A STUDY ON DRUG ABUSE AMONG YOUTHS AND

FAMILY RELATIONSHIP

<<青年濫藥與家庭關係的研究>>

THE FINAL REPORT

(FINAL version)

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PREFACE

The project on the study on "DRUG ABUSE AMONG YOUTHS AND FAMILY RELATIONSHIP" ("the Study") is being undertaken by the Centre for Suicide Research and Prevention and the Department of Social Work and Social Administration at the University of Hong Kong ("the Consultant").

The research team comprises the principal investigator (PI), Professor Paul YIP, Director of the Centre for Suicide Research and Prevention and Professor of the Department of Social Work and Social Administration at the University of Hong Kong, and eight co-investigators (Co-Is), Dr. CHEUNG Siu Lan Karen (Demographer), Dr. Sandra Tsang (Social and Family Worker), Dr. Samson Tse (Focus group expert on mental health and drug abuse), Dr. Wong Oi Ling (Family therapist, Family Institute), Prof. Karen Laidler (Sociologist, expertise on assessing drug abuse problem), Dr. Paul Wong (Clinical psychologist), Ms. Frances Law (Social Worker), and Dr. Lilian Wong (Associate Consultant, Department of Pediatrics and Adolescent Medicine, Tseung Kwan O Hospital, Hospital Authority).

We would like to thank Mr. Gary Ip, the research assistant of the Department of Social Work and Social Administration, Ms. Garlum Lau, the senior research officer

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EXECUTIVE SUMMARY

(1) Based on the extensive literature review on family role in helping teen drug abusers with a family perspective and the comparisons with the results and evidence of the local and overseas studies and Eastern and Western practices dealing with teen drug addictions, this final report makes policy recommendations with regard to the key findings from the secondary data analysis, the focus groups and the case studies.

(2) Some previous studies show that the overall trend of lifetime drug-taking secondary students rose from 3.3% in 2004/05 to 4.3% in 2008/09. The age of students starting to take drugs has become younger: for those aged 12 or below, there was a close to double increase in drug prevalence of 2.4% in 2004/05 to 4.6% in 2008/09. Among this group of students, 7.7% did not live with either of the parents, compared to 2.5% for their non-drug-using counterparts. From the experiences of front-line social workers and research studies, Hong Kong experiences the process of "normalization" of drug use, especially among marginal youth. The major problem is that they do not consider themselves as having problems or in need of help.

(3) Chapter 2 summarizes overseas experiences, including Western countries such as Australia, Canada, the U.K., and the U.S. and Asian countries such as Taiwan, Mainland China and Singapore. In those Western countries, there are several initiatives to deal with drug taking and prevention: (i) identifying and reducing the risk factors related to youth substance use; (ii) enhancing protective factors and strengthening the family functioning and attached bonding, maintaining effective communications and harmonized relationships with adults through

family-based intervention like parental or family training, provision of nation-wide meaningful youth engagement; (iii) addressing the needs of not only the adolescent themselves, but also the young adults, their families and the broader community; (iv) acknowledging the importance of supporting parents and the families to build healthy families at an early stage so that children and youth can benefit from growing up in a positive environment, thereby naturally building resistance against delinquent behaviors; (v) collaborating with different stakeholders (e.g. NGOs and government) to assist at-risk families, so as to minimize drug and other social problems being spread inter-generationally (especially in the U.K. and Australia); (vi) mobilizing different sectors of the community to address the drug issue (especially in the U.S.); and (vii) emphasizing youth-focused community prevention initiatives involving different partners (especially in Canada). However, in Asian countries, such as Taiwan, Mainland China and Singapore: more emphasis on information dissemination, school drug education and law enforcement are placed. Little is to do with risk and protective factors or the ecological framework of drug use.

(4) Chapter 3 shows that use of psychotropic substance has become more prevalent among boys in older adolescents (Form 3-7) than for younger adolescents (Form 1-2), and exceed the prevalence of using inhalant. There is about 5% prevalence of drug abuse among our youth of aged 15-24. The drug prevalence for working young adults soars up to 14% for males and 9% for females. The drug abusers have similar risk profiles with other deviant behaviors, e.g. deliberate self-harm, smoking and drinking. From the study of odds ratios of logistic regression models, there is a significant association between family structure and drug abuse among boys. The adjusted odds ratios showed that, compared to those who have

married parents, boys whose either or both parents has passed away were more likely to be drug users (OR=4.633, CI=2.294, 9.355), whereas girls whose parents were divorced or separated were more likely to be drug users (OR=2.367, CI=1.178, 4.759). Parents' divorce, separation or passing away has a high influence on substance abuse among adolescents. Feeling happy about family life, good relationship with parents and acceptance to parenting are significant protective factors to substance abuse.

(5) In Chapter 4, the results of focus groups show that there are four themes. First, young people's initial drug use must be understood in the context and primacy of their peers. Second, both young people and their children recognize the lack of communication in the family as one of the risk factors, and want to develop the ability to have meaningful interactions. Third, youth and their family relationships are heavily shaped by parents' work and other commitments in a culture which is perceived to place heavy emphasis on materialism. This can add further pressure on parents and their children. Fourth, at the community and education levels, young people tend to thrive in an environment of creativity.

(6) Based on the four in-depth case studies as presented in Chapter 5, a number of risk and protective factors around five themes have been identified: including 1) family crisis; 2) attachment to family members; 3) factors attributable to drug use; 4) factors conducive to drug withdrawal; and 5) issues in tacking drug use. Youths seem to share a very similar pattern of taking drug and other deviant behaviors. These youths started to experiment with drugs after the occurrence of a family crisis (i.e., presence of parent's physical illness, parents' relationship problems) which strongly weakens the parental monitoring and family system. The results reveal a common pathway of marginal youths taking drug when they possessed

less family and school social capital, suffered from more educational disadvantages and failures, and had involvement with drug-taking peers. However, with the help of the attached parent(s) or significant others and efforts from professionals, the four cases demonstrated that they were able to stop using drugs. More importantly, the non-psychiatric medical services have helped the drug-taking youths have a better understanding of the physical harmfulness of drug use on them. They have also provided a platform for multi-disciplinary effort in dealing with recreational drug-taking youths who have yet to develop substance-use disorders that require psychiatric service.

(7) In short, a common trajectory of the youths taking drug is ascertained in this study. Drug use like other adolescent behavioral issues involves a number of factors, some of which interact or operate jointly. Firstly, most of them are heavily affected by dysfunction families due to unstable family condition (e.g. poor marital relationship, family crisis, divorce, single-parent family), low income and long working hours of family members (e.g. limited family time, little attention to young people, poor attachment with parents/significant others), poor/ineffective communication between youth and his/her family (e.g. inadequate/poor parenting and bad relationship with parents). Secondly, easy access to drugs within immediate neighborhood (e.g. convenient supply and relatively cheap cost) increases the exposure of risk to drug. Thirdly, failure of school achievement, feeling boredom and affected by undesirable peer influence and intergenerational addiction are also the major risk factors.

(8) Given the evidence and findings from this study, a public health approach with a multi-layered intervention is therefore recommended to empower family. Efforts on preventions and interventions should be made to enhance protective factors

through family-based intervention like parental or family training, provision of community-wide meaningful youth engagement, and reduce risk factors, instead of focusing on the drug issue per se and individual. The target would not only cover among the school youths, but also drop-out, unemployed or working youngsters. FOUR themes should be included **<u>youth-centered</u>** (for, with, and by the youth); **<u>family-focused</u>** (equal-finality proposition); **<u>neighborhood and community-sensitive</u>** (ecological, public health, social development, broken window (early intervention); cultural/contextual); and **<u>government-led</u>** (top-down directives especially for cross-departmental collaborations) approach focusing on transitional periods and developmental stages. Specific recommendations should be included: (i) **to identify and support high risk families**: single-parent, inter-generational addictions (drug/gambling/drinking), poorer social economic status (e.g. receiving CSSA), having frequent family crises involving school-age children, out of school youths and working youths through the cooperation of different sectors of the community (i.e. outreach social workers, non-clinical & clinical professionals, teachers and schools, police, etc.) and link with referral of family services (e.g. in-home family support); (ii) **to nurture positive family relationship**: a family-friendly working environment should be promoted and reinforced in Hong Kong; (iii) **to enhance community involvement**: especially for poorer household income and at-risk districts.; (iv) **to curb drug sources covering a wider range**: such as random drug tests at the border between Mainland and Hong Kong to handle cross-border drug and liaison with the Mainland authority in making it more difficult for young people to get hold of the drug rather than just imposing drug tests at school; (v) **to extend more professional trainings**: which include to develop a manual to work

with children and parents in dysfunctional families, provide more trainings, seminars and workshops for identifying at-risk families and suggesting measures to strengthen family protective factors that can be held at the district level and school-based with the support of the parent association in the school; family and school social workers as trusted professionals in the neighborhood and in the workplace to provide family parenting education and early identification and to help family recover the resiliency of family function; (vi) **to provide more efficient anti-drug programs**: it is necessary to examine how different existing programs modify the youth's drug-related attitude and behavior in the long run; (vii) **to reform the mindset in the educational system**: such as making school curriculum more attractive and developing interactive joint parental activities and to reinforce the importance of family values which can help the youths become a full competent, self-regulated and caring person. Incentives such as scholarships can be awarded to the students who might not perform well in academic, but in other domains such as sports and arts; (viii) **to disseminate credible anti-drug and family-harmonized environment messages/slogans**: youth-respite and drug-free and family-harmonized ambassadors should be appointed through public events to establish a positive idol to the youngsters and enhance parental relationship.

報告摘要

(1) 這份報告書的政策建議是根據廣泛的文獻回顧、數據分析、焦點小組和個案研究的結果所提出。並從家庭觀點上，綜合中西方在實踐處理青少年濫用毒品成癮的結果和證據中找出家庭角色如何能幫助濫用毒品的青少年。

(2) 從過往的研究顯示，中學生曾經濫用毒品的趨勢由 2004/05 年度的 3.3％上升至 2008/09 年度的 4.3％。濫用毒品的年齡更有年輕化的跡象；對於 12 歲或以下的學童，比率由同時期的 2.4％大幅增加至 4.6％，上升接近一倍。這群濫用毒品的學生當中有 7.7％並非與父母同住，相比沒有濫用毒品的學生祇有 2.5％為高。根據前線社工的經驗和調查結果，香港正經歷濫用毒品「正常化」的問題，特別是對於邊緣青年，關鍵是他們不認為自己有問題或需要幫助。

(3) 第二節綜合外國的經驗，包括西方國家如澳大利亞、加拿大、英國、美國，及亞洲國家如台灣、中國大陸和新加坡。在這些西方國家中，已有數項措施以應付及預防濫用毒品：（一）先找出和減少有關青年使用毒品的風險因素；（二）加強保護因素和強化家庭關係及保持家庭成員之間有效的溝通與和諧的關係，並通過以家庭為基礎的干預，如父母或家庭培訓及提供更全面性和有意義的活動供青少年參與;（三）在處理這些濫用毒品的問題時，不僅針對青少年本身的需要，還有他們的家庭及整個社會;（四）確立支援家長及家庭的重要性，協助建立一個健康家庭，讓兒童和青年在早期階段中能夠在一個積極的環境中成長，從而自然地抵抗偏離的行為;（五）與不同的服務機構平台（如非牟利機構和政府）合

作，協助有問題的家庭，使濫用毒品和其他社會問題跨代傳播的風險降至最低（參考如在英國和澳大利亞）；（六）動員社會各界人士來解決毒品問題（參考如在美國）和（七）以青年為重點，與不同的夥伴合作的制定社區預防措施（參考如在加拿大）。但是，在亞洲國家，如台灣、中國大陸及新加坡：則強調資料信息的傳播，特別集中加強在學校禁毒教育和執法上的位置。對於利用風險和保護因素或是從社會生態學角度上所做的工作仍然很少。

(4) 第三節顯示年紀較大並就讀中三至中七的男學生比就讀中一至中二的更為普遍使用精神科藥物，這情況比使用吸入式的更為嚴重。在 15-24 歲的青年中，濫用毒品的比率約為 5％。在職青年的的比率更飆升至男性為 14％及女性為 9％。濫用毒品與其他偏差行為 (如蓄意自我傷害、吸煙和酗酒) 都擁有類似的風險特徵。從羅吉斯的迴歸勝算比法中，家庭結構與濫用毒品在男性中有顯著的關係。調整後的數值顯示，假若男孩的其中一名或雙親已過世，他更有可能使用毒品（OR = 4.633，CI 為 2.294，9.355）；另一方面，假若女孩的父母已離婚或分居，她使用毒品的風險亦相對增加（OR = 2.367，CI 為 1.178，4.759）。父母離婚、分居或離世均明顯地影響青少年濫用毒品。對家庭生活感到快樂、與父母有良好的關係及接受父母的教導都是防止濫用毒品的保護因素。

(5) 在第四節中，聚焦小組結果顯示四個主題。首先，要了解年青人初次吸毒必須從其背景和朋輩著手。第二，無論是兒童或年青人都認為缺乏家庭溝通是其中一種風險因素，他們亦希望能在家庭中發展有意義的互動交流。第三，青年與家庭的關係大部分受父母的工作和社會文化中「唯物主義」所塑造，這樣會加重父母與子女間相處的壓力。第四，在社區和教育層面上，年青人較希望能在富創造力的環境中成長。

(6) 在第五節中，根據四個深入的個案研究，分別找出一些風險和保護因素並圍繞著五個主題：包括，一）家庭危機；二）與家庭成員之間的情感；三）導致使用毒品的因素；四）停止使用毒品的因素；及五）打擊使用毒品的問題。在使用毒品及其他偏離的行為，青年似乎有著非常類似的模式。這些青少年在經歷家庭危機後便開始嘗試毒品（如父母患病或父母之間出現問題），這些情況強烈地削弱了父母的管教和家庭制度。研究結果顯示，邊緣青少年吸毒都擁有一個共同模式，就是當他們在家庭及學校獲得較少的資源、並在學業上觸礁和失敗、以及受周圍朋輩吸毒所影響。可是，隨著父母或其他重要人物和專業人士的努力和幫助，他們亦能夠停止使用毒品。最重要是，非精神科的醫療服務能幫助吸毒青年更了解毒品對他們身體上的損害。這些服務還提供了一個平台作多方面的接觸，處理一些吸毒情況未致於需要精神科服務及視毒品為「娛樂性質」的青年。

(7) 總括而言，這項研究確定了青少年濫用毒品擁有一個共同軌跡。他們使用毒品就如其他偏離行為問題一樣涉及多種因素，而這些因素亦彼此互動及相連的。首先，大多數的因素是由於不穩定的家庭狀況影響，以致喪失家庭功能（如父母關係變差、家庭危機、離婚及單親家庭），家庭成員工作時間長或低收入（如缺乏家人相聚的時間、較少時間注意青少年、與父母或重要人物有惡劣的關係），青年與他/她的家庭之間缺乏有效的溝通（如管教不足及不善或與父母有惡劣的關係）。其次，一個容易獲得毒品的鄰舍（如方便供應和相對低廉的成本）亦增加使用毒品的風險。第三，在學習上的失敗，感到厭倦和受不良朋輩影響及隔代毒癮也是主要風險因素。

(8) 根據這項研究的證據和調查結果，我們建議應該以家庭為基礎，並使用公共健康的模式與多層次的干預。在防治和干預上應加強保護因素和降低危險因素，如提供父母或家庭培訓，增加全體性及有意義的青年參與行動；而不是只集中在個人或濫毒者身上。我們的目標不僅包括在學的青少年；還有輟學、失業或在職的青年。四個主題包括以**青年為核心**（給他們、與他們、並由他們的角度出發），以**家庭為重點**（如平等及阻截性的建議）、**針對鄰舍及社區**（如生態上、公共衛生、社會發展、破窗理論（及早干預）、文化及背景）和**政府主導**（由上而下的指示，並進行跨部門的合作）的方式，並將焦點集中在過渡時期和成長階段。具體建議應包括：（一）**透過社會各界人士的合作**（如外展社工、非臨床及臨床專業人員、教師和學校、警察等）**和轉介家庭服務**（例如家庭探訪支援）**找出和支援一些高風險家庭**：如單親，隔代成癮（毒品／賭博／酗酒），經濟能力較差（如領取綜援人士），頻密發生家庭危機的學齡兒童、輟學及在職青年；（二）**培養正面的家庭關係**：應促進和加強一個友善家庭的工作環境；（三）**加強社區參與**：特別是針對幫助貧困和低收入的家庭及高危的地區；（四）**擴大毒品來源的涵蓋範圍**：如在內地與香港邊境之間作隨機驗毒，並聯繫內地當局及有關部門以處理跨境毒品，令青少年更難得到毒品；而不是僅僅在學校實施驗毒計劃；（五）**延長更專業的培訓**：當中包括制定一本家庭手冊，或為高風險的家庭提供更多的培訓、研討會和講習班，用以加強家庭保護因素；並以地區層面和學校為基礎，透過家長會的支持，家人和駐校社工分別擔當在鄰舍和工作單位中可信任的專業人士，目的是提供家庭教導孩子的教育、識別濫用毒品的知識及幫助家庭重新恢復家庭功能；（六）**提供更有效的禁毒計劃**：必須評估現階段不同研究計劃中青少年對毒品的態度和行為上的長遠影響；（七）**改革教育思維**：如使學校的課程更具吸引力及發展和父母共同

參與互動的活動，以致力加強對家庭價值觀的重要性，從而幫助青少年成為一個完整，自我調節和關懷他人的人。並可設置獎學金獎勵一些雖在學業上不太理想，但在其他領域，如體育和藝術表現出色的學生；及

（八）**傳播有公信力的反濫用毒品及強化和諧家庭的信息或標語** ：甚至推舉以青少年為主的無毒大使及和諧家庭大使，從而透過一些公眾活動對青少年建立一個正面的形象及強化青年與父母之間的關係。

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CHAPTER 1: INTRODUCTION

Introduction

This project on the study of "***drug abuse among youths and family relationship***" ("the Study") is being undertaken by a multidisciplinary team consisting of public health researchers, medical doctors, psychologist, and social worker, starting from 7 May 2010. The Principal Investigator, Professor Paul S F Yip is in the Centre for Suicide Research and Prevention at the University of Hong Kong. The ethical approval has been sought on 11 May 2010 and approved by the Human Research Ethics Committee for Non-Clinical Faculties (Reference No. EA380410).

Research Aims

This study aims to examine the underlying causes of the youth drug abusers and how they are related in his/her family and to identify problems and needs that young drug abusers are facing. The emphasis would be in understanding how to empower the family's role for prevention of drug abuse in the community. Specific and evidence-based policy recommendations are expected.

Themes and Research Questions

This study focuses on a community based sample of youngsters aged 12-34 (involving different age developmental stages).

