1999). A study comparing children aged 6 – 18 years from opioid dependent, alcohol dependent, and non-substance using families reported that children in the opioid group and the alcohol group had significantly higher rates of conduct disorder as compared to controls (Wilens et al., 2002). Children in the opioid group also displayed higher rates oppositional defiant disorder and attention deficit disorder than controls.

Cognitive and Educational Impacts

There is evidence that children living with parental substance abuse experience inconsistent school attendance patterns due to poor family cohesion or lack of supervision (Barnard & McKeganey, 2004). As a result, COSAPs may experience a negative impact on academic achievement and other cognitive outcomes. Wilens and colleagues (2002) report that children with an opiate or alcohol addicted parent scored lower on the WISC-R and on achievement tests, as compared to controls. COSAPs are also more likely to have repeated a grade at some point during their academic careers (Barnard & McKeganey, 2004; Wilens et al., 2002). Interestingly, a Norwegian study found that among a sample of adolescents, witnessing their parents being drunk was more predictive of poor school adjustment than the extent of parental alcohol use as measured by the CAGE, an alcohol screening questionnaire (Torvik, Rognmo, Ask, Roysamb, & Tambs, 2011).

Transmission of Addiction

A relationship between parental substance abuse and subsequent substance abuse in children has been repeatedly documented in the literature. It is estimated that over 50% of

individuals exposed to parental substance abuse during adolescence will go on to develop their own substance use disorders (Beiderman, Faraone, Monuteaux, & Feighner, 2000), and longitudinal studies indicate that COSAPs are more likely to have a lifetime diagnosis of drug and alcohol abuse or dependence as compared to controls (Chassin et al., 1999; Jennison & Johnson, 1998). Current etiologic theories suggest a combination of genetic and environmental pathways (Johnson & Leff, 1999).

Genetic heritability of alcoholism has been estimated to range from 50-60% (Goldman, Oroszi, & Ducci, 2005; Gruber & Taylor, 2006), although it is difficult to tease out the unique effects of genetics over environment. Twin studies of inherited alcoholism confirm a modest causal effect of direct exposure to parental substance abuse (Slutske et al., 2008). Biederman and colleagues (2000) demonstrated that exposure to parental substance abuse predicted adolescent substance use over and above genetic risk factors and socio-economic status, suggesting a critical role of family environment in understanding substance abuse transmission. It is likely that characteristics associated with the substance abusing family environment, such as inconsistent caretaking, transient living conditions, and attitudes towards drugs and alcohol, have compounding effects on pre-existing genetic risk factors (Gruber & Taylor, 2006).

Family-Level Correlates of Parental Substance Abuse

Literature on parental substance abuse reveals some common characteristics and patterns experienced by families of substance abusers. Correlational research suggests that families in which one or more parents has a substance abuse problem are more likely to experience abuse and domestic violence and be characterized by a chaotic and unstable family environment.

Abuse and Domestic Violence

Substance abuse has been documented as a risk factor for domestic violence (Gruber & Taylor, 2006). Inter-parental conflict is common in substance abusing families and can manifest itself as verbal or physical aggression (Lam & O'Farrell, 2011). Recent reviews suggest that alcohol consumption by either partner is common in a large proportion of domestic assault cases (Klostermann & Fals-Stewart, 1998). For example, in cases of male-to-female physical aggression, rates of domestic abuse are significantly higher on days of substance use than non-use days (Lam & O'Farrell, 2011). Intimate partner violence and child abuse commonly co-occur, with prevalence rates estimated to be around 40% (Appel & Holden, 1998).

A direct link may exist between parental substance abuse and child maltreatment. According to surveys by the National Institute of Mental Health in the US, self-reported alcohol or drug abuse was predictive of physical abuse perpetration, where adults with a history of drug and alcohol abuse were three and four times more likely to report committing physical child abuse and child neglect, respectively (Walsh, MacMillan, & Jamieson, 2003). Parental stress, low frustration tolerance, and poor emotion regulation have been cited as possible consequences of substance abuse, resulting in an increased potential for child abuse (Gruber & Taylor, 2006; Landers, Howsare, & Byrne, 2013). Families with histories of alcohol abuse have been found to have an increased likelihood of using harsh physical punishment with children (Ritter et al., 2002). Parental substance abuse has been reported to result in a two- to three-fold increase in the risk of childhood physical or sexual abuse (Landers, Howsare, & Byrne, 2013; Walsh et al., 2003).

Unstable or Chaotic Environment

Substance abusing families are often characterized by disrupted family roles, poor communication, and lack of predictability (Gruber & Taylor, 2006). The home environment is often marked with instability or chaos due to frequent cycles of relapse or general neglect due to parental substance use (Barnard & McKeganey, 2004). Disrupted family routines and rituals are also common, contributing to an overall lack of structure for COSAPs (Velleman & Templeton, 2007).

Alcohol abuse has been found to correlate with marital separation and divorce, and such households may be more likely to be single parent and low income (Conners et al., 2004; Willens et al, 2002). However, the direction of this relationship is unclear as problem drinking may precipitate or be a consequence of marital discord (Gruber & Taylor, 2006). Regardless, the disruptive nature of substance abuse within the family is associated with a chaotic family environment characterized by frequent residence changes, reduction in family resources, and reduced ability for parents to fulfill appropriate caregiving roles (Gruber & Taylor, 2006).

Theoretical Understanding of Substance Abusing Families

Given the evidence that the repercussions of substance abuse extend beyond the individual abuser, there has been increased recognition for the need to understand the disorder from a family perspective. A number of theoretical models conceptualizing the impact of substance abuse within the family have been proposed in order to explain how exposure to parental substance abuse might result in negative child outcomes. A brief overview of these models is presented below followed by implications for family-based treatment. Note that there is currently no dominant theory of family substance abuse in the literature and all have varying degrees of empirical support.

Addiction as a Family Disease

Family disease orientations view substance abuse as a disease that affects all members of the family (O'Farrell & Fals-Stewart, 1999; White & Savage, 2005). In particular, addiction is viewed as an illness that can progress due to family denial and lack of treatment-seeking (Werner, Joffe, & Graham, 1999). The family disease model contends that family members will display defence mechanisms and codependence in response to substance abuse within the family. Denial and minimization are frequently cited as defence mechanisms used by non-addicted family members in an effort to protect the substance abuser and other family members. Denial may be expressed in response to family members' perceived stigmatization or ignorance as to the true extent of a loved one's addiction (Werner et al., 1999). Minimization is said to occur when other family members attempt to diffuse the impact of the substance abuser by taking on additional roles or making excuses that enable addictive behaviour (Werner et al., 1999).

Codependence, another hallmark of the disease model, is defined as an overreliance on others for approval and self-worth, excessive caretaking and rescuing behaviours, and compulsive tendencies that perpetuate these characteristics (Hurcom, Copello & Orford, 2000). Codependence is conceptualized as a symptom developed in response to a diseased family system so as to protect the substance abuser from the negative consequences associated with alcohol and drug use and enable them to continue engaging in substance abuse (O'Farrell & Fals-Stewart, 1999; Prest & Protinsky, 1993). Codependency is also a fundamental assumption of the Alcoholics Anonymous (AA) movement, which takes the perspective that addiction is a disease over which the abuser and their family have no control (Hurcom et al., 2000). Although codependence is frequently noted as having clinical significance amongst treatment professionals (Harkness, Hale, Swenson, & Madsen-Hampton, 2001), empirical support for the concept of

codependency is lacking. There is little consensus in the field as to how the term should be operationalized (O'Farrell & Fals-Stewart, 1999), making the concept difficult to reliably measure. Nevertheless, it remains a predominant feature among practitioners who endorse this model.

Treatment implications of a family disease approach specify the importance of addressing denial, secrecy, and codependence related to substance use within the family. Social support for children, education about the impact of addiction on the family, and opportunities for children to express feelings have all been hypothesized to improve children's coping skills and have been recommended as important features of COSAP interventions (Dies & Burghart, 1991).

Family Systems Approaches

A family systems approach to addiction is similar to a family disease orientation in that it proposes that substance abuse disrupts the family system; however the conceptualization of addiction as a disease or illness is not a predominant organizing theme. From this perspective, substance abuse is one of a number of personal dysfunctions that can cause imbalance within the family system (Bowen, 1974). This theory proposes that family members function as an integrated system that is constantly adjusting and compensating for changes within the family. From a family systems perspective, family members seek to adapt their interactions around the addiction in an attempt to maintain balance or homeostasis (Hurcum et al., 2000). This model assumes a "reciprocal relationship between the family's functioning and the substance abuse" (Smock et al., 2011, p. 184). Disrupted family roles, distorted boundaries, role reversal, low levels of family cohesion, and poor parenting practices are key aspects of this model (O'Farrell & Fals-Stewart, 1999; Sheridan, 1995). Evidence for a blurring of boundaries between

individuals in substance abusing families has been suggested as pathway to dysfunctional family functioning, leading to either enmeshed or disengaged relationships (Ripple & Luthar, 1996).

Studies support the notion that parents with substance abuse issues display more negative parenting such as poor monitoring and inconsistent discipline, and less positive parenting such as praise, emotional responsiveness, warmth, and guidance (Barnard & McKeganey, 2004; Stanger, Dumenci, Kamon, & Burstein, 2004). In addition, substance abuse has the capacity to interfere with emotion regulation, executive functioning (e.g. goal planning, attentional control), and sensitivity to environmental cues, all of which are necessary for responsive and stable parenting (Mayes & Truman, 2002). Stanger and colleagues (2004) tested path models between negative parenting and children's externalizing behaviours in a sample of 251 substance abusing families. Significant pathways between poor parental monitoring, inconsistent discipline and child externalizing behaviours were found, suggesting an association between poor parenting skills and behavioural problems in COSAPs. Further, the frequent co-occurrence of substance abuse with other mental health problems may exacerbate this relationship (Mayes & Truman, 2002). Parents with both a substance abuse problem and a mental health disorder such as depression have been found to display increased negative parenting behaviours over parents with a substance use problem only (Eiden, Colder, Edwards, & Leonard, 2009; Lam & O'Farrell, 2011).

Treatment implications stemming from the family systems model suggest that parenting skills, family cohesion, and psycho-education around roles and boundaries are important targets for treatment. Education and knowledge, skills building, and healthy family activities are some of the recommended components for COSAP interventions cited in the literature (Emshoff & Price, 1999).

Stress and Coping Models

In contrast to the family disease and family systems models, family-based stress and coping models of addiction originally emerged from health psychology and related disciplines that seek to explain how people respond to stressful events such as a family member's chronic illness (Orford, Copello, Velleman, & Templeton, 2010). A central premise of these models is that when faced with stressful life events, individuals have the capacity to cope and that some may cope in ways that are more effective than others. This is based on the underlying assumption that people are active, problem-oriented, and strive to resolve difficulties through coping behaviours (Hurcom et al., 2000). If coping strategies are inadequate, however, strain will be evident in the form of compromised health and well-being (Orford et al., 2010).

With respect to substance abuse, stress and coping models propose that when one person in the family suffers from addiction, it is highly stressful for other family members as well as for the substance user themselves. Problems often continue or intensify over a long period of time, thus creating an enduring stressful environment within the family (Orford et al., 2010). Family members experience strain as a direct consequence of this stressful environment, resulting in negative health and mental health outcomes. Coping strategies will be used a way of responding to stress and strain, which may or may not be helpful in buffering family stress. Another key element to the stress and coping model is social support. Researchers argue that social support is a key factor in the context of substance abusing families and that the quality of support received by family members will impact coping ability (Orford et al., 2010).

The stress underlying the experiences of addicted families has also been suggested as an important factor in poor child outcomes in response to parental substance use. Abuse of drugs and alcohol can disrupt the ability to regulate emotions and modulate arousal (Fox, Hong, &

Sinha, 2008). Substance abusing parents therefore may have difficulty responding to their child's cues, contributing to a stressful environment, which may in turn perpetuate the use of substances as a form of coping (Mayes & Truman, 2002). Qualitative research conducted with family members of substance abusers has uncovered some common themes that characterize the stressful nature of this relationship. These include aggressive or disagreeable relationships, increased financial conflict, the experience of uncertainty, worry about the addicted family member, and disrupted family life (Orford, Velleman, Copello, Templeton, & Ibanga, 2010).

While the relationship between addiction and marital distress has been well documented, few studies have specifically investigated the relationship between marital distress and subsequent child outcomes in substance abusing populations. Preliminary evidence with alcohol abusing samples suggests that marital distress can act as a mediator between parental addiction and child externalizing behaviour problems (Leonard & Eiden, 2007). Research supports the impact of poor parenting practices and parental stress on behaviour problems among children in substance abusing households. Burlew and colleagues (2012) tested the pathways between parenting practices, parental stress, and child internalizing and externalizing behaviours in a sample of COSAPs aged 6 – 8 years (N = 105). Structural equation modeling revealed a process by which inadequate parenting practices, defined as poor monitoring and lack of involvement, were associated with increased parental stress, which subsequently lead to increased child behavioural problems. Gender differences were found such that female COSAPs were more likely to exhibit depressive symptoms and male COSAPs were more likely to display hyperactive behaviours.

Stress and coping models provide evidence that family-based COSAP interventions should target coping skills, stress reduction, and increasing social support. These elements are

often found in family-based substance abuse interventions. Emphasis on self-care and teaching of adaptive coping skills are common elements recommended in the literature, and group support programs actively encourage and provide a social support network for families (Emshoff & Price, 1999).

Current Approaches to COSAP Intervention

Despite the fact that there are significant consequences of substance abuse for the entire family, until recently few interventions specifically targeted the needs of children or other family members. Historically, even when family members were included in treatment, measurement of proximal outcomes such as changes in coping skills or psychological symptoms were neglected in favour of direct substance abuse reduction targets (Copello, Velleman, &Templeton, 2005). Further, given the lack of consensus on a theoretical model of family addiction, it is perhaps not surprising that existing family-based programs for COSAPs often draw upon elements from a wide range of approaches and orientations. It is clear that the literature on COSAP interventions lack an explicit program theory.

It should be noted that the primary goal of family-based interventions for COSAPs is not necessarily the prevention of substance use among children. While this may be hoped for as long-term outcome, the focus of these programs is most often on immediate, proximal outcomes. Proximal outcomes are those that more closely reflect the immediate negative consequences experienced by COSAPs and their families. In other words, these programs seek primarily to improve outcomes such as children's psychological functioning, coping skills, family functioning, and parenting skills.

Further, these programs may or may not directly involve the individual substance abusing family member. While perhaps desirable from a treatment perspective, there are a variety of

reasons why the individual substance abuser may not be capable of participating in family-based program. For example, they may be in a residential treatment program, not willing to seek treatment, or be separated from the family as a consequence of divorce, incarceration, or intervention from child welfare services.

One issue that confounds the field is the relative lack of published data on COSAP program outcomes. Grey literature such as technical reports and community evaluations often contain valuable information on COSAP interventions, however, outcome studies of such interventions appear to be infrequently published in scholarly journals. This may suggest that few COSAP programs are implemented, despite the documented need for COSAP supports. Alternatively, it could be an indication that programs are implemented, but yet not evaluated, or that evaluations are conducted but not documented. A recent systematic review examining selective prevention programs for children from substance using families (Broning et al., 2012) uncovered only nine programs that met inclusion criteria. Further, within those nine programs only four were considered to be family-based. Given that the inclusion criteria for that study was restrictive in terms of quality assessment and peer-reviewed status, it is likely that other community-based COSAP interventions that may only have grey literature evidence were excluded. Nevertheless, it is clear that a more comprehensive picture of COSAP program outcomes, implementation, and theory is needed.

Addressing the Gap in COSAP Intervention Research

The paucity of literature on COSAP program evaluations, as outlined above, clearly indicates a need for practical, meaningful, and rigorous evaluations that promote the application of evidence-based findings within the field. Community-based, family-focused addiction treatment would arguably have much to gain from research and evaluation that adheres to best

practices. More specifically, best practices in which evaluation is tied to clinical practice, involves front-line staff as stakeholders, and serves to inform program development, and policy.

Implementing Relevant Evaluation Approaches

The use of best practices in community-based program evaluation should emphasize the importance of stakeholder engagement, collaboration, and respect of organizational capacity for evaluation. Within the program evaluation landscape, it is understood and expected that the evaluation process will interact with and have an impact on the organization, regardless of evaluation outcomes (Rowe & Jacobs, 1998). Evaluations of program effectiveness must reflect real-world implementation, setting, and populations, and as such must be dynamic so as to have the capacity to respond to changing environmental and organizational demands (Rodriguez-Campos, 2012). As such it is incumbent upon academic researchers who wish to engage in community-based evaluation to adopt an integrative approach to evaluation integrity and validity. Integrative validity is increasingly recognized as one of the most important factors in evaluations, meaning that evaluations must be both scientifically credible and have practical relevance and utility to stakeholders (Chen, 2010; Chen & Garbe, 2011). The stakeholder perspective is therefore a key aspect to rigorous and comprehensive program evaluation research, and is an important component of collaborative or participatory approaches to evaluation.

Participatory evaluation by definition involves collaboration between evaluators and program stakeholders (Cousins & Whitmore, 1998; Patton, 2008). A core premise of participatory evaluation is that stakeholder collaboration will increase relevance, ownership, and utilization of evaluation results and ultimately contribute to continued program development and improvement (Cousins & Whitmore, 1998; Rowe & Jacobs, 1998). The use of collaborative evaluation approaches can foster team learning and increase the likelihood that evaluation results

will be used by stakeholders because of the ongoing involvement and respect within in the decision making process (Rodriguez-Campos, 2012).

A prime example of the challenges of conducting community-engaged research is the need for evaluators to be mindful of organizational resources and capacity for effective implementation of evaluation protocols, such as evaluation design and data collection procedures. One way of mitigating these challenges is to adopt embedded approaches to evaluation. An embedded evaluation approach is one whereby data collection is made integral to the program and serves to reinforce and strengthen the intervention. Patton (2008; 2012) refers to this process as *intervention-oriented evaluation*, the primary principle of which is to "build a program delivery model that logically and meaningfully interjects data collection in ways that enhance achievement of program outcomes, while also meeting evaluation information needs" (p. 166). Under this approach, evaluation is integrated into the intervention such that it supports desired program goals (Patton, 2012). One of the positive features of using an embedded approach is that additional costs, both human and financial, to the organization are minimized as data collection is fully integrated into program design, delivery, and implementation.

Finally, a comprehensive approach to community-based program evaluation should include both outcome and process factors. Process factors are those that reflect how the program is implemented in a real-world setting and may include intervention fidelity, dosage, quality, and participant responsiveness (Saunders, Evans, & Joshi, 2005). Although program outcomes are often more heavily emphasized in program effectiveness research, process and implementation factors are equally important. In fact, there is strong empirical evidence that monitoring implementation improves program outcomes (Durlak & DuPre, 2008).

Systematic Review for Theory Development

Systematic review and evidence synthesis of prior evaluations within a set of related programs can reveal patterns of findings and guide future program development and policy. A realist review, also known as a realist synthesis, is a type of systematic review that examines research evidence on social interventions in an effort to explain how and why they work, or do not work, in particular contexts (Pawson, Greenhalgh, Harvey, & Walsh, 2004), and is increasingly used as a tool to inform evidence-based program implementation and policy. This is in contrast to other methods of systematic review such as meta-analysis where the goal is simply an adjudication of program effectiveness (i.e. does the program work, and if so what is the magnitude of effect). Realist review tends to be a better approach when investigating social or health interventions because of the increased complexity of such programs, relative to medical or clinically controlled treatments. Social interventions often have multiple goals and activities, and serve heterogeneous populations in diverse settings (Pawson et al., 2004). Realist approaches to evaluation and synthesis are uniquely equipped to handle complexity because realist methodology purposely seeks a broad evidence base in recognition that interventions implemented in real-world settings are prone to modification and exist within diverse social contexts (Pawson et al., 2004). Research that is singularly focused on whether a program works will be of little value to stakeholders and practitioners because it lacks explanatory details that will guide implementation. In other words, evidence synthesis must answer the question of "what works, for whom, and in what circumstances" in order to support real-world program development (Pawson, 2002; Pawson, et al, 2004; Pawson, Greenhalgh, Harvey, & Walshe 2005).

Realist review and synthesis is also a theory-based approach to program evaluation and takes a generative view of causality. From a realist perspective, it is not the programs that work but rather the resources that programs offer to participants and how those resources are used that generate outcomes (Pawson, 2002). The causal power of programs lies in the underlying mechanisms (M), which are triggered in particular contexts (C), which generate outcomes (O). This results in a pattern (or CMO configuration), which becomes the basis of program theory. In realist language, a mechanism is the underlying process of how individuals interpret and make use of program strategies and resources (Pawson, 2002). Mechanisms are a central feature to understanding program logic.

With respect to COSAP programming, theory development is lacking. The benefits of a realist approach to evidence synthesis in this field are numerous and could greatly inform future implementation of such interventions. COSAP programs are frequently delivered in settings where contexts are likely to vary considerably. Realist review methodology allows for the inclusion of grey literature as a data source in addition to published scholarly literature. The broad scope of what is considered evidence is ideal in community-based research where many agencies do not have the resources to document and publish program outcomes in academic journals. Furthermore, realist methodology views stakeholder engagement as integral to the review process where it is often used as a tool to inform policy on social program implementation within communities (Rycroft-Malone, et al., 2012). Ideally, there should be a two-way dialogue between researcher and stakeholder in identifying the review questions (Pawson, Greenhalgh, Harvey, & Walshe, 2005). Realist review has substantial potential to contribute to theoretical and practitioner knowledge by documenting real-world program implementations.

Summary and Rationale for Current Study

Family-based approaches to substance abuse treatment have been relatively neglected in Canada, as compared to the US where this treatment approach is much more common (Csiernik, 2002). A decade ago, a review of addiction treatment options available in Ontario reported that less than 15% of the addiction treatments facilities in the province offered professional work with family members (Csiernik, 2002). Note that this review was not specific to children and presumably the number would have been much smaller had it been limited in this way. Since then, there is little evidence that much has changed in the family-based substance abuse treatment landscape. The reader is referred to the Ontario Drug & Alcohol Helpline directory, which does not currently list family-based treatment as a separate category for substance abuse treatment options (ConnexOntario Health Services Information, 2013). While some COSAP programs are now beginning to emerge in Canada, they tend not to be dictated by a singular treatment orientation (Csiernik, 2002), further compounding the lack of a cohesive theoretical approach to COSAP programming.

In light of the evidence presented, two major gaps in the literature can be identified. First, there lacks an explicit theoretical framework or program theory for interventions targeting COSAPs. Although common elements can be found across programs, there is no conclusive evidence to date that these components are indeed the most important or effective (Cuijpers, 2005). Second, because so few theory-driven programs have been developed and evaluated, solid evidence for the effectiveness of such programs is difficult to ascertain.

There is undeniably a need for interventions that help family members of substance abusers in their own right, particularly children. The potential for adverse outcomes is well documented and preliminary evaluation research suggests that family-based programming for

COSAPs can yield positive changes. Despite this, it is unclear whether common elements of such programs are universally indicated. Indeed, researchers stress that children of substance abusers are a heterogeneous group (Johnson & Leff, 1999). As such, children will experience different risk factors, which in turn is likely to differentially impact response to treatment. Further, not all children impacted by parental addiction will experience adversity at all. At present, it is unknown how and why particular programs are effective and what groups of children are most likely to benefit.

Another issue is the limited scope of available evaluation research on COSAP programs. Until recently, substance users themselves were the primary focus of family interventions and evaluations often failed to measure changes in symptoms or coping behaviours in family members following intervention (Copello et al., 2005). There are few evidence-based programs specifically designed for COSAPs and fewer still have been evaluated (Moe et al., 2008). This is despite the fact that impacts of substance abuse on the family are well-documented and that family members may even act as agents of change (Copello et al., 2005). Further, many programs are delivered in community settings, which often lack the resources, skills, funding, or time to rigorously evaluate their interventions. While some high-quality evaluations using experimental designs are published (e.g. The Strengthening Families Program), many evaluations exist as grey literature, which typically do not reach broader academic or clinical audiences.

