Tung Wah Group of Hospitals
CROSS Centre

The University of Hong Kong
Department of Social Work and Social Administration

Report on Engagement of Parents in Anti-drug Work

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Collaborators of the Research Project:

Department of Social Work and Social Administration,
The University of Hong Kong

Tung Wah Group of Hospitals Community Services Division

Research Team Members:

Dr. Sandra K.M. TSANG, Principal Investigator
Head, Department of Social Work and Social Administration,
The University of Hong Kong

Mr. Ivan T.L. YIU, Assistant Community Services Secretary (Youth & Family)
Tung Wah Group of Hospitals

Ms. Brenda Y.T. CHUNG, Supervisor,
CROSS Centre, Tung Wah Group of Hospitals

Ms. Keens H.W.CHENG, Clinical Psychologist,
CROSS Centre, Tung Wah Group of Hospitals

Ms. Polly W.Y. CHUNG, Project Manager,
CROSS Centre, Tung Wah Group of Hospitals

Mr. Can W.K. TSANG, Project Officer,
CROSS Centre, Tung Wah Group of Hospitals

Ms. Daisy C.W.C. LAM, Research Assistant,
Department of Social Work and Social Administration,
The University of Hong Kong

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Colleagues:

77. Dr. Cheung Kin Leung, Ben
78. Mr. David Cheung
79. Mr. Frankie Cheng
80. Mr. Lam Hay Sing, Jacob
81. Mr. Lau Tong Ching
82. Mr. Lee Chung Ho
83. Mr. Leung Tai Yiu
84. Mr. Lo Po Sing, Paul
85. Mr. Ng Ho Hei, Elvis
86. Mr. Poon Yan Chi
87. Mr. Raymond Jao
88. Mr. Szeto Ming Wong, Max
89. Mr. Wong Wai Hung
90. Mr. Yip Kim Hung, Henry
91. Ms. Thomasina Chook
92. Ms. Ng Yuen Han, Winnie
93. Ms. Hazel Or
94. Ms. Tang Suk Yee
95. Ms. Ying Fung Sau, Winnie

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Engagement of Parents in Anti-drug Work

Executive Summary

1 Introduction

This study was launched to develop an evidenced-based parent education program to enhance the engagement of Chinese parents with adolescent children in anti-drug work. In Phases I and II of the study, large-scale parent surveys and focus group discussions were used to explore the factors that motivate or discourage parents' participation in drug-prevention programs in Hong Kong. In Phase III, a three-level parent education group program equipping Hong Kong Chinese parents with the necessary knowledge and skills in drug prevention was developed. Its effectiveness was evaluated through randomized control-trial studies.

2 Assessment of Hong Kong parents' involvement in anti-drug programs

2.1 **Phase I: Large-scale parent surveys.** The surveys tried to assess parents' participation in and awareness of anti-drug programs, and factors that motivate or discourage their participation. Data was collected via self-administered questionnaires from 5612 parents (Parents) from 14 primary schools and 21 secondary schools selected through random sampling. In addition, 100 parents with drug-taking history (DrugP) were individually interviewed using the same questionnaire with additional items on their drug-taking attitude and habits.

2.2 **Phase II: Focus group discussions.** 39 parents with or without drug-taking history and professionals involved with drug prevention or rehabilitation work participated in focus group discussions to share their views and experience regarding how best to design an effective drug-abuse prevention program for parents. The questions for the focus groups included: perceived factors that motivate or discourage parents' participation in drug-abuse prevention programs, past experiences regarding such programs, perceived parents' preferences and role in adolescents' drug abuse prevention, types of activities that would attract parents' attention and increase program participation, and the do's and don'ts during intervention.

2.3 **Results:** Using SPSS 16.0 for Windows, the quantitative data was analyzed mainly by MANOVA, t-test and logistics regression. Phase I survey results indicated that compared to Parents, DrugP showed higher level of awareness and participation in local drug-prevention program. The average level of awareness was reported to be 27.2% and participation rate was only 2.5% among all parents. Parents in general considered the followings to be factors that discouraged their participation: insufficient publicity, lack of awareness to their child's

problem, limited confidence and skills in child management, and problems with program logistics. For motivational factors, parents perceived increased program publicity, appropriate logistic arrangements, support from others, emergence of child's behavioral problems and having a child with younger age to be essential to their participation. Parents with primary and secondary school children were generally comparable in demographic patterns. Parents with older children tended to report more child behavior problems and lower parental self-efficacy.

In Phase II, focus group participants suggested the followings to be essential elements in drug-abuse prevention programs for parents: sufficient and relevant content coverage matching the diverse needs of parents, interactive format of presentation, clearly themed sessions to facilitate immediate gains by the parents, provision of incentives and the adoption of appropriate logistics (free of charge, use of appealing promotional strategies, easy to access venues and convenient application method).

3 Development and evaluation of education program to enhance parents' knowledge and skills in anti-drug work

3.1 **Phase III: Program development, implementation and evaluation.** Theory and goal-driven drug-abuse prevention group programs were tailor-made for primary, secondary and tertiary prevention purposes for three types of parents respectively: general parents (GenP), parents of at-risk youths (RiskP) who reported that their focal child had more than one behavior problems in the past 12 months, and parents with drug-using history (DrugP). A total of 140 education sessions were conducted through 44 groups for 621 parents. The effectiveness of the drug-prevention programs for these parents was evaluated using randomized-control trial study on experimental and control groups for the GenP and RiskP. A total of 437 parents finished their respective programs and completed evaluation questionnaires before and after the intervention. 27 workers from the 24 collaborative units which hosted the GenP and RiskP groups also gave feedback after the project regarding their perceived effectiveness of the program and their interest in further participation in the program.

3.2 **Results:** 64% of GenP, 79% of RiskP and 58% of DrugP finished over 75% of their respective group programs. More individualized approach was needed for the DrugP. Participants who completed the intervention generally reported lower parenting stress, increased drug knowledge and attitude, improved sense of self-efficacy, improved parent-child relationship and improved sense of parental competency. They also gave very high ratings on perceived program effectiveness at post-intervention. Regarding collaborative units' feedback, all the responding staff showed great satisfaction with the performance of the instructors and said that the program should be continued. Workers

from 22 units showed interest to further collaborate in this program in the future.

4 Discussion and Recommendations

This project adopted very rigorous quantitative and qualitative methods which yielded important information on why Hong Kong Chinese parents have limited exposure to anti-drug programs, how to effectively engage them, and how to help different types of parents to benefit from tailor-made anti-drug abuse parent education group programs. The project has proposed policy, service and research implications worthy of government and public attention. It is recommended that appropriate resources be allocated immediately to disseminate the programs to fight drug-abuse problems in Hong Kong. Dissemination should include mass production of the program packages, training of the right personnel to deliver the programs, and research resources to further demonstrate the sustainability of the program benefits over time.

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「家長在預防青少年濫用藥物的參與」研究

研究摘要

1 引言

本研究旨在發展一套有實證爲本的家長教育活動，以提升家長在預防青少年濫用藥物的參與。在本研究的第一及第二階段，研究隊以大型的家長問卷調查及焦點小組，探討促進及阻礙家長參與預防青少年濫藥活動的因素。在第三階段，研究隊爲三類家長分別設計了三套協助家長預防子女濫藥的教育活動，並採用隨機控制組方式進行成效評估。

2 香港父母在參與預防濫藥活動的情況評估

2.1 第一階段：大型家長問卷調查

是項調查嘗試探索家長在參與預防青少年濫藥問題活動的程度及意識，以及了解推動及阻礙家長參與的因素。問卷調查以隨機抽樣形式，得到 14 間小學及 21 間中學的協助，共 5612 位家長以自行作答方式完成問卷。此外，研究隊亦以面談方式訪問了 100 位曾經濫藥之家長，除了收集家長問卷調查所包括的資料外，也進一步了解濫藥家長服食藥物的態度和習慣。

2.2 第二階段：焦點小組

39 人參與 5 次焦點小組討論，當中包括戒毒及復康服務的專業人士、曾經及從未濫藥的家長，一同分享如何推行成功的預防濫藥家長活動。討論重點包括：推動及阻礙家長參與預防參與的因素、過往推行活動的經驗、家長對活動設計的愛好、家長的角色、推動家長參與的策略，及舉辦活動的宜與忌。

2.3 研究結果：量性的數據透過 SPSS 16.0 for Windows 內的 MANOVA、t-test 及 logistic regression 作分析。第一階段的研究結果顯示，相對非濫藥家長，濫藥家長在預防青少年濫藥的活動上，有較高的意識及參與。綜合兩種家長，平均有 27.2%留意到社區有預防青少年濫藥的家長活動，但當中平均只有 2.5%有參與活動。家長大體上認爲下列因素阻礙他們的參與：宣傳不足、欠缺留意孩子有否濫藥的意識、對處理子女行爲問題欠缺信心及技巧，及活動安排不方便參與等等。而推動家長參與的因素則如下：廣泛有效的宣傳、合適的活動安排、有其他人鼓勵參與、子女已出現行爲問題，及子女的年齡較小。子女年紀越大的家長多數覺得子女有較多行爲問題，親職方面的自我效能感也較低。

在**第二階段**，焦點小組的參加者認爲預防青少年濫藥的家長活動必

須包括以下元素：活動內容充足及能配合不同家長的需要、活動形式要相向及互動、每節的訊息要清晰且能幫助家長有即時的學習、設立出席獎勵，以及配合適當的活動安排 如：免收費用、正面的宣傳策略、方便的場地、簡便的報名方法等等。)

3 提升家長預防青少年濫藥的知識及技巧：家長教育活動設計及成效評估

3.1 第三階段：活動設計、推行及成效評估

研究隊以理論和目標爲本的原則，分別爲一般家長、高危家長(子女在過去 12 個月內曾有一項或以上的行爲問題)及濫藥家長(家長在過去或現在有濫用藥物的行爲)，特別制定三層各有特色的預防濫藥家長教育活動。研究隊組織了 44 個家長小組，推行了 140 節教育活動，惠及 621 位家長，共有 437 位家長完成活動及成效評估。在一般家長及高危家長兩個組別中，成效評估採用隨機控制組方式進行，而濫藥家長組別的成效評估則較個別化。另外，在 24 個合作舉辦一般家長及高危家長活動的機構中，有 27 位合作同工對本計劃的成效及繼續參與的興趣，作出回應。

3.2 研究結果：一般家長、高危家長及濫藥家長三個組別的出席率分別爲 64%、79%及 58%。在提升濫藥家長的參與方面，研究隊以較靈活的手法，配合他們個別不同的情況。參加者在完成活動後，普遍在藥物知識和態度、自我效能感、親子關係、及管教能力感各方面皆有所提升，親職壓力則得到紓緩。參加者亦對活動成效給予高度的評價。在收集機構意見方面，所有回應的同工也對活動的導師表現表示滿意，並指計劃有延續發展的價值。有 22 間機構的同工表示有興趣與本計劃作進一步的合作。

4 討論和建議

是次計劃採用了精細的量性及質性的方法收集資料，了解香港家長未積極參與預防子女濫藥活動的原因，及推動家長參與的策略，亦爲不同家長度身設計預防子女濫藥的家長活動。本計劃並就政策、服務及研究三個層面，作出建議，以喚起政府及公眾的關注。本計劃建議應立即推廣有效的家長教育活動，以協助家長打擊青少年濫藥問題。這包括大量印製家長教育資源套、培訓導師及繼續投放資源作研究用途，以進一步確保家長教育活動的成果能持續造福社會。

2008 年 4 月

Chapter 1

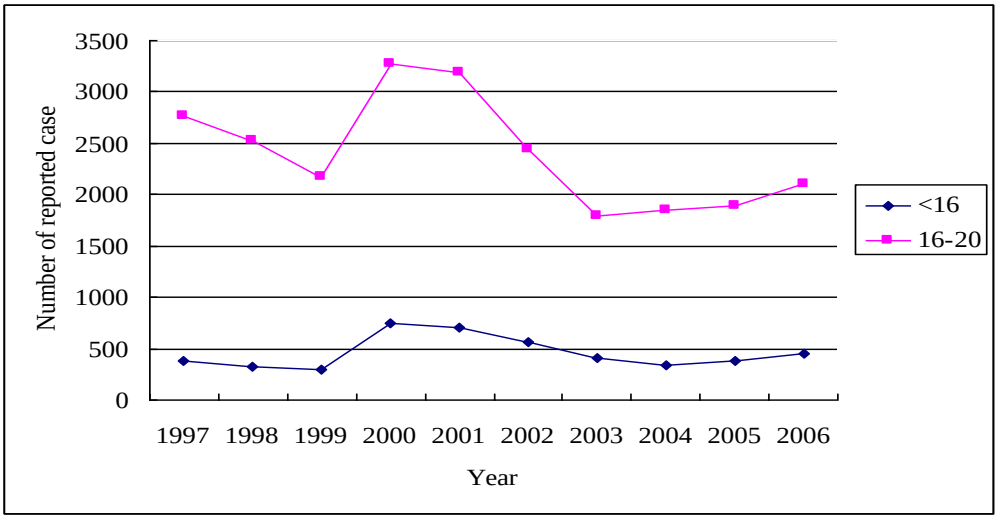
Introduction

In this chapter, relevant background information related to youth drug abuse problem and the important role of parenting to reduce the risk of substance abuse would be introduced.

1 Prevalence of adolescent drug abuse in Hong Kong

The total number of drug users in the world was estimated to be over 200 million in 2006 (United Nations, 2007). The increasing number of substance abuse among young people has become a global phenomenon. In Hong Kong, the growth of substance abuse among youth aroused increase social attention. For example, the Central Registry of Drug Abuse (CRDA) 56th Report[1] showed that the averaged age of new reported drug abusers was 23, which was younger than their previously reported counterparts with an average age of 38. While the number of newly reported drug abusers below the age of 16 represented 8.2% (298 cases) of all newly reported drug abusers in 1997, they represented about a-tenth of the newly reported drug abusers (10.2%, 357 cases) in 2006. Likewise, while newly reported drug abusers with age below 21 represented 43.1% (1559 cases) of all newly reported drug abusers in 1997, the percentage rose to 50.1% (1746 cases) in 2006. Figure 1.1 indicated the re-emergence of a growing trend of young drug abusers under aged 21 from 2003-2006, after a peak period in 2000 and a decline in 2001-2003. In addition, the number of newly reported cocaine users in the 56th CRDA Report has also risen drastically over the past 10 years among those under the aged of 21 (i.e. from 8 cases in 2000 to 110 cases in 2006).

Figure 1.1: The growing trend of young substance abusers under aged 21 from 1997-2006



[1]Narcotics Division, Security Bureau, The Government of the HKSAR. (2007). *Central Registry of Drug Abuse 55th Report (1996-2005)*. Retrieved Feburary 22, 2008, from: http://www.nd.gov.hk/drugstatistics.htm

The phenomenon of poly-drug abuse is very problematic among young drug abusers in Hong Kong. The reduced purity and quality of street drugs significantly increases the likelihood of fatality and causes problems with diagnoses and intervention (Leung, 2002). The upsurge of drug abuse among youth and its lethal consequences clearly call for the development and evaluation of innovative prevention strategies that build on theory and prior researches.

2 Importance of parental prevention programs for adolescent drug abuse

2.1 Youth development and family factors

Family factors have been found to be important predictors of general maladjustment in existing youth and family education programs. For example, greater family engagement in prevention has proved to bring benefits for children across multiple domains including increased academic performance, reduced substance use involvement and maintenance of weight loss (Golan & Crow, 2004; Liddle, 2004; Sheldon & Epstein, 2004). In the absence of protective parenting practices, children seem more likely to engage in a range of hazardous behaviours[2]. The important role of parents in drug-abuse prevention has led to the development of a number of prevention-oriented parenting and family intervention programs that aim at reducing family risk factors and promoting family protective factors associated with drug abuse (Dishion & Kavanagh, in press; Kumpfer & Turner, 1990; Spoth & Redmond, 1995; Spoth, Redmond & Shin, 1998).

2.2 Positive parenting and family functioning

Abundant studies now showed that parenting is a critical facilitator of development in child socialization and a buffer against risk factors known to be associated with dysfunction (Maccoby & Martin, 1983; Hawkins, Catalano & Miller, 1992; Gross et al., 2003). Increasing evidence also confirmed positive collateral effects of parents' education programs in other areas of family functioning such as significant reduction in marital conflict over parenting (Dadds, Schwartz & Sanders, 1987), reduced parental depression and stress (Connell, Sanders & Markie-Dadds, 1997; Sanders & McFarland, in press), reduced parental anger and hostility (Sanders & Gravestock, 2000), and an increased level of parenting competence (Connell et al., 1997).

3 Lack of parental enthusiasm in anti-drug preventive intervention

Despite the importance of parental influence, most parent-targeted educational interventions implemented in the last 15 years have been only partially encouraging due to difficulties in recruiting and maintaining substantial parent participation (e.g. Sanders, 2000; Cohen & Linton, 1995;

[2] Department of Human Services. (2000). *Evidence-based health promotion: Resources for planning no. 2 adolescent health* (pp. 1-35). Melbourne Centre for Adolescent Health, Public Health Division, Victorian Department of Human Services. Retrieved June 21, 2007, from http://www.health.vic.gov.au/healthpromotion/downloads/adolescent_health.pdf

Young, Kersten & Werch, 1996). For example, Western prevention programs focusing on parents showed a population-based recruitment rates to range from 49-70% (Dumka et al., 1997). Other researches demonstrated even lower recruitment rate of 20-25% in preventive intervention for parents (e.g. Coie et al., 1991; Fontana et al., 1988; Myers et al., 1990). Studies also showed gender differences in recruitment with a majority of participants being the mother. For example, 2.5% of fathers participated in a 5-session program for parents in the UK (Velleman et al., 2000). In Hong Kong, two recent studies that explored parent-adolescent mediation revealed father's participation rate to be less than 11% and 20% respectively (Tsang, 2004; Tsang & Leung, 2005).

Research findings showed that the participation rates in parents' training groups tend to be lowest amongst those groups of parents whose children are considered at highest risk of maladjustment (Sanders et al., 1999). Difficulties in getting parents involved in preventive services for their children has been well documented across problem areas, such as substance abuse (Kumpfer & Alvarado, 2003) and parenting and behavioral skills training (e.g., Titterington, 1990). Moreover, published evaluations of parent programs specifically designed to prevent or reduce drug use by high-risk youth are rare (DeMarsh & Kumpfer, 1986). These evaluations have been fraught with problems including high attrition (DeMarsh & Kumpfer, 1986) as mentioned above; small sample size (Klein & Swisher, 1983; Klitzner, Gruenewald & Bamberger, 1990); selection bias (DeMarsh & Kumpfer, 1986; Albert, Simpson & Eaglesham, 1983); and inability to secure and maintain control groups and lack of longitudinal designs (Lorion & Ross, 1992).

To explore this issue further, Beatty and Cross (2006) consulted 200 parents and collected their preferences in the development and implementation of a parent-directed drug related educational intervention. They suggested that the removal of parents' perceived barriers should subsequently enhance engagement and achieve higher percentages of participation in parent training programs. Since most of the previous formative research about parents' recruitment has been conducted in North America, the method and knowledge of recruiting and engaging a high percentage of parents in drug prevention program in Hong Kong remained an important area of investigation.

4 Motivational factors to parents' participation in drug-abuse prevention program

This study aimed to identify factors that motivate and discourage parents' participation in preventive intervention for adolescent drug abuse in Hong Kong. Particular emphasis was put on at-risk youth and the children of parents with drug-taking history. Based upon the findings, recommendations will be made regarding the modification to the promotion strategies of preventive education programs so that the participation rate of parents could be enhanced.

Motivational factors identified in previous studies could be roughly categorized into three types, including perceived benefits of program, perceived severity of child problem, and perceived child susceptibility to drug

abuse (Redmond, Spoth, Shin & Hill, 2004). Based on the Health Belief Model which has been intensively studied in healthy behavior, perceived benefits of intervention is the major motivation for parents to participate in preventive program for adolescent drug abuse (Janz & Becker, 1984; Spoth & Redmond, 1995).

Another potential motivational factor is the perceived severity of child problem. Earlier studies have shown that parents' concern about the severity of a child's illness predicted mothers' compliance with the child's medication (Becker, Drachman & Kirscht, 1972). The positive association between the level of child problem behaviors and the participation in parent intervention was found in studies of general children problem behavior and children with developmental disabilities (Sutton & Dixon, 1986; Campbell, Strickland, & La Forme, 1992). In addition, higher parent-reported externalizing problems of children or self-report of children anti-social behavior were associated with increased enrollment in parent training program (Cunningham et al., 2000). In other words, parent motivation to enroll in a prevention trial is likely to be low if the perceived need for help is low (Perrino et al., 2001). Moreover, it is found that the perceived severity mediated the impact of perceived benefits of intervention on the intention to enroll in a parenting intervention (Spoth & Redmond, 1995).

Perceived susceptibility to drug abuse refers to parents' perception of their child's probability of engaging in drug abuse (Spoth & Conroy, 1993). A positive relation was found between perceived susceptibility and inclination to enroll in a parenting intervention for adolescent drug abuse (Spoth & Redmond, 1995). Parents' perceived efficacy to prevent future problem behaviors among their children was significantly related to perceived child susceptibility of drug abuse (Spoth & Conroy, 1993; Redmond, Spoth, Shin & Hill, 2004).

5 Factors discouraging parents' participation in drug-prevention program

Aside from motivational factors, it is important to gather data specific to the type of intervention and the type of target participants for the intervention because barriers can vary with different categories of interventions and can also differ among target groups (Carter, Elward, Malmgren, Martin & Larson, 1991; Spoth & Redmond, 1993; Vernon, Laville, & Jackson, 1990). Nonetheless, there has been a dearth of research directed toward exploring these barriers with parents with general youth or at-risk youth, as well as parents with drug abuse history.

To address the issues raised in the relevant barrier literature, the current study would gather detailed information on a comprehensive set of discouraging factors to participation in existing drug-abuse prevention activities. The information can be used to guide the development of effective recruitment strategies for parents, such as time scheduling conflicts or time demands and location.

Perceived barriers to participation in healthy behavior are strong predictors of engagement in any health behavior (Janz & Becker, 1984; Rosenstock, 1990).

Barriers to taking action typically include those related to time required, effort expended, and monetary cost (Weinstein, 1988). Studies on varying types of programs serving different populations have consistently indicated that time-related barriers are most critical (Grady, Gersick, & Boratynski, 1985; Spoth & Molgaard, 1993; Spoth & Redmond, 1993).

Other logistic barriers, such as transportation difficulties, child care, and program demands were also found to be barriers to attending parent education programs. Providing logistic support such as transportation and child care increased the program participation for parents (Saylor, Elksnin, Farah, & Pope, 1990). Similarly, needing to find child care, having to travel to the meetings, and monetary cost of intervention materials had been identified as barriers to participating in parenting intervention for prevention of adolescent drug abuse (Spoth & Redmond, 1995).

In a retrospective study of participation barriers to parental prevention programs for economically stressed families, the most frequent reason for decisions against participation was time demands (Spoth & Redmond, 1993). Similar findings are reported in a study of participation rates for parents in a family-focus skills training program (Spoth, Redmond, Hockaday & Shin, 1996). Therefore, the time and location of the parent training program are linked to enrollment rate in general parenting program and universal parental intervention for general children conduct and behavior problems (Cunningham, Bremner & Boyle, 1995). This barrier might even be stronger for low-income families (Garvey, Julion, Fogg, Kratovil & Gross, 2006). Lastly, non-awareness of the programs was also identified as one major barrier to enrolling in parent-focused prevention program (Garvey et al., 2006).

6 Anti-drug programs in Hong Kong

The Hong Kong Narcotics Division and non-governmental agencies provide various kinds of anti-drug programs. However, the nature and target of these anti-drug programs are diverse and the effectiveness of these programs was rarely examined systematically. For example, among the 207 drug prevention programs subsidized by the Hong Kong Beat Drugs Fund from 1996-2006, only 11 were found to focus on parent as their primary target (Table 1.1).

Table 1.1: Drug preventive program for parents subsidized by the Hong Kong Beat Drugs Fund (1996-2006)

Year	Total Preventive Program	Parents as primary target
1996-1997	29	1
1997-1998	35	5
1998-1999	39	1
1999-2000	23	0
2000-2001	28	0
2001-2002	21	2
2002-2003	11	0
2004-2005	9	0
2005-2006	12	2
Total	207	11

The limited attention to the effects of parent or family characteristics and intervention certainly warrant more exploration and rectification. The present study expands the local parenting literature on drug-prevention by incorporating an experimental test of a theory-based, comprehensive intervention with a reasonably large sample, multi-method measurement to evaluate the effectiveness of a structured anti-drug prevention treatment program for parents in the Chinese community. An examination of parenting-focused programs such as the Triple-P program in the West (Sanders, 1999) and in the East (Leung et al., 2003), and Project Astro Mind in Hong Kong (Lam et al., 2003) showed that these programs utilized important concepts that stemmed from the ecological system theory, social learning theory, positive psychology as well as the cognitive behavioral model. To ensure the efficacy and effectiveness of the current parent anti-drug prevention program, references will be drawn from the above theoretical frameworks throughout the design and implementation of this study.

7 Criteria for an effective prevention program

Nation et al. (2003) and Dusenbury (2000) identified eight principles (i.e. theory-driven, comprehensive, sensitive to developmental needs of parents and youth, culturally sensitive, sufficient coverage, interactive techniques, trained staff and evaluation) in designing effective prevention intervention. These principles will be adopted to guide the development of the current project.

8 Aim of the present study

According to the project outline specified by the Narcotics Division, which funds this project, this project should fulfill the following objectives:

8.1 To assess the extent of parents' involvement in existing drug prevention activities in Hong Kong and to study factors that motivate/discourage parents from being involved; and

8.2 To develop and implement preventive and education programs with a view to:

a. equipping parents (particularly parents of vulnerable youth) with the necessary knowledge and skills to advise and help their children when they come across drug related problems; and

b. arousing the awareness of drug-taking parents about the severe negative impacts of their drug-taking habits on the upbringing of their children so that they would be motivated to stop inter-generational drug abuse.

8.3 To consolidate relevant experience and documents/materials for the proposed programs and evaluate their effectiveness.

Chapter 2
Assessment of Hong Kong Parents' Involvement in Anti-drug Programs

1 Objectives of the assessment

1.1 To examine the extent of parents' involvement in existing drug prevention programs in Hong Kong;

1.2 To identify motivational and discouraging factors associated with the participation of parents (of young people aged between 11 and 21) in existing drug prevention activities in Hong Kong;

1.3 To identify the most effective way to arouse the awareness of those with drug-taking history about their drug taking habits on the upbringing of their children and motivate them to stop intergenerational drug abuse.

2 Method

2.1 The assessment was based on extensive literature review and accomplished through two Phases: a large-scale parent survey (Phase I) and focus group interviews of concerned professionals and parents (Phase II).

3 Phase I: Parent Surveys

3.1 Research design

3.1.1 The survey was a retrospective study of two types of parents: parents sampled from primary and secondary schools (referred as "parents" in this section), as well as parents with drug-taking history (referred as "DrugP").

3.1.2 Literature informed that parental participation in anti-drug programs will be low. In this study, a measure of parents' (school sample parents and DrugP) awareness of existing drug-prevention program in the past was included in the questionnaire for analyses. It is likely that parents' with awareness in past anti-drug prevention activities would be more inclined to participate in these programs as well. The following section would explore the differences between parents who have participated in anti-drug prevention in the past and those who did not. Likewise, analyses would examine the differences between parents with awareness of anti-drug prevention program in the past and parents without awareness.

3.2 Sampling method and data collection

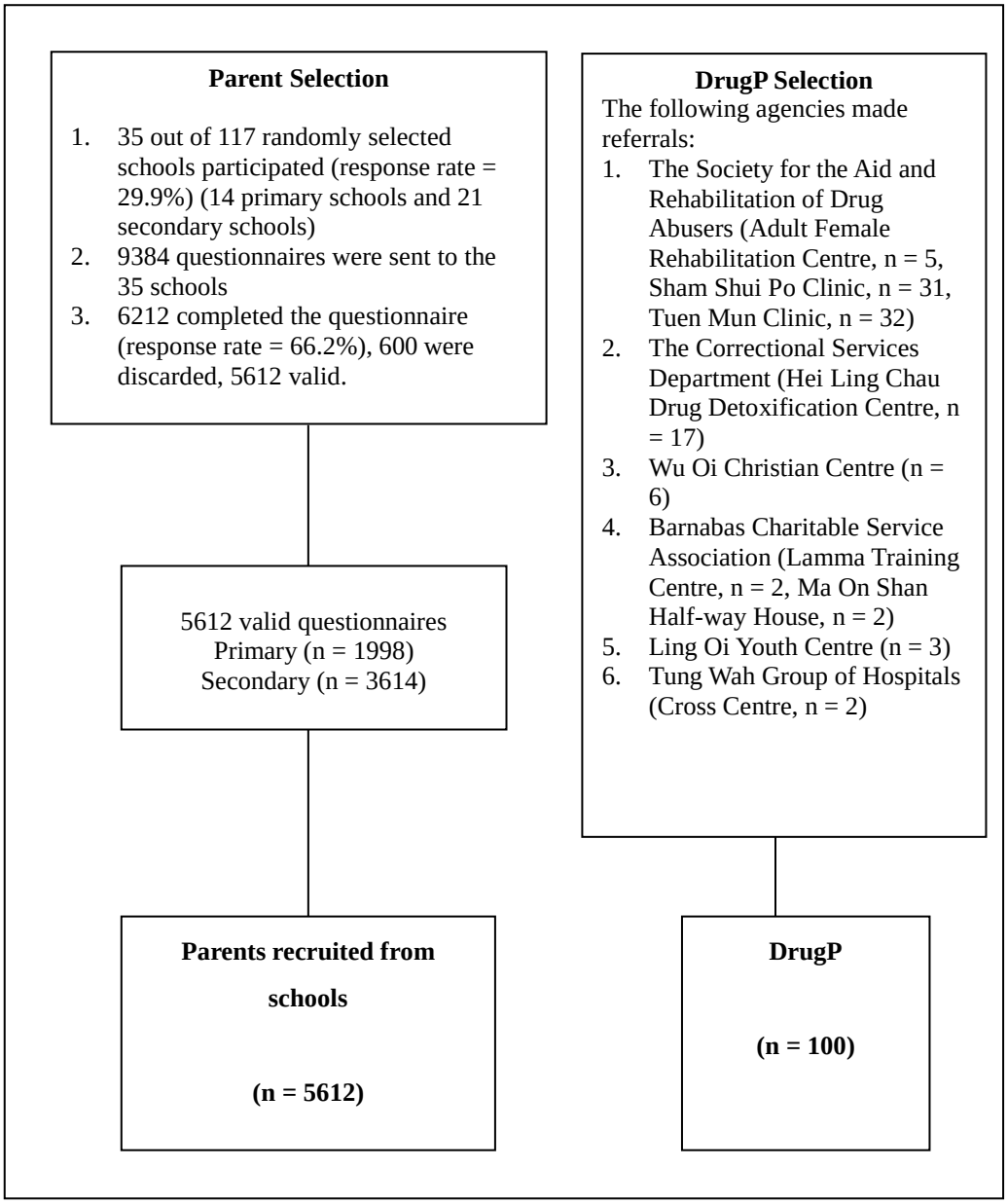
3.2.1 A random sampling method was used to select target parents from each of the 14 consenting primary schools and 21 consenting secondary schools which responded to the invitation to participate.

3.2.2 A total of 5612 parents (1998 from primary and 3614 from secondary schools) completed the self-administrated questionnaires (Appendices 2.1 and 2.2).

3.2.3 For DrugP: snowball sampling recruited 100 DrugP who were individually interviewed by the project research officers (Appendix 2.3). Participating agencies and units are listed in Appendix 2.4.

3.2.4 Flow chart of the procedure and sampling for the parent surveys is shown in Table 2.1.

Table 2.1: Flow chart of procedure and sampling (N = 5712) for parent surveys



3.3 The survey questionnaire

The survey questionnaire used in Phase I was designed after extensive literature review. The questionnaires for primary and secondary school parents were each piloted with 10 parents. The questionnaire designed for drug-used parents was piloted with 3 parents with drug-taking history. The feedback from the pilot test was used to finalize the questionnaires. The data collection was conducted during the period from May 2006 to October 2006. The focus of study in the questionnaires for all three groups of parents is listed as follows:

3.3.1 Socio-economic characteristics of parents and the focal child

a. Parents: gender, age, marital status, age of spouse, the status of new arrival (individuals who have resided in Hong Kong for less than 7 years), spouse's status of new arrival, number of children, education level, employment status, household income, and the status of welfare recipients.
b. Focal child: age and current education level (primary school and secondary school).
c. Behavioral problems presented by focal child in the past 12 months, obtained by 11 items in binary format.

3.3.2 Participation in and awareness of drug abuse prevention programs

a. Participation in adolescent drug abuse prevention program for parents in the past 12 months was obtained by one item in binary response format.
b. Awareness of adolescent drug abuse prevention program for parents in the past 12 months was obtained by one binary item.
c. Indication of preferences regarding the future adolescent drug abuse prevention programs.

3.3.3 Family context factors

a. Involvement with child in terms of the amount of time spent with the child per week.
b. Perceived family cohesion was assessed by a question that "What is your family cohesion?" on a 5-point scale ranging from 1 = very low to 5 = very high.
c. Parenting style was assessed by one item related to buying clothes for their child and authoritative, authoritarian, permissive, and neglectful parenting styles was scored.

3.3.4 Motivational factors for joining drug abuse prevention programs for parents

a. Self-efficacy of managing child drug-abuse problem was measured by one hypothetical question "If your child was involving in some problem behaviors, do you agree that you have the capability to handle it effectively?" on a 4-point scale ranging from 4 = strongly agree to 1 = strongly disagree.

b. Sensitivity to adolescent drug abuse was measured by a hypothetical scenario in which misconduct behaviors associated with adolescent drug abuse were asked to be identified by participants through 10 binary items including decline in adverse impact on learning, truancy, self-talk, early psychotic symptoms, frequent illness, smoking, deteriorated relationship with other family members, run away from home, listen to funk music, and fatigue.

c. Help seeking for adolescent drug abuse was assessed by the same scenario in which participants were asked the sources of assistance they would seek if they found that their child was a drug abuser. 15 binary items were used to measure informal and formal sources of support including spouse, parents, siblings, other children, relatives, close friends, neighbor, friends in church, social workers in social service organization, school social workers, teachers, other parents in the same school, medical doctors, and Governmental agencies like the Narcotics Division or would not seek help at all.

d. Concern related to adolescent drug abuse was measured by asking participants whether they considered their child's substance abuse to be the family greatest concern. This question was answered on a yes-no response format.

e. Perceived child susceptibility to drug abuse was assessed by one item in which participants were asked "Have you ever suspected that your child was taking drug?" on a binary response format.

3.3.5 Discouraging factors to participate in drug abuse treatment and prevention programs

a. Discouraging factors to enroll in drug abuse treatment program were obtained by asking respondents what barriers would prevent them from participating in drug-abuse treatment if they found that their focal child was taking drugs. The barriers included fear to accept child's drug abuse, fear that others know the child's drug abuse, fear of spouse's reaction, fear of affecting child's future development, fear of being looked down on by others, lack of confidence to deal with child's drug abuse, lack of time to deal with child's drug abuse, fear of child's quitting from school for treatment, child's drug abuse not a concern for the family, lack of communication with child, fear of worsening of parent-child relationship, and don't know how to manage and seek help.

b. Discouraging factors to enroll in drug-abuse prevention program were obtained by asking respondents what barriers would prevent them from participating in drug-abuse prevention program. The barriers included the followings: unmatched timing, undesirable venue, undesirable date, undesirable format, unsuitable program

content, lack of promotion, partner was unsupportive, my child does not have substance abuse problem, preventing child drug abuse is not the greatest concern in my family, fear of stigma (i.e. others misunderstand that my child has drug abuse problem), fear that if participated, nobody is at home to take care of other children.

3.3.6 DrugP questionnaires collected additional information that informed the prevention of intergenerational drug abuse:

a. Ten binary items were used to examine parental attitudes to adolescent drug abuse.

b. Participants were asked whether they placed illicit drugs at home and where they placed it.

c. Participants were asked whether they gave illicit drugs to their children for storage.

d. Participants were asked whether they allowed their children to have friends with drug abuse problem

e. Parents' perceived impact of their own drug taking habit on their own family and children was assessed by nine items which scored on 3-point scale ranging from 1 = worse, 2 = no effect, to 3 = better.

3.4 Data Analysis

3.4.1 Bivariate analyses were performed to identify the differences between those who participated in or were aware of the existing drug prevention programs, and those who did otherwise, in terms of their demographic characteristics, family context factors, motivational factors, discouraging factors and child's behavioral problems.

3.4.2 Logistic regression analyses were then performed to identify correlates of the participation and awareness of the prevention program. Only independent variables found to be significant at the bivariate level were examined in the logistic regression models. Separate analyses were conducted on parents (with primary and secondary child) and DrugP.

4 Parent surveys results

4.1 Response Rate

4.1.1 The school response rate was 29.9% (35 schools participated of 117 sampled). Approximately 160 parents from each participating school completed the questionnaire.

4.1.2 A total of 9384 questionnaires were sent out to the target population and 6212 parents replied. The response rate was 66%.

Out of the 6212 parents who were administered the questionnaires, 600 questionnaires were found to be invalid with excessive missing data. Finally, 5612 valid questionnaires were used for analysis.