FOUR MAJOR THEMES AND RESEACH QUESTIONS are investigated in the project:

1. Family antecedent of youth drug abusers – the forerunning family background of youth drug abusers will be juxtaposed. Research questions are developed in terms of family composition and structure e.g. whether the teen drug abusers have a broken family with a single-parent or not and whether only living with grandparents and relatives are more likely to hazard to take drugs. A combination of different family composition is taken into consideration as in the following matrix, (i) a completed family currently living with father and mother with siblings, such as brothers and/or sisters; (ii) a completed family currently living with father and mother without siblings, such as a single child in family; (iii) a single parent family currently living with either father or mother with siblings, such as brothers and/or sisters; (iv) a single parent family currently living with either father or mother without siblings, such as brothers and/or sisters; and (v) no parent family currently only living with grandparents and relatives with or without siblings. Step-father, step-mother and step-siblings are also taken into account as the divorce rate has been rising in Hong Kong over time. Family members' socio-economic and demographic backgrounds are

also of prime importance in the study. The characteristics of family members including the level of educational attainment, the occupation of their parents, the length of work of their parents, income and financial situation, the place of residence, the type of housing, social class (i.e. whether CSSA family recipient), culture diversity (such as whether one of the parents (i.e. mother) coming from Mainland China in Hong Kong less than 1 year and whether the mother is still staying in Mainland China) etc. will be investigated.

2. Family members' reactions to youth drug abusers – youth drug abuse affects the family unit. Family members' reactions could also affect the decision of youth drug abusers. The discovery of proof of drug abuse may be devastating and making a familial relationship greatly deteriorated. Youngsters could become more hostile if they are not positively supported by the family. They could find themselves using drugs as escapist. Youth drug abusers' interactions within family and family members' reactions are essential to understand the mechanisms behind why some youth drug abusers have fallen prey to drugs. This aspect is also related to whether the youth drug abusers would be able to successfully get rid of the drugs. Reactions can widely cover on different aspects, such as verbal/linguistic responses and skills of communication which can be negative or positive, time dedication and understanding (i.e. how often and long parents and/or family members speak and

interact with the youth drug users), patience, realization and taking immediate actions (i.e. whether and/or when the parents discover or realize their child(ren) who have been involved with drug abuse and whether any immediate actions have been taken such as seeking professional advice and assistance from social workers from the community or at school). In this regard, the research question is to examine whether those adolescents with poor family relationship and interactions are more prone to be drug abusers.

3. How the family can cope and help the youth drug abusers – it is a proactive and multi-directional process between not only the youth drug abusers and the family members, but also clinical professionals (such as medical doctors and clinical psychologists) and non-clinical professionals (such as social workers and teachers) and peers and classmates. The process sets off from (i) a stage one - "realization of the facts" by a parent or other professionals (revealed the evidence that a teen is a drug addict that could be grouped into different extents such as causally/ recreationally abused, progressively used and severely addicted. The last refers to the occurrence of the psychiatric illusions and physical impairments; (ii) the family involvement – the addicted teen probably also hurts for transgressions. Learn and listen what the family members such as parents cope with this problem and whether they have any difficulty in accessing the trained addiction specialists to their

addicted child(ren) and themselves are one of the focuses in the study; and (iii) family and peers conjunction – the youth drug abusers could be affected by their peers group. The linkage between the family members and the peer groups reflects the familial relationship and how much the parents know the world of teen drug abusers. Questions are posed such as do the parents know with whom their teen addicted child(ren) is/are acquainted? How many? And how often they meet each other and where? Where did the parents seek help? Can the family relationship be improved after the treatment services?

4. Specific measures and recommendations will be given to the Family Council based on the results of the study.

Methodology and plan

This study is organized in two Phases (Phases I and II). Each part of the work is led by one Co-I and other team members and presented in each chapter individually.

In PHASE I

1. An extensive and thorough literature review on family role in helping teen drug abusers – with a family perspective – review including the results and evidence of the local and overseas studies and Eastern and Western practices dealing with

teen drug addictions is being led by Dr. Sandra Tsang with the help of Miss Erica

Tong. The literature review covers three major areas: (1)the trends and statistics

in Hong Kong; (2) overarching framework of understanding the youth drug issues

problem, and studies that utilize this framework; and (3) current practices and

intervention strategies from seven countries (i.e. Australia, Canada, PRC, Taiwan,

Singapore, the U.K. and the U.S.A.) on how to prevent youth drug use. The

literature review is presented in Chapter 2.

2. For the secondary data analysis – to examine the prevalence of drug/substance

abuses collaborated by the Centre, the Family Planning Association and Hospital

Authority which is being led by Prof. Paul Yip and Dr. Karen Cheung with the help

of Mr. Derek Cheung. Based on the Youth Sexuality Study (The Family Planning

Association 2006), the longest running community-based sexuality survey in

Hong Kong, we estimate the prevalence of substance use including alcohol,

cigarettes, inhalants and psychotropic substances among Hong Kong in-school

adolescents and young adults (aged 18-27) and examine how family relationship

and qualities affect the likelihood of substance use. In the dataset, the

participants of in-school survey were recruited from day schools through random

sampling, while the young adults' survey was conducted though random

household survey across the territory. The key findings of the secondary data

analysis are shown in Chapter 3.

In PHASE II

3. For the focus group – aims (i) to examine the underlying causes of young drug

    abusers and their relationship with family and assess the impact of drug using on

    the family as a whole and individually ; (ii) to identify risk and protective factors

    of the drug abuse problem – emphasis on the voices of young drug users and

    their family members to share their insiders' stories in relation to their personal

    experience into drug abuse; and (iii) to identify problems and needs that young

    drug abusers see as relevant to the road to recovery (led by Dr. Samson Tse and

    Prof. Karen Laidler). The key results are presented in Chapter 4.

4. For case studies among youth drug abusers – clinical and psychological analysis

    and assessments are used to characterize users' profiles, patterns, problems and

    barriers of accessing to professional help (including relapse) (led by Dr. Paul

    Wong, Dr. Lilian Wong from Hospital authority, Dr. Wong Oi Ling and Ms. Frances

    Law). To understand diverse pathways of the young drug abuse problem and the

    roles of family in terms of the drug use pattern and "intervention", four

    idiographic examinations of four cases are proposed to explore the role of family

    involvement regarding the development of their drug use behaviors and help-

seeking patterns. A semi-structured interview procedure is adopted to investigate the role of the family plays in the adolescent drug use behavior. All 4 cases have been successfully interviewed. The findings are presented in Chapter 5.

CHAPTER 2: LITERATURE ON DRUG ABUSE

2.1. Drug-use situation among youth in Hong Kong

The dramatic increase in the use of drugs among students has raised

concerns in Hong Kong. The finding of over 99% of sampled secondary school[1] has

drug-taking students from the latest *Survey of Drug Use among Students* was

alarming to the society (Hong Kong Narcotics Division, 2010a). The percentage of

lifetime drug-taking secondary students rose from 3.3% in 2004/05 (the last release

of the survey) to 4.3% in 2008/09. The number of 30-day drug taking secondary

students — a number that implies more frequent drug use — almost doubles from

0.8% in 2004/05 to 1.5% in 2008/09. The age of students starting to take drugs is

also getting lower: for those aged 12 or below, there is a close to double increase in

drug prevalence of 2.4% in 2004/05 to 4.6% in 2008/09 (Hong Kong Narcotics

Division, 2010a). The results released in July 2010 from a large scale survey on over

2,700 senior primary school students aged 10 to 12 in 37 primary schools in the New

Territories of Hong Kong further indicated that over 20% of these children assumed

quite an accommodating attitude to drug taking. They under-estimated the risk of

dependence and also considered drug-taking will not affect their peer relationship

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[1] Lifetime drug-taking students were reported in 111 out of the 112 secondary schools surveyed, 84 out of 94 primary schools surveyed, and all of the 17 post-secondary institutions surveyed.

and future development. Over 21% actually claimed they lacked confidence in their

self-control to resist temptations for taking drugs (Barnabas Charitable Service

Association, 2010). These rising trend for youth drug use and weakening of resistance

is worrying to the public, as it has increased over 50% from 2,200 in 2005 to 3,360 in

2010 for the group under 21, as shown in Figure 1 (Hong Kong Narcotics Division,

2010a).

Figure 1. Number of reported substance abusers under aged 21 from 1997 – 2010 1st Quarter
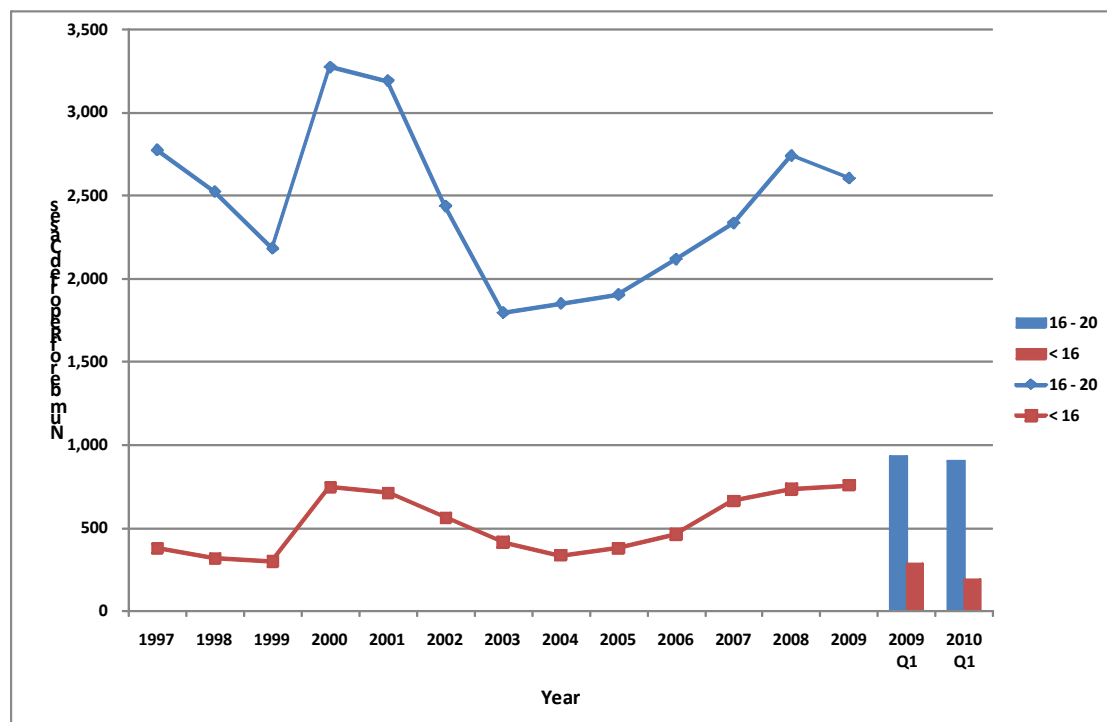
(Source: Central Registry of Drug Abuse [CRDA] 56th Report, 2007 [ND, 2007] & 58th Report, 2009 [ND, 2009a], CRDA Drug Statistics, 2010)

Furthermore, contrary to popular belief, most young drug abusers actually

Group	Frequency	Type of Drugs	Location of Use
Upper primary (Primary 4 – 6)	1.6% (Lifetime), 0.8% (1-year), 0.5% (30-day)	Cough medicine (37.5%), Thinner (30.7%)	Own home (28.1%), Internet café (20.8%), Friend's home (11.4%)
Secondary	4.3% (Lifetime), 2.6% (1-year), 1.5% (30-day)	Ketamine (49.4%), Cannabis (35.6%), Ecstasy (32.0%)	Friend's home (36.2%), Karaoke/disco (25.15), Own home (25%)
Post-Secondary	5.4% (Lifetime), 2.1% (1-year), 1.1% (30-day)	Cannabis (63.3%)	Karaoke/disco (47.4%), Friend's home (34.6%), Pub (26.6%)
Undergraduates	2.9% (Lifetime), 1.3% (1-year), 0.6% (30-day)	Cannabis (70.8%)	Friend's home (54.9%), Own home (28.8%), Karaoke/disco (26.4%)

take drugs at their own or friends' home rather than in public places such as karaoke

or disco (as shown in Table 1), reflecting the hidden nature of the issues.

Table 1. Overview of the frequency, type of drugs used, and location of drug use by group in 2008/09.
Source: The 2008/09 Survey of drug use among students, [ND ,2010a])

The correlation between family structure and drug-using students is also noteworthy. Among this group of students, 7.7% do not live with either of the parents, compared to 2.5% for their non-drug-using counterparts (Hong Kong Narcotics Division, 2010a).

There have been similar periods of drug trends found in other countries and Hong Kong. An example is a downward trend of illicit drug use in most western countries and Hong Kong since the year 2000. Yet, in the West the downward trend

continued until a surge reappeared in the U.S. and U.K. in 2007. In the U.S., the surge was largely contributed by an increase in cannabis use after a decade of downward trend. In the U.K., it can largely be explained by the increased use of cocaine and ketamine. In Canada, the trend continues to be downward. Hong Kong's upward trend of illicit drug use, beginning in 2003/04, precedes that in the U.K., U.S. and Canada.

Figure 2. Percentage of youth drug use in U.K., U.S., Canada, and Hong Kong (note variation in age groupings across countries)
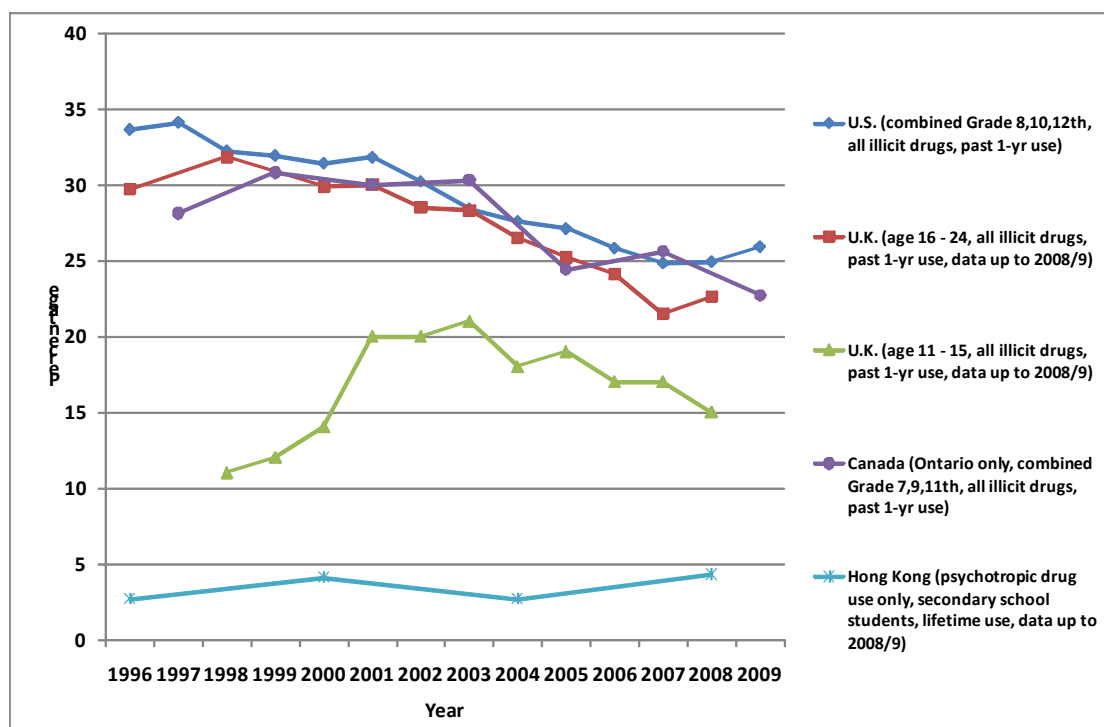
(Source: U.K.: British Crime Survey, 2008/09[2]; U.K.: Smoking, drinking and drug use among young people in England, 2008[3]; U.S.: Monitoring the Future survey, 2009[4]; Canada: Drug Use among Ontario Students, 2009[5]; Hong Kong: The 2008/09 Survey of drug use among students[6].).

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[2] U.K.: British Crime Survey annually examines the prevalence and trends of illicit drug use among a nationally representative sample of 16 to 59 year olds resident (with a particular focus on young people aged 16 to 24) in households in England and Wales (Hoare, 2009).
[3] U.K.: Smoking, drinking and drug use among young people in England is an annual secondary school survey examines young people age 11- 15. About 7,800 students in 264 schools were surveyed in 2008

2.1.1. The changing attitude of drug abuse

From the experiences of front-line social workers and research studies, Hong Kong experiences what is considered the normalization of drug use, especially among marginal youth (Cheung and Cheung, 2006). It stems from the rise of dance club culture in the early 2000 spreading from the West to Asia and the rise of "club" drugs used (i.e., psychotropic drugs) (Joe Laidler, 2005). This normalization encompasses a few aspects: occasional use of psychotropic drugs is deemed acceptable for leisure and recreation (e.g., birthday parties and festivals); misconception (specifically, underestimation) about the level of harm these psychotropic drugs entail as compared to traditional drugs like heroin; misconception of the legal consequences of psychotropic drug use, e.g., unaware that even consumption of such drugs is illegal (Hong Kong Narcotics Division, 2008a). More importantly, the common terminology used to describe psychotropic drug use in Hong Kong — in Chinese it literally means "excessive use of medication" — does not carry the same connotation as "poisonous drug abuse" in its severity. The Task

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(Fuller, 2009).

[4] U.S.: Monitoring the Future is an annual study of the secondary school, college students, and young adults in the U.S. Approximately 50,000 are surveyed each year. Annual follow-up questionnaires are mailed to a sample of each graduating class for a number of years after their initial participation (Johnston, O'Malley, Bachman, & Schulenberg, 2009).

[5] Canada: Drug Use Among Ontario Students is a survey conducted every two years for Ontario secondary school students. It surveyed about 9,000 students in 181 schools (Paglia-Boak, Mann, Adlaf, & Rehm, 2009).

[6] Hong Kong: The survey of drug use is conducted once every four years for secondary school students. The latest issue also covers primary 4 students to post-secondary and university students. A total of about 150,000 students and over 1,000 schools were covered.

Force Report (Hong Kong Narcotics Division, 2008a) made recommendations on changing the terminology in the future. Before the introduction of the Trial Scheme on School Drug Testing in Tai Po District in the 2009–2010 academic year, the subject of youth substance abuse was still a taboo in many schools (The Hong Kong Federation of Youth Groups, 2008). All of the above suggest that some youth drug users regard drug use as an alternative way of life, being part of a social norm within the youth subculture, and that they can make a cost-benefit drug decision. Thus, they do not consider themselves as having problems or in need of help.

In fact, as early as in 2000 the United Nations has already warned about the rise of club drugs and cannabis, as well as their "recreational use" in developed countries in the West, that such use was no longer confined to a small number of marginalized youth (UN Economic and Social Council, 2001). Examples include drug abuse mentioned in the lyrics of popular songs, behavior of entertainment artists, and advertisement that targeted at youth. It had slowly become part of life among mainstream youth during their free time and become a subculture (UN Economic and Social Council, 2002). Drug use was then found not only in disco or at dance parties (UN Economic and Social Council, 2002), and it was portrayed as having a fashionable lifestyle (UN Economic and Social Council, 2001). Young people were

found to become more tolerant towards drugs experimentation (UN Economic and Social Council, 2001). The United Nations therefore called for increased sharing of information among countries to address the then emerging problem at an early stage, especially because youth cultures tend to globalize (UN Economic and Social Council, 2002).