The issues highlighted above and the impetus to fill important gaps in the literature is timely. Best practice guidelines published by the Canadian Centre on Substance Abuse (CCSA) state that COSAP program theory should be explicit, evidence-based, and fit with local context of program delivery (CCSA, 2011). Moreover, they recommend creating a culture of evaluation

within organizations delivering COSAP programming whereby evaluation is viewed as a routine part of program delivery (CCSA, 2011).

In keeping with these recommendations and the need for additional research in this area, this dissertation study seeks to address these gaps in the literature by conducting a systematic review for the purpose of theory refinement and undertaking a program evaluation of a unique Canadian program for COSAPs, the Renascent Children's Program. This dissertation will therefore consist of two inter-related studies: 1) a realist review of existing literature on family-based COSAP programs, and 2) an evaluation of the Renascent Children's Program. The goal of study 1 is two-fold. First, study 1 examines how, for whom, and under what circumstance such programs work, or do not work; and second, explores and refines program theory. Study 2 is an evaluation of a unique program for COSAPs in Canada called the Children's Program. Study 2 comprises a process evaluation and an outcome evaluation. Through these two studies, this dissertation seeks to address the following research questions.

Research Questions

1. *How, for whom, and in what circumstances do programs designed for COSAPs work?*

Because so few programs targeting COSAPs are documented in the research literature, there lacks a comprehensive synthesis of existing evaluation research. More specifically, this research question asks: What patterns of contextual factors and mechanisms can be identified, and how do they generate outcomes? This research question will be addressed through the realist review (study 1).

2. *Can a COSAP program theory be articulated and refined, and if so, what are the implications for program implementation?*

It is clear that there lacks a comprehensive theoretical framework for family-based addictions programs, particularly those targeting COSAPs. Based on the data elicited from the realist review (study 1) this research question will seek to develop and refine a preliminary program theory.

3. *Is the Children's Program being effectively implemented at Renascent?*

This research question will be addressed though the process evaluation component of study 2. Program fidelity, recruitment, participation, and client satisfaction are key components of effective intervention delivery, and must be established in order for outcome evaluation results to be meaningful. Implementation data will be collected to determine the extent to which the Children's Program is being effectively delivered and administered.

4. *What changes in knowledge, behaviour, and psychological functioning have occurred for families participating in the Children's Program?*

The Children's Program is unique in Canada and thus its impacts have yet to be documented. This question will be addressed through the outcome evaluation component of study 2. A mixed methods, repeated measures design will be used to examine changes in behaviour, psychological functioning, and knowledge in families participating in the program.

5. *What is the experience of families participating in the Children's Program?*

An in-depth exploration of the experience of families participating in the Children's Program will be conducted and serve to complement the results obtained from answering research questions 3 and 4 in study 2.

STUDY 1: REALIST REVIEW

Method

Rationale for Realist Review

This review seeks to synthesize existing knowledge of family-based interventions for COSAPs and articulate a theoretical framework for how such programs work. Realist review was chosen as the methodological approach for this study. A realist approach to a systematic review is ideal for examining social interventions, particularly those delivered in community settings, because it is recognized that programs are rarely delivered in precisely the same manner, nor will they have the same outcomes, due to contextual variables that can never be fully controlled (Pawson et al., 2004; Wong, Greenhalgh, Westhorp, & Pawson, 2011). Many COSAP programs are delivered in community settings, which often lack the resources to rigorously evaluate their interventions. While there are published research studies that use experimental designs, many evaluations exist as grey literature, which typically do not reach broader audiences in the form of peer-reviewed publications. Multiple forms of evidence are included in a realist review, including qualitative research and grey literature, both of which are typically excluded from traditional systematic reviews. Decisions on the merits of document inclusion favour their potential for theoretical contribution over methodological hierarchy of empirical studies (Jackson et al., 2014; Wong, Greenhalgh, Westhorp, Buckingham, & Pawson, 2013).

In addition to evidence synthesis, theory refinement is a secondary goal of this study. Part of the theory refinement process of a realist review is to examine the relationship between contextual factors and outcomes and the underlying mechanisms that connect the two (Pawson et al., 2004). This is often referred to as a context-mechanism-outcome (CMO) configuration.

Mechanisms can be thought of as underlying processes that operate in certain contexts to generate outcomes. Mechanisms are not visible; rather, they are inferred from observable data, are context dependent, and generate outcomes (Wong et al., 2011). Mechanisms represent the internal responses generated by participants in response to the intervention (Pawson & Tilley, 1997). Contexts, mechanisms, and outcomes are extracted during the realist review process and can be thought of as the "data" that provide evidence to support, reject, or refine a program theory. CMO configurations are then compiled in order to map patterns of demi-regularities. A demi-regularity refers to a semi-predictable pattern of program functioning, which helps to explicate program theory (Jagosh et al., 2012).

Key steps in realist review. The process of conducting a realist review has been detailed extensively through the RAMESES (Realist and meta-narrative evidence synthesis: Evolving standards) project (Greenhalgh, Wong, Westhorp, & Pawson, 2011; Wong, Greenhalgh, Westhorp, & Pawson, 2014), which outlines methodological standards and publication guidelines including key steps involved in conducting a realist review. Briefly, they involve: (1) Clarifying the scope of the review. This includes identifying the review questions, refining the purpose of the review, and articulating candidate theories to be explored. (2) Searching for evidence. This involves systematic searching for programs that fit inclusion criteria, which become the dataset for the review. Snowball searching for additional literature continues throughout the review process. (3) Appraise primary studies and extract data. This involves critical appraisal of documents and extraction of data pertaining to program contexts, mechanisms, and outcomes. Relevance and rigour of each document is also assessed at this stage. (4) Synthesize evidence and draw conclusions. Data (i.e. CMO configurations) extracted during the previous stage is used to refine initial program theory and draw conclusions. (5)

Disseminate findings. This final stage outlines the recommendations and implications of the realist review findings. Stakeholder and policy maker involvement is common at the dissemination stage (Pawson, Greenhalgh, Harvey, & Walshe, 2005; Wong, Westhorpe et al., 2013). This realist review followed practice guidelines and current publication standards for document selection, appraisal, data extraction, and presentation of results, as outlined by the RAMESES project (Wong, Greenhalgh, et al., 2013; Wong, Westhorp, Pawson, & Greenhalgh, 2013).

Scoping the Literature for Candidate theories

A scoping search was conducting in order to identify any existing theories on family-based addiction interventions with a focus on children, as well as identify key programs or authors of note. Two candidate theories of how parental addiction progressively impacts children, upon which COSAP programs are theoretically based, were identified: (1) the family disease model and (2) the family prevention model. These theoretical models of how addiction progresses within the family were helpful in making preliminary classifications of each program identified in the search according to underlying addiction theory.

Family disease models. The origins of family disease model programs are rooted in the abstinence and 12-step facilitation movements. Addiction is viewed as a family disease, whereby the entire family is affected by one person's addiction (White & Savage, 2005). This theory posits that parental addiction leads to secrecy, shame, codependency, and isolation, which in turn leads to child and family dysfunction (Barnard & Barlow, 2003; Kroll, 2004; White & Savage, 2005). Children living in this environment, therefore, are in need of specific intervention within a family context in order to disrupt the cycle of addiction. Consequently, interventions that espouse this philosophy will attempt to break down existing patterns of secrecy and isolation,

often by providing education and knowledge to family members about the impacts that addiction has on children in an attempt to (Dies & Burghardt, 1991).

Family prevention models. In contrast, family prevention models view addiction as one of many risk factors that characterize dysfunctional families. This theory suggests that parental addiction leads to poor parenting skills, poor emotion regulation, and poor family cohesion, which in turn leads to childhood psychosocial problems, delinquency, and eventually substance use (Lockman & Steenhoven, 2002; Thompson, Pomeroy, & Gober, 2005). Improving the family environment is key to reducing risk factors for COSAPs (Kumpfer, 1998). Interventions that adhere to the family prevention model will target risk and resiliency factors such as strong family bonds, supportive parental monitoring and supervision, and relapse prevention and substance refusal skills (Kumpfer & Alvarado, 2003; Small & Huser, 2010).

Both candidate theories are similar in that they share short terms goals of improving child psychosocial outcomes, parenting behaviours, and family functioning, as well as a longer term goal of eventually reducing probability that COSAPs will develop substance use disorders later in life. Both approaches use the family unit as the vehicle for change. However, differences lie within the pathways to achieving those short and longer term goals. A distinction is made between knowledge versus skill, as well as parent versus child as the primary target for family change. Programs based in family prevention will emphasize skills over knowledge and primarily target parents, while those taking a family disease perspective typically accentuate knowledge and the child's experience. In sum, while both models ultimately aspire to similar ends (and may even achieve similar goals), the origins and pathways inherent to each model are slightly different. The goal of this study was to refine these program models and articulate a

COSAP program theory that could account for their success (or lack thereof). It was hypothesized that differing mechanisms would be at play for each model of program.

Search Process

The document search process began with a systematic search of academic databases in the psychology, social services, and health fields including PsycINFO, Medline, Scopus, CINAHL, Social Work Abstracts, and Social Services Abstracts, in September 2013. Search terms included: [program OR intervention OR treatment OR therapy] AND [child OR youth OR adolescent OR teenager OR student OR COA OR COSAP] AND [substance OR addiction OR drug OR alcohol] AND [family based OR family skills OR parent training OR parenting skills]. Other search engines such as Google and grey literature databanks were used in an attempt to identify grey literature such as community evaluations, government reports, conference proceedings, and other documents not found in academic databases. This was an iterative process and snowball searching was also undertaken by combing through article reference lists to identify any relevant documents that may have been missed through the initial search process. Snowball searching continued until December 2014 to ensure that all relevant literature was identified. Only documents written in English were considered for inclusion.

Selection and Appraisal of Documents

Documents were reviewed in stages at the title, abstract, and full-text level to determine whether they met inclusion/exclusion criteria. These criteria were as follows: participants were children between the ages of 6 and 18 who have a parent who is a substance user; the parent with the addiction or another caregiver must attend the program with the child; and programs are delivered in a group format. A decision was made to exclude programs geared towards infants and toddlers, as program format and content would likely be fundamentally distinct from those

aimed at school-age children and their parents. Any program that was not explicitly family-based (i.e. did not involve both parents and children as participants) was excluded. Appraisal of selected documents were further screened by consensus for relevance and rigour, defined as the ability to make a theoretical contribution to the review and trustworthiness of evidence presented in empirical studies (Wong, Greenhalgh, et al., 2013).

Data Extraction

An iterative approach to data extraction was adopted for this study using a team approach. The research team consisted of the author, an academic supervisor with expertise in realist methodology and clinical interventions for children, and a volunteer research assistant with research and personal lived experience with addiction. A coding extraction sheet template created by the author was used with each document in order to extract data relating to program descriptions, contexts, mechanisms, and outcomes. The author and the research assistant independently coded all documents. Completed abstraction sheets were then reviewed as a group and an initial round of discussion took place about potential CMO configurations emerging from the data. CMO configurations were revised based on consensus and documents were subsequently re-coded to ensure that CMOs had been properly identified. The research team convened on a regular basis to discuss demi-regularities emerging from the data and their degree of fit with candidate theories.

Results

Document Characteristics

Figure 1 presents a flow diagram outlining the document search and appraisal process. Throughout the search process, it became evident that relatively few COSAP programs existed that met the review criteria; however multiple documents were found as sources of evidence to

support each program. A total of 30 documents were retained for this review, spanning 7 different COSAP programs implemented in the US, UK, and Spain. Types of documents retained included outcome evaluation studies (*n* = 15), grey literature community evaluation reports (*n* = 9), qualitative studies (*n* = 3), and book chapters (*n* = 3). Tables 1 and 2 outline the COSAP programs and related documents that were included in this review, and all included documents can be found marked with an asterix in the reference section at the end of this document.

A wide range of outcomes was reported for these programs. The majority were proximal and measured shortly after program completion. Outcomes were summarized to reflect general categories: child behavioural changes (e.g. aggression, conduct), child emotional changes (e.g. anxious, depressive, loneliness, self-esteem), parenting (e.g. parenting skills, parent mental health), relapse prevention (reduction in parental substance use), and family cohesion (e.g. bonding, family communication, time spent together). Very few studies were longitudinal and measured reduction or prevention of child substance use later in life. There were also slight variations in terms of dosage, structural format, content, target population (e.g. parents enrolled in concurrent drug treatment, African-American families), and eligibility for program participation (e.g. abstinence during program, demonstrated program commitment, length of time in recovery).

The COSAP programs included in this review were classified by the research team according to their potential support for the two candidate theories, based on the program descriptions found in supporting documents. For example, programs that promoted a disease-based conceptualization of addiction, emphasized the important of abstinence, and implemented a primarily knowledge-based curriculum were categorized within the family disease model. Programs that used a skills-based curriculum aimed at reducing risk factors for substance use and

enhancing protective factors within the family were categorized within the family prevention model. Programs that appeared to draw elements from both models were classified at hybrids (see Table 2). It is important to note that the purpose of this review was not to rank or compare programs in terms of relative merit or level of efficacy. Rather, main findings with respect to how and why these programs may achieve outcomes are presented below.

Main Findings: Demi-Regularities

Four demi-regularities were identified in this review as being fundamental in generating positive COSAP program outcomes. These are presented below along with key examples of the contexts, mechanisms, and outcomes. A visual representation of the demi-regularities can be found in Figure 2.

1. Creating opportunities for positive parent-child interactions

Programs that consistently provided opportunities for positive parent-child interactions were found to produce outcomes of improved family cohesion. Documents from a number of programs (e.g. Safe Haven, Strengthening Families Program (SFP), Moving Parents and Children Together (MPACT), Family Competence Program (FCP)) discussed that the program succeeded in bringing families together for shared time that would not have otherwise occurred. It was frequently noted that providing opportunities for parent-child interactions in an enjoyable and supportive environment led to improvements in family cohesion.

The mechanism of *hopeful enjoyment* was identified, through which the outcome of family cohesion is achieved. Providing multiple opportunities for positive parent-child interactions during program was found to foster a sense of joy and pleasure among family members and an increased sense of hope that the family unit could be restored. A qualitative evaluation of MPACT program provides a useful example of this process:

"*I think the sheer fact that we went every week and we didn't miss a week and we all did it together, just that alone I think … It made us feel good about ourselves*" (Templeton, 2012, p.3).

The review uncovered multiple instances of programs that encouraged families to spend time together in a supportive and non-punitive environment. This allowed parents to develop empathy for their children, and in turn children were allowed a safe space to express themselves to their parent during the program (Aktan, 1995). Having parents and children attend together increased positive interactions and encouraged children to feel loved and appreciated by parents (Kumpfer, 1998).

Another useful illustration of this demi-regularity is an example where desired program outcomes were not achieved. The Focus on Families (FOF) evaluation indicated that the program did not achieve desired outcomes for family cohesion (Catalano et al., 1997; 1999; 2002). In this case, program structure was such that children did not attend all sessions with parents, suggesting a lack of sufficient opportunities for positive-parent child interactions. In this case, it is hypothesized that the mechanism of *hopeful enjoyment* did not have sufficient opportunity to fire. Further, older children actually reported negative effects of parental involvement, suggesting that attempts by parents to increase parent-child interaction time were not only lacking in enjoyment, but were in fact met with rejection. The authors of that paper hypothesized that older children who were accustomed to lack of supervision perceived increased family time as an unwelcome intrusion (Catalano, et al., 1999). This provides further evidence that the mechanism of *hopeful enjoyment* needs to be triggered in order for positive outcomes in family cohesion to occur, in the context of child age. Programs that facilitate positive parent-child interactions can help families achieve a restored connection when it is

developmentally appropriate for them to do so, as is more likely to be the case for younger children. For older children who are at an individuation developmental stage, attempts at eliciting hopeful enjoyment of family interactions may misfire and fail to yield positive outcomes.

2. Supportive peer-to-peer relationships

Environments that fostered supportive peer relationships among child participants and among parents were noted across many programs as being instrumental in achieving positive child psychosocial outcomes, and to a lesser extent positive parenting outcomes. Evidence was found to support this process in a couple of ways. First, supportive peer-to-peer relationships between the child participants elicited mechanisms of *trust and safety* within the group as well as *validation of experience*. Improvements in child psychosocial functioning were consistently reported in these cases (e.g. Moe, Johnson, & Wade, 2008; Templeton, 2012; Kumpfer et al., 2010). Social isolation is common among children living with parental substance use, and the mere fact of being placed in a supportive group of their peers may have allowed for feelings of safety to emerge and enabled the sharing of experiences. For example, a qualitative evaluation of the Betty Ford Children's Program demonstrates this finding:

> "*I have a lot of, you know, really close friends but they … can't relate to my situation … you come here and you meet friends who are just like you*" (Moe, Johnson, & Wade, 2007, p. 389)

Second, it was noted that parent participants who were placed in supportive groups with other peers also exhibited positive outcomes through a mechanism of *validation of experience*. Parents struggling with parenting at the same time as recovering from substance abuse were reported to have found the group dynamics and peer relationships fostered with other parents

during the COSAP programs to be beneficial. The process of *validation* for these parents can be described as the normalization of experience and sharing of mutual struggles among supportive peers. Further, at least one program evaluation discussed the possibility that the strong bonds formed between participants was a motivator to continue attending sessions (Boon & Templeton, 2007). It is possible that the creation of supportive peer relationships was a contributing factor to engagement and program commitment, also leading to improvements in parenting skills and child psychosocial outcomes.

> *Both adults and children appeared to benefit greatly from meeting others and making friends, specifically with people who lived in similar circumstances. For many, this seemed to bring mutual understanding as families' experiences were normalized and they realized that they were not alone with their struggles.* (Templeton, 2012, p. 4)

3. (Addiction) knowledge is power

Programs that specifically emphasized knowledge about addiction and education about the impact that substance abuse has on children and families were found to yield improvements in parenting and child psychosocial outcomes. The following key mechanisms were identified that within this demi-regularity: *parental recognition and responsibility* and *children relinquishing responsibility for parental addiction*.

In the Betty Ford program, for example, knowledge was described as "opening the door for them" (Moe, Johnson, & Wade, 2007, p.390) and that simply knowing the truth about their parent's addiction was helpful. Further, the provision of knowledge allowed children to realize that they were not responsible or at fault for their parent's addiction (Templeton, 2011). Shame and secrecy are hallmarks of family addiction, according to the family disease model. The mechanism of *relinquishing responsibility* is triggered when children are provided with

information about parental addiction that had been previously withheld or downplayed. Under these circumstances, improvements in child emotional and behavioural outcomes are observed.

Further, parents who attend these programs are also provided with knowledge about how their alcohol or drug use has impacted their children and the family unit. The *parental recognition and responsibility* mechanism is triggered under these circumstances, whereby parents are able to recognize the impact of their behaviours and take responsibility for how it has affected their children. For example, evaluations of the Celebrating Families! program and MPACT program both documented instances where parents gained new understanding of the impact that alcoholism has on the family (Sparks, Tisch, & Gardner, 2013), a realization of not playing the appropriate role as a parent (Templeton, 2012), and "the shock that some of the adults conveyed as they began to take in the effects of their lifestyle on their children" (Boon & Templeton, 2007, p.18). These programs reported positive outcomes with respect to parenting, such as improved positive parenting and parenting efficacy (Boon & Templeton, 2007).

4. Engaging hard to reach or marginalized families

For certain programs where the participating families were reported to be from particularly marginalized groups (e.g. poverty, cultural minority, etc.), *engagement* emerged as an important intermediary process that was necessary in order for outcomes to be achieved. Interestingly, the process of engagement is not explicit within the family prevention model nor the family disease model, perhaps because engagement is assumed to occur once recruitment is established or that engagement is equated with program attendance. As such, engagement did not initially emerge within either candidate theory. However, as data extraction progressed, it was noted that only those programs classified in this review as aligning with the family prevention model were attuned to this issue. Information on recruitment best-practices exists within family-

based intervention literature (e.g. Dusenbury, 2000), however engagement is rarely distinguished from attendance. For the purpose of this present realist review, engagement is conceptualized more broadly than mere program attendance; it refers also to acceptance and uptake of program materials. Given the nature of COSAP intervention, engagement is not limited to the client-staff dyad or therapeutic alliance. COSAP programs are provided in a group delivery format where clients must engage with each other, the program content, and with the program staff. Other realist reviews have identified engagement as an important feature of program success (e.g. Jackson et al, 2014).

In this realist review, two instances were identified where successful program engagement yielded positive outcomes: responsiveness to client socio-economic needs, and matching to client lived experience. These are discussed below.

Responsiveness to client socio-economic status (SES) needs. Programs that are responsive to the SES realities and needs of their clients will encourage program engagement by fostering a sense of *trust* among families who are typically marginalized. For example, SFP and the Safe Haven program both went to extensive lengths to encourage and incentivize participants, such as providing meals, transportation, childcare, basic necessities, and vouchers redeemable for family activities. Families participating in these programs were characterized as having low income, low education, having unstable housing, child welfare involvement, and, unsurprisingly, as often mistrustful of service providers. The key mechanism here is the sense of *trust* and acceptance that is developed on the part of the client in response to these program efforts, as evidenced here: *"Basic material supports provide a message to needy families that the staff really care about them"* (Kumpfer, Molgaard, & Spoth, 1996, p. 260). In the case of the Safe Haven program, this process was described thusly, as a result of basic necessity provisions:

> *The Safe Haven staff began to know and understand the unique circumstances of each of the participating families. This seemed to increase staff empathy for the families. The families, in turn, reported to the process evaluator that they felt the staff "cared about them"* (Aktan, 1998, p. 46).

In the example above, the program's responsiveness to client SES needs impacted both the staff's ability to engage with the families and vice versa, through a process of trust building.

Matching to client lived experience. Programs that took appropriate steps to match staff and client lived experience of family addiction and/or cultural background were more successful in engaging clients by fostering *trust* and personal identification with the program materials. This was true of programs such as Safe Haven where extensive efforts to make the program and staff culturally consistent with an African-American worldview led to increases in client acceptance and engagement: "*They put it in a way Black people can understand"* (Aktan, 1999, p. 233). This program also specifically recruited staff who were themselves also in recovery from substance use. This shared life experience was noted by clients as being beneficial: *"They share of their experiences… this helps"* (Aktan, 1999, p. 233). The ability of clients to identify with program content and program staff facilitated *trust* in program and led to increased *engagement*. We hypothesize that once engagement is established, program outcomes will be more easily facilitated via the demi-regularities explored above, creating a series of CMO chains.

This review revealed that cultural adaptation, such as the one described in the Safe Haven program, did not always lead to better outcomes. For example, SFP has been culturally adapted for a variety of different ethnic groups in the US. However, comparisons between generic SFP and culturally adapted versions yielded no improvements in positive outcomes, beyond an increase in retention (Kumpfer et al., 2002). Based on the findings above, it is hypothesized that

Safe Haven was successful in this regard because the appropriate matching of staff to client lived experience of culture trigged mechanisms of trust and client identification with program materials. This review did not find evidence of these mechanisms being fired in other culturally adapted programs (e.g., Celebrating Families!).

Alignment with Candidate Theories

As part of the analysis process, the four demi-regularities described above were examined with respect to their alignment with the candidate theories. Programs classified within the family disease model were supported with evidence from the "knowledge" and "supportive peer relationships" demi-regularities. This suggests that the provision of knowledge that is specific to family addiction facilitates children in relinquishing the responsibility for their parent's addiction and enables parents to recognize and take responsibility for the impact of their addiction on their family, leading to improved coping and reduced family stress. Further, social support provided to families within the context of a supportive peer relationship serves to validate the experiences of families living with addiction, leading to improved coping and parenting behaviours. The family disease model asserts that defining addiction as a disease is fundamental to the process of relieving oneself from the guilt and responsibility for a family member's addiction (Timko, Young, & Moos, 2012). The "knowledge" demi-regularity supports this theoretical assertion. Additionally, the importance of social support and interpersonal bonding are viewed as essential components of Al-Anon and other support groups that exist within the family disease addiction treatment landscape (Timko et al., 2012). While COSAP programs extend beyond the scope of a support group, the "peer relationships" demi-regularity accounts for these findings within family disease model programs.