4.1.3 A total of 100 DrugP were interviewed.

4.2 Sample Characteristics

4.2.1 Among the total of 5712 parents (including 100 DrugP) who participated in Phase I, their general characteristic is as follows:

a. Among the 5712 respondents, 4542 (79.5%) were female and 1170 (20.5 %) were male.

b. 80% of the parents were mothers. DrugP respondents were mostly fathers (65%).

c. Approximately 42.4%, 23.9% and 16.6% of participants were in the 40-44, 45-49, and 35-39 age groups. Their mean age was 43.4 (SD = 5.8).

d. 85.5% were married and 54.3% of respondents had an educational attainment of F.3 or below.

e. The mean age of focal child in primary school and secondary school was 11.37 and 14.88 respectively.

f. 47.1% of the respondents had a full-time (at least 44 hours per week) employment and the median of household income in the range of $10000 to $19999 for parents. The median of household income for DrugP was in the range of $5000 to $9999.

g. 10.4% of parents with focal child studying in primary and secondary school were on CSSA, compared to 65% for DrugP.

h. Regarding parents' perceived susceptibility to child drug abuse, 1.7% of parents without drug abuse history reported suspicion in the past compared with 17% for DrugP.

i. Regarding level of awareness and participation in anti-drug prevention activities in the past 12 months, 10.9% of primary school parents and 16% of secondary school parents (χ^2=23.669, p<.01) were aware of anti-drug program in the past 12 months. Table 2.2 listed the percentage of parents with awareness or participation in anti-drug prevention activities in the past. The averaged participation rate for parents with secondary and primary school children was 2.3% and nearly 27% reported awareness in the past. DrugP reported higher participation and awareness with 12% and 45% respectively.

Table 2.2: Percentage of parents (N=5612) and DrugP (N=100) who participated in or were aware of anti-drug programs in the past 12 months

	Parents (N = 5612)	DrugP (N = 100)	Total (N = 5712)
Participated in	2.3%	12.0%	2.5%
Aware of	26.9%	45.0%	27.2%

4.2.2 Demographic characteristics of parents who participated and did not participate in anti-drug prevention program in past 12 months

a. Table 2.3 showed that no significant differences were observed between non-participated and participated parents regarding their age, gender, marital status, education attainment, household income, parents' and their spouses' status of new arrival, the number of children and status of CSSA.

b. Significant difference was found in the age and educational level of focal child for participated and non-participated parents. Compared with non-participated parents, more parents who have participated in anti-drug prevention program in the past had younger focal child (mean age=12.89 vs. 13.64, $t=3.57$, $p<.01$), studied up to primary level (51.2% vs. 35.1%, $\chi^2=13.94$, $p<.01$), and had younger spouse (mean age=44.34 vs. 45.81, $t=2.23$, $p<.05$) and had a part-time job (25.9% vs. 15.4%, $\chi^2=10.74$, $p<.05$).

c. 73.9% of participated parents were female, with median age that falls in the range of 41-50. 91.9% were married or cohabited and 45.5% had a full-time job. Their median household income was in the range of $5000-19999. 11% of parents with participation and 10.2% of parents without participation in anti-drug prevention program in the past were on CSSA.

Table 2.3: Demographic characteristics of parents who participated and did not participate in anti-drug prevention program in the past 12 months (N=5612)

Variables	Participants % or Mean (SD)	Non-participants % or Mean (SD)	Chi-Square/ T-test values
Age group of focal child			8.60*
6 - 10	10.1	5.2	
11 - 15	75.6	72.7	
16 - 21	14.3	22.1	
Mean (SD)	12.89 (2.14)	13.64 (2.29)	3.57**
Current education level of Focal child			13.94**
Primary	51.2	35.1	
Secondary	48.8	64.9	
Parent age group			2.26
18 - 30	1.6	0.9	
31 - 40	32.3	30.7	
41 - 50	46.5	51.8	
51 - 60	7.9	7.2	
61 +	11.8	9.4	
Mean (SD)	42.96 (5.41)	43.39 (6.01)	0.74
Gender of parent (Female)	73.9	79.6	2.28
Marital status			1.16
Married or Cohabited	91.9	90.0	
Separated or Divorced	5.7	7.3	
Widowed	2.4	2.2	
Unmarried father/mother	0.0	0.5	
Education level of parent			0.92
No education	2.4	2.5	
Primary	24.4	21.8	
Secondary	63.4	63.7	
Matriculation/Diploma	7.3	8.9	
University or above	2.4	3.2	
Employment status			10.74*
Full-time	45.5	52.0	
Part-time	25.9	15.4	
Retired	7.1	9.1	
Unemployed	17.0	20.6	
Housewife	4.5	2.8	
Household income			5.58
<4999	13.8	7.7	
5000-19999	63.3	67.3	
20000-39999	17.4	17.7	
>40000	5.5	7.2	
Parent's status of new arrival	8.7	5.8	1.84
Age of parent's spouse			27.58**
18-30	3.9	0.5	
31-40	15.7	14.3	
41-50	50.4	49.8	
51-60	7.9	12.2	
61+	22.0	23.1	
Mean (SD)	44.34 (6.61)	45.81 (6.53)	2.23*
Spouse's status of new arrival	4.7	2.7	1.82
Number of children	2.11(1.01)	2.08(0.91)	-0.31
CSSA recipient	11.0	10.2	0.75

Note. *p <0.05, **p <0.01

4.2.3 Family context factors for parents who participated and non-participated in anti-drug prevention program in the past 12 months

a. Regarding family context factors, no significant differences were found between participated and non-participated parents regarding quality time spent with child, perceived level of family cohesion and parenting style. Table 2.4 showed that participated parents in general perceived higher level of family cohesion and more than 64% adopted the authoritative type of parenting. About a-tenth of non-participated parents had permissive type of parenting and 3.4% reported neglectful type of parenting. Neglectful type of parenting was only evident among non-participated parents.

Table 2.4: Family context factors for parents who participated and not participated in anti-drug prevention program in the past 12 months (N=5612)

Variables	Participants % or Mean (SD)	Non-participants % or Mean (SD)	Chi-Square/ T-test values
Involvement with child in terms of the amount of time (hours) spent with the child per week	34.73 (32.86)	35.12 (31.34)	0.13
Perceived family cohesion	3.90 (0.81)	3.77 (0.86)	-1.55
Parenting style			7.25
Authoritarian	28.8	22.8	
Authoritative	64.9	63.6	
Permissive	6.3	10.3	
Neglectful	0.0	3.4	

Note. * p <0.05, ** p <0.01

4.2.4 Motivational factor: differences between parents who participated and did not participate in anti-drug prevention program in the past 12 months

a. Table 2.5 showed that compared with non-participated parents, parents who participated showed higher sense of self-efficacy to manage their child's drug abuse problem (mean=2.98 vs. 2.85, t=-2.02, p<.05) and higher perceived child susceptibility to drug abuse (4.5% vs. 1.6%, χ^2=5.39, p<.05), but were less likely to indicate concern related to adolescent drug abuse (54.4% vs 57.4%, χ^2=4.08, p<.05).

b. Both participated and non-participated parents showed sensitivity towards adolescents' drug abuse with non-participated parents differed significantly from participated parents and perceived worsened relationship with family members to be a significant warning sign of adolescent drug abuse (78.2% vs. 70.6%, χ^2=4.13, p<.05).

c. Significant difference was found between participated and non-participated parents in terms of help-seeking pattern.

Participated parents were significantly more likely to seek help from own parents (25.6% vs. 17.8%, χ^2=5.04, p<.05) and friends in church (26.4% vs. 18.2%, χ^2=5.49, p <.05).

d. For both participated and non-participated parents, the top three sources of help they would seek upon discovery of their child's drug abuse problem were 1) social workers in social service units, 2) school social workers, and 3) teachers of the school the child studies.

Table 2.5: Motivational factors for parents who participated or non-participated in in anti-drug prevention program in the past 12 months (N=5612)

Variables	Yes/ No	Participants % or Mean (SD)	Non-participants % or Mean (SD)	Chi-Square/ T-test values
Self-efficacy of managing child drug abuse problem		2.98 (0.66)	2.85 (0.68)	-2.02*
Sensitivity to adolescent drug abuse (measured by a hypothetical question, see note)				
Adverse impact on learning	Yes	88.9	87.0	0.41
Truancy	Yes	61.1	53.4	2.94
Self-talk	Yes	36.5	41.4	1.21
Psychotic symptoms	Yes	51.6	54.7	0.47
Frequent sickness	Yes	22.2	25.7	0.79
Smoking	Yes	44.4	40.8	0.68
Worsened relationship with family members	Yes	70.6	78.2	4.13*
Run away from home	Yes	30.2	32.5	0.32
Like to listen to funk music	Yes	24.6	22.4	0.33
Easy to become tired	Yes	77.8	75.7	2.9
Help Seeking for adolescent drug abuse from				
Spouse	Yes	51.2	57.0	1.70
Parents	Yes	25.6	17.8	5.04*
Siblings	Yes	17.6	19.1	0.17
Other children	Yes	12.0	8.1	2.43
Relatives	Yes	16.0	14.9	0.12
Close friends	Yes	26.4	25.5	0.05
Neighbors	Yes	3.2	4.1	0.25
Friends in church	Yes	26.4	18.2	5.49*
Social workers in social service units	Yes	66.4	61.6	1.19
Social workers in school which the child studies	Yes	63.2	64.2	0.05
Teachers in the school which the child studies	Yes	54.4	57.4	0.46
Parents in the school which the child studies	Yes	9.6	8.3	0.26
Doctors	Yes	37.6	36.0	0.14
Governmental departments (e.g. Narcotics division)	Yes	48.0	41.0	2.47
Would not seek help at all	Yes	0.8	1.3	0.24
Concern related to adolescent drug abuse	Yes	54.4	57.4	4.08*
Perceived child susceptibility to drug abuse	Yes	4.5	1.6	5.39*

Note. * p <0.05, ** p <0.01, hypothetical question: If Chan has a drug abuse problem, he is likely to present with the following behaviors (10 items measured in binary format)

4.2.5 Discouraging factor between parents who participated and did not participate in anti-drug prevention program in the past 12 months

a. Table 2.6 showed that compared with non-participated parents, participated parents were more likely to indicate "lack of confidence to deal with child's drug abuse" (18.9% vs. 12.2%, χ^2=4.44, p<.05) and their "child's drug-abuse problem is not a major concern for the family" (7.2% vs. 3.6%, χ^2=4.10, p<.05) as discouraging factors to participate in drug treatment program but less likely to report "don't know how to manage and seek help" (19.8% vs. 31.1%, χ^2=6.44, p<.05) as a discouraging factor to treatment.

b. As can be seen in Table 2.6, the endorsement rates for "unmatched venue" (42.3% vs. 25.2%, χ^2=11.85, p<.01), "unmatched date" (48.7% vs. 26.1%, χ^2=20.13, p<.01), "preventing child drug abuse is not a family concern" (11.5% vs. 4.7%, χ^2=7.77, p<.01), and "fear other misunderstand that my child gets drug abuse problem" (11.5% vs. 5.7%, χ^2=4.72, p<.05) were greater for participated parents than for non-participated parents.

c. The top three barriers to prevention program among non-participants were: "my child did not have drug abuse problem" (61.4%), "unmatched time" (49.6%), and "insufficient publicity" (36.5%).

Table 2.6: Discouraging factors between parents who participated and did not participate in anti-drug prevention program in the past 12 months (N=5612)

Variables	Yes/ No	Participants %	Non-participants %	Chi-Square
Discouraging factors to enrolment in drug abuse treatment				
Fear to accept child's drug abuse	Yes	27.9	21.5	2.68
Fear that others know the child's drug abuse	Yes	22.5	22.8	0.06
Fear of spouse's reaction	Yes	6.3	8.1	0.48
Fear of affecting child's future development	Yes	61.3	58.9	0.25
Fear of being looked down by others	Yes	23.4	19.9	0.86
Lack of confidence to deal with child's drug abuse	Yes	18.9	12.2	4.44*
Lack of time to deal with child's drug abuse	Yes	8.1	11.1	1.01
Fear of child's quitting from school for treatment	Yes	31.5	28.8	0.40
Child's drug abuse not a major concern for the family	Yes	7.2	3.6	4.10*
Lack of communication with child, fear of worsening of parent-child relationship	Yes	12.6	14.7	0.39
Don't know how to manage and seek help	Yes	19.8	31.1	6.44*
Discouraging factors to enrolment in drug abuse prevention				
Unmatched time	Yes	59.0	49.6	2.71
Unmatched venue	Yes	42.3	25.2	11.85**
Unmatched date	Yes	48.7	26.1	20.13**
Unattractive format	Yes	14.1	10.9	0.82
Unmatched content with parent's needs	Yes	15.4	14.7	0.03
Insufficient publicity	Yes	33.3	36.5	0.34
Spouse did not support for parent's participation	Yes	1.3	1.9	0.14
My child did not have drug abuse problem	Yes	24.4	61.4	43.30**
Preventing child drug abuse not a major family concern	Yes	11.5	4.7	7.77**
Fear others misunderstand that my child gets drug abuse problem	Yes	11.5	5.7	4.72*
No one will take care of my other children at home if I participate in the program	Yes	12.8	8.3	2.03
Others	Yes	2.6	1.6	0.42

Note. * $p < 0.05$, ** $p < 0.01$

4.2.6 Differences in child's behavioral problems between parents who participated and did not participate in anti-drug prevention program in the past 12 months

a. Table 2.7a showed that participated parents in general reported more child behavioral problems in the past 12 months. For example 9.5% of participated parents reported an average of 7-12 behavioral problems compared with 2.2% for non-participated parents ($\chi^2=51.33$, $p<.01$).

b. Table 2.7b showed that the child of participated parents were significantly more likely to present with the following problems for more than once in the past year, in descending order of

frequency. These include: to fight (8.2%, χ^2=25.14, p<.01), to smoke (7.6%, χ^2=25.79, p<.01), hanged out with dubious peers (7.5%, χ^2=21.40, p<.01), staying late outside without parental permission (6.7%, χ^2=11.56, p<.01), had psychotic symptoms (5.1%, χ^2=33.38, p<.01), absence from school (4.2%, χ^2=13.04, p<.01), possess or sell illegal drugs (2.6%, χ^2=29.37, p<.01), steal (2.5%, χ^2=11.56, p<.01) and running away from home (2.5%, χ^2=9.03, p<.05), than non-participants' focal child.

Table2.7a Differences in the total number of child's behavioral problem between parents who participated and did not participate in drug prevention program in the past year (N=5612)

Total Number of Behavioral Problems	Participants %	Non-Participants %	Chi-square
0	72.4	79.2	51.33**
1-3	14.2	14.7	
4-6	3.9	3.9	
7-9	2.4	1.4	
10-11	7.1	.8	
Total	100	100	

Note. * p <0.05, ** p <0.01

Table 2.7b: Differences in each behavioral problem of focal child between parents who participated and did not participate in drug-prevention program in the past year (N=5612)

Variables	Freq.	Participants %	Non-participants %	Chi-Square
Fighting	0	84.4	94.8	25.14**
	1	7.4	2.7	
	>1	8.2	2.6	
Smoking	0	89.9	97.4	25.79**
	1	2.5	0.7	
	>1	7.6	1.8	
Hanged around with dubious peers	0	90.8	97.2	21.40**
	1	1.7	1.1	
	>1	7.5	1.8	
Staying late outsides without parental permission	0	93.3	95.8	11.56**
	1	0.0	1.9	
	>1	6.7	2.3	
Presence of psychotic symptoms	0	94.0	98.9	33.38**
	1	0.9	0.5	
	>1	5.1	0.6	
Absence from school	0	94.9	98.0	13.04**
	1	0.8	1.1	
	>1	4.2	0.9	
Possession or selling illegal drugs	0	95.7	99.5	29.37**
	1	1.7	0.2	
	>1	2.6	0.2	
Stealing	0	93.2	97.9	11.56**
	1	4.2	1.3	
	>1	2.5	0.8	
Running away from home	0	94.9	98.5	9.03*
	1	2.5	0.8	
	>1	2.5	0.8	
Self-talk	0	96.6	94.1	1.63
	1	1.7	1.9	
	>1	1.7	4.0	
Presence of suicidal ideation	0	97.4	98.5	1.69
	1	0.9	0.8	
	>1	1.7	0.7	

Note. * p <0.05, ** p <0.01

4.2.7 Logistic regression analysis on factors predicting parents' participation

a. The variables which were found to be significantly different for those who participated and did not participate in drug prevention program were entered into the logistic regression in which the dependent variable was the participation in drug prevention activities. As can be seen in Table 2.8, unmatched date (OR=2.31, p<.05) and the absence of child drug abuse problem (OR=0.14, p<.01) were considered to be significant discouraged factors to parents' participation in anti-drug prevention program.

Table 2.8: Logistic regression results for parents who participated and did not participate in drug-prevention program in the past year (N=5612)

Independent Variable	Participation	
	Odds ratio	95 % of CI
Age of focal child	0.99	0.79-1.25
Current education level of focal child (Secondary school students as reference)	0.57	0.20-1.61
Primary school students	0.95	0.90-1.00
Age of parent's spouse	0.95	0.90-1.00
Employment status (full-time employed as reference)		
Part-time employed	2.04	0.96-4.37
Retired	0.00	0.00-0.00
Unemployed	0.91	0.36-2.31
Housewife	0.00	0.00-0.00
Self efficacy of managing drug abuse problem	1.03	0.65-1.64
Help seeking for adolescent drug abuse from		
Parents	1.11	0.48-2.56
Friend in church	1.54	0.72-3.30
Concern related to adolescent drug abuse	0.81	0.27-2.45
Perceived child susceptibility to drug abuse	0.82	0.10-6.92
Discouraging factors to enrolment in drug abuse treatment		
Worsened relationship with family members	0.84	0.39-1.79
Discouraging factors to enrolment in drug abuse prevention		
Unmatched venue	1.91	0.90-4.07
Unmatched date	2.31*	1.09-4.97
My child did not have drug abuse problem	0.14**	0.06-0.33
Preventing child drug abuse not a family concern	1.82	0.45-7.31
Fear others misunderstand that my child gets drug abuse problem	1.46	0.44-4.84
Total of problem behaviors	1.38	0.99-1.93
Constant	0.34	
Nagelkerke R^2	0.19	
-2 log likelihood	352.84	

Note. * p <0.05, ** p <0.01

4.2.8 Demographic characteristics of parents with and without awareness of anti-drug prevention program in the past 12 months

a. Table 2.9 showed that no significant differences were observed between aware and non-aware parents regarding gender (nearly 80% in parents were female), marital status (about 90% of parents were married), employment status (over 50% of parents had a full time job), the status of new arrival and the status of CSSA in Hong Kong.

b. 78.1% of parents with awareness were female, with median age that falls in the range of 41-50. 90.3% were married or cohabited and 50.7% had a full time job. Their median household income was in the range of $5000-19999. 9.5% of parents with awareness and 10.6% of parents without awareness in anti-drug prevention program in the past were on CSSA.

c. Compared with parents who were not aware of anti-drug prevention program in the past year, parents with awareness were significantly younger (mean age=42.9 vs.43.54, $t=20.43$, $p<.01$), and with younger focal child (mean age=13.35 vs. 13.72, $t=5.34$, $p<.01$) studying in primary level (40.7% vs. 33.6%, $\chi^2=23.67$, $p<.01$). They also had higher household income because nearly a-fifth of parents with awareness earned $20000-39999 compared with 16.7% among parents without awareness ($\chi^2=9.45$, $p<.05$). In addition, parents with awareness tended to have higher education ($\chi^2=25.48$, $p<.01$), younger spouse ($t=2.71$, $p<.01$), and less children ($t=2.72$, $p<.01$) than those without awareness.

4.2.9 Family context factors for parents with or without awareness of drug-prevention program in the past 12 months

a. Table 2.10 showed that compared with parents without awareness, parents with awareness would spend significantly more quality time with their child (mean=38.61 hours vs. 33.7 hours per week, $t=-4.97$, $p<.01$), with higher level of perceived family cohesion (mean=3.88 vs. 3.73, $t=-5.79$, $p<.01$) and adopted more authoritative style of parenting (70.2% vs. 61.6%, $\chi^2=51.34$, $p<.01$).

Table 2.9: Differences in socio-demographic variables between parents with and without awareness of anti-drug prevention program in the past year (N=5612)

Variables		Aware % or Mean (SD)	Not Aware % or Mean (SD)	Chi-Square/ T-test values
Age Group of Focal Child				12.95**
6-10		5.6	5.2	
11-15		75.8	71.7	
16-21		18.6	23.1	
	Mean (SD)	13.35 (2.19)	13.72 (2.31)	5.34**
Current Education Level of Focal Child				23.67**
Primary		40.7	33.6	
Secondary		59.3	66.4	
Parent Age Group				20.43**
18-30		1.2	0.8	
31-40		33.5	29.7	
41-50		52.1	51.8	
51-60		5.7	7.6	
61+		7.5	10.1	
	Mean (SD)	42.9 (5.66)	43.54 (6.12)	3.24**
Gender of Parent (Female)		78.1	80.0	2.31
Marital Status				2.96
Married or Cohabited		90.3	89.8	
Separated or Divorced		7.4	7.2	
Widowed		1.7	2.5	
Unmarried father/mother		0.5	0.5	
Education Level of Parent				25.48**
No education		1.5	2.8	
Primary		18.6	23.0	
Secondary		66.0	62.9	
Matriculation/Diploma		10.5	8.2	
University or above		3.4	3.0	
Employment Status				3.69
Full-time		50.7	52.4	
Part-time		16.9	15.2	
Retired		9.4	8.9	
Unemployed		19.8	20.8	
Housewife		3.1	2.8	
Household Income				9.45*
<4999		7.3	8.0	
5000-19999		66.3	67.9	
20000-39999		20.1	16.7	
>40000		6.3	7.4	
Parent's new arrival status		6.2	5.8	0.34
Age of Parent's Spouse				17.48**
18-30		0.5	0.6	
31-40		15.5	13.9	
41-50		52.9	48.8	
51-60		11.5	12.2	
61+		19.6	24.5	
	Mean (SD)	45.35 (5.99)	45.94 (6.71)	2.71**
Spouse new arrival status		2.6	2.7	0.09
Number of Children		2.03 (0.88)	2.10(0.92)	2.72**
CSSA Recipient		9.5	10.6	1.37

Note. * p <0.05, ** p <0.01

Table 2.10: Family context factors for parents with and without awareness of anti-drug prevention program in the past 12 months (N=5612)

Variables	Aware % or Mean (SD)	Not Aware % or Mean (SD)	Chi-Square/ T-test values
Involvement with child in terms of the amount of time (hours) spent with the child per week	38.61 (32.19)	33.70 (30.76)	-4.97**
Perceived Family Cohesion	3.88(0.84)	3.73(0.86)	-5.79**
Parenting Style			51.34**
Authoritative	21.9	23.0	
Authoritarian	70.2	61.6	
Permissive	6.3	11.5	
Neglectful	1.6	3.9	

Note. * p <0.05, ** p <0.01

4.2.10 Motivational factors for parents with and without awareness of anti-drug prevention program in the past 12 months

a. Table 2.11 showed that compared with parents with non-awareness, parents with awareness showed higher sense of self-efficacy to manage their child's drug abuse problem (mean=2.93 vs. 2.83, χ^2=-4.73, p<.01) and higher concern towards child's drug abuse (95.2% vs. 92.1%, χ^2=15.64, p<.01).

b. Parents with awareness differed significantly from parents with non-awareness in terms of their level of sensitivity to adolescents' drug abuse. Parents with awareness gave higher rating for the following items as signs of adolescents' drug abuse, namely adverse impact on learning (89.6% vs. 86.1%, χ^2=11.72, p<.01), truancy (55.7% vs. 52.6%, χ^2=4.32, p<.05), self-talk (43.3% vs. 40.3%, χ^2=4.07, p<.05), presence of psychotic symptoms (58.1% vs.53.1%, χ^2=11.04, p<.01), run away from home (34.8% vs. 31.5%, χ^2=5.35, p<.01), likes to listen to funk music (25.5% vs. 21.3%, χ^2=11.20, p<.01) and becomes tired easily (78.7% vs. 74.6%, χ^2=9.86, p<.01). The top three ranking of early warning signs perceived by parents with and without awareness in past anti-drug activities were 1) adverse impact on learning, 2) worsened relationship with family members and 3) child easily becomes tired.

c. Regarding help seeking pattern, compared with parents with non-awareness, parents with awareness were significantly more likely to seek help from own parents (20.3% vs. 17.2%, χ^2=6.82, p<.01), friends in church (21.9% vs. 17.2%, χ^2=16.47, p<.01), social workers in social service units (66.5% vs. 60.1%, χ^2=16.47, p<.01), school social worker (69.3% vs. 62.1%, χ^2=24.58, p<.01), school teachers (60.5% vs. 56.2%, χ^2=8.31, p<.01) and Governmental departments (i.e. Narcotics Division) (44.7% vs. 40.0%, χ^2=10.01, p<.01).

d. For parents with awareness and non-awareness, they were most likely to seek help from social workers in social service units or in school, as well as from spouse if they discovered that their child has a drug abuse problem.

Table 2.11: Motivational factors for parents with and without awareness of anti-drug prevention program in the past 12 months (N=5612)

Variables	Yes/ No	Aware % or Mean (SD)	Not Aware % or Mean (SD)	Chi-Square/ T-test values
Self-efficacy of managing child drug abuse problem		2.93 (0.68)	2.83 (0.68)	-4.73**
Sensitivity to adolescent drug abuse				
Adverse impact on learning	Yes	89.6	86.1	11.72**
Truancy	Yes	55.7	52.6	4.32*
Self-talk	Yes	43.3	40.3	4.07*
Psychotic symptoms	Yes	58.1	53.1	11.04**
Frequent sickness	Yes	25.8	25.4	0.69
Smoking	Yes	42.3	40.2	1.86
Worsened relationship with family members	Yes	79.9	77.5	3.67
Run away from home	Yes	34.8	31.5	5.35*
Like to listen to funk music	Yes	25.5	21.3	11.20**
Easy to become tired	Yes	78.7	74.6	9.86**
Help Seeking for adolescent drug abuse				
Spouse	Yes	58.1	56.5	1.18
Parents	Yes	20.3	17.2	6.82**
Siblings	Yes	20.7	18.5	3.59
Children	Yes	8.1	8.3	0.31
Relatives	Yes	14.2	15.2	0.77
Friends	Yes	26.8	25.0	1.85
Neighbors	Yes	4.6	3.9	1.33
Friends in church	Yes	21.9	17.2	16.47**
Social workers in social service units	Yes	66.5	60.1	18.44**
Social workers in school which the child studies	Yes	69.3	62.1	24.58**
Teachers in the school which the child studies	Yes	60.5	56.2	8.31**
Parents in the school which the child studies	Yes	9.4	8.0	2.58
Doctors	Yes	37.1	35.6	1.07
Governmental departments (e.g. Narcotics division)	Yes	44.7	40.0	10.01**
Won't not seek help	Yes	0.7	1.4	4.26*
Concern related to adolescent drug abuse	Yes	95.2	92.1	15.64**
Perceived child susceptibility to drug abuse	Yes	1.9	1.7	0.20

Note. * p <0.05, ** p <0.01

4.2.11 Discouraging factors for parents with and without awareness in anti-drug prevention program in the past 12 months

a. Table 2.12 showed that compared with parents without awareness, parents with awareness were more unlikely to have lack of time to deal with child's drug abuse problem (8.3% vs. 12.0%, χ^2=13.05, p<.01) and ertr better at managing their child and seeking help if their child had drug-abuse problem (25.8% vs. 32.8%, χ^2=20.91, p<.01).

b. Compared with parents without awareness, parents who showed awareness in the past showed higher level of fear in terms of child's future development (61.7% vs. 58.0, χ^2=5.01, p<.05) and considered this to be a major discouraging factor to drug treatment.

c. Compared with parents without awareness, parents with awareness considered logistic arrangements such as unmatched time, venue and date to be significant discouraging factors to their participation in drug prevention program. Likewise, for parents without awareness, unsuitable format and program content would significantly reduce their motivation to participate. Other significant discouraging factors for parents without awareness included insufficient publicity (39.7% vs.27.9%, χ^2=62.89, p<01), absence of child drug abuse problem (61.4% vs. 57.5%, χ^2=6.43, p<.05) and that preventing child drug abuse was not a major family concern (5.2% vs. 3.8%, χ^2=4.60, p<.05).

d. 25.8% of parents with awareness and 32.8% of parents without awareness reported that they did not know how to manage their child or seek help when discovered that their child had a drug abuse problem.

Table 2.12: Discouraging factors for parents who showed awareness of anti-drug prevention program in the past 12 months (N=5612)

Variables	Yes/ No	Aware %	Not Aware %	Chi-Square
Discouraging factors in enrolment in drug abuse treatment				
Fear to accept child's drug abuse	Yes	23.0	21.1	2.08
Fear that others know the child's drug abuse	Yes	22.2	23.0	0.37
Fear of spouse's reaction	Yes	7.1	8.4	2.07
Fear of affecting child's future development	Yes	61.7	58.0	5.01*
Fear of being looked down by others	Yes	20.4	19.8	0.22
Lack of confidence to deal with child's drug abuse	Yes	12.2	12.4	0.03
Lack of time to deal with child's drug abuse	Yes	8.3	12.0	13.05**
Fear of child's quitting from school for treatment	Yes	30.2	28.2	1.76
Child's drug abuse not a major concern for the family	Yes	3.0	3.8	1.60
Lack of communication with child, fear of worsening of parent-child relationship	Yes	13.5	15.1	1.71
Don't know how to manage and seek help	Yes	25.8	32.8	20.91**
Discouraging factors in enrolment in drug abuse prevention				
Unmatched time	Yes	57.8	46.9	49.34**
Unmatched venue	Yes	29.4	24.0	15.69**
Unmatched date	Yes	31.3	24.9	21.78**
Unattractive format	Yes	9.4	11.5	4.70*
Unmatched content with parent's needs	Yes	11.6	15.7	14.21**
Insufficient publicity	Yes	27.9	39.7	62.89**
Spouse did not support for parent's participation	Yes	1.4	2.0	2.03
My child did not have drug abuse problem	Yes	57.5	61.4	6.43*
Preventing child drug abuse not a major family concern	Yes	3.8	5.2	4.60*
Fear others misunderstand that my child gets drug abuse problem	Yes	4.9	6.2	3.11
No one will take care of my other children at home if I participate in the program	Yes	9.1	8.2	1.05
Others	Yes	1.7	1.6	0.03

Note. * p <0.05, ** p <0.01

4.2.12 Child's behavioral problems and parents' awareness of anti-drug prevention program in the past 12 months

a. Table 2.13a showed that there were no significant differences for parents with awareness or without awareness in terms of their reported number of child behavioral problems in the past 12 months. However, a higher percentage of parents with awareness reported that their child had 7-12 behavioral problems in the past year (i.e. 3% vs. 2.2%).

b. Table 2.13b showed a break down of the 11 behavioral problems. No significant differences were found regarding the types of child behavioral problems between the two groups of parents.

Table 2.13a Total number of child's behavioral problem for parents with and without awareness of drug prevention program in the past 12 months (N=5612)

Total Number of Behavioral Problems	Aware of (%)	Not aware of (%)	Chi-square
0	79.0	78.9	3.76
1-3	14.4	14.9	
4-6	3.6	4.0	
7-9	1.9	1.3	
10-12	1.1	.9	
Total	100	100	

Note. * p <0.05, ** p <0.01

Table 2.13b: Differences between parents who were aware and not aware of the drug abuse prevention program regarding behavioral problem of focal child in the past 12 months (N=5612)

Variables	Freq.	Aware %	Not Aware %	Chi-Square
Smoking	0	96.9	97.4	3.50
	1	0.6	0.9	
	>1	2.4	1.7	
Fighting	0	93.3	95.0	5.70
	1	3.4	2.6	
	>1	3.3	2.5	
Stealing	0	97.3	97.9	2.65
	1	1.8	1.2	
	>1	0.9	0.8	
Staying late outsides without parental permission	0	95.1	96.0	3.27
	1	1.9	1.9	
	>1	3.0	2.2	
Running away from home	0	98.3	98.4	2.37
	1	0.6	0.9	
	>1	1.0	0.7	
Absence from school	0	98.0	98.0	0.00
	1	1.0	1.0	
	>1	1.0	1.0	
Self-talk	0	94.9	93.7	8.91
	1	1.6	2.0	
	>1	3.3	4.3	
Presence of psychotic symptoms	0	98.6	98.8	2.41
	1	0.4	0.6	
	>1	1.0	0.6	
Possession or selling illegal drugs	0	99.4	99.4	0.37
	1	0.4	0.3	
	>1	0.3	0.3	
Hanged around with dubious peers	0	96.9	97.1	0.64
	1	1.3	1.0	
	>1	1.8	1.9	
Presence of suicidal ideation	0	98.0	98.6	1.98
	1	1.0	0.8	
	>1	0.9	0.7	

Note. * p <0.05, ** p <0.01

4.2.13 Logistic regression analysis on factors predicting parents' awareness of drug abuse prevention programs

a. The variables which were found to be significantly different for those who showed awareness and did not show awareness in drug prevention program were entered into the logistic regression in which the dependent variable was the awareness in drug prevention activities. As can be seen in Table 2.14, parents who had less children (OR=0.91, p<.05), had more involvement with child (OR=1.01, p<.01) and had higher perceived family cohesion (OR=1.13, p<.05) were more likely to be aware of anti-drug prevention program in the past.

b. Authoritative parents (OR=0.81, p<.05) were more likely to be aware of existing anti-drug prevention program, and parents with permissive/neglectful (OR = 0.47, p<.01) type of parenting were unlikely to be aware of these programs. Parents who considered listening to funk music as a sign of adolescents' drug abuse were more likely to show awareness (OR=1.29, p<.05).

c. Parents who showed more concern related to adolescents' drug abuse (OR=1.80, p<.01) were significantly more likely to be aware of anti-drug programs and to seek help from friends in church (OR=1.39, p<.01). The more behavioral problems the focal child had in the past year (OR=1.19, p<.01), the higher the awareness of parents. Regarding discouraging factors, parents were unlikely to show awareness if the program does not match with their time (OR=1.43, p<.01), content does not match with their needs (OR=0.73, p<.01), a lack of publicity (OR=0.49, p<.01) and the absence of child drug abuse problem (OR=0.77, p<.01).

Table 2.14: Logistic regression results for parents with and without awareness of anti-drug prevention programs in the past (N=5612)

Independent Variable	Participation	
	Odds ratio	95 % of CI
Age of focal child	0.98	0.93-1.03
Current Education Level of Focal Child (Secondary school students as reference)		
Primary school students	0.91	0.72-1.16
Parent age	1.00	0.99-1.02
Parent Education (Secondary School as reference)	1.00	0.99-1.02
Primary School and Lower	0.75	0.48-1.16
Marticulation /Diploma and Higher	1.25	0.97-1.60
Household Income ($5,000-19,999 as reference)	1.00	0.99-1.02
Low income (<$4,999)	1.19	0.83-1.70
High income ($20,000 and above)	0.78	0.53-1.17
Age of parent's spouse	0.99	0.98-1.01
Number of children	0.91*	0.83-1.00
Involvement with child in terms of the amount of time spent with the child per week	1.01**	1.00-1.01
Perceived family cohesion	1.13*	1.03-1.25
Parenting style (Authoritarian as reference)		
Authoritative	0.81*	0.66-0.99
Permissive / Neglectful	0.47**	0.34-0.65
Sensitivity to adolescent drug abuse problem:		
Adverse impact on learning	1.14	0.87-1.50
Truancy	0.95	0.80-1.14
Self-talk	1.10	0.92-1.32
Psychotic symptoms	0.98	0.82-1.18
Running away from home	1.02	0.84-1.23
Like to listen to funk music	1.29*	1.06-1.56
Easy to become tired	1.12	0.91-1.37
Help seeking for adolescent drug abuse from		
Parents	1.08	0.87-1.34
Friends in church	1.39**	1.13-1.70
Social workers in social service units	1.14	0.96-1.35
Social workers in school which the child studies	1.11	0.92-1.34
Teachers in the school	1.05	0.88-1.26
Governmental department	1.23	0.87-1.21
Concern related to adolescent drug abuse	1.80**	1.22-2.66
Barriers to enroll in drug abuse prevention		
Unmatched time	1.43**	1.18-1.73
Unmatched venue	1.67	0.86-1.33
Unmatched date	1.20	0.97-1.50
Unattractive format	1.02	0.76-1.35
Unmatched content with parent's need	0.73**	0.57-0.93
Insufficient publicity	0.49**	0.41-0.58
My child did not have drug abuse problem	0.77**	0.65-0.92
Preventing child drug abuse not a major family concern	0.80	0.54-1.20
Total number of problem behaviors	1.19**	1.07-1.32
Constant	0.27	
Nagelkerke R^2	0.11	
-2 log likelihood	3860.53	

Note. * p <0.05, ** p <0.01

4.2.14 Sample characteristics of parents with drug-taking history (DrugP) who had participated in anti-drug prevention program

a. Table 2.15 showed the sample characteristics of DrugP who had participated in anti-drug prevention program in the past 12 months. Only those with significant differences between DrugP with participation and those without participation were presented in the following section.

b. Significant differences were observed between non-participated and participated DrugP regarding their employment status, household income, motivational and discouraging factors to participation.

c. Compared with non-participated DrugP, more participated DrugP had a full-time job (33.3% vs. 6.8%, χ^2= 8.76, $p<.05$), had a higher household income (16.7% had a household income within the range of $20000-39999 vs. 1.1% for non-participated DrugP, χ^2=8.85, $p<.05$), did not think that truancy (66.7% vs. 92.0%, χ^2=6.95, $p<.01$) and run away from home (33.3% vs. 65.9%, χ^2=4.76, $p<.05$) to be signs of adolescents' drug abuse, more unlikely to seek help from own parents (8.3% vs. 38.6%, χ^2=4.26, $p<.05$), had less fear that their child needs to quit school for drug treatment (8.3% vs. 37.5%, χ^2=4.00, $p<.05$), perceived unmatched time (58.3% vs. 28.4%, χ^2=4.35, $p<.05$) and other factors such as lack of needs, uninterested or had confidence in their child that they would not be involved in drug abuse (25.0% vs. 6.8%, χ^2=4.26, $p<.05$) to be a discouraging factor to their participation in anti-drug prevention program.

d. Compared with participated DrugP, non-participated DrugP showed significantly more fear that others would misunderstand that their participation to equate their child had drug abuse problem (28.4% vs. 0%, χ^2=4.55, $p<.05$) and that the absence of child's drug abuse problem to discourage their participation (70.5% vs. 8.3%, χ^2=17.48, $p<.01$).