This paper examines the prevention efforts in Hong Kong and other countries. Guided by Bronfenbrenner's ecological theory of development (1979), the public health model (CADCA, 2008), and Hawkins and Catalano's social development system (Hawkins et al., 1987, 2008, 2009; Kawkins, Catalano & Miller, 1992; Hawkins & Catalano, 2005), the complex interplay of factors that contribute to substance abuse in adolescents is investigated. In particular, the role of family is examined— a domain that has often not been addressed sufficiently in the anti-drug efforts in Hong Kong — in how it could become both a risk and a protective factor relating to youth substance use.

2.1.2. Hong Kong: Prevention Initiatives

2.1.2.1 Government bodies

The anti-drug policy in Hong Kong encompasses five areas: preventive education and policy, treatment and rehabilitation, legislation and law enforcement,

external cooperation, and research. Narcotics Division (ND) is responsible for the formulation of anti-drug policy and the overall co-ordination in all five areas of the anti-drug strategy in Hong Kong. Action Committee Against Narcotics (ACAN) is an advisory body to the government on all anti-drug matters. In 2007 the Secretary for Justice was appointed to lead a high-level departmental task force to tackle the issues and make over 70 recommendations in a Task Force Report in 2008 (Hong Kong Narcotics Division, 2008a). In addition, in July 2009 the Chief Executive decided to lead relevant Principal Officials to expedite the implementation of the task force's recommendation with five strategic directions: community mobilization, community support, drug testing, treatment, and law enforcement.

In Hong Kong, prevention education and policies are achieved in the following areas (ND, 2010b):

2.1.2.2 Central Publicity Campaign

Anti-drug publicity activities are spread through mass media such as television dramas and video announcements in radio, slogan and theme songs, anti-drug drama clubs, print media, roving exhibitions, and short-film competitions. Launched in June 2008, a two-year territory-wide campaign with the slogan "No Drugs, No Regrets. Not Now, Not Ever" conveys to the public the negative and

severe consequences of drug abuse and drug trafficking in all areas of life including

health, legal implications, family, peer relationships, etc.

2.1.2.3 Hotline

Anti-drug telephone enquiry service (186-186 run by ND), launched in August

2009, provides both information and counseling service regarding drug abuse.

Parents and teachers can also call this hotline and request talking directly to a social

worker from Tung Wah Group of Hospitals' (TWGHs) CROSS center, a counseling

center dedicated to youth drug use issues (TWGHs CROSS, 2009).

2.1.2.4 Community Sector: Funding and Programs

Beat Drug Funds is the main source of funding provided by the government

to community to launch anti-drug projects and programs ranging from preventive

education and publicity, to treatment and rehabilitation, and to research. Sample

projects include education seminars in various districts and in schools for teachers,

parents, and students, workshops, sports and recreational activities, online radio

station, and research by institutions and NGO that may contribute to the

development of toolkits and resources for the wider community. Unlike the funding

procedures in other countries such as U.S. and Canada, the ND currently does not

require the Beat Drug Funds projects to adhere to a specific prevention or

intervention framework. However, they are required to provide progress report and have visits by ACAN or staff from the Funds or ND. The government is going to inject another HK $ 3 billion in 2010 to the Fund to support community projects in combating drugs (HKSAR Government, 2010).

Also, the "Community Program against Youth Drug Abuse" programs provide a wide range of activities to increase the youth's positive engagement in 18 districts. The District Councils, Home Affairs Bureau, District Fight Crime Committee (DFCC), partnering with various NGOs, parent-teacher associations, uniformed groups, business groups and professional organizations such as the Hong Kong Medical Associations together organize various activities that can potentially attract young people. These include both sports and recreational activities, such as rock climbing and drama, and vocational training, such as sales and hair dressing. In addition, fitness tests, counseling services and treatment would be provided to participants if necessary. Under this umbrella, seminars and sharing sessions are organized for parents and teachers as a means to educate the public about the causes of the youth drug problem, and as ways to identify the physical symptoms and tackle the issue (Home Affairs Bureau, 2009).

Anti-Drug Volunteer Group

The group, under ND, assists in drug education and publicity programs at the Hong Kong Jockey Club Drug Information Centre. Corporate volunteers participate in anti-drug activities organized by ACAN and help spread anti-drug messages to their staff members and families. There are currently 104 corporate volunteers and 350 individual volunteers (ND, 2010b).

Path Builders

Established in September 2008, it is a service platform led by ND to encourage and assist professional bodies and community associations to take up social responsibilities in caring for young people facing drug issues, guiding them to establish positive goals. They can do so by providing job or training opportunities, donations, mentorship, or as anti-drug ambassadors. Currently, over 200 organizations and individuals have pledged support for the Path Builders initiatives. Moreover, ND is in the process of matching the contributors' officers with potential beneficiaries based on their preferences (ND, 2008b).

District Youth Outreaching Social Work Teams and Young Night Drifters

Operated under the Social Welfare Department (SWD), the teams teach and provide guidance and counseling to youth between 6–24 who are at risk of undesirable influences, such as juvenile gangs, as they are not reachable through conventional social and youth activities (Social Welfare Department, 2010).

The health sector also collaborates with the social work sectors in the

prevention and early intervention on drug use. For example, the Northern District

Hospital's UROK Clinic is an outreach team comprised of psychiatrist, urologists,

nurses, physical therapists, social workers and other professionals. They offer health

check-up for young night drifters who are early substance users so that the youth

can understand how their bodies are negatively affected by drugs, thereby

motivating them to receive treatment (Hospital Authority, 2010).

2.1.2.5 Education Sector

The Education Bureau (EB) leads and co-ordinates efforts in the

institutionalization of the "Healthy School Policy" with an anti-drug element. The

following details their anti-drug efforts.

<u>Drug Screening</u>

Starting in September 2009, the Trial Scheme on School Drug Testing was

launched in Tai Po District for one year (ND, 2009b). It is a voluntary, random, non-

punitive urinalysis to test the five most popular drugs used by Hong Kong students:

Ketamine, ecstasy, ice, cannabis, and cocaine. It has two purposes: (1) enhancing the

<u>resolve</u> of non-drug-taking students to continue staying away from drugs, and (2)

motivating drug-taking students to quit drugs and seek help, and providing

appropriate resources for them in doing so. School principals would be informed if the result is tested positive, and principal would inform the parents and the relevant teachers. For experimental users, they would continue school and receive counseling service from school social workers and designated teachers, and may join community-based support service (such as the Counseling Centers for Psychotropic Substance Abusers / CCPSA). As for dependent users, they may join voluntary residential programs in the treatment and rehabilitation centers, and return to school after completion.

The community has had a heated debate about this scheme concerning intrusion of privacy, chance for being persecuted, negative impact on the harmonious atmosphere in school, and its effectiveness to discourage drug use. As of today there have not been any student tested positives in his or her sample, yet the number of students seeking help on drug-related issues increase by more than two-fold (ND, 2010c; Radio Television Hong Kong [RTHK], 2010). The government has yet to decide if the scheme will be implemented at other schools or districts until a research and evaluation of this scheme is completed by the third quarter in 2010. There are concern or questions raised about the drug testing in school in reducing the number of drug abusers among our youth (Yip, 2010, Mingpao)

<u>Anti-drug resource kit for schools</u>

Anti-drug resource kit developed by the Hong Kong Federation of Youth Groups (HKFYG) and ACAN was distributed to schools in March 2010 to assist schools by providing a framework and practical guidelines to develop a healthy school policy. That includes promoting a healthy lifestyle, building positive values, acquiring practical life skills, acquiring resistance skill, and developing protocols for handling suspected or confirmed drug abuse case among students. A half-day on-site training for class and subject teachers and a two-day advanced training for guidance and discipline teacher would be provided to teachers to increase their anti-drug knowledge. This is done in addition to existing anti-drug elements in school curriculum and other activities. The government also intends to progressively extend the coverage of anti-drug education programs from senior primary to junior primary level especially on the use of cough medicine and inhalant. It also targets at enhancing anti-drug training for management and teachers in primary schools (HKFYG, 2010).

<u>Anti-drug talks and activities</u>

To enhance the students' knowledge on drugs, ND, Social Work Department (SWD), the Police, NGO, and the Department of Health have always been responsible

for organizing or sponsoring talks and activities in upper primary (primary 4 and above) and secondary schools. The content includes common abused drugs and their harmful effects, reasons for drug abuse, refusal skills, and sharing session with rehabilitated persons. In 2010–11, the talks in primary schools would be extended to primary 3 and all secondary school students (Lam, 2010). Hong Kong Narcotics Division and Education Bureau also aim at reaching out to more parents for increased home-school cooperation with parent-teacher associations, the Committee on Home-School Co-operation, and parent education service units.

Anti-drug elements in school curriculum

Currently, anti-drug elements are infiltrated in various courses in primary and secondary schools, including general studies in primary school, social studies in secondary school, humanities, biology, etc. Anti-drug elements were strengthened in the various stages of revised civic and moral education curriculum starting in 2008. Under the New Senior Secondary Academic Structure starting in 2009, Liberal Studies core curriculum and The Health Management and Social Concern course electives aim at enhancing drug education element. A new subject "Life and Society" will also be offered at junior secondary school students covering anti-drug topics (Lam, 2010).

<u>Police School Liaison Program</u>

They provide assistance and advice to schools in handling crime related activities, and also take part in providing anti-drugs talk. The police school liaison officers under the Police School Liaison Program (PSLP), which has added 27 officers in 2008–09, would be further increased by 9 officers in 2010–2011 (Lam, 2010).

<u>Programs that promote the well-being and resiliency in students</u>

Several large scale personal growth development projects coordinated by Education Bureau, Social Welfare Department and 5 major universities, such as the Understanding Adolescent Project (UAP), P.A.T.H.S. (to Adulthood, Enhanced Smart Teen Project, are available to the students ranging from senior primary to junior secondary schools with potentially greater developmental needs. They help students to promote development of the students' resiliency on their way to growing up, including learning the skills in anger management, conflict resolution, interpersonal relationships, self-discipline, teamwork, and building up resiliency, ultimately promoting psychosocial well being. Students with healthy attitude would be less prone to negative influences including drug abuse and other adolescent problem behaviors (Education Bureau, 2004; Education Bureau, 2006; P.A.T.H.S, 2005).

In addition, the Department of Health (DH) organizes the Adolescent Health Program (AHP) focusing on promoting adolescent's psychosocial health through health knowledge, self-understanding, acceptance, emotion, stress management, interpersonal and problem-solving skills. Drug education has become a core basic life skill training for all Form 1 students enrolled with this program. Junior Health Pioneers Workshop, started in 2007, is a health workshop organized by the Student Health Centre under the Department of Health. Targeted at primary 3 students, it aims at enhancing their understanding of the harmful effects of smoking, drug abuse, and alcoholism, and at building resistance skills (DH, 2009).

2.1.2.6 Labor Sector

The combined Youth Pre-employment Training Program (YPTP) and Youth Work Experience and Training Scheme (YWETS) are targeted at school leavers (i.e., those between schools and employment) aged 15–24 with sub-degree education level. It provides pre-employment courses and on-the-job training activities. It helps them improve self-understanding and work aptitudes, enhance work motivation and computer skills, and provide work experiences to enhance their employability. The project can also prevent the youth from being disengaged and prone to negative influences (Labour Department, 2009).

2.1.3. Treatment and Rehabilitation Programs

2.1.3.1 Counseling Centers for psychotropic substance abusers (CCPSA)

Currently seven Counseling Centers for psychotropic substance abusers (CCPSA) provide counseling service, including information, counseling, treatment and rehabilitation services for drug abusers, and are resource centers for other professionals who may encounter issues of psychotropic drugs at their work. The length of service can range from three months to three years (ND, 2010b).

2.1.3.2 Voluntary In-patient Treatment / Residential Drug Rehabilitation Program

17 NGOs are running these programs, and they provide services to those who voluntarily seek residential treatment and rehabilitation, using different treatment models depending on the organization and the needs of the abusers (ND, 2010b).

2.1.3.3. Substance Abuse Clinic

There are currently seven substance abuse clinics, operated by the Hospital Authority, that accept referrals through CCPSA, voluntary agencies, health care providers and by self-referral. They provide drug treatment, counseling and psychotherapy (ND, 2010b).

2. 1.3.4 Compulsory Placement Programs

Operated by Correctional Services Department, this program targets at drug dependent persons convicted of related offences and deemed suitable by the Court

for treatment under such program. It focuses on preparing inmates for social reintegration without relapse into drug use (ND, 2010b).

2.1.3.5 Out-patient methadone treatment program

Run by the Department of Health and targets for opiate addicts, it offers both methadone maintenance and methadone detoxification programs. Patients may choose to be maintained on methadone in the case where they are unable to achieve total abstinence, or detoxified through gradual reduction in the consumption of methadone (ND, 2010b).

2.1.4 Research

ND and ACAN also endorse universities and NGO to conduct research that covers a wide range of anti-drugs topics — parents' engagement in anti-drug work, anti-drug efforts in school, underground rave culture, drug abuse in minorities, medical treatment — to broaden the general understanding of the drug situation in Hong Kong. Some of the research also leads to the development of toolkits that assist schools and parents in combating the drug issues around them (ND, 2010b).

2.1.5 Parent Education Program in Hong Kong

Regarding training specifically provided to parents to address substance use issues, the "Anti-Drug Resource Kit for Parents" was developed in June 2009 to offer training to parents via NGO and address general parents (universal prevention),

parents with high-risk children (selective prevention), and parents with drug-use

history (indicated prevention) (ND, 2010b). A series of parenting talks were arranged

in the 18 districts. In addition, train-the-trainer workshops were arranged to help

teachers, parent education service units and parents to use the kit. The Community

Drug Advisory Council (CDAC) also has workshop specifically on parenting skills

(CDAC, 2010). The Life Education Activity Program (LEAP) provides health-based

education program for young people including primary and secondary schools up to

Form 3, and students from special-needs school. They also provide parents program,

such as the parents "Safe and Successful" program, which includes enhancing

parenting skills, foster effective communications, handle drug abuse and other crises,

providing information about drugs, tips on how to positively nurture their children,

and further their understanding on children's developmental change and needs

(LEAP, 2010).

2.1.6 Summary

The anti-drug prevention efforts in Hong Kong cover a few domains: for

youth, events through the use of seminars, workshops, leisure events, dramas and

movies, etc. These programs are typically isolated, and a systematic evaluation

examining how they modify the youth's drug-related attitude and behavior in the

long run is severely limited. School is also an important platform in Hong Kong to

spread anti-drug messages through drug-testing, recreational activities, and classroom education. Meanwhile, community education is done through the media campaign, roving exhibitions and educational seminars in the district. Yet in the domain of family or parents, they are included in the prevention efforts in a few yet limited areas: (1) educational seminars or workshops organized through schools, ND, or District Councils and NGOs at the community level. (2) Drug-resources online and parent training, such as the "Anti-Drug Resource Kit for Parents", short TV videos, and parenting and anti-drug leaflets for parents that are available on the ND and Education Bureau websites, and (3) Information and counseling service at 186-186 hotline. In the past ten years from 1999–2009, among the over 300 preventive programs subsidized by the Hong Kong Beat Drug Funds, only 17 of them have parents as their primary target (ND, 2010b).

Family and youth drug abuse

Drug abuse in adolescence does not merely emerge at that point of lifespan, but is a manifestation of deeper family issues and a symptom of an ongoing pattern of youth development problems (ND, 2008a; Northeast Center for the Application of Prevention Technologies [Northeastern CAPT], 1999). Numerous studies have developed various theories and models which outline the factors influencing youth substance use, and comprehensive approach involving different domains, including

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communities, schools, peers, and families, is essential to tackling the issues. However, among all these spheres of influences and different approaches, parental and family factors are of paramount importance (Substance Abuse and Mental Health Services Administration [SAMHSHA], 2009; United Nations' Office on Drugs and Crime [UNODC], 2009; Vellenman et al., 2005). Family environment is considered the major underlying factor determining whether young people would engage in disruptive behaviors, including substance abuse. Peer influence works more as a contributing factor closer to the time of substance use initiation (Gardner et al., 2006; Kumpfer et al., 2003; UNODC, 2009). More importantly, young people with healthy relationship with their parents are likely to choose peers with positive influences (UNODC, 2009), thereby reducing the chances of encountering drugs. This perspective also explains why prevention efforts focusing on knowledge dissemination and refusal skills have limited effects on drug issues, because they do not sufficiently address the underlying cause of the issues. According to the UNODC, evidence-based family skills training programs are considered to be the most effective measure to prevent substance abuse among youth after nurse home-visitation program (UNODC, 2009).

From a policy perspective, little has been done in Hong Kong to specifically support family or parents in the anti-drug prevention efforts. In the following

sections, evidence from theories and previous literature to elucidate the importance

of targeting family in combating the anti-drug battle is provided.

2.2. Theoretical framework

In this section, we focus on the three most common theories and models on

youth substance abuse. We will first examine the ecological systems theory

(Bronfenbrenner, 1979), followed by the public health model and the social

development model (Hawkins and Catalano, 1992).

2.2.1. The Ecological System Theory

It provides a fundamental understanding of human behavior that can be

explained by the "layers of systems", and their interactions, around the person. Such

interactions are also affected by relations between these settings and also by the

larger contexts in which these settings are embedded (Bronfenbrenner, 1979). In

other words, these systems are interrelated and interdependent (Waller, 2001).

There are five levels of systems:

Microsystem: the person's immediate environment (e.g., family, peer group, school,

   neighborhood).

Mesosystem: interrelations between Microsystems (e.g., mother [family]

   accompanies child to school [school])

Exosystem: external settings that do not involve the person as an active participant

but still affect the person, or affected by, the person (e.g., mother's workplace,

which affects the mothers' mood, and mother carries that mood to the child

when she returns from work to home)

Macrosystem: larger cultural and the underlying ideological context (e.g., filial piety

in Chinese, subculture among youth, political and economic situation)

Chronosystem: the effect of time or the dimension of life span (e.g., physiological

change for a child, timing when the significant change occur).