Programs developed from a family prevention model were evidenced with the "positive parent-child interactions", "supportive peer relationships", and the "engagement" demi-regularities. This suggests that opportunities for positive parent-child interactions encourage families to seek joy in spending time together and find hope in the restoration of the family unit, ultimately leading to improved family cohesion. Family prevention theory argues that involving parents in the promotion of healthy child functioning will reduce risk factors and enhance strength and protective factors (Hogue & Liddle, 1999). The importance of social support in coping with family addiction is also noted in some family prevention literature (Orford, Velleman, Copello, Templeton, & Ibanga, 2010). The fact that both the "positive parent-child interaction" and "peer support" demi-regularities were found to align with the family prevention model adds evidence for this theory.

Engagement was found to be present within programs originating in family prevention models only. Despite the fact the engagement has not previously been noted within COSAP program literature, it has been validated elsewhere. Findings from Jackson and colleagues' (2014) realist review of methadone treatment programs emphasized the importance of client engagement, specifically within the contexts of client-centred treatment, attention to client SES conditions, and positive therapeutic relationships. From a broader perspective, other health care fields such as nursing have also emphasized the importance of patient engagement. One particularly useful comparison within the nursing literature is the link between treatment preference, patient engagement, and health outcomes (Sidani, Epstein, Bootzin, Moritz, & Miranda, 2009; Sidani, Miranda, Epstein, & Fox, 2009). Included in treatment preference is the suitability of the treatment to individual life style (Miranda, 2009; Sidani, Epstein et al., 2009). Suitability to personal style could be akin to appropriate matching of client lived experience, as

was found in the present study. This alignment was not previously included within the family prevention candidate theory; as such it is concluded that this theory should be refined in order to account for this finding.

It is notable that two programs included in this review were classified as hybrids, as they drew upon elements common to both candidate theories. Hybrid programs were evidenced from a combination of all demi-regularities to varying degrees, with the exception of engagement. This is an interesting finding in and of itself, but also supports the case for using realist methodology in evaluation inquiry. It would suggest that in practice, program implementation is complex. The MPACT program, for example, was reportedly influenced by the SFP model (Boon & Templeton, 2007) and was subsequently adapted. MPACT maintained policy objectives of improving parent-child communication, parenting skills, and child wellbeing (Boon & Templeton, 2007), which is consistent with SFP and other family prevention model programs. However, a review of the MPACT program documents revealed a significant emphasis on understanding the impact of parental addiction on children and families, communicating about addiction, and empowering children to take responsibility for their own safety and wellbeing, the latter examples being consistent with family disease model program objectives. It was concluded that MPACT was best classified as a hybrid, as it appeared to successfully integrate elements from both candidate theories.

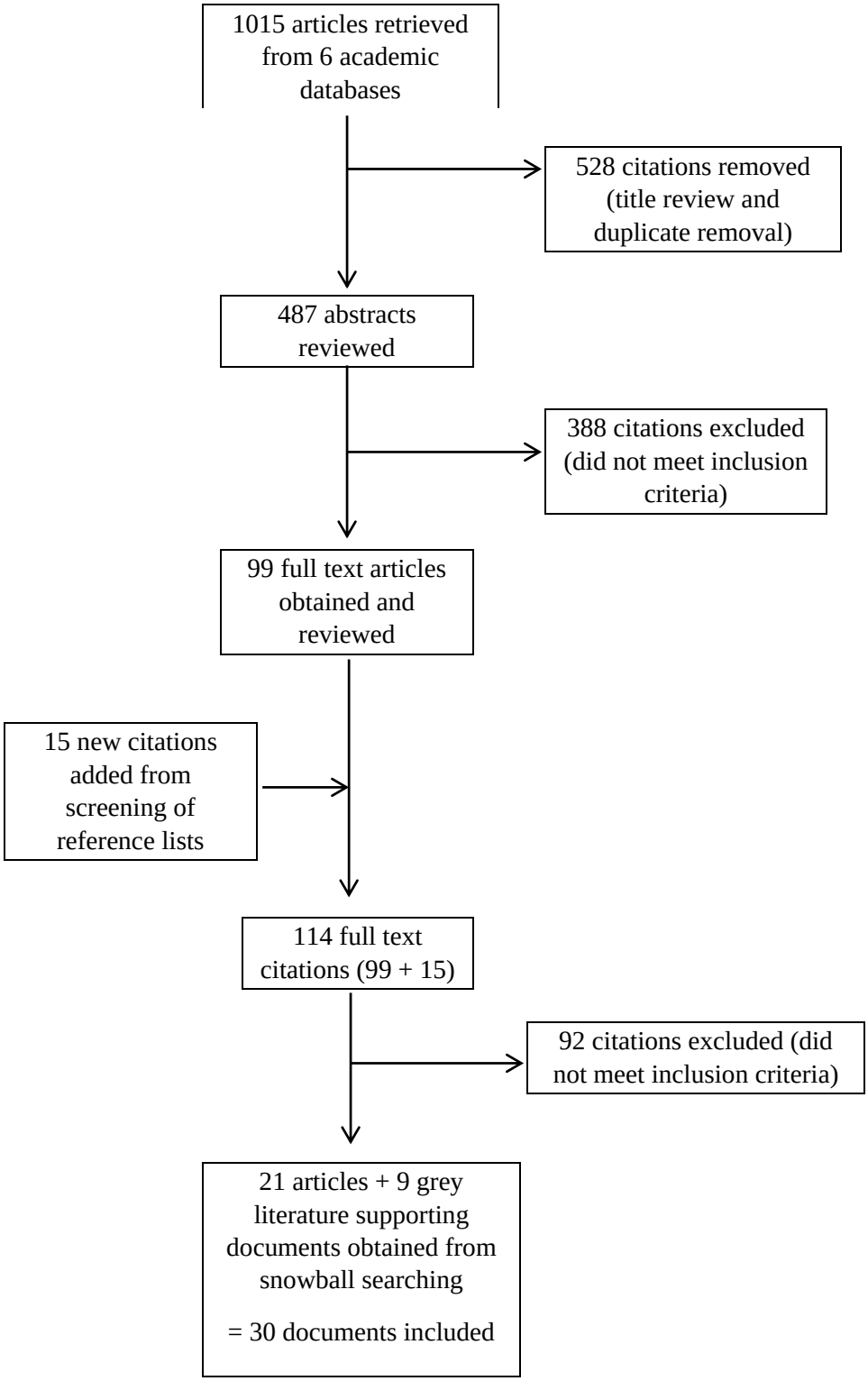


Figure 1. *Article search flow chart*

Table 1

Description of COSAP Programs and Associated Documents Retained for Review (Alphabetical)

Program Name	Citations	Population & Setting	Evaluation design
Betty Ford Children's Program	Moe et al (2007; 2008)	Predominantly White Child age range 7 – 13 yrs Mixture of parents in recovery/in treatment/non-addicted partners Betty Ford centre in California Urban	Pre-post-follow-up design. No comparison group Qualitative
Celebrating Families!/ Celebrando Familias!	Coleman (2008) Lutra Group (2006; 2007) Sparks et al. (2011; 2013)	1) Predominantly non-White Mixture of parents in early recovery and other caregivers. Predominantly female Child age range 3 – 18 yrs Community agencies and treatment centres in San Jose Urban 2) Spanish-speaking Hispanic Mixture of parents in early recovery and other caregivers Child age range 8 – 17 yrs Community agencies in California and Oklahoma Urban	Retrospective pre-post design. No comparison group
Family Competence Program (FCP)	Orte et al. (2008)	Spanish (Balearic Islands, Spain) Child age range 6 – 14 Mixture of parents concurrently in drug treatment program and non-addicted partners Urban	Pre-post design with comparison group (not randomized)
Focus on Families (FOF)	Catalano et al (1997; 1999; 2002) Gainey et al. (2007) Haggerty et al. (2008)	Parents predominantly White (At 12-15 yr follow-up, children predominantly identified as non-White) Parent concurrently receiving methadone treatment in Seattle Child age range 3 – 14 yrs	Pre-post design with control group (random assignment) Long term follow-up (12-15 yrs post intervention)

		Urban	
Moving Parents and Children Together (MPACT)	Altobelli (2007) Barton (2014) Boon et al. (2007) Templeton (2011; 2012) Templeton et al. (2011; n.d.)	Predominantly White Mixture of parents in treatment/in recovery/still using/non-addicted partners from 13 sites across UK Child age range 8 – 17 yrs Urban/Rural	Qualitative
Safe Haven	Aktan (1995; 1997; 1999) Aktan et al. (1996)	African American Child age range 6 – 12 yrs Mixture of parents concurrently in drug treatment program in Detroit and non-addicted partners Urban	Pre-post design. No comparison group
Strengthening Families Program (SFP)[a]	DeMarsh et al. (1986) Kumpfer (1998) Kumpfer et al. (1996; 2002; 2003; 2010)	1) Parents concurrently in outpatient drug treatment (methadone or other outpatient) in Salt Lake City, Utah Child age ranges 6 – 12 yrs Urban 2) African American Mixture of mothers in drug treatment in rural Alabama and not in treatment Rural 3) Predominantly non-White (Asian, Pacific Islander, American Indian, Hispanic) Mixture of parents in treatment/recovery/non-addicted partners Child age range 6 –13 yrs 4) Multi-ethnic Mixture of parents currently in treatment, not in treatment, in recovery in New Jersey Child age ranges: 3-16 yrs Urban	Pre-post design with control group (random assignment) Pre-post-follow up design with comparison group (not randomized) Quasi-experimental retrospective pre-post design with post-hoc comparison groups

[a] SFP was originally designed for COSAPs; however subsequent program implementations have been revised to include at-risk youth whose parents are not substance users. Only documents/evaluations specific to COSAPs were retained for this review.

Table 2

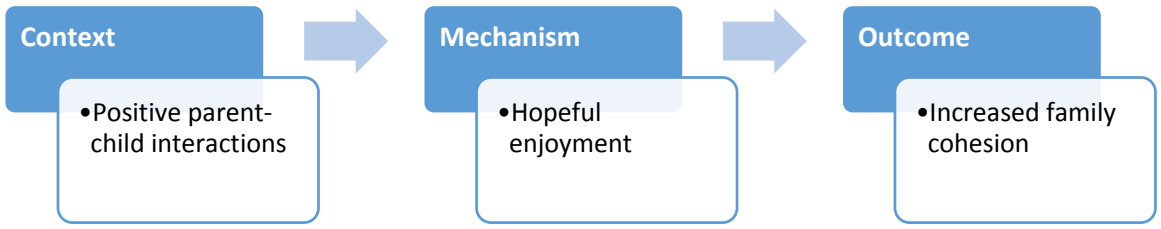
Selected Contexts, Mechanisms, and Outcomes of COSAP Programs Retained for Review (Alphabetical)

Program Name	Citations	Selected outcomes reported	Contextual factors	Mechanisms	Demi-regularities identified for which there was sufficient evidence	Candidate theory alignment
Betty Ford Children's Program	Moe et al (2007; 2008)	Reduced child loneliness Improved child social skills (younger children and girls only)	Peer grouping Knowledge provision	Trust/safety Relinquishing responsibility	Supportive peer relationships Knowledge	Family disease
Celebrating Families!/ Celebrando Familias!	Coleman (2008) Lutra Group (2006; 2007) Sparks et al. (2011; 2013)	Improved Family cohesion Improved parenting skills	Knowledge provision	Recognition and responsibility	Knowledge	Hybrid
Family Competence Program (FCP)	Orte et al. (2008)	Improved family cohesion Improved parenting skills Improved child behaviours and social skills	Opportunities for parent-child bonding	Hopeful enjoyment	Positive parent-child interactions	Family prevention
Focus on Families (FOF)	Catalano et al (1997; 1999; 2002) Gainey et al. (2007) Haggerty et al. (2008)	Improved parenting skills Reduced parental substance use Reduced incidence in child SUD (males only)	SES sensitivity	Hopeful enjoyment (Lack of)	None (Lack of mechanisms sufficiently explored)	Family prevention
Moving Parents and Children Together (MPACT)	Altobelli (2007) Barton (2014) Boon et al. (2007) Templeton (2011; 2012) Templeton et al. (2011; n.d.)	Improved Family cohesion Improved parenting skills Improved child behaviours and emotions	Opportunities for parent-child bonding Peer grouping Knowledge provision	Hopeful enjoyment Trust/safety Validation Relinquishing responsibility	Positive parent-child interactions Supportive peer relationships Knowledge	Hybrid

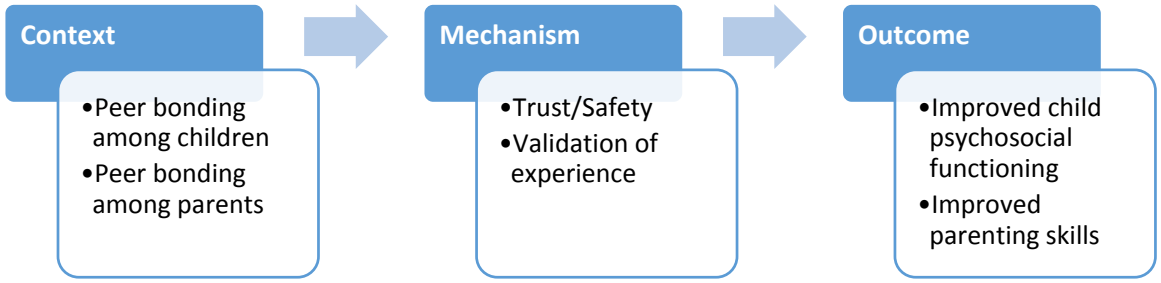
				Recognition and responsibility		
Safe Haven	Aktan (1995; 1997; 1999) Aktan et al. (1996)	Improved family cohesion Improved child behaviours (high drug using families only) Reduced parental substance use	SES sensitivity Matching services to lived experience Opportunities for parent-child bonding	Trust Hopeful enjoyment	Positive parent-child interactions Engagement	Family prevention
Strengthening Families Program (SFP)[a]	DeMarsh et al. (1986) Kumpfer (1998) Kumpfer et al. (1996; 2002; 2003; 2010)	Improved family cohesion Improved child behaviours and emotions Improved parenting skills	SES sensitivity Opportunities for parent-child bonding Peer grouping	Trust/safety Hopeful enjoyment Validation	Positive parent-child interactions Supportive peer relationships Engagement	Family prevention

[a] SFP was originally designed for COSAPs; however subsequent program implementations have been revised to include at-risk youth whose parents are not substance users. Only documents/evaluations specific to COSAPs were retained for this review.
SUD = substance use disorder. SES = socio-economic status

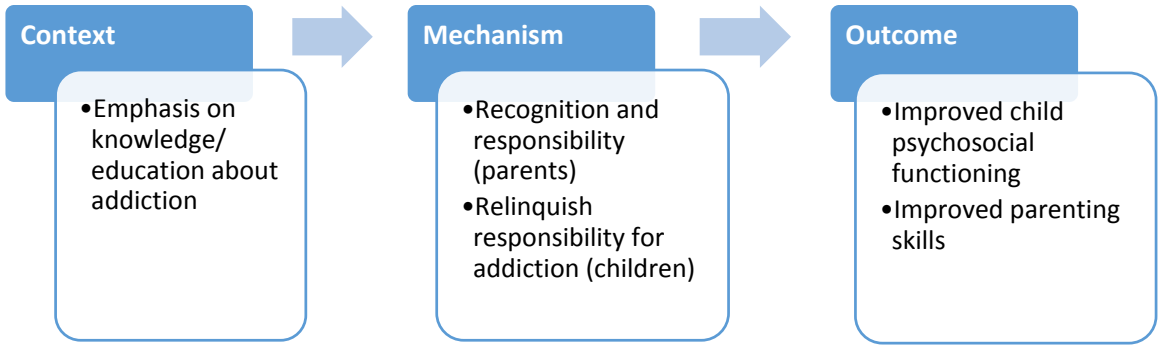
1. Creating opportunities for positive parent-child interactions



2. Supportive peer-to-peer relationships



3. (Addiction) knowledge is power



4. Engagement

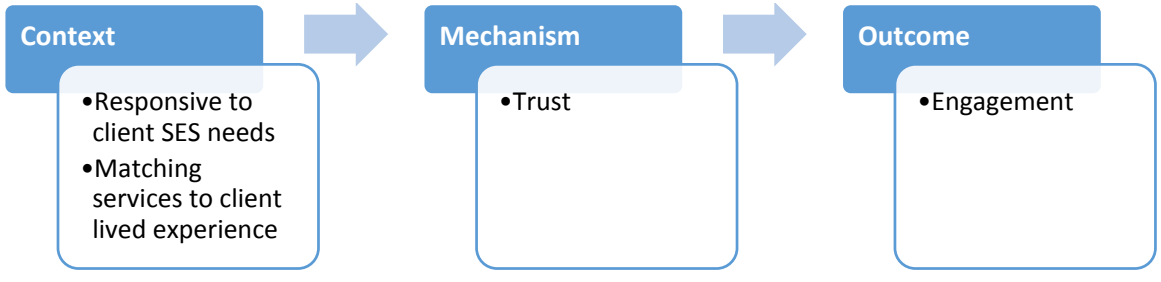


Figure 2. *Visual depiction of demi-regularities identified in realist review*

STUDY 2: CHILDREN'S PROGRAM EVALUATION

Methods

Program Description

The Children's Program was created in 2010 by Renascent in collaboration with Dr. Robert Ackerman, co-founder of the National Association for Children of Alcoholics in the US, and two lead consultants in Canada, Lucy Van Wyck and Janine Gates. The Renascent Children's Program was designed to meet the needs of children aged 7 to 13 who have been affected by parental substance abuse. The program is a four-day intensive program and children are accompanied by a parent or guardian playing a key care-giving role. The parent accompanying the child may or may not be the parent with addiction, and family members attending must remain sober for the duration of the program. The program runs parallel groups for the child and parent participants with frequent overlapping activities, and follows a treatment manual. The Renascent Children's Program format and family-based intervention approach is unique in Canada and closely resembles the Betty Ford Children's Program offered in the US.

The overarching goals of the Children's Program are to create a safe environment for children in which to learn about how addiction impacts their family, help foster coping skills, and increase emotional and psychological well-being through peer-support. Parents and caregivers are provided with information on family addiction and are taught parenting skills and coping skills. Families are also provided with opportunities for positive interactions within a safe and supportive environment. Over the longer term it is hoped that the family cycle of addiction can be disrupted. Upon completion of the program, families are invited to attend monthly Alumni Night meetings where they can continue to interact with Renascent staff and other families from the Children's Program. Two Alumni Night groups, one for younger children and

one for teens, are offered in order to accommodate increasing numbers of alumni since the Children's Program ran its first group in January, 2011.

Table 2 provides an overview of the Children's Program curriculum. Parents and children are guided through the program in separate groups, although there are shared activities that families will participate in together. The children's group is led by up to two Masters level counsellors who have training in addiction treatment and work with children. The children's group content is focused on learning about addiction, emotions, safe people, and coping skills. The parents' group is also lead by two counsellors with training and certification in addiction treatment. The parents' group content is focused on understanding the impact of addiction on children, how to support children living with addiction, appropriate parenting skills, and building positive parent-child interactions. Practicum students or other trainees often assist with group facilitation.

Table 3

Children's Program Curriculum Overview

	Topics	
Session	Children's Group	Parents' Group
Day 1	Addiction: What is happening to my family?	Addiction: The elephant in the living room
Day 2	It's OK to share my feelings	Rewriting the rules
Day 3	The heart of recovery: Telling my parent and celebrating myself	Your recovery toolbox
Day 4	Changing the family legacy: Celebrating you and me	Taking it with you

A logic model for the evaluation of the Children's Program was developed in collaboration with Renascent, and can be found in Figure 3.

Evaluation Approach

In keeping with principles of community-based collaborative evaluation, continued efforts to foster and maintain a partnership between the researchers at Ryerson and staff at Renascent were made. Partnership development was fostered prior to the study implementation through the creation of a memorandum of understanding (MOU). This process was consistent with those outlined for community involvement in participatory research (Minkler & Baden, 2008). The MOU served as a partnership agreement and outlined the roles, responsibilities, and expectations of all partners for the duration of this evaluation study. In particular, guiding principles for community-based participatory research were described, including mutual respect and communication, the value of research and lived experience emerging from community-engagement, and the importance of capacity building for the project partners. This MOU was co-created and signed by all partners at Ryerson and Renascent. Further, extensive consultations with Renascent stakeholders took place at all stages of the evaluation: design, implementation, data collection, and dissemination. Stakeholders comprised key staff members at Renascent who were directly involved in the implementation of the Children's Program, including front-line program counsellors, management, and administrative staff. Proposed methodology, outcomes to be measured, recruitment strategies, and dissemination of results were mutually agreed upon through frequent consultation and discussions. As community-based evaluation best practices recognize that programs are dynamic and that evaluation must adapt to shifting contextual factors (Rodriguez-Campos, 2012), expectations for flexibility of process was respected throughout the partnership.

Resources/ Inputs	Activities	Outputs	Outcomes		
			Short-term	Medium-term	Long-term
1. Human Resources • Intake coordinator • Children's Program counsellors • Parent's Program counsellors 2. Funding and in-kind donations • Funding from donors • Program fees • Academic researchers for evaluations 3. Materials and other resources • Program manuals and curriculum • Activities and other materials for use with program 4. Lived experience of addiction	Intake and Administration • Referral • Assessment and group placement • Ongoing communication and rapport with client	• # participants enrolled • # sessions attended • Post-program satisfaction survey (parents and children)	• Participant attendance • Retention • Satisfaction • Word of mouth recommendation to others		
	Children's Group • Relaxation time • Teaching about addiction • Teaching about feelings • Sharing feelings • Teaching about healthy choices • Celebrating myself	• Letter to addiction • I'm a safe person (safety plan) • Artwork (e.g. family portrait) • I'm a star	• Self-care (relaxation techniques and making healthy choices) • Increased knowledge of addiction and relapse (addiction as a family disease; who in family has addiction) • Emotional intelligence (Identification and communication of feelings) • Empathy (for parents and peers) • Psychological well-being (self-esteem, reduced shame/ shyness) • Follow-up care (phone calls)	• Self-care (Relaxation and stress reduction; engaging in healthy choices) • Communication skills (assertiveness) • Improved self-esteem /self-efficacy • Psychological well-being (anxiety/depression/isolation/ loneliness) • Engaging in age-appropriate activities • Improved family relationships(parent with and without addiction, siblings) • Follow-up care (alumni night)	• Breaking the cycle of silence • Breaking traditional family roles • Abstaining from alcohol/drugs
	Parents Group: • Teaching about addiction/families • Teaching about parenting skills • Stress reduction/ relaxation • Family recovery plan	• Parenting recovery plan • Family shield	• Knowledge of impact of addiction on children • Knowledge of appropriate parenting skills • Creation of family recovery plan • Use of relaxation techniques	• Parenting skills (appropriate boundaries, affirming child's needs) • Participation in family activities • Following family recovery plan • Relaxation/stress reduction • Coping with own emotions/shame/guilt • Follow-up care (12 step meetings, online support)	• Continued sobriety • Family closeness (spends quality time together as a family)

Figure 3. *Logic model*

This evaluation study also adhered to best practices of intervention-oriented evaluation, whereby evaluation is integrated into the intervention such that it supports desired program goals (Patton, 2008; 2012). Consultations conducted with Renascent staff during the initial planning phase made clear the necessity to mitigate additional burden to staff and clients as a result of participating in the evaluation. An embedded approach was chosen in order to support Renascent's organizational capacity for evaluation and complement the delivery of the Children's Program. One of the positive features of using an embedded approach is that additional costs, both human and financial, to the organization are minimized as data collection is fully integrated into program design, delivery, and implementation. As such, evaluation measures were integrated directly into the Children's Program curriculum as much as possible.