Table 2.15: Significant differences between participated and non-participated DrugP in anti-drug prevention program in the past (N=100)

Variables		Participants %	Non-participants %	Chi-Square
Demographic Variables				
Employment Status				8.76*
Full-time		33.3	6.8	
Part-time		16.7	14.8	
Retired		8.3	8.0	
Unemployed		41.7	70.5	
Housewife		0.0	0.0	
Household Income				8.85*
<4999		41.7	41.4	
5000-19999		41.7	57.5	
20000-39999		16.7	1.1	
>40000		0.0	0.0	
Motivational Factors				
Sensitivity to adolescent drug abuse				
Truancy	Yes	66.7	92.0	6.95**
Run away from home	Yes	33.3	65.9	4.76*
Help Seeking upon discovery of adolescent drug abuse				
Parents	Yes	8.3	38.6	4.26*
Discouraging Factors				
Barriers to enroll in drug abuse treatment				
Fear of child's quitting from school for treatment	Yes	8.3	37.5	4.00*
Barriers to enroll in drug abuse prevention				
Unmatched date	Yes	58.3	28.4	4.35*
My child did not have drug abuse problem	Yes	8.3	70.5	17.48**
Fear others misunderstand that my child gets drug abuse problem	Yes	0.0	28.4	4.55*
Others	Yes	25.0	6.8	4.26*

Note. * p <0.05, ** p < 0.01

4.2.15 Logistic regression analysis on DrugP participation in drug-abuse prevention programs

a. The variables which were found to be significantly different for DrugP with or without participation in anti-drug prevention program were entered into the logistic regression in which the dependent variable was the participation in drug prevention activities. As can be seen in Table 2.16, parents were most unlikely to participate given unmatched time (OR=33.29, <.05) and absence of child drug abuse problem (OR=0.04, <.05).

Table 2.16: Logistic regression results for DrugP who participated in anti-drug prevention program in the past 12 months (N=100)

Independent Variable	Participation	
	Odds ratio	95 % of CI
Employment status (full-time employed as reference)		
Part-time employed	0.30	0.01-7.93
Retired	0.28	0.01-15.47
Unemployed	0.40	0.28-5.63
Household Income ($5,000-19,999 as reference)		
Low income (<$4,999)	1.82	0.18-18.58
High income ($20,000 and above)	1.14	0.18-7.16
Sensitivity to adolescent drug abuse problem:		
Truancy	0.17	0.01-2.60
Run away from home	0.12	0.01-1.44
Help seeking for adolescent drug abuse from		
Parents	0.16	0.01-2.81
Barriers to enroll in drug abuse prevention		
Unmatched date	33.29*	2.31-480.07
My Child did not have drug abuse problem	0.04*	0.00-0.59
Fear others misunderstand that my child gets drug abuse problem	0.00	0.00-0.00
Constant	3.27	
Nagelkerke R^2	0.64	
-2 log likelihood	32.86	

Note. * p <0.05, ** p < 0.01

4.2.16 Sample characteristics of parents with DrugP with and without awareness of anti-drug prevention program in past 12 months

a. Table 2.17 showed the sample characteristics of DrugP with or without awareness of anti-drug prevention program in the past 12 months. Only significant finding between DrugP with awareness and DrugP without awareness of anti-drug prevention program is presented in the following sections.

b. Significant differences were observed between DrugP with or without awareness regarding their perceived motivational factors and discouraging factors to participation. Compared with DrugP without awareness, DrugP with awareness did not consider self-talk to be one of the signs of adolescent drug abuse (53.3% vs. 74.5%, χ^2=4.90, p<.05), showed more fear to accept their child's drug abuse problem (28.9% vs. 10.9%, χ^2=5.20, p<.05) and fear of spouse reaction in drug treatment program (31.1% vs. 14.5%, χ^2=3.96, p<.05) and considered unmatched time (62.2% vs. 34.5%, χ^2=7.61, p<.01), unmatched venue (51.1% vs. 25.2%, χ^2=6.99, p<.01), unmatched date (46.7% vs. 20.0%, χ^2=8.09, p<.01) and unattractive format (37.8% vs. 18.2%, χ^2=4.82, p<.05) to be major discouraging factors to their participation in drug prevention program. A majority of DrugP without awareness considered the lack of publicity to be the reason that prevent their participation in program (72.7% vs. 40%, χ^2=10.88, p<.01).

Table 2.17: Significant differences of DrugP with and without awareness of anti-drug abuse prevention program in the past 12 months (N=100)

Variables		Aware %	Not Aware %	Chi-Square
Motivational factors				
Sensitivity to adolescent drug abuse				
Self-talk	Yes	53.3	74.5	4.90*
Barriers				
Discouraging factors to enrolment in drug abuse treatment				
Fear to accept child's drug abuse	Yes	28.9	10.9	5.20*
Fear of spouse's reaction	Yes	31.1	14.5	3.96*
Discouraging factors to enrolment in drug abuse prevention				
Unmatched time	Yes	62.2	34.5	7.61**
Unmatched venue	Yes	51.1	25.2	6.99**
Unmatched date	Yes	46.7	20.0	8.09**
Unattractive format	Yes	37.8	18.2	4.82*
Insufficient publicity	Yes	40.0	72.7	10.88**

Note. * p <0.05, ** p < 0.01

4.2.17 Logistic regression analysis on DrugP awareness in drug abuse prevention program

a. The variables which were found to be significantly different for DrugP with or without awareness of anti-drug prevention program were entered into the logistic regression in which the dependent variable was the awareness in drug prevention activities. As can be seen in Table 2.18, parents who showed awareness did not consider self-talk (OR=0.32, p<.05) to be one of the early signs of adolescents' drug abuse. Insufficient publicity (OR=0.11, p<.05) would also significantly reduce parents' awareness of drug-prevention program.

Table 2.18: Logistic regression results for DrugP with awareness of anti-drug prevention program in the past 12 months (N=100)

Independent Variable	Awareness	
	Odds ratio	95 % of CI
Sensitivity to adolescent drug abuse		
Self-talk	0.32*	0.12-0.89
Discouraging factors to enrolment in drug abuse prevention		
Unmatched time	1.94	0.55-6.78
Unmatched venue	2.42	0.36-16.40
Unmatched date	1.61	0.26-9.98
Unattractive format	2.15	0.49-9.50
Insufficient publicity	0.11*	0.03-0.34
Constant	2.11	
Nagelkerke R^2	0.39	
-2 log likelihood	103.50	

Note. * p <0.05, ** p < 0.01

4.2.18 Preferences on future drug abuse-prevention programs for parents and DrugP

Table 2.19 showed the respondents' preferences on parental prevention program for adolescent drug abuse.

a. Significant differences were found between parents with focal child studying in primary and secondary school (referred to as parents in this section) and DrugP regarding future preferences of anti-drug prevention programs for parents.

b. Preferred logistics (Time and location): compared with parents, significantly more DrugP indicated preference for the program to take place in the weekdays (40%, χ^2=8.45**), weekends (84%, χ^2=5.60**), morning (18%, χ^2=4.58*), noon (72%, χ^2=16.34**) or evening (40%, χ^2=19.74**). At school (23.0%, χ^2=32.32**) or community centers nearby home (89%, χ^2=53.38**) and other places (14%, χ^2=104.92**) such as outdoor venues or church. The top choice of time for DrugP and parents is in the weekends, at noon and the program take place at community centers nearby home.

c. Preferred formats: compared with parents, significantly more DrugP preferred talks and seminars (76%, χ^2=11.49**), parents' group activities (67%, χ^2=120.39**), large scale community education program (52%, χ^2=15.75**), camping for parent and child (68%, χ^2=93.08**), visits to drug-rehabilitation agencies (64%, χ^2=41.60**), provision of self-help materials (62%, 59.68**) and others such as outdoor activities (6%, χ^2=27.85**). For both parents and DrugP, the top choice of format was talks and seminars with 76% and 59.2% respectively.

d. Preferred content: compared with parents, DrugP showed more preference for the program to cover the following: the nature of psychotropic drugs and its consequences (88%, χ^2=16.92**), strategies to discuss drug abuse problem with child (82%, χ^2=28.71**), parenting techniques (82%, χ^2=29.94**), sharing of parenting experience (81%,χ^2=53.08**), mutual support by other parents (67%, χ^2=124.01**), sharing by ex-drug abusers and their family members (84%,χ^2=98.35**) and introduction to drug counseling services (77%, χ^2=130.47**). The top choice of content for DrugP and parents was the coverage of the nature of psychotropic drugs and its consequences.

e. Preferred speaker: compared with parents, more DrugP preferred the program to be held by social worker (89%, χ^2=11.55**), doctors (82%, χ^2=17.23**), ex-drug abusers and their family members (79%, χ^2=10.78**), Government officials (16%, χ^2=8.77**) and university professors (49%, χ^2=48.72**). The top choice of speaker for parents and DrugP was social workers.

f. Preferred organizer: compared with parents, more DrugP preferred the drug-prevention activity to be organized by social service agencies (94%, χ^2=14.06*), university (41%, χ^2=60.95**) and others (3%, χ^2=10.36*). The top choice of organizer among parents and DrugP was social services agencies.

g. Preferred objectives: compared with parents, more DrugP preferred the objective of the anti-drug program to be able to: increase their understanding to the nature of psychotropic drugs and its consequences (87%, χ^2=5.74**), increase skills to communicate with child over drug abuse problems (83%, χ^2=24.07**), able to share parenting experiences (84%, χ^2=58.38**), skills learning (87%, χ^2=44.83**), gain mutual support from other parents (68%, χ^2=98.95**), enhance family functioning and child's mental health (88%, χ^2=99.46**) and learn to detect early signs of child's drug abuse problems (82%, χ^2=33.71**).

h. Other preference: compared with parents, more DrugP showed interests for the following arrangements: to have baby sitting service (40%, χ^2=66.54**), traveling allowance (64.0%, χ^2=90.28**), refreshment (60%, χ^2=23.66**), and others such as the support from peer counselor (14%, χ^2=105.6**). For DrugP and parents, the most important arrangement was the provision of leaflets/booklets on drug abuse prevention.

Table 2.19: Preferences on future drug-prevention program of parents and DrugP (N=5712)

	Parents N = 5612 (%)	DrugP N = 100 (%)	χ^2
Date			
Weekdays	26.9%	40.0%	8.45**
Weekends	73.4%	84.0%	5.60**
Morning	28.2%	18.0%	4.58*
Noon	51.9%	72.0%	16.34**
Evening	22.0%	40.0%	19.74**
Venue			
School	52.9%	23.0%	34.32**
Community Center nearby home	52.9%	89.0%	53.38**
Others	1.3%	14.0%	104.92**
Format			
Talks and Seminars	59.2%	76 .0%	11.49**
Parents' Group Activity	21.1%	67.0%	120.39**
Large Scale Community Education Program	33.1%	52.0%	15.75**
Camping for parent and children	25.3%	68.0%	93.08**
Visits to drug-rehabilitation agencies	33.2%	64.0%	41.60**
Self-help materials, VCD/manuals	27.1%	62.0%	59.68**
Others	0.9%	6.0%	27.85**
Content			
The nature of psychotropic drugs and its consequences	68.8%	88.0%	16.92**
Strategies to discuss drug abuse problems with child	55.1%	82.0%	28.71**
Parenting techniques	58.9%	86.0%	29.94**
Sharing of parenting experiences	44.4%	81.0%	53.08**
Mutual supports by other parents	20.8%	67.0%	124.01**
Sharing by ex-drug abusers and their family members	35.8%	84.0%	98.35**
Introduction to drug counseling services	25.9%	77.0%	130.47**
Others	0.5%	2.0%	3.98
Speaker			
Social Worker	74.0%	89.0%	11.55**
Teacher	22.6%	27.0%	1.11
Police	17.3%	12.0%	1.95
Doctors	61.7%	82.0%	17.23**
Ex-drug abusers and their family members	63.0%	79.0%	10.78**
Government Officials	7.9%	16.0%	8.77**
University Professors	20.4%	49.0%	48.72**
Others	0.8%	3.0%	5.61
Organizer			
Social Services Agencies	78.5%	94.0%	14.06**
School	51.0%	46.0%	.99
Government	57.4%	58.0%	.013
University	13.6%	41.0%	60.95**
Others	0.5%	3.0%	10.36*
Program Objectives			
Increase understanding to the nature of psychotropic drugs and its consequences	76.8%	87.0%	5.73**
Knowing how to communicate with child over drug abuse problems	58.7%	83.0%	24.07**
Sharing of parenting experiences	45.6%	84.0%	58.38**
Skills learning	53.3%	87.0%	44.83**
Able to gain mutual support from other parents	24.4%	68.0%	98.95**
Enhancement of family functioning and children's mental health	38.8%	88.0%	99.46**
Learned to detect early signs of child's drug abuse problems	52.8%	82.0%	33.71**
Others	0.6%	1.0%	.22
Other Arrangements			
Baby sitting service	12.4%	40.0%	66.54**
Traveling allowance	23.2%	64.0%	90.28**
Provision of refreshments	34.7%	60.0%	28.66**
Provision of leaflets/booklets on drug prevention	75.2%	82.0%	2.42
Others	1.35%	14.0%	105.60**

Note. * $p < 0.05$, ** $p < 0.01$

4.2.19 DrugP responses that informed prevention of inter-generational drug abuse

a. Table 2.20 presented the perceived impact of drug abuse on children among the 100 individually interviewed DrugP.

b. The first two items reflect that a majority of DrugP (over 80%) had a clear concept on the definition of drug abuse.

c. 94.0% of the DrugP indicated that parent plays the most important role in prevention of adolescent drug abuse.

Table 2.20: DrugP perceived impact of drug abuse on their children (N=100)

Variables	Agree %	Disagree %
Drug abuse is defined as drug use without the doctor's instruction	85	15
Taking illicit drug once is already count as drug abuse e.g. use of MDMA, Ketemine etc.	82	18
Small amount of cannabis does not count as drug abuse	21	79
The behavior of drug abuse is inherited thus could not be changed.	4	96
Parent's role is important to prevent drug abuse among adolescent	94	6
The reduction of work efficiency is a sign of drug abuse	81	19
If someone does not use the drugs regularly, he/she does not count as drug abuse	34	66
Increased irritability after ceasing drugs is a sign of drug abuse	97	3
Drug abuse problem will be resolved after the adolescent had growth up.	7	93
The organization of drug preventive activities in school should resolve the drug problem of adolescent efficiently.	28	72

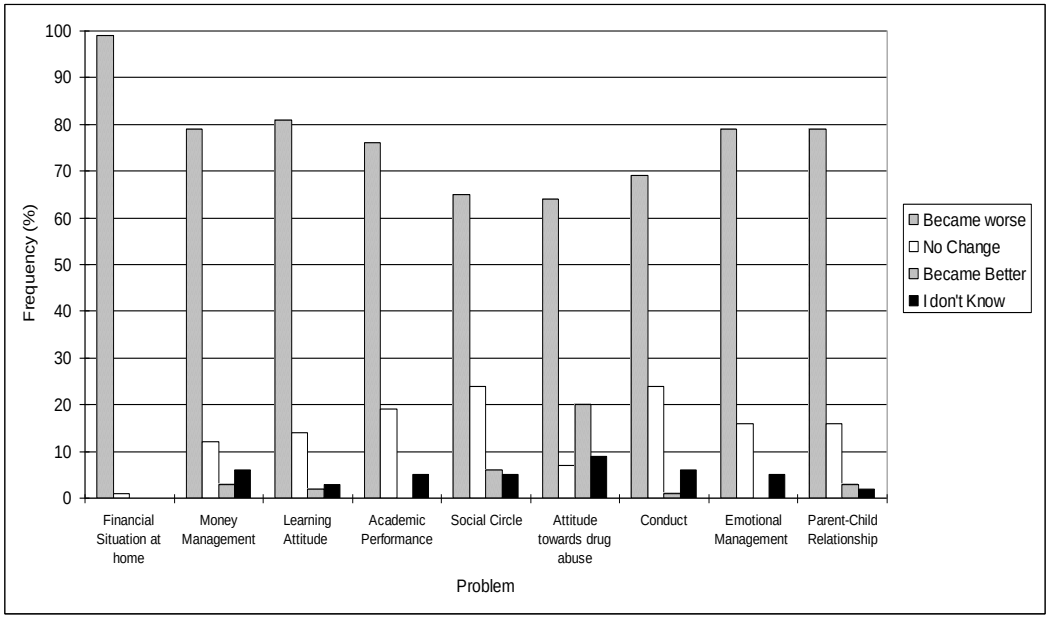
d. 3% of DrugP would give illicit drugs to their children for storage. Table 2.21 showed that 52% of DrugP reported to keep their abused drugs at home. 40.4% indicated that they would causally place drug around the house and keep their drugs where their children could reach easily (i.e. in unlocked cabinets or in the refrigerator). However, 92% of DrugP indicated that they would most likely to stop their children from interacting/hanging out with other drug taking individuals. Their perception towards the negative impact of their drug-taking behavior on their children is presented in Figure 2.1.

Table 2.21: Drug exposure to children at home (DrugP, N=100)

Q: Will you place your abused drugs at home?	Yes, I would keep drugs at home (N = 52)
I'll place them casually around	9.6%
I'll place them in unlocked cabinets or drawers	25%
I'll place them in the refrigerator	5.8%
I'll place them where I could reach only	63.5%
I'll hide them so that my child can't find it	80.8%

e. Figure 2.1 showed that DrugP perceived their drug taking behavior to have a significant negative impact on all aspects of their children, which includes family financial condition, budget control, learning attitude, academic performance, social network, the likelihood of accepting drug abuse behavior, conduct, emotions and parent-child relationship. However, 6% of DrugP perceived that their children's social network would become better and 20% of parents even perceived their child's attitude towards drug abuse would improve. Likewise, over 20% of DrugP considered that their children's academic performance, conduct and emotional status would remain unchanged.

Figure 2.1: DrugP perceived impact of their drug-taking behavior on their children (N=100)



5 Phase II: Focus Groups

In Phase II, five focus groups involving 39 informants were conducted to collect their opinion and experience regarding anti-drug prevention programs in Hong Kong. The composition of the 39 informants is described in Table 2.22.

All focus groups were led by the program team using an open forum format with standardized discussion questions (Appendix 2.5). With the participants' consent, all the sessions were audio-recorded and transcribed for content analysis. Each session lasted for around 90 minutes. Their suggestions were then summarized into six categories, namely,

a. Perceived factors that motivate or discourage parents' participation in anti- drug prevention programs;
b. Past experiences in anti-drug prevention programs;
c. Parents' preferences in future recruitment and logistic arrangements in anti-drug prevention program;
d. The role of parents in adolescents' drug-abuse prevention;
e. The types of activities that would attract parents attention and increase program retention; and
f. The Do's and Don'ts when providing preventive intervention to different types of parents.

Table 2.22: Types of focus groups and the individuals involved (N = 39)

Group	Types of Focus Group	Number of informants (N = 39)	Background of Group Members
1	Professionals (Group A)	9	1 Parent Teacher Association 1 Rehabilitation Services for Drug Abusers 1 Youth Development Service 1 Educational Consultant 1 Volunteer for Drug Abuse Prevention 1 Psychiatrist 1 School Social Worker 1 Evangelical Drug Abuse Rehabilitation Service 1 Youth Hostel Service
2	Professionals (Group B)	7	1 Rehabilitation Service for Drug Abusers 1 Gambling Service 1 New Life Rehabilitation Service 1 Youth Out-Reach Service 1 Probation Service 1 Evangelical Drug Abuse Rehabilitation Service 1 Integrated Family Services Centre
3	Parents with no drug-taking history	9	7 Mothers 2 Fathers
4	Parents with drug-taking history (Group A)	6	1 Mother 5 Fathers
5	Parents with drug-taking history (Group B)	8	8 Mothers

5.1 Focus group results

5.1.1 Motivational factors to parents' participation in anti-drug prevention programs

a. Sufficient and relevant content coverage
b. Fun and interactive experience
c. Content should be positive, have immediate gains
d. Provision of reinforcements: gifts, money, food
e. Workers' qualification, enthusiasm and positive attitude
f. Good rapport between worker and parents

5.1.2 Discouraging factors to parents' participation

a. Parents themselves as drug-users
b. Unawareness of local resources to drug-prevention
c. Avoidance of stigmatization
d. Long traveling time and place, busy work schedule and lack of time
e. Predicted negative consequences of confronting their child with their drug-use problem

f. Lack of insight from DrugP as they might minimize their children's drug-use problem
g. Parents' personal beliefs and values towards parenting and drug-abuse
h. Parents' avoidance to seek help

5.1.3 Past experiences in anti-drug prevention programs

a. Seminars are not a good means to attract parents in need. War-games and interactive activities are more helpful
b. Tactics aiming at scaring parents into action do not work
c. The program materials should match with the severity of parents' needs and drug-use problems
d. Mothers usually participated more actively than fathers
e. Parents usually lack the necessary drug knowledge to manage their child's drug problems

5.1.4 Parents' preferences in future recruitment and logistic arrangements in anti-drug prevention programs

a. Preferred to be conducted in the evenings, possibly near Methadone Centers. The place should be easy to find
b. Before work, provision of food
c. Should be free of charge
d. Used of local newspapers and posters for promotion
e. Program can take the form of drama
f. Fax and E-mail may not be good for promotion
g. Workers could liaise with schools and parent-school associations for recruitment

5.1.5 The role of parents in adolescents' drug-abuse prevention

a. Parents are often insensitive at detecting their child's drug problems and could only begin to tackle them upon discovery. Therefore, more attention should be focused on prevention
b. Attention should be paid when the children are promoted to secondary school as peer influence will escalate
c. There is a downward trend of drug abuse thus intervention should target on younger primary school students (i.e. P.4) as well
d. Parents themselves have blind-spots thus the program instructors should point them out more explicitly

5.1.6 The types of activities that would attract parents' attention and increase program retention

a. Activities should be interactive
b. Parents' support group will help
c. Activities should target towards increasing parents' drug knowledge and ability to detect early signs of drug abuse
d. Invite ex-drug-users to share their experiences in parenting

e. Introduction of clear and relevant themes
f. Case discussion, games, video watching, group activities
g. Use of brochures with fonts that are eye-catching and easy to digest

5.1.7 Do's and Don'ts in providing intervention to different types of parents

a. Workers should be flexible when managing parents' problems
b. Couples should be encouraged to attend together
c. Avoid stigmatization, especially in phrasing the program title
d. Promotional clips should be reality-based because exaggerations would be easily dismissed by the parents
e. Program instructor could learn about the participants' history of drug-use before conducting the program
f. Should be more than skills teaching (i.e. counseling elements, training of positive attitude and beliefs)
g. Could introduce check-list for parents so that they could follow the guidelines easily
h. The program could provide visits to drug prevention or drug rehabilitation centers
i. Empower parents through a strength-based instead of a problem-based approach
j. Encourage parents to set more realistic expectations towards their children
k. Improve parents' ability to communicate effectively and positively with their children
l. Worker should pay close attention to other problems that is of concern to the participants (i.e. martial discord)

6 Implication on program recruitment and content development

The findings from the parent survey in Phase I and the suggestions given by informants in Phase II confirmed earlier findings (Heinriches, et al, 2005; Spoth & Redmond, 1993; Spoth & Redmond, 1994) that there is a very low parental participation rate in drug abuse prevention programs. The finding however provided useful information on locally-useful strategies in program recruitment and program content to attract parents' participation in drug abuse prevention programs.

6.1 Publicity:

The informants emphasized that the unawareness of local resources was one of the discouraging factors to participation. This is consistent with the survey finding when insufficient publicity was perceived as a significant discouraging factor to participate in anti-drug prevention and treatment by parents. In addition 31.1% of parents who did not participate in anti-drug prevention programs in the past 12 months reported that they "did not know the existence of drug prevention program thus did not seek help". Therefore, publicity for the parental prevention program has to be carried out through a wide network. In

this study, we promoted the program through invitational letters and follow-up calls to all schools and social welfare agencies to ensure these units were informed of the availability of our program. We also advised them to adopt strategies such as the use of positive wordings during the recruitment process (i.e. via phone calls or invitation letters), and use of posters designed by the research team to maximize parents' awareness and motivation to participate in program.

6.2 Schedule:

Time and scheduling constraints are key discouraging factors to program participation. Higher level of responsiveness to family scheduling needs and flexibility in scheduling should be considered. In this study, all the parenting groups were held in the mornings or evenings, and in weekdays and weekends to maximize options and accommodate the differing needs of parents.

6.3 Format and content:

Parents can be attracted to participate if they can share with group members, and if the program content can meet their needs. Preferred content include enriching their knowledge on the harmful effect of drug abuse, equipping them with skills on how to talk with children about drug abuse, and having chances to share and check parenting skills. All these will be included in the parental program. According to some literature, parent educational programs should not be overly demanding on the parents' attention and literacy. In this program, the comprehensive content will be delivered through interactive processes and various means, such as drawing, watching videos, and performing role-plays to stimulate parents' attention, facilitate group sharing, and enhance reflection and retention.

6.4 Parental sensitivity:

The survey findings indicated that many parents reported that they need not participate in preventive program since their children were not suffering from any drug abuse problems. It showed that parents are prone to underestimate their children's drug abuse risk when drug abuse signs are often subtle and transient. To arouse parent's attention and awareness, the program worker will engage the parents' attention by beginning with issues of common concern: internet surfing and playing video games. Through illustrations and examples, program worker would facilitate the parents to understand the progressive development of addictive behaviors. Moreover, a comprehensive checklist of both physical and psychosocial behaviors for early identification of drug abuse problem is elaborated to parents by using examples from real case of drug-detoxification and demonstration of props of the tools for drug-taking.

6.5 Avoiding stigma:

Using fight-indulgence as the general theme, parents with adolescent children are very worried about their children's excessive engagement in internet surfing and playing video games. As internet addiction and drug addiction can both be subsumed under the broad area of fighting-indulgence, this broader heading can draw more ready parental attention and participation and reduce the stigma of seeking help.

6.6 Parental competence:

As mentioned in Chapter 1, the high drop-out rate has been a significant problem for sustaining a cost-effective intervention. Findings from the survey indicated that parents with higher level of self-efficacy on managing their child's behavioral problem and concern about adolescent drug abuse will be more motivated in participation. Therefore a strength-based intervention will be employed for the prevention program for heightening the sense of self-efficacy of the parent participants. In the program sessions, the workers would emphasize the strengths of the parents, compliment their keen motivation to improve their parenting, and encourage them to think positively. RiskP and DrugP will be encouraged to give more positive self regards to enhance their sense of parental competence.

Chapter 3
Evaluation Study on Parent Education Program

1 Objectives

This is a strength-based cognitive-behavioral parent education group program with the following objectives:

1.1 To increase the knowledge of parents in drugs and developmental issues of their children

1.2 To promote positive changes on parents' attitude towards anti-drug and indulgence prevention

1.3 To enhance the skills and parental competencies in managing common behavior problems in their children

1.4 To promote awareness on intergeneration drug abuse problem among drug-taking parents

2 Schedule

2.1	Sept 2006 – Nov 2006:	Development of program content
2.2	Dec 2007 – Jan 2007:	Pilot run of the program
2.3	Feb 2007 – Mar 2008:	Program finalization; training of group leaders and facilitators; Recruitment
2.4	Apr 2007 – Jan 2008:	Implementation of the program
2.5	Feb 2008 – Apr 2008	Effectiveness study

3 Guiding principles in program development

3.1 According to Nation et al. (2003) and Dusenbury (2000), eight principles are very useful in guiding the development of effective prevention programs. They include: theory-driven, comprehensive, sensitive to developmental needs of parents and youth, culturally sensitive, sufficient coverage, interactive techniques, trained staff and evaluation. These principles, together with the information collected in the parent survey and focus group discussions, will be adopted to guide the development of the parent education programs in this project. Registered social workers with experience in parent education will be group leaders and facilitators. Interactive and multiple techniques will be used to engage parents' interest and enhance their retention of acquired knowledge and skills. In particular, theory-driven, culturally-sensitive and evidence-based principles will be given particular attention.

3.2 Theory-driven

A number of parent-focused programs, such as Project STAR in the US[3] and ASTRO Mind in HK (Lam et al., 2005) demonstrated significant

[3] Family Resource and Referral Centre. *The Project STAR Parent Education Program, Supportive Training to Assist Parent-Child Relationship.* Retrieved July 27, 2007, from http://www.children-count.org/psnew.html

influence by theoretical premises like the ecological system theory, risk and protective factors, models on determinants of parenting behavior, positive psychology, learning theories, cognitive behavioral theory and group theory. The Australia-based Triple-P positive parenting program using cognitive-behavioral principles, community health and multi-level approach also has demonstrated effectiveness on helping parents. In the summer of 2006, three members of the research team attended a four-day training on the Triple-P Levels 3 and 4 program at Brisbane, Australia. All the relevant theories and research information from the literature and the training were applied as appropriate in the design of the current programs.

3.3 Culturally-sensitive

Local research consistently suggested that Chinese parenting still emphasized parental authority and parental control (Ho, 1996). Parents might not feel most comfortable to explicitly show affection for their children. They might not be able to relate with their children as peers to break the generation gap. Moreover, disclosing family problem to others is perceived as an act against family honor (Leung, Leung, Mak & Lau, 2003), and working on the child's behavior problem could be very threatening on parent-adolescent relationship. In this program, effective parenting skills drawn from overseas programs and the survey and focus group findings will be carefully selected and adapted for use.

3.4 Evidence-based

A detailed review had been done on four well-established effective parenting programs on prevention of young drug abuse, namely the Positive Parenting Program (Triple-P), (Sanders, 2003) in Australia, Strengthening Families Program (Kumpfer, 1999) in US, Preparing for the Drug Free Year (Haggerty et al., 1999) in US and ASTRO Mind (Shek et al., 2003) in HK. Subsequently, we identified and selected three core components that were commonly shared by these programs to guide the development of the current prevention program. Core components include, 1) promoting awareness and positive attitude towards drug abuse prevention; 2) enhancing parent child bonding and communication; and 3) enhancing parenting skills and competence in dealing with youths' problem behaviors.

4 Program Content

4.1 To respond to the principles of "comprehensiveness" and "sensitivity to the needs of the target groups" mentioned in section 3.1, three programs were developed for three types of parents: a primary prevention program for GenP, a secondary prevention program for RiskP, and a tertiary prevention program for DrugP. Each level covered the core and specific components targeted on helping the participants to obtain a change across knowledge, attitude and skills aspects. Parents without drug-taking history were classified into GenP or RiskP according to a 13-item child behavior problem checklist which was included in the

application form (Appendix 3.1). The checklist was developed from literature review, former local research (Tsang & Chu, 2007), Phase I survey and Phase II focus group discussions. Parents who reported that their focal child showed no behavior problems during the past 12 months were grouped as GenP to attend the primary prevention program. Parents who endorsed one or more behavior problems in their focal child are grouped as RiskP. Parents with drug-taking history, the DrugP, were grouped to take the tertiary prevention program.

4.2 A multi-session approach with weekly meetings was adopted. Considering the difference in felt need of the different types of parents and the potential resource implications, the GenP program covered two sessions, while the RiskP and DrugP programs covered four sessions.

4.3 A structured, closed-group format was adopted as parents preferred to share with their peers, and a closed group will facilitate team building amongst members. The structured format will make them feel secure about the well-planned quality of the program and enhance their compliance with the ground-rules on program attendance and participation.

4.4 In each group session, various means were employed to increase active participation, and to facilitate and stimulate the learning and sharing of the participants. Examples and case studies were used to help them acquire and apply skills appropriate to the age and problem of their children. Parents' personal needs were also addressed and they were encouraged to taking care of themselves, instead of investing all energy on their children and families. Self-care was included as a component in the program.

4.5 The core components of the 3-level parent education program are presented in Table 3.1

Table 3.1: Core components for the 3-level parent education program

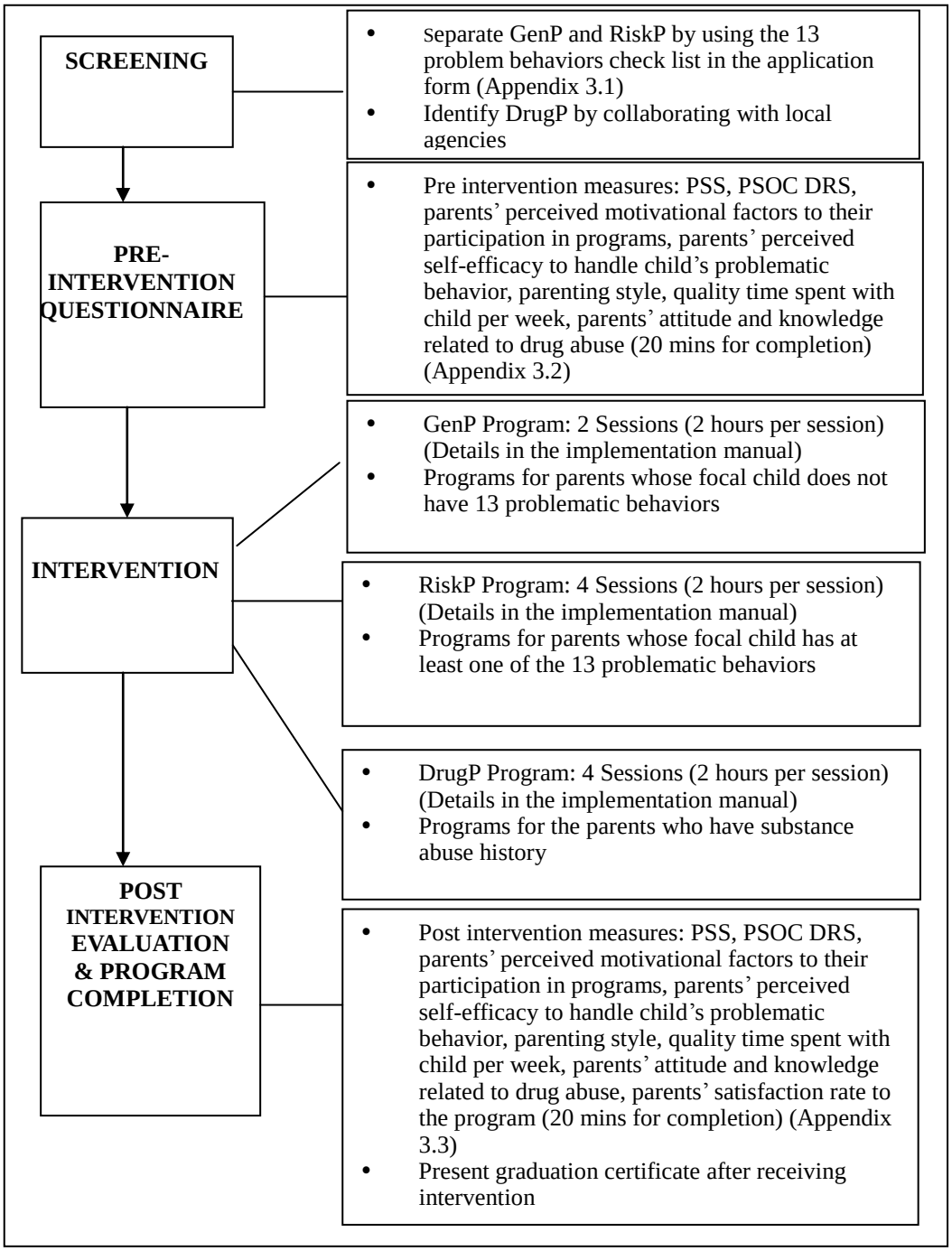
		Core Components		
		Parents of general youths (GenP)	Parents of at-risk youths (RiskP)	Parents with history of drug use (DrugP)
Enhancement of communication ability	Basic	1. Authoritarian parenting style 2. Youth culture 3. Communication skills 4. Skill to develop good behavior of teens	1. Authoritarian parenting style 2. Youth culture 3. Communication skills 4. Skill to develop good behavior of teens	1. Authoritarian parenting style 2. Youth culture 3. Communication skills 4. Skill to develop good behavior of teens
	Advanced	--	5. Skills to reinforce good behaviors 6. Skills to make win-win behavioral contract 7. skills to manage problem behavior 8. Skills to handle conflict	--
Enhancement of preventing youth drug abuse	Basic	1. Developmental needs of youths and its relationship with deviant behaviors 2. Family protective factors 3. Drug abuse among youths in Hong Kong 4. Skills to have early identification of youth drug use 5. Community resources and help seeking	1. Developmental needs of youths and its relationship with deviant behaviors 2. Family protective factors 3. Drug abuse among youths in Hong Kong 4. Skills to have early identification of youth drug use 5. Community resources and help seeking	1. Developmental needs of youths and its relationship with deviant behaviors 2. Family protective factors 3. Drug abuse among youths in Hong Kong 4. Skills to have early identification of youth drug use 5. Community resources and help seeking
Enhancement of emotion management	Advanced	--	1. Effect of emotion on parenting 2. Skills to handle stress and emotion	1. Effect of emotion on parenting 2. Skills to handle stress and emotion
Prevention of intergenerational drug abuse	Advanced	--	--	1. Effect of parents' drug use on children 2. Skills to prevent intergenerational drug abuse

5 Recruitment, sampling and assignment into experimental and control groups

5.1 Randomized control trial method was used to evaluate the effectiveness of the program on the GenP and RiskP. A more individualized approach had to be adopted for the DrugP who often had difficulties attending group programs. In view of the difficulties in recruiting the target number of DrugP, the inclusion criteria had to be loosened up. Therefore, all DrugP with a history of drug taking were recruited regardless of the types of drugs consumed.