Figure 3. Bronfenbrenner's ecological systems theory
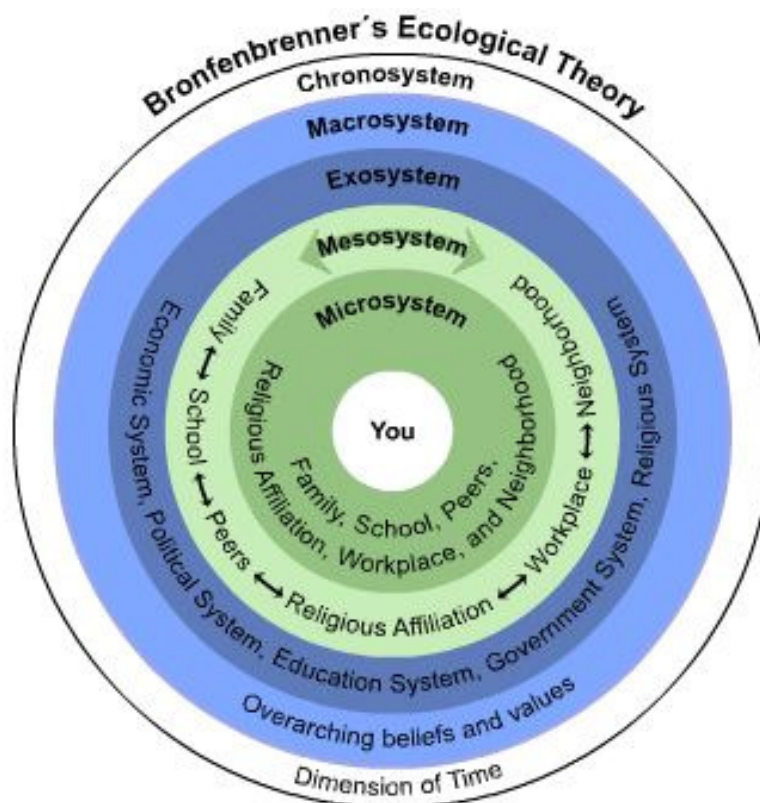
In the context of youth substance abuse, the ecological theory emphasizes that it is the interaction of factors within these layers that contribute to the issues of substance abuse (Stormshak & Dishion, 2009). Indeed, scholars have called for interventions that should not focus on harm minimization and prohibition (Vimpani , 2005). The key to any prevention efforts should instead address each of the relevant layers as indicated by Bronfenbrenner. In the case of substance abuse in youth, examples that target prevention at relevant layers would include, but not limited to (Randall and Cunningham, 2003):

- Individual level: Address the youth's positive attitude towards substance experimentation (microsystem)

- Family level: Enhance parents or carers to monitor the youth effectively (exosystem)

- School level: Increase youth's attachment to school (exosystem)

- Political / economic / cultural level: Promote healthy lifestyle (macrosystem)

This model is used extensively in not only substance abuse prevention and intervention initiatives but also family intervention programs, such as Project Steps To Achieving Resilience (STAR), Strengthening Families Program (SFP), multisystemic therapy, multidimensional family therapy (MDFT), functional family therapy (FFT),

brief strategic family therapy (BSFT) (Kaminski, Ruth, Stormshak, and Elizabeth A., 2007; Swenson et al., 2009; Liddle, 2004). This theory provides a helpful framework for conceptualizing risk and protective factors (explained in later sections) for problem behaviors that exist at each level, and also interact at various levels. This theory also serves as the foundation in the U.S.'s Substance Abuse and Mental Health Services Administration (SAMHSA) in assisting communities to identify the multiple points of entry for drug problem intervention within their communities. This means an effective prevention strategy needs to address the underlying risk and protective factors that are present, and interacts in each of the layers in order to achieve positive outcomes (SAMHSA, 2009). This model has been tested applicable across culture, including Chinese (Deng and Roosa, 2007; Williams, 2010). Scholars in Hong Kong have also called for the need to use an ecological perspective and holistic approach in order to both understand and tackle the adolescent drug issue (Shek, 2007; Tsang & TWGHs, 2008).

2.2.1.1 Using this model to understand parents with substance abuse problems

Parental substance abuse is highly disruptive to family functioning (Dawe et al., 2006). It is a risk factor towards negative parenting practices (Huxley and Foulger, 2008). Their children usually have a higher rate of exhibiting behavioral and emotional problems, and they also have a higher rate of child abuse and neglect

(Walsh et al., 2003). Children may receive from their drug-using parents limited time and attention, inconsistent care, and a lack of emotional availability and control, not to mention that the easier availability of drugs to the children and the parents' positive attitudes towards drug use may lead to the likelihood of inter-generational substance abuse. All these could cause ineffective parenting and affect adversely the parent-child attachment (Scaife, 2008). Further, if we put the ecological model into context, parent substance abuse is not necessarily the causal factor responsible for poor child outcome (Dawe et al., 2006), as child outcome could be a result of personal, developmental, familial and environmental factors. More often, it is a combination of various factors associated with the parental substance abuse, such as poor parenting practices, poor or even violent marital relationship, limited social support, economic disadvantages, that make their children at risk (Bancroft et al., 2004). In addition, even if the parents see themselves as needing treatment help, current services may not sufficiently balance managing child protection issues with engaging the parent in treatment. This serves as a barrier for drug-using parents, especially mothers, when they try to access treatment services (Huxley and Foulger, 2008). Thus prevention and intervention strategies should not only focus on the parental substance use per se. Rather, based on the ecological model they should

also address the factors in various domains, and the complex interplay among them (Dawe et al., 2006).

2.2.1.2 Using this model to understand parents of substance abusing children

Such families typically suffer from deterioration of family relationships, and parents reported to have increased level of anxiety, stress and other behavioral disorders, as there is a pervasive worry about the well being of their drug-using children in their absence. A formerly loving, or at least stable parent-child relationship, is now characterized by suspicion and mistrust after the discovery of drug use by children (Barnard, 2005). As a large amount of time and energy are spent, often with a long period of time in both the discovery and also in treatment, this ongoing stress and anxiety pose threats to the parents' job performance and marital relations. Some may even rely on substance such as alcohol to de-stress themselves (Frye et al., 2008). The social stigma attached to drug use also makes the parents and other family members, such as sibling, unwilling to seek support from friends in schools and relatives, as it is difficult to find others who can render support in a non-judgmental way (Frye et al., 2008). Needs of the non-drug-using sibling are pushed sidelines as the family is busy struggling with the issues stemming from the drug-using child (Gregg & Tombourou, 2003). Some studies also point out the increased financial strain on the family, and its related conflicts between the parents

and drug-using children, when the addicted children ask for money to buy more drugs (Barnard, 2005). Overall, drug use in children creates significant risk to their family members, causing tremendous negative impact on them physically, emotionally and financially. It exerts a ripple effect on the entire family and may extend to other domains such as the parents' work, siblings' schooling, and level of social support (Gregg & Tombourou, 2003). Like the drug-users, the family members also need support in managing the emotional and related physical impact as a result of drug use in the family.

2.2.2. The Public Health Model, Environmental Approach, and The Broken Windows Theory (TBD)

2.2.2.1 Public Health Model and the Environmental Approach

The second commonly used model in prevention science is the public health model. It emphasizes the broader physical, social, cultural and institutional forces (Community Anti-Drug Coalitions of America [CADCA], 2008). This model believes that individual actions are a result of interactions among the environment (physical and social context), the person (host), and the agent (substance). Prevention initiatives that focus on the agent are generally considered supply reduction strategies. Initiatives that attempt to alter an individual's demand are generally considered as demand reduction strategies. Initiatives that focus on the surrounding

of the substance abuser are considered as environmental approach (National

Institute on Drug Abuse [NIDA], 1997). By restructuring the settings or environment

where the person lives, it can shape the individual's behavior, and such an

environmental approach can be used for both supply and demand reduction. They

target at shaping the perception in communities, homes or schools, focusing on

affecting a large number of people through systems change and ongoing effective

enforcement (CADCA, 2008).

Figure 4. The Public Health Model

Substance (Agent)

Individual (Host)   Physical & Social Context
                              (Environment)
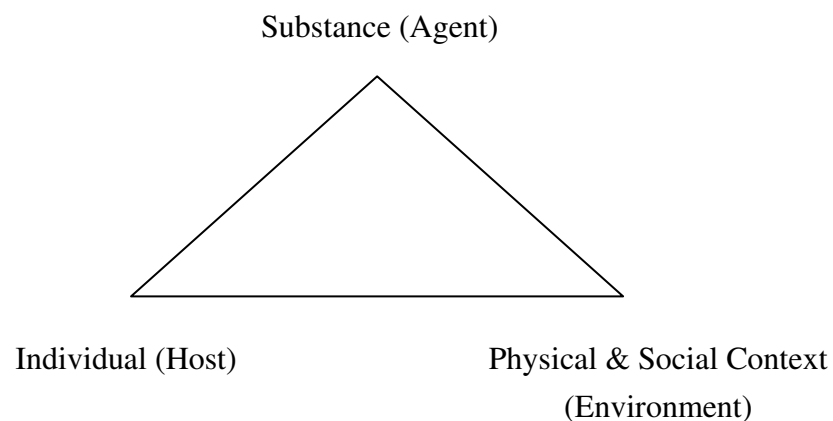
There are seven strategies which put such "environmental prevention"

approach into actions. For example, in the case of preventing licit and illicit substance

use (CADCA, 2008):

1. Provide information (e.g., educational presentation, media about the

    effects of alcohol and drug use)

2. Enhance skills (e.g., parenting class, model programs in school)

3. Provide support (e.g., provide alternative activities that reduce risk behaviors)

4. Enhance access / reduce barriers (e.g., taxes, fines, hours of sales)

5. Change consequences (e.g., incentives / disincentives)

6. Change physical design (e.g., more difficult outlet to purchase alcohol)

7. Modify / change policies (e.g., formal change in rules and law enforcement)

Hence, addressing the environment through policy and practice changes the community norm, which in turn would chance the individuals' behavior (CADCA, 2008).

Within the public health classification of prevention, efforts are organized along a continuum of primary, secondary, and tertiary prevention (NIDA, 1997). Primary prevention aims at protecting individuals from developing the disease, and in the case of substance abuse, that means protecting the individuals who have not begun using substances from drug use initiation. Secondary prevention aims at preventing progression of the disease, or in other words, early intervention with

those at the beginning stage of substance use. Tertiary prevention aims at ameliorating the negative impact of established diseases, and in the case of substance abuse, it restores the individuals' functions through treatment, rehabilitation, and relapse prevention.

In 1994, the U.S. Institute of Medicine (IOM) proposed a new framework for classifying all preventions efforts based on Gordon's (1987) operational classification of disease prevention, namely, prevention, treatment, and maintenance. Within the prevention category, it is further divided into three classifications: universal, selective, and indicated prevention interventions, which replace the concept of primary, secondary and tertiary preventions (NIDA, 1997). Universal prevention strategies address the entire population without any prior screening for risk, and aim at deterring the onset of substance abuse by providing all individuals the information and skills to prevent the problem. Examples of universal prevention strategies specific to substance abuse include media and public awareness campaigns, and drug-free policies in schools, and for specific programs such as the "Guiding Good Choice" developed by Hawkins et al. (1987). Selective prevention strategies target subsets of the population who are deemed to be at a higher risk for substance abuse (e.g., children of adult alcoholics, school dropouts, or other biological, psychological,

social or environmental factors known to be associated with substance abuse).

Selective prevention programs are typically presented to the entire subgroup

regardless of the individual's degree of risk within that group. Examples include

special clubs and groups for children of alcoholics, and skills training programs

specific to children of substance-abusing parents, and the Strengthening Families

Program developed by Kumpfer et al. (1989). Indicated prevention strategies have

the mission to identify individuals who are exhibiting early signs of substance abuse

and to target them with special programs. These programs typically address risk

factors associated with the individuals such as low self-esteem, conduct disorder,

alienation from parents and positive peer group. Less emphasis is placed on

addressing environmental influences such as community values (NIDA, 1997). They

are designed to stop the progression of substance abuse and other related disorder,

and can target multiple behaviors simultaneously. Examples of indicated preventions

include student assistance programs where teachers and counselors would refer

students exhibiting multiple issues (e.g., academic, behavioral, emotional problems)

to counseling groups or family-focused programs for the prevention of substance

abuse (NIDA, 1997), and specific programs such as the Reconnecting Youth

developed by Eggert et al. (1990).

The public health model and especially the environmental approach is widely

adopted in the U.S., and in the field of prevention of alcohol consumption in

particular (Wood et al., 2009). In Hong Kong, the public health approach is adopted in

a parent education program in which evidence-based resources in the form of

manuals for mass and group programs, case counseling and website resources are

designed and disseminated for general parents, parents with children at risk, and

parents with drug-taking history (Tsang & TWGHs, 2008). The public health model is

also found applicable in suicide prevention work in Hong Kong (Yip, 2008; WHO,

2010). It stresses on intervention at three levels, namely universal, selected and

indicated for different stage and phases of drug abusers.

2.2.2.2 The Broken Windows Theory

Developed by Kelling and Wilson (1982) in the field of criminology, this

theory suggests that effective crime prevention should start with what are

considered as "minor" offenses within a city, such as vandalism, graffiti, etc. Ignoring

such minor offenses and problems is an invitation for more serious crime. An

analogy of broken window is used in this theory – within a neighborhood, if one

window of a house is broken but is left unrepaired, the rest of the windows will soon

be broken. That is because such neglect (of one unrepaired window over time)

serves as a signal that "no one cares" about the house, making it susceptible to

vandalism and even burglary. Therefore, what is important in crime prevention is to fix and uproot a small issue before the situation deteriorates (Kelling and Wilson, 1982). Such analogy could also be applied in the field of drug abuse prevention among youth (Mak, 2010). If we consider the issue of drug use is still limited to a minority of youth and only the "marginal" youth, and does not sufficient address the root of the issue, the situation would deteriorate. Early identification and timely damage control and prevention are thus the key assertions of this theory.

2.2.3. Social Development Strategy / Model (SDS)

One of the most influential and helpful ways to understand youth drugs issues is by using the social development model, which addresses risk and protective factors. Developed mainly by Hawkins and Catalano (1992), this model is a synthesis of social learning, social control and differential association theory (Catalano et al., 1999). The SDS identifies risk factors that contribute to the development of the five most common adolescent behavioral problems, including (1) substance abuse, (2) delinquency, (3) teen pregnancy, (4) school drop-out, and (5) violence. Risk factors, as the name suggest, are shown to increase the risk or likelihood that the above problems would emerge in adolescence and young adulthood. On the contrary, protective factors buffer them from exposure to risks, and hence reduce the likelihood in exhibiting such behaviors (Hawkins and Catalano, 1992). Both risks and

protective factors encompass four spheres where young people grow up: (1) peer and individual, (2) school, (3) family, and (4) community (Hawkins and Catalano, 2005).

Table 2. Risk factors of adolescent problem behavior.

	Substance Use	Delinquency	Teen Pregnancy	School Drop-Out	Violence
Community					
Availability of drugs	X				X
Availability of firearms		X			X
Community laws and norms favorable towards drug use, firearms, and crime	X	X			X
Media portrayals of violence					X
Transitions and mobility	X	X		X	
Low neighborhood attachment and community disorganization	X	X			X
Extreme economic deprivation	X	X	X	X	X
Family					
Family history of the problem behavior	X	X	X	X	X
Family management problem	X	X	X	X	X
Family conflict	X	X	X	X	X
Favorable parental attitudes and involvement in the problem behavior	X	X			X
School					
Academic failure beginning in late elementary school	X	X	X	X	X
Lack of commitment to school	X	X	X	X	X
Peer and Individual					
Early and persistent antisocial behavior	X	X	X	X	X
Rebelliousness	X	X		X	
Friend who engage in the problem behavior	X	X	X	X	X
Gang involvement	X	X			X
Favorable attitudes towards the problem behavior	X	X	X	X	
Early initiation of the problem behavior	X	X	X	X	X
Constitutional factors	X	X			X

Source: Communities that Care (Hawkins and Catalano, 2005, p. 16)

While the table above lists the risk factors which are predictors of the problems, the presence of protective factors can neutralize the "harm" that are associated with risk factors. These protective factors include:

(1) Healthy beliefs and clear standards for behavior as communicated by families, schools, communities, and peer groups

(2) Strong attached bonding and relationships with at least one adult (can be parents, grandparents, relative, mentor, etc.), who has healthy beliefs and clear standards for young people

(3) Individual characteristic of the young person, such as a positive social orientation, high intelligence, and resilient temperament

SDS is concerned with the socializing processes of the children, and the process involving the following constructs: giving *opportunities* for children's positive and meaningful engagement, providing the *skills* for children to participate in these involvements, and giving *recognition* and corrective feedback to them as reinforcement (Hawkins & Catalano, 2005). Family unit remains dominant in their socialization during the home and elementary school periods, and school plays a more important role later on (Fleming et al., 2002). Such risk and protective factors that influence the children's path to socialization then make children internalize and normalize a standard of behaviors that are pro-social or anti-social.

Figure 5. Building Protection: The Social Development Theory

The goal…
Healthy behaviors
for all children and youth

Start with…
Healthy beliefs & clear standards
… in families, schools, communities and peer groups

Build…
Bonding
- Attachment   - Commitment
… to families, schools, communities and peer groups

By providing…
Opportunities

By providing…
Skills

By providing…
Recognition

… in families, schools, communities and peer groups

And by nurturing…
Individual characteristics

Source: Communities that Care (Hawkins and Catalano, 2005, p. 12)

It is important to note that these common risk factors would predict diverse problem behaviors, such as the five listed above. They can be present across development, with some factors becoming more salient than others depending on the course of human development. More importantly, the number of risk factors is

proportional to the chance of exhibiting problem behaviors, and the presence of protective factors would neutralize such effects (Harachi, Ayers, Hawkins and Catalano, 1996). In addition, these factors are present across racial groups (Choi et al., 2005; Fleming et al., 2002).

Therefore, it is essential for any prevention strategy to address both risk and protective factors in order to be effective (Harachi et al., 1996; Hawkins & Catalano, 2005). For example, most drug prevention efforts focus on community laws and norms on drug use, and the social influences that relates to them. The prevention approach most frequently used and also most evaluated, as a result, is resistance training for teenagers. Yet resistance skills training method do not change the basic developmental conditions experienced by children (Harachi et al., 1996). Those who have the highest risk of drug experimentation and abuse are likely to also experience poor family management, lower bonding to family, early and possibly persistent behavior problems, low commitment to school, and academic failure. They are likely to be unmotivated to refuse or avoid drugs by the time they are exposed to drugs (Harachi et al., 1996). Therefore, addressing these underlying problems shown in the risk factors, finding ways to minimize them, and increasing the protective factors are the most effective ways to tackle any adolescent issues including substance abuse.

Furthermore, if these various factors are tackled effectively, the result would also mean that the range of, and not just a single, adolescent problem behaviors can be reduced.

One of the most important domains that are addressed among these risk and protective factors in studies on adolescent problem behavior is family. In the following section we examine how the theoretical frameworks, especially from the ecological theory and risk and protective factors, relate family and youth substance abuse. We would examine family in various contexts: family members such as parents, sibling, grandparents, domestic helpers or nannies, relationship with youth in family and how they are related to substance abuse

2.2.4. Theories and family studies

Family vis-à-vis youth substance abuse

Family factors play a critical role in substance abuse, and it is acknowledged in virtually every psychological theory on the subject (Bry et al., 1998). Supportive families are the key to raising well-adjusted children (UNODC, 2009). The children in these families tend to be healthier socially, mentally, and physically, thereby preventing later adolescent problems (UNODC, 2009). Families are building block of the society, and also the cradle where young people grow up (Tsang and Leung, 2005;

ND, 2008a), and is believed to be the first line of defense against any type of adolescent problem behaviors. Thus risk and protective factors within the family context are considered to have the greatest degree of influence over adolescent, as they play a critical role in the development of resilient children and adolescent (Patin, 2003; Dawe et al., 2006). As mentioned in Section 1.2, growing up in a supportive family is the underlying reason youth do not engage in a variety of disruptive behaviors that include substance abuse (Gardner et al., 2006; Kumpfer et al., 2003). Peer influence is at best a contributing factor near the time of drug use initiation (UNODC, 2009). In contrast, exposure to familial conflict increases the risk of substance use disorders during late adolescence due partly to higher levels of externalizing problems (Skeer et al., 2009). Local study also agrees that family functioning is significantly related to adolescent delinquent and substance abuse behavior (Shek, 2002a). Thus, by altering the family functioning, it could likely prevent substance abuse (Bry et al., 1998).