Mixed methods design. A concurrent triangulation mixed methods research design (Creswell, 2003) was adopted for this study because the combination of qualitative and quantitative data allows for a more complete exploration of the research questions and provides better overall understanding of social phenomena. Green, Benjamin, and Goodyear (2001) argue that the purposeful mixing of methods enhances the validity and credibility of inferences, contributes to a greater comprehensiveness and insightful understanding of findings, and is best used in situations where a single data set (either qualitative or quantitative) is insufficient to answer the research questions. The use of a mixed methods design allows for qualitative data to be integrated within a quasi-experimental design (Creswell & Plano Clark, 2007). The present study employed a quantitative baseline and follow-up design, where outcomes will be measured using standardized questionnaires at baseline and after the intervention. Qualitative data were collected at follow-up in the form of semi-structured interviews with parent and child

participants of the Children's Program, as well as key informant interviews with Renascent staff members.

Process Evaluation Design

The process evaluation component was designed to assess the extent to which the Children's Program is being effectively implemented at Renascent. This component is intended to address Research Questions 3: *Is the Children's Program being effectively implemented at Renascent?* Subsumed under this research question are five core aspects of program implementation: fidelity, recruitment, dose delivered, participation rate, and client satisfaction.

Fidelity is defined as the extent to which an intervention is delivered as intended, and is considered a measure of quality and integrity of program delivery (Linnan & Steckler, 2002). Fidelity of delivery was conceptualized in two ways: process (the manner in which content is delivered) and content (adherence to core content curriculum). Client fidelity was also assessed, which encompasses the extent to which clients are engaged and involved in program curriculum (Sidani & Braden, 2011). Fidelity checklists and a client summary checklist were developed for this study and were used to measure program fidelity.

Recruitment refers to the methods used by the organization to approach and attract potential program participants (Saunders et al., 2005). Key information interviews with staff and a recruitment survey were used to measure this construct. Dose delivered refers to the number of program units or components offered to participants, and is a reflection of the efforts of the program delivery providers (Linnan & Steckler, 2002). Participation was determined by the number of sessions received by participants as a function of enrollment. Administrative data obtained from Renascent was used to measure dose delivered and participation rates. Finally, client satisfaction refers to the degree to which participants were satisfied with the program and

their interactions with staff (Linnan & Steckler, 20020; Saunders et al., 2005). Client satisfaction questionnaires and semi-structured interviews were used to measure this construct. A more detailed description of all these materials is outlined in the measures section below.

Outcome Evaluation Design

The outcome evaluation component was intended to measure the effectiveness of the program in achieving its stated goals for child, parent, and family level changes. This component was designed to address Research Questions 4 and 5: *What changes in knowledge, behavior, and psychological functioning have occurred for families who participate in the Children's Program?* and *What is the experience of families who participate in the Children's Program?* A repeated measures design was used, where data were collected at baseline and at follow-up 1 – 3 months after program completion. Given the structure of the Children's Program and the outcomes desired, separate constructs were measured at the child, parent, and family level, using a combination of quantitative and qualitative measures. Child constructs measured include anxiety and depressive symptoms, social skills, loneliness and isolation, conduct behaviours, communication skills, coping skills, and knowledge. Parental constructs measured include parenting behaviours, emotion regulation, and self-care. Family constructs measured include family functioning and family communication. A more detailed description of these measures is provided in the measures section below. Participants completed quantitative measures independently, although they were assisted with reading comprehension by program or research staff as needed.

Quantitative Measures

Parenting Style Questionnaire. The Parenting Style Questionnaire (Robinson, Mandleco, Olsen, & Hart, 1995) is a 30-item questionnaire designed to measure parenting

behaviours consistent with Baumrind's parenting typology of parenting styles (authoritative, authoritarian, and permissive; see Appendix B). Items are measured on a five-point Likert scale ranging from 1 (never) to 5 (always). The original scale contained 62 items and has since been revised to its current form. Reliability for each subscale is reported to range from α =.75 to α = .91 (Robinson et al., 1995). For the present study, internal consistency ranged from acceptable (α = .70) to excellent (α = .93) at baseline and from acceptable (α = .66) to excellent (α = .90) at follow-up.

Self-Care Questionnaire. The Self-Care Questionnaire (Powell, 2000) is a 15-item questionnaire developed to measure self-reported activities related to individual health and well-being (see Appendix C). Items are measured on a four-point Likert scale ranging from 0 (Very unlike me) to 3 (Very like me). For the present study internal consistency was found to be good, ranging from α = .79 at baseline to α = .86 at follow-up.

Difficulties with Emotion Regulation Scale (DERS). The Difficulties with Emotion Regulation Scale (DERS) is a 36-item questionnaire developed by Gratz and Roemer (2004). The DERS is rated on five-point Likert scale ranging from 1 (almost never) to 5 (almost always), and consists of six subscales (see Appendix D). These subscales include: Non-acceptance of emotional responses; Difficulty engaging in goal-directed behavior; Impulse control difficulties; Lack of emotional awareness; Limited access to emotion regulation strategies; and Lack of emotional clarity. Internal consistency of this measure is reported as high (α = .93) overall and for each subscale (α >.80; Gratz & Roemer, 2004). This scale also demonstrates good test-retest reliability (r = .88, p < .01; Gratz & Roemer, 2004). The DERS has recently been validated on alcohol abusing populations (Fox, Hong, & Sinha, 2008) and cocaine dependent patients (Fox, Axelrod, Paliwal, Sleeper, & Sinha, 2007). For the present study, internal consistency ranged

from good (α = .84) to excellent (α = .90) at baseline, and good (α = .77 to α = .89) at follow-up with the exception of the Difficulties engaging in self-directed behaviour subscale which was found to have poor reliability (α = .49) at follow-up.

Family Adaptability and Cohesion Evaluation Scales Version IV (FACES-IV). The FACES was originally created by Olsen and colleagues based on the Circumplex Model of family functioning (Olsen, 1986). The most recent version (FACES-IV; Olsen, 2010) contains 62 items and eight subscales. For the purpose of this research study, only the following five subscales will be used, for a total of 38 items: balanced cohesion, balanced flexibility, rigid, chaotic, and family communication (see Appendix E). Items are measured on a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Internal consistency alphas for each subscale range .70 to .90 (Olsen, 2010). The FACES-IV has been used with problem drinking populations (Laghi, Baiocco, Lonigro, Capacchione, & Baumgartner, 2012; Woodson, Softas-Nall, & Johnson, 2012) and drug abusing populations (Asberg & Renk, 2012). For the present study, internal consistency ranged from poor (α = .53) to good (α = .88) at baseline, and from poor (α = .50) to good (α = .81) at follow-up.

Strengths and Difficulties Questionnaire, Parent Report Measure for Children (SDQ-PC). The Strengths and Difficulties Questionnaire (SDQ) was developed by Goodman (1997) as a brief behavioural screening measure completed by parents of children aged 3-16. The measure consists of 25 items and five subscales in the form of a three-point checklist (not true, somewhat true, certainly true). For the purpose of this research study only the following four subscales are included, for a total of 20 items: conduct problems, emotional symptoms, peer problems, and prosocial (see Appendix F). The SDQ is widely used in clinical and developmental research and is highly correlated with the Child Behaviour Checklist (CBCL;

Achenbach, 1991; Goodman & Scott, 1999). Psychometric research has found satisfactory internal consistency (α = .73; Goodman, 2001). For the present study, internal consistency ranged from poor (α = .58) to acceptable (α = .78) at baseline, and good at follow-up (α = .70 to α = .81) with the exception of the Peer problems subscale (α = .44 at follow-up).

Short Moods and Feelings Questionnaire (SMFQ) – Parent report version. The Short Moods and Feelings Questionnaire (SMFQ; Angold , Costello, Messer, Pickles, Winder & Silver, 1995) is a 13 item scale completed by parents of children aged 6 and older in a common response format (0 = never, 1 = sometimes, 2 = always; see Appendix G). Internal consistency is reported as high (α = .87) and the SMFQ was found to correlate moderately with the Children's Depression Inventory (Angold et al., 1995). Internal consistency ranged from excellent (α = .90) at baseline to good (α = .75) at follow-up.

Client Satisfaction Questionnaire Version 8 (CSQ-8). The Client Satisfaction Questionnaire was originally published by Larson and colleagues in 1979 and is now used in its current form (CSQ-8) worldwide in numerous healthcare, social service, educational, and community mental health settings (Larson, Atkisson, Hargreaves, & Nguyen, 1979; Nguyen, Atkisson, & Stegner, 1983). The CSQ-8 consists of eight items rated on a four-point Likert scale (see Appendix H), and 2 open-ended questions ("The thing I liked best about the program was" and "If I could change one thing about the program"). Coefficient alphas reportedly range from .83 to .93 (Atkisson, 2012). De Wilde and Hendriks (2005) reviewed the psychometric properties of the CSQ-8 in a Dutch substance abusing population and reported high internal consistency and concurrent validity. For the present study, internal consistency was found to be good (α = .81).

Child Client Satisfaction Survey. A review of available satisfaction questionnaires designed for children yielded no suitable existing measure. As such, the Child Client Satisfaction

Survey was created for this study (see Appendix I). This measure contains five items, three of which are rated on a Likert scale. The remaining two items are open ended ("The part I like best was…" and "I did not enjoy…").

Fidelity checklists. Fidelity checklists for the both the children's group and the parents' group were created by the author for this study (see Appendix J). Counsellors delivering the program independently rated whether components of the program were delivered as specified. These checklists will be completed daily for the duration of the program. Responses between raters will be compared to ensure reliability of the fidelity data. These checklists included a content component (adherence to program content) and a process component (manner in which content is delivered). Checklists were created in collaboration with Renascent staff to reflect key content areas to be covered during the program, as well as desirable skills necessary for successful program delivery. The self-report procedures for the fidelity checklist are in line with recommended practices for fidelity assessment where direct observation is not feasible or appropriate (Sidani & Braden, 2011).

Client summary checklist. A client summary checklist for child participants was developed for this study in collaboration with the Renascent family counsellors, as a measure of client fidelity or engagement. This checklist is designed as a behavioural observation tool, where counsellors rate the child's behaviour, participation, progress, or mastery of key program components. It contains a total of 43 items rated on a 10-point scale ranging from 1 (not at all) to 10 (completely), and is completed at the end of each day for the duration of the program (see Appendix K). Some items were scored daily for each child while other items are specific to the content covered that day and thus only scored once. An overall mean score was calculated for each child and served as an indicator of program engagement, where higher scores indicate

higher levels of engagement. Checklists are routinely used as a means of measuring client engagement and program uptake (Sidani & Braden, 2011). In the present study, internal consistency was found to be excellent ($\alpha = .93$).

Recruitment survey. Key staff members involved in the implementation and management of the Children's Program were administered a survey designed to document client recruitment practices for the Children's Program, barriers to family participation in the program, and suggested solutions to those barriers (see Appendix L). This survey was administered electronically via Qualtrics and was completely anonymous. No identifying information was collected from respondents during this survey.

Follow-up Qualitative Tools

Parent semi-structured interview protocol. An interview was administered to parents approximately 1 to 3 months after their family had participated in the Children's Program. The parent interview protocol consisted 5 questions designed to assess their family's experience of participating in the Children's Program, program satisfaction, and perception of program effectiveness. Example questions include: "Tell me about your decision to participate in the Children's Program" and "What parts of the program were most useful for you?". Interview questions can be found in Appendix M. Parent interviews ranged in length from 11 to 28 minutes. Interviews were conducted by the author and a trained research assistant.

Child semi-structured interview protocol. An interview was administered to children approximately 1 to 3 months after they had participated in the program. The protocol was designed to assess knowledge, identification of emotions, coping skills, healthy choices, and communication skills. The interview format centered on the use of a brief vignette, followed by questions relating to the narrative. The use of vignettes or narratives in qualitative research with

children is well documented (Barter & Renold, 2000) and has been used in previous studies involving COSAP populations (Moe, Johnson, & Wade, 2007). Vignettes are stories that provide concrete examples of people or situations. Researchers are then able to facilitate a discussion with children in response to the vignette (Barter & Renold, 2000). Socially desirable responding may be mitigated through the use of vignettes when participants are invited to respond on behalf of a character (Hughes & Huby, 2004).

The authenticity of a vignette approach is increased when the narrative is relevant to the participant's life and is perceived to be realistic (Barter & Renold, 2000; Hughes & Huby, 2004). The character in the vignette for this study was adapted to the gender of the child participant and to reflect the specifics of the child's family situation (i.e. which family member has an addition), so as to make the narrative as relatable as possible. Feedback on the appropriateness of this vignette was solicited from Renascent children's counsellors. A copy of the vignette and interview questions can be found in Appendix N. Interviews ranged in length from 5 to 17 minutes. Interviews were conducted by the author and a trained research assistant.

Staff key informant interviews. Key staff members involved in the delivery or management of the Children's Program were asked to participate in a semi-structured interview. The interview protocol was designed to elicit information about program implementation and recruitment strategies, as well as the experience of being a stakeholder in the evaluation project. Specific areas covered during the interview included perceptions of the pre-implementation consultation process, the experience of implementing the evaluation materials, and the organizational benefits of community-research partnerships for program evaluation. A copy of the key information interview protocol can be found in Appendix O. Interviews ranged in length from 18 to 42 minutes. Interviews were conducted by the author.

Ethical Approval and Data Collection Procedures

Ethical approval for this study was obtained from Ryerson University's Research Ethics Board (REB) in August 2012, prior to data collection. The purpose of the ethics application was twofold: 1) To gain approval for a data sharing agreement between the Renascent and the author at Ryerson. This was considered to be third party use of administrative program data. 2) To gain approval to conduct follow-up interviews with families who participated in the Children's Program. Consent procedures, recruitment, and data storage agreements outlined in the REB process are described in more detail below.

Consent procedure. All families who were enrolled in the Children's Program at Renascent between October 2012 and February 2014 were eligible to participate. On day 1 of the Children's Program, families were approached by Renascent staff, explained the purpose of the evaluation, and given an opportunity to voluntarily participate. Given the embedded nature of this evaluation study, all of the quantitative measures described below were incorporated into the program curriculum and as such were completed by all clients enrolled in the Children's Program regardless of decision to participate in the evaluation research. However, only those families who consented to participate in the evaluation had their data shared with the author at Ryerson University as a third party. Families who consented to the evaluation were informed that they would be contacted at a later date and invited to participate in the follow-up portion of the study. In other words, families who consented to participate in this evaluation study did so in a two-step process. First, they consented to allow the data they generated throughout the course of the Children's Program (i.e. questionnaire data) confidentially shared with the author at Ryerson University as a third party, as well as agree to be contacted at a later date for follow-up. Those participants who agreed to be contacted for follow-up undertook a second consent procedure that

informed them as to the nature of follow-up interviews. All consent forms can be found Appendix P.

For the follow-up portion of the study, participants were contacted and arrangements were made for follow-up interviews with both parents and children. Interviews took place in the evenings at Renascent, just prior to the optional Alumni Night programming that Renascent offers for all alumni of the Children's Program. Alumni Night takes place the first Tuesday of every month and was deemed to be the best way of engaging families in the follow-up portion of the evaluation. Parents went through a second consent process and children signed an assent form. Parents were offered a $10 incentive to participate in the follow-up interview and children were offered a small token (e.g. school supplies) for their participation at follow-up. A pizza dinner was also provided to all families who participated in the follow-up interviews in order to facilitate scheduling of interviews around the supper hour. Interviews were conducted by the author and a trained research assistant. Interviews were audio-recorded once consent was obtained. Upon completion of the interviews parents were re-administered all measures with the exception of the *CSQ-8*. In summary, data were collected at two time points: Baseline data were collected during the program (Time 1) and follow-up data were collected 1 to 3 months after completion of the program (Time 2).

In addition to the families who participated in the Children's Program, Renascent staff members involved in implementation and delivery of the program were approached after data collection with families was complete and asked to voluntarily participate in key informant interviews. Key informant interviews were conducted by the author. A copy of this consent form can also be found in Appendix P.

Storage and ownership of data. Data obtained from the Children's Program participants at baseline was collected and maintained by Renascent. Baseline data from consenting participants was confidentially shared with the author as a third party evaluator, as per the processes outlined above. All baseline data generated during the implementation of the Children's Program was considered to be property of Renascent and thus ownership resided with the organization. Upon competition of each Children's Program group, photocopies of the all questionnaires and measures completed by consenting families were provided to the author. At follow-up, data collection and management was the responsibility of the author. Consent procedures for follow-up participation clearly outlined to participants that only the researchers at Ryerson University would have access to the data generated from those interviews and questionnaires. Due to the nature of the questioning (i.e. satisfaction with the program, program staff, and perceived effectiveness), it was important that participants were assured confidentiality. As such, ownership of the follow-up data resided with the author at Ryerson.

All data were kept in a secure location at 105 Bond St at Ryerson University. Participants were assigned a unique ID code and names were removed from all written materials. A master copy of the participant names matched with the ID codes was kept by the author and stored in a separate secure cabinet. Data obtained from quantitative measures was entered into an SPSS data file and stored on a secured network at Ryerson University. Datasets contained only participant ID codes as identifiers; no names were included. Interviews were digitally audio-recorded. At the commencement of the interviews, participants were identified solely by their ID code and efforts were made on the part of the interviewer to omit any identifying information including the participant's full name. Once completed, these recordings were uploaded to a secured network at Ryerson University and transcribed. Interview transcripts were cleaned of any identifiable data

(such participant name or name of family members) and were also stored on a secured network. Audio-recordings and transcripts were accessible only to the author.

Participants

A total of 23 families participated in the Children's Program between October 2012 and February 2014. Renascent ran a total of six Children's Program groups over this time period, with each program session comprising three to five families. Of these, two families declined to participate in the evaluation study. A further two families agreed to participate in the evaluation, but did not complete the full 4 days of the program and were therefore excluded from analysis due to incomplete data. The sample for this evaluation study therefore consists of 19 families, comprising of 52 individuals (26 parents and 26 children). Follow-up data (Time 2) was obtained from 11 of the 19 families who participated at baseline (Time 1). Although efforts were made to contact all families who participated at baseline, the follow-up sample represents approximately 57.9% of the families who participated at baseline. Families were contacted via email and phone number provided during the initial consent process. Up to three attempts at contact were made by the author, in addition to other attempts at contact made by Renascent staff as part of regular follow-up counselling procedures. Those eight families who chose not to participate at follow-up were unreachable and thus reasons for dropout are unknown. See Tables 3 – 4 for a demographic description of the child and adult participants, both at baseline and at follow-up. Socio-economic data were not available. In addition to the families who participated in the outcome evaluation, seven staff members were recruited to participate in key informant interviews. These staff members comprised family counsellors (n = 4), student interns (n = 2), and a senior manager (n = 1).

Table 4

Demographic Description of Adult Participants in the Children's Program (N = 26)

All adults (*N* =26)		Adults with follow-up data (*N* = 14)	
Gender	*n* (%)	Gender	*n* (%)
Male	8 (31%)	Male	4 (29%)
Female	18 (69%)	Female	10 (71%)
Age	(yrs)	Age	(yrs)
Mean	43.31	Mean	42.5
SD	8.47	SD	8.6
Range	26 – 59	Range	26 – 55
Relation to child	*n* (%)	Relation to child	*n* (%)
Mother	15 (58%)	Mother	9 (64%)
Father	6 (23%)	Father	2 (14%)
Grandmother	3 (12%)	Grandmother	1 (7%)
Uncle	1 (4%)	Uncle	1 (7%)
Step-father	1 (4%)	Step-father	1 (7%)
Was legal guardian of child in program	*n* (%)	Was legal guardian of child in program	*n* (%)
Yes	17 (65%)	Yes	9 (64%)
No	9 (35%)	No	5 (36%)
Has addiction history (current or in recovery)	*n* (%)	Has addiction history (current or in recovery)	*n* (%)
Yes	11 (42%)	Yes	4 (29%)
No	15 (58%)	No	10 (71%)

Note. Percentages may not add up to 100 due to rounding. No significant differences between groups on any demographic variables.

Table 5

Demographic Description of Child Participants in the Children's Program (N = 26)

All Children (*N* =26)		Children with follow-up data (*N* = 15)	
Gender	*n* (%)	Gender	*n* (%)
Male	12 (46%)	Male	6 (40%)
Female	14 (54%)	Female	9 (60%)
Age	(yrs)	Age	(yrs)
Mean	9.65	Mean	9.33
SD	2.56	SD	2.53
Range	6 – 15	Range	6 – 13
Parent with addiction	*n* (%)	Parent with addiction	*n* (%)
Mother	7 (27%)	Mother	4 (27%)
Father	17 (65%)	Father	9 (60%)
Other*	2 (8%)	Other*	2 (13%)
Parent with addiction attended program	*n* (%)	Parent with addiction attended program	*n* (%)
Yes	13 (50%)	Yes	6 (40%)
No	13 (50%)	No	9 (60%)

Note. Percentages may not add to 100 due to rounding. No significant differences between groups on any demographic variables. *Two children (from the same family) had an older sister with an addiction.

Data Analysis Strategy

Missing data. Quantitative data obtained from the questionnaires were entered into an SPSS file and scored according to published guidelines. All quantitative data were screened for data entry errors and missing data and verified against original documents. Missing data were addressed as follows: 1) Scales with missing items were dealt with according to published guidelines, where they existed. For example, the SDQ specifies that scales may still be scored if at least 3 items per scale were completed (i.e. no more than 2 missing items per scale) (Youth in

Mind, 2014); 2) In cases where measures could not be scored due to too many missing items, these cases were removed listwise from analyses. This occurred in 5 cases. Little's MCAR test (Little, 1998) was performed to determine whether data were missing at random. Little's MCAR test was not significant (Chi square = .000, DF = 2499, sig. = 1.000.), indicating that data can be considered missing at random.

As previously noted, participant attrition occurred from baseline to follow-up whereby fewer questionnaires were completed at Time 2 than at Time 1. As this study employed a repeated measures design, only those participants with complete data from both time points were included in the repeated measures analyses (i.e. paired-sample t-tests). All participants were retained, however, for analyses that did not involve repeated measures, such as the client satisfaction questionnaires (which were administered only at baseline).

Multiple informants. The Children's Program welcomes multiple members of the same family to participate in the program. As such, family composition varied in this sample. In some cases, two children from the same family attended the program (n = 7 families); in other cases two parents accompanied one or more children (n = 8 families). Because the measures of child behaviours were parent-rated (SDQ and SMFQ), there were cases where data from multiple informants was obtained for a single child. Contemporary approaches to addressing multiple informants discourage the use of pooled data or averaging, and likewise there are drawbacks to performing separate analyses (Goldwasser & Fitzmaurice, 2001; Kaur, 2013). Because multiple informant data were available in a minority of cases (n = 8 children with multiple parent raters, two of whom did not participate at follow-up and were thus excluded from certain analyses), a decision was made to use information provided from the biological mother only. While family

composition varied for each child (e.g. mother and step-father attended; mother and grandparent attended), in all cases the biological mother was present and provided data.

Quantitative analysis strategy. All continuous scale variables were screened for outliers. No outliers were identified as being more than three standard deviations beyond the mean. Continuous subscale variables were also screened for normality. A Shapiro-Wilk test was conducted to determine if any variables differed significantly from a normal distribution. All scale variables, at baseline and follow-up, met the assumption of normality ($p > .05$), with the exception of the Self-Care Total Score at baseline ($p = .047$). Given that this variable only just meets significance level, a decision was made to maintain this variable in its current form for subsequent analyses.

Two subscales (Difficulties Engaging in Goal Directed Behaviour from DERS and Peer Problems from SDQ) were found to demonstrate below acceptable levels of internal consistency ($\alpha < .50$) at follow-up. An examination of item-total statistics revealed that internal consistency would not be significantly improved ($\alpha > .50$) with removal of any individual items. A decision was made to retain scales in their current form or purpose of these analyses.