5.2 Actual procedures in the Phase III evaluation study covered the following stages: completion of application form (Appendix 3.1) for screening into GenP, RiskP or DrugP, completion of pre-intervention questionnaire (Appendix 3.2), intervention, completion of post-intervention evaluation (Appendix 3.3). A flowchart of the program is presented in Table 3.2.

Table 3.2: Program flowchart for the three parenting levels



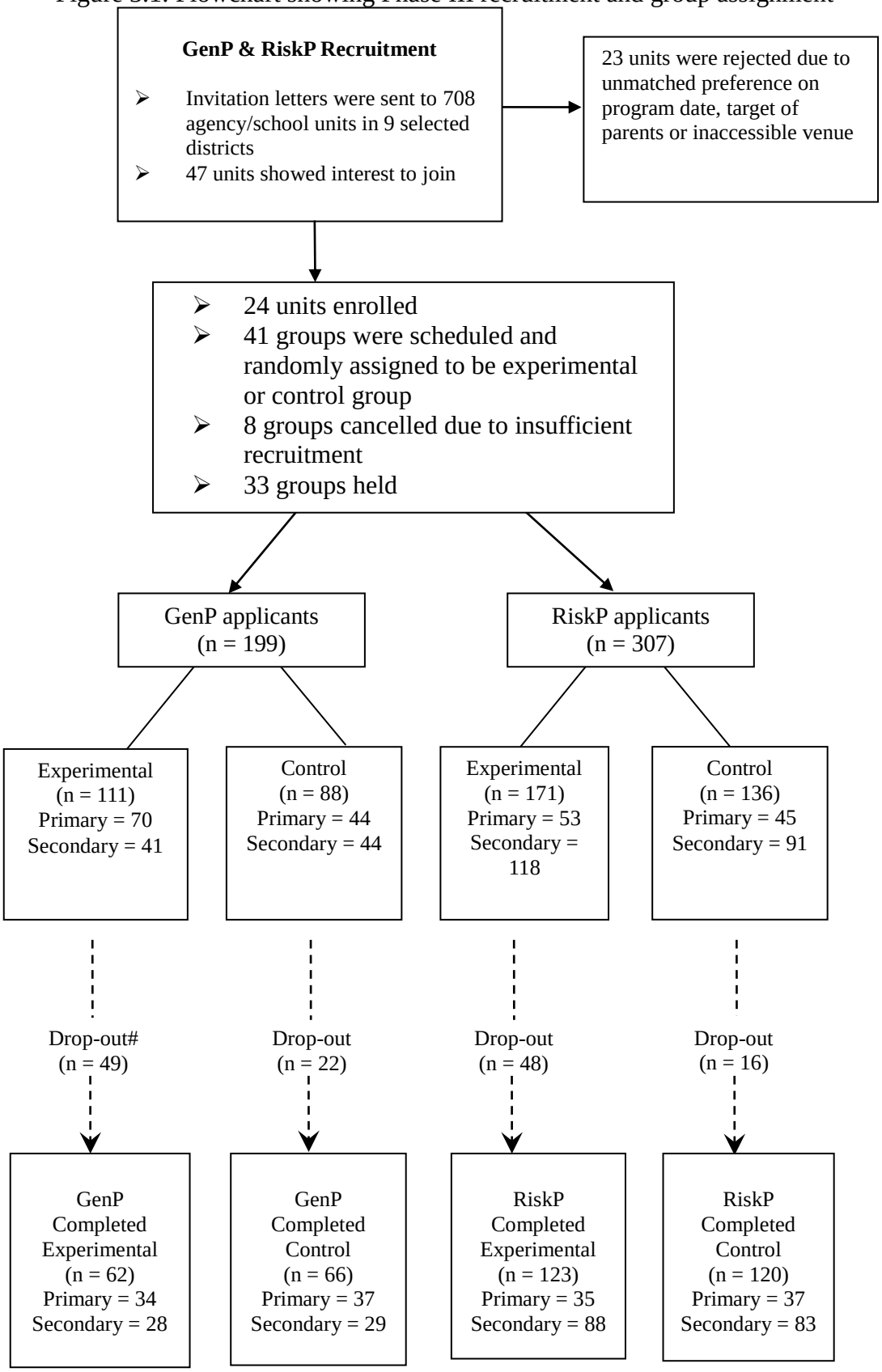
Note. PSS = Parenting Stress Scale, PSOC = Parenting Sense of Competence Scale, DRS = Dyadic Relationship Scale

5.3 437 parents (128 GenP, 243 RiskP and 66 DrugP) attended over 75% of the programs prepared for them and completed the pre and post test questionnaires. The recruitment procedure for these parents is explained in the following sections. An overview of the distribution of the experimental and control groups for the three types of parents is shown in Table 3.3. A flowchart of the recruitment procedure in this Phase is described in Figure 3.1.

Table 3.3: Distribution of experimental and control groups in the three types of parents

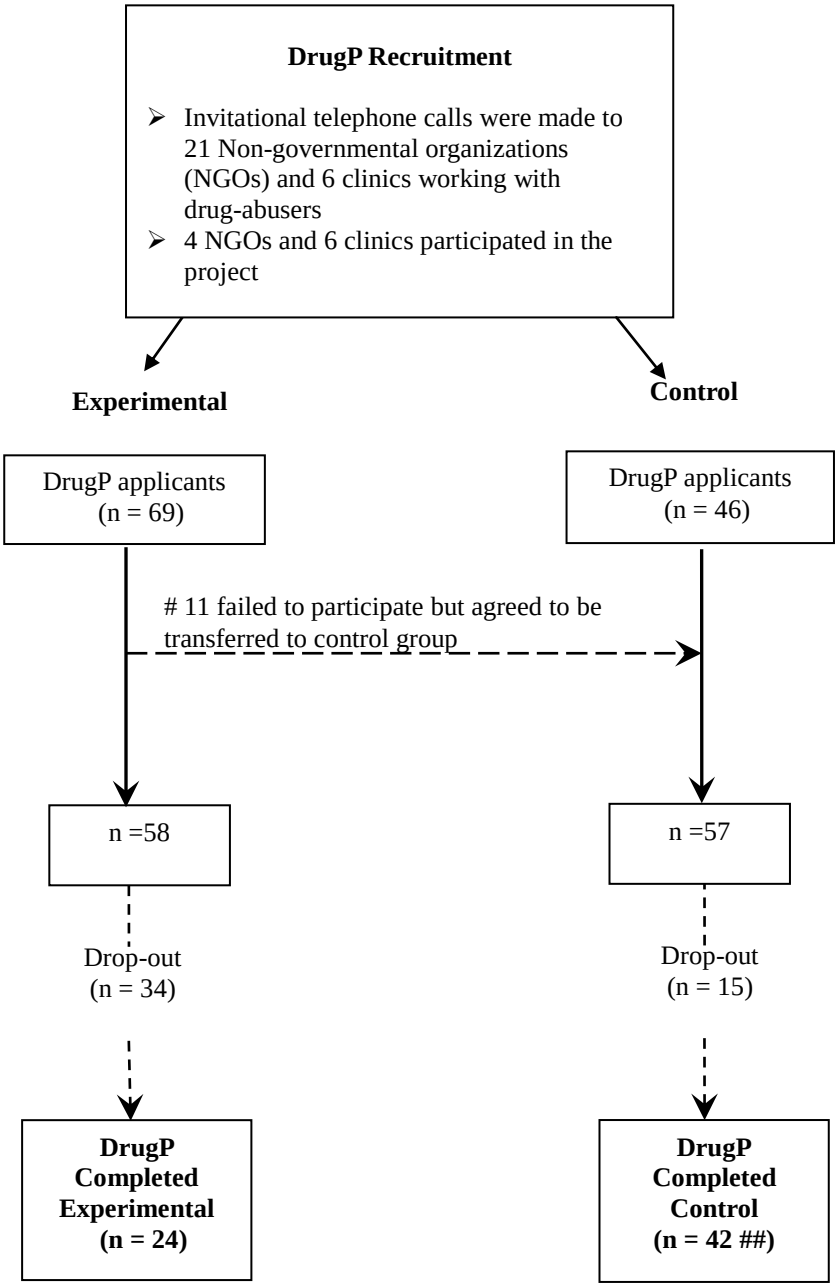
	GenP	RiskP	DrugP	Total
Experimental group	5	12	7	24
Control group	4	12	4	20
Total	9	24	11	44

Figure 3.1: Flowchart showing Phase III recruitment and group assignment



Drop-out for experimental group is defined as parents who attended less than 75% of the program. Drop-out for control group is defined as parents who failed to complete the pre-post questionnaire.

Figure 3.1: Continued



\# Originally, 69 and 49 participants were assigned to the experimental and control groups respectively. However, 11 parents from the experimental group failed to show up for group sessions but were willing to transfer to be control group participants instead. Therefore, after the transfer there were 58 and 57 participants in the experimental and control group respectively.

\## Out of the 42 participants, 14 of them completed the pre-post questionnaire without receiving further service due to conflicting time schedules with the collaborative agencies. Otherwise, all control subjects received service after a month.

5.4 GenP and RiskP recruitment and group assignment

5.4.1 Referencing on the Central Registry of Drug Abuse 55th Report in 2005, nine districts with the highest reported cases of drug abuse below the age of 21 were selected for recruitment.

5.4.2 708 invitation letters with program brochure were sent to 299 primary schools, 409 secondary schools and 72 social service units which included the Integrated Family Services Centres (IFSC), outreach teams, probation services, Night-Drifters Reaching Out services.

5.4.3 41 (87%) of the 47 units that showed interest replied within 6 weeks and the rest replied within 29 weeks. Workers from a few units suggested including parents with children aged from 9 because there was evidence of increasing early drug use. With the endorsement of the Narcotics Division in September 2007, parents with children aged 9 or in P.4 were included in some groups. Among the 47 units, 18 were rejected due to problems arising from program date, types of targeted parents and arrangement of venues. 5 were rejected due to insufficient recruitment of parents. 24 units finally participated.

5.4.4 All the 41 groups from the 24 units were randomly assigned into experimental and control groups. Unfortunately, eight groups were eventually cancelled because of insufficient enrollment. A total of 33 groups were held for GenP and RiskP with 506 parents. The group distribution is described in Table 3.4. A total of 371 parents attended over 75% of their respective programs and completed the pre and post questionnaires for analysis. The responses from 135 parents who completed lesser than 75% of the respective program were not included in the analysis.

5.4.5 All data were collected from 13/4/2007 to 18/12/2007.

5.4.6 After the program, nine units requested further services to be conducted in their units.

Table 3.4: Distribution of the 33 groups of GenP and RiskP in Phase III

Unit	Types of Units	**GenP**				**RiskP**				Total No. of Groups Con-ducted
		Prim_E	Sec_E	Prim_C	Sec_C	Prim_E	Sec_E	Prim_C	Sec_C	
1	Primary School 1	1								8
2	Primary School 2	1								
3	Primary School 3			1						
4	Primary School 4					1				
5	Primary School 5	1				1				
6	Primary School 6			1					1	
7	Secondary School 1		1				1			7
8	Secondary School 2				1					
9	Secondary School 3		1							
10	Secondary School 4								1	
11	Secondary School 5				1					
12	Secondary School 6								1	
13	SWD IFSC 1					1	1		1	11
14	SWD IFSC 2							1	1	
15	SWD IFSC 3						2	1		
16	SWD IFSC 4								1	
17	SWD IFSC 5						1			
18	SWD PO service						1			
19	NGO 1					1	1			5
20	NGO 2					1			1	
21	NGO 3								1	
22	Church 1									2
23	Church 2								1	
24	Church 3							1		
	Total	3	2	2	2	5	7	3	9	33

Note: Prim = Primary School, Sec = Secondary School
E = Experimental Group, C = Control Group

5.5 DrugP recruitment and group assignment

5.5.1 Invitation letters were sent to 21 non-governmental agencies serving adult drug-users through counseling program or residential drug rehabilitation service, two substance abuse clinics and four methadone clinics. Most of the contacted NGOs reported difficulties in recruiting parents with both drug-taking history and children aged 9 (or in P.4) to 21, and eventually failed to participate in the project.

5.5.2 Additional efforts to recruit DrugP included making phone calls to all agencies or organizations related to drug rehabilitation services. Many of them reported they welcomed the collaboration but there was difficulty in finding parents with both drug-taking history and children aged 9 (or in P.4) to 21. The research team then stationed in Methadone clinics for 3 sessions per day on different week days from Aug to October 2007 to outreach the potential group participants. However there were not many methadone users with children aged 9 (or in P.4) to 21, and their motivation to learn parenting skills in structured group format was rather low.

5.5.3 As it was observed that regular group schedule created great obstacles for the methadone users who had great mood swings and seldom observed life routines, all the absent members were invited to take individual supplementary sessions so that the key message of the group session could be conveyed to them.

5.5.4 Subsequently, a total of seven experimental groups and four control groups were held for 115 DrugP with children aged from 9 to 21. Among the 115 DrugP, 66 parents attended over 75% of the program. Some parents who missed a session (due to residual effects of drugs, physical discomforts, mood swings, unexplained absence or lateness) were given individual sessions to make up. The 66 completed sets of pre and post questionnaire were used for analysis.

5.5.5 It is noteworthy that most of the DrugP who participated in this study were engaged in drug-detoxification programs with a fixed discharged plan. Therefore, the participating units were only assigned to control groups when the group schedule matched with their discharge plan. In addition, 11 DrugP in the experimental group failed to show up for sessions but agreed to participate in control group. In view of the relatively small sample size and difficulties in recruitment, they were assigned to control group instead. Other than these, the research team followed the standard randomization procedure.

5.5.6 Like other control groups for GenP and RiskP, all the control groups among DrugP received the service after a month. All the participants in the experimental or control groups were given incentives (i.e. $50 supermarket coupons) for completing the pre-post intervention questionnaires. In addition, free buffet were offered for those with 100% group attendance.

6 Motivating Strategies adopted

The following strategies were employed to maximize recruitment effect across different stages:

6.1 Pre-program strategies:

6.1.1 Time: Most of the group meetings were held in the afternoons or evenings. Multiple scheduling options will be presented to potential targets for maximizing their participation. Supplementary sessions were offered to DrugP who were seriously late or absent in group sessions.

6.1.2 Venue: All programs were held at venues accessible to the participants. Rooms with relaxing and non-disturbing environment and comfortable furniture were identified in the district for group meetings.

6.1.3 Rapport building by direct personal contact: Individual contact was made by the group leader to introduce the group content and identify any barriers for participation that required additional resources and arrangement. Referring social workers or teachers were also asked to encourage the RiskP to participate. For the DrugP, recruitment was done through out-reaching in clinics or places like playgrounds which were frequented by drug-users, and snowballing through other drug-users.

6.2 Program strategies:

6.2.1 Reward systems: All parents who completed the program were given certificate for good attendance and active participation. For DrugP, supermarket coupon, tangible gift and free camping were offered.

6.2.2 Remind call: Reminder telephone calls were made to every participant one or two days before the session; calls were made to DrugP again three hours before the program.

6.2.3 Variations in teaching methods: Use of role play or visual aids to reduce literacy barriers; introduction of pop jargons used by students, at-risk youth or drug users to help parents engage with their children, use of daily examples and sharing of real cases to stimulate reflections on parenting; use of small group discussion to maximize parents' participation and sustain attention.

6.2.4 Traveling allowance was granted for drug taking parents and parents with financial difficulties.

6.2.5 Provision of refreshment, and distribution of leaflets on adolescent indulgent behavior.

6.3 Post-program strategies:

6.3.1 A parent-child interactive day camp was held for DrugP in which parents could enjoy quality time and practice the communicating skills with their child.

7 Manpower and Training

7.1 Staff characteristics have long been documented as critical to program effectiveness (Dumka, Garza, Roosa & Stoerzinger, 1997). Workers who are mature, can consistently show respect to the target parents and are familiar with the beliefs, values and difficulties encountered as a parents will be selected. In this project, two registered social workers with training in parent education (e.g. the Triple-P program in Australia) were responsible for program delivery. One acted as group leader, while the other was the group facilitator.

7.2 The workers reviewed their work after each session to ensure quality control on the intervention and to maintain appropriately-distanced and productive relationship with the parent participants. Regular supervision was rendered by the principal investigator for monitoring the intervention.

8 Evaluation questionnaires

8.1 Pre-intervention questionnaire

8.1.1 Composition of the pre-intervention questionnaire

Similar to Phase I, the evaluation questionnaire employed in Phase III was developed after extensive literature review and pilot test run of the program on 26 GenP, 33 RiskP (total 59) and 5 DrugP. Adjustments were made in the length and wordings of the questionnaires, and in the process of administration allowing the questionnaire to be read to illiterate parents. The final version of the pre-intervention questionnaire contained the following ten sections listed in Table 3.5.

Table 3.5: Composition of the pre-intervention questionnaire

Variable	**Number and description of items**
1. Demographic details	Age and gender of focal child and parent, parents' marital status, relationship with child, educational level, employment status, monthly income, district of residence, CSSA
2. Perceived effective recruitment strategies for parents in anti-drug prevention program	12 items measured on a 4-point Likert scale (1= strong disagree, 4 = strongly agree)
3. Perceived effective retention factors in anti-drug prevention program	10 items measured on a 4-point Likert scale (1 = strongly disagree, 4 = strongly agree)
4. Perceived program effectiveness	15 items measured on a 4-point Likert scale (1 = strongly disagree, 4 = strongly agree)
5. Parenting style	3 items measured using the multiple choice format, parents have to choose which parenting style suit them the most under specific circumstances (i.e. buying clothes for child)
6. Quality time spent with child per week	2 items measured using the open-ended format, parents have to indicate how many minutes they usually communicate with their child per week
Seven outcome measures	
7. Perceived level of self-efficacy of child management	1 item measured on a 5-point Likert scale, (1 = total lack of ability, 5 = strong ability)
8. Relationship with child (DRS)	Dyadic Relationship Sub-scale, 4 items measured on a 5-point Likert scale, (1= strongly disagree, 5 = strongly agree) The Dyadic Relationship Scale (Skinner, Steinhauer, & Santa-Barbara, 1983) is a scale that examines how a family member views his/her relationship with other family members. Cheng (1992) use the scale to assess the martial relationship of 312 middle-class adults, 88 pairs of which being couples. The scale was abridged from 46 to 18 items and its psychometric properties were improved. He also reported factor analyses results yielding 4 subscales (acceptance, trust, congruence on values and communication) from the general scale. We adopted the communication subscale in this study which reported to have an excellent internal

	consistency alpha coefficient of .77 in a local study (Tsang, 1997).
9. Perceived level of family cohesion	1 item measured on a 5-point Likert scale with higher scores equating to higher level of family cohesiveness
10. Drug knowledge	20 binary items measured by asking parents to indicate (agree/disagree) with each statements
11. Drug attitude	7 binary items measured by asking parents to indicate (agree/disagree) with each statements
12. Parenting stress (PSS)	Parenting Stress Scale, 17 items measured on a 6-point Likert scale (1 = strongly disagree, 6 = strongly agree) Parenting Stressor Scale (PSS; Berry & Jones, 1995) is a self-report scale that contains 18 items representing pleasure or positive themes of parenthood (emotional benefits, self-enrichment, personal development) and negative components (demands on resources, opportunity costs and restrictions). Respondents are asked to agree or disagree with items in terms of their typical relationship with their child or children and to rate each item on a five-point scale. We adopted the Chinese version of the PSS which was validated by Cheung (2000) with 257 samples. The 17-item scale scores were found to have high internal consistency thus was employed in the present study.
13. Parenting competency (PSOC)	Parenting Sense of Competence Scale, 7 items measured on a 6-point Likert scale (1 = strongly disagree, 6 = strongly agree) Parenting Sense of Competence Scale (PSOC; Johnston & Mash, 1989) is a 16-item self-report questionnaire designed to measure parents' satisfaction and efficacy in their parenting role. Items are rated on a 6-point Likert scale. The nine items in the Satisfaction scale are forward scores and the seven items in the Efficacy scale are scored in the reverse direction. The Satisfaction scale reflects parenting frustrations, anxiety and motivation, while Efficacy assess capability, problem-solving ability, and competence. High scores represent high degrees of satisfaction and efficacy. We adopted the Efficacy sub-scale in this study which reported to have high internal consistency alpha coefficients of .76 in a previous study (Johnston and Mash, 1989).

8.1.2 Reliability estimates

The reliability estimates (Cronbach Alpha) for the scales adopted in this phase were above .70 in all cases. The details are shown in Table 3.6.

Table 3.6: Reliability estimates of the outcome scales (Cronbach Alpha)

Variables	Experimental Group (n = 209)	Control Group (n =228)	Total (n = 437)
Pre PSS total	.85	.85	.85
Post PSS total	.85	.86	.82
Pre PSOC total	.82	.83	.83
Post PSOC total	.84	.79	.83
Pre DRS total	.70	.70	.70
Post DRS total	.76	.70	.72

Note. PSS = Parenting Stress Scale, PSOC = Parenting Sense of Competence Scale, DRS =Dyadic Relationship Scale

All control group members completed the post questionnaire which was identical with the pre-one. Experimental group members completed post-intervention questionnaires with the following additional sections:

8.2 Post-intervention questionnaire: The following sections were added into the post-intervention questionnaire for the experimental group participants

8.2.1 Retention factors enhancing attendance and participation: This included 10 items measured on a 4-point Likert scale, 1 = strongly disagree, 4 = strongly agree.

8.2.2 Participants' perceived program effectiveness: This included 15 items measured on a 4-point Likert scale,1 = strongly disagree, 4 = strongly agree.

9 Feedback on program from workers in collaborative units

9.1 A feedback form (Appendix 3.4) was sent by post to all the 27 workers from the 24 units in this study. 23 workers responded. The workers were asked to rate on four point scale (1= very agree, 4 = Very Disagree) regarding the performance of program instructors and perceived importance of program continuation. Using a binary item (yes/no), they were asked about their likelihood to participate in this program in the future. Using multiple choice answering formats, the following information was also collected (time needed for recruitment, main source of participant, means used for recruitment, perceived difficulties during the recruitment process, and contents that could attract parents' participation).

10 Data analysis

10.1 To explore the compatibility of data between the experimental and control groups, bivariate analyses were performed to identify differences between the experimental and control groups at pre-test.

10.2 MANOVA was performed to assess the effect of the group assignment (experimental and control groups) and the groups of parents (GenP, RiskP and DrugP) on the changes of the scores on the seven outcome measures between pre and post tests.

11 Results

11.1 Sample Characteristics

11.1.1 Out of a total of 621 parents who enrolled in the group programs, 437 parents (GenP = 128, RiskP = 243, DrugP = 66) completed the pre and post intervention questionnaire for final analysis. The distribution of the experimental and control group members is presented in Table 3.7. The demographic characteristics of the three groups of parents are listed in Table 3.8 and described in the following sections.

Table 3.7: Total number of participants in experimental and control groups who completed pre and post intervention questionnaire. Participants in experimental groups attained ≥75% attendance. (N =437)

	Experimental (n=209)			Control (n=228)			Averaged participation rate (N=437)
	Enrolled	Drop-out	Attended ≥75% of program and Completed pre-post questionnaire	Enrolled	Drop-out	Completed pre-post questionnaire	
GenP	111	49 (44%)	62 (56%)	88	22 (25%)	66 (75%)	64%
RiskP	171	48 (28%)	123(72%)	136	16 (12%)	120(88%)	79%
DrugP	58	34 (59%)	24 (41%)	57	15 (26%)	42 (74%)	57%
Total	340	131(39%)	209(61%)	281	53 (19%)	228(81%)	67%

11.1.2 Demographic characteristics of parents in general: Among the 437 participants, 356 (81.5%) were female and 81 (18.5 %) were male. 75.2% of the respondents were married and 64.6% attained F.1-F.5 education level. The mean age of parents was 43.56 (S.D. =6.34). 30% of the respondents had a full-time (at least 44 hours per week) employment and the median monthly income was $5000-9999.

11.1.3 Gender and age of focal child: 262 (60%) of the focal child were male and 175 (40%) of the focal child were female. The mean age of the focal child was 13.32 (S.D.=2.70).

11.1.4 Relationship with focal child: 90.6% of GenP and 88.1% of RiskP were the mother of the focal child. However, 54.4% of DrugP participants were the father of the child. Table 3.8 showed a break down of demographic characteristics of the three groups of parents.

Table 3.8: Demographic characteristics of GenP, RiskP and DrugP (N = 437)

Demographic Characteristics	GenP N = 128	%	RiskP N = 243	%	DrugP N = 66	%
Mean Age of focal child	Mean = 12.11 (SD = 1.58)	--	Mean = 13.61 (SD = 2.55)	--	Mean = 14.61 (SD = 3.87)	--
Gender of focal child	M = 64 F = 64	--	M = 161 F = 82	--	M = 37 F = 29	--
Educational level of focal child						
Primary	71	55.5	72	29.6	NA	
Secondary	57	44.5	171	70.3	NA	
Parents Age	Mean = 42.86 (SD = 6.25)	--	Mean =43.25 (SD = 5.69)	--	Mean = 46.03 (SD = 8.08)	--
Relationship with child						
Biological Mother	116	90.6	214	88.1	21	31.8
Step Mother	0	--	1	0.4	0	--
Biological Father	10	7.8	26	10.7	43	54.4
Step Father	0	--	0	--	2	3.0
Others	2	1.6	2	0.8	0	--
Marital Status						
Married	112	88.2	179	74.0	36	54.5
Cohabited	2	1.6	3	1.2	5	7.6
Separated	2	1.6	2	0.8	6	9.1
Divorced	11	8.7	45	18.6	17	25.8
Widowed	0	--	10	4.1	0	--
Single	0	--	3	1.2	2	3.0
Parents' Educational Level						
No education	1	.8	4	1.6	2	3.1
Primary	16	12.6	54	22.2	29	44.6
Secondary (F1-F3)	33	26.0	84	34.6	22	33.8
Secondary (F4-F5)	53	37.3	78	32.1	11	16.9
Matriculation	13	10.2	7	2.9	1	1.5
Diploma	2	1.6	12	4.9	0	--
University or above	9	7.1	4	1.6	0	--
Employment Status						
Full time (>44 hrs/wk)	52	40.6	68	28.1	11	16.7
Part time (<44 hrs/wk)	17	13.3	34	14.0	12	18.2
Retired	3	2.3	3	1.2	2	3.0
Unemployed	4	3.1	15	6.2	26	39.4
Housewife	52	40.6	122	50.4	15	22.7
Household income						
<4999	9	7.1	28	11.8	40	60.6
5000-9999	28	19.6	94	39.5	21	31.8
10000-19999	46	36.5	72	16.7	4	6.1
20000-29999	17	13.5	28	11.8	1	1.5
30000-39999	12	9.5	12	5.0	0	--
>40000	14	11.1	4	1.7	0	--
On CSSA						
Yes	20	15.6	71	29.6	46	69.7
No	108	84.4	169	70.4	20	30.3

Note. * $p < 0.05$, ** $p < 0.01$

11.2 Experimental and control group pre-intervention compatibility

11.2.1 No significant differences were found between experimental and control groups at the pre-intervention stage for the three groups of parents regarding demographic variables (i.e. marital status, educational level, employment status, monthly income and recipients of CSSA) and outcome variables (i.e. parenting style, parenting stress, drug knowledge, drug attitude, relationship with child, communication with child, sense of self-efficacy and perceived level of family cohesiveness).

11.3 Participation rate and attrition analysis

11.3.1 Participation rate: Participants who attended less than 75% of their respective programs are considered dropped-out cases. A total of 621 parents enrolled in this program and 437 completed and the breakdown amongst the 3 groups is presented in Table 3.9. The averaged drop-out rate was kept under 30% for all the participants. The drop-out rate, as expected, was more serious with the DrugP. RiskP showed only 20% drop-out rate.

Table 3.9: Percentages of drop-out among the three groups of parents

	Pre-Test	Post-Test	Total number of dropped out	Averaged % of drop out at the end of the program
GenP	199	128	71	35.68
RiskP	307	243	64	20.84
DrugP	115	66	49	42.60
Total	621	437	184	29.63

11.3.2 Attrition analysis: Results showed no significant difference between the drop-outs and non-dropouts regarding demographic characteristics. Parents who dropped out early tended to show less need to participate in the program. For example, they reported significantly higher quality time spent with their child every week (mean = 184.48, S.D. = 614.51 vs. mean = 102.43, S.D. = 216.60, $F = 5.67$, $p<.05$), with a higher level of self-efficacy in managing the child's problem (mean = 2.43, S.D. 1.012 vs. mean = 2.19, S.D. = .92, $F = 7.79$, $p<.01$) and better relationship with child as reflected by the score in DRS (mean = 25.98, S.D. = 5.70 vs. mean = 24.94, S.D. = 6.17, $F = 3.79$, $p<.05$). In addition, parents who dropped out in general reported less parenting stress (mean = 57.27 vs. 59.07).

11.4 Evaluation of program effectiveness

11.4.1 A 3 x 2 (experimental/control group assignment) x (3 groups of parenting) multivariate analysis of variance (MANOVA) was conducted. Results revealed a significant group effect ($F=3.308$, $p<.01$), a significant condition effect ($F=8.96$, $p<.01$) and a significant Condition x Group level interaction ($F=12.97$, $p<.01$). Analysis conducted on outcome variables (parenting stress, parental competency, relationship with child, perceived family cohesion and sense of self-efficacy, drug knowledge and drug attitude) revealed significant group assignment effects on all the variables except for perceived level of family cohesion. Mean differences at pre and post intervention for the three groups of parents are presented in Table 3.10. The impact of intervention was different for the three groups of parents in two outcome measures, namely drug attitude ($F=6.08$, $p<.01$) and sense of self-efficacy ($F=5.60$, $p<.01$). More specifically, DrugP benefited substantially from intervention and gained the most improvement in drug attitude compared with the other two groups of parenting (Figure 3.2). RiskP and DrugP both showed significant improvements in sense of self-efficacy after the program (Figure 3.3).

Table 3.10: Means difference on outcome measures between pre- and post-intervention assessment in experimental and control groups by three parent groups, mean (SD) (GenP, RiskP and DrugP)

	GenP		RiskP		DrugP	
Outcome	Experimental	Control	Experimental	Control	Experimental	Control
PSS	0.95	-1.14	4.01	1.58	1.79	0.11
	(7.29)	(7.31)	(9.95)	(7.92)	(6.38)	(7.65)
PSOC	2.24	0.07	4.42	0.13	2.05	-0.68
	(5.14)	(3.76)	(6.52)	(4.67)	(5.27)	(5.86)
DRS	1.4	0.46	0.64	-0.21	1.56	0.53
	(2.04)	(2.01)	(2.56)	(1.34)	(2.17)	(1.75)
COHES	-0.03	0.02	0.19	0.07	-0.05	0.24
	(0.84)	(0.81)	(0.97)	(0.76)	(1.13)	(1.10)
SELFCOM	0.21	0.23	0.74	0.13	0.53	-0.34
	(1.23)	(0.63)	(1.23)	(0.92)	(1.35)	(0.85)
DBEH	3.67	2.07	3.38	0.60	3.05	0.45
	(6.96)	(5.55)	(6.96)	(5.70)	(5.40)	(5.09)
DATT	0.19	-0.12	0.05	0.18	1.21	0.11
	(1.25)	(1.02)	(1.28)	(1.00)	(1.23)	(1.31)

Note. PSS = Parenting Stress Scale, PSOC = Parenting Sense of Competence Scale, DRS = Dyadic Relationship Scale, COHES = Perceived Level of Family Cohesiveness, SELFCOM = Parental self-efficacy, DBEH = Drug Knowledge, DATT = Drug attitude

Figure 3.2: Significant intervention effect on drug attitude for the three parent groups

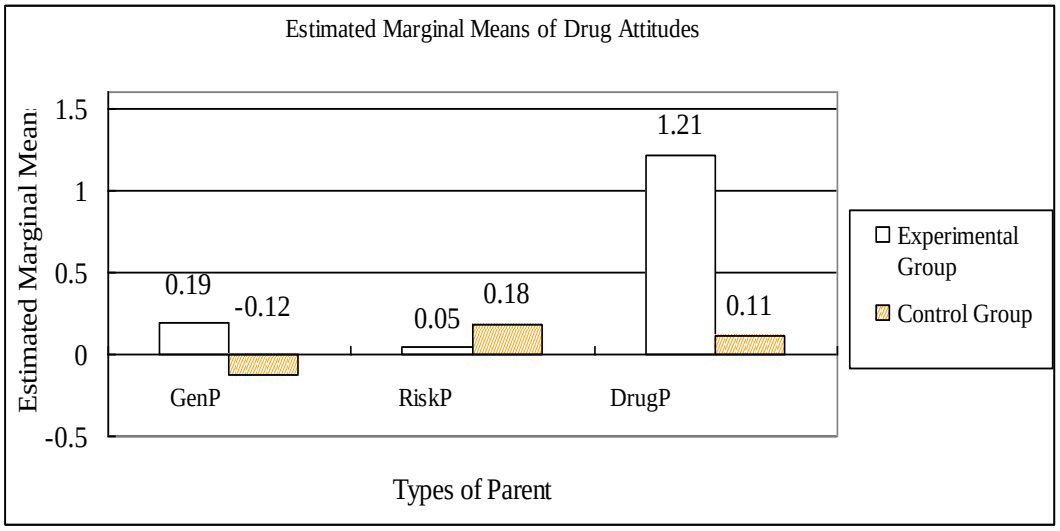
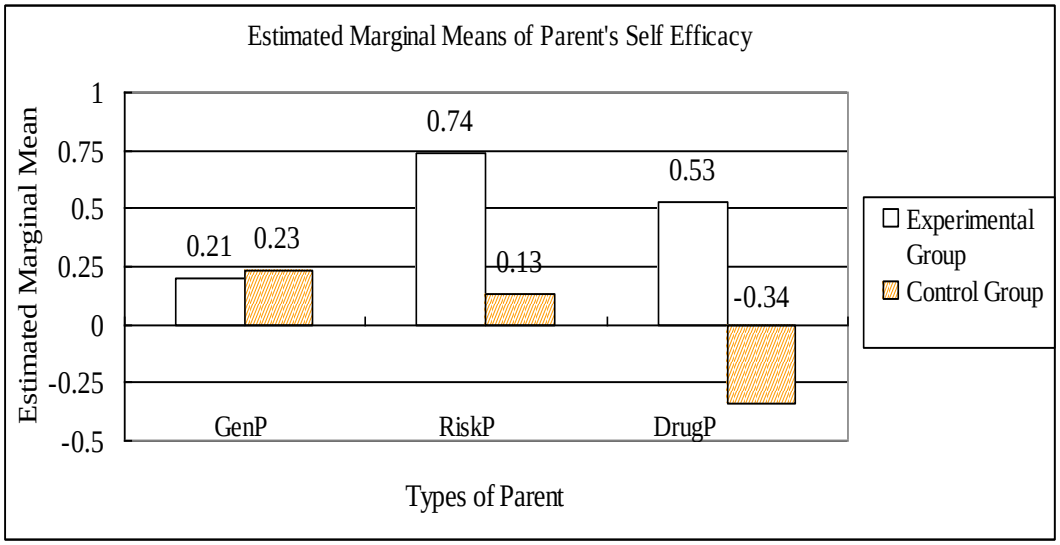


Figure 3.3: Significant intervention effect on perceived sense of self-efficacy for the three parent groups



11.4.2 GenP program effectiveness

a. Among GenP, the impact of the two-session intervention was significantly different for experimental and control groups on two outcome measures, namely parental competency (F=6.65, p<.05) and relationship with child (F=6.65, p<.05). Table 3.11 shows that GenP in the experimental group improved significantly on parental competency and relationship with child compared with control group.