Family dynamics plays an important role in youth development, and competent parenting is a powerful protective factor (UNODC, 2009; Cummings et al., 2000). Specifically, healthy parent-child attachment, functional family structure, appropriate parental monitoring, authoritative parenting style, and communications

of pro-social values by family members all laid the foundations of family factors that prevent youth substance abuse (UNODC, 2009). In contrary, parental conflicts serve as a significant risk factor for youth substance abuse.

2.2.4.1 Parents

This section on parents includes parent-child relationships, parental monitoring, parenting style, family structure, parent-child communication and long work hours, and parental conflicts.

Parent-child relationships

In families with frequent outburst of anger and hostility, and where relationships among family members are cold and irresponsive, children are more vulnerable to problematic behavior and substance abuse (Repetti, Taylor, and Seeman, 2002). Parents who are low in warmth and high in hostility are associated with having children who are prevalent in conduct issues and tobacco use (Melby, Conger, Conger, and Lorenz, 1993). Parent-child connectedness is inversely associated with substance use and other health indicators such as depressive symptoms and self-esteem (Ackard et al., 2006). In cases where the biological parent fails to become the person whom the child or young person can attach to, a sense of belonging and closeness to at least one caring and competent member of the family (who may be grandparents, an older sibling, a relative, hired caregivers,

adoptive/foster parents, etc.) is a protective factor, because it is likely that this person can provide surrogate care-giving and play a mentoring role (Dawe et al., 2006; UNODC, 2009). In addition, adolescents who have high conflicts with parents are less likely to conform to the parents' supervision, as evident from a study in Taiwan (Yen et al., 2007). Youth who are satisfied with the relationship with their parents have a lower chance to be heavy substance users (Pasch et al., 2010). Alienated relationship among family members, especially between parents and the teenagers, is a push factor that drives certain adolescents away from home to become night drifters in Hong Kong (Lee, 2000). Such night drifting makes them more susceptible to negative influences including substance abuse, involvement with gangs, and risky sexual behaviors (Lee, 2000).

Certain research also examines the relative influence between fathers versus mothers on children (Shek, 2005; Tsang, 1996). In a study that focused on homeless and runaway youth, Stein et al. (2009) found that positive paternal relationships significantly predicted less substance use and less criminal behaviors, whereas positive maternal relationships predicted less risky sex behaviors. Differential contributions of fathers versus mothers on adolescent developmental outcomes also vary with the gender of the adolescent children (Shek, 2005). A local study on

Comprehensive Social Security Assistance (CSSA) recipients showed that fathers

exerted influences on adolescent boys in terms of existential well being and

delinquency, but not on adolescent girls. In contrast, mothers exerted influences on

adolescent girls in terms of mental health and problem behavior, but not on

adolescent boys (Shek, 2005). Another study on intact families indicated that

positive influence of father-child relationship is stronger for adolescent males than

females (Bronte-Tinkew, Moore & Carrano, 2006). A more positive father-child

relationship (defined as having both emotional closeness and father involvement) is

associated with a reduced risk of first delinquency and substance use after

controlling for mother-child relationship, maternal monitoring, other maternal

characteristics, family- and household-level characteristics, and child-level

characteristics (Bronte-Tinkew et al., 2006).

Family structure

As indicated by the drug use statistics in Hong Kong, a larger proportion of

drug-taking students are not living with either of their parents compared to the non-

drug-taking counterparts (7.7% vs. 2.5%) (ND, 2010a). In fact, substantial amount of

studies are dedicated to examining relationships between multiple family structure

and adolescent drug use (e.g., single-parent family, foster-parents family, traditional

biological two-parent family, grandparent-led family), as transitions in family

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structure can affect attachment and have a profound effect on children (Krohn et al.,

2009). Hemovich and Crano pinpointed the two schools of thought popular in

explaining the relationship between family structure and substance use, namely

maternal hypothesis (i.e., children staying with the mother are less prone to

delinquent behavior because of better overall supervision and stronger affective

bonds than staying with the father), versus the same-sex hypothesis (i.e., same-sex

parent-child pairings have the strongest protection of children against drug use)

(Hemovich and Crano, 2009).

Comparing households headed by single-fathers versus singe-mothers,

adolescents reportedly have more delinquent behaviors in single-father families.

However, this is entirely accounted for by the weaker direct and indirect controls

exerted by single fathers and not the family structure per se (Demuth and Brown,

2004). No significant impact is found by family structure on adolescent delinquency

once they account for family processes including parental involvement, parental

supervision, parental monitoring, and parent closeness. In addition, indirect control

(defined as parent-child closeness in that study) imposes a more significant impact

than direct control (defined as parental involvement and monitoring) in determining

the prevalence of delinquent behavior. Parents' psychological and emotional

presence appears to have a bigger impact than their physical presence (Demuth and

Brown, 2004). Booth, Scott and King (2010) also found that adolescents benefit more

from a close bond to a nonresident father than a weak bond to a resident father.

Hemovich and Crano (2009)'s study found that daughters in single-father household

reported significantly higher chance of substance abuse than in single-mother

household. Gender of custodial parent is unrelated to sons' chances of substance

abuse. It's noteworthy that this is not a causal relationship but only correlation, and

the study did not account for parental attachment. And even if adolescents have a

poor relationship with their mothers, strong ties with nonresident father alone are

found to be associated with having fewer internalizing behaviors and less acting out

at school when they are compared to adolescents who have weak ties with both

parents (King and Sobolewski, 2006).

Yet, regardless of the family structure, strong parent-child attachment with

parental involvement, supervision and monitoring are found to reduce the negative

effects of living in a single-parent or step family on delinquency (Demuth and Brown,

2004). Thus it is the quality of the relationship between the parent and the children,

rather than the family structure per se, that could become either a risk or protective

factor for adolescent problem behavior (Krohn, Hall and Lizotte, 2009).

<u>Parental monitoring</u>

Parents are regarded as an influential factor in determining whether youths use substance, including licit or illicit ones (SAMHSA, 2009). Low parental supervision and monitoring have been found to be a strong predictor of tobacco and alcohol use in children and other delinquent behaviors (Griffin, Botvin, and Scheier, 2000; Robertson and Stein, 2008). Parental attitudes regarding drug use exert a strong influence on adolescent (Peterson, 2010; Sawyer & Stevenson, 2008). Explicit expression of disapproval by parents about substance use, and appropriate involvement in their daily activities, are found to be the key deterrent against substance use (SAMHSA, 2009). Adolescents are found to benefit from having clear rules from their parents concerning substance, and from believing that there are consequences attached to their behaviors (Parsai, Marsiglia, and Kulis, 2010). In contrast, parents who indicate a permissive attitude towards substance use increase the likelihood of their children actually using it (Frye et al., 2008). Effective parental monitoring therefore is a significant protective factor against adolescent drug abuse. However, previous research shows that many parents are unaware of the influence — including their beliefs, languages, behavior — that they exert on their children (Mallick & Stein, 1999). In addition, the prerequisite for appropriate parental monitoring is having a strong parent-child relationship (Frye et al., 2008)

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<u>Parenting style</u>

Those who practice "authoritative parenting" — namely, parents who are supportive, expect compliance with rules, show consistency and fairness in their discipline, and encourage their children to become independent — usually can raise children who are resilient (UNODC, 2009), which is also a significant protective factor against drug abuse and other adolescent problematic behaviors. Support and nurturance should be combined with structure and control in order to have a positive and lasting impact on children, which is exemplified in school achievement, psychological well-being, social adjustment, and less delinquency (Baumrind, 1996). This can have an enormous impact on how children develop self-control and compliance with social rules (Dawe et al., 2006). Such positive effects are found to even last until middle and late adulthood (Rothrauff, Cooney and An, 2009). Gender differences are also found in terms of how boys and girls react to different parenting quality. A local longitudinal study examining parenting quality and parent-adolescent conflict shows that earlier negative parenting quality predicted a heightened level of later parent-adolescent conflict for adolescent girls but not for boys (Shek, 2002b).

On the contrary, negative parenting practice could increase the risk of youth substance use. Physical abuse and exposure to violence increase the likelihood of

substance abuse (Dembo et al., 1992). A Hong Kong study found that physical maltreatment at home is associated with a higher prevalence of psychoactive drugs use among students and a higher likelihood of approving others using such substances, although the study did not examine the direction of the causality (Lau et al., 2005).

Parent-child communication and long work hours

Positive parent-child communication is also a protective factor. Open and frequent communications could become a protective factor in situations like alcohol use (Pasch et al., 2010; Wills et al., 2003). Some scholars call for the need to enhance parental communication competence and improve family communication environments to capitalize on the influence that parents still have on their children to reduce the chance of substance use (Miller-Day, 2008). Also, adolescents who engage in more regular family activities (such as frequent dining together), greater parent's knowledge of their children's friends and teachers all report a lower level of substance use through mid adolescence than their counterparts (Coley, Votruba-Drzal, and Schindler, 2008). Yet in Hong Kong, finding time to dine or even communicate with the children becomes a luxury because of long working hours. The latest work-life balance survey in Hong Kong indicates that over 70% of employees spend less than two hours per day on personal or private activities in

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2009 (Ng and Bernier, 2009). The same survey conducted in 2008 found that over

half of the survey respondents need to work late in the evenings (Welford, 2008). As

indicated by Bittman (1999), leisure time is important for not only the employees but

also their children and the family. More time at work also means less time spent by

parents supervising the children, engaging in meaningful activities with them, or

simply accompanying them. Work-family conflict remains a concern in Hong Kong,

and long work hours definitely exert impact on parenthood (Lau, 2009; Wharton and

Blair-Loy, 2006).

Parental conflicts

While family cohesion and positive attachment to significant caregivers serve

as a protective factor, family conflicts and family transitions could be disruptive to

adolescents. For instance, transition events such as divorce are linked to the loss in

the effectiveness of parenting. Supervising the children could become more difficult,

as this is related to the hostility and lower attachment caused by an addition or

subtraction of a parent figure in the household (Krohn, Hall and Lizotte, 2009). The

negative outcomes of divorce on children are well studied (Strohschein, 2005),

although the impact on the children prior to the separation versus after the divorce

may differ by gender (Doherty & Needle, 1991). Even not in the case of divorce,

constant exposure to inter-parental conflict has significant negative impact on the

children's well being (Ali, 2010). They often become triangulated in the marital conflict and display their distressed experience through physical and psychological symptoms (Ali, 2010). These may exhibit through externalizing behavior (such as substance abuse and delinquency) or internalizing behaviors (such as depression and self-inflict injuries) (Ali, 2010). Also, these children often show a higher rate of substance use, and score poorer on both physical and mental health (Hair et al., 2009). In Hair's study, the adolescents who indicate the worst physical and mental health outcomes are those with poor parents' marital quality coupled with poor relations with their parents. Family discord is also linked to higher instances of major depressive disorder and substance disorder in offspring, which can have lasting impact (Pilowsky et al., 2006). Marital relationship could therefore have a spillover effect on parent-child relationship and young people's well being (Bradford et al., 2008). A local study on Hong Kong Chinese pinpointed that such spillover could be mediated by other factors such as parental well-being. Yet the spillover effect of marital quality to parent-child relationship is stronger in fathers than in mothers (Shek, 2000). In summary, poor marital relation is a risk factor increasing the susceptibility of young people to negative influences and, in turn, causing the increase of problematic behaviors.

2.2.4.2 Sibling

Sibling can be an important source of influence for many children and adolescence (Engels et al., 2005). There is high similarity in drinking and drug use in siblings (Latimer et al., 2004; Poelen et al., 2007). If siblings are less than two years apart in age, of the same sex, and spend time together at home or outside of home with little parental monitoring, siblings can become significant role models (Windle, 2000; Boyle et al., 2001). This is true especially related to the effects that older siblings have on younger ones, and if they are of the same gender (Vorst et al., 2007). This is not surprising since the access to licit drugs such as alcohol and tobacco is determined by age, and hence the presence of an older sibling who engages in substance use would naturally provide the means for the younger sibling to obtain it (Boyle et al., 2001). In addition, it is found that siblings of drug abusers are at a greater risk compared to peers of the same age to use various types of drugs (Bamberg, Toumbourou and Marks, 2008). Rather than attributing to genetic predisposition, it is more likely that the environmental influence the non-user faces, and the shared environment that both siblings are exposed to, cause the higher prevalence of drug use. That includes easier access to drugs (nonuser getting drugs from his or her sibling), exposure to family conflict and violence, and disruption of school in case of a crisis (Gregg & Tombourou, 2003). However, a study by Fagan and

Najman (2005) argued that it is the sibling relationship itself, rather than the shared family environment, that best accounts for sibling resemblance in drug use. Also, it is found that exposure to siblings' substance use may contribute to affiliation with substance-using peers (Windle, 2000). That is likely because the younger sibling may develop a more positive attitude towards drug use than their counterpart in these cases (Frye et al., 2008).

Some studies even argue that, when comparing sibling versus parental influences, the former serves as a more powerful role model especially during adolescence (Epstein, Williams, and Botvin, 2002; Fagan and Najman, 2005). Siblings have a long history of shared experiences that peers cannot replace and cannot have an effect of "peer selection" (Gregg & Tombourou, 2003). In addition, families with drug-using children likely have a pervasive negative atmosphere in the family, as the entire family may focus their attention on the drug-using sibling, making the non-user sibling feel marginalized. Sense of shame and embarrassment would also increase the sense of isolation felt by the non-drug-using sibling, and leading to a decrease in family attachment (Gregg & Tombourou, 2003), and also an unwillingness to seek social support from outside the family because of fear of disclosure and the intense feeling of shame (Frye et al., 2008; Bamberg et al., 2008).

They are likely to be expected to play "good" in the family and not to elicit more troubles to their families, often requiring more maturity beyond their ages (Frye et al., 2008). It is reported that young people with drug-taking older siblings typically have a pervasive sense of loss about "losing" a former, more "normal" relationship with his/her sibling, and experience more anxiety and concern of the well being of their siblings. They also need to cope with seeing their parents struggle with their drug-using sibling (Frye et al., 2008). Thus a sibling with drug use may present a risk factor for sibling who is a not (Lloyd, 1998).On the other hand, in view of the growing number of single child in Chinese families, sibling support or the lack of it should become another focus when it comes to drug prevention and intervention (Fagan & Najman, 2005; Bamberg et al., 2008).

2.2.4.3 Grandparents

It is worth noticing that in the latest student drug survey in Hong Kong, more than 7% of the secondary school students who use drugs live with neither of their parents (ND, 2010). Grandparents, especially grandmothers, often assume surrogate parenting when one or both of the biological parents are unavailable for various reasons, for example, parents' long hours of work, family crisis such as divorce, drug or alcohol abuse in parents, mental or other illness in parents, or incarcerated parents (Frederick, 2010; Tan et a., 2010).

The issues with grandparenting often relate to child management, for instance, whether the grandparents have the sufficient stamina to have proper monitoring of "unruly" adolescents (Frederick, 2010), especially for grandparents who are older. Grandparents also face challenges in assuming the role as caregivers, especially if the arrangement is developmentally off-time and if they take the role with ambivalence (Landry-Meyer and Newman, 2004). Such psychological distress could increase the possibility of dysfunctional parenting. There are occasions where grandparents may not understand sufficiently the basis of their grandchildren's disturbance, or believe blindly that the children will outgrow the difficulty or the problem that they are facing (Mayer, 2002). Earlier studies found that some grandchildren under the custodial care of grandparents may make attempts to stretch limit setting, being manipulative, resist authority, and struggling over grief and rage as they feel that their parents have abandoned them (de Toledo & Brown, 1995). Children under kinship care are found to possess more behavioral, emotional, and school-related problems than other children (Smith & Palmieri, 2007; Billing, Ehrle, and Kortenkamp, 2004).

However, the above findings do not suggest a causal relation between grandparenting and increased level of youth delinquent behavior. As

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aforementioned, most children who need extensive kinship care are those who are also exposed to high-risk environment in their immediate family characterized by family crisis and conflicts, such as having substance-misusing parents, or incarcerated parents, or parents undergoing divorce (Frederick, 2010). Grandchildren who establish reliable and loving relationships with their grandparents and who live in a structured environment can have some of the risk offset. For instance, a study indicated that comparing single-parent family-raised versus grandparents-raised children, the latter performed significantly better across health, academic and behavioral dimensions (Solomon and Marx, 1995). Again it shows that the presence of protective factors (in this case, good parenting role performed by grandparents) could offset the harm brought about by risk factors (e.g., family issues that lead to the need to use extensive grandparenting). This is also one reason, as we will explore later, that countries such as the U.K. has stepped up efforts in providing resources and support for grandparents who take up this role.

2.2.4.4 Domestic helpers and nanny

In Hong Kong, hiring live-in foreign domestic helpers (FDH) and nannies is a common solution to household chores and child care for working mothers, number for over 250,000 in Hong Kong (Hong Kong Census & Statistics Department, 2009). This is a practice found also in other parts of Asia, Middle East, and parts of North

America (Statham & Mooney, 2003; Tam, 2001). In Hong Kong, although many working mothers still prefer close kin to FDH to have a child care role (Tam, 2001), the norm of having nuclear family and the relative affordability of FDH makes FDH still a more viable options (Chan, 2005; Tam, 2001).

The FDH in Hong Kong have live-in stipulation and technically can provide "round the clock" care around the household. These domestic workers do all types of work related to infant, children and teenager's need at home: escort them to and from school and extra-curricular activities, feeding, laundry, monitor their homework, entertain them, and even share the same room with the children. Some FDH and even their employers would consider the workers as "surrogate mother", as the time spent with them, their level of interactions (and sometimes affection), and the roles and responsibilities are comparable to that of a mother (Lai, 2009). However, as employees, they often do not have the same status in the live-in family. In fact, their role as employees in the family likely makes them feel that they are the subordinates of the children (Hong Kong Christian Service, 2002). Thus there is essential a conflicting role in terms of child care – as surrogate mother they should have certain power to discipline the children, yet as the children's subordinate they may not have the power to, or has reservation about, when and how to discipline the children.

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They are therefore likely to seek for the children's cooperation rather than playing a

role in teaching or disciplining them (Ip et.al., 2008; Hong Kong Christian Service,

2002).