As this study used a repeated measures design, paired sample t-tests were used to compare questionnaire data at baseline (Time 1) to follow-up (Time 2). Mean time elapsed between baseline and follow-up was 66.14 days (SD = 19.76, range = 33 – 102 days). Descriptive statistics were used for questionnaires that were administered at a single time point (e.g. client satisfaction questionnaires, recruitment survey).

Qualitative analysis. Interviews conducted with parents, children, and staff were audio-recorded and transcribed verbatim. Transcripts were analyzed with thematic content analysis and immersion/crystallization. Thematic analysis is a method for identifying, grouping, and

reporting patterns or themes emerging from within the data (Braun & Clarke, 2006). Immersion/crystallization is commonly used in qualitative research as an organizational style (Crabtree & Miller, 1999). In immersion/crystallization, no pre-existing theory or template is used to generate themes. Rather, the researcher engages in an iterative process of identifying and coding patterns as they emerge from the text (Crabtree & Miller, 1999). Pieces of text are then re-arranged into categories such that a meaningful summary emerges. A process of continual comparison ensures that content within categories and subcategories is thematically similar, and that categories are distinct from one another. This is consistent with a general inductive approach to analysis of qualitative evaluation data, and is commonly used in social science and health evaluation research (Thomas, 2006).

In accordance with best practices in qualitative analysis (e.g. Braun & Clarke, 2006; Creswell & Plano Clark, 2007; Thomas, 2006), the following strategies were applied. Initial readings of the raw data allowed for preliminary themes and categories to emerge, and was guided by the evaluation objectives. A coding scheme was devised by the author and applied to the data through multiple readings in order to summarize data in to key themes. Frequent discussions about the coding scheme, data categories, and preliminary themes took place between the author and the academic supervisor. A detailed coding manual was created as an organizational tool that outlined how themes were defined, how they were differentiated from each other, and provided examples to guide the coding process. Data coding proceeded in an iterative fashion between the author and the supervisor, such that continued revision and refined of key themes and codes occurred and were ultimately determined by consensus. This process of peer debriefing and stakeholder checks is key to ensuring trustworthiness of qualitative analysis, particularly in evaluation research (Thomas, 2006). The current study upheld these best practices

to ensure reliability and validity of data, as per the process described above. Lastly, the coding schemed was finalized in such a way that the categories consisted of qualitative themes that could also be counted to provide quantitative frequency data (Creswell & Plano Clark, 2007).

Preliminary Analyses

Participants who completed the Children's Program but failed to participate in the follow-up assessment (n = 23) were compared to those who completed the evaluation at both time points (n = 29). Both groups were similar across all demographic variables presented in Tables 3 and 4. To further compare groups, independent t-tests were conducted to compare baseline scores between groups. No statistically significant differences were found on any of the outcomes measures, client satisfaction measures, or client engagement measures (see Tables 5 – 6). This suggests that the findings from this study are likely representative of all clients who enrolled in the Children's Program during the evaluation time period.

Table 6

Comparison of Baseline Scores for Child Measures

Measure	Participants with baseline and follow-up (N = 13) M (SD)	Participants with baseline only (N = 10) M (SD)	t
SDQ			
Prosocial	8.69 (1.49)	9.00 (1.05)	.553
Conduct problems	2.31 (2.72)	2.40 (1.84)	.092
Peer problems	1.69 (1.93)	1.43 (1.07)	-.422
Emotional symptoms	4.15 (1.77)	4.45 (3.10)	.270
SMFQ	4.88 (4.51)	7.43 (5.04)	1.276
Client summary checklist	8.31 (1.31)	7.48 (1.19)	-1.504

Note. $p > .05$ in all cases. N reflects number of participants for whom scores could be calculated.

Table 7

Comparison of Baseline Scores for Parent Measures

Measure	Participants with baseline and follow-up (N = 14) M (SD)	Participants with baseline only (N = 12) M (SD)	t
Parenting Style			
Authoritative	4.12 (0.40)	3.91 (0.85)	.818
Authoritarian	2.15 (0.37)	2.41 (0.81)	1.027
Permissive	2.23 (0.63)	2.53 (0.80)	-1.064
Self-care	24.23 (7.26)	25.79 (3.97)	-.659
DERS			
Non-acceptance of emotional response	11.57 (4.57)	15.00 (6.61)	-1.558
Difficulty engaging in goal directed behaviour	15.43 (5.14)	14.36 (5.05)	.518
Impulse control difficulties	12.50 (3.35)	13.75 (5.80)	-.685
Lack of emotional awareness	17.43 (5.35)	15.83 (5.59)	.743
Limited access to emotion regulation strategies	16.93 (4.83)	18.00 (8.08)	-.418
Lack of emotional clarity	12.07 (3.43)	13.00 (4.33)	-.610
Total score	85.93 (17.73)	89.73 (33.02)	-.375
FACES			
Cohesion	27.09 (3.30)	27.20 (6.49)	-.348
Flexibility	24.27 (2.93)	24.30 (4.45)	-.017
Rigid	20.92 (4.03)	22.25 (3.52)	-.874
Chaotic	17.31 (4.15)	15.83 (5.04)	.801
Family communication	35.15 (5.48)	34.82 (6.95)	.132
CSQ-8 Total score	31.0 (1.80)	30.82 (1.75)	-.239

Note. $p > .05$ in all cases. N reflects number of participants for whom scores could be calculated.

Complete analyses are presented in the results section below. Process evaluation results are presented first in order to establish effective program implementation. This is followed by quantitative and qualitative outcome evaluation results.

Process Evaluation Results

Research Question 3 "Is the Children's Program being implemented effectively?" was designed to assess fidelity of implementation, dose delivery and participation, as well as examine any contributing factors that might have impacted on effective program implementation. Effective implementation must be first established in order for outcome evaluation results to be credible.

Fidelity of Implementation

Fidelity of the Children's Program was operationalized in three ways in order to capture a broad picture of intervention implementation. This included content fidelity, process fidelity, and client fidelity (engagement).

Content fidelity. Content fidelity refers to adherence to intervention protocol and is intended to evaluate the extent to which the Children's Program curriculum was delivered as intended. Results (see Table 7) are reported as an overall percentage of content coverage, as well by specific day, and indicate high levels of adherence to program content.

Table 8

Percentage of Program Content Covered Overall and by Day

	Overall	Day 1	Day 2	Day 3	Day 4
Children's Group	90%	92.9%	84.7%	91.7%	90.3%
Parent's Group	91.9%	90.9%	87.2%	94.4%	96.3%

Process fidelity. Process fidelity refers to the manner in which content is delivered and the skills demonstrated by program facilitators. This was measured using a daily rating checklist completed independently by each counsellor responsible for facilitating the program. The checklist measured the presence of skills such as empathy, respect for client, modeling

appropriate behaviour and checking for client understanding. Again, these results were compiled separately for the children and parent groups, overall and by day. A rating of 100% was achieved for all groups for each day and overall.

Client engagement. Client engagement and uptake of program material was measured using a client summary checklist that was rated by staff on behalf of each child enrolled in the program. This checklist is measured on a 10-point scale (high scores represent high levels of program engagement). Mean overall score was 7.98 (SD = 1.30, range = 5.60 – 9.73), indicating fairly strong program participation and engagement on the part of child participants. For example, the majority of children were rated as making sufficient eye contact throughout the program, were able to name safe adults, and were engaged with their parent during the Family Shield activity.

Dose Delivered and Participation Rates

During the course of this evaluation study (October 2012 to February 2014), the Children's Program ran a total of 6 groups. The program was originally intended to be implemented on a monthly basis, however insufficient enrollment occurred and targets were subsequently lowered to bi-monthly groups part-way through the evaluation. Even with these lowered expectations, dose delivery fell below desired rates. Retention or attrition rates are used to measure program participation, and refer to the percentage of participants who withdraw from the intervention out of the total number of consenting participants (Sidani & Braden, 2011). Here, post-inclusion attrition rate was used as it best reflects the number of families who withdrew from the program after having enrolled and consented to the Children's Program. Of the 19 families who enrolled in the Children's Program and consented to the evaluation, 2 families did not complete the full program and thus did not provide full baseline data. This

represents a 10.5% post-inclusion attrition rate (or 89.5% retention rate). High retention rates generally signify high levels of intervention acceptability (Sidani & Braden, 2011).

Despite the low attrition rate once enrolled in the Children's Program, an examination of the recruitment practices at Renascent was conducted in order to further investigate low enrollment. Renascent staff members completed an electronic survey and participated in key informant interviews. Staff members identified a number of barriers to participation as well as areas where participant recruitment could be improved. These were found to be contributing factors to the lower than anticipated enrollment rates. A summary of these factors are presented below.

Recruitment practices (staff recruitment survey). Fourteen staff members completed the survey examining program referral sources and existing recruitment practices. The majority of respondents indicated that referrals for the Children's Program primarily came from existing Renascent clients (n = 12) as well as clients' friends and family (n = 8), with the predominant recruitment method being the Renascent website (n = 13) and internal promotion to current clients (n = 13). Although other methods of recruitment were noted such as outreach and promotion to other community agencies (n = 10) and advertising campaigns (n = 3), these were not endorsed as being the most effective. These results suggest that the reach of the Children's Program is limited in its current format and could be expanded in order to improve enrollment rates.

Barriers to participation (staff recruitment survey data). Survey participants (n = 14) were asked to identify up to four potential barriers faced by families with respect to enrollment and participation in the Children's Program, follow by potential solutions to those barriers. This question was open-ended; participants could describe barriers and solutions in as little or as

much detailed as desired. Responses were coded and grouped thematically. Barriers related to accessibility of the program (e.g. financial, time commitments, location) were noted frequently, as were barriers related to lack of awareness (e.g. about the impact of addiction on kids, about the program itself, denial that problem exists), fear (e.g. about what children will learn or say in the program), and stigma (e.g. addiction stigma prevents families from reaching out for help). The suggested solutions to be these barriers involved better promotion of the program and outreach to needy families, structural changes to the program to increase accessibility, and providing research and testimonials about program effectiveness to parents who may be reluctant to enroll.

Barriers to participation (key informant interview data). Staff members who participated in the key informant interviews ($N = 6$) were asked to reflect on the types of families who typically participate in the program and those who are not being adequately reached by the Children's Program. Staff discussed a number of themes that support the barriers previously reported in the recruitment survey above. In particular, it was noted that families who choose to participate are generally already accepting of the difficulties faced by their children as a result of addiction. These are typically families who are existing Renascent clients and open to a 12-step philosophy. Families who show reluctance to participate were perceived by staff as lacking recognition of the impact of that addiction has on children or who were not ready to openly discuss addiction in a family context. The fear and stigma associated with addiction were also identified as barriers to participation during the staff interviews. Families who are socially or economically unstable were also highlighted as being more difficult to engage in the program and were anecdotally perceived to be less likely to return to Renascent for monthly Alumni Nights. It is interesting to note that a large proportion of the families who participated in this

evaluation had received a bursary in order to attend (indicating financial need), and yet continued to attend Alumni Nights after the program. Possibly those families whose need is most dire do not choose to enroll in the first place. Finally, a number of staff discussed the need to reach out to CAS involved families, minority families, and economically disadvantaged families. It was suggested that a stronger relationship with CAS and other groups (e.g. Native Family Services, Jewish Family Services, new immigrant family services) could be forged, as well as having a more diverse range of counsellors representing other ethnic background. The need for more promotion of the program in general was highlighted during the key informant interviews.

Credibility of the Evaluation Partnership

Staff reflections on the evaluation process. As a final stage in the collaborative evaluation with Renascent, staff members (n = 7) who participated in the key information interviews were asked to reflect on the evaluation process as a whole and to offer their perception of the embedded approach to the Children's Program evaluation study. All staff who were interviewed reported having a positive experience during the evaluation project. The evaluation was described as seamless (n = 4), the evaluators as accommodating (n = 2), and the staff in general felt supported throughout the process (n = 3).

When asked about any challenges that were encountered during the evaluation, major themes discussed by staff were increased paperwork (n = 4) and additional client burden in filling out the questionnaires (n = 3). Three staff members indicated that no challenges were encountered. As a follow-up to this question, staff were asked to discuss how these challenges were addressed. Staff noted that additional time was taken in order to explain the purpose of the questionnaires to the clients and that staff built in additional time to their day to accommodate the additional paperwork (n = 3). One staff member felt that these challenges had already been

dealt with during the consultations conducted prior to the evaluation launch, and another noted that s/he had ultimate confidence in the ability of front-line staff to deal with those challenges as they arose. No staff member who participated in the interview indicated that any of these challenges were insufficiently addressed.

Staff reflections on key informant interviews. All staff members who participated in the key informant interviews were asked to reflect on the impact of being interviewed by the author, as opposed to an independent third party. It is acknowledged that collaborative community research involves evolving relationships between partners, and that complete objectivity and neutrality on the part of the evaluator is neither attainable nor expected. The purpose of this line of inquiry with key informants was to serve as a validity check to assess the potential for socially desirable responding and to provide staff with an opportunity to voice any concerns with this process. All participants responded that it would have been strange had another individual conducted the interviews or that it had no impact on their responses. For example, one participant responded thusly: "*I preferred that it was you. We have a connection, we have a bond through this experience and if it was somebody else, would they know all of this?*" One individual acknowledged that he/she had an awareness of the potential for bias and that he/she made a deliberate effort to brush aside the urge to provide desirable responses.

Outcome Evaluation Results

Research Questions 4 and 5 were addressed by the outcome evaluation component of this study. Quantitative and qualitative results are presented below in the following order: a) changes in behaviour and psychological functioning based on quantitative questionnaire data; b) changes in behaviour and psychological functioning based on qualitative parent interview data; c) changes in knowledge and skills for children based on qualitative interview data.

Changes in Behaviour and Psychological Functioning

Questionnaire data. Within-subjects repeated measures t-tests were calculated to measure any significant changes over time on the following outcomes: child emotional symptoms, child loneliness and isolation, child social skills, child behavioural symptoms, parenting skills, parent emotion regulation, parent self-care, family cohesion, and family communication. Results for child, parent, and family level outcome are presented in Tables 8 – 10. Note that due to small sample size, gender, age, participation, and cohort level analyses were not feasible. As such, only full sample analyses are presented below.

With respect to child-level outcomes, significant changes were found on the Conduct Problems and Emotional Symptoms subscales of the SDQ, as well as the SMFQ (See Table 8). This indicates that children experienced significantly fewer emotional symptoms, behavioural problems, and depressive symptoms after participating in the Children's Program. Corresponding effects sizes were moderate to large (Cohen's d = .65 to .95). The decreases noted in the Emotional Symptoms subscale resulted in scores moving from the "borderline" range at baseline to the "normal" range at follow-up according to published norms (Youth in Mind, 2014). All other means for SDQ subscales and for the SMFQ (depressive symptoms) fell within the

normally accepted range of scores, both at baseline and at follow-up (Angold et al., 1995; Youth in Mind, 2014).

For the parent level outcomes, significant changes were found on the DERS total score and four of the six DERS subscales (see Table 9). This indicates that parents reported significantly improved awareness of their own emotions and ability to deal with their emotions after participating in the Children's Program. Effect sizes noted for changes in the DERS were moderate to large (Cohen's d = .60 to .87). A significant decrease was also noted in the Authoritarian Parenting Style subscale of the Parenting Style Questionnaire. This indicates that fewer parents endorsed this parenting style, which is characterized by highly controlled discipline and low levels of warmth, after participating in the program. A moderately large effect size was noted (Cohen's d = .70). No changes were observed for the self-care questionnaire.

Finally, significant changes at the family level were also observed. Significant increases were noted on the Cohesion and Flexibility subscales of the FACES questionnaire, as well as the Family Communication scale (see Table 10). This indicates that families reported greater family functioning and communication after participating in the Children's Program. Family Communication scores increased from "moderate" at baseline to "high" at follow-up, according to published norms (Olsen, 2010). Other FACES subscale means fell within acceptable levels (Olson, 2010). Corresponding effect sizes were considered large (Cohen's d = .73 to 1.02).

Table 9

Child Outcomes (*N* = 13)

Measure	Baseline *M* (SD)	Follow-up *M* (SD)	Difference (*t*)	*d*
SDQ				
Prosocial	8.69 (1.49)	8.92 (1.26)	-0.71	-.20
Conduct problems	2.31 (2.72)	1.15 (1.63)	3.43**	0.95
Peer problems	1.69 (1.93)	1.02 (1.00)	1.73	0.48
Emotional symptoms	4.15 (1.77)	2.77 (2.52)	2.77*	0.77
SMFQ	4.88 (4.51)	2.31 (2.69)	2.33*	0.65

Note. *N* includes only participants who completed measures at both time points.
*$p < .05$ **$p < .01$

Table 10

Parent Outcomes (*N* = 14)

Measure	Baseline *M* (SD)	Follow-up *M* (SD)	Difference (*t*)	*d*
Self-Care	24.23 (7.26)	25.46 (6.19)	-0.91	-0.25
DERS				
Non-acceptance of emotional response	11.57 (4.57)	9.29 (3.05)	2.36*	0.63
Difficulty engaging in goal directed behaviour	15.43 (5.14)	13.36 (2.53)	1.76	0.47
Lack of emotional awareness	17.43 (5.35)	13.57 (5.14)	2.61*	0.70
Impulse control difficulties	12.50 (3.35)	10.29 (3.00)	2.26*	0.60
Limited access to emotion regulation strategies	17.31 (4.80)	14.00 (4.12)	3.07*	0.85
Lack of emotional clarity	12.07 (3.43)	10.64 (3.78)	1.47	0.39
Total score	87.38 (16.46)	71.69 (14.52)	3.13**	0.87
Parenting Style				
Authoritarian	2.15 (0.37)	1.90 (0.54)	2.62*	0.70
Authoritative	4.12 (0.40)	4.32 (0.45)	-1.89	-0.51
Permissive	2.23 (0.63)	2.25 (0.77)	-0.11	-0.03

Note. Includes only participants who completed measures at both time points
*$p < .05$ **$p < .01$

Table 11

Family Outcomes (*N* = 14)

Measure	Baseline *M* (SD)	Follow-up *M* (SD)	Difference (*t*)	*d*
FACES				
Rigid	20.92 (4.03)	21.62 (2.93)	-0.67	-0.19
Chaotic	17.31 (4.15)	15.31 (3.15)	1.74	0.48
Cohesion	27.09 (3.30)	28.82 (3.55)	-2.41*	-0.73
Flexibility	24.00 (2.94)	26.30 (2.91)	-3.21*	-1.02
Family communication	35.15 (5.48)	38.69 (4.09)	-3.50**	-0.97

Note. Includes only participants who completed measures at both time points
*$p < .05$ **$p < .01$

Parent interview data (qualitative). Fourteen parents participated in a semi-structured follow-up interview approximately 1 – 3 months post program completion. These parents were asked to discuss any changes they had noticed in their family's functioning after participating in the program, as compared to before the program. Parents were free to discuss as many different types of changes as they wished. A wide range of family changes were discussed and responses were coded thematically. The themes that emerged reflect the findings from the quantitative outcome measures: child behavioural and emotional improvements, family communication, and family functioning were all noted by parents as positive changes occurring after participating in the Children's Program. A full list of themes is presented below in Table 11, followed by illustrative quotes that exemplify each theme.

Table 12

Changes Reported by Parents after Participating in the Children's Program

Type of change reported	*N* = 14 % (*n*)
Improved child ability to express self	78.6 (11)
Improved family relationship	71.4 (10)
Better understanding of impact of addiction on the family	50.0 (7)
Child seems happier or less distressed	42.6 (6)
Less secrecy and denial	35.7 (5)
Improved family communication	35.7 (5)
Fewer angry or emotional outbursts	21.4 (3)
More time spent together as a family/establishing new family traditions	21.4 (3)
Increased trust	21.4 (3)
Free to be a kid again	21.4 (3)
Child recognition that addiction is not their fault	14.3 (2)
Improved relationship with partner	14.3 (2)
Improved parenting skills	14.3 (2)
Child recognition they are not alone	7.1 (1)

Note. Participants could endorse more than one theme.

Improved child ability to express self. The most frequently cited change noted by parents after participation in the Children's Program was their child's improved ability to express themselves (*n* = 11). This was discussed in terms of being more confident in expressing their thoughts and emotions, using words to express their feelings as opposed to emotional outbursts, being less afraid to express their thoughts and feelings with their addicted parents, and generally feeling safer in expressing themselves.

> 63P2: "The kids are able to articulate themselves differently… I guess just talking about how they are feelings, you know, instead of yelling at each other"

> 12P1: "They are both pretty comfortable that they can say whatever they want. And they are not afraid to talk in front of their dad. … they know that I am always supporting them and I have their back."

Improved family relationship. Most parents (*n* = 10) reported that their relationship with their children felt closer and that there was a stronger family bond after participating in the program.

> 62P1: "I think there is more closeness and it is more honest. Right? That is really the bottom line."

> 41P1: "Definitely my relationship with them is better"

> 22P1: "Well it has drawn us closer together because she knows that she has someone that she can talk to and trust and is a safe place for her to talk with me."

Better understanding of impact of addiction on family. Half of the parents (*n* = 7) noted that they and their children had gained a better understanding of addiction and the impact that addiction has had on their family. Parents also discussed how the conceptualization of addiction as a disease was helpful.

> 62P1: "I think there is, I don't know how to explain it, but there is a calmness that comes from the situation through knowledge."

> 31P1: "I think because he has a little bit of a better understanding of why the family is the way it is. And I think because he was told honestly what has happened and what was going on, it helped him ease his mind. He has changed for sure."

Child is happier and less distressed. Many parents (*n* = 6) reported that their child seemed to be happier after participating in the program or that their children appeared to be less distressed.

> 63P2: "The kids just seem more relaxed and they seem to enjoy being at home, as opposed to wanting to leave because it's all so tense"

41P1: “They are less stressed, the kids are less stressed. They know they can call [counsellor name**]**, they can call a counsellor, and say if they need to talk to somebody.”

***Less secrecy and denial*.** Five parents reported that the secrecy surrounding addiction had been reduced in their family after participating in the Children’s Program. Parents discussed being able to more openly and honestly discuss addiction in the family.

41P1: And, I think, and it’s not, it’s not a big secret, you know, like it’s, it’s okay to talk about it, it’s even okay to talk about it with other family member who knew there was an issue, they’re much more able to do that.

62P1: “We didn’t name it [before]. I never really knew what to say to her. And now I know that she has the context for that. And I don’t have to walk around and pretend that I am feeling perfect all the time. It is just a much more honest way of living.”

***Improved family communication*.** Five parents discussed improvements in the level and quality of communication within the family, after having participated in the program. This was described in terms of healthy communication and using appropriate language and techniques learned in the program.

32P1: “There is an openness that has been expanded on. I mean we have always been open with each other but it is a lot deeper now. We can talk about much more intimate things now. And in a healthy way.”

62P1: “I find now that there is almost like a common language that we can use with each other, so it is easier to communicate with her because we both have the same baseline of information.”

63P2: “I think initially before the program they were feeling really misunderstood about their feelings or emotions and what was going on. So there was a lot more, I guess, arguing and it was the littlest things. But now after the program there’s, you know, like the “I” statement strategies, the whole idea of put-ups instead of put-downs.”

Changes in Knowledge and Skills (child interview data)

Children were read a vignette and asked a series of questions about the characters in the story and to describe their reactions to the story. Recall that the character in the vignette was

intended to reflect the child's own experience of having a substance abusing parent. Children were free to respond to questions by making direct reference to the characters in the story or to draw from their own lives. Questions centered on the following themes: the child's ability to identify a range of emotions that might be experienced by the characters in the story; ability to identify appropriate coping strategies; demonstration or examples of communication skills and assertiveness; ability to generate a list of safe people; and exploration of child's understanding of addiction and recovery. Responses were coded thematically and are presented below along with frequency of themes endorsed.