Table 3.11: Intervention effects for GenP between experimental group and control group at pre and post test, mean (SD) (N=128)

	GenP				Effect Size Partial eta squared
	Experimental		Control		
Outcome measures	Pre (SD)	Post (SD)	Pre (SD)	Post (SD)	
PSS	55.60 (13.41)	54.66 (14.06)	50.75 (12.18)	51.89 (11.55)	--
PSOC*	26.07 (6.14)	28.31 (5.21)	26.74 (5.35)	26.81 (5.28)	0.29
DRS*	15.05 (1.88)	16.48 (1.71)	15.53 (2.35)	15.98 (1.71)	0.29
COHES	3.63 (0.87)	3.63 (0.91)	3.56 (0.83)	3.52 (0.73)	--
SELFCOM	2.66 (0.79)	2.86 (0.63)	2.37 (0.75)	2.60 (0.70)	--
DBEH	14.03 (6.69)	17.63 (4.07)	13.85 (7.28)	15.69 (5.79)	--
DATT	5.48 (0.98)	5.67 (0.93)	5.72 (0.90)	5.60 (0.90)	--

Note. PSS = Parenting Stress Scale, PSOC = Parenting Sense of Competence Scale, DRS = Dyadic Relationship Scale, COHES = Perceived Level of Family Cohesiveness, SELFCOM = Parental self-efficacy, DBEH = Drug Knowledge, DATT = Drug attitude, * p <0.05, ** p < 0.01

b. Regarding gender differences, 10 male GenP and 118 female GenP participated in the program. No significant gender differences were observed between female and male participants regarding the following outcome measures at pre and post test, namely parenting stress, parental competency, relationship with child, perceived family cohesion, parental sense of parental efficacy, drug knowledge, and parenting style. However, at pre-test, male participants reportedly spent significantly more time with their child compared with their female counterparts (mean=188.8, s.d.=229.627 minutes per week vs. 107.50, s.d.=131.398 minutes per week, t=-3.548, p<.001). At pre-test, female participants reported higher anti-drug attitude compared with their male participants (mean=5.66, s.d.=.908 vs. mean=5.00, s.d.=1.054, t=2.184, p<.05)

c. The 7 outcome measures correlated positively with each other with r>.99, p<.01. In terms of the correlations between outcome measures and perceived program effectiveness, GenP who reported less parenting self-efficacy perceived significantly higher program effectiveness for the following (positive correlation with p<.05): they have learned more about the trend and impact of adolescent drug abuse, know how to prevent child drug abuse, know how to early identify child drug abuse, know more about intergenerational drug abuse, know more about youth culture, more skillful to communicate with child, more tactful to handle conflict, more skillful to manage child problem behavior, more optimistic to deal with child problem behavior, more skillful to handle emotion and stress, perceived desirable date, suitable venue, program content fulfills my needs and satisfactory performance of workers.

d. Similarly, those with less anti-drug attitude at post-test perceived higher perceived program effectiveness for the following measures (positive correlation with p<.05): better knowing how to prevent child drug abuse, get more resources for help seeking, know more about intergenerational drug abuse, know more about youth culture, more skillful to communicate with child, more tactful to handle conflict, more skillful to manage child problem behavior, more optimistic to deal with child problem behaviors, suitable date and time, suitable venue, program content fulfills my needs and satisfactory performance of workers.

11.4.3 RiskP program effectiveness

a. For RiskP, the impact of intervention was significantly different for experimental and control groups on five outcome measures, namely parental stress (F=3.89, p=.05), drug knowledge (F=10.17, p<.01), parental competency (F=30.56, p<.01), relationship with child (F=9.52, p<.01) and perceived sense of self-efficacy (F=18.99, p<.01). Table 3.12 shows that RiskP in the experimental group showed significant improvements on the above mentioned outcome measures compared with RiskP in the control group.

Table 3.12: Intervention effects for RiskP between experimental group and control group at pre and post test, mean (SD) (N=128)

	RiskP				Effect size Partial eta squared
	Experimental		Control		
Outcome measures	Pre (SD)	Post (SD)	Pre (SD)	Post (SD)	
PSS*	64.52 (11.05)	60.51 (10.27)	62.06 (9.96)	60.47 (9.99)	0
PSOC**	24.39 (6.43)	28.82 (5.60)	23.74 (6.10)	23.87 (5.52)	0.89
DRS**	15.69 (2.08)	16.33 (1.95)	15.45 (1.92)	15.25 (1.94)	0.56
COHES	2.96 (0.91)	3.15 (0.89)	2.90 (0.93)	2.94 (0.83)	--
SELFCOM*	1.78 (0.83)	2.52 (0.94)	2.06 (0.85)	2.19 (0.94)	0.35
DBEH*	14.24 (6.00)	17.54 (4.66)	15.66 (4.62)	16.19 (4.57)	0.29
DATT	5.72 (1.13)	5.77 (1.02)	5.67 (0.88)	5.85 (0.79)	--

Note. PSS = Parenting Stress Scale, PSOC = Parenting Sense of Competence Scale, DRS = Dyadic Relationship Scale, COHES = Perceived Level of Family Cohesiveness, SELFCOM = Parental self-efficacy, DBEH = Drug Knowledge, DATT = Drug attitude, * $p < 0.05$, ** $p < 0.01$

b. 26 male RiskP and 217 female RiskP participated in the program. No significant gender differences were observed for the following outcome measures at pre and post test, namely parental competency, perceived family cohesion, sense of parental self-efficacy, drug knowledge, drug attitude and quality time spent with child. However, at pre and post test, female reported significantly higher parenting stress compared with male participants (at pre-test, mean=63.98, s.d.=10.369 vs. 57.54, s.d.=9.872, t=3.007 p<.01), at post-test, mean=60.79 vs. 56.35, t=2.143, p<.05). At pre-test, male reported to have better relationship with child compared with their female counterparts, mean=16.31, s.d.=1.614 vs. 15.39, s.d.=1.989, t=-2.120, p<.05). Regarding parenting style at pre-test, based on the pure parenting style (i.e. answered all three questions using the same parenting style), more male participants adopted the mixed parenting style (92.3%) and more female adopted the authoritarian style of parenting (38.2%), df=2, X=9.775, p<.01.

c. The 7 outcome measures correlated positively with each other with r >.99, p<.01. In terms of the correlations between outcome measures and perceived program effectiveness, RiskP with lower level of parenting self-efficacy perceived significantly higher program effectiveness for the following (positive correlation with p<.05): they have learned more about the trend and impact of adolescent drug abuse, know how to prevent child drug abuse,

know how to early identify child drug abuse, get more resources for help seeking, know more about intergenerational drug abuse, know more about youth culture, more skillful to communicate with child, more tactful to handle conflict, more skillful to manage child problem behavior, more optimistic to deal with child problem behaviors, more skillful to handle emotion and stress, suitable date and time, suitable venue, program content fulfills my needs and satisfactory performance of workers.

11.4.4 DrugP program effectiveness

a. Table 3.13 shows that for DrugP, the impact of intervention was significantly different for experimental and control groups on three outcome measures, namely relationship with child ($F=4.29$, $p<.05$), drug attitude ($F=9.38$, $p<.01$) and perceived sense of efficacy ($F=8.86$, $p<.01$). Table 3.13 shows that DrugP in the experimental group showed significant improvements on the above mentioned outcome measures compared with DrugP in the control group.

Table 3.13: Intervention effects for DrugP between experimental group and control group at pre and post test, mean (SD) (N=128)

	DrugP				Effect size Partial eta squared
	Experimental		Control		
Outcome measures	Pre (SD)	Post (SD)	Pre (SD)	Post (SD)	
PSS	56.74 (9.64)	54.95 (7.66)	55.11 (9.79)	55.00 (9.71)	--
PSOC	26.00 (6.60)	28.05 (5.34)	25.11 (6.99)	24.42 (5.57)	--
DRS*	15.11 (1.97)	16.26 (1.70)	15.79 (1.83)	15.84 (1.87)	0.23
COHES	3.30 (1.22)	3.21 (1.02)	2.80 (1.03)	3.10 (1.12)	--
SELFCOM**	2.21 (1.18)	2.74 (0.73)	2.74 (0.98)	2.39 (0.92)	0.41
DBEH	15.92 (4.73))	18.83 (1.80)	17.43 (3.51)	17.76 (4.16)	--
DATT**	5.26 (1.20)	6.47 (0.61)	5.66 (1.12)	5.76 (0.94)	0.85

Note. PSS = Parenting Stress Scale, PSOC = Parenting Sense of Competence Scale, DRS = Dyadic Relationship Scale, COHES = Perceived Level of Family Cohesiveness, SELFCOM = Parental self-efficacy, DBEH = Drug Knowledge, DATT = Drug attitude, * $p<0.05$, ** $p<0.01$

b. Unlike GenP and RiskP, a majority of DrugP participants were male (45 vs. 21). No significant differences were observed for the following outcome measures at pre and post-test for male and female participants, namely parenting stress, parental competency, relationship with child, perceived family cohesion, drug

knowledge, anti-drug attitude and parenting style. At pre-test, male participants reported significantly higher level of perceived parenting self-efficacy compared with female participants (mean=2.73, s.d. =1.031 vs. mean=2.05, s.d.=1.024, t=-2.522, p<.05)

11.5 Recruitment strategies effectiveness

11.5.1 At pre-intervention, the three groups of parents were asked to report on the strategies that most strongly attracted them to join anti-drug prevention program. The percentage and rank ordering of the recruitment strategies agreed to be effective are presented in Table 3.14.

Table 3.14: Perceived effective recruitment strategies for the three types of parents at pre-intervention (N=621)

	Rank of importance in descending order 1-12 (%)		
Variables	GenP (n=199) Agree	RiskP (n=307) Agree	DrugP (n=155) Agree
Teaching parenting skills	1 (98.4)	1 (99.2)	1 (97.2)
Concepts illustrated by daily examples	2 (96.1)	2 (96.7)	5 (87.0)
Suitable date and time	3 (95.3)	5 (88.1)	3 (91.1)
Convenient application procedure	4 (91.4)	8 (82.3)	4 (90.2)
Suitable venue	5 (91.4)	6 (87.7)	2 (92.0)
Group as format	6 (89.8)	4 (89.7)	3 (91.1)
Explaining indulgence	7 (88.3)	3 (90.9)	5 (87.0)
Provision of gift/vouchers	8 (68.8)	12 (42.0)	9 (64.6)
Attractive speaker	9 (68.0)	9 (67.1)	6 (72.8)
Encouraged by others	10 (58.6)	7 (82.7)	7 (70.8)
Provision of certificate	11 (54.7)	10 (57.6)	8 (64.7)
Provision of refreshment	12 (38.3)	11 (44.9)	10 (55.0)

Note. “Agree” included parents who endorsed “agree” or “strongly agree”

11.5.2 For GenP, the top five choices of successful recruitment strategies included the teaching of parenting skills (98.4%), concepts illustrated by examples (96.1%), suitable date and time (95.3%), convenient application procedure and suitable venue (91.4%). The three least attractive recruitment strategies included encouragements by others (58.6%), provision of certificates (54.7%) and provision of refreshments (38.3%).

11.5.3 For RiskP, the top five choices of successful recruitment included the teaching of parenting skills (99.2%), concepts illustrated by daily examples (96.7%), explanation of indulgence behavior (90.9%), group format (89.7%) and suitable date and time (88.1%). The three least attractive recruitment strategies included provision of certificate (57.6%), provision of refreshment (44.9%) and the provision of gift/vouchers (37.0%). Compared with GenP, the teaching parenting skills and illustration of concepts using daily examples were perceived as important factors to them joining anti-drug prevention programs, the convenience of application,

venue and provision of gifts/vouchers were perceived as less important factors to successful recruitment.

11.5.4 For DrugP, the top five successful recruitment strategies included teaching parenting skills (97%), suitable venue (92%), suitable date and time (91.1%), group format (91.1%) and concepts illustrated with daily examples (87.0%). The three least attractive recruitment strategies included provision of certificates (64.7%), provision of gift/vouchers (64.6%) and the provision of refreshments (55.0%). Compared with GenP, DrugP perceived the venue of the program, the use of group format, attractiveness of the speaker and encouragement by others to be much more essential factors to their joining of anti-drug prevention program.

11.6 Drug knowledge improvement

11.6.1 Parents across the three levels (GenP, RiskP and Drug P) showed significant increase in correct responses on drug knowledge after intervention. Table 3.15 presented the mean score of drug knowledge at pre and post test for the three groups of parents. At pre-test, DrugP showed significantly more drug knowledge than GenP ($F=5.86$, $p<.01$). At post-test, all parenting groups in the experimental group showed significant within group improvements in drug knowledge. GenP in the control group also showed significant within group difference at pre and post test. Table 3.16 presented a break down of the number of correct responses in drug knowledge at pre and post intervention for the three groups of parents in the experimental condition. Results showed that the percentage of GenP, RiskP and DrugP who scored more than 16-20 increased by 20.9%, 26.2% and 24.9% respectively.

Table 3.15: Drug knowledge at pre and post test for the three groups of parents in experimental and control condition (N=437)

Experimental	Group	Mean	Std. Deviation	Between Group F	Post Hoc.	Within Group t
Pre-Test	GenP	14.03	6.698			GenP: 4.156**
	RiskP	14.24	5.946	.905	--	
	DrugP	15.92	4.727			RiskP: 5.278**
Post-Test	GenP	17.63	4.075			
	RiskP	17.54	4.663	.895	--	DrugP: 2.832**
	DrugP	18.83	1.800			
Control	**Group**	**Mean**	**Std. Deviation**	**Between Group F**	**Post Hoc.**	**Within Group t**
Pre-Test	GenP	13.85	7.282			GenP: 2.405*
	RiskP	15.66	4.625	5.856**	GenP<DrugP	
	DrugP	17.43	3.507			RiskP: 1.118
Post-Test	GenP	15.69	5.788			
	RiskP	16.19	4.574	2.407	--	DrugP: .439
	DrugP	17.76	4.917			

Note. * p <0.05, ** p < 0.01

Table 3.16: Drug knowledge (DBEH, Q1-20, full score =20), analysis of correct responses at pre and post-test for experimental group (%) (N = 209)

No. of correct responses	GenP (N = 62)		RiskP (N = 123)		DrugP (N = 24)	
	Pre	Post	Pre	Post	Pre	Post
0-5	18.0	3.3	10.7	5.9	4.2	0
6-10	6.6	1.7	14.0	3.4	12.5	0
11-15	18.0	16.7	18.2	7.6	12.5	4.3
16-20	57.4	78.3	57.0	83.2	70.8	95.7

11.6.2 A closer examination of drug knowledge of parents in experimental group at post-intervention is presented in Table 3.17. Results showed that there were no significant differences between parents with different scores on the seven outcome measures. However, by looking at the mean scores, parents who showed poorer drug knowledge at post intervention indicated less sense of self-efficacy in managing child, lower drug related attitude, lower level of parental competency, poorer relationship with child, higher parenting stress, lower perceived family cohesion and would spend less quality time with their child.

Table 3.17: Analysis of correct responses in drug knowledge and its relation with other major variables at post-intervention for experimental group (N = 209), mean (SD)

DBEH	PSS	PSOC	DRS	COHES	SELF-COM	DATT	ATSC
0-5	**62.25**	**26.67**	**15.56**	**3.00**	**2.56**	**4.67**	**31.56**
	(7.54)	**(5.45)**	**(1.24)**	**(.71)**	**(.73)**	**(1.41)**	**(25.42)**
6-10	54.20	30.80	16.40	3.80	3.00	5.60	13.20
	(15.97)	(4.21)	(2.19)	(.84)	(.71)	(1.14)	(16.60)
11-15	53.05	28.85	16.75	3.55	2.75	5.75	40.50
	(12.07)	(4.61)	(1.97)	(.83)	(.79)	(.91)	(24.67)
16-20	**56.06**	**28.58**	**16.36**	**3.32**	**2.66**	**5.80**	**34.75**
	(11.40)	**(5.38)**	**(1.81)**	**(.94)**	**(.86)**	**(.99)**	**(27.92)**
F	1.98	.68	.90	1.23	.40	4.59	1.32

Note. DBEH = Drug knowledge, PSS = Parenting Stress Scale, PSOC = Parenting Sense of Competence Scale, DRS = Dyadic Relationship Scale, COHES = Perceived Family Cohesiveness, SELFCOM = Parental self efficacy, DATT = Drug attitude, ATSC = Averaged time spent with child/week (hrs), * $p < 0.05$, ** $p < 0.01$

11.7 Anti-drug attitude improvement

11.7.1 Table 3.18a showed that all groups of parents showed improvements in anti-drug attitude after attending the program. A positive main effect was evident in all parenting groups regarding their perceptions and attitude towards substance abuse. At pre-test, DrugP in control group showed a higher score for drug attitude than GenP and RiskP ($F=7.34$, $p<.01$). At post test, only DrugP showed significant between group effects (mean DATT score = 5.25 vs. 6.50, $t = -5.15$, $p<.01$) as well as within group effects ($t=-5.15$, $p<.01$). DrugP also scored the highest at post-test compared with the other two groups of parents. A breakdown of the number of correct items at pre and post intervention is described in Table 3.18b.

11.7.2 A closer examination of anti-drug attitude of parents in experimental group at post-intervention was presented in Table 3.19. Results showed that parents with more positive attitude towards anti-drug abuse scored significantly higher on drug knowledge ($F=11.51$, $p<.01$). In addition, by looking at the mean scores, parents who showed more positive attitude towards anti-drug abuse had higher sense of self-efficacy as well as reduced parental stress.

Table 3.18a: Anti-drug attitude at pre and post test for control and experimental group for the three groups of parents (N=437)

Control	**Group**	**Mean**	**Std. Deviation**	**Between Group F**	**Post Hoc.**	**Within Group t**
Pre-Test	GenP	5.47	.970			
	RiskP	5.71	1.114	2.317)	--	GenP: 1.15
	DrugP	5.25	1.152			
Post-Test	GenP	5.68	.919			RiskP: -1.964
	RiskP	5.72	1.027	7.341**	GenP<DrugP RiskP<DrugP	
	DrugP	6.50	.590			DrugP: -4.88
Experimental	**Group**	**Mean**	**Std. Deviation**	**Between Group F**	**Post Hoc.**	**Within Group t**
Pre-Test	GenP	5.47	.970			
	RiskP	5.71	1.114	2.317	--	GenP: -1.301
	DrugP	5.25	1.152			
Post-Test	GenP	5.68	.919			RiskP: -.14
	RiskP	5.72	1.027	7.341**	GenP<DrugP RiskP<DrugP	
	DrugP	6.50	.590			DrugP: -5.152**

Note. * p <0.05, ** p < 0.01

Table 3.18b: Analysis of correct responses for anti-drug attitude at pre and post test for experimental group (%) (N = 209)

No. of Correct responses	GenP (N = 62)		RiskP (N = 123)		DrugP (N = 24)	
	Pre	Post	Pre	Post	Pre	Post
0-2	1.6	1.6	4.1	1.6	0	0
3-5	24.2	16.1	23.6	15.4	58.3	4.2
6-7	74.2	82.3	72.4	82.9	41.7	95.8

Table 3.19: Analysis of correct responses for anti-drug attitude and its relation with other major variables at post-intervention for experimental group (N = 209), mean (SD)

DATT	PSS	PSOC	DRS	COHES	SELF-COM	DBEH	ATSC
0-2 #	55.00	34.00	18.00	4.00	2.00	2.00	56.00
	(--)	(--)	(--)	(--)	(--)	(--)	(--)
3-5	60.11	28.57	16.35	3.32	2.70	16.54	38.16
	(10.49)	(5.37)	(1.53)	(.98)	(.89)	(5.38)	(30.51)
6-7	57.01	28.38	16.33	3.29	2.62	18.31	34.75
	(11.62)	(5.44)	(1.91)	(.92)	(.86)	(3.36)	(27.20)
F	1.66	.55	.43	.29	.45	11.51**	1.03

only one parent was in this category thus SD was not presented

Note. DATT = Drug attitude, PSS = Parenting Stress Scale, PSOC = Parenting Sense of Competence Scale, DRS = Dyadic Relationship Scale, COHES = Perceived Family Cohesiveness, SELFCOM = Parental self efficacy, DBEH = Drug knowledge, ATSC = Averaged time spent with child/week (hrs), * p <0.05, ** p < 0.01

11.8 Parenting Style

11.8.1 The parenting style adopted by the parents was assessed by three questions (see note in Table 3.20a). An overview of the three groups of parents under the experimental and control conditions at pre-intervention showed that authoritative and authoritarian parenting styles were the dominant parenting styles among the three groups. GenP consistently reported the highest proportion of authoritarative style, followed by authoritarian style. In comparison to GenP and RiskP, DrugP consistently showed the highest proportion of permissive and neglectful parenting style.

Table 3.20a: Parenting style among the three parent groups at pre-test (%) (N = 437)

	Parenting Style	GenP (n = 128)	RiskP (n = 243)	DrugP (n = 66)	X^2
Q1	Authoritarian	21.1	21.2	15.4	56.001**
	Authoritative	75.8	67.6	44.6	
	Permissive	2.3	7.9	26.2	
	Neglectful	.8	3.3	12.3	
Q2	Authoritarian	19.7	19.8	31.8	26.270**
	Authoritative	78.0	62.4	53.0	
	Permissive	.8	8.3	4.5	
	Neglectful	.8	7.0	9.1	
Q3	Authoritarian	2.3	8.2	25.8	44.941**
	Authoritative	86.7	80.2	51.5	
	Permissive	9.4	8.2	25.8	
	Neglectful	.8	2.1	7.6	

Note. * p <0.05, ** p < 0.01

Q1: If your child grew taller and need a change of clothes, what would you usually do?

Q2: If your child failed to hand in homework assignments, what would you usually do?

Q3: How do you manage your child's relationship with other friends or classmates?

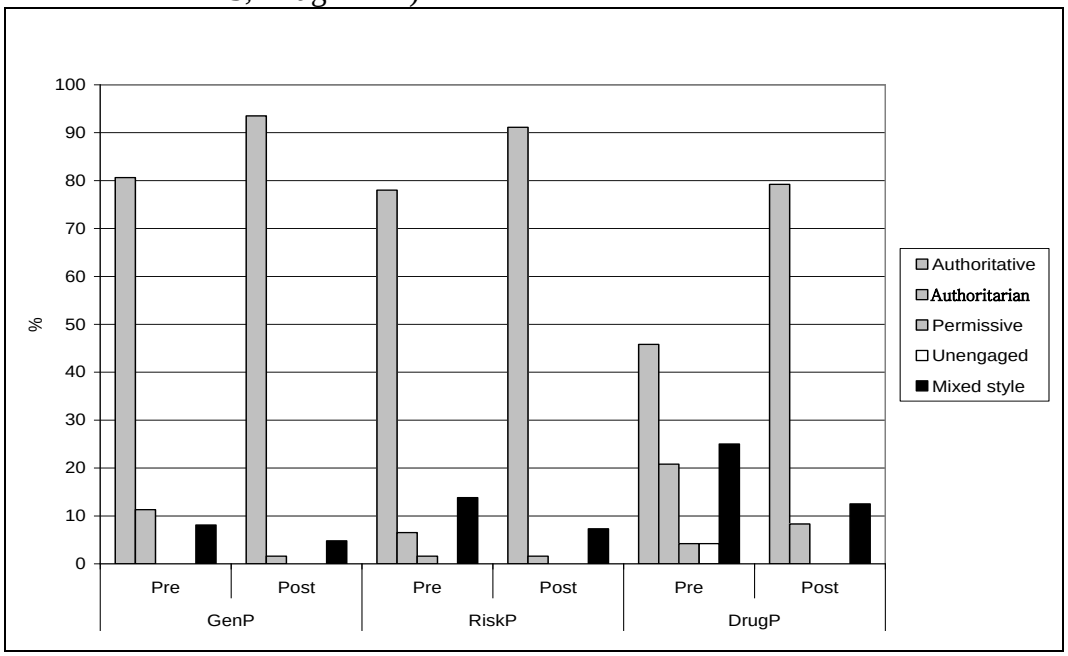
11.8.2 To better address different patterns in responses to the three questions on parenting style, attempts were made to regroup the responses into two groups, namely "closely matched" and "mixed style". "Closely matched" group defined those parents who endorsed the same style of parenting for at least two of the three questions, and their most often endorsed style was named as the final parenting style. Those who endorsed different parenting styles for all of the three questions were categorized into the "Mixed style" group. Using this new grouping, Table 3.20b provides an overview of the percentages of parenting style for the three groups of parents in the experimental and control group at pre and post test. Figure.3.4 and Figure. 3.5 provide a pre-post intervention comparison of parenting style for experimental and control groups respectively.

11.8.3 Results showed that while parenting style remained similar at pre and post intervention for control group, parents in the experimental group showed an increase in authoritative parenting and a decline in authoritarian, permissive and unengaged style at post intervention. Moreover, parents in the experimental group showed no more permissive or neglectful parenting style at post test. In addition, the amount of authoritative style of parenting was about 20% more in the experimental group than the control group at post test.

Table 3.20b: Re-grouped parenting style among the three groups of parents in the experimental group at pre and post test (%) (N=437)

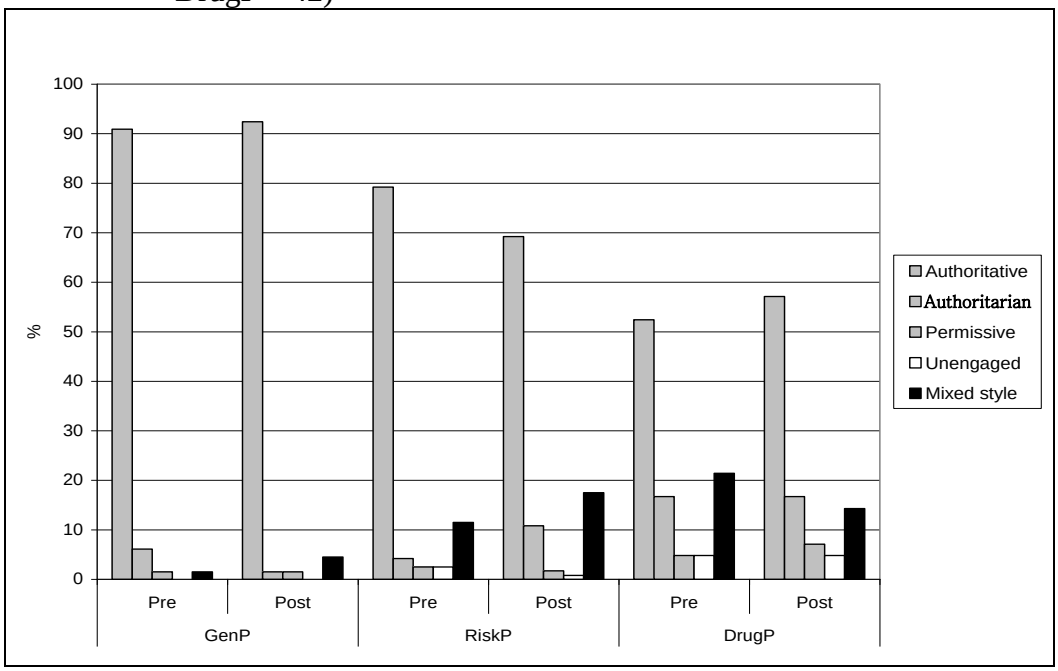
Experimental	GenP (n=62)		RiskP (n=123)		DrugP (n=24)	
	Pre	Post	Pre	Post	Pre	Post
Authoratrian	11.3	1.6	6.5	1.6	20.8	8.3
Authoratative	80.6	93.5	78.0	91.1	45.8	79.2
Permissive	0	0	1.6	0	4.2	0
Neglectful	0	0	0	0	4.2	0
Mixed style	8.1	4.8	13.8	7.3	25.0	12.5
Control	GenP (n=66)		RiskP (n=120)		DrugP (n=42)	
	Pre	Post	Pre	Pre	Post	Pre
Authoritarian	6.1	1.5	4.2	10.8	16.7	16.7
Authoritative	90.9	92.4	79.2	69.2	52.4	57.1
Permissive	1.5	1.5	2.5	1.7	4.8	7.1
Neglectful	0	0	2.5	.8	4.8	4.8
Mixed style	1.5	4.5	11.7	17.5	21.4	14.3

Figure 3.4: Pre and post intervention comparison for the three parenting style questions on experimental groups (N = 209, GenP = 62, RiskP = 123, DrugP = 24)



Q1: If your child grew taller and need a change of clothes, what would you usually do?
Q2: If your child failed to hand in homework assignments, what would you usually do?
Q3: How do you manage your child's relationship with other friends or classmates?

Figure 3.5: Pre and post intervention comparison for the three parenting style questions on the control groups (N = 228, GenP = 66, RiskP = 120, DrugP = 42)



Q1: If your child grew taller and need a change of clothes, what would you usually do?
Q2: If your child failed to hand in homework assignments, what would you usually do?
Q3: How do you manage your child's relationship with other friends or classmates?

11.9 Retention factors that enhance parents' participation in program

11.9.1 After intervention, parents were asked about the factors that would retain their attendance in the programs. Table 3.21 shows that all three types of parents ranked program content, workers' attitude and skills, group format, daily life illustration and provision of lesson handouts to be the most important retention factors. The provision of gifts and souvenirs were only more important for the DrugP.

Table 3.21:Retention factors for GenP in the experimental group (%) (N=62)

	Rank order in descending priority		
Variables	GenP (% Agree)	RiskP (% Agree)	DrugP (% Agree)
Program content	1(100.0)	1 (99.2)	2 (95.8)
Worker's attitude	1(100.0)	1 (99.2)	1 (100)
Worker's skills	1(100.0)	1 (99.2)	1 (100)
Group as format	2(98.4)	2 (97.6)	1 (100)
Concepts illustrated by daily examples	2(98.4)	1 (99.2)	1 (100)
Provision of lesson notes	3(83.9)	3 (90.2)	5 (79.2)
Encouraged by others	4(82.3)	4 (86.2)	4 (83.3)
Provision of certificate	6(66.1)	5 (76.4)	5 (79.2)
Provision of refreshment	7(50.0)	6 (70.7)	6 (70.8)
Provision of gift/voucher	8(38.7)	7 (48.8)	3 (91.7)

Note. Agree included parents who rated 'agree' or 'strongly agree'

11.10 Perceived Program Effectiveness

11.10.1 At post-intervention, the three groups of parents were highly satisfied with the program and rated positively on most of the 15 variables on perceived program effectiveness. Compared with Chapter 3 section 13 on their reported recruitment attractions at the pre-intervention stage, there is a shift of appreciation of the drug specific program content and parenting skills instead of the program logistics (date and time).

11.10.2 Table 3.22 showed a break down of perceived program effectiveness among the three groups of parents. All GenP strongly agreed or agreed that the following criteria were fulfilled by the program that they had joined, namely to learn more about the trend and impact of adolescents drug abuse, know how to detect early signs of child drug abuse, know and obtained more resources for help seeking, gained skills to communicate with child, handle parent-child conflicts and suitable venue. Similarly, all RiskP were strongly agreed or agreed that the program that they had joined had helped them to learn more about the trend and impact of adolescent drug abuse, learn to detect early signs of child drug abuse and understanding of youth culture. All DrugP were strongly agreed or agreed that the program helped them to learn ways to prevent child abuse, learn to detect early signs of child drug abuse, understand more about inter-generational drug abuse, understanding youth culture, master the skills to communicate with their child, handle parent-child conflicts, and could do so with optimism. Finally, all DrugP agreed that the program facilitate them to handle stress and emotions better.

Table 3.22: Perceived program effectiveness reported by GenP, RiskP and DrugP on 15 items (N=209)

Variables	GenP	RiskP	DrugP
	13 items achieved 98-100% rating	9 items achieved 98-100% rating	10 items achieved 98-100% rating
Component to enhance ability for drug abuse prevention			
Learn more about the trend and impact of adolescent drug abuse	100.0	100.0	95.8
Know how to prevent child drug abuse	98.4	99.2	100.0
Know how to early identify child drug abuse	100.0	100.0	100.0
Get more resources for help seeking	100.0	99.2	95.8
Know more about intergenerational drug abuse	98.4	98.4	100.0
Component to enhance parenting skills			
Know more about youth culture	98.4	100.0	100.0
More skillful to communicate with child	100.0	95.9	100.0
More tactful to handle conflict	100.0	97.6	100.0
More skillful to manage child problem behavior	98.4	94.3	95.8
More optimistic to deal with child problem behaviors	98.4	98.4	100.0
More skillful to handle emotion and stress	93.5	95.1	100.0
Logistic arrangement			
Suitable date and time	95.2	96.7	95.8
Suitable venue	100.0	97.6	100.0
Program content fulfills my needs	98.4	98.4	95.8
Satisfactory performance of workers	98.4	98.4	100.0

Note. % was based on parents who "Agreed" or "Strongly Agreed" with the above variables

11.11 Staff feedback from collaborative units

11.11.1 At the end of the program, quantitative and qualitative data were collected from the staff of the collaborative units to evaluate their impression on the programs, and the experience of collaboration. All concerned colleagues from the collaborative units were satisfied with the performance of the program instructors and indicated needs for program continuation. Likewise, 22 out of 23 workers said that they welcomed collaboration in the future. The one staff who indicated reservation felt the program was too long, and would be happy to participate if the program was shorter. Collaborative staffs on average took 0.5-1 month to complete the recruitment process with the main source of referrals coming from the social workers or teachers' own networks (69.6%).

11.11.2 Nine staff gave feedback regarding the discouraging factors in recruitment and gave the following suggestions accordingly:

a. Parents would be less motivated when their child already had behavioral problems thus anti-drug prevention should begin earlier.

b. Some children already displayed problem behavior at the age of 8-9 thus future programs should include parents with younger children.

c. Some parents who signed up for the program dropped out before the beginning of the program. Therefore, the recruitment period should not take too long, say over a month.

d. Parents often lost contact after participation in the program. Thus more frequent telephone follow-up should be used to enhance participation.

e. Regarding program content, staff in general considered the followings to be the most essential to increase parents' participation, namely 1) direct teaching of methods to improve communication/relationship with child and problem solving skills; 2) educate parents regarding the different types of addictive behaviors and its development; and 3) the use of daily examples while explaining concepts.

11.12 Workers' observation

11.12.1 Program content:

a. Target service recipients were excellent informants on program content: When the research team began to develop the program, some target participants were invited to share what were their primary concerns in attending parenting education, and whether the planned course fulfilled their needs. Their constructive feedback helped to confirm the blueprint of the program content.

b. Pilot testing is important to provide significant information for fine-tuning the program content. It was obvious that participants from different groups differ in their needs and interests. Therefore, basic and advanced core elements were generated for the 3-level intervention to carter different needs of participants.

c. GenP were most concerned about their children' academic performance instead of drug prevention. More efforts have to made to enhance their awareness and interest, e.g. by citing examples of drug-abuse problems in Band One schools.

d. RiskP were most concerned about skills in managing the at risk behavior of their children, early identification of such problems and how to seek help. Many RiskP reported that the session on stress management catered for their needs and some of them requested to move that session earlier.

e. DrugP were most diversified in their background, needs and interests. Some seemed rather ignorant in basic child care and needed information on environmental safety and child welfare. Some were interested in promoting quality parent-child communication. The importance of preventing intergenerational drug abuse and strategies in achieving such prevention were emphasized o the DrugP.

11.12.2 Program participants

a. Hard to reach parents: It was observed that fathers and working parents were very hard to reach. Mothers shared that most of their spouse thought that it was useless, boring or unnecessary to attend such parenting program.

b. Hard to change parents: It was often found that parents with limited education, limited social exposure, reluctance to reflect on their current parenting practice, or were occupied by family problems and mental illness were more difficult to improve through the program even when their attendance was satisfactory. This shows that the two to four group program was insufficient to help these parents, and case work back up from family service centres will be useful.

c. Obstacle to parents' continuous participation in the program: Some participants reported that the unsupportive manner of their partners and the deteriorating performance of their child discouraged them to try what was learnt further.

d. Commitment to program completion: Most GenP and RiskP had the sense of responsibility to attend all sessions once they enrolled. DrugP's commitment was much weaker for various reasons, ranging from poor memory to disordered daily living pattern.

e. Research mindset of parents: Most of the parents were willing to cooperate in providing information for research. But the length of the questionnaire and some terminology posed difficulties for them. Some parents could only complete the questionnaire when the questions were read to them and this arrangement has manpower and time management implications.

11.12.3 Program implementation

a. Program title should avoid stigmatization: Sensitivity towards anti-drug prevention: many participants said that even when they recognize the need to learn more about drug-abuse prevention, they would not enroll for programs with such explicit purpose. The title and objective (i.e. parenting and anti-indulgence) of the current program provides the appropriate cover.

b. Motivating strategies: The strategies adopted were effective in motivating parents to join. For example, RiskP with problematic youth were more motivated to join after the encouragement from their caseworkers. Some DrugP would remind workers about the supermarket coupon whenever they attended the program, but they insisted that they also came to benefit from the group because spending 8 hours to get a $50 coupon was not enough as an incentive.

c. Roles of workers: When participants built up relationship with the workers, they shared family or personal problems with the workers

to seek help. Workers have to keep to the parent educator role and effectively connect these parents to caseworkers or other community resources for follow-up.

Chapter 4
Discussion and Recommendations

1 **The Narcotics Division funded this study to address the following objectives:**

1.1 To assess the extent of parents' involvement in existing drug prevention activities in Hong Kong and to study factors that motivate/discourage parents from being involved; and

1.2 To develop and implement preventive and education programs with a view to:

1.2.1 equipping parents (particularly parents of vulnerable youth) with the necessary knowledge and skills to advise and help their children when they come across drug related problems; and

1.2.2 arousing the awareness of drug-taking parents about the severe negative impacts of their drug-taking habits on the upbringing of their children so that they would be motivated to stop inter-generational drug abuse.

1.3 To consolidate relevant experience and documents/materials for the proposed programs and evaluate their effectiveness.

2 Phase I parents survey and Phase II focus group discussions yielded representative information from 5712 parents with children aged 11 to 21 on the extent of parents' involvement in existing drug prevention activities in Hong Kong and identified factors that motivated or discouraged the parents' participation and awareness of such programs.

2.1 Parents' participation in drug prevention programs in Hong Kong

2.1.1 Only 2.3% of the 5612 parents from the school samples and 12% from the 100 parents with drug-taking history participated in such programs in the past 12 months. Participated parents were mostly mothers and with focal child with mean age at around 11-12 and 14-15 studying in primary and secondary school respectively. Although low participation and awareness rates, especially by fathers, were generally observed in all parent education and drug-prevention programs, the current evidence indicates that more efforts are needed in early prevention to attract the attention of primary school parents, and parents who have children in more senior forms of secondary school. Fathers remain a challenging but necessary target group for parent education programs.

2.1.2 Consistent with Western findings (Redmond, Spoth, Shin & Hill, 2004), parental participation was motivated by sensitivity to some

behavior problems of the focal child, including adverse impact on learning, child become tired easily, worsened relationship with family members and truancy. RiskP were therefore consistently more motivated to participate than GenP (Cunningham et al., 2000; Perrino et al., 2001). However, both types of parents showed insufficient sensitivity to other apparently milder child behavior problems that can also be related to drug abuse. So, continuous and more effective promotion showing clearly the early and inconspicuous signs of drug abuse is still needed.