In their study in Singapore, Ebbeck and Gokhale (2004) found that majority of

the parents surveyed do not expect the FDH as being one of the disciplining adults,

although they spend a disproportion amount of time (compare to the parents) to

care for the children. The author hence raised concerns about if children have a clear

understanding of boundaries and misbehavior and their consequences if consistent

behavior and correcting strategies are not enforced by FDH versus by parents.

Roumani (2005), based on the study in Saudi Arabia, raised the awareness of

using housemaids as caregivers to their young children. Since FDH are not trained

childcare professional and given their low positions in the family, the author is

especially concerned with the social and emotional development of young children,

including attachment issues, separation anxiety (especially involved in change of

maids), issues in children's personality and social attitudes if FDH spent extensive

amount of time with the children. And yet if non-parental child care is with high-

quality, it could still have a positive impact on children's social competence and

positive development (Ip et al., 2008).

In terms of relating FDH with risk factors for youth development, there have been relatively few studies conducted on that topic. However, the aforementioned issues about inconsistent parenting practice by FDH versus parents, ineffective monitoring, and poorer attachment to parents (especially facing FDH more than parents because of long work hours) that are exhibited in childhood could also transcend to youth. This can be an issue especially if the quality of childcare is not high.

2.2.5. Religion and Spirituality

Religion and spirituality have a significant role in both preventing and treating substance abuse. Religious affiliation — be it Christianity, Judaism, Hinduism, Islamism, Buddhism, etc. — is found to be negatively correlated with substance abuse in both adolescence and adults (National Center on Addiction and Substance Abuse at Columbia University, 2001). It has been shown to be a protective factor against substance abuse (SAMHSA, 2007). This can be explained as follows: First, proscriptions from religious groups likely prohibit and restrict substance use in various ways. It works as a form of social control and provides guidelines for behaviors (Koenig, 2009). Second, the spiritual community can play a supportive role, including the family's religious values that typically discourage substance use, and involving with peers who are less likely to be using drugs. Adults also tend to have a

more stable connection with community and social network (NSDUH, 2007). Third, a relation with God or a "higher power" greater than self often produces a psychological or physical reaction that satisfies an individual's spiritual, physical and mental needs (NSDUH, 2007). In terms of substance abuse treatment and recovery, values such as respect, forgiveness and honesty that are emphasized by many religious faiths can be helpful to recovering addict and their families. Feelings of acceptance and instillation of hope for the future are important components in the recovery process, and these needs can often be met in a religious or spiritual context (Miller, 1998). Positive outcomes are found in substance abuse treatments that include greater commitment in the treatment program, and active and sustained involvement during and after treatment (Hill, Burdette, Weiss, and Chitwood, 2009). Furthermore, this positive impact is not limited through participation in specific or tradition religion per se, but also in a broader sense of faith and spirituality such as an individual's search for the ultimate meaning and purpose in life (Grodzicki, 2005). One prime example of using faith-based approach in treatment is the twelve-step programs adopted by Alcoholics Anonymous (AA) in North America to combat alcoholic use. Local examples include Fresh U Christian New Being Fellowship and Christian Zheng Sheng Association, which use Christianity as a means to drug rehabilitation. Notwithstanding the positive impact of religious influences, there are

cases that work the opposite. For instance, individuals who practice religion that advocate strict substance abstinence may completely withdraw from their religious involvement when they start using drugs, thereby worsening their psychological health due to guilt, shame and increased social isolation (Koenig, 2009). Yet overall, systematic research to date generally suggests positive influences of religious affiliations (Koenig, 2009). In addition, regardless of the various styles and structures of the faith-based program such as faith-permeated, faith-centered, faith-affiliated, or merely having background of faith (Tangenberg, 2005), religiosity and spirituality can be an important correlate for success in a variety of treatment programs including substance abuse (Walton, 2007).

2.2.6. Family well-being: facilitative and hindering factors

An extensive body of research confirms that family functioning has a significant impact on the life chances of individual family members (Stevens, Dickson and Poland, 2005). So the question remains — what constitutes a healthy family? A family study from New Zealand conducted in 2005 (Stevens et al., 2005) may shed light on the issue.

The three key facilitative characteristics of what is considered a "successful" family are, reportedly, (1) family has the resilience to cope with change and adversity, (2) parents possess positive parenting skills, and (3) a strong communication among

family members. Other successful outcomes for a family include a continuous, ongoing relationship between family members and children, reciprocity of support among family members, and transmission of cultural, spiritual and religious values to their children. The study also found that the parents' aspirations for their families largely focus on desired outcomes for their children, such as to achieve good educational outcomes so that they can become responsible, happy, and self-sufficient adults. The success of their children and the overall family functioning are considered a more important indicator of family well-being than wealth.

Yet, there are several factors hindering such positive family outcomes. First and foremost is being economically disadvantaged. A reasonable income through employment is critical to building family well-being through meeting the family's basic needs, achieving a reasonable standard of living, and supporting the aspirations of individual family members. This is also necessary to increase the chance of achieving successful outcomes both in the short run and across generations (Stevens et al., 2005). Another issue is time constraints. One of the most prevalent challenges reported is the ability to balance family time and income without compromising the standard of living. Work-life balance seems even more challenging for low-income and single-parent families. Third, a lack of parenting

knowledge and poor communication skills within the family is also problematic.

Many respondents indicate the benefits they receive from participating in parenting

courses. Most of them acknowledge the parents' need for parenting advice, and

encourage greater community access to such advice and parent education — while

many people still consider it embarrassing to seek help or are unsure where to go for

help when needed. Fourth, poor access to resources such as an adequate income,

good education, health services, housing, and transportation is also a barrier

hindering the well-being of families. Furthermore, conflicts between social

expectations of their role as parents and as contributors to the economy, societal

and cultural values on materialism, expectations of young people, etc., all serve as a

source of tension and hinder the functioning of the families if not addressed

appropriately (Stevens et al., 2005).

It is also noteworthy that low-income and "non-traditional" family structures,

such as single-parent families, face more challenges than others in achieving family

well-being. Fewer economic resources and possibly longer working hours make them

less flexible and with less control in their time management, in contrast with families

with greater economic resources who can hire domestic helpers to take up a part of

the household chores to compensate for the time lost from, for instance, commuting

to work. These all have implications on the family functioning (Ma, Wong, Lau and Pun, 2009). Another local study on low-income families also argues that the social capital of marginal communities in Hong Kong cannot sufficiently mediate the stress of the poor (Wong, 2004). For single-parent families, juggling between work and family commitment such as child care is more serious than families that can have shared-parenting (Stevens et al., 2005).

Informal networks from friends, neighbors and families also have a key role to play on impacting children and family well-being. Quality networks such as a stable and resourceful neighborhood, and where families (the core and / or extended families) are willing to render support, can improve outcomes for families. Factors in the work setting can also have significant impacts on families as it directly affects the amount and quality of time people can spend with family members (Stevens et al., 2005). Flexible working conditions, supportive employers, reduced working hours, availability of longer annual and parental leave, and increased wage levels can all contribute positively to building healthy families (Hand, 2005).

Thus, achieving family well-being requires an ecological understanding and tackling of the issues involving different "layers" of the systems, which include family

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dynamics, friends, communities, workplace, government policies and services, and

the broader economic and social environment (Stevens et al., 2005). Inevitably, the

influences from the immediate environment such as family dynamics, friends,

communities and workplace are often more salient and direct than from the

macrosystem such as government policies and services. What is important, however,

is to ensure a "family perspective" to be integrated in the development and

evaluation of policies and program in order to reflect the importance of family

unit — in both the workplace and public policies — which in turn can make a

stronger impact on family well-being (Stevens et al., 2005).

A Hong Kong study conducted in 2008 revealed what is considered to be

family well-being in a local context. An ideal family is regarded as a harmonious

family (and in a majority of case, a "nuclear family" with parents and children). Such

harmonious family should be able to provide emotional and/or financial support,

having feeling of togetherness, have happiness and fun with each other family

members (Chow and Lum, 2008). Specifically, harmony refers to effective

communication, acceptance, and lack of conflict. Similar to the aforementioned

survey conducted in New Zealand, income could become a major source of conflict

as pointed out by participants from more economically disadvantaged areas such as

Sham Shui Po and Tin Shui Wai. Yet survey participants also agree that money is necessary but not sufficient to contribute to harmonious family relationship. Most survey participants also indicate that people are always too busy, making it difficult for family to spend time together (Chow and Lum, 2008). While parents spend long hours on work, children in Hong Kong also spend disproportional amount of time on homework assignment and meeting other demands from school that they have little time to spare to spend with family members. Education also becomes a source of conflicts between parent and children and between the couple. The report therefore calls for more family-friendly policies in both the public and private sectors. Examples include setting a limit for maximum number of working hours, "happy learning initiatives" in schools, increased flexibility in work schedule, etc (Chow and Lum, 2008). The close to 20-year advocacy in Hong Kong on home-school cooperation to promote child development is also another approach to enhance child and family well-being through better communication between the parent and school systems. The movement has led to the setting up of the Committee on Home-School Cooperation in 1993, and the establishment of Parent-Teacher Associations in nearly all primary and secondary schools and some of the kindergartens by 2010 (Committee on Home School Cooperation, 2010). However, evidence on the impact

of such on the enhancement of children and family well-being has yet to be established.

2.2.7. Summary

As we see in this section, family functioning has significant impact on adolescent substance abuse. Simultaneously, substance abuse can have a significant impact on family members. As family encompass parent-child relationships, inter-parental relationships, sibling, grandparents, and domestic helpers, etc., prevention and intervention efforts should therefore not only address the drug user per se but different parties within the family and the drug-user's surrounding in its entirety, i.e., the most significant risk and protective factors in the person's development system. After in-home family support, family skills training programs are proven to be the most effective approach in preventing substance abuse(UNODC, 2009). It is stated in the UNODC report lessons learned from the alcohol abuse prevention. The effects of family skills training tend to sustain over time. In comparison, positive impact from community-based prevention tends to decrease over the years (UNODC, 2009). This is because family programs focus on strengthening powerful protective factors, which in turn reduce the risks and thereby changing the family environment that the youth are facing. The most effective programs are those who have an emphasis on active parental involvement, and developing skills in the young people's social

competence and self-regulation (Petrie, Bunn, and Byrne, 2006). They focus not only

on the issue of substance abuse, but on a broader topic such as maintaining good

familial bonds and setting clear standards. Also, the best time to deliver the

programs is found to be the major transition period, such as the change from

primary to secondary school (Petrie et al., 2006; Lockman and Steenhoven, 2002).

This is a key developmental point where there is a normative change in peer and

family relationships, the increasingly independent nature of the academic studies,

and increased peer pressure (Lockman and Steenhoven, 2002). By addressing these

baskets of risk and protective factors, family skills training programs could prevent

not only substance abuse but also other problematic adolescent behaviors which are

shown to have similar factors as substance abuse (UNODC, 2009).

2. 3. Countries Analysis

In this section, we will provide an overview of anti-drug prevention initiatives

in certain countries: U.K., U.S., Australia, Canada, Taiwan, PRC, and Singapore.

2.3.1. United Kingdom

Overview

Family is their priority in addressing drug issues. U.K. drug strategy, as they

have put it, has a long-term view about drug prevention issues. They believe that

parents and families have the ultimate responsibilities to protect and educate their

own children about drugs, and hence the government's role is to equip families in doing this job.

In fulfilling their duties rightfully, families can significantly offset risk factors that cause youth substance abuse, and potentially other youth problematic issues. Also, UK emphasizes the collaboration among agencies and groups in delivering families and in youth service. Thus the government urges both children and adult services and delivery systems to think from the "whole family" perspective and preventing youth drug abuse by managing their parents and family issues in a holistic manner, especially those with the higher risks. This new "Think Family" approach is still undergoing its initial stage for national-wide implementation and would undergo regular review.

2.3.1.1 U.K. Drug Strategy

The ten-year drug strategy (2008 – 2018) prioritizes families for the first time (Department for Children, Schools and Families [DCSF] web site, 2008). It places sharp focus on effective prevention and intervention before problems arise (Home Office, 2008). This new approach emphasizes family support, intervening early with at-risk families (such as families with substance-abuse parents), improve drug education by strengthening the role of schools, provide targeted youth support for

vulnerable youth (i.e., youth that at the verge of displaying problematic behaviors), and provide effective treatment.

On prevention, the strategy focuses on the following key actions –

<u>Family-specific</u>

(1) Utilize family-based intervention, which strengthens and supports more families, and in turn builds young people's resilience and hence reduce the harms caused by substance abuse. This can be done through providing better information and training to strengthen parents and carers' (including grandparents) role in preventing youth substance abuse

(2) For parents with substance abuse issues, ensure prompt access to treatment for all drug-misusing parents. All assessments will take account of the needs of the entire family so that the children are under appropriate care during and after treatment.

(3) Deliver a package of interventions for families at risk to improve parenting skills, helping parents to educate their children about the risk of drugs, supporting families to stay together and break the intergeneration transfer of problems

(4) Support kin carers (e.g., grandparents caring for children with substance-abuse parents) by improved information for them, and exploring the options to make payments to children classified as "in need".

<u>Mainstream prevention</u>

It aims at intervening early through school and youth services rather than through specialist service only when substance misuse occur

(1) Strengthen the role of mainstream prevention, such as reinforcing the roles of schools in delivering drug education in school, and identify at-risk young people early

(2) Improve access to social inclusion programs.

(3) Provide integrated responses for vulnerable youth, such as through Targeted Youth Support, to address related issues such as youth crime, teenage pregnancy.

<u>Public information campaign</u>

(1) Extend the use of FRANK (media campaign) to provide access to support and intervention

(2) Improved support and information for parents

The strategy also calls for making improvements to the treatment system for young people and building a U.K. evidence base of what works (Home Office, 2008).

<u>2.3.1.2 Family Programs</u>

The paragraphs below outline the programs that are directed specifically towards families. It is noteworthy that these initiatives do not address only substance abuse. Rather, they use families as a unit and target at assisting families at risk who

typically face multiple problems including substance abuse, as drug abuse is a manifestation of the underlying problems within the family.

Parenting Early Intervention Programs (PEIP)

Background

PEIP: Pathfinder (2006 – 2008)

PEIP is a large-scale implementation of parenting programs in the local communities. There are three main publications and campaigns that drive the development of PEIP. First, "Every Child Matters: Change for Children" was published in December 2004 and proposed an improved and integrated children services' delivery to improve outcomes for children and young people[7]. It aims at achieving five outcomes for children: be healthy, stay safe, enjoy and achieve, make a positive contribution, and achieve economic well-being. In "Every Child Matters: Change for Children – Young People and Drugs" (Department for Education and Skills, 2005), it further identifies parents, carers and families are having a key role in preventing drug use among young people.

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[7] "Every Child Matter" was a Green Paper published by the British Government in 2003 in partial response to a unique child abuse case in Britain. Victoria Climbié, an eight year old girl, was horrifically abused when she was under the care of her great aunt and her boyfriend, and died in 2000. Her death caused tremendous awareness in the severe lack of coordination, insensitivity and bureaucracy in public services including health services, welfare agencies, child services system, police, etc., as Victoria's abuse case was repeatedly handled by various public service systems yet none of them seemed to take the ultimate accountability to ensure her safety. A public inquiry was conducted after her death which led to major changes in the child welfare system in the U.K (DCSF, 2008a).

Second, the "Respect" Campaign and hence its Action Plan in 2006 mainly addresses issues of anti-social behaviors (ASB), with drug abuse and its related crime being one of the ASB. It recognizes parents are fundamental to the children's development and committed to develop further parenting services especially to those families needing the most help with developing and maintaining proper parenting role.

Third, alongside it is The Children's Plan (December 2007), which has an aim of making "England the best place in the world for children and young people to grow up". The plan clearly states that as it is parents, and not government, who bring up children, and hence the government needs to do more to back parents and families. As families are considered the bedrock of society and the first place that happy, capable and resilient children are nurtured (DCSF, 2007a), the government is responsible for assisting parents to do the best for the family, offer advice and prevent problems to arise.

Therefore, based on the notion of early intervention, PEIP were first rolled out from September 2006 – March 2008 to support parents in "doing their jobs as parents". The pathfinder program (Wave 1), targeting children from 8 to 13 years old

at risk of negative outcomes (and anti-social behavior in particular). It utilized three

evidence-based parenting programs:

- Incredible Years

- Triple P

- Strengthening Families Strengthening Communities (SFSC)

Results of PEIP Pathfinder

The three programs were found to be equally effective in improving parents'

mental well-being, parenting skills, the sense of being a parent, and in the behavior

of the child (Lindsay et al., 2008). The number of parents who classified their children

as having significant behavioral difficulties cut by half by the end of the program.

Parents reported to be calmer and giving more time to communicate with their

children – both talk and listen to them. They perceived their relationship with

children have improved, although one point to note is that these are based on

parents' perceptions rather than direct measure of behavioral change.

PEIP (2008 – 2011)

With its successful pilot from Wave 1, the DCSF decided to expand this

program across most of the country from 2008 – 2011. Local authorities (LA) are

allowed to select parenting programs other than the three used in Wave 1, and in

addition, Strengthening Families (8-14) and Families and Schools Together (FAST) are

added (DCSF, 2008b)

<u>Family Intervention Projects (FIPs)</u>

Background

Stemming from the Respect Action Plan, FIPs aims at stopping the anti-social behaviors of problematic families that are causing threats to the neighborhood, and achieve the five outcomes outlined in the "Every Child Matters". Launched in January 2006, FIPs deal with the most challenging families showing intergenerational disadvantages, likely having multiples issues such as drug and alcoholic abuse, domestic violence, school absenteeism, youth crime, unemployment and debt (White et al., 2008).

FIPs employs an "assertive" and "persistent" working style to both challenge and support families to address the root causes of their ASB (Home Office, 2008), with an aim of reducing ASB, preventing youth crime, and tackling child poverty (Home Office, 2010). Services were conducted in two ways: outreach support to families in their own home, or a 24-hour support in a residential core unit where the family live with project staff, and they will move out when the behavior of the family improves. Specific support provided to these families include one-to-one parenting support, provide meaningful activities for parents and children, financial

management, locate education and job opportunities, etc.

Results

Periodic review in July 2008 and March 2010 indicated that the outcomes for families are overwhelmingly positive. A 64% reduction in ASB were recorded, 89% reduction in four or more ASB problems, 58% reduction in truancy, exclusion and bad behaviors at school, and 70% reduction in substance abuse problem. Early indications suggest that these outcomes are able to be sustained up to 9 to 14 months after they exited from FIPs (National Centre for Social Research, 2010) for the 10% of the families that have been followed-up.