Identification of emotions (own and parent). Questions were posed to assess child's ability to identify and describe their own thoughts and feelings, as well as engage in perspective taking on their parental situation. Children identified a wide range of emotions and were free to discuss as many as they desired. Tables 12 and 13 below present a summary of the results, organized thematically.

Table 13

Child's Own Thoughts and Feelings Identified

Thoughts and feelings identified	*N* = 14 % (*n*)
Shame/embarrassment	92.9 (13)
Sadness	64.3 (9)
Helplessness/hopelessness	50.0 (7)
Fear/anxiety	42.9 (6)
Anger/frustration	35.7 (5)
Loneliness	35.7 (5)
Wishful thinking	35.7 (5)
Guilt	21.4 (3)
Disappointment in parent	21.4 (3)
Somatic	7.1 (1)
Other/unclear	28.6 (4)

Note. Children could endorse multiple emotions.

Table 14

Identification of Parent's Thoughts and Feelings

Parent's thoughts and feelings	*N* = 14 % (*n*)
Anger	57.1 (8)
Denial/lack of awareness	42.9 (6)
Sadness/hopelessness	35.7 (5)
Remorse/sense of responsibility	35.7 (5)
Other/unclear	35.7 (5)

Note. Children could identify multiple emotions.

Coping skills. Children were asked what the character in the story could do to cope with their situation and feel good about themselves. Children were also probed to describe what they

would do if they were in a similar situation to that of the character. These questions were designed to assess the range of coping skills demonstrated by the children. Responses were thematically coded according to a four-factor model of dispositional coping that is specific to children (Ayers, Sandler, West, & Roosa, 1996) and has been previously validated in COSAP populations (Smith et al., 2006). Table 14 provides as summary of these coping strategies, followed by a description and sample quotations.

Table 15

Coping Strategies Identified by Children

Coping strategies	*N* = 14 % (*n*)
Distraction	92.9 (13)
Support-seeking	85.7 (12)
Active	28.6 (4)
Avoidant	28.6 (4)

Note. Children could endorse multiple themes.

The two most frequently reported coping strategies were distraction and support-seeking. Distraction coping is defined as engaging in activities to keep oneself from thinking about the problem or efforts to provide emotional relaxation (Ayers et al., 1996; Smith et al., 2006). In the present study, children frequently cited examples such as playing games and sports, drawing, or watching movies. Support-seeking coping strategies are those that involve the use of social support for dealing with problems, such as seeking advice or expressing emotions (Ayers et al., 1996; Smith et al., 2006). Children frequently stated that they would share their feelings with a trusted adult or friend or that the character in the story should talk to a safe person.

A smaller number of children provided examples of active and avoidant coping strategies. Active coping is defined as directly focusing on the problem and attempting to

problem-solve (Ayers et al., 1996; Smith et al., 2006). In this case, children actively problem-solved by telling their parent to stop drinking or seek treatment. Avoidant coping is distinguished from distraction coping in that efforts are made to escape or stop thinking about the problem without substituting an alternative activity (Ayers et al., 1996; Smith et al., 2006). This included wishful thinking (e,g. "I wish my dad would stop drinking") or trying to forget the problem.

Assertiveness/communication skills. Children were asked to describe what they thought the character in the story should say or do in order to express their feelings, or what they would do if they were in a similar situation. A large majority of children (*n* = 11) provided an example of assertive communication (see Table 15). Some illustrative quotes are provided as examples below.

> 32C1: "Well, tell them how she is feeling and why she is feeling this way. And explain what happened to make her feel this way, the situation"
>
> 22C1: "[I would say] that I don't like how you are acting and it feels like you are leaving us out."
>
> 62C1: "I would probably say to them that I was feeling angry or upset and that doesn't make me feel good."

Aside from assertive communication, one child discussed a method of non-verbal communication that he/she had previously used in his/her family. One child stated that he/she would opt to not communicate his/her feelings for fear of being yelled at or reprimanded by his/her parents. Two children chose not to respond to this question.

Table 16

Communication Styles Endorsed by Children

Communication styles	*N* = 14 % (*n*)
Assertive	78.6 (11)
Non-verbal	7.1 (1)
Do not communicate	7.1 (1)
No response	14.3 (2)

Note. Children could endorse multiple themes

Safe people. Children were asked to identify one or more safe people that they could contact. The concept of safe people featured prominently in the Children's Program curriculum. All children were able to identify at least one safe person. One child mentioned that he/she would prefer not to get anyone else involved, but was still able to identify a safe person. Table 16 below presents a summary of safe people that were identified.

Table 17

Safe People Identified by Children

Safe people identified	*N* = 14 % (*n*)
Extended family (e.g. aunt, uncle, grandparent)	57.1 (8)
Renascent staff member	50.0 (7)
Other trusted adult (e.g. babysitter, teacher, police, CAS worker)	50.0 (7)
Trusted friend	28.6 (4)
Non-addicted parent	28.6 (4)

Note. Children could identify more than one safe person

Understanding of addiction and recovery. The final portion of the semi-structured interviews included questions about the child's understanding of addiction and recovery. The Children's Program emphasizes that addiction is a lifelong disease that cannot be cured, only

managed. Children are taught that the disease affects the whole family including children, that people need help to stop using drugs or alcohol, and that recovery is a journey that may take a long time. Children were asked to explain in their own words the concept of addiction and recovery, in order to determine what information was retained from the program.

Children provided a wide range of explanations for addiction (see Table 17). The most frequent theme was a psychological or behavioural understanding of addiction (n = 10). This included concepts of loss of control, being unable to stop, or doing bad things under the influence of alcohol or drugs. (e.g.: 63C2: "It means like you're always wanting to drink or use drugs and you can't stop yourself"). About half the children demonstrated an understanding of addiction as a persistent disease (n = 8) or as having a biological basis (n = 6).

> 63C1: "It is always there and it is never going to go away, but if you go into treatment then you are learning all these ways that you are not alone and to deal with it"

Four children discussed some of the positive aspects of substance use (e.g. 41C1: "Maybe because he likes it. A lot of people like alcohol and like to drink it"), and four children stated that addiction was curable. Three children did not know or were unable to provide an explanation of this concept.

Table 18

Child Understanding of Addiction

Theme	*N* = 14 % (*n*)
Psychological/Behavioural understanding	71.4 (10)
Persistent disease	57.1 (8)
Biological understanding	42.9 (6)
Positive aspects	28.6 (4)
Curable condition	28.6 (4)
Unsure	21.4 (3)

Note. Children could endorse more than one theme.

A range of responses was also provided by children about their understanding of recovery (see Table 18). Half of the children (*n* = 7) indicated that recovery meant sobriety. Children also discussed recovery in both individual (*n* = 6) and family (*n* = 5) contexts. For example:

> 41C1: "Well I think they [addict] get stronger emotionally and they know what the side effects of doing it are that impacts them"
>
> 21C1: "Their family feels better and they are not worried anymore"

Other responses included seeking help (*n* = 5) and that it required hard work (*n* = 2).

Table 19

Child Understanding of Recovery

Theme	*N* = 14 % (*n*)
Sobriety	50.0 (7)
Individual recovery	42.9 (6)
Family recovery	35.7 (5)
Seeking help	35.7 (5)
Hard work	14.3 (2)
Unsure	14.3 (2)

Note. Children could endorse more than one theme.

In summary, the qualitative interviews conducted with child participants in the Children's Program reveals that children demonstrated a wide range of emotional self-awareness and empathy, adaptive coping strategies, assertiveness and communication skills, as well as knowledge of safe people and principles of addiction and recovery.

Client Satisfaction

Research question 5 addressed the experience of families participating in the Children's Program, and was assessed via satisfaction questionnaires and qualitative interviews.

Parent Satisfaction (CSQ-8). Results from the CSQ-8 (*N* = 26) were overwhelmingly positive. All parents responded that they were mostly to very satisfied with the services provided by Children's Program. Mean overall score for the CSQ-8 was 30.92 (SD = 1.74). The highest possible score for this scale is 32. This was higher than reported norms that have been found to range from 27.09 to 27.23 for adults receiving counselling or mental health services (Attkisson & Greenfield, 2004). For the open-ended portion of the questionnaire, participants reported the following aspects they liked best about the program: group dynamics and peer support (*n* = 11),

quality and helpfulness of the staff (*n* = 10), positive impact of the program on their children (*n* = 9), general positive statements about program content (*n* = 6), and positive impact of the time they spent with their children during the program (*n* = 5). Participants were also asked to provide suggestions to improve the program. The most frequent responses were related the scheduling of the program (*n* = 5), the content or structure of the program (*n* =5), and the location of the where the program is offered (*n* = 5). A number of participants responded that there was nothing they would change about the program (*n* = 4) and two participants noted that time management could be improved (*n* = 2).

Child Client Satisfaction Questionnaire. Children also reported high levels of program satisfaction. When asked "overall, how well did you like the program?", 88.4% (*n* = 23) responded either "awesome" or "I liked it a lot". The majority of children reported that they would "absolutely" recommend the Children's Program to a friend (57.7%, *n* = 15), although nearly one third responded "maybe" (30.7%, *n* = 8), and three children responded "no way" (11.5%). The proportion of children who appear to be reluctant to recommend the program to others is interesting. It may be an indication of persistent shame or embarrassment about having an addicted parent, or it could simply be a reflection that these children do not know of anyone else who could benefit from the program.

For the open-ended portion of the child satisfaction questionnaire, children were asked to describe what they liked best about the program and what they did not enjoy. The majority of children reported that they enjoyed the games and artwork the best (*n* = 15), followed by sharing their feelings and talking about addiction (*n* = 9) and meeting and connecting with other kids (*n* = 6). Other comments included mention of the Dear Addiction letter (*n* = 3), how much they liked the staff (*n* = 3), the food and snacks (*n* = 2), and the safe people list (*n* =1). Three children

reported that they like everything about the program. The most common response children provided to what they did not enjoy was "nothing" (n = 7) or having to leave at the end of the program (n = 6). Other responses included mention of particular activities in the program (n = 4), food or snacks (n = 3), and the addiction monster (n = 2). One child felt that the program was too geared towards younger children.

Parent follow-up interviews (qualitative). Parents who participated in the follow-up interviews were given the opportunity to describe in greater depth their levels of satisfaction with the program and the benefits they did or did not receive from participating. Responses were analyzed thematically are presented below, along with illustrative quotes that exemplify each theme.

Peer support. Reflections on the peer-support nature of the program featured prominently in the parent interviews (n = 13). Many parents reported that sharing their experience with other parents with whom they could relate was valuable. This was often framed as a sense of relief that others could share and identify with their experiences, as well as the impact that came from hearing the experiences of parents who were the spouses of substance abusers and vice-versa.

> 31P1: "It was interesting seeing the other families' perspectives, you know the people who are not addicts. What they have gone through and what we have put them through. So that was pretty interesting to see."

> 41P2: "Well, that I am not alone. Just that other people are going through the exact same bullshit. And that you are not unique."

In addition to support for themselves, parents noted that the opportunity for their children to meet other children who also had a substance abusing parent was a positive feature of the program. Parents reported that their children quickly formed a bond with the others in the program.

> 63P2: "And it was really neat to see the dynamics, like the kids really connected with each other."
>
> 62P1: "And then she meets kids that she actually really likes and come from the same kind of family. It just makes her feel, frankly, not so weird."

Strengthening family bonds. Many parents noted that an important aspect of the Children's Program was the opportunity it provided for family bonding (n = 7). Parents reported that they enjoyed spending time with their child in a supportive environment. The notion of strengthening family values and encouraging positive family routines and rituals is an integral part of the Children's Program curriculum, and this was reflected in the parent interviews. Parents noted that the program reinforced shared family activities and the importance of spending time together.

> 63P1: "So it was very helpful again in terms of reassessing and looking at what your family values are, your family traditions, and what is important to all of you, and how to work towards maintaining those things. So that was very helpful."
>
> 63P2: "And, yeah it was just, especially when they brought us together with our children for some the activities it was just fun, you know, so that was really good."

Gaining knowledge. The knowledge gained about parenting, addiction, and how addiction impacts children, was frequently discussed as being key aspects of the Children's Program (n = 9). Parents reflected that the program provided a new understanding about how their children were impacted by substance abuse and provided useful skills for parenting and family communication. A number of parents also commented on the quality of learning materials and curriculum (n = 5).

> 63P2: "It just really gave us an understanding how a family gets out of balance, which we didn't really understand before. So that was very helpful, just understanding how a family is affected by addiction, and that it is a family illness."

> 21P1: “I was enlightened and learned a lot on the parenting side. Because you have a kid and no one gives you a course on how to be a parent.”

Taken as a whole, the findings pertaining to client satisfaction shed light on the processes through which changes occurred for families participating the Children’s Program. Peer bonding, both for parents and children, enjoyment from spending time together as a family during the program, and the perceived benefits of knowledge all appear to have contributed the improved outcomes noted for families participating in the Children’s Program.

DISCUSSION

The purpose of this dissertation was two-fold. First, a realist review of existing COSAP programs was conducted. Over 30 relevant documents spanning 7 COSAP programs were examined using a theory building approach to determine what patterns of contexts and mechanisms generate program outcomes. Second, a process and outcome evaluation of the Renascent Children's Program was undertaken. A mixed-methods, repeated measures design was used to explore program implementation and outcomes with 19 families who participated in the Children's Program. The state of current COSAP programming literature suggests a significant gap in the provision of evidence-based interventions for this population, as well as a gap in the broader understanding of program theory. This dissertation makes a meaningful contribution to the literature on COSAP interventions by filling the theoretical and practical gaps in the current knowledge base.

The fact that significant improvements were found in child emotional and behavioural functioning, parent emotional regulation, parenting style, family functioning, and family communication as a result of participating in the Renascent Children's Program is promising given the well-documented risk factors for COSAPs. While it is difficult to make direct comparisons to findings from other COSAP intervention evaluations due to methodological differences, the current study's findings are consistent with other positive outcomes reported in the literature (e.g. Broning et al., 2012). For example, the program most similar in structure to the Renascent Children's Program is the Betty Ford Children's Program. With respect to child outcomes, the Betty Ford evaluation (N = 129) noted significant improvements in child social skills and program related knowledge, as well as significant reductions in child loneliness (Moe et al., 2008). No changes in child assertiveness were found and no parent or family outcomes

were measured. In comparison, the current evaluation study of the Renascent Children's Program found a number of positive outcomes with moderate to large effect sizes across child, parent, and family domains, despite having a smaller sample size than the Betty Ford evaluation. Further, although both the current study and the Betty Ford evaluation lacked a comparison group, the current study employed standardized outcome measures and established high levels of implementation fidelity, both of which contribute to evaluation rigour. Few published COSAP evaluations document program fidelity; this can be considered a strength of the current study.

Combined with the findings from the realist review study, this dissertation makes a significant contribution to the literature on COSAP program theory. The four key pathways, or demi-regularities, that emerged from the realist review help explain how COSAP programs improve outcomes for families living with substance abuse. In an effort to answer the overarching research questions of this dissertation, an integrated discussion of results from studies 1 and 2 is presented below.

How do Family-Based Programs for COSAPs Generate Outcomes?

The evaluation study found that families who participated in the Renascent Children's Program experienced improvement in key areas of child, parental, and family functioning. Further, the demi-regularities uncovered in the realist review study help to explain the significant improvements noted in the evaluation study of the Renascent Children's Program. These findings shed light on how change occurs for both children and parents via differing mechanisms that are triggered in particular contexts. Results indicate that parents, children, and the family unit go through distinct processes in response to participating in the intervention, and that particular mechanisms are triggered in response to program contexts.

Child-related pathways. Findings from the realist review study indicate that, in the context of a group program where children are exposed to peers who have similar experiences of living with an addicted parent, children develop a sense of *trust and safety* within the group as well as the sense of having these experiences *validated*. These two mechanisms represent key internal processes that must occur in order to facilitate positive outcomes. With respect to the Children's Program evaluation study, positive outcomes included reduced depressive and emotional symptoms and improved conduct behaviours.

Alcohol and drug use is typically hidden within the family for many reasons including stigma, shame, and a reluctance to access services that could trigger child welfare involvement (Barnard & Barlow, 2003; Kroll, 2004; Lander, Howsare, & Byrne, 2013). As a result, children are often complicit in the secrecy surrounding parental substance use. Research has found that children are frequently encouraged from an early age to not talk or tell others about their parent's substance use (Hill, 2013; Kroll, 2004). The resulting culture of secrecy and fear leads to significant social isolation for many of these children (Peleg-Oren & Teichman, 2006). For many children, participation in a COSAP program may have been their first exposure to other children living with parental substance use. Supportive peer bonds can help to create an environment where children begin to feel safe speaking about their experiences and to develop a sense of trust. Indeed, bonding with other children with similar experiences was a recurring theme among participants interviewed for the Children's Program evaluation. Many parents reported that their children quickly developed a friendship with others in the program, which helped to reinforce the message that they were not alone in their struggles. Combined, these findings suggest that an internal process, or mechanism, wherein children develop of sense of safety and establish trust with other peers is vital in order for changes in behaviours and emotional functioning to occur.

Likewise, the presence of other peers allows for children to feel that their experiences of living with family addiction are valid. Sharing of similar experiences helps to break down feelings of loneliness and isolation. Again, the process of having their unique experiences validated sets the stage for changes to occur in behavioural and emotional functioning. Kroll (2004) notes that the mere fact of validating the existence of addiction within the home can be liberating for children. COSAP programs that successfully foster this process are likely to achieve better outcomes for children as a result. The Children's Program appears to successfully tap into this process.

In addition, the realist review study found that within the context of knowledge provision, COSAP programs can facilitate children to *relinquish responsibility* for their parent's addiction. Previous research suggests that children often feel an acute sense of responsibility and self-blame for their parent's addictive behaviour and their family's dysfunction (Kroll, 2004; Lander et al., 2013). Programs that successfully integrate addiction-specific knowledge and education will facilitate children to relieve themselves of the responsibility for their parent's addiction. The promotion of a disease-based understanding of addiction is often used as a means of explaining parental behaviour to children in order to reduce self-blame and guilt (Emshoff & Price, 1999). Indeed, the results from the current study confirm this. Addiction-specific knowledge provision and the mechanism of children relinquishing responsibility were found to be evident within programs originating in a family disease model. From a realist perspective, the successful firing of this mechanism will enable children to achieve positive outcomes in well-being and psychosocial functioning. Results from the Children's Program evaluation support these findings. Addiction knowledge was a core component of the Children's Program and it was found that children were able to demonstrate a range of understanding of the impact of addiction and recovery on the family.

Parent-related pathways. The realist review study findings indicated that in the context of a group program where parents interact with peers who share their experience of raising children in an addicted family (either as an individual with a substance use problem or the partner of the parent with substance use issues), participants experience a sense of supportive *validation*. Parent participants in the Children's Program likewise had the opportunity to interact with other parents experiencing similar struggles raising children in a household where one parent misuses substances. Follow-up interviews yielded themes where parents frequently noted the peer-based structure of the program and the benefits they received from interacting with other families with similar experiences. It may be that COSAP programs successfully create a safe space for parents within a peer-based context, which leads to an environment welcoming of social change (Rhodes et al., 2010). Parents who are in an environment in which they feel their experiences are shared by others and are validated will then be primed to better utilize the parenting resources the program has on offer, thus generating positive outcomes. Results from the Children's Program evaluation study found improvements in parenting style and parent emotion regulation, which supports this assertion.

Furthermore, results from the realist review suggest that parents who are provided with knowledge about how addiction impacts the family will undergo a process of *recognition and responsibility* for how their behaviours have impacted their children. Prior research with parents who are substance users indicates they often express a strong desire to keep their alcohol or drug use hidden from children, often out of shame or guilt (Barnard & Barlow, 2003; Rhodes, Bernays, & Houmoller, 2010). Yet, children have been found to have a detailed awareness of their parent's substance use (Barnard & Barlow, 2003; Hill, 2013). This suggests that despite parental efforts to hide their substance use, children are keenly aware of their behaviours and

thus parents may lack true awareness of the impacts of their substance use on children. This process has been referred to in the literature as damage denial (Rhodes, Bernays, & Houmoller, 2010). Parental desire to maintain secrecy, or at least ambiguity around their substance use activities, results in a lack of full awareness and recognition of the extent to which their children are impacted by addiction. Research suggests that parents who engage in damage acceptance, as opposed to damage denial, are more readily accepting of interventions that support recovery, particularly those involving parenting and substance management in the context of family life (Rhodes et al., 2010). Evidence for the existence of the *parental recognition and responsibility* mechanism, whereby internalized recognition will encourage parents to take responsibility for their behaviours, further supports this existing literature. This suggests that COSAP programs that provide knowledge and information to parents about the impacts of substance use on children and the family will enable parents to experience an increased recognition of the impacts of their lifestyle on children.

These findings may help to explain the positive outcomes found in the Children's Program evaluation study. The Children's Program strongly emphasizes knowledge about addiction from a family disease perspective. Improved parenting and parental emotion regulation were found as a result of program participation. During the follow-up interviews, parents frequently reported that the program had given them a better understanding of the impact that addiction has had on their family, and in particular a number of parents noted the conceptualization addiction as a disease had been helpful for their family. For example, one parent noted that knowledge brought a sense of calmness to the family and another reported a positive shift away from anger towards her addicted partner. Although many of the parents who participated in the follow-up interviews were not themselves substance users, they nonetheless

reported that increased knowledge was a significant benefit they received from the program, and may account for some of the changes observed in parenting style and emotion regulation.

Family-level pathways. Improved family functioning and family communication were noteworthy outcomes for families participating in the Children's Program. This is consistent with previous literature indicating that COSAP programs can have a positive impact on family relationships (Broning et al., 2012). Findings from the realist review study suggest that creating opportunities for positive parent-child interactions, and in particular those interactions that trigger the mechanism of *hopeful enjoyment*, can account for these positive findings. Previous research confirms that parental substance use can result in an unstable home environment. Cycles of relapse and recovery and preoccupation with substances can impair parent ability to display responsiveness, warmth, and consistency toward children, which over time may lead to poor attachment and poor quality family relationships (Barnard & McKeganey, 2004; Lander et al., 2013). Further, family routines and rituals (e.g. shared meals, birthday and holiday celebrations, being picked up consistently from school) are often disrupted as a consequence of family substance use and have been noted frequently in the literature as having a negative impact on family functioning and cohesion (Hawkins, 1997; Lander et al., 2013; Velleman & Templeton, 2007). Poor family communication has also been noted in the literature. The imposed secrecy and inability to speak openly about addiction compounded with disruptive or chaotic family environment are likely to account for poor communication skills among substance using families (Rangarajan & Kelly, 2006). These findings clearly establish that deficits in family functioning and communication exist within substance using families, and that opportunities to repair family bonds are necessary factors in COSAP programming.

Evidence from both the Children's Program evaluation and realist review study suggests that opportunities provided to parents and children to reconnect and interact in a positive, supportive environment may have facilitated positive outcomes for these families. Parents interviewed for the evaluation study discussed positive changes with respect to spending more time with their children and improved levels of family communication after participating in the Children's Program. In particular, shared parent-child program activities emphasizing the reestablishment of family rituals were frequently noted by parents during the interviews as being particularly enjoyable and impactful components of the program. This is consistent with findings from the realist review where families experienced a sense of joy and hopefulness as a result of positive family interactions during the COSAP program. Supportive opportunities for parents and children to spend time together may elicit positive feelings, enjoyment in spending time together, allowing for a positive reframing of family interactions (Kumpfer & Alvarado, 2003). From a realist perspective, the triggering of the *hopeful enjoyment* mechanism must occur in order for outcomes to be achieved. With respect to the Children's Program, the significant improvements observed in family functioning and family communication combined with the aforementioned qualitative findings would support this assertion.