2.1.3 Parental participation was discouraged by logistic inconvenience, fear of stigma, and belief that the focal child had no drug abuse problem. Overseas literature (Garvey, Julion, Fogg, Kratovil & Gross, 2006) suggested that the logistics problems were most challenging for low income parents who had less flexibility in work time. For Hong Kong parents, even greater flexibility in program implementation in terms of timing (outside regular work hours), venue (in the workplace, or in schools where parents must visit to collect their children's academic reports) or format (web-based materials) needs to be considered. To reduce the stigma, more active promotion of such programs by professionals trusted by parents (like teachers and social workers) should be helpful. Some of the recent efforts to conduct anti-drug dramas in schools can also be extended to benefit their parents as well.

2.1.4. Compared with DrugP who have participated in anti-drug prevention program in the 12 months, DrugP who never participated in such programs named more reasons or excuses for non-participation. They need to be further alerted to the importance of inter-generational drug-abuse, especially when evidence in the current study indicated that quite a number of them would keep drugs at home, did not make a point to prevent their children's casual access to such drugs, or even underestimated that their drug-taking behavior would affect their children's academic performance, conduct and emotional status.

2.2 Parents' awareness of drug prevention programs in Hong Kong

2.2.1. Nearly 30% of the school sample parents reported awareness of drug prevention program in the past 12 months compared with 45% of those of DrugP. Again, the school sample parents who were aware of the anti-drug programs were mostly mothers with children in junior secondary school, spent more quality time with their children and claimed higher level of family cohesion. This suggested that more efforts should be made to enhance the awareness of fathers, and parents who claimed less favorable family context conditions.

2.2.2 Parental awareness was motivated by sensitivity to a number of adolescent at-risk behavior, including adverse impact on learning, worsened relationship with family, easy to become tired, truancy, psychotic-like symptoms, and smoking.

2.2.3 Parental awareness was discouraged by belief that the focal child had no drug-abuse problem, fear of affecting child's future development, and some logistics concerns. About one-third of the school sample parents claimed there was insufficient publicity of such programs. Also 25.8% of the aware parents and 32.8% of the unaware parents claimed they did not know how to manage and seek help should they have problems with their focal child. These indicate services to parents with adolescent children need to be more widely publicized to promote their awareness and readiness to seek help.

2.3 Parents' preferences for future drug-prevention programs

2.3.1 All parents preferred the program logistics to be flexible to match their available time (e.g. weekends, afternoons) and convenience in access (nearby schools and community centres). A majority of them preferred talks and seminars by professionals, and so the multi-session group format set out to be tested in this project is a demonstrated challenge. DrugP seemed to be interested in more variety in format and expressed greater need for additional arrangements such as financial support (i.e. travel allowance), provision of leaflets/booklets on drug prevention and refreshments during program.

2.3.2 While most school sample parents preferred future program's content to cover the nature of psychotropic drugs, its negative consequences, ways to improve parent-child relationship and strategies to discuss drug abuse with their children, DrugP wished to include more sharing of parenting experiences by those with a history of drug-use, more opportunity to participate in parenting support groups and to be introduced to local drug counseling resources. Program organized by social services or Government agencies were most welcome by the parents. Resources in this project did not allow arrangements of visits to drug rehabilitation projects. But such package should be introduced to PTAs in schools so that some might arrange visits to such projects.

2.3.3 The focus group discussions confirmed most of the findings generated from the parent surveys. The informants showed sound support to try out the more demanding group format in the parent education program, and proposed many micro skills in the recruitment of applicants and the retention of participants. Emphasizing the need for early prevention, helping parents' to set realistic expectations on themselves and their children, using a

strength rather than problem-based approach, and using more interactive group processes to generate group members' mutual support and learning were found to be useful reminders in program development.

3 Phase III program development and evaluation

3.1 Programs catered for different levels of prevention

3.1.1 As requested by the Narcotics Division, the parent education programs developed in this program have to address the needs of three types of parents: parents with no at risk children, parents with at risk children, and parents with drug-taking history, and the programs have to take multiple-session format.

3.1.2 As a result, three different programs for each of the parenting group, catering for primary, secondary and tertiary levels of prevention were developed. Program development was guided by the eight useful principles proposed by Nation et al.(2003) and Dusenbury (2000). They include: theory-driven, comprehensive, sensitive to developmental needs of parents and youth, culturally sensitive, sufficient coverage, interactive techniques, trained staff and evaluation. These principles were found to be useful and practical in program development.

3.2 Programs were theory and culture-based

3.2.1 Theoretical premises like the ecological system theory, risk and protective factors, models on determinants of parenting behavior, positive psychology, learning theories, cognitive behavioral theory and group theory informed the program development.

3.2.2 Some team members' training in 2006 in the Australia-based Triple-P positive parenting program further enhanced their use of some cognitive-behavioral principles, community health and multi-level approaches in the preparation of the program. Some modifications were needed to suit the culture in Chinese families (e.g. clearer explanation and more encouragement were needed to help the parents be more willing to use praise and to consider win-win tactics rather than giving directions to their children).

3.2.3 The program instructors' experience in professional training and practice, information generated in the parent survey and focus group discussions, as well as pilot run of the programs informed the workers to polish the program into their final implementation form.

3.2.4 Immediate reflection on program logistics and delivery after each session also helped the program instructors to ensure quality and standardized delivery of the program across the extended time of the evaluation study. The adjustments for program delivery for the DrugP were carefully monitored to ensure program quality.

However, as the DrugP proved to be a very unique group with the highest drop-out rate and lowest program attendance, it is necessary to assume more tailor-made tactics to engage their completion of the programs.

3.3 Guidebooks and manuals were comprehensive and user-friendly

3.3.1 This project created four manuals, which included a Guidebook for program instructors and a manual for each of the three types of target parents: GenP, RiskP and DrugP.

3.3.2 The Guidebook outlined the background and conceptual framework of the program design and important principles in program recruitment, preparation and delivery. It also incorporated the program evaluation questionnaires and a summary of the key findings.

3.3.3 The Manuals contained level-specific tips on recruitment, preparation and program delivery, as well as details of the sessions for each of the three-level programs. The relevant presentation powerpoints, handouts and worksheets were compiled into ready-to-print format to facilitate immediate implementation of the content.

3.4 Evaluation study was rigorous

3.4.1 Randomized control trial study was adopted in the experimental design of this evaluation study. It posed a big challenge to program recruitment and implementation but was achieved with the great efforts from the project team and the generous cooperation of the collaborating organizations, which reported a lot of expressed needs from parents to help them fight their children's indulgence on games, spending, etc. Recruitment was found to be the most challenging over the summer holidays when the families were expected to be more mobile.

3.4.2 Valid and reliable scales previously used in local setting were utilised to demonstrate program effectiveness in this study. The sound psychometric properties of the major scales adopted were confirmed in this study with correlations of relevant variables in the right directions, and reliability estimates (Cronbach Alpha) all above .70. The systematic methodology and reliable measures significantly strengthen the validity and generalizability of the current findings.

3.5 Evaluation findings were positive

3.5.1 The randomized control trial study results yielded very encouraging results on the effectiveness of all programs.

3.5.2 The GenP experimental group participants showed significant improvement over the control group participants on two of the seven outcome measures, namely parental competency and relationship with the focal child. This is very encouraging in view of the small sample and the relatively short duration of a two-session group program. This is recommended to be offered as universal program in schools.

3.5.3 The RiskP experimental group participants showed significant improvement over the control group participants on five of the seven outcome variables, namely drug knowledge, parental stress, parental competency, relationship with child and perceived sense of self-efficacy. This is a fruitful demonstration that the program achieved the mission posed by the Narcotics Division to equip parents (particularly parents of vulnerable youth) with the necessary knowledge and skills to advise and help their children when they come across drug related problems. It is most exciting to find that these parents were empowered by the four-session program to feel more competent to manage their adolescent children's problems. It is expected that such energy will also encourage their motivation to watch out for and participate in similar parent education programs in the future.

3.5.4 The DrugP experimental group participants showed significant improvement over the control group participants on three of the seven outcome measures, namely drug attitude, relationship with child, and perceived sense of self-efficacy. Again, these results showed that the four-session program was able to achieve the commissioned target in arousing the awareness of drug-taking parents about the severe negative impacts of their drug-taking habits on the upbringing of their children so that they would be motivated to stop inter-generational drug abuse.

3.6 Participants perceived programs to be effective

3.6.1 The participants' high level of satisfaction was reflected by parents' generally high ratings for perceived program effectiveness and perceived benefits after intervention. More specifically, the three types of parents were most satisfied with the instructors' performance, and found the program content useful to enhance their knowledge of adolescents' drug abuse, adolescents' culture and impact of drug abuse on their child.

3.6.2 They also reported increased ability to communicate with their child, detect early signs of drug abuse and its prevention, emotional management and more appropriate used of award and punishment. The positive feedback from collaborative units' workers also confirmed the success of this program. Their eagerness to join in this program in the future reflected not only the effectiveness of program, but also the high demands and needs of local parents.

3.7 Risk factors identified in intergenerational drug abuse

3.7.1 Apart from pre-post intervention comparison, this study helped to identify some of the potential risk factors to intergeneration drug abuse. Findings from DrugP showed that they achieved the highest level of drug knowledge at pre-test. However, over half of DrugP expressed that they would keep their drugs within easy reach of their children (i.e. in the refrigerator, unlocked drawer). This indicated that the DrugP have the needed knowledge but lack the self-discipline to protect their children from drugs.

3.7.2 Similarly, despite their awareness that their drug taking behavior would have a negative impact on their children, about a-fifth of the DrugP reported to have no time to mange their child's problem. DrugP also adopted the most permissive and neglectful style of parenting compared with the other types of parents. Expectedly, they reported to spend the least quality time with their child. It is clear there is a need to step up the counseling work on the DrugP to help them acquire the attitude and skills in parenting.

4 Limitations of the study

4.1 Uneven representation of mothers and fathers: In the school sample survey, the GenP and RiskP groups were over-represented by mothers, while the DrugP survey respondents and program participants were over-represented by fathers. Although this gender ratio closely matches with the general pattern of parent education participation in Hong Kong, and the Narcotic Division's figures on adults' drug abusers, more efforts have to be made to attract fathers to be more alert to anti-drug programs.

4.2 Difficulties in DrugP's recruitment: The response rate in Phase III from NGOs was about 30% and the most frequent feedback from participated NGO's was the unavailability of drug-used parents with child whose age matched with our inclusion criteria (age 9-21). Furthermore, some of the DrugP who resided in hostels were not ready to participate since they were already engaged in some form of drug abuse treatment. The DrugP's more irregular participation patterns also somehow hampered the comparability between the DrugP program with the GenP and RiskP programs.

4.3 Questionnaires confined to be brief: The questionnaires in the survey and the evaluation study had to be cut to a bare minimum to cover the numerous variables to be explored in this pioneer study, and to enhance the completion rate. For example, only sub-scales instead of full scales could be used to measure parent-child relationship as well as parental competency, and single items had to be used to measure sense of parental self-efficacy and perceived family cohesion. In future studies with more specific focus, more proper measurements can be adopted.

4.4 Brief GenP program: Given the lack of time and resources, a brief program of two sessions was devised for GenP compared to a more comprehensive program of four sessions for RiskP and DrugP. The briefness and short lapse between pre and post intervention would reduce the likelihood of observing significant improvements, especially on items that takes time and practice for positive progression (i.e. perceived level of family cohesiveness and attitude towards drug abuse). Nevertheless, the fact that GenP still showed significant improvement on stress level, sense of competency, parent-child relationship, drug knowledge at post-intervention reflected that the current program delivered by the current team of parent educators could still achieve sufficient intervention intensity even with brief parenting program. It must be acknowledged that the program instructors' experience, attitude and skills were pivotal for less intensive programs to achieve the intended effect.

4.5 Program monitoring requires intense resource: The heavy reliance on staff quality was reflected by the parents' high ratings on worker's attitude and performance as one of the determinants of program effectiveness. The program instructors for this study have attended Triple-Ps Level 3 and 4 training thus are well equipped with the necessary skills to conduct parenting programs. However, the instructors' attitude is often more difficult to monitor than their skills. This study has paid specific attention to this by using close monitoring and supervision during and between sessions. In addition, mutual sharing group was held after each session by the program instructors to refine performance. The resource implications for such efforts at quality assurance must not be under-estimated in future program provisions.

4.6 Worker variable not adequately studied: The variation of program workers may affect program outcome based on the differences in personal factors such as attitude, characteristics and level of enthusiasm. In this study, all the groups were conducted by the same workers. On one hand, the design of this study allowed consistency and reduced likelihood of the data being compromised by the possible variations in workers' characteristics. On the other hand, the effect of differing workers could not be explored properly. Secondly, in view of the limited time and resources, the sustained effect of this program could not be explored through longitudinal study design.

4.7 Parents were the major data source: This study only obtained outcome measures from the parent participants but not from the children or other family members. There was more reliance on quantitative rather than qualitative data to demonstrate program effectiveness. Finally, the participants of this study were limited to parents with children aged ranged from 9-21 with restricted number of sessions and group formats. Future studies should extend the sample, format and number of sessions to examine the usefulness of anti-drug prevention program. The extent

to which this program can be adapted to other types of addictive behavior is also worth exploring.

4.8 More advanced statistic testing can be used: It is acknowledged that the three types of parents in this study could be interpreted as nested data (i.e. individuals tend to share certain characteristics) thus the observations based on these individuals were not fully independent. The use of Hierarchical Linear Modeling could be used to further test these issues. However, the complexity of the analysis was beyond the scope of this study.

5. Implications and Recommendations

5.1 Overall, the results of this pioneer research study suggest that anti-drug prevention program targeting for parents is effective in enhancing parental competency, drug knowledge and attitude, reducing parenting stress and increasing positive parenting practices among Chinese parents in Hong Kong. Given such encouraging evidence on the effectiveness of the current program with Chinese parents, the research team would like to make some recommendations on policy, service and research.

Policy Implications:

5.2 Parents should be treated as one of the key stakeholders in drug prevention work

Given that parents are the primary agents to facilitate the healthy physical, psychological, social and moral development of children, such low participation and awareness rate is very unacceptable though not surprising. While such phenomenon could be partially attributable to the low sensitivity and lack of motivation of the parents, the inadequate promotion and provision of programs tailored for parents must also be noted. In the 4th 3-year Plan on Drug Treatment and Rehabilitation Services in Hong Kong, parent began to be treated as one of the stakeholders. In the Task Force on Youth Drug Abuse which is recently set up and led by the Secretary of Justice, the importance of targeting parents in drug prevention work has still to be geared up.

5.3 Family approach is needed to deal with adolescent drug abuse

In the latest policy address, the Chief Executive of HKSAR clearly stated that the provision of social services has to be planned from a holistic family approach. Families should be strengthened to meet the needs of the family members. From this perspective, target of drug prevention and treatment could not be confined to drug abusers but also their family members.

5.4 Anti-drug activities for parents should be included in regular social services

Currently, there are five region-based Counseling Centres for Psychotropic Substance Abusers (CCPSA) which aim at providing a

wide range of anti-drug services in the community. However, parents have not been recognized as one of the service targets and therefore, no resource is allocated for anti-drug program to parents. Occasion advocacies are piecemeal and often ineffective. The project team suggests that anti-drug program to parent should be included in the normative service provisions of social service agencies with matching resource allocations, so that parents can receive general anti-drug program without stigmatization and parents with at-risk children on drug abuse and parents having drug taking history can also be served intensively.

5.5 Extensive and multi-method publicity work needed to penetrate different types of parents

Existing anti-drug publicity works mainly target at young people. These include the API produced by the government, and relevant posters and leaflets on drug abuse. The low parent participation (2.3%) and awareness rate (27%) in drug-abuse programs revealed in this study pointed out clearly that parents must be included immediately as key targets for propaganda. This study further demonstrated that different types of parents have different concerns and can be accessed and attracted differently. More target-specific strategies suggested by the informants and respondents in this study should provide ample information on how to launch publicity work more effectively.

5.6 Parenting programs for DrugP should be strengthened for prevention of inter-generational drug abuse problem

The DrugP in this study admitted that their drug taking behavior would detrimentally affect their children's life, including family financial condition, academic performance, the likelihood of accepting drug abuse behavior, emotions and parent-child relationship. However, 52% of the DrugP respondents in Phase I study continued to place their drugs at home despite running the risk of ready access by their children. This reflects their low level of awareness of the problem of inter-generational drug abuse. In addition, the project team also noticed that parent education and support programs have substantial room for improvement in the drug treatment centres like Methadone Clinics frequently visited by the DrugP. More specifically, both the physical facilities and professional support for these settings must be stepped up to capture the fleeting motivation of this very vulnerable group of parents.

5.7 Early prevention and intervention are necessary

From the Central Registry of Drug Abuse Fifty-sixth Report issued by the Narcotics Division, it is known that the mean age of first abuse of drug of youngsters under 21 is in a descending trend from the mean age 18 in 2005 to 15 in 2006. In this study, some of the collaborating agencies have raised that there is service demand on drug prevention program for the parents with child aged below 10. Such explicit expressed need for a downward extension of drug-prevention work

should be sufficient alert that early prevention work should be further extended to primary schools instead of merely focusing on secondary school students.

Service Implications:

5.8 Evidence-based effective strategies have been identified and should be used to engage parents in anti-drug work

Findings from Phases I and II of the current project clearly identified factors that motivate and deter parents from attention anti-drug programs. Parents were excellent informants in program development, and their specific suggestions collected in the program planning and pilot testing stages were found to be most useful in program promotion and program fine-tuning. Such information should be seriously considered and incorporated into drug prevention or other parent education programs that carry similar challenges, e.g. threats of stigmatization, or low awareness rate. It is further suggested that collaboration with schools to provide these programs as part of the standard parent education packages should be effective in reducing stigmatization and ensuring higher rates of attendance.

5.9 Different levels and modes of intervention warrant attention and use

The programs developed in this project are designed for structured and closed-group application. The program content is also divided into core and non-core components that address flexibility in program implementation. It is obvious that the program can be easily edited into mass program and even media presentations. However, should the target group be parents with at risk youths or drug-using history, it is still advisable to adopt the multi-session closed group format to more firmly engage the parents to solicit and benefit from the instructors and group members' input.

5.10 Systematic training to anti-drug workers both on program design and skills on intervention evaluation

According to the findings in Phase III, the attitude and skills of the workers are ranked as the two most important factors affecting the participants' retention of the program benefits. Indeed, the quality and the skills of the group leader significantly affect the program effectiveness, and also the welfare of the parents who expressed needs for help. Although a practice manual will be published in this study, systematic training on the articulation of the program in actual practice is vital to ensure program effectiveness and to build up practice wisdom in this field. Moreover, it is most beneficial that if an evaluative study can be included in these programs to refine program execution, update program content that will match with the needs of parents and to provide insight on how to improve parental involvement in anti-drug work.

Research Implications:

5.11 Longitudinal studies are needed to demonstrate program effectiveness and sustainability

This study involving three Phases has been completed in two years. Firstly, the time constraint imposed difficulties to follow up on parents' progress after this study. Secondly, since some of the parents have already participated in anti-drug prevention activities before, the effectiveness of this program may be compromised and intervention's effect could not be differentiated clearly. Therefore, resources must be provided for longitudinal study in the future to further examine the sustainability of the effectiveness of the programs.

5.12 Research attitude of workers and parents

Social services professionals in Hong Kong are showing increasing subscription to evidence-based practice. However, enlisting their readiness and effective participation in the research process still has a journey to go. This study has adopted a very demanding randomized-control study design to establish program effectiveness and even efficacy, and it is a very positive sign that the majority of staff in the collaborating agencies appreciated the effort and committed to support similar programs in the future. It is also noticed that many parents appreciate the need to conduct research and were cooperative in providing information. However, sometimes they were deterred by the length and the wordings in the questionnaires. These also point to the need to develop locally-sensitive and user-friendly research instruments to facilitate research on parents.

Major Recommendations:

Parents are key stakeholders in drug prevention work but this project has yielded clear evidence on their very limited participation and awareness of such programs. This project has produced a goal- and theory-driven and local program which has been demonstrated through randomized control-trial efficacy study to be effective in enhancing parents' knowledge, attitude and skills in anti-drug work. It is advocated that appropriate resources to be allocated immediately to disseminate the programs to fight drug-abuse problems in Hong Kong. Dissemination should include mass production of the program packages, training of the right personnel to deliver the programs, and research resources to further demonstrate the sustainability of the program benefits over time.

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Chapter Two

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Chapter Three

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Appendix 2.1 Questionnaire for Primary School in Phase I

社會工作及社會行政學系

DEPARTMENT OF SOCIAL WORK
AND SOCIAL ADMINISTRATION

香 港 大 學
香 港 薄 扶 林 道

The University of Hong Kong
Pokfulam Road, Hong Kong

樣本，只供參考用

編號：_____
不用填寫

預防濫藥，家長何責?

家長在預防青少年濫用藥物的參與問卷（小學版）

爲深入了解及提升家長在預防子女濫用藥物的參與，香港大學社會工作及社會行政學系與東華三院越峰成長中心(該中心爲濫用精神藥物者及其家屬提供輔導與小組活動，也提供社區教育服務)正在香港各小學及中學，向年齡介乎十一至廿一歲青少年的家長進行問卷調查。研究隊現懇請閣下以**家長**的身份，填答這份有關家長參與預防青少年濫用藥物情況的問卷。

問卷共分五部份，收集的資料只作參考，雖然部分問題可能涉及閣下的私隱，但由於本調查只會探討整體研究對象的狀況，並不會將結果對應個別資料，而研究隊亦不會發表有關個別人士的資料，希望閣下能支持此調查。填妥這份問卷後，請放入附上的信封內，於兩星期內經貴子女交回學校。

填答問卷純屬自願性質，如閣下對是項調查有任何查詢，或有興趣提供更多有關資料，歡迎與東華三院越峰成長中心鍾小姐聯絡（2884 0282)。如閣下想知道更多有關研究參與者的權益，請聯絡香港大學非臨床研究操守委員會（2241 5267）。多謝合作!

香港大學社會工作及社會行政學系
副教授及研究計劃總監
曾潔雯博士

請細心閱讀及按自己對問卷內容的理解回答下列問題，並用☑或圈出最合適的答案。除特別註明外，請根據閣下過去一年之經驗作答問題。調查所得資料只作研究之用，並沒有對或錯的答案，內容亦會絕對保密，請安心作答。謝謝你的參與！

<u>第一部份：案例研究（家長對子女濫用藥物認識、尋求協助的想法及其問題的重要）</u>

以下是一個模擬的個案，試以陳大文家長的身份，回答第一部份的問題。

陳大文(男)，今年十一歲，就讀小學五年級，半年前開始有濫用藥物(如: 吸食大麻, K 仔)情況，

如果你是陳大文的家長:

1．你估計已經開始濫藥的陳大文，會有甚麼行爲表現？（可☑多項）

☐ 學業成績退步
☐ 逃學
☐ 自言自語
☐ 有思覺失調現象
☐ 常常病
☐ 其他，請註明_____
☐ 吸煙
☐ 與家人關係變得惡劣
☐ 離家出走
☐ 喜歡聽嘈吵的音樂
☐ 容易疲倦

2．當你發現陳大文濫用藥物後，你會找誰人幫助及尋求意見？（可☑多項）

☐ 配偶
☐ 自己的父母
☐ 自己的兄弟姊妹
☐ 其他子女
☐ 親戚
☐ 好朋友
☐ 鄰居
☐ 教會朋友
☐ 社會服務機構的社工
☐ 子女就讀學校的社工
☐ 子女就讀學校的老師
☐ 子女就讀學校的家長
☐ 醫生
☐ 政府部門（例如: 禁毒處）
☐ 不會找任何人幫助
☐ 其他，請註明 _____

3．你覺得陳大文濫用藥物問題是不是你家庭最關注的問題?
爲什麼?（可☑多項）

☐ 不是，因爲:
- ☐ 有其他更加值得我家庭關注的問題 (例如: 他的學業、行爲或情緒問題)
- ☐ 沒有時間關注他濫用藥物問題
- ☐ 覺得他濫用藥物問題只是暫時性，他長大後這問題就自動消失
- ☐ 其他，請註明 _____

☐ 是，因爲:
- ☐ 濫用藥物會導致其他問題 (例如: 精神病、學業或行爲問題)
- ☐ 都想花多些時間了解他濫用藥物問題，從而幫助他
- ☐ 意識到他濫用藥物會引起其他嚴重的後果，產生永久損害
- ☐ 其他，請註明 _____

第二至第五部份問題，會探討你和你子女的情況。目標子女是帶本問卷給你填答那位。

<u>第二部份: 子女情況及家長管教模式</u>

4. 你有沒有曾經懷疑該子女濫用藥物?
☐ 有 ☐ 無

5. 在<u>過去十二個月</u>，該子女曾有或做過下列事情嗎？

a.吸煙	☐多過一次	☐有一次	☐沒有	☐不知道
b.打架	☐多過一次	☐有一次	☐沒有	☐不知道
c.偷竊	☐多過一次	☐有一次	☐沒有	☐不知道
d.在父母禁止下仍深夜在外逗留	☐多過一次	☐有一次	☐沒有	☐不知道
e.離家出走	☐多過一次	☐有一次	☐沒有	☐不知道
f.逃學	☐多過一次	☐有一次	☐沒有	☐不知道
g.自言自語	☐多過一次	☐有一次	☐沒有	☐不知道
h.有思覺失調現象	☐多過一次	☐有一次	☐沒有	☐不知道
i.藏有毒品	☐多過一次	☐有一次	☐沒有	☐不知道
j.與不良朋輩在一起	☐多過一次	☐有一次	☐沒有	☐不知道
k.有自殺念頭或行動	☐多過一次	☐有一次	☐沒有	☐不知道

6. 如該子女有以上的行爲問題，你覺得你有能力有效地處理嗎?
☐十分同意 ☐同意 ☐不同意 ☐十分不同意

7. 你每週平均與該子女相處時間: _____ 小時

8. 你覺得你家庭的凝聚及團結力有幾高? (請圈出最合適的數字)
| ---------- | ---------- | ---------- | ---------- |
1 2 3 4 5
(十分低) (十分高)

9. 該子女長高了，要買新衣物換季，你通常會怎樣做?
☐ 我知道他/她的需要，我會買給他/她
☐ 我會和他/她按需要，款式及價格商量買甚麼，有時讓他/她自己買，有時和他/她一起去買
☐ 我會付錢，他/她喜歡買甚麼都可以
☐ 我不會理這些事

10. 如該子女有濫用藥物問題，有什麼因素阻礙你參加處理子女濫用藥物的活動?（可☑多項）
☐ 害怕接受子女濫用藥物的事實
☐ 恐怕其他人會知道子女有濫用藥物
☐ 害怕配偶的反應
☐ 恐怕對子女前途有壞影響
☐ 害怕被其他人看不起
☐ 自己無信心及能力去處理子女濫用藥物問題，所以避而不談，不求協助
☐ 無時間去處理這個問題
☐ 害怕子女要停學戒藥
☐ 子女濫藥不是家中重要問題
☐ 與子女根本沒有溝通，恐怕將關係變得更惡劣
☐ 不知怎樣處理及求助
☐ 其他，請註明 _____

<u>第三部份：家長參與預防子女濫藥活動</u>

11．你過去 12 個月內有無留意到政府部門或其他機構有爲家長舉辦預防子女濫用藥物活動?
☐ 有　☐ 無

12．你過去 12 個月內有無參與預防子女濫用藥物的活動?
☐ 有 (請回答第 13 題)　☐ 無 (請回答第 17 題)

13．你過去 12 個月內有否參與預防子女濫用藥物活動及其次數? 那些活動你認爲有沒有效用呢?

	有否參與? (請以 √ 表示曾參與的活動) (可√多項)	參與次數? (請填上數字)	有無效用? (請填上數字 1 至 5) 1 - 完全無效用, 2 - 無效用, 3 - 一般, 4 - 有效用, 5 - 十分有效用
(i) 講座或研討會			
(ii) 家長小組活動			
(iii) 大型社區活動或宣傳教育活動			
(iv) 參觀活動，例如:探訪戒毒服務機構等			
(v) 其他，請註明: _____			

14．你過去 12 個月內所參與的預防子女濫用藥物活動由哪些機構或人員舉辦? （可☑多項）
☐ 學校的老師
☐ 學校的社工
☐ 社會服務機構的社工
☐ 警察
☐ 政府部門 (例如: 禁毒處)
☐ 其他，請註明 _____

15．你過去 12 個月內參與的預防子女濫用藥物活動的內容（可☑多項）
☐ 對濫用藥物性質及其後果的認識
☐ 學習與子女討論濫用藥物問題
☐ 學習技巧 (例如:親子溝通、問題處理、危機處理及處理與子女衝突等的技巧)
☐ 分享管教子女的經驗
☐ 與其他家長作分享及支持
☐ 其他，請註明 _____

16．有什麼原因令你參與預防子女濫用藥物活動?（可☑多項）
☐ 時間適合
☐ 地點適合
☐ 日期適合
☐ 形式吸引
☐ 內容切合我的需要
☐ 宣傳足夠，使我知道有這些活動舉行
☐ 得到配偶支持參與活動
☐ 社工或老師鼓勵及推動下參加
☐ 子女濫用藥物問題是我所關注的問題
☐ 有活動資助費用
☐ 活動講者吸引
☐ 其他，請註明 _____

17. 有什麼原因令你沒有參與預防子女濫用藥物活動?（可☑多項）

☐ 時間不配合，例如:沒有時間參加 (時間不便)
☐ 地點不適合，舉辦地點與所居住地方相距太遠 (場地太遠)
☐ 日期不適合
☐ 形式不吸引
☐ 內容不能切合我的需要
☐ 宣傳不足，根本不知道有機構舉辦這些活動
☐ 配偶不支持我參加這些活動
☐ 我的子女沒有濫用藥物的問題
☐ 預防子女濫用藥物不是我家庭最關注的問題
☐ 恐怕別人誤會我的子女有濫用藥物問題
☐ 如我參加這些活動，便沒有人照顧我其他子女
☐ 其他，請註明 _____

<u>第四部份：對將來爲家長舉辦預防子女濫用藥物活動的意見</u>

18. 如將來有機構爲家長舉辦預防子女濫用藥物活動，而你又有時間參與，你希望活動如何安排?

(i) 日期: ☐ 平日 ☐ 假日
(ii) 時間: ☐ 上午 ☐ 下午 ☐ 晚上
(iii) 地點: ☐ 學校 ☐ 我家附近的社區中心 ☐ 其他，請註明_____
(iv) 形式: （可☑多項）
- ☐ 專家講座、研討會
- ☐ 家長小組活動
- ☐ 大型社區活動或宣傳教育活動
- ☐ 親子宿營
- ☐ 探訪或參觀戒藥服務機構
- ☐ 自學的教材，例如: 光碟、錄影帶或手冊等
- ☐ 其他，請註明 _____

(v) 內容: （可☑多項）
- ☐ 藥物性質及濫用藥物的後果
- ☐ 怎樣與子女討論濫用藥物問題
- ☐ 親子技巧 (例如:親子溝通、問題處理、危機處理及處理與子女衝突等的技巧)
- ☐ 分享管教子女的經驗
- ☐ 與其他家長互相支援
- ☐ 與曾濫藥人仕或其家人分享
- ☐ 戒藥服務介紹
- ☐ 其他，請註明 _____

(vi) 講者: （可☑多項）
- ☐ 社工
- ☐ 老師
- ☐ 警察
- ☐ 醫生
- ☐ 曾濫藥人仕及家人
- ☐ 政府官員
- ☐ 大學教授
- ☐ 其他，請註明 _____

(vii) 主辦單位 （可☑多項）
- ☐ 社會服務機構
- ☐ 學校
- ☐ 其他，請註明 _____
- ☐ 政府部門 (例如禁毒處)
- ☐ 大學

(viii) 活動可以達到的目標: （可☑多項）

☐ 能增加對藥物的認識及其濫用的後果
☐ 能知道怎樣與子女討論濫用藥物問題
☐ 分享管教子女的經驗
☐ 學習技巧(例如:親子溝通、問題處理、危機處理及處理與子女衝突等的技巧)
☐ 能與其他家長作分享及支援
☐ 促進家庭生活及子女精神健康
☐ 學習如何識別子女有濫藥問題
☐ 其他，請註明 _____

(ix) 其他安排

☐ 暫託孩子服務　　☐ 派發預防濫藥小冊子
☐ 發放交通津貼　　☐ 其他，請註明 _____
☐ 提供茶點

<u>第五部份：家長及家庭關係資料</u>

19. 帶本問卷給你填答那位子女的年齡及就讀級別是: _____歲　　小學_____年級

20. 你與該子女之關係:
☐生母 ☐繼母 ☐生父 ☐繼父 ☐其他：_____

21. 你所有子女的年齡及數目：
0-6 歲:__個, 7-9 歲:__個,10-12 歲:__個,13-15 歲:___個,16-18 歲:___個,19-21 歲:__個

22. 你的婚姻狀況：
☐已婚 ☐同居 ☐分居 ☐離婚 ☐喪偶 ☐未婚

23. 你的年齡:　　_____歲

24. 你配偶的年齡：　　_____歲　　☐不適用

25. 你的居港年期:　　_____年

26. 你配偶的居港年期：　　_____年　　☐不適用

27. 你所居住的地區:　　_____

28. 你的教育程度:
☐沒有受過教育 ☐小學 ☐中一至三 ☐中四至中五 ☐預科 ☐大專 ☐大學或以上

29. 你現在工作情況是：
☐全職（每週 44 小時或以上） ☐兼職（每週少於 44 小時） ☐退休 ☐待業

30. 你過去 12 個月內，平均每週工作時間:
☐21 小時或以下 ☐22-43 小時 ☐44-50 小時 ☐51-60 小時 ☐61 小時或以上

31. 你如有工作，請填上就業地區：_____

32. 你每月家庭總收入：
☐$4,999 以下　　☐$5,000-$9,999 ☐$10,000-$19,999 ☐$20,000-$29,999
☐$30,000- $39,999 ☐$40,000 或以上

33. 你目前有否領取綜援：☐有　　☐沒有

如填寫問卷後有任何疑問或查詢，請致電東華三院越峰成長中心 (電話: 2884 0282)。
「東華三院越峰成長中心」是一所專爲濫用精神藥物者及其家屬而設的輔導中心，
服務包括個案輔導、小組活動、社區教育及預防子女濫用藥物的家長教育等。

~ 問卷完，謝謝你的幫忙 ~

Appendix 2.2 Questionnaire for Secondary School in Phase I

社會工作及社會行政學系

DEPARTMENT OF SOCIAL WORK
AND SOCIAL ADMINISTRATION

香 港 大 學
香 港 薄 扶 林 道

The University of Hong Kong
Pokfulam Road, Hong Kong

樣本，只供參考用

編號：_____
不用填寫

預防濫藥，家長何責?

家長在預防青少年濫用藥物的參與問卷（中學版）

爲深入了解及提升家長在預防子女濫用藥物的參與，香港大學社會工作及社會行政學系與東華三院越峰成長中心(該中心爲濫用精神藥物者及其家屬提供輔導與小組活動，也提供社區教育服務)正在香港各小學及中學，向年齡介乎十一至廿一歲青少年的家長進行問卷調查。研究隊現懇請閣下以**家長**的身份，填答這份有關家長參與預防青少年濫用藥物情況的問卷。

問卷共分五部份，收集的資料只作參考，雖然部分問題可能涉及閣下的私隱，但由於本調查只會探討整體研究對象的狀況，並不會將結果對應個別資料，而研究隊亦不會發表有關個別人士的資料，希望閣下能支持此調查。填妥這份問卷後，請放入附上的信封內，於兩星期內經貴子女交回學校。

填答問卷純屬自願性質，如閣下對是項調查有任何查詢，或有興趣提供更多有關資料，歡迎與東華三院越峰成長中心鍾小姐聯絡（2884 0282)。如閣下想知道更多有關研究參與者的權益，請聯絡香港大學非臨床研究操守委員會（2241 5267）。多謝合作!