<u>Think Family Pathfinders and the Think Family Approach</u>

Background

The Think Family Pathfinder was launched from May 2008 to 2011 and it is the latest approach in U.K. on dealing with drug abuse and other social issues related to at-risk families. By "Think Family", it means an approach that aims at delivering well co-ordinated, multi-agency interventions to join up both the children and adult's services to families in need, and offer PEIP to improve parenting skills for at-risk families. Its mentality is based on the report published in January 2008 by the Cabinet Office, "Think Family: Improving the Life Chances of Families at Risk" which studies families at risk – families who are the most vulnerable with multiple and

complex problems. Typically, these families are characterized by having these common risk factors:

- Substance abuse

- Mental health issues (adult mental health in particular)

- Domestic violence

- Anti-social behavior

- Housing issues

- Adult learning difficulties and disabilities

- Unemployment

- School attendance and behavior

The Cabinet Office's report findings argue that in order to break the intergenerational cycle of disadvantage, all systems and services should meet the individual needs in the context of the entire family. In other words, clients should not be seen just as individuals but as parents or family members (Cabinet Office Social Exclusion Task Force, 2008). Such "whole family" and "integration of services" approaches also draws on the success of projects such as the FIP (Cabinet Office Social Exclusion Task Force, 2008; DCSF, 2010a). It also coincides with theme from the Children's Plan in 2007.

The program aims at reaching families with highest level of need so that families would not "yo-yo" in and out of the thresholds for statutory interventions, and also to carry out more preventative work for those whose situation may exacerbate without preventative support (DCSF, 2010a). Besides the 15 Family Pathfinders who initially led the implementation of the Think Family, six more Extended Family Pathfinders and in November 2009, 12 two-year Young Carer Pathfinders were launched to prevent inappropriate caring from a young person in a family (DCSF, 2010).

Figure 6. The Building Blocks of Family Pathfinders

Interagency governance

Integrated strategy

Integrated processes

Families at the centre

Integrated frontline delivery
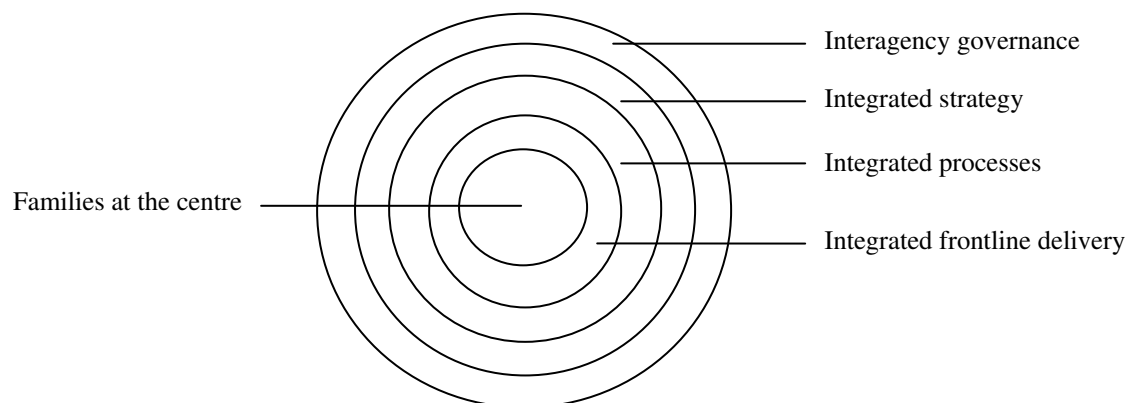
<u>Families at the centre</u>: Families are involved in the design of their support wherever possible and empowered through devolved budgets and family-led decision making.

<u>Integrated frontline deliver</u>: Empowered and assertive practitioners provide tailored

and joined-up support around the whole family. The identify needs early and proactively engage families.

Integrated processes: Shared assessments and information across agencies give a full picture of a family's needs and help ensure support is fully co-ordinated.

Integrated strategy: Joined-up planning and commissioning drive a focus on families at risk across all agencies.

Inter-agency governance: Accountability for family outcomes is clear, with strong leadership at the top and protocols setting out agreed responsibilities between agencies.

Besides an integration of service delivery, the LA would offer PEIP to improve parenting skills using evidence-based programs to parents of 8 – 13 years old whose children are at risk. Ideally, the program should provide a more effective and cost-effective models for service delivery (DCSF, 2010a).

Interim Results and Challenges for Think Family Pathfinders

Based on the latest (being the first) update published in early 2010, there are emerging positive impacts on families:

1.   the program is able to streamline package of support offered to a family who is at the verge of disengagement . Otherwise there are, in some cases, more than 20

agencies working with the same family simultaneously.

2.   In some cases where both parents have alcohol misuse issues and the child is still young, detoxification program has factored in both parents need to be detoxified at the same time but at different locations so that one parent can take care of the child at home while the other is at residential care.

Challenges are found at both the strategic and operational level. At the strategic level, there is lack of clarity regarding their positioning as there are no senior leaders driving the development of the Pathfinder. There is also a need to develop data sharing protocols on the family's data. And currently, as this program is led by the DCSF, it is viewed locally to be a children's services initiative and thus seems to be too focused on children's services. At the operational level, different thresholds for accessing services across different services led to difficulties in constructing cross-service packages of support for families (DCSF, 2010b). Lack of referral of adult services is also a challenge. Suitability of existing assessment tools as the basis for the "Think Family" assessment varied. Staff issues such as key personnel on sick leave would also impact on delivery.

As this "Think Family" approach is still underway, there will be periodic

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update over the next 12 months.

Other Family-related Initiatives

Children's Workforce Development Council (CWDC)'s parenting academy

CWDC takes up the parenting academy's functions in March 2010. Formerly

known as the National Academy for Parenting Practitioners (NAPP) which was

originally established in November 2007, they provide parenting skills training to

practitioners that parents turn to for advice. They provide advice on the best practice

in parenting support that is evidence-based. A Commissioning Toolkit was created in

December 2008 to serve as a database that help Children's Trusts to deliver effective

parenting strategies (CWDC, 2009).

Parent Support Advisors (PSA)

Parent Support Advisors are provided in schools and aims at helping parents

to increase their involvement in their children's learning, behavior and attendance in

school. Evaluation of PSA during their pilot run from 2006 – 2008 found that it

improves parents' engagement with their child's learning, improved relationships

between parents and schools and most importantly, improve pupil attendance.

Secondary schools' persistent absentees were reduced by a quarter during that

period (Lindsay et al., 2009).

Support for Young Parents

The DCSF has launched a refreshed strategy improve outcomes for teenage parents and their children. The guideline required Local Authorities to bring together different services including midwifery, health visiting, children's centers and targeted youth support (TYS) services to provide integrated, tailored support for young parents. It aims at improving child health outcomes (including infant mortality and birth weight), emotional health and well-being experienced by teenage mothers, and economic well-being. Examples of such support for young parents include Sure Start's Children Centers that bring together early education, childcare, health and family support (DCSF, 2009a). They cover a wide range of programs – both universal and those targeted on particular local areas or disadvantaged groups within England. The "Care to Learn" scheme provides financial help with childcare if the applicant is in college, at school or taking part in a work-based learning program. In addition there is the Family Nurse Partnership (FNP) Program. Originated from the U.S., it is an intensive nurse home visitation programs that run in certain U.K. locations as part of their aforementioned Early Intervention Program to break cycles of intergenerational underachievement and deprivation. Target participants of FNP are first time young parents and nurse home visitations which continue until the child is two years old.

Their roles encompass helping young women engage in good preventative health practices including antenatal care, healthy diet and reduction in smoking and substance misuse; increase the involvement with fathers and improvements in the child's readiness to attend school; support parents to provide responsible and competent care; improve the economic self sufficiency of the family by supporting parents to develop a vision for their own future; plan future pregnancies; and make plans to continue education and finding work (Department of Health, 2009). The Teenage Pregnancy Independent Advisory Group (TPIAG) was set up in 2000 to advise the Government on the Teenage Pregnancy Strategy and to monitor its implementation. The strategy aims at reducing the rate of conceptions to under-18s by 2010 by half, and to increase the participation of teenage parents in education, training and employment (DCSF, 2009b).

Drug education in school and Blueprint

Drug education is one component within a wider strategic approach on targeted prevention for vulnerable youth who are most at risk (DCSF, 2008c). Currently, drug education in the U.K. is incorporated as part of the statutory requirement of science (Sc) and citizenship (Ct) programs of study. Drug education is also an important element in the UK's Personal, Social and Health Education (PSHE) in the school curriculum, which as of to-date is not yet a statutory subject. Plans to

make it statutory in September 2011 are underway, subject to the legislation. Drug

education starts in their curriculum Key Stage 1 (i.e., beginning of primary school),

and the content progress as pupils develop their knowledge (Department for

Education and Skills, 2004).

In fact, the UK drug policy in school and drug education has been undergoing

significant review. Based on the 2004 Drug Guidance for School, drug testing and use

of sniffer dog is allowed, yet schools are strongly advised to state clearly the school's

drug policy which should be developed after consulting students, parents, staff,

governors, the whole school community, and police (if involve sniffer dog and

determine whether search warrant is necessary). Schools are also reminded to use

these measures with extreme caution. They are also reminded that these measures

should not be an isolated action but part of a whole-school approach to manage

drugs issues in school. On drug education, the project "Blueprint" was used to guide

the piloting of appropriate approaches in school drug education (Home Office, 2009).

Blueprint was a research-based multi-component approach to school-based drug

education including school, parent, community, health policy, and media. Held

between 2004 – 2005 for children at their first two years of secondary school (i.e.,

age 11-12), the key findings provided the basis for the Substance Misuse Education

Review. The findings also help revise the current Drug Guidance for Schools.

Key learning points from the Blueprint program include:

a. increase the pupil and parent components and co-coordinating pupil's education with parental support, and less on community, health policy and media components (Home Office, 2009)

b. Introduction of drug education program before the average age of drugs experimentation (quoted as age 11 in UK), such as in primary school, could pre-empt this stage in their development (Home Office, 2009)

c. PSHE education should be made statutory in the school curriculum (target to be implemented in 2011 subject to legislation).

2.3.1.4 Positive Futures

It a national sports and leisure activities-based social inclusion program for people aged 10 – 19, with priorities given to deprived neighborhood (Home Office, 2010). These activities include football, canoeing, climbing, biking and creative arts and drama. Young people in the program receive coaching skills in sports and opportunities to play competitively in sports clubs. Also, they receive educational opportunities such as through Sports Leaders UK and Open College Network. The program also provides them opportunities to volunteer, to have meaningful engagement by involving them in casual and part-time work, train up to have

leadership skills, and have pathways to full-time employment. Substance abuse

preventions and interventions are infiltrated in this program, such as through drop-in

surgeries and discussion through sport sessions and healthy lifestyle programs and

workshops. Most importantly, by creating new opportunities for alternative lifestyles,

solid personal relationships are built between responsible adults and participants so

that the younger generations are steered towards educational and employment

opportunities.

2.3.1.5 Targeted Youth Support (TYS)

Under the "Youth Matter" green paper (2005)'s commitment TYS was formed

as a pilot scheme in 2006. It is not a specific program. Rather, it is an approach to

reform young people' service that emphasize a collaboration of services and agencies

to work more efficiently. Staff are trained at universal settings (e.g., health visitors,

voluntary sector staff, youth workers) to be enhanced their awareness of youth risk

factors and intervene early. The establishment of "Contact Point", a secured online

directory shared by agencies and community organizations so that they know who

are working with the same individual at the same time. And by using the Common

Assessment Framework (CAF), government, voluntary and community organization

work together to achieve a holistic understanding of the needs of the identified

young person. A multi-agency panel would be formed and strengthen the response

to early problems in universal settings. TYS also emphasize support in transitions period, e.g., transitions into and out of specialist or statutory interventions – young people coming to the end of a youth justice disposal or period in care or returning to school. TYS also work alongside with parenting strategies and family support service so that parents of these youth are also taken care of while the targeted youth are served. In addition, outreach programs, more convenient opening hours for drop-in centers, provision of more attractive activities, using communication channels (e.g., texting messages) to promote activities are among the means that TYS use (DCSF, 2007b).

2.3.1.6 Public Information Campaign: FRANK

FRANK is a U.K. government's national drug media campaign. It encompasses a wide variety of domains including advertising, print media, a 24/7 helpline for young people and parents, email to ask questions anonymously, and website with lots of resources about drugs and for concerned family members. The campaign targets to ensure young people to make informed decisions by understanding the risks and dangers of drugs, and know the place to go for advice and help. It also equips parents with confidence and knowledge to discuss drug issues with their children (Home Office, 2007).

2.3.1.7 U.K. Summary

Family is at the center of their drug strategy. Using the "think family" approach, they also target at bringing efforts in service integration to minimize intergeneration cycles of poor outcomes. In addition, engaging parents in their work, family skills training program that target not only drugs but other issues, meaningful engagement for young people, drug education in school, and the use of the mass media campaign and national hotline "FRANK", are all involved to combat the battle against drugs.

2.3.2. United States

Overview

The drug strategy in the U.S. is characterized by its emphasis on "community-based" strategies. By community, it means the local neighborhood where everybody lives, work, and go to school. And hence, participation from representatives from all sectors of the community is essential to contribute to the success of any drug prevention and intervention efforts. In 2010, the strategy is moving towards a direction to require agencies to collaborate and deliver evidence-based programs that address common risk factors that cause a range of youth problems across different segment of the communities. In this new strategy, it has the plan to reduce the 30-day prevalence of drug use among 12 – 17 year olds by 15% by 2015 (White

House, 2010a).

2.3.2.1 U.S. Strategy

New in 2010: Prevention-Prepared Communities Program (PPC)

PPC supplements existing community-based efforts and focuses on youth and young adults age 9 – 25. This pilot program include an effort in conducting epidemiological needs assessments, creating comprehensive strategic plan, implement evidence-based prevention services through multiple venues, and address common risk factors for mental, emotional and behavioral problem. In other words, the previous approach on giving prevention grant that focus on single outcome (e.g., drug abuse, bullying) to a narrow segment of the communities (e.g., a school district, a police department) is no longer encouraged. PPC's aim to encourage agencies to co-ordinate their grant and technical assistance so that their communities could be surrounded by a range of protective factors rather than protected only in a single setting or at a single age group. SAMHSA would be responsible for the design, implementation and evaluation of PPC (Office of National Drug Control Policy, U.S [ONDCP], 2010).

Drug Free Communities Program (DFC)

DFC is the U.S.' leading effort to mobilize communities in preventing drug abuse (ONDCP, 2009). It provides the federal funding necessary for communities to

identify and respond to local substance use problems. It is based on the notion that communities must be organized and equipped to deal with their individual substance abuse problem in a comprehensive and coordinated manner (CADCA, 2009). Local communities, commonly called "coalitions", who apply for such grant needs to have the goal of reduction in youth substance abuse, and address multiple drugs. Most importantly, each coalition supported by DFC funding must have the representation of the following 12 community sectors from its target community to be eligible for funding:

1.   Youth (under 18 years old)

2.   Parents

3.   Business

4.   Media

5.   School

6.   Youth-serving organization

7.   Law enforcement

8.   Religious / fraternal organization

9.   Civic / volunteer group

10.   Healthcare professional (i.e., doctor, nurse, dentist, pharmacist, etc.)

11.   State / local/ tribal government agency with expertise in substance abuse

12.   Other organization involved in reducing substance abuse

The National Community Anti-Drug Coalition Institute, which is part of the Community Anti-Drug Coalitions of America (CADCA), provides training and assists the communities in their anti-drug efforts and also to get the DFC funding. They propose using the "environmental strategies", which is grounded in the field of public health and emphasizes the broader physical, social, cultural and institutional forces that contribute to the problems that coalitions address. Therefore, they are asked to incorporate prevention efforts aimed at changing community conditions, standards, institutions, structures, systems and policies. The ultimate goal is to modify the settings where a person lives, which in turn would influence how the person behaves (CADCA, 2008). As mentioned in the literature review section (page XX-XX), there are seven strategies of the "environmental prevention" approach into actions that can affect community changes: provide information, enhance skills, provide support, enhance access and reduce barriers, change consequences, change physical design, and modifying change policies. Examples of such strategies in use include local coalitions on alcohol, tobacco and other drugs that limit youth access to alcohol at grocery and convenience stores by training retailer employees, increases penalties for retailers that sell to minors, media campaign to educate parents on the dangers of smoking and underage drinking, etc.

<u>Strategic Prevention Framework – State Incentive Grants (SPF-SIG) and Communities</u>

<u>that Care (CTC)</u>

SAMHSA's mission is to reduce the impact of substance abuse and mental illness. Center for Substance Abuse Prevention (CSAP) is her working arm directed at substance abuse. SAMHSA requires all the prevention programs run in the U.S. to uptake their Strategic Prevention Framework (SPF), which is a five-step process (Assessment, Capacity, Planning, Implementation and Evaluation) to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the life span (SAMHSA, 2004). Their SPF is built based on a community-based risk and protective factors. Evidence-based prevention programs are expected to be used within this grant to build capacity within each State.

Figure 7. SAMHSA's Strategic Prevention Framework

One of the most important tools that SAMHSA utilizes is "Communities that Care" (CTC), a prevention-planning system that assists communities to identify issues and implement changes. CTC has two important components:

(1) Using the public health approach – a comprehensive and community-wide mobilization. The entire community is involved to promote behavior change. The "heart disease model" is often quoted as an illustration of such approach.

(2) Assessing the risk and protective factors, and addressing them by using evidence-based programs, with the ultimate goal of developing healthy and positive behaviors among young people

Grounded on the Social Development Strategy (SDS), CTC provides a research-based framework for developing the processes necessary for positive youth development (Hawkins and Catalano, 2005). Communities are asked to identify the elevated risk factors and depressed protective factors with the help of the CTC youth survey, prioritize the targeted factors that they will address, select the evidence-based programs to tackle the factors, implement them in their communities, and monitor and evaluate the progress.

SAMHSA has identified tested and effective prevention programs, policies and

strategies that are proven to increase protective factors, reduce risk factors and in turn, reduce adolescent problem behaviors. Examples of these evidence-based programs include Guiding Good Choice (formerly known as the Preparing for the Drug-Free Years), Celebrate Families! (CF!), Strengthening Families Program (SFP), Project ALERT, etc. CTC would help the communities to match their unique risk and protection profile and current resources with such proven programs and practices – programs can range from birth through adolescence and cover all areas of young people's lives. CTC would also help the community to implement such program, develop action plan, and conduct evaluation at both program-level (annually) and community level (every two years).

In fact, various adolescent problem behaviors including substance abuse, delinquency, teen pregnancy, school drop-out, and violence can be predicted by a series of common risk and protective factors (Hawkins & Catalano, 2005). These factors exist at all levels including the community, family, school, and peer and individual. This basket of risk factors was outlined in Table 2 in Section Two. Thus by implementing evidence-based programs that address these factors effectively, they can have positive effects on multiple behaviors. It is hypothesized by CTC that it takes from two to five years to observe community level effects on risk factors, and five or

more years to observe effects on adolescent delinquency or substance use (Hawkins et al., 2008).

The evaluations of CTC are promising. The youth in communities that implement CTC have significantly lower substance abuse and delinquency than others in the controlled communities (Hawkins et al., 2008; Hawkins et al., 2009).

SAMHSA's SPF and CTC system's approach align with the latest 2010 U.S. drug strategy. With SAMHSA being delegated the task of reviewing the brand new PPC program grant, it is likely that the SPF framework and CTC would be used significantly across the U.S. in all prevention efforts to address a range of youth problems.