Implications for Clinical Practice and Evaluation

There is a significant need for evidence-based interventions for COSAPs in the community. Results from the outcome evaluation of the Children's Program provide preliminary evidence for the program's success. Appropriate interventions delivered with fidelity can have meaningful impacts of child emotional and behavioural functioning, parenting style and parent ability to regulate emotions, family functioning, and family communication. These are important findings suggesting that families can receive significant benefits from participating in the

Children's Program. Results found in this dissertation call for targeted family-based interventions for COSAPs that appropriately provide addiction specific knowledge to children and parents, create opportunities for parents and children to interact in a positive environment so as to restore healthy routines and rituals, and facilitate peer relationships with other substance abusing families. Based on the combined process and outcome evaluation results, the Children's Program is a valuable resource for COSAPs and their families, and efforts to increase the reach of the program to more families is advised.

Recruitment and engagement of families is a crucial element of effective COSAP intervention. Literature on hard-to-reach families, which include substance-using families, suggests a number of barriers in accessing and engaging with community programming. Difficulty recognizing need, fear of judgment, mistrust of service providers, anxiety about involving children, and lack of awareness of the existence of suitable programs have all been identified as barriers (Boag-Monroe & Evangelou, 2012). Not surprisingly, results of the process evaluation component of the Children's Program evaluation revealed that additional recruitment efforts are needed in order to improve client enrollment. The realist review study also found that client engagement was an important factor that could enhance program outcomes. Key findings from this dissertation indicate that program implementation should be mindful of client SES and client lived experience. Provision of basic needs such as childcare, meals, or vouchers for family activities could enhance participant capacity and willingness to enroll in a COSAP program. Additionally, the matching of client lived experience of either cultural background or addiction history could enhance engagement and retention of hard-to-reach families. These strategies, among others, have been supported elsewhere in the literature (e.g. Bonevski et al., 2014).

This dissertation has further implications for conducting program evaluation in a community context. The success of the evaluation design speaks to the need for program evaluations that are collaborative and involve stakeholders throughout the duration of the project. Further, continued use of an embedded evaluation design could increase the feasibility of community-based evaluations as it reduces the resource burden on staff and clients. Finally, this dissertation demonstrates the importance of fidelity measurement in program evaluation. Fidelity assessments should be standard practice in program evaluation, as acceptable levels of implementation fidelity must be established in order for outcome findings to be credible.

Limitations and Future Directions

A number of limitations to this dissertation are worth noting. First, generalizations of the findings from the Children's Program evaluation beyond the current sample should proceed with caution. Although no significant differences were noted between participants who participated at follow-up and those who participated only at baseline, the lack of a comparison group limits ability to generalize findings to other COSAPs in the general population. Feasibility and resource limitations did not allow for recruitment of a suitable comparison group, and as such the evaluation is considered a pilot study. Further, because multiple children from the same family were included in the sample, the statistical assumption of independence of errors may have been violated, resulting in reduced strength of the findings.

In addition, participant recruitment for the Children's Program fell below expectations and thus sample size was smaller than anticipated. This precluded any additional gender- or age-based moderator analyses. However, families with substance abuse problems have been noted in the literature as being a particularly hard-to-reach and hard-to-engage population, for both research and community intervention purposes (Boag-Monroe & Evangelou, 2012; Bonevski et

al., 2014). Many families with substance use histories are reluctant to seek services due to stigma, risk of child-welfare involvement, or general mistrust of service providers. The fact that the vast majority of participants who enrolled in the program consented to the evaluation is positive, nevertheless an increased sample size and comparison group could have improved generalizability of findings. Continued follow-up research is recommended in order to determine whether child and family improvements are sustained over the longer term. Continued evaluation with the use of comparison group is also suggested in order to determine if the positive outcomes found in this study can be replicated. Further, although it was not logistically feasible to measure fidelity using independent observers, the use of self-reported fidelity checklists should be noted as a limitation.

Limitations to the realist review study are also worthy of discussion. Only 7 COSAP programs were found during the search process and consequently included in the review. While many programs had rich data embedded within the supporting documents, it is entirely possible that other CMOs not reported in this study might also explain program outcomes. As such it cannot be claimed that findings are exhaustive. Second, there were some contextual factors not consistently reported in the included documents that may have otherwise been relevant. For example, some parents were concurrently enrolled in addiction treatment programs yet no consistent pattern of outcomes could be found. Other parents were described as being "in recovery", although this was not clearly defined nor were outcomes compared at this level. Level of substance use severity was also inconsistently reported. Child specific contextual factors were also rarely reported and no discernable patterns of outcomes by age or gender were found across programs. It is possible that, had more data been available, these contextual factors would have yielded different demi-regularities; however, for the purpose of this review it is concluded that

there was not enough evidence to confidently make assertions about the impact of those contextual factors. Finally, as in any systematic review, the quality and rigour of the evaluations varied considerably. While the realist review methodology is broad in scope and allows for supporting documents to be included to mitigate these factors, there may have been outcomes not sufficiently explored due to methodological constraints of the COSAP program research currently available. This speaks to the need for enhanced evaluation and research of COSAP programs in applied settings.

Future exploration of COSAP program theory would benefit from evaluations that explicitly document program fidelity, contextual factors, and employ a mixed methods research design. The inclusion of qualitative studies in the present realist review was highly valuable to the exploration of CMO configurations and demi-regularities. Had more mixed-methods approaches been reported in the literature, it is anticipated that the richness of data uncovered would have been even greater. Moreover, the collecting and reporting of contextual data in evaluation research in this field needs to be more nuanced. Improved documentation of facilitator characteristics, parent recovery status or addiction severity, and child-related factors could significantly enhance evaluation research and improve the theoretical knowledge base for COSAP interventions

Conclusions

In summary, this dissertation sought to fill a gap in the literature on COSAP interventions and program theory. The Renascent Children's Program was found to yield positive changes for children, parents, and families who participated in the program. Further, the Children's Program demonstrated high levels of implementation fidelity and high client satisfaction. The realist review study made significant contributions to COSAP program theory. Demi-regularities

explaining program outcomes were identified, including specific parent and child mechanisms necessary to elicit change.

Appendix A

PARENTING STYLE QUESTIONNAIRE

Please rate how often you engage in the different parenting practices listed below. Scores range from "Never" to "Always" on a 5-point scale. Please circle your answer.

1. I am responsive to my child's feelings and needs.

1 2 3 4 5

Never Always

2. I take my child's wishes into consideration before I ask him/her to do something.

1 2 3 4 5

Never Always

3. I explain to my child how I feel about his/her good/bad behaviour.

1 2 3 4 5

Never Always

4. I encourage my child to talk about his/her feelings and problems.

1 2 3 4 5

Never Always

5. I encourage my child to freely "speak his/her mind", even if he/she disagrees with me.

1 2 3 4 5

Never Always

6. I explain the reasons behind my expectations.

1 2 3 4 5

Never Always

7. I provide comfort and understanding when my child is upset.

1	2	3	4	5
Never				Always

8. I compliment my child.

1	2	3	4	5
Never				Always

9. I consider my child's preferences when I make plans for the family (e.g. weekends away and holidays).

1	2	3	4	5
Never				Always

10. I respect my child's opinion and encourage him/her to express them.

1	2	3	4	5
Never				Always

11. I treat my child as an equal member of the family.

1	2	3	4	5
Never				Always

12. I provide my child reasons for the expectations I have for him/her.

1	2	3	4	5
Never				Always

13. I have warm and intimate times together with my child.

1	2	3	4	5
Never				Always

14. When my child asks me why he/she has to do something I tell him/her it is because I said so, I am your parent, or because this is what I want.

1 2 3 4 5

Never Always

15. I punish my child by taking privileges away from him/her (e.g. TV, games, visiting friends).

1 2 3 4 5

Never Always

16. I yell when I disapprove of my child's behaviour.

1 2 3 4 5

Never Always

17. I explode in anger towards my child.

1 2 3 4 5

Never Always

18. I spank my child when I don't like what he/she does or says.

1 2 3 4 5

Never Always

19. I use criticism to make my child improve his/her behaviour.

1 2 3 4 5

Never Always

20. I use threats as a form of punishment with little or no justification.

1 2 3 4 5

Never Always

21. I punish my child by withholding emotional expressions (e.g. kisses and cuddles).

1 2 3 4 5

Never Always

22. I openly criticize my child when his/her behaviour does not meet my expectations.

1 2 3 4 5

Never Always

23. I find myself struggling to try to change how my child thinks or feels about things.

1 2 3 4 5

Never Always

24. I feel the need to point out my child's past behavioural problems to make sure he/she will not do them again.

1 2 3 4 5

Never Always

25. I remind my child that I am his/her parent.

1 2 3 4 5

Never Always

26. I remind my child of all the things I am doing or have done for him/her.

1 2 3 4 5

Never Always

27. I find it difficult to discipline my child.

1 2 3 4 5

Never Always

28. I give into my child when he/she causes a commotion about something.

1	2	3	4	5
Never				Always

29. I spoil my child.

1	2	3	4	5
Never				Always

30. I ignore my child's bad behaviour.

1	2	3	4	5
Never				Always

Appendix B

Self-Care Questionnaire

PLEASE CIRCLE YOUR ANSWER

1. **I occasionally give myself something nice like a present or treat.**

3	2	1	0
Very like me	Like me	Unlike me	Very unlike me

2. **I make time to do relaxing activities.**

3	2	1	0
Very like me	Like me	Unlike me	Very unlike me

3. **I believe it is necessary to be selfish at times.**

3	2	1	0
Very like me	Like me	Unlike me	Very unlike me

4. **I like it when others look after me when I am ill.**

3	2	1	0
Very like me	Like me	Unlike me	Very unlike me

5. **I plan events in my life that I can look forward to, such as holidays or outings.**

3	2	1	0
Very like me	Like me	Unlike me	Very unlike me

6. **Every day I make sure I have some time to do something pleasurable for myself.**

3	2	1	0
Very like me	Like me	Unlike me	Very unlike me

7. **I make a point of looking after my appearance and health.**

3	2	1	0
Very like me	Like me	Unlike me	Very unlike me

8. **I like it when someone gives me a present or compliments me on something I've done.**

3	2	1	0
Very like me	Like me	Unlike me	Very unlike me

9. I can praise myself if I think I have done a good job.

3	2	1	0
Very like me	Like me	Unlike me	Very unlike me

10. I feel in control of my life, I do not simply live my life according to what other people want.

3	2	1	0
Very like me	Like me	Unlike me	Very unlike me

11. I make a point of eating a healthy diet and I do not skip meals.

3	2	1	0
Very like me	Like me	Unlike me	Very unlike me

12. I deliberately do exercise and keep myself physically fit.

3	2	1	0
Very like me	Like me	Unlike me	Very unlike me

13. I deliberately make time to build friendships with people I like.

3	2	1	0
Very like me	Like me	Unlike me	Very unlike me

14. Sometimes I have to put my own needs first which means I may have to hurt others.

3	2	1	0
Very like me	Like me	Unlike me	Very unlike me

15. I can say 'no' when other people make demands on me.

3	2	1	0
Very like me	Like me	Unlike me	Very unlike me

Appendix C

Difficulties with Emotion Regulation Scale (DERS)

Please indicate how often the following statements apply to you by circling the number on the scale below.

1. I am clear about my feelings.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

2. I pay attention to how I feel.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

3. I experience my emotions as overwhelming and out of control.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

4. I have no idea how I am feeling.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

5. I have difficulty making sense out of my feelings.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

6. I am attentive to my feelings.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

7. I know exactly how I am feeling.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

8. I care about what I am feeling.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

9. I am confused about how I feel.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

10. When I am upset, I acknowledge my emotions.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

11. When I am upset, I become angry with myself for feeling that way.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

12. When I am upset, I become embarrassed for feeling that way.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

13. When I am upset, I have difficulty getting work done.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

14. When I am upset, I become out of control

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

15. When I am upset, I believe that I will remain that way for a long time.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

16. When I am upset, I believe that I will end up feeling very depressed.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

17. When I am upset, I believe that my feelings are valid and important.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

18. When I am upset, I have difficulty focusing on other things.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

19. When I am upset, I feel out of control.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

20. When I am upset, I can still get things done.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

21. When I am upset, I feel ashamed at myself for feeling that way.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

22. When I am upset, I know that I can find a way to eventually feel better.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

23. When I am upset, I feel like I am weak.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

24. When I am upset, I feel like I can remain in control of my behaviours.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

25. When I am upset, I feel guilty for feeling that way.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

26. When I am upset, I have difficulty concentrating.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

27. When I am upset, I have difficulty controlling my behaviours.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

28. When I am upset, I believe that there is nothing I can do to make myself feel better.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

29. When I am upset, I become irritated at myself for feeling that way.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

30. When I am upset, I start to feel very bad about myself.

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

31. **When I am upset, I believe that wallowing in it is all I can do.**

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

32. **When I am upset, I lose control of my behaviour.**

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

33. **When I am upset, I have difficulty thinking about anything else.**

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

34. **When I am upset, I take time to figure out what I am really feeling.**

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

35. **When I am upset, it takes me a long time to feel better.**

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

36. **When I am upset, my emotions feel overwhelming.**

1	2	3	4	5
Almost never	Sometimes	About half the time	Most of the time	Almost always

Appendix D

FACES-IV

For each statement, please circle the answer that best describes your family.

	Strongly Disagree	Generally Disagree	Un-decided	Generally Agree	Strongly Agree
1. Family members are involved in each other's lives	1	2	3	4	5
2. Our family tries new ways of dealing with problems	1	2	3	4	5
3. There are strict consequences for breaking the rules in our family	1	2	3	4	5
4. We never seem to get organized in our family	1	2	3	4	5
5. Family members feel very close to each other	1	2	3	4	5
6. Parents equally share leadership in our family	1	2	3	4	5
7. There are clear consequences when a family member does something wrong	1	2	3	4	5
8. It is hard to know who the leader is in our family	1	2	3	4	5
9. Family members are supportive of each other during difficult times	1	2	3	4	5
10. Discipline is fair in our family	1	2	3	4	5
11. Our family has a rule for almost every possible situation	1	2	3	4	5
12. Things do not get done in our family	1	2	3	4	5
13. Our family is highly organized	1	2	3	4	5
14. It is unclear who is responsible for things (chores, activities) in our family	1	2	3	4	5
15. Family members like to spend some of their free time with each other	1	2	3	4	5
16. We shift household responsibilities from person to person	1	2	3	4	5

	Strongly Disagree	Generally Disagree	Un-decided	Generally Agree	Strongly Agree
17. Our family becomes frustrated when there is a change in our plans or routines	1	2	3	4	5
18. There is no leadership in our family	1	2	3	4	5
19. Although family members have individual interests, they still participate in family activities	1	2	3	4	5
20. We have clear rules and roles in our family	1	2	3	4	5
21. It is important to follow the rules in our family	1	2	3	4	5
22. Our family has a hard time keeping track of who does various household tasks	1	2	3	4	5
23. Our family has a good balance of separateness and closeness	1	2	3	4	5
24. When problems arise, we compromise	1	2	3	4	5
25. Once a decision is made, it is very difficult to modify that decision	1	2	3	4	5
26. Our family feels hectic and disorganized	1	2	3	4	5
27. Family members are satisfied with how they communicate with each other	1	2	3	4	5
28. Family members are very good listeners	1	2	3	4	5
29. Family members express affection for each other	1	2	3	4	5
30. Family members are able to ask each other for what they want	1	2	3	4	5
31. Family members can calmly discuss problems with each other	1	2	3	4	5
32. Family members discuss their ideas and beliefs with each other	1	2	3	4	5
33. When family members ask questions of each other, they get honest answers	1	2	3	4	5
34. Family members try to understand each other's feelings	1	2	3	4	5

	Strongly Disagree	Generally Disagree	Un-decided	Generally Agree	Strongly Agree
35. When angry, family members seldom say negative things about each other	1	2	3	4	5
36. Family members express their true feelings to each other	1	2	3	4	5
37. Family members consult other family members on important decision	1	2	3	4	5
38. My family is able to adjust to change when necessary	1	2	3	4	5

Appendix E

Strengths and Difficulties Questionnaire (SDQ)

Please check whether the following statements about your child's behavior are **not true**, **somewhat true**, or **certainly true**. For each question, please give your answer based on your child's behaviour **over the last six months**.

Note: Please respond in reference to the child attending the Children's Program. If you have more than one child registered in the program, please complete a second form.

Name of child: _____

	Not True	Somewhat True	Certainly True
1. Considerate of other people's feelings			
2. Often complains of headaches, stomach-aches, or sickness			
3. Shares readily with other children			
4. Often loses temper			
5. Rather solitary, prefers to play alone			
6. Generally well behaved, usually does what adults request			
7. Many worries or often seems worried			
8. Helpful if someone is hurt, upset, or feeling ill			
9. Has at least one good friend			
10. Often fights with other children or bullies them			
11. Often unhappy, depressed, or tearful			
12. Generally liked by other children			
13. Nervous or clingy in new situations, easily loses confidence			
14. Kind to younger children			
15. Often lies or cheats			
16. Picked on or bullied by other children			
17. Often volunteers to help others (parents, teachers, other children)			
18. Steals from home, school, or elsewhere			
19. Gets along better with adults than with other children			
20. Many fears, easily scared			

Appendix F

Short Moods and Feelings Questionnaire (SMFQ)

For each question, please check how much your child has felt or acted this way in the **past two weeks.**

If a sentence was true for your child most of the time, check **TRUE**.

If it was only sometimes true, check **SOMETIMES**.

If a sentence was not true about your child, check **NOT TRUE**.

Note: Please respond in reference to the child attending the Children's Program. If you have more than one child registered in the program, please complete a second form.

Name of child: _____

	TRUE	SOME TIMES	NOT TRUE
1. S/he felt miserable or unhappy			
2. S/he didn't enjoy anything at all			
3. S/he felt so tired that s/he just sat around and did nothing			
4. S/he was very restless			
5. S/he felt s/he was no good anymore			
6. S/he cried a lot			
7. S/he found it hard to think properly or concentrate			
8. S/he hated him/herself			
9. S/he felt s/he was a bad person			
10. S/he felt lonely			
11. S/he thought nobody really loved him/her			
12. S/he thought s/he could never be as good as other kids			
13. S/he felt s/he did everything wrong			

Appendix G

CSQ-8

TELL US WHAT YOU THINK!

Please help us improve our program by answering some questions about the services you have received at Renascent. We welcome your comments and suggestions.

CIRCLE YOUR ANSWER

Note: When we say **program**, we mean the **Children's Program**

1. How would you rate the quality of services you have received?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of service you wanted?

1	2	3	4
No, definitely not	No, not really	Yes, generally	Yes, definitely

3. To what extent has our program met your needs?

4	3	2	1
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need of similar help, would you recommend our program to him or her?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the amount of help you have received?

1	2	3	4
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

6. Have the services you received helped you to deal more effectively with your problems?

4	3	2	1
Yes, they helped a great deal	Yes, they helped somewhat	No, they really didn't help	No, they seemed to make things worse

7. In an overall general sense, how satisfied are you with the service you have received?

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

8. If you were to seek help again, would you come back to Renascent?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

Please write your comments

The thing I like best about the program is:

_____

_____

_____

_____

If I could change one thing about the program, it would be:

_____

_____

_____

_____

Appendix H

Child Client Satisfaction Survey

What do you think?

1. Overall, how much did you like the program? Circle one.





Awesome I liked it a lot It was OK I didn't like it Blah

2. The part I liked best was:

_____

_____

_____

3. I did not enjoy:

_____

_____

_____

4. If you know someone else who has a parent with an addiction, will you tell them about this program? Circle one.



Absolutely! Maybe No Way!

Appendix I

Children's Program Fidelity Checklists

Program Dates:

_____

Name of evaluator:

_____

Name(s) of other counsellor(s) facilitating this group:

_____

Program Implementation:

For each major objective or activity listed below, please check "**yes**" or "**no**" to indicate whether it was covered during the appropriate session.

DAY 1: What is happening to my family?

Program Content	**YES**	**NO**
1. Morning preparation		
2. Discussed group rules (privacy, consequences)		
3. Reviewed housekeeping info (washrooms, safety, snacks)		
4. Performed introductions and took attendance		
5. Reviewed program goals and plan for the day		
6. Performed opening exercise		
7. Relaxation time		
8. Performed team building exercise		
9. Teaching: What's happening to my family?		
10. Introduction to the 7 Cs		
11. Children's group discussion		
12. Puppets		
13. Wrap up relaxation time with parents		
14. Counsellor debriefing and planning for next day		
Please note any program adjustments or changes:		

Program Delivery:

Please indicate whether the following core competencies of treatment delivery where demonstrated.

Counsellor Competency	**Description/Examples**	**YES**	**NO**
Expectation of adherence to group rules and etiquette	Communicates expectation of respect for privacy and listening during group		
Providing corrective feedback	Provides direction when rules or expectation are violated, when inappropriate communication is observed, suggestions for improvement are needed		
Positive reinforcement/praise	Comments on what clients are doing well		
Respect for clients	Listening and acknowledging client's experience, emotions, point of view		
Modeling use of skills during program	Includes appropriate communication style, empathy, self-care, safety, healthy choices		
Adapts instructions or examples to enhance understanding	Uses variety of methods to ensure comprehension (e.g. role plays, examples, narratives, etc.)		
Checking in for understanding	Asks about understanding of program content		
Checking in for emotional state	Asks how client is feeling and responds to expressed emotion		

DAY 2: It's OK to share my feelings

Program Implementation

Program Content	**YES**	**NO**
1. Morning preparation		
2. Reviewed daily agenda with children		
3. Reviewed group rules with children		
4. Took attendance		
5. Relaxation time		
6. Performed opening exercise		
7. Naming Your Feelings activity		
8. Dear Addiction Letter activity		
9. Safe People activity		
10. Celebrating Myself: My Special Collage		
11. Wrap us session with children		
12. Counsellor debriefing and planning for next day		
Please note any program adjustments or changes:		

Program Delivery

Counsellor Competency	**Description/Examples**	**YES**	**NO**
Expectation of adherence to group rules and etiquette	Communicates expectation of respect for privacy and listening during group		
Providing corrective feedback	Provides direction when rules or expectation are violated, when inappropriate communication is observed, suggestions for improvement are needed		
Positive reinforcement/praise	Comments on what clients are doing well		
Respect for clients	Listening and acknowledging client's experience, emotions, point of view		
Modeling use of skills during program	Includes appropriate communication style, empathy, self-care, safety, healthy choices		
Adapts instructions or examples to enhance understanding	Uses variety of methods to ensure comprehension (e.g. role plays, examples, narratives, etc.)		
Checking in for understanding	Asks about understanding of program content		
Checking in for emotional state	Asks how client is feeling and responds to expressed emotion		

DAY 3: The Heart of Recovery

Program Implementation

Program Content	**YES**	**NO**
1. Morning preparation		
2. Reviewed daily agenda with children		
3. Took attendance		
4. Relaxation time		
5. Performed opening exercise		
6. Preparation for Family Session		
7. Family Session		
8. Celebrating myself: I'm a Star		
9. Sailing the 7 Cs		
10. Wrap us session with children		
11. Relaxation time with parents		
12. Counsellor debriefing and planning for next day		
Please note any program adjustments or changes:		

Program Delivery

Counsellor Competency	**Description/Examples**	**YES**	**NO**
Expectation of adherence to group rules and etiquette	Communicates expectation of respect for privacy and listening during group		
Providing corrective feedback	Provides direction when rules or expectation are violated, when inappropriate communication is observed, suggestions for improvement are needed		
Positive reinforcement/praise	Comments on what clients are doing well		
Respect for clients	Listening and acknowledging client's experience, emotions, point of view		
Modeling use of skills during program	Includes appropriate communication style, empathy, self-care, safety, healthy choices		
Adapts instructions or examples to enhance understanding	Uses variety of methods to ensure comprehension (e.g. role plays, examples, narratives, etc.)		
Checking in for understanding	Asks about understanding of program content		
Checking in for emotional state	Asks how client is feeling and responds to expressed emotion		

DAY 4: Changing the Family Legacy

Program Implementation

Program Content	**YES**	**NO**
1. Morning preparation		
2. Reviewed daily agenda with children		
3. Took attendance		
4. Facilitated opening relaxation exercise		
5. 7 Cs Rehearsal		
6. Teaching of 7 Cs to parents by children		
7. Family Shield		
8. Stone Ceremony		
9. Magic Box		
10. Relaxation time with parents		
11. Graduation ceremony		
12. Counsellor debriefing		
Please note any program adjustments or changes:		

Program Delivery

Counsellor Competency	**Description/Examples**	**YES**	**NO**
Expectation of adherence to group rules and etiquette	Communicates expectation of respect for privacy and listening during group		
Providing corrective feedback	Provides direction when rules or expectation are violated, when inappropriate communication is observed, suggestions for improvement are needed		
Positive reinforcement/praise	Comments on what clients are doing well		
Respect for clients	Listening and acknowledging client's experience, emotions, point of view		
Modeling use of skills during program	Includes appropriate communication style, empathy, self-care, safety, healthy choices		
Adapts instructions or examples to enhance understanding	Uses variety of methods to ensure comprehension (e.g. role plays, examples, narratives, etc.)		
Checking in for understanding	Asks about understanding of program content		
Checking in for emotional state	Asks how client is feeling and responds to expressed emotion		

PARENTS' GROUP

Program Dates:

_____

Name of evaluator:

_____

Name(s) of other counsellor(s) facilitating this group:

_____

Implementation Checklist:

For each major objective or activity listed below, please check "**yes**" or "**no**" to indicate whether it was covered during the appropriate session.