香港大學社會工作及社會行政學系
副教授及研究計劃總監
曾潔雯博士

請細心閱讀及按自己對問卷內容的理解回答下列問題，並用☑或圈出最合適的答案。除特別註明外，請根據閣下過去一年之經驗作答問題。調查所得資料只作研究之用，並沒有對或錯的答案，內容亦會絕對保密，請安心作答。謝謝你的參與！

<u>第一部份：案例研究（家長對子女濫用藥物認識、尋求協助的想法及其問題的重要）</u>
以下是一個模擬的個案，試以陳大文家長的身份，回答第一部份的問題。
陳大文(男)，今年十三歲，就讀中學一年級，半年前開始有濫用藥物[如：吸食大麻，K仔]情況，
如果你是陳大文的家長：

1．你估計已經開始濫藥的陳大文，會有甚麼行爲表現？（可☑多項）

☐ 學業成績退步
☐ 逃學
☐ 自言自語
☐ 有思覺失調現象
☐ 常常病
☐ 容易疲倦
☐ 吸煙
☐ 其他，請註明_____
☐ 多出夜街
☐ 與家人關係變得惡劣
☐ 離家出走
☐ 有財政困難，常向家人索錢
☐ 喜歡聽嘈吵的音樂
☐ 可能會犯上刑事罪 (有關毒品的罪)
☐ 想自殺

2．當你發現陳大文濫用藥物後，你會找誰人幫助及尋求意見？（可☑多項）

☐ 配偶
☐ 自己的父母
☐ 自己的兄弟姊妹
☐ 其他子女
☐ 親戚
☐ 好朋友
☐ 鄰居
☐ 教會朋友
☐ 社會服務機構的社工
☐ 子女就讀學校的社工
☐ 子女就讀學校的老師
☐ 子女就讀學校的家長
☐ 醫生
☐ 政府部門（例如：禁毒處）
☐ 不會找任何人幫助
☐ 其他，請註明 _____

3．你覺得陳大文濫用藥物問題是不是你家庭最關注的問題？
爲什麼？（可☑多項）

☐ 不是，因爲:
- ☐ 有其他更加值得我家庭關注的問題 (例如: 他的學業、行爲或情緒問題)
- ☐ 沒有時間關注他濫用藥物問題
- ☐ 覺得他濫用藥物問題只是暫時性，他長大了這問題就自動消失
- ☐ 其他，請註明 _____

☐ 是，因爲:
- ☐ 濫用藥物會導致其他問題 (例如: 精神病、學業或行爲問題)
- ☐ 都想花多些時間了解他濫用藥物問題，從而幫助他
- ☐ 意識到他濫用藥物會引起其他嚴重的後果，產生永久損害
- ☐ 其他，請註明 _____

第二至第五部份問題，會探討你和你子女的情況。目標子女是帶本問卷給你填答那位。

第二部份: 子女情況及家長管教模式

4. 你有沒有曾經懷疑該子女濫用藥物?
   □ 有　□ 無

5. 在***過去十二個月***，該子女曾有或做過下列事情嗎？

a.吸煙	□多過一次	□有一次	□沒有	□不知道
b.喝酒	□多過一次	□有一次	□沒有	□不知道
c.打架	□多過一次	□有一次	□沒有	□不知道
d.偷竊	□多過一次	□有一次	□沒有	□不知道
e.在父母禁止下仍深夜在外逗留	□多過一次	□有一次	□沒有	□不知道
f.離家出走	□多過一次	□有一次	□沒有	□不知道
g.逃學	□多過一次	□有一次	□沒有	□不知道
h.販賣私煙或翻版光碟	□多過一次	□有一次	□沒有	□不知道
i.自言自語	□多過一次	□有一次	□沒有	□不知道
j.有思覺失調現象	□多過一次	□有一次	□沒有	□不知道
k.藏有或販賣毒品	□多過一次	□有一次	□沒有	□不知道
l.與不良朋輩在一起	□多過一次	□有一次	□沒有	□不知道
m.有自殺念頭或行動	□多過一次	□有一次	□沒有	□不知道

6. 如該子女有以上這些行爲問題，你覺得你有能力有效地處理嗎?
   □十分同意　□同意　□不同意　□十分不同意

7. 你每週平均與該子女相處時間: _____ 小時

8. 你覺得你家庭的凝聚及團結力有幾高? (請圈出最合適的數字)

1	2	3	4	5
(十分低)				(十分高)

9. 該子女長高了，要買新衣物換季，你通常會怎樣做?
   □ 我知道他/她的需要，我會買給他/她
   □ 我會和他/她按需要，款式及價格商量買甚麼，有時讓他/她自己買，有時和他/她一起去買
   □ 我會付錢，他/她喜歡買甚麼都可以
   □ 我不會理這些事

10. 如該子女有濫用藥物問題，有什麼因素阻礙你參加處理子女濫用藥物的活動?（可☑多項）
   □ 害怕接受子女濫用藥物的事實
   □ 恐怕其他人會知道子女有濫用藥物
   □ 害怕配偶的反應
   □ 恐怕對子女前途有壞影響
   □ 害怕被其他人看不起
   □ 自己無信心及能力去處理子女濫用藥物問題，所以避而不談，不求協助
   □ 無時間去處理這個問題
   □ 害怕子女要停學戒藥
   □ 子女濫藥不是家中重要問題
   □ 與子女根本沒有溝通，恐怕將關係變得更惡劣
   □ 不知怎樣處理及求助
   □ 其他，請註明 _____

第三部份：家長參與預防子女濫藥活動

11．你過去 12 個月內有無留意到政府部門或其他機構有爲家長舉辦預防子女濫用藥物活動?
☐ 有　☐ 無

12．你過去 12 個月內有無參與預防子女濫用藥物的活動?
☐ 有 (請回答第 13 題)　☐ 無 (請回答第 17 題)

13．你過去 12 個月內有否參與預防子女濫用藥物活動及其次數? 那些活動你認爲有沒有效用呢?

	有否參與? (請以 √ 表示曾參與的活動) (可√多項)	參與次數? (請填上數字)	有無效用? (請填上數字 1 至 5) 1 - 完全無效用, 2 - 無效用, 3 - 一般, 4 - 有效用, 5 - 十分有效用
(i) 講座或研討會			
(ii) 家長小組活動			
(iii) 大型社區活動或宣傳教育活動			
(iv) 參觀活動,例如:探訪戒毒服務機構等			
(v) 其他，請註明: _____			

14．你過去 12 個月內所參與的預防子女濫用藥物活動由哪些機構或人員舉辦? (可☑多項)
☐ 學校的老師
☐ 學校的社工
☐ 社會服務機構的社工
☐ 警察
☐ 政府部門 (例如: 禁毒處)
☐ 其他，請註明 _____

15．你過去 12 個月內參與的預防子女濫用藥物活動的內容 (可☑多項)
☐ 對濫用藥物性質及其後果的認識
☐ 學習與子女討論濫用藥物問題
☐ 學習技巧 (例如:親子溝通、問題處理、危機處理及處理與子女衝突等的技巧)
☐ 分享管教子女的經驗
☐ 與其他家長作分享及支持
☐ 其他，請註明 _____

16．有什麼原因令你參與預防子女濫用藥物活動? (可☑多項)
☐ 時間適合
☐ 地點適合
☐ 日期適合
☐ 形式吸引
☐ 內容切合我的需要
☐ 宣傳足夠，使我知道有這些活動舉行
☐ 得到配偶支持參與活動
☐ 社工或老師鼓勵及推動下參加
☐ 子女濫用藥物問題是我所關注的問題
☐ 有活動資助費用
☐ 活動講者吸引
☐ 其他，請註明 _____

17. 有什麼原因令你沒有參與預防子女濫用藥物活動?（可☑多項）

☐ 時間不配合，例如:沒有時間參加 (時間不便)
☐ 地點不適合，舉辦地點與所居住地方相距太遠 (場地太遠)
☐ 日期不適合
☐ 形式不吸引
☐ 內容不能切合我的需要
☐ 宣傳不足，根本不知道有機構舉辦這些活動
☐ 配偶不支持我參加這些活動
☐ 我的子女沒有濫用藥物的問題
☐ 預防子女濫用藥物不是我家庭最關注的問題
☐ 恐怕別人誤會我的子女有濫用藥物問題
☐ 如我參加這些活動，便沒有人照顧我其他子女
☐ 其他，請註明 _____

<u>第四部份：對將來爲家長舉辦預防子女濫用藥物活動的意見</u>

18. 如將來有機構爲家長舉辦預防子女濫用藥物活動，而你又有時間參與，你希望活動如何安排?

(i) 日期: ☐ 平日 ☐ 假日
(ii) 時間: ☐ 上午 ☐ 下午 ☐ 晚上
(iii) 地點: ☐ 學校 ☐ 我家附近的社區中心 ☐ 其他，請註明_____
(iv) 形式: （可☑多項）
- ☐ 專家講座、研討會
- ☐ 家長小組活動
- ☐ 大型社區活動或宣傳教育活動
- ☐ 親子宿營
- ☐ 探訪或參觀戒藥服務機構
- ☐ 自學的教材，例如: 光碟、錄影帶或手冊等
- ☐ 其他，請註明 _____

(v) 內容: （可☑多項）
- ☐ 藥物性質及濫用藥物的後果
- ☐ 怎樣與子女討論濫用藥物問題
- ☐ 親子技巧 (例如:親子溝通、問題處理、危機處理及處理與子女衝突等的技巧)
- ☐ 分享管教子女的經驗
- ☐ 與其他家長互相支援
- ☐ 與曾濫藥人仕或其家人分享
- ☐ 戒藥服務介紹
- ☐ 其他，請註明 _____

(vi) 講者: （可☑多項）
- ☐ 社工
- ☐ 老師
- ☐ 警察
- ☐ 醫生
- ☐ 曾濫藥人仕及家人
- ☐ 政府官員
- ☐ 大學教授
- ☐ 其他，請註明 _____

(vii) 主辦單位 （可☑多項）
- ☐ 社會服務機構
- ☐ 學校
- ☐ 其他，請註明 _____
- ☐ 政府部門 (例如禁毒處)
- ☐ 大學

(viii) 活動可以達到的目標（可☑多項）

☐ 能增加對藥物的認識及其濫用的後果
☐ 能知道怎樣與子女討論濫用藥物問題
☐ 分享管教子女的經驗
☐ 學習技巧(例如:親子溝通、問題處理、危機處理及處理與子女衝突等的技巧)
☐ 能與其他家長作分享及支援
☐ 促進家庭生活及子女精神健康
☐ 學習如何識別子女有濫藥問題
☐ 其他，請註明 _____

(ix) 其他安排

☐ 暫託孩子服務
☐ 發放交通津貼
☐ 提供茶點
☐ 派發預防濫藥小冊子
☐ 其他，請註明 _____

第五部份：家長及家庭關係資料

19. 帶本問卷給你填答那位子女的年齡及就讀級別是: _____歲　　中學_____年級
20. 你與該子女之關係：
☐生母 ☐繼母 ☐生父 ☐繼父 ☐其他：_____
21. 你所有子女的年齡及數目：
0-6 歲:__個, 7-9 歲:__個,10-12 歲:__個,13-15 歲:___個,16-18 歲:___個,19-21 歲:__個
22. 你的婚姻狀況：
☐已婚 ☐同居 ☐分居 ☐離婚 ☐喪偶 ☐未婚
23. 你的年齡：　　_____歲
24. 你配偶的年齡：　　_____歲　　☐不適用
25. 你的居港年期 ：　　_____年
26. 你配偶的居港年期：　　_____年　　☐不適用
27. 你所居住的地區：　　_____
28. 你的教育程度:
☐沒有受過教育 ☐小學 ☐中一至三 ☐中四至中五 ☐預科 ☐大專 ☐大學或以上
29. 你現在工作情況是：
☐全職（每週 44 小時或以上） ☐兼職（每週少於 44 小時） ☐退休 ☐待業
30. 你過去 12 個月內，平均每週工作時間:
☐21 小時或以下 ☐22-43 小時 ☐44-50 小時 ☐51-60 小時 ☐61 小時或以上
31. 你如有工作，請填上就業地區：_____
32. 你每月家庭總收入：
☐$4,999 以下 ☐$5,000-$9,999 ☐$10,000-$19,999 ☐$20,000-$29,999
☐$30,000-$39,999 ☐$40,000 或以上
33. 你目前有否領取綜援：☐有 ☐沒有

如填寫問卷後有任何疑問或查詢，請致電東華三院越峰成長中心 (電話: 2884 0282)。
「東華三院越峰成長中心」是一所專爲濫用精神藥物者及其家屬而設的輔導中心，
服務包括個案輔導、小組活動、社區教育及預防子女濫用藥物的家長教育等。

～問卷完，謝謝你的幫忙～

Appendix 2.3 Questionnaire for drug-used parents in Phase I

社會工作及社會行政學系

DEPARTMENT OF SOCIAL WORK
AND SOCIAL ADMINISTRATION

香 港 大 學
香 港 薄 扶 林 道

The University of Hong Kong
Pokfulam Road, Hong Kong

預防濫藥，家長何責?
「家長在預防青少年濫用藥物的參與」
訪問邀請信

親愛的家長：

爲深入了解及提升家長在預防子女濫用藥物的參與，香港大學社會工作及社會行政學系與東華三院越峰成長中心(該中心爲濫用精神藥物者及其家屬提供輔導與小組活動，也提供社區教育服務)，於本年二月接受禁毒處委託，進行是項調查。由本年五月至八月，研究隊會在全港各社會服務機構及學校，向有年齡介乎十一至廿一歲子女的家長進行問卷調查，並邀請 100 位家長進行面談形式的訪問，藉此更深入地收集家長的意見。現誠邀閣下參與是次**爲時約五十分鐘的**面談訪問，讓我們得到您的寶貴意見。

調查所收集的資料只作研究參考，雖然部分問題可能涉及閣下的私隱，但本調查只會探討整體研究對象的狀況，並不會將結果對應個別人士的情況，研究隊亦不會發表有關個別人士的資料，懇請閣下放心參與此項調查！

是次問卷調查純屬自願性質，如閣下對是項調查有任何意見或查詢，請與越峰成長中心主任鍾燕婷小姐聯絡(2884 0282)。如閣下想知道更多有關研究參與者的權益，請聯絡香港大學非臨床研究操守委員會 (2241 5267)。多謝合作！

香港大學社會工作及社會行政學系
副教授及研究計劃總監
曾潔雯博士

預防濫藥，家長何責?
「家長在預防青少年濫用藥物的參與」
參與同意書

本人 _____ 同意參與「家長在預防青少年濫用藥物的參與」的面談訪問。

簽名:_____ **日期:**_____

社會工作及社會行政學系

DEPARTMENT OF SOCIAL WORK
AND SOCIAL ADMINISTRATION

香 港 大 學
香 港 薄 扶 林 道

The University of Hong Kong
Pokfulam Road, Hong Kong

編號：_____

樣本，只供參考用

預防濫藥，家長何責?

家長在預防青少年濫用藥物的參與問卷

《調查引言》：

今次呢項研究係由禁毒處委託**香港大學社會工作及社會行政學系**與**東華三院越峰成長中心**合作進行嘅。(東華三院越峰成長中心係一間專爲濫用精神藥物者及其家屬提供輔導與小組活動，亦會提供社區教育服務嘅中心)

係今年五月至八月期間，我地嘅研究隊會係全港各社會服務機構同學校，向有**十一至廿一歲子女嘅家長**進行問卷調查，當中更會邀請 100 位家長進行面談訪問。而今次研究嘅目的，係希望**了解家長係參與預防青少年濫用藥物活動嘅情況，所得嘅資料，會用作設計有效預防青少年濫用藥物嘅活動**。我地誠意邀請您參與今次嘅訪問，希望可以得到您嘅寶貴意見！

我地所收集嘅**資料只會作研究用途**，雖然部份問題可能涉及您嘅私隱，但由於今次調查只會探討整體研究對象嘅狀況，並唔會將結果對應個別人士嘅情況，我地更加唔會發表有關個別人士嘅資料，所以您可以放心參與！

若果你願意接受今次**爲時約五十分鐘**嘅面談訪問，就請你**細心閱讀同簽署呢一份參與同意書**。

(家長簽署同意書後，請收回同意書，並將邀請信留給家長保存，然後便可正式開始訪問)

中心專用：

調查員姓名：_____

面談日期：_____

面談時間：_____

多謝您參與今次的調查！

以下的時間，請您細心聆聽有關的問題，只要按照自己的理解回答就可以了。

除了特別註明之外，請您根據自己過去一年的經驗回答問題。調查所得的資料只會作爲研究用途，並無對或者錯的答案，內容亦會絕對保密，請安心作答。

第一部份：案例研究（家長對子女濫用藥物認識、尋求協助的想法及其問題的重要）

以下是一個模擬的個案，試以陳大文家長的身份，回答第一部份的問題。

陳大文(男)，今年十三歲，就讀中學一年級，半年前開始有濫用藥物(如: 吸食大麻, K 仔情況)，

如果你是陳大文的家長:

1. 你估計已經開始濫藥的陳大文, 會有甚麼行爲表現? （可☑多項）

☐ 學業成績退步
☐ 逃學
☐ 自言自語
☐ 有思覺失調現象
☐ 常常病
☐ 容易疲倦
☐ 吸煙
☐ 多出夜街
☐ 與家人關係變得惡劣
☐ 離家出走
☐ 有財政困難，常向家人索錢
☐ 喜歡聽嘈吵的音樂
☐ 可能會犯上刑事罪 (有關毒品的罪)
☐ 想自殺
☐ 其他，請註明_____

2. 當你發現陳大文濫用藥物後，你會找誰人幫助及尋求意見？（可☑多項）

☐ 配偶
☐ 自己的父母
☐ 自己的兄弟姊妹
☐ 其他子女
☐ 親戚
☐ 好朋友
☐ 鄰居
☐ 教會朋友
☐ 社會服務機構的社工
☐ 子女就讀學校的社工
☐ 子女就讀學校的老師
☐ 子女就讀學校的家長
☐ 醫生
☐ 政府部門 (例如: 禁毒處)
☐ 不會找任何人幫助
☐ 其他，請註明 _____

3. 你覺得陳大文濫用藥物問題是不是你家庭最關注的問題?
爲什麼?（可☑多項）

☐ 不是，因爲:
- ☐ 有其他更加值得我家庭關注的問題 (例如: 他的學業、行爲或情緒問題)
- ☐ 沒有時間關注他濫用藥物問題
- ☐ 覺得他濫用藥物問題只是暫時性，他長大了這問題就自動消失
- ☐ 其他，請註明_____

☐ 是，因爲:
- ☐ 濫用藥物會導致其他問題 (例如: 精神病、學業或行爲問題)
- ☐ 都想花多些時間了解他濫用藥物問題，從而幫助他
- ☐ 意識到他濫用藥物會引起其他嚴重的後果，產生永久損害
- ☐ 其他，請註明 _____

第二部份：子女情況及家長管教模式

4. 你有多少個 11-21 歲的子女？
_____個

請以問卷所附的隨機數字及受訪家長的子女數目代入下列算式，以決定家長回答問卷時所選取的目標子女。

隨機數字(　　)x 11-21 歲內的子女數目(　　)個
=(_____)*

*請參照下表確定目標子女:

	目標子女(11-21 歲內)
(0 - 0.999)	第一位出生的子女
(1 - 1.999)	第二位出生的子女
(2 - 2.999)	第三位出生的子女
(3 - 3.999)	第四位出生的子女
(4 - 4.999)	第五位出生的子女

如此類推。

此問卷以第幾位介乎於 11-21 歲出生的子女爲目標子女？_____

平時你會怎樣稱呼這位子女呢？_____ (往後請以此稱呼發問問題)

5. 你有沒有曾經懷疑（該子女稱呼）濫用藥物?
□ 有 □ 無

6. 在***過去十二個月***，（該子女稱呼）曾有或做過下列事情嗎？

a.	吸煙	□多過一次	□有一次	□沒有	□不知道
b.	喝酒	□多過一次	□有一次	□沒有	□不知道
c.	打架	□多過一次	□有一次	□沒有	□不知道
d.	偷竊	□多過一次	□有一次	□沒有	□不知道
e.	在父母禁止下仍深夜在外逗留	□多過一次	□有一次	□沒有	□不知道
f.	離家出走	□多過一次	□有一次	□沒有	□不知道
g.	逃學	□多過一次	□有一次	□沒有	□不知道
h.	販賣私煙或翻版光碟	□多過一次	□有一次	□沒有	□不知道
i.	自言自語	□多過一次	□有一次	□沒有	□不知道
j.	有思覺失調現象	□多過一次	□有一次	□沒有	□不知道
k.	藏有或販賣毒品	□多過一次	□有一次	□沒有	□不知道
l.	與不良朋輩在一起	□多過一次	□有一次	□沒有	□不知道
m.	有自殺念頭或行動	□多過一次	□有一次	□沒有	□不知道

7. 「如 (該子女稱呼) 有以上這些行爲問題，你覺得你有能力處理。」你同意這句說話嗎?
☐十分同意 ☐同意 ☐不同意 ☐十分不同意

8. 你每週平均與 (該子女稱呼) 相處時間: _____ 小時

9. 若以 5 分爲標準，5 分爲最高，1 分爲最低，你覺得你家庭的凝聚及團結力值多少分?
(請圈出最合適的數字)

| ---------- | ---------- | ---------- | ---------- |
1 2 3 4 5
(十分低) (十分高)

10. (該子女稱呼) 長高了，要買新衣物換季，你通常會怎樣做?
☐ 我知道他/她的需要，我會買給他/她
☐ 我會和他/她按需要，款式及價格商量買甚麼，有時讓他/她自己買，有時和他/她一起去買
☐ 我會付錢，他/她喜歡買甚麼都可以
☐ 我不會理這些事
☐ 其他，請註明_____

11. 如 (該子女稱呼) 有濫用藥物問題，有什麼因素阻礙你參加處理子女濫用藥物的活動?(可☑多項)

☐ 害怕接受子女濫用藥物的事實
☐ 恐怕其他人會知道子女有濫用藥物
☐ 害怕配偶的反應
☐ 恐怕對子女前途有壞影響
☐ 害怕被其他人看不起
☐ 自己無信心及能力去處理子女濫用藥物問題，所以避而不談，不求協助
☐ 無時間去處理這個問題
☐ 害怕子女要停學戒藥
☐ 子女濫藥不是家中重要問題
☐ 與子女根本沒有溝通，恐怕將關係變得更惡劣
☐ 不知怎樣處理及求助
☐ 其他，請註明 _____

第三部份：家長參與預防子女濫藥活動

12．你過去 12 個月內有無留意到政府部門或其他機構有爲家長舉辦預防子女濫用藥物活動?
□ 有 □ 無

13．你過去 12 個月內有無參與預防子女濫用藥物的活動?
□ 有 (請繼續回答第 14 題) □ 無 (請跳往第 19 題)

14．你過去 12 個月內有否參與預防子女濫用藥物活動及其次數? 那些活動你認爲有沒有效用呢?

	有否參與? (請以 √ 表示曾參與的活動) (可√多項)	參與次數? (請填上數字)	有無效用? (請填上數字 1 至 5) 1 - 完全無效用, 2 - 無效用, 3 - 一般, 4 - 有效用, 5 - 十分有效用
(i) 講座或研討會			
(ii) 家長小組活動			
(iii) 大型社區活動或宣傳教育活動			
(iv) 參觀活動，例如:探訪戒毒服務機構等			
(v) 其他，請註明: _____			

15．你過去 12 個月內所參與的預防子女濫用藥物活動由哪些機構或人員舉辦? （可☑多項）
□ 學校的老師 □ 警察
□ 學校的社工 □ 政府部門 (例如: 禁毒處)
□ 社會服務機構的社工 □ 其他，請註明 _____

16．你過去 12 個月內參與的預防子女濫用藥物活動的內容是：(可☑多項）
□ 對濫用藥物性質及其後果的認識
□ 學習與子女討論濫用藥物問題
□ 學習技巧 (例如:親子溝通、問題處理、危機處理及處理與子女衝突等的技巧)
□ 分享管教子女的經驗
□ 與其他家長作分享及支持
□ 其他，請註明 _____

17．在你參加過的活動中，你認爲哪些活動內容最能夠有效預防子女濫用藥物呢？（請只選一項）
□ 對濫用藥物性質及其後果的認識
□ 學習與子女討論濫用藥物問題
□ 學習技巧 (例如:親子溝通、問題處理、危機處理及處理與子女衝突等的技巧)
□ 分享管教子女的經驗
□ 與其他家長作分享及支持
□ 其他，請註明 _____

18．有什麼原因令你參與預防子女濫用藥物活動?（可☑多項）

☐ 時間適合
☐ 地點適合
☐ 日期適合
☐ 形式吸引
☐ 內容切合我的需要
☐ 宣傳足夠，使我知道有這些活動舉行
☐ 得到配偶支持參與活動
☐ 社工或老師鼓勵及推動下參加
☐ 子女濫用藥物問題是我所關注的問題
☐ 有活動資助費用
☐ 活動講者吸引
☐ 其他，請註明 _____

19．有什麼原因令你沒有參與預防子女濫用藥物活動?（可☑多項）

☐ 時間不配合，例如:沒有時間參加（時間不便)
☐ 地點不適合，舉辦地點與所居住地方相距太遠（場地太遠)
☐ 日期不適合
☐ 形式不吸引
☐ 內容不能切合我的需要
☐ 宣傳不足，根本不知道有機構舉辦這些活動
☐ 配偶不支持我參加這些活動
☐ 我的子女沒有濫用藥物的問題
☐ 預防子女濫用藥物不是我家庭最關注的問題
☐ 恐怕別人誤會我的子女有濫用藥物問題
☐ 如我參加這些活動，便沒有人照顧我其他子女
☐ 因爲我自己也有濫用藥物
☐ 其他，請註明 _____

***第四部份：對將來爲家長舉辦預防子女濫用藥物活動的意見*（以下各題均可☑選多項）**

20. 如將來有機構爲家長舉辦預防子女濫用藥物活動，而你又有時間參與，你希望活動如何安排?

(i) 日期: ☐ 平日 ☐ 假日

(ii) 時間: ☐ 上午 ☐ 下午 ☐ 晚上

(iii) 地點: ☐ 學校 ☐ 我家附近的社區中心 ☐ 其他，請註明_____

(iv) 形式:

☐ 專家講座、研討會
☐ 家長小組活動
☐ 大型社區活動或宣傳教育活動
☐ 親子宿營
☐ 探訪或參觀戒藥服務機構
☐ 自學的教材，例如: 光碟、錄影帶或手冊等
☐ 其他，請註明 _____

(v) 內容:

☐ 藥物性質及濫用藥物的後果
☐ 怎樣與子女討論濫用藥物問題
☐ 親子技巧 (例如:親子溝通、問題處理、危機處理及處理與子女衝突等的技巧)
☐ 分享管教子女的經驗
☐ 與其他家長互相支援
☐ 與曾濫藥人仕或其家人分享
☐ 戒藥服務介紹
☐ 其他，請註明 _____

(vi) 講者:

☐ 社工
☐ 老師
☐ 警察
☐ 醫生
☐ 曾濫藥人仕及家人
☐ 政府官員
☐ 大學教授
☐ 其他，請註明 _____

(vii) 主辦單位

☐ 社會服務機構
☐ 學校
☐ 政府部門 (例如禁毒處)
☐ 大學
☐ 其他，請註明 _____

(viii) 活動可以達到的目標

☐ 能增加對藥物的認識及其濫用的後果
☐ 能知道怎樣與子女討論濫用藥物問題
☐ 分享管教子女的經驗
☐ 學習技巧(例如:親子溝通、問題處理、危機處理及處理與子女衝突等的技巧)
☐ 能與其他家長作分享及支援
☐ 促進家庭生活及子女精神健康
☐ 學習如何識別子女有濫藥問題
☐ 其他，請註明 _____

(ix) 其他安排

☐ 暫託孩子服務
☐ 發放交通津貼
☐ 提供茶點
☐ 派發預防濫藥小冊子
☐ 其他，請註明 _____

第五部份：家長濫藥行爲對子女的影響

21. 以下是一些關於濫用藥物的句子，請依據你的看法，表示同意或不同意:

		同意	不同意
a.	濫用藥物是沒有經醫生指導下服用藥物	□	□
b.	只曾試過一次服用精神藥物，如搖頭丸、K 仔等，已算是濫用藥物	□	□
c.	吸食少量的大麻，不算是濫用藥物	□	□
d.	濫用藥物的行爲是遺傳的，無法改變	□	□
e.	要預防青少年濫用藥物，家長的角色最重要	□	□
f.	服食某種藥物，而影響了工作或學習效率，這便算是濫用藥物	□	□
g.	如果不是恒常地使用某種藥物，不算是濫用藥物	□	□
h.	不服用某種藥物，便覺得有「囉囉攣」的感覺，這就算是濫用藥物	□	□
i.	青少年期間有濫用藥物行爲，長大後問題會自行消失	□	□
j.	只需在學校內設有預防濫藥活動，便能十分有效地預防青少年濫用藥物	□	□

22. 你會否將自己濫用的藥物收藏於家中？如有，會收藏在哪裡?

□ 不會。 □ 會。 我會：(可☑多項)

□ 隨意地擺放。
□ 擺放於沒有鎖上的櫃或抽屜中。
□ 擺放於雪櫃。
□ 擺放於只有自己可以使用的地方。
□ 收藏於隱蔽地方，不致讓子女發現或拿取。
□ 其他，請註明 _____

23. 你曾否將自己濫用的藥物交給子女保管?

□經常 □間中 □多數不會 □從不會

24. 你會否阻止自己的子女與其他有濫藥行爲的人士交往?

□一定會 □多數會 □多數不會 □從不會

25. 您覺得父母的濫用藥物行爲，會對下列各個項目帶來什麼影響?

a.	家庭財政狀況	□變得更好	□沒有影響	□變得更差	□不知道
b.	子女運用金錢的習慣	□變得更好	□沒有影響	□變得更差	□不知道
c.	子女的學習態度	□變得更好	□沒有影響	□變得更差	□不知道
d.	子女學業成績	□變得更好	□沒有影響	□變得更差	□不知道
e.	子女的社交圈子	□變得更正面	□沒有影響	□變得更負面	□不知道
f.	子女對濫藥行爲的接受程度	□變得更高	□沒有影響	□變得更低	□不知道
g.	子女操行	□變得更好	□沒有影響	□變得更差	□不知道
h.	子女的情緒	□變得更正面	□沒有影響	□變得更負面	□不知道
i.	親子關係	□變得更好	□沒有影響	□變得更差	□不知道

第六部份：家長及家庭關係資料

26. __(該子女稱呼)__的年齡是: _____歲
27. __(該子女稱呼)__在學情況：
□小學_____年級
□中學_____年級
□全日制香港專業教育學院_____年級
□兼讀制香港專業教育學院_____年級
□夜間中學_____年級
□大專學院_____年級
□其他，請註明：_____
□沒有讀書
28. __(該子女稱呼)__就業情況：
□全職工作 □兼職／散工 □待業 □仍在學中，不適用
29. __(該子女稱呼)__之關係：
□生母 □繼母 □生父 □繼父 □其他：_____
30. 你所有子女的年齡及數目：
0-6 歲:__個, 7-9 歲:__個,10-12 歲:__個,13-15 歲:___個,16-18 歲:___個,19-21 歲:__個
31. 你的婚姻狀況：
□已婚 □同居 □分居 □離婚 □喪偶 □未婚
32. 你的年齡：_____歲
33. 你配偶的年齡：_____歲 □不適用
34. 你的居港年期 ：_____年
35. 你配偶的居港年期：_____年 □不適用
36. 你所居住的地區：□中西 □灣仔 □東區 □南區 □深水埗 □九龍城
□油尖旺 □觀塘 □黃大仙 □葵青 □荃灣 □屯門
□元朗 □離島 □大埔 □沙田 □西貢 □北區
□其他：_____
37. 你的教育程度:
□沒有受過教育 □小學 □中一至三 □中四至中五 □預科 □大專 □大學或以上
38. 你現在工作情況是：
□全職（每週 44 小時或以上） □兼職（每週少於 44 小時） □退休(請跳往第 41 題)
□待業(請跳往第 41 題)
39. 你過去 12 個月內，平均每週工作時間:
□21 小時或以下 □22-43 小時 □44-50 小時 □51-60 小時 □61 小時或以上
40. 你如有工作，請填上就業地區：
□中西 □灣仔 □東區 □南區 □深水埗 □九龍城
□油尖旺 □觀塘 □黃大仙 □葵青 □荃灣 □屯門
□元朗 □離島 □大埔 □沙田 □西貢 □北區
□其他：_____
41. 你每月家庭總收入：
□$4,999 以下 □$5,000-$9,999 □$10,000-$19,999 □$20,000-$29,999
□$30,000-$39,999 □$40,000 或以上
42. 你目前有否領取綜援：□有 □沒有

～問卷完～

隨機數表 (適用於題目 4，以便對應問卷隨機數字，並找出目標子女)

問卷	子女數目			
	隨機數	X 2	X 3	X 4
1	0.20	0.39	0.59	0.79
2	0.77	1.54	2.31	3.08
3	0.84	1.67	2.51	3.34
4	0.22	0.44	0.66	0.88
5	0.35	0.69	1.04	1.39
6	0.85	1.71	2.56	3.42
7	0.57	1.14	1.72	2.29
8	0.98	1.97	2.95	3.94
9	0.16	0.32	0.48	0.64
10	0.18	0.35	0.53	0.71
11	0.34	0.68	1.03	1.37
12	0.52	1.03	1.55	2.07
13	0.39	0.77	1.16	1.55
14	0.21	0.42	0.63	0.83
15	0.34	0.68	1.02	1.37
16	0.59	1.18	1.77	2.36
17	0.18	0.36	0.54	0.72
18	0.14	0.27	0.41	0.55
19	0.50	1.00	1.49	1.99
20	0.84	1.68	2.52	3.36
21	0.39	0.77	1.16	1.54
22	0.38	0.75	1.13	1.50
23	0.13	0.27	0.40	0.53
24	0.62	1.24	1.86	2.48
25	0.12	0.23	0.35	0.46
26	0.81	1.62	2.43	3.24
27	0.85	1.70	2.54	3.39
28	0.11	0.21	0.32	0.42
29	0.57	1.14	1.70	2.27
30	0.61	1.22	1.83	2.44
31	0.57	1.14	1.71	2.28
32	0.27	0.54	0.81	1.08
33	0.10	0.21	0.31	0.41
34	0.42	0.84	1.26	1.69
35	0.25	0.50	0.75	1.00
36	0.55	1.09	1.64	2.19
問卷	子女數目			
	隨機數	X 2	X 3	X 4
37	0.25	0.49	0.74	0.99
38	0.41	0.83	1.24	1.65
39	0.05	0.11	0.16	0.22
40	0.56	1.12	1.68	2.24
41	0.30	0.61	0.91	1.21
42	0.75	1.50	2.25	3.00
43	0.93	1.86	2.79	3.73
44	0.30	0.61	0.91	1.22
45	0.40	0.80	1.20	1.60
46	0.87	1.73	2.60	3.46
47	0.89	1.78	2.66	3.55
48	0.68	1.36	2.04	2.72
49	0.38	0.76	1.14	1.52
50	0.77	1.55	2.32	3.09
51	0.54	1.08	1.62	2.15
52	0.02	0.04	0.07	0.09
53	0.67	1.35	2.02	2.69
54	0.49	0.98	1.46	1.95
55	0.09	0.19	0.28	0.37
56	0.61	1.21	1.82	2.42
57	0.44	0.87	1.31	1.74
58	0.47	0.93	1.40	1.86
59	0.08	0.16	0.24	0.33
60	0.13	0.27	0.40	0.53
61	0.67	1.34	2.00	2.67
62	0.92	1.85	2.77	3.70
63	0.96	1.92	2.88	3.84
64	0.70	1.40	2.10	2.80
65	0.01	0.03	0.04	0.05
66	0.39	0.77	1.16	1.54
67	0.26	0.53	0.79	1.06
68	0.97	1.94	2.92	3.89
69	0.80	1.61	2.41	3.22
70	0.77	1.54	2.31	3.09
71	0.90	1.79	2.69	3.59
72	0.54	1.07	1.61	2.15
問卷	子女數目			
	隨機數	X 2	X 3	X 4
73	0.07	0.14	0.21	0.28
74	0.04	0.08	0.12	0.15
75	0.18	0.37	0.55	0.74
76	0.47	0.95	1.42	1.89
77	0.73	1.47	2.20	2.93
78	0.60	1.20	1.79	2.39
79	0.05	0.09	0.14	0.18
80	0.26	0.52	0.78	1.04
81	0.44	0.88	1.32	1.76
82	0.52	1.03	1.55	2.06
83	0.89	1.79	2.68	3.57
84	0.21	0.42	0.63	0.83
85	0.08	0.16	0.25	0.33
86	0.89	1.78	2.66	3.55
87	0.58	1.15	1.73	2.30
88	0.15	0.30	0.45	0.60
89	0.70	1.40	2.10	2.80
90	0.55	1.09	1.64	2.18
91	0.84	1.68	2.53	3.37
92	0.18	0.36	0.53	0.71
93	0.18	0.36	0.54	0.72
94	0.04	0.08	0.13	0.17
95	0.46	0.92	1.37	1.83
96	0.10	0.19	0.29	0.39
97	0.89	1.79	2.68	3.58
98	0.77	1.55	2.32	3.09
99	0.88	1.76	2.64	3.51
100	0.03	0.06	0.09	0.12

*參照下表確定目標子女:

	目標子女(11-21 歲)
(0 - 0.99)	首位子女
(1 - 1.99)	第二位子女
(2 - 2.99)	第三位子女
(3 - 3.99)	第四位子女

Appendix 2.4 List of Participating Agencies and Units for Recruiting DrugP in Phase I

Collaborative parties referring interviewees for individual interviews in summer 2006

No.	Name of Referring Agency
1.	The Society for the Aid and Rehabilitation of Drug Abusers (SARDA) - Adult Female Rehabilitation Centre - Methadone Clinic Counseling Service: ● Sham Shui Po Clinic ● Tuen Mun Clinic
2.	The Correctional Services Department - Hei Ling Chau Drug Detoxification Centre
3.	Wu Oi Christian Centre Shun Tin Half-way House
4.	Barnabas Charitable Service Association, -Lamma Training Centre -Ma On Shan Half-way House
5.	The Finnish Evangelical Lutheran Mission Ling Oi Youth Centre
6.	Tung Wah Group of Hospitals CROSS Centre

Appendix 2.5 Discussion Questions for Focus Groups with professionals, parents and DrugP in Phase II

社會工作及社會行政學系

DEPARTMENT OF SOCIAL WORK
AND SOCIAL ADMINISTRATION

香 港 大 學
香 港 薄 扶 林 道

The University of Hong Kong
Pokfulam Road, Hong Kong

編號：_____

預防濫藥，家長何責?
「家長在預防青少年濫用藥物的參與研究」
家長(甲組) 焦點小組

樣本，只供參考用

親愛的　　：

香港大學社會工作及社會行政學系與東華三院越峰成長中心(該中心爲濫用精神藥物者及其家屬提供輔導與小組活動，也提供社區教育服務)，於二零零六年二月接受禁毒處委託，進行研究調查及設計有助家長預防子女濫用藥物的活動教材套，日後供全港專業人仕參考。

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爲了豐富研究調查的內容，研究隊亦會分別召開焦點小組，向專業人仕、及家長收集意見。現**特誠邀閣下參加爲時約九十分鐘的家長焦點小組**，向研究隊直接提供寶貴的意見。焦點小組所收集的資料只作研究用途，雖然部份問題可能涉及閣下的私隱，但我們只會探討整體研究對象的狀況，並不會將結果對應個別人士的情況，研究隊亦不會發表有關個別人士的資料，懇請閣下放心參與是次小組！

是次焦點小組討論純屬自願性質，如閣下對是次小組有任何意見或查詢，請與越峰成長中心鍾惠儀小姐聯絡(2884 0282)。如閣下想知道更多有關研究參與者的權益，請聯絡香港大學非臨床研究操守委員會 (2241 5267)。多謝合作！

香港大學社會工作及社會行政學系
副教授及研究計劃總監
曾潔雯博士

預防濫藥，家長何責?
「家長在預防青少年濫用藥物的參與」
家長(甲組)焦點小組參與同意書

本人 _____ 同意參與「家長在預防青少年濫用藥物的參與」的家長(甲組)焦點小組討論。

簽名：_____　　日期：_____

預防濫藥，家長何責?
「家長在預防青少年濫用藥物的參與研究」
家長（甲組）焦點小組

流程及問題

1. 介紹工作員
2. 介紹焦點小組背景及目的

問題一

a) 有人說:「香港社會近年來比較關注市民濫藥或吸毒等情況」，你同意嗎?何以見得?
b) 若果孩子對濫用藥物很感興趣，你認爲家長應如何處理?
c) 若果家長是濫用藥物的人士，他們又應如何處理?
d) 跟進問題：你覺得以上提及的各種方法效果如何?爲什麼？

問題二

a) 你覺得子女會怎樣看家長濫用藥物一事？
b) 子女的看法會對家庭有甚麼影響 (跟進:溝通，家長教導， 預防濫藥)？
c) 跟進問題：
   i. 你會如何面對這些影響？
   ii. 你曾否覺得需要協助?需要哪些協助?經驗如何?