DAY 1: The Elephant in the Living Room

Program Content	**YES**	**NO**
15. Morning preparation		
16. Introductions		
17. Reviewed group expectations		
18. Took attendance		
19. The Process of Addiction		
20. Where Does the Energy Go?		
21. Impact of Addiction on Parenting		
22. Affirmations for My Child		
23. Relaxation exercise		
24. Relaxation time with children		
25. Counsellor debriefing and planning for next day		
Please note any program adjustments or changes:		

Treatment Delivery Process:

Please indicate whether the following core competencies of treatment delivery where demonstrated.

Counsellor Competency	**Description/Examples**	**YES**	**NO**
Expectation of adherence to group rules and etiquette	Communicates expectation of respect for privacy and listening during group		
Providing corrective feedback	Provides direction when rules or expectation are violated, when inappropriate communication is observed, suggestions for improvement are needed		
Positive reinforcement/praise	Comments on what clients are doing well		
Respect for clients	Listening and acknowledging client's experience, emotions, point of view		
Modeling use of skills during program	Includes appropriate communication style, empathy, self-care, safety, healthy choices		
Adapts instructions or examples to enhance understanding	Uses variety of methods to ensure comprehension (e.g. role plays, examples, narratives, etc.)		
Checking in for understanding	Asks about understanding of program content		
Checking in for emotional state	Asks how client is feeling and responds to expressed emotion		

DAY 2: Rewriting the Rules

Program Implementation

Program Content	YES	NO
13. Morning preparation		
14. Took attendance		
15. Impact of Addiction and Recovery on Children		
16. Common Concerns of Children		
17. Common Feelings of Parents in Recovery		
18. Self-care exercise		
19. Strengthening Family Functioning		
20. Boosting Children's Resilience		
21. Affirmations for My Child		
22. Wrap up and debriefing with parents		
23. Homework exercise: Parent's Recovery Plan		
24. Relaxation time with children		
25. Counsellor debriefing and planning for next day		
Please note any program adjustments or changes:		

Program Delivery

Counsellor Competency	Description/Examples	YES	NO
Expectation of adherence to group rules and etiquette	Communicates expectation of respect for privacy and listening during group		
Providing corrective feedback	Provides direction when rules or expectation are violated, when inappropriate communication is observed, suggestions for improvement are needed		
Positive reinforcement/praise	Comments on what clients are doing well		
Respect for clients	Listening and acknowledging client's experience, emotions, point of view		
Modeling use of skills during program	Includes appropriate communication style, empathy, self-care, safety, healthy choices		
Adapts instructions or examples to enhance understanding	Uses variety of methods to ensure comprehension (e.g. role plays, examples, narratives, etc.)		
Checking in for understanding	Asks about understanding of program content		
Checking in for emotional state	Asks how client is feeling and responds to expressed emotion		

DAY 3: Your Recovery Toolbox

Program Implementation

Program Content	**YES**	**NO**
13. Morning preparation		
14. Took attendance		
15. Preparation with parents for Family Session		
16. Family Sessions		
17. Debriefing with parents about Family Session		
18. Preparation for Family Session		
19. Family Session		
20. Routine, Rituals, and Traditions		
21. Parent's Recovery Plan		
22. Wrap us session with parents		
23. Relaxation time with children		
24. Counsellor debriefing and planning for next day		
Please note any program adjustments or changes		

Program Delivery

Counsellor Competency	**Description/Examples**	**YES**	**NO**
Expectation of adherence to group rules and etiquette	Communicates expectation of respect for privacy and listening during group		
Providing corrective feedback	Provides direction when rules or expectation are violated, when inappropriate communication is observed, suggestions for improvement are needed		
Positive reinforcement/praise	Comments on what clients are doing well		
Respect for clients	Listening and acknowledging client's experience, emotions, point of view		
Modeling use of skills during program	Includes appropriate communication style, empathy, self-care, safety, healthy choices		
Adapts instructions or examples to enhance understanding	Uses variety of methods to ensure comprehension (e.g. role plays, examples, narratives, etc.)		
Checking in for understanding	Asks about understanding of program content		
Checking in for emotional state	Asks how client is feeling and responds to expressed emotion		

DAY 4: Taking It with You

Program Implementation

Program Content	**YES**	**NO**
13. Morning preparation		
14. Took attendance		
15. Preparation for Session with Children		
16. Children teach parents about 7 Cs		
17. Family Shield activity with children		
18. Debriefing feedback with parents		
19. Taking it with You		
20. Graduation Ceremony with children		
21. Counsellor debriefing		
Please note any program adjustments or changes:		

Program Delivery

Counsellor Competency	**Description/Examples**	**YES**	**NO**
Expectation of adherence to group rules and etiquette	Communicates expectation of respect for privacy and listening during group		
Providing corrective feedback	Provides direction when rules or expectation are violated, when inappropriate communication is observed, suggestions for improvement are needed		
Positive reinforcement/praise	Comments on what clients are doing well		
Respect for clients	Listening and acknowledging client's experience, emotions, point of view		
Modeling use of skills during program	Includes appropriate communication style, empathy, self-care, safety, healthy choices		
Adapts instructions or examples to enhance understanding	Uses variety of methods to ensure comprehension (e.g. role plays, examples, narratives, etc.)		
Checking in for understanding	Asks about understanding of program content		
Checking in for emotional state	Asks how client is feeling and responds to expressed emotion		

Appendix J

Client Summary Checklist

Child's name: _____ **Program dates**: _____

Counsellor name(s): _____

Attendance: _____

Day 1: What's Happening to my Family?	**1** **Not at all**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10** **Completely**
1. Child could correctly identify who in family has an addiction										
2. Child was able to correctly identify and name their emotions										
3. Child made an attempt to use the relaxation techniques taught in the program										
4. Child showed mastery of the relaxation techniques taught in program										
5. Child was able to make and maintain eye-contact with facilitators										
6. Child engaged in positive social interactions with other children in the group										
7. Child was physically closed off during program (e.g. kept physical distance between self and other children)										
8. Child displayed a range of emotions during the day (e.g. smiling , laughing, appropriate sadness or distress)										
9. Child had difficulty engaging in group activities (e.g. was reluctant to participate or collaborate with other children										

Day 2: It's OK to Share my Feelings	**1** **Not at all**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10** **Completely**
10.Child was able to correctly identify and name their emotions 11.										
12.Child was able to identify safe adults 13.										
14.Child made an attempt to communicate feelings to peers and facilitators during group										
15.Child was successful in communicating feelings to peers and facilitators during group										
16.Child demonstrated empathy for other children in the group										
17.Child was able to make and maintain eye-contact with facilitators										
18.Child engaged in positive social interactions with other children in the group										
19.Child displayed a range of emotions during the day (e.g. smiling , laughing, appropriate sadness or distress)										
20.Child had difficulty engaging in group activities (e.g. was reluctant to participate or collaborate with other children)										
Day 3: The Heart of Recovery	**1** **Not at all**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10** **Completely**
21. Child was willing to read "Dear Addiction" letter to parent										
22. Child requested counsellor assistance to read letter for or with him or her										
23. Child asked parent to read letter out loud or silently to himself or herself										

24. Child chose to "pass" on sharing "Dear Addiction" letter with parent										
25. Child made an attempt to communicate feelings to parent (e.g. attempted to tell parent that they were feeling sad, angry, happy, etc.)										
26. Child was able to successfully communicate feelings to parent (e.g. was able to tell parent that they were feeling sad, angry, happy, etc.)										
27. Child demonstrated empathy for parent (e.g. addiction as a disease that parent is not able to fully control)										
28. Child was able to identify strengths when completing the "I'm a star" activity										
29. Child was able to make and maintain eye-contact with facilitators										
30. Child engaged in positive social interactions with other children in the group										
31. Child displayed a range of emotions during the day (e.g. smiling , laughing, appropriate sadness or distress)										
32. Child had difficulty engaging in group activities (e.g. was reluctant to participate or collaborate with other children)										
Day 4: Changing the Family Legacy	**1 Not at all**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10 Completely**
33. Child demonstrated knowledge of 7Cs during the puppet play										
34. Child was engaged with parent to create family shield										
35. Child appeared stressed or uncomfortable during family shield activity										

36. Child was able to express emotions, needs and wants to parent during creation of family shield										
37. Child was unable to verbally express emotions, needs and wants to parent during creation of family shield										
38. Child easily and appropriately shared positive feedback with other group members and staff during closing stone ceremony										
39. Child struggled to identify or express positive feedback for group members and staff during stone ceremony										
40.Child was able to make and maintain eye-contact with facilitators										
41.Child engaged in positive social interactions with other children in the group										
42.Child displayed a range of emotions during the day (e.g. smiling , laughing, appropriate sadness or distress)										
43.Child had difficulty engaging in group activities (e.g. was reluctant to participate or collaborate with other children)										

Appendix K

Recruitment Survey

1. Below is a list of recruitment methods used by Renascent to attract potential participants to the Children's Program. Please indicate which ones were used and which ones you think are most effective?

Ever Used (Check)	Recruitment Method	Most Effective (Check up to 2)
	Renascent website	
	Media advertising campaigns	
	Promotion of the program to existing Renascent clients	
	Outreach and promotion to other addiction treatment facilities	
	Outreach and promotion to other community organizations (e.g. CAS, AA groups, etc).	
	Other Please specify:	

2. To the best of your knowledge, previous participants of the Children's Program have been (check all that apply):

	Existing clients at Renascent
	Referrals from CAS
	Referrals from other addiction treatment facilities
	Self-referred via website or other promotional materials
	Referrals from family doctor/medical provider
	Referrals from a friend or family member
	Other: (Please specify)

3. What would you identify as potential barriers (and potential solutions *if possible*) for families in accessing the Children's Program?

Barriers		Solutions
	➔	
	➔	
	➔	
	➔	

Appendix L

Interview Guide for Parent Participants of the Children's Program

Introduction

As you know, Ryerson is partnering with Renascent to evaluate the Children's Program…. We are very interested in the experiences you have had in the program. The information collected today will be used to help Renascent better understand how to meet its goals, which parts of the program you found most useful, and which parts could be made better.

The purpose of today's interview is to talk about:

- What it was like to participate in the Children's Program
- What you got out of the Children's Program or how it has made a difference in your life
- What parts worked for you and what parts did not.

Warm-Up Questions

1. Tell me a bit about your decision to participate in the Children's Program.

Key Questions

2. What impact did the program counsellors have on your experience in the Children's Program?
   →How would you describe your relationship with the program counsellors?

3. Which parts of the program were most useful for you?
   →What it is about that component that you liked? (try to be as specific as possible)

4. Which parts of the program didn't work for you?
   →What didn't you like about that part?
   →What was missing from the program for you? OR What did you want more of?

5. I want you to think about how your family was functioning before you participated in the Children's Program. Think about how your family is functioning now. Tell me about the changes you have noticed.
   →How has your relationship with your child changed?

6. What kind of support do you need now to help with your family's recovery?

Wrap-Up Questions

7. If there was one thing you would want to share with the staff about the Children's Program, what would it be?

Appendix M

Interview Guide with Children Participants of the Children's Program

I'm going to tell you a little story now, and then I'm going to ask you some questions about that story.

There are no right or wrong answers and you can skip any questions you don't want to answer. Since it is hard for me to take notes while we are talking, I'm going to record our conversation. I won't say your name so don't worry about anyone hearing your answers. No one else will listen to our conversation, just me.

Here's our story: (ADAPT GENDER OF CHILD AND PARENT TO INDIVIDUAL CASE)

Johnny (Jenny) is a boy/girl who lives with his/her mom/dad. Sometimes his/her mom/dad drinks or uses drugs. When Johnny/Jenny's mom/dad drinks too much or uses drugs, his/her parents yell at each other or at Johnny/Jenny. Sometimes, Johnny/Jenny's mom/dad is too sick to make supper or do fun activities as a family. Johnny/Jenny doesn't like having friends over to play anymore.

Interview Questions and Prompts

1. How do you think Johnny/Jenny feels when his/her mom/dad is drinking/using drugs? (empathy)
   →prompt: if one-word answer (e.g. sad, mad), ask "what does that feel like? Can you describe it to me?"

   →prompt: "can you tell me more about that?" "What do you think Johnny/Jenny is thinking to him/herself?"

2. Why do you think Johnny/Jenny doesn't invite his/her friends over to play? (knowledge)
   →prompt: "what do you think Johnny would say to his friends if they wanted to come over to play?"

3. How do you think Johnny/Jenny's mom/dad is feeling? (empathy for parent)
   →prompt: "can you tell me more about that? What does that mean?"
   →prompt: "what do you think Johnny/Jenny's mom/dad is thinking when they are yelling at each other or at Johnny?"

4. How should Johnny/Jenny deal with this situation? (coping strategies)
   →prompt: "What should Johnny do?"
   →prompt: "What should Johnny say?"
   →prompt: "Who should Johnny talk to?"

5. What kinds of activities could Johnny/Jenny to do feel good about him/herself, even if his/her family life is still chaotic? (celebrating myself)
6. What do you think Johnny/Jenny should say to his/her parents when Johnny/Jenny feels sad or angry? (communication)
   →prompt: "What would you say to your mom/dad if you were angry or sad?"

7. If you were in that situation, who is a safe person you would call? (healthy choices)

8. What does it mean to have an addiction? (knowledge)
   →prompt: "Why can't Johnny/Jenny's mom/dad just stop drinking or using drugs?"

   →prompt: "Do you think it is possible to cure addiction? Why?"

9. What does recovery mean? (knowledge)
   →prompt: "What happens when someone recovers?"

Appendix N

Key Informant Interview

Preamble: Undertaking a program evaluation can be challenging and can place a burden of staff and organizational resources. This evaluation attempted a participatory and embedded approach to evaluation. We want to better understand what this process was like for you.

Questions:

1. Describe your own experience of collaborating with Ryerson for the evaluation of the Children's Program.
   →At what stage in the evaluation process did you become involved?

2. What challenges did you or other staff members face when trying to integrate the evaluation process into the delivery of the Children's Program?

3. How were these challenges addressed?

4. Were there challenges that were not adequately dealt with? If so, what suggestions would you have for better handling them in the future?

5. How has the evaluation of the Children's Program impacted day to day operations at Renascent? What about organizational culture?

6. What kinds of families are being reached by the Children's Program? Who is not being reached?

7. What are some of the Children's Programs strengths and weaknesses? What are some areas for improvement?

8. In closing, I am conducting a series of interviews with Renascent staff to evaluate the experience of participating in the Children's Program evaluation project, but I considered bringing in someone else to ask these questions in case staff might feel more comfortable providing feedback. What impact was there, if any, in having me conduct this follow-up interview with you? What impact would there have been if someone else had been asked to conduct this interview?

Appendix O

Consent Forms

Evaluation of the Children's Program

What is this project about?

We want to find out what works and what could be improved. We want to ask about changes you and your child have experienced in your knowledge, skills, and overall family functioning.

Who is running this project?

Renascent has partnered with Ryerson University to evaluate the Children's Program. There are 2 evaluators from the Department of Psychology who are involved: Kelly McShane, Ph.D., C.Psych (Assistant Professor) and Amelia Usher, M.Ed. (PhD student).

What am I being asked to do?

We are asking for you and child to take part in this evaluation. By agreeing to participate, you understand that:

1. Renascent will share information with the evaluators at Ryerson University on you and your child's participation in the Children's Program. This includes questionnaires, activity sheets, and artwork completed during the program.

2. You and your child will be contacted by the Ryerson University evaluation team one month after the Children's Program has finished to ask you some follow-up questions about your experience in the Children's Program (as a group for the parents; and in an interview with the kids).

Do I have to participate?

No, you don't. Your participation in this evaluation is **voluntary**. Your decision will not affect your relationship with Renascent now or in the future. Also, you can skip questions you don't want to answer or stop altogether and withdraw your information at any time without penalty.

How will you keep my information private?

Participating in this evaluation will not result in information about you or your family becoming known or available to the public. Your responses will be confidential, which means that your name will not be tied to your responses when the evaluators look at them. To ensure this, your questionnaire will be assigned a code, instead of your name.

Are there any risks?

Some of the questions ask about addiction and how you are feeling. You might find this uncomfortable. If you do, you can stop filling out the surveys or take a break – whatever you prefer.

What are the benefits?

We don't expect that you will get any direct benefits from this study. By sharing your experiences you can help the program improve for future families. If you decide to participate in the group discussion after the program is done, you will be compensated with $10 and your child will receive a $10 gift.

Who can I contact if I have questions?

If you have any questions about this evaluation project now or at any time during the study, you may contact Dr. Kelly McShane by email at kmcshane@psych.ryerson.ca or by phone at 416-979-5000 extension 2051.

Agreement:

Your signature below indicates that you have read the information in this agreement and have had a chance to ask any questions you have about the evaluation project. Your signature also indicates that you agree to be in the study and have been told that you can change your mind and withdraw your consent to participate at any time. You have been given a copy of this agreement.

_____

Name of Participant (please print)

I agree that Renascent may release information on my family's participation in the Children's Program to Ryerson University evaluation team for the purpose of this evaluation.

_____ _____

Signature of Participant Date

I agree to be contacted by the Ryerson University evaluation team after the Children's Program has ended to answer some questions about my experience and my child's experience in the program.

_____ _____

Signature of Participant Date

_____ _____

Signature of Investigator Date

Child's Agreement:

I am willing to talk with _____ about the Renascent Children's Program.

It's OK by me that:

1. Our conversations will not name or identify me.
2. Our conversations will be audio-recorded.
3. Only the researchers will listen to the recordings. The researchers will protect the tapes by keeping them in locked filing cabinet for 10 years. When they are not needed anymore they will be erased.
4. I can stop the study at any time. One way I can do this is by saying "stop now" or "next question please".
5. I can end being part of this study at any time without any questions being asked.
6. The researchers might talk to someone if they are worried about my safety.
7. It is ok to ask that a counsellor or another safe adult be with me during our conversation.

My name: _____

My signature or special mark: _____

Today's date: _____

Consent to Participate in Follow-up Evaluation of the Children's Program

What is this project about?

We want to find out what works and what could be improved. We want to ask about changes you and your child have experienced in your knowledge, skills, and overall family functioning.

Who is running this project?

Renascent has partnered with Ryerson University to evaluate the Children's Program. There are 2 evaluators from the Department of Psychology who are involved: Kelly McShane, Ph.D., C.Psych (Assistant Professor) and Amelia Usher, M.Ed. (PhD student).

What am I being asked to do?

You are being asked to participate in an audio-recorded interview and to complete some questionnaires.

Do I have to participate?

No, you don't. Your participation in this evaluation is **voluntary**. Your decision will not affect your relationship with Renascent now or in the future. Also, you can skip questions you don't want to answer or stop altogether and withdraw your information at any time without penalty.

How will you keep my information private?

Participating in this evaluation will not result in information about you or your family becoming known or available to the public. Your responses will be confidential, which means that your name will not be tied to your responses when the evaluators look at them. To ensure this, the following steps have been taken:

1. The interview will be transcribed and the audio-recording will be kept in a locked cabinet and deleted after the evaluation in completed. No identifying information (e.g. your name, your child's name) will be included in the transcript.
2. Your questionnaires will be assigned a code instead of your name.

Are there any risks?

Some of the questions ask about addiction and how you are feeling. You might find this uncomfortable. If you do, you can stop filling out the surveys or take a break – whatever you prefer.

What are the benefits?

We don't expect that you will get any direct benefits from this study. By sharing your experiences you can help improve the program for future families. If you decide to participate in the follow-up evaluation, you will be compensated with $10 and your child will receive a $10 gift.

Who can I contact if I have questions?

If you have any questions about this evaluation project now or at any time during the study, you may contact Dr. Kelly McShane by email at kmcshane@psych.ryerson.ca or by phone at 416-979-5000 extension 2051.

Agreement:

Your signature below indicates that you have read the information in this agreement and have had a chance to ask any questions you have about the evaluation project. Your signature also indicates that you agree to be in

the study and have been told that you can change your mind and withdraw your consent to participate at any time. You have been given a copy of this agreement.

_____

Name of Participant (please print)

_____ _____

Signature of Participant Date

_____ _____

Signature of Investigator Date

Consent to Participate in Staff Interview

What is this project about?
Undertaking a program evaluation can be challenging and can place a burden of staff and organizational resources. This evaluation attempted a participatory and embedded approach to evaluation. We want to better understand what this process was like for you.

Who is running this project?
Renascent has partnered with Ryerson University to evaluate the Children's Program. There are 2 evaluators from the Department of Psychology who are involved: Kelly McShane, Ph.D., C.Psych (Assistant Professor) and Amelia Usher, M.Ed. (PhD candidate).

What am I being asked to do?
You are being asked to participate in an audio-recorded interview lasting 20 – 45 minutes about the experience of implementing the Children's Program evaluation.

Do I have to participate?
No, you don't. Your participation in this evaluation is **voluntary**. Your decision will not affect your relationship with Ryerson University or Renascent. Also, you can skip questions you don't want to answer or stop altogether and withdraw your information at any time without penalty.

How will you keep my information private?
Participating in this evaluation will not result in information about you available to the public. Your responses will be confidential, which means that your name will not be tied to your responses when the evaluators look at them. To ensure this, the following steps have been taken:

1. The interview will be transcribed and the audio-recording will be kept in a locked cabinet and deleted after the evaluation in completed. No identifying information will be included in the transcript.
2. Your interview will be assigned a code instead of your name.

Are there any risks?
It is possible that during this interview you will become uncomfortable. If you do, you can stop the interview or take a break – whatever you prefer. If you would prefer not to be audio recorded, paper-and-pencil notes can be taken instead.

What are the benefits?
We don't expect that you will get any direct benefits from this study. By sharing your experiences you can help improve the implementation of the Children's Program and inform future program evaluations at Renascent. If you decide to participate in this interview, a donation equivalent to $10 will be made to the Children's Program for the purchase of program supplies

Who can I contact if I have questions?
If you have any questions about this evaluation project now or at any time during the study, you may contact Dr. Kelly McShane by email at kmcshane@psych.ryerson.ca or by phone at 416-979-5000 extension 2051.

Agreement:
Your signature below indicates that you have read the information in this agreement and have had a chance to ask any questions you have about the evaluation project. Your signature also indicates that you agree to be in

the study and have been told that you can change your mind and withdraw your consent to participate at any time. You have been given a copy of this agreement.

_____
Name of Participant (please print)

_____ _____
Signature of Participant Date

_____ _____
Signature of Investigator Date

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