問題三

a) 你曾否參加一些預防青少年濫用藥物的家長活動或服務?你覺得這些活動怎樣?
b) 跟進問題
   i. 有什麼因素推動你參與以上活動？（如活動設計、對濫藥的看法、家庭因素）
   ii. 若家長分享自己從不參與有關活動，請他/她分享阻礙他/她參加的因素

問題四

若有機構希望舉辦一些活動，讓家長用更有效的方法預防子女濫用藥物，你覺得這些活動應有何特色?
可按以下列項目分享意見:
1. 內容、主持人
2. 形式及舉辦單位/人士
3. 舉辦時間、地點、交通安排
4. 宣傳途徑及報名方法
5. 其他安排:如津貼、託兒服務

問題五

如果招募的服務對象爲有濫藥經驗的家長，你認爲要怎樣宣傳才會有效呢?

問題六

有沒有什麼方法或特別安排可以吸引這些家長積極及持續地參與這類活動或家長小組？

社會工作及社會行政學系

DEPARTMENT OF SOCIAL WORK
AND SOCIAL ADMINISTRATION

香 港 大 學
香 港 薄 扶 林 道

The University of Hong Kong
Pokfulam Road, Hong Kong

編號：_____

預防濫藥，家長何責?
「家長在預防青少年濫用藥物的參與研究」
家長(乙組）焦點小組

樣本，只供參考用

親愛的家長：

香港大學社會工作及社會行政學系與東華三院越峰成長中心(該中心爲濫用精神藥物者及其家屬提供輔導與小組活動，也提供社區教育服務)，於二零零六年二月接受禁毒處委託，進行研究調查及設計有助家長預防子女濫用藥物的活動教材套，日後供全港專業人仕參考。

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爲了豐富研究調查的內容，研究隊亦會分別召開焦點小組，向專業人仕、中小學生家長、及曾經濫藥的家長收集意見。素仰台端熱心公益，現**特誠邀參加爲時約九十分鐘的家長焦點小組**，向研究隊直接提供寶貴的意見。焦點小組所收集的資料只作研究用途，雖然部份問題可能涉及閣下的私隱，但我們只會探討整體研究對象的狀況，並不會將結果對應個別人士的情況，研究隊亦不會發表有關個別人士的資料，懇請閣下放心參與是次小組！

是次焦點小組討論純屬自願性質，如閣下對是次小組有任何意見或查詢，請與越峰成長中心鍾惠儀小姐聯絡(2884 0282)。如閣下想知道更多有關研究參與者的權益，請聯絡香港大學非臨床研究操守委員會（2241 5267)。多謝合作！

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預防濫藥，家長何責?
「家長在預防青少年濫用藥物的參與」
家長焦點小組參與同意書

本人 _____ 同意參與「家長在預防青少年濫用藥物的參與」的家長焦點小組討論。

簽名：_____ 日期：_____

預防濫藥，家長何責?
「家長在預防青少年濫用藥物的參與研究」
家長焦點小組

流程及問題

1. 介紹工作員
2. 介紹焦點小組背景及目的

問題一

a) 一般來說，作爲家長，在預防子女濫用藥物的事情上，可以做什麼呢?
b) 跟進問題：你覺得以上提及的方法有沒有作用? 你有沒有採用這些方法?

問題二

a) 通常與子女溝通或處理有關濫用藥物的事情上，家長往往面對什麼困難?
b) 跟進問題：面對以上困難，你覺得什麼人的協助最能幫到你? (家庭層面、專業人仕等)

問題三

a) 在你的經驗中，有那些預防青少年濫用藥物的家長活動或服務，令你有所得著呢?
b) 跟進問題
   i. 有什麼因素推動你參與以上活動？（如活動設計、對濫藥的看法、家庭因素）
   ii. 若家長分享自己從不參與有關活動，請他/她分享個人阻礙他/她的因素。

問題四

若有機構希望舉辦一些活動，讓家長用更有效的方法預防子女濫用藥物，你覺得這些活動應有何特色?
以下列項目分享意見:

1. 內容
2. 形式及辦單位/人士
3. 舉辦時間、地點、交通安排
4. 宣傳途徑及報名方法
5. 其他安排:如津貼、託兒服務

問題五

如果參加對象爲有濫藥經驗的家長，你認爲怎樣的招募及宣傳才可吸引他們呢?

問題六

若以大家的意見設計活動，你會否報名及積極參與? 爲甚麼?
(請讓參加者放心，答案只作參考，不代表作任何承諾！)

社會工作及社會行政學系

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預防濫藥，家長何責?
「家長在預防青少年濫用藥物的參與研究」
專業人仕焦點小組

樣本，只供參考用

尊敬的　　：

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曾潔雯博士

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「家長在預防青少年濫用藥物的參與」
專業人仕焦點小組參與同意書

本人 _____ 同意參與「家長在預防青少年濫用藥物的參與」的專業人仕小組討論。

簽名：_____　　日期：_____

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「家長在預防青少年濫用藥物的參與研究」
專業人仕焦點小組

流程及問題

1. 介紹工作員
2. 介紹焦點小組背景及目的

問題一
請介紹自己名字及工作單位，並簡略分享閣下在工作裡面，會透過哪些途徑接觸/服務家長或青少年。

問題二
你們曾否舉辦預防青少年濫用藥物的家長活動? 請分享當中的經驗。
(若沒有相關經驗，可就其他青少年問題，如逃學、上網成癮、親子溝通問題作分享)

問題三
就你所有的經驗，家長決定會否參與預防濫用藥物的活動，通常會取決於什麼因素? 換言之，
a) 有什麼是吸引他們參加的因素呢?
b) 有什麼是阻礙他們參加的因素呢?

問題四
我們希望設計家長教育活動，加強他們預防子女濫用藥物的意識及能力。你認爲甚麼活動會最適當，又能吸引家長參加? 可討論：
a) 招募方法
b) 內容
c) 形式
d) 時間、地點

問題五
就以上的提議，若參與的家長曾有濫藥的經驗，還要特別注意些什麼呢?

問題六
總括而言，你認爲可以如何在香港推廣有關的預防活動? 有什麼方法可以減少家長的流失率?

Appendix 3.1 Application Form for the 3-level Programs in Phase III

香港大學社會工作及社會行政學系　東華三院越峰成長中心　合辦

「溝通管教有妙法」家長證書課程
報名表格

樣本，只供參考用

本人(家長姓名)_____有興趣參加「溝通管教有妙法」家長證書課程。

手提電話: _____　家居電話:_____

爲方便課程安排，請提供以下資料。資料將會絕對保密，不會公開，多謝合作!

(1) 你是爲**哪一位**年齡介乎 11 至 21 歲的子女參加本小組? 請填上他/她的資料：

1. 子女姓名：_____
2. 子女年齡：_____
3. 子女性別：☐ 男　☐女　(請✓選合適答案)
4. 就讀年級：(小學 / 中學) _____年級_____班
5. 你與該子女之關係： ☐父親 ☐母親 ☐其他：_____(請✓選合適答案)

(2)在過去一年內，該子女有沒有以下任何行爲表現?　(請✓選合適答案)

		有	沒有
1.	吸煙	☐	☐
2.	喝酒	☐	☐
3.	打架	☐	☐
4.	偷竊	☐	☐
5.	在父母禁止下仍深夜在外逗留	☐	☐
6.	離家出走	☐	☐
7.	逃學	☐	☐
8.	販賣私煙或翻版光碟	☐	☐
9.	自言自語	☐	☐
10.	思覺失調現象 (如: 幻聽幻覺)	☐	☐
11.	藏有或販賣毒品	☐	☐
12.	與不良朋輩在一起	☐	☐
13.	有自殺念頭或行動	☐	☐

其他：_____

有關本課程的查詢，請與東華三院越峰成長中心社工曾宏強先生聯絡 (2884 0282)。
有關課程研究參與者的權益，可聯絡香港大學非臨床研究操守委員會 (2241 5267)。

歡迎你的參與!

【工作員專用】

報名表編號：_____　收表日期：_____　課程編號：_____

Appendix 3.2 Pre-test Questionnaire in Phase III

社會工作及社會行政學系

DEPARTMENT OF SOCIAL WORK
AND SOCIAL ADMINISTRATION

香 港 大 學
香 港 薄 扶 林 道

The University of Hong Kong
Pokfulam Road, Hong Kong

樣本，只供參考用

編號：

親愛的家長:

「溝通管教有妙法」家長問卷 (活動前)

多謝您參加「溝通管教有妙法」的家長課程。我們誠邀您填寫課前問卷，讓我們了解您目前的管教模式及能力，以便爲您提供最適切的活動內容。課程完成後，我們會請您填答課後問卷，讓我們按您的意見，進一步提升活動質素。

整個過程中，您大可以放心，因爲您所提供的資料，將會絕對保密，不會公開。若您對自己問卷的分析有興趣，我們樂意個別向您解釋分析結果。

假如您對本問卷有任何查詢，或有興趣提供更多有關資料，歡迎與東華三院越峰成長中心鍾惠儀小姐聯絡 (2884 0282)。若您想知道更多有關研究參與者的權益，請聯絡香港大學非臨床研究操守委員會 (2241 5267)。多謝合作!

香港大學社會工作及社會行政學系
副教授及研究計劃總監
曾潔雯博士
二零零七年一月三日

填寫指示

- **你是爲著那一位子女而參加課程呢? 請以他/她爲 目標子女，回答以下各題。**
- **完成問卷後請依照工作人員指示交回問卷。謝謝！**

【工作員專用】
1. □家長已簽署
2. □已收活動報名表
3. □已填寫所有答案
4. □已記下尚欠的答案作跟進
5. □給予家長問卷首頁副本作存根
6. □交回負責同工 **工作員姓名:**_____

問卷填寫同意書

我明白我所提供的資料只作活動成效研究用途，將會絕對保密，不會公開。我同意參與此問卷調查。

家長姓名：_____ 簽名：_____ 日期：_____

第一部份 (引起動機元素)

(1) 你同意以下安排，能吸引你報名參與是次課程？（請用✓出適合答案）

		十分同意	同意	不同意	十分不同意
1.	教授親子溝通、問題及衝突處理技巧	☐	☐	☐	☐
2.	講解成癮行爲(如:沉迷上網、濫藥)	☐	☐	☐	☐
3.	以小組形式進行	☐	☐	☐	☐
4.	配合生活例子講解	☐	☐	☐	☐
5.	別人鼓勵參與(如：社工、老師)	☐	☐	☐	☐
6.	講員或導師吸引	☐	☐	☐	☐
7.	報名方法方便	☐	☐	☐	☐
8.	派發出席證書	☐	☐	☐	☐
9.	派發禮物或禮券	☐	☐	☐	☐
10.	舉辦日期及時間合適	☐	☐	☐	☐
11.	舉辦地點合適	☐	☐	☐	☐
12.	提供茶點	☐	☐	☐	☐
13.	其他：(請說明)_____				

第二部份 (管教能力自我評估)

(2) 假如你的**目標子女**有吸煙、喝酒、打架、偷竊、在父母禁止下仍深夜在外逗留、離家出走、逃學、販賣私煙或翻版光碟、自言自語、有思覺失調現象、藏有或販賣毒品、與不良朋輩在一起、有自殺念頭或行動等行爲問題，你認爲自己有能力處理嗎?

☐極欠能力 ☐略欠能力 ☐一般能力 ☐很有能力 ☐極有能力

第三部份 (管教模式)

(3) 以下描述你和目標子女的一般關係。請在合適的方格加✓。

		十分同意 ✓✓	同意 ✓	一半半	不同意 ✖	十分不同意 ✖✖
1.	當**目標子女**犯錯時，我是通情達理的。	☐	☐	☐	☐	☐
2.	當目標子女想跟我談話，我樂意奉陪。	☐	☐	☐	☐	☐
3.	當目標子女犯錯，我會給他/她機會解釋。	☐	☐	☐	☐	☐
4.	即使我不同意目標子女觀點，我仍會聆聽。	☐	☐	☐	☐	☐

(4) 如**目標子女**長高了，要買新衣物換季，你通常會怎樣做？(請只✔選一個答案)

☐ 我知道他/她的需要，我會買給他/她
☐ 我會和他/她按需要、款式及價格商量買甚麼，有時讓他/她自己買，有時和他/她一起去買
☐ 我會付錢，他/她喜歡買甚麼都可以
☐ 我不會理這些事
☐ 其他，請註明_____

(5) 如**目標子女**欠交功課，你通常會怎樣做？(請只✔選一個答案)

☐ 我會先去了解他/她是否有困難完成功課，再給予一些提點，避免再犯
☐ 他/她喜歡做功課便會做，不喜歡便不會做
☐ 我會嚴厲警誡，不能讓他/她再犯
☐ 老師會處理這些事，不用我理
☐ 其他，請註明_____

(6) 在**目標子女**結交朋友/同學的事情上，你通常會怎樣處理？(請只✔選一個答案)

☐ 我會教導他/她小心結交朋友，並留意他/她與何人來往，偶然加以提點
☐ 我不會理他/她和甚麼人交往
☐ 我不會讓他/她和損友來往
☐ 我會讓他/她和自己喜歡的朋友來往
☐ 其他，請註明_____

(7) 你每週平均與該**目標子女**相處(如:一同在家)多少時間（請填上）:_____**小時**

(8) 你每週平均能夠有質素地與**目標子女**溝通的時間佔（請填上）:_____**分鐘**

(9) 若以 1-5 分爲標準，5 分爲最高，1 分爲最低，你覺得你家庭的凝聚及團結力值多少分?

☐1 分　☐2 分　☐3 分　☐4 分　☐5 分

第四部份 (有關預防濫藥行爲的知識及態度)

(10)你同意以下是濫用藥物者的特徵嗎？請在合適方格加✔。

		同意	不同意
1.	學業或工作表現轉差	☐	☐
2.	曠課或無故請假	☐	☐
3.	經常索取金錢，甚至偷取財物	☐	☐
4.	在不當的場合配戴眼鏡/帽子，想遮掩擴張的瞳孔	☐	☐
5.	擁有錫紙/飲管/經改裝的飲品樽或盒等服食毒品的工具	☐	☐
6.	有不明來歷的藥物/煙紙/煙管	☐	☐
7.	紙袋或膠袋內有藥粉	☐	☐
8.	數小時內不斷飲用大量清水或凍飲	☐	☐
9.	情緒不穩定	☐	☐
10.	進食的習慣改變了	☐	☐
11.	精神不集中/神不守舍	☐	☐
12.	經常沒精打采或反常地亢奮	☐	☐
13.	反應遲鈍	☐	☐
14.	記憶力衰退	☐	☐
15.	長時間流連在外、離家出走	☐	☐

10. (續) 以下是否濫用藥物者的特徵？請在合適方格加✔。

		同意	不同意
16.	聯絡朋友時表現神秘	☐	☐
17.	獨留房中、逃避與家人接觸	☐	☐
18.	和一些背景可疑的朋友交往	☐	☐
19.	落的士高、參加狂野派對、流連機舖等高危地方	☐	☐
20.	向同學、同事、朋友借錢，但說不出理由	☐	☐

(11)以下是一些關於濫用藥物的句子，請依據你的看法，在合適方格加✓。

		同意	不同意
1.	吸食少量的大麻，不算是濫用藥物	☐	☐
2.	如果不是經常地使用某種藥物，不算是濫用藥物	☐	☐
3.	學校舉辦預防濫藥活動，能十分有效地預防青少年濫用藥物。	☐	☐
4.	若果我的目標子女有濫用藥物的情況，我會諮詢專業人仕的幫助或意見。	☐	☐
5.	作爲家長，我有需要了解青少年人濫用藥物的原因、藥物影響等。	☐	☐
6.	我會找機會與**目標子女表達**(溝通)我對青少年濫用藥物的意見。	☐	☐
7.	父母濫藥會增加子女濫藥的機會。	☐	☐

第五部份 (管教壓力及滿足感　樣本)

(12)請就以下各題，在合適方格加✓以表示你在最近一、兩星期的想法。

		十分同意✓✓✓	同意✓✓	有些同意✓	有些不同意✖	不同意✖✖	十分不同意✖✖✖
1.	我很高興能夠爲人父母。	☐	☐	☐	☐	☐	☐
2.	照顧**目標子女**----------。	☐	☐	☐	☐	☐	☐
3.	我有時擔心自己是否已爲**目標子女**做足要做的事。	☐	☐	☐	☐	☐	☐
4.	我和----------。	☐	☐	☐	☐	☐	☐
5.	我很喜歡和**目標子女**共渡時光。	☐	☐	☐	☐	☐	☐
6.	**目標子女**讓我有被愛的感覺。	☐	☐	☐	☐	☐	☐
7.	**目標子女**令----------。	☐	☐	☐	☐	☐	☐
8.	**目標子女**在我一生中帶來很大的壓力。	☐	☐	☐	☐	☐	☐
9.	有了**目標子女**，----------。	☐	☐	☐	☐	☐	☐
10.	養兒育女是一項經濟重擔。	☐	☐	☐	☐	☐	☐
11.	因爲有了**目標子女**，----------。	☐	☐	☐	☐	☐	☐
12.	**目標子女**的行爲常令我尷尬和感受到壓力。	☐	☐	☐	☐	☐	☐
13.	如果可以重新選擇，我可能決定不會生兒育女。	☐	☐	☐	☐	☐	☐
14.	作爲父母的責任令我感到吃不消。	☐	☐	☐	☐	☐	☐
15.	有了**目標子女**，----------。	☐	☐	☐	☐	☐	☐
16.	作爲一個父母，我感到十分滿足。	☐	☐	☐	☐	☐	☐
17.	我的**目標子女**爲我帶來樂趣。	☐	☐	☐	☐	☐	☐

(13)在以下各部份的問題中，請✓選一個最能代表你心中意見的答案。

		十分同意✓✓✓	同意✓✓	有些同意✓	有些不同意✖	不同意✖✖	十分不同意✖✖✖
1.	做父母並不困難，甚麼問題都可以很容易解決。	□	□	□	□	□	□
2.	我已經達到我期望自己應有的水平，來照顧我的目標子女。	□	□	□	□	□	□
3.	如果有人可以找出困擾我的目標子女的原因，那人必定是我。	□	□	□	□	□	□
4.	在我做父/母親這段日子，我感到我已經完全熟習這個角色。	□	□	□	□	□	□
5.	我確信我已擁有一切所需的技巧去做我目標子女的好父/母親。	□	□	□	□	□	□
6.	我已經領悟到一個道理，那就是只要你明白你的行爲是怎樣影響到你的目標子女，那麼，照顧目標子女的困難便會很容易解決。	□	□	□	□	□	□
7.	我認爲自己可以爲剛爲人父/母親的人做個好榜樣，讓他們知道如何做個好父/母親。	□	□	□	□	□	□

第六部份 個人資料

(14)你所有的子女年齡分別是：___歲、___歲、___歲、___歲、___歲，共有□□個子女

(15)婚姻狀況：□已婚 □同居 □分居 □離婚 □喪偶 □未婚

(16)你的年齡（請填上）：_____歲

(17)配偶年齡（請填上）：_____歲 □不適用

(18)你的居港年期（請填上）：_____年

(19)你配偶的居港年期（請填上）：_____年 □不適用

(20)你所居住的地區： □中西 □灣仔 □東區 □南區 □深水埗 □九龍城
□油尖旺 □觀塘 □黃大仙 □葵青 □荃灣 □屯門 □元朗 □離島
□大埔 □沙田 □西貢 □北區 □其他：_____

(21)你的教育程度： □沒有受過教育 □小學 □中一至三
□中四至中五 □預科 □大專 □大學或以上

(22)你的職業： □全職(每週 44 小時或以上) □兼職(每週少於 44 小時)
□退休 □待業 □料理家務

(23)每月家庭總收入： □$4,999 或以下 □$5,000-$9,999 □$10,000-$19,999
□$20,000-$29,999 □$30,000-$39,999 □$40,000 或以上

(24)目前有否領取綜援：□有 □沒有

問卷完畢，謝謝!!

Appendix 3.3 Post-test Questionnaire in Phase III

社會工作及社會行政學系

DEPARTMENT OF SOCIAL WORK
AND SOCIAL ADMINISTRATION

香 港 大 學
香 港 薄 扶 林 道

The University of Hong Kong
Pokfulam Road, Hong Kong

編號：

樣本，只供參考用

「溝通管教有妙法」家長問卷 (活動後)

親愛的家長:

謝謝您完成課程，並協助填寫活動後問卷!

回答問卷時，請繼續以目標子女爲填答重心。問卷只供分析活動成效之用，內容絕對保密，而每題的答案亦沒有對錯之分，請各位放心回答。完成後，請依照發放問卷的工作人員之指引交回問卷。

如您對是項調查有任何查詢，或有興趣提供更多有關資料，歡迎與東華三院越峰成長中心鍾惠儀小姐聯絡 (2884 0282)。如您想知道更多有關研究參與者的權益，請聯絡香港大學非臨床研究操守委員會 (2241 5267)。多謝合作!

香港大學社會工作及社會行政學系
副教授及研究計劃總監
曾潔雯博士
二零零七年一月三日

填寫指示

家長姓名：_____
目標子女姓名：_____
填答日期：_____

【工作員專用】

1. ☐ 已填寫所有答案
2. ☐ 已記下尚欠的答案作跟進
3. ☐ 交回負責同工

工作員姓名：_____ **日期：**_____

第一部份 (引起動機元素)

(1) 你同意以下各項安排，能吸引你**持續出席各節課程**嗎?

		十分同意	同 意	不同意	十分不同意
1.	課程內容	☐	☐	☐	☐
2.	工作員態度	☐	☐	☐	☐
3.	工作員技巧	☐	☐	☐	☐
4.	以小組形式進行	☐	☐	☐	☐
5.	配合生活例子講解	☐	☐	☐	☐
6.	別人鼓勵參與(如：社工、老師)	☐	☐	☐	☐
7.	派發出席證書	☐	☐	☐	☐
8.	派發禮物/禮券	☐	☐	☐	☐
9.	派發筆記/家長錦囊	☐	☐	☐	☐
10.	提供茶點	☐	☐	☐	☐
11.	其他：(請說明)_____	☐	☐	☐	☐

第二部份 (課程成效)

(2) 以下是有關你對小組成效的意見，請在適當的地方加 ✓。

		十分同意 ✓✓	同意 ✓	不同意 ✖	十分不同意 ✖✖
課程令我：					
1.	更認識青少年最常用濫用的藥物名稱、影响及吸食方法。	☐	☐	☐	☐
2.	更掌握如何預防我的**目標子女**濫藥。	☐	☐	☐	☐
3.	更容易分辨我的**目標子女**有沒有濫藥。	☐	☐	☐	☐
4.	認識更多求助途徑，處理子女可能有的濫藥問題。	☐	☐	☐	☐
5.	更了解跨代濫藥的原因及影響。	☐	☐	☐	☐
課程令我：					
1.	更明白青少年的特性及青少年潮流文化。	☐	☐	☐	☐
2.	更懂得與我的**目標子女**溝通。	☐	☐	☐	☐
3.	更懂得處理我與目標子女的衝突。	☐	☐	☐	☐
4.	更有效運用獎罰處理**目標子女**的行爲。	☐	☐	☐	☐
5.	更能夠積極面對**目標子女**的行爲問題。	☐	☐	☐	☐
6.	更能夠處理自己的情緒問題及能力。	☐	☐	☐	☐
小組舉辦形式方面：					
1.	時間合適。	☐	☐	☐	☐
2.	地點合適。	☐	☐	☐	☐
3.	課程內容合適。	☐	☐	☐	☐
4.	導師表現令人滿意。	☐	☐	☐	☐

第三部份 (管教能力自我評估)

(3) 假如你的**目標子女**有吸煙、喝酒、打架、偷竊、在父母禁止下仍深夜在外逗留、離家出走、逃學、販賣私煙或翻版光碟、自言自語、有思覺失調現象、藏有或販賣毒品、與不良朋輩在一起、有自殺念頭或行動等行爲問題，你認爲自己有能力處理嗎?

□極欠能力　□略欠能力　□一般能力　□很有能力　□極有能力

第四部份 (管教模式)

(4) 以下是描述你和目標子女的一般關係。請在合適的方格加✓。(DRS)

		十分同意✓✓	同意✓	一半半	不同意✖	十分不同意✖✖
1.	當目標子女犯錯時，我是通情達理的。	□	□	□	□	□
2.	當目標子女想跟我談話，我樂意奉陪。	□	□	□	□	□
3.	當目標子女犯錯，我會給他/她機會解釋。	□	□	□	□	□
4.	即使我不同意目標子女的觀點，我仍會聆聽。	□	□	□	□	□

(5) 如**目標子女**長高了，要買新衣物換季，你通常會怎樣做？(請只✓一個答案)

□ 我知道他/她的需要，我會買給他/她
□ 我會和他/她按需要、款式及價格商量買甚麼，有時讓他/她自己買，有時和他/她一起去買
□ 我會付錢，他/她喜歡買甚麼都可以
□ 我不會理這些事
□ 其他，請註明_____

(6) 如**目標子女**欠交功課，你通常會怎樣做？(請只✓選一個答案)

□ 我會先去了解他/她是否有困難完成功課，再給予一些提點，避免再犯
□ 他/她喜歡做功課便會做, 不喜歡便不會做
□ 我會嚴厲警誡，不能讓他/她再犯
□ 老師會處理這些事，不用我理
□ 其他，請註明_____

(7) 在目標子女結交朋友/同學的事情上，你通常會怎樣處理？(請只✓選一個答案)

□ 我會教導他/她小心結交朋友，並留意他/她與何人來往，偶然加以提點
□ 我不會理他/她和甚麼人交往
□ 我不會讓他/她和損友來往
□ 我會讓他/她和自己喜歡的朋友來往
□ 其他，請註明_____

(8) 你每週平均與該目標子女相處(如:一同在家)多少時間（請填上）:_____小時

(9) 你每週平均能夠有質素地與目標子女溝通的時間佔（請填上）: _____ 分鐘

(10)若以 1-5 分爲標準，5 分爲最高，1 分爲最低，你覺得你家庭的凝聚及團結力值多少分?
□1 分 □2 分 □3 分 □4 分 □5 分

第五部份 (有關預防濫藥行爲的知識及態度)

(11)你同意以下是濫用藥物者的特徵嗎？請在合適方格加✓。

		同意	不同意
1.	學業或工作表現轉差	□	□
2.	曠課或無故請假	□	□
3.	經常索取金錢，甚至偷取財物	□	□
4.	在不當的場合配戴眼鏡/帽子，想遮掩擴張的瞳孔	□	□
5.	擁有錫紙/飲管/經改裝的飲品樽或盒等服食毒品的工具	□	□
6.	有不明來歷的藥物/煙紙/煙管	□	□
7.	紙袋或膠袋內有藥粉	□	□
8.	數小時內不斷飲用大量清水或凍飲	□	□
9.	情緒不穩定	□	□
10.	進食的習慣改變了	□	□
11.	精神不集中/神不守舍	□	□
12.	經常沒精打采或反常地亢奮	□	□
13.	反應遲鈍	□	□
14.	記憶力衰退	□	□
15.	長時間流連在外、離家出走	□	□
16.	聯絡朋友時表現神秘	□	□
17.	獨留房中、逃避與家人接觸	□	□
18.	和一些背景可疑的朋友交往	□	□
19.	落的士高、參加狂野派對、流連機舖等高危地方	□	□
20.	向同學、同事、朋友借錢，但說不出理由	□	□

(12)以下是一些關於濫用藥物的句子，請依據你的看法，在合適方格加✓。

		同意	不同意
1.	吸食少量的大麻，不算是濫用藥物	□	□
2.	如果不是經常地使用某種藥物，不算是濫用藥物	□	□
3.	學校舉辦預防濫藥活動，能十分有效地預防青少年濫用藥物。	□	□
4.	若果我的**目標子女**有濫用藥物的情況，我會諮詢專業人仕的幫助或意見。	□	□
5.	作爲家長，我有需要了解青少年人濫用藥物的原因、藥物影響等。	□	□
6.	我會找機會與**目標子女表達**(溝通)我對青少年濫用藥物的意見。	□	□
7.	父母濫藥會增加子女濫藥的機會。	□	□

第六部份 (管教能力感及管教壓力　　樣本)

(13)請就以下各題，請在合適方格加✓以表示你在最近一、兩星期的想法。

		十分同意✓✓✓	同意✓✓	有些同意✓	有些不同意✖	不同意✖✖	十分不同意✖✖✖
1.	我很高興能夠爲人父母。	□	□	□	□	□	□
2.	照顧**目標子女**所----------。	□	□	□	□	□	□
3.	我有時擔心自己是否已爲**目標子女**做足要做的事。	□	□	□	□	□	□
4.	我和**目標子女**十----------。	□	□	□	□	□	□
5.	我很喜歡和**目標子女**共渡時光。	□	□	□	□	□	□
6.	**目標子女**讓我有被愛的感覺。	□	□	□	□	□	□
7.	**目標子女**令----------。	□	□	□	□	□	□
8.	**目標子女**在我一生中帶來很大的壓力。	□	□	□	□	□	□
9.	有了**目標子女**，使我再沒有甚麼時間和做其他事的餘地。	□	□	□	□	□	□
10.	養兒育女是一項經濟重擔。	□	□	□	□	□	□
11.	因爲有了**目標子女**，----------。	□	□	□	□	□	□
12.	**目標子女**的行爲常令我尷尬和感受到壓力。	□	□	□	□	□	□
13.	如果可以重新選擇，我可能決定不會生兒育女。	□	□	□	□	□	□
14.	作爲父母的責任令我感到吃不消。	□	□	□	□	□	□
15.	有了**目標子女**，我----------。	□	□	□	□	□	□
16.	作爲一個父母，我感到十分滿足。	□	□	□	□	□	□
17.	我的**目標子女**爲我帶來樂趣。	□	□	□	□	□	□

(14)在以下各部份的問題中，請✓一個最能代表你心中意見的答案。

		十分同意✓✓✓	同意✓✓	有些同意✓	有些不同意✖	不同意✖✖	十分不同意✖✖✖
1.	做父母並不困難，甚麼問題都可以很容易解決。	□	□	□	□	□	□
2.	我已經達到我期望自己應有的水平，來照顧我的**目標子女**。	□	□	□	□	□	□
3.	如果有人可以找出困擾我的**目標子女**的原因，那人必定是我。	□	□	□	□	□	□
4.	在我做父/母親這段日子，我感到我已經完全熟習這個角色。	□	□	□	□	□	□
5.	我確信我已擁有一切所需的技巧去做我**目標子女**的好父/母親。	□	□	□	□	□	□
6.	我已經領悟到一個道理，那就是只要你明白你的行爲是怎樣影響到你的**目標子女**，那麼，照顧目標子女困難便會很容易解決。	□	□	□	□	□	□
7.	我認爲自己可以爲剛爲人父/母親的人做個好榜樣，讓他們知道如何做個好父/母親。	□	□	□	□	□	□

問卷完畢，謝謝!!

Appendix 3.4 Feedback Form for Collaborative units' workers in Phase III

香港大學社會工作及社會行政學系　　東華三院越峰成長中心

【溝通管教有妙法】預防及處理青少年成癮行為家長證書課程

參與機構回應表

樣本，只供參考用

親愛的_____先生/女士：

感謝貴　機構參與是次研究計劃及協助招募家長參與課程。是次研究計劃得以順進行，實有賴閣下及貴　機構全力協助及支持，而貴 機構在招募家長參與的經驗更對研究隊改善研究設計及課程內容十分有幫助。

我們很希望收集貴 機構有關 (1) 招募參加者，及(2)對本課程 設計和行政安排的意見。現誠邀閣下抽空填妥隨函之回應表，於一月二十日前傳真至 2884 3262 計劃社工曾宏強收。如有查詢或其他意見，歡迎致電 2884 0282 與計劃主任鍾惠儀聯絡。

勞煩之處，不勝感謝，並祝

新年快樂！

香港大學社會工作及社會行政學系系主任
「家長在預防青少年濫用藥物的參與」研究計劃總監

曾潔雯博士　謹上
二零零八年一月十日

附件：「溝通管教有妙法」家長證書課程機構回應表

香港大學社會工作及社會行政學系　　東華三院越峰成長中心

傳真號碼： 2884 3262 (曾宏強先生)　　聯絡電話：2884 0282　課程編號：

「溝通管教有妙法」家長證書課程機構回應表

第一部份 (招募家長之經驗) (可選多項)

1.	宣傳和招募方面所花的時間	□一星期以下 □半個月 □一個月 □一個半月 □兩個月 □兩個半月 □三個月 □三月半月 □四個月或以上
2.	參加者主要來自：	□ 從未或較少參與活動之家長 □ 間中或經常參與活動之家長 □ 兩者參半 □ 其他：_____
3.	宣傳的渠道（可選多項）	□ 負責老師 / 社工的家長網絡 □ 海報宣傳 □ 跨校 / 機構的家長網絡 □ 學校 / 機構通訊 □ 其他：_____
4.	你認爲家長如何得知此活動	□ 海報 / 宣傳單張 □ 校方 / 社工主動邀請 □ 家長信/ 中心通訊 □ 其他家長 □ 其他途徑：_____
5.	招募時遇到的困難及處理方法 (如有)。	
6.	課程有什麼吸引家長的參與？	□教授親子溝通、問題及衝突處理技巧 □報名方法方便 □講解成癮行爲(如:沉迷上網、濫藥) □派發出席證書 □以小組形式進行 □派發禮物或禮券 □配合生活例子講解 □舉辦日期及時間合適 □別人鼓勵參與(如：社工、老師) □舉辦地點合適 □講員或導師吸引 □提供茶點 □其他：(請說明)_____

第二部份 (課程設計及推行)(只選一項)

7.	課程的內容設計能配合家長的需要。	□十分同意 □同意 □不同意 □十分不同意 詳細意見：
8.	每節課後的個別電話跟進(家長)能提升家長的參與率	□十分同意 □同意 □不同意 □十分不同意 詳細意見：
9.	研究隊能與貴 機構保持良好溝通及作出合宜的跟進。	□十分同意 □同意 □不同意 □十分不同意 詳細意見：
10.	課程導師表現令人滿意。 **(如閣下列席課程不足 兩堂，則可選不適用)**	□十分同意 □同意 □不同意 □十分不同意 □不適用 詳細意見：
11.	本計劃/家長課程有繼續開辦或延伸的價值。	□十分同意 □同意 □不同意 □十分不同意 詳細意見：
12.	若再辦課程，貴 校/機構會否考慮繼續參與?	□會考慮 □不會考慮 建議延伸 / 合作方向：

學校/機構名稱：_____　聯絡電話：_____

回應者姓名：_____　職位：_____　日期：_____

Documentation of the project on Engagement of Parents in Anti-drug Work
「家長在預防青少年濫用藥物的參與」研究計劃書籍一覽表:

1. Report on Engagement of Parents in Anti-drug Work
   「家長在預防青少年濫用藥物的參與」研究計劃報告書

2. Implementation manuals for drug prevention parent education program
   「溝通管教有妙法」預防及處理青少年偏差及成癮行爲家長證書課程
   Manual One: Workers' guide
   第一冊：推行手冊 **(設計理念及工作人員指引)**
   Manual Two: Program for parents with general youth
   第二冊：課程推行手冊【GenP】**(適合子女尚未有高危行爲之家長)**
   Manual Three: Program for parents with at-risk youth
   第三冊：課程推行手冊【RiskP】**(適合子女已有高危行爲之家長)**
   Manual Four: Program for parents with drug-taking history
   第四冊：課程推行手冊【DrugP】**(適合曾有濫藥經驗之家長)**

End of report

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