Other SAMHSA websites, such as "A Family Guide to Keeping Youth Mentally Healthy and Drug Free" (target at families with youth between 7 to 18 years old), and "Building Blocks for a Healthy Future" (target at families with young children ages 3 to 6), are public education websites for parents and carers providing numerous resources on tips to effective parenting, communication skills, importance in spending quality time with children, how to monitor children's activities, activity suggestions for family-time and information on drug facts. Both websites are

designed with the purpose of promoting protective factors – the situations and conditions that decrease chances for children to engage in risky behaviors including drug abuse – within families.

<u>Substance Abuse Prevention and Treatment (SAPT) Block Grant</u>

Such funds are administered by SAMHSA and 20% of the grant is used on substance abuse primary prevention. The programs are based on five broad strategies: Information dissemination, education, alternative activities, problem identification and referral, community-based processes, and environmental strategies (ONDCP, 2010).

2.3.2.2 National Youth Anti-Drug Media Campaign

It is a media campaign targeting to influence youth attitudes towards drugs. They launched the youth-targeted "Above the Influence" brand using televisions and websites, and national hotline (the "Nineline"), providing drug information and anti-drug message to both parents and teenagers. While its branding strategy is very successful (as measured by the brand's awareness among youth comparing to mega-brands such as Coca-Cola and Nike, and on average of 800,000 website visits a month), the 2010 National Drug Control Strategy decided to revamp and reenergize this campaign. This is because, according to the US government, the current media

increasingly includes pro-drug content which normalizes drug use. It recognizes the importance of delivering anti-drug messages in the media to neutralize that. Such revamp effort would include increasing its emphasis on paid advertising (teen-centric television, print, internet and digital media), public communications (community events, corporate partnership with youth brands, youth-centered activities), and place more relevant content on teen destination websites. In addition, it would include both a national component that delivers broad prevention message to teens ages 12 – 17, and a local component which will target to be tailored to high-risk youth at the local community level.

2.3.2.3 Drug Education in School

The latest Education "Blueprint for Reform" (March 2010) propose the elimination of the former "Safe and Drug Free School" program and replace it with the "Successful, Safe, and Healthy Students" program. It calls for using data-based decision making and achieving an accurate understanding of the students' issue in order to devise all school safety strategies – drug use being one of the many components of such safety issues (Department of Education, U.S., 2010). In addition, school districts need to compete on a national basis for funding their programs, unlikely previously it was a federal-to-state funding to all school districts on a non-competitive basis. There are also critics saying such elimination would make the anti-

drug efforts in school from "being explicit to implicit", thereby undermining the effects of the program (CADCA, 2010).

Voluntary, non-punitive drug testing is used in the U.S., mainly for athletic teams and students who involved in certain competitive extra-curricular activities. Each community within the 50 State has its discretion to decide if they would use such means to screen students. As for drug education, again the community can have its discretion of what to include in their curriculum. Before the 1990s, the Drug Abuse Resistance Education (D.A.R.E) was very popular in the U.S. and was implemented in about 70% of nation's school district. Yet its effectiveness was under scrutiny; by the year 2001 it was classified by Surgeon General of the United States that this program was ineffective (Department of Health and Human Services, U.S., 2001). Currently there is no national strategy that governs drug education in school although elements of drug education could be infiltrated in their health curriculum.

2.3.2.4 Mentoring at-risk youth

Children with incarcerated parents, alcoholics or drug users are also exposed to high risks of initiating substance abuse and also other risky behaviors. The White House's Office of Faith-Based and Neighborhood Partnerships Initiatives provide funding to support mentorship of children with incarcerated parents, and the Department of Justice's Office of Juvenile Justice and Delinquency Prevention also

support training and administering such grant (White House, 2010b).

2.3.2.5 Spread Prevention to the Workplace

Since parents spend a significant part of their day at work, the U.S. government believes that the workplace is an excellent place to educate parents about youth drug use. Workforce-focused strategies, including more widespread adoption of effective drug-free workplace programs encompassing employee education, supervisor training, testing programs, and treatment referral, is believed to be able to deliver prevention messages to employees and their families(White House, 2010b).

2.3.2.6 Mobilize Parents to Educate Youth to Reject Drugs

In addition to supporting parents by using family-focused and evidence-based programs, the White House' Office of Faith-Based and Neighborhood Partnerships Initiatives and the Administration for Children and Families (ACF) try to foster greater engagement of fathers in the lives of their children. A national fatherhood tour was launched to hear from local communities on how to strengthen the nation's families (White House, 2010b).

2.3.2.7 Support Substance Abuse Prevention on University campuses

The U.S. government believes that prevention efforts should continue after secondary school education, as the largest drug-using population is among 18 to 25-

years-olds in the U.S. (White House, 2010b).

2.3.2.8 Expand Research on New Drugs

Inhalants, pain killer and "study drugs" such as Ritalin become increasingly popular among youth but they are currently understudied in scientific research. Thus the National Institute of Drug Abuse (NIDA) would actively support research in to these areas (White House, 2010b)..

2.3.2.9 Increase Collaboration: Criminal Justice and Prevention Organizations

Law enforcement officers would increase their participation in the local drug prevention campaigns according to the 2010 new drug strategy, since they are believed to be able to garner the attention of youth. This is especially so in the High Intensity Drug Trafficking Areas (HIDTA) (e.g., Southwest Border). Drug courts, Border Patrol program, youth service organizations, community coalitions and public awareness campaigns all work together to education the community about drug use (White House, 2010b).

2.3.2.10 Support for Young Parents

Maternal-child health program such as the Nurse Family Partnership (NFP) assisted first time, low-income mother and provide in-depth relationship between nurse and client through intensive home visits. Client is visited throughout her pregnancy and the first two years of her child's life. The nurse offers guidance on

breastfeeding, child development, parenting skills, future pregnancy planning, preventive health measures such as help with alcohol or cigarette dependency, better diet information, advice on better financial planning and advice for mothers wanting to go back to education or employment. Improve pregnancy outcomes It has the purpose of improving child health and development outcome, prepare for the mother's future school readiness and achievement, and improving parents' economic self-sufficiency (Nurse Family Partnership, 2009). In terms of financial assistance, The Temporary Assistance for Needy Families (TANF) program provides cash assistance and supportive assistance to low-income families. Minor parents (those under 18) can only receive TANF if they participate in education or training activities. They also need to adhere to a living arrangement rule whereby they need to live with a parent, legal guardian, or another adult relative, or in a living arrangement approved by the state (Department of Health and Human Services, U.S., 2006).

3.2.11 U.S. Summary

U.S. emphasizes using community-based approach in dealing with drug prevention, requiring the community to examine and address the relevant risk and protective factors for substance use in different ecological environment. The use of evidence-based programs is also increasingly important as noticed by the

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introduction of the Prevention-Prepared Communities program in the 2010 strategy

which encourage funding to use only with such programs. SAMHSA's Strategic

Prevention Framework provides a national framework that encourages prevention

efforts in communities to address risk and protective factors and systematically

evaluate their progress. The "Communities that Care" system also assists community

to use evidence-based programs in combating drug issues. These programs target to

build the resilience in youth in the schools and community settings, strengthen

parenting abilities, and improve family functioning.

2.3.3. Australia

Overview

Their national drug strategy reflects strongly that family and children are their

priority. Similar to U.K.'s emphasis on family support, Australia's latest initiative Kids-

in-Focus – Family Drug Support also calls for cross-agencies collaboration to help the

most vulnerable families and kids suffering from substance abuse within the family.

Also, school-based drug education is not meant to carry out through classroom

education (although it is still mostly covered by health curriculum at this point), or

using drug-testing or screening. Rather, they emphasize a whole-school approach

that uses evidence-based information to make strategic decision in designing the

methods to manage drug issues on school premise.

2.3.3.1 National Drug Strategy: 2004 – 2009

The Australian government is still drafting their latest drug strategy and will be available in the first half of 2010.

2.3.3.2 Strengthening Families Program, Family Support Program and "Kids In Focus"

Strengthening Families Program

The former "Strengthening Families Program" was part of a broader National Illicit Drug Strategy (NIDS), funded by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). It focused on family support rather than the health, education or criminal aspect of the strategy, and assists families by adopting early intervention and family-focused strategies to combat impacts of substance abuse (FaHCSIA, 2008). Family members could include parents, grandparents, kinship carers, and children of drug-using parents. Strengthening Families Program reflects the Australian Government understands that substance abuse by one person within a family can have significant negative impacts on other family members, and has far reaching implications for the broader community. The program is comprised of series of programs including parent education, counseling, advice, therapeutic group programs, case management, and services for Indigenous families (FaHCSIA, 2008). They also include counseling and support for families with

young person suffering from drug problem, and support children of drug-using parents the opportunity to participate in normal children activities such as playgroup, music and sports activities (FaHCSIA, 2009a).

<u>Family Support Program (FSP)</u>

In February 2009 the new Family Support Program (FSP) was formed and will be in full implementation in July 2011 nation-wide. It is a re-focusing of the Strengthening Family Program which now target at supporting vulnerable families and their children. It utilizes an integrated approach by linking the existing family, children and parenting services under a single umbrella program, so that there is a seamless approach where clients would have "no wrong door" and can receive appropriate support through entering any FSP service (FaHCSIA, 2009b). The ultimate goal of FSP is to support families and nurture children to enable them to better manage life's transitions and contribute to building stronger and more resilient communities.

It involves three core service streams:

1.	Family and Parenting Services – provide early intervention and prevention services to families to build and strengthen relationships, develop skills and support parents and children

2.	Community and Family Partnerships – provide intensive and coordinated

support targeted at significantly disadvantaged communities and families

3.   Family Law Services (through Attorney-General's Department) – assist families to manage the process and impacts of separation in the best interests of children

The new Family Support Program operates within the context of broader government priorities, including:

■   National Framework for Protecting Australia's Children (2009 – 2020): It is an important framework developed in response to the dramatic increase of child abuse and neglect found in Australia in the past 10 years

■   National Plan to Reduce Violence against Women and their Children;

■   National Compact between the Government and the non-profit sector; and

■   Social inclusion agenda.

The FSP hope to enhance the outcomes for families and their children through the following six means:

1.   Strengthening collaboration between and amongst providers and Government and community.

2.   Improving access to relevant services

3.   Ensuring services link families and children with other relevant community

support services.

4. Offering more flexible and responsive service delivery approaches.

5. Operating within an outcome based accountability framework

6. Improving the business environment for providers

Kids in Focus – Family Drug Support

With regards to the subject of drug abuse, "Kids in Focus – Family Drug Support" is an initiative (under the Family and Parenting Services stream of the broader FSP) starting in May 2010 which targets at assisting substance-abusing parents, their children and their families. It is an early intervention, family-focused program. This service model focuses on providing integrated, long-term and intensive support to families dealing with substance abuse (FaHCSIA, 2009c). That would mean meeting the goal of supporting parents more effectively, to overcome their substance abuse, and supporting the children by normalizing their lives (including school, sport, regular routines) through targeted counseling and if necessary, intervention through the child protection system. That could include one-on-one long term family support, residential parenting support, advice / referral service, brokerage to assist the children to normalize their experiences, and intensive aftercare support for families where parents have left alcohol and other drug rehabilitative service, telephone

advice service, and early intervention support for at-risk parents. Thus the focus is an integrative direct service delivery requiring a strong collaboration of NGOs and government systems' service.

The long-term goal of Kids in Focus is to increase access to and timely provision of integrated services for vulnerable families, and to improve child development, safety and family functioning. Specifically, the program targets to achieve the following outcomes (FaHCSIA, 2009d):

1.   The emotional, social and economic impact of substance misuse on children and the families of substance using people is minimized and family capacity is strengthened.

2.   Reduced psychological and physical harm caused to substance users, their children and other family members.

3.   Enhanced or improved family-functioning and relationships through provision of services to drug using parents and their children.

4.   To increase access to and timely provision of integrated services for families in a community context, particularly vulnerable and at-risk families, to improve child development, safety and family functioning.

5.   Improve parenting skills.

6.   Normalize experiences of children with substance using parents or family members (e.g. involvement in sport, child care places) and building resilience.

7.   Increased collaboration and partnerships within the family support, child welfare and AOD sectors.

Currently, Kids in Focus is not yet in operation but it is hoped that service delivery will start in the near future.

In a way, the "Kids in Focus" is similar to the "FIP" approach in the U.K. where intensive and integrated "case by case" service is offered to those at highest risk – in this case, substance-abuse parents and their families; it is also similar to the "Think Family" approach in the U.K. where service is based on not only individual but as members of the entire family. However, in Australia's "Kids in Focus", they intentionally prioritize children's well-being (hence its name "Kids" in Focus), whereas in the U.K. the focus is placed on the entire family.

Other initiatives under FSP

The Family Relationship Education and Skills Training (FREST) assist families to increase awareness of family and marital relationship issues at the earliest intervention point. They provide training to improve parenting capabilities and style,

assist parents and families to foster positive and stable relationships between partners, specific family members or the entire family, positively manage transitions across relationship cycle (including separation and divorce), increase family resilience, and to resolve conflict effectively. In addition, the Raising Children Network is a national information, online and hotline services providing parenting advice. Both of these initiatives are under the broader "Communities for Children" (which also is under the umbrella of FSP) and mainly provides services for families with children up to 12 years. Facilitating partners in each site that require funding need to establish a committee with broad representation from stakeholders in the community to manage the initiatives (FaHCSIA, 2009e).

2.3.3.3 The former Community Partnerships Initiative (CPI)

It was developed in 1997 under their National Illicit Drug Strategy (NIDS) aiming at reducing drug-use and drug-related harm through community projects, and focus on young people. These projects include peer programs, parent-based programs, basic life skills, job preparation, and recreational activities. Evaluation of CPI in 2003 prove them effective in delivering to the community the intended outputs of education on illicit drugs, information resources, training and community development project. Yet the evaluation did not assess their long-term outcomes of behavioral change in community. In March 2008 this Initiative has been redirected to

focus on binge drinking since it is believed to be of more concern than illicit drugs (Siggins Miller, 2009).

2.3.3.4 Other Funding Initiatives: Local Answers and Community Investment Program

The former "Local Answers" initiatives provide funding to local, small-scale, time-limited projects that focused on children, family and community capacity building under the Stronger Families and Communities Strategy 2004 – 2009. And currently some projects under "Local Answers" are funded under the "Community Investment Program" that aims at strengthening communities and promote social inclusion of vulnerable members of the community. These projects include mentorship, parenting workshop, alternative schooling, and range of activities for the community (FaHCSIA, 2009f).

2.3.3.5 Support for Young Parents

Local Answers provided funding to community projects that support high-risk young parents (typically under the age of 25). That could include ante and post natal education and intensive support, positive parenting training, create sustainable relationships with key services and peers, and develop their ability to access ongoing employment, education and training opportunities. There are also community projects that work with local hospitals, health service organizations and NGO that deliver financial assistance, emergency accommodations, parenting skills training,

and online information to support young parents, especially teenage or single mothers, who are in need. Further examples include the Young Parents Early Intervention Parenting Program (YPEIPP) and Positive Parenting for Young Parents (PPYP) [(under the Child, Youth and Women's Health Program (CYWHP)) , which were funded earlier to support young parents, with the latter program specifically targeted for young parents having substance abuse problems (Youth Action and Policy Association, 2007; Department of Health and Ageing, 2004).

2.3.3.6 Communities that Care (CTC) Australia

The CTC initiated in the U.S. is also rolled out in Australia. Since 2001, there had been three communities that piloted CTC in Australia. In 2008 the survey report provided evidence that shows positive outcomes such as indication of positive improvement in adolescent health behaviors. More randomized trials are currently under progress in 14 of the communities in Victoria, Queensland and Western Australia (Royal Children's Hospital, 2010).

2.3.3.7 Drug Education in School

In Australia, there is currently no mandatory drug education curriculum nation-wide, although elements of drug education are usually covered under the health and physical education program / curriculum. Some states (such as Victoria) would conduct review of its effectiveness in the schools within the state. Schools can

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use the "Principles of Drug Education in School" published by the Department of Education, Science and Training in 2004 that outlines 12 principles that guide schools in designing their own school's drug education strategy and programs – with the first principle being that their programs and initiatives need to be evidence-based (Department of Education, Science and Training, 2004). Australian National Council on Drugs (ANCD) also does not recommend a "compulsory" curriculum within school on drug education since the effect on reducing drug use in such case is found to be not sustainable. As for drug test, ANCD does not recommend this approach since it is found to be ineffective in deterring drug use in students, especially while other better alternatives are available. The approach they propose would rather be a comprehensive, whole-school (e.g., healthy school, develop resiliency among students) approach that address a range of risk and protective factors in different "layers" of relationship (e.g., peers, family, school and community) that influence health and education outcomes and help students to make choice on drug use (Roche et al., 2008).

2.3.3.8 National Drug Campaign (NDC)

The Campaign includes the use of different media such as radio, print, outdoor, online and in-venue advertising, website, and a national information hotline. It has an important mission of meeting the information needs of youth, parents,

carers and the broader community. Different phases of the campaign (which started in 2001) focusing on different drugs depending on the emerging drug trend at that phase of the campaign, and use different strategies to enhance prevention in youth and their families (Department of Health and Ageing, 2007). While the current phase of the campaign aims at reinforcing the negative perceptions of certain drugs – ice, ecstasy, speed and marijuana, earlier phases of the campaign contain other important elements such as:

1.   Encourage parents to play an active role in preventing drug use by encouraging them to talk with their children about drugs and provide them the strategies to communicate, and providing them with drug-related information and treatment option

2.   Parent television commercials

3.   Promote positive alternatives to drug use

4.   Recognize the important role of family relationships, and how health, welfare and education professionals can provide support for youth

5.   Normalize treatment with people facing drug problems, rather than emphasizing law enforcement

        Information on how parents can talk to their children about drugs, drug

knowledge information, where to get help, etc. are provided on the internet and through the national phone lines for children and adults – but those are generic phone lines and not drug-specific.

2.3.3.9 Australia Summary

In combating drug abuse, Australia's anti-drug efforts reflect their priority on children and their family. Besides FSP's Kids in Focus, certain phases of their media campaign also emphasize the need for parents to communicate with children on drugs. The government put a lot of resources in strengthening family protective factors especially at the early years of children's life, such as training and educating parents how to strengthen their marital relationship, and how to improve the role of parenting. When drug-use do occur in family (such as parental drug use), the government tackles the issues by placing children first such as through activities that can normalize the children's life. This is important in reducing risk factors, and can prevent inter-generational substance use and other behavioral problems later on. Also, recognizing that drug abuse not only affects the drug users but also the people around them, Australia government center their prevention and intervention services on all members of the entire family and not only on individuals. Another key element indicated by the Kids in Focus initiative is the steps to integrate services delivery so that the family in need would not need to go through multiple agencies to receive

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services. Australia's school drug education also acknowledge the importance of using an ecological approach that address risk and protective factors in different layers in order to achieve sustainable effects in anti-drug prevention on school premise.

2.3.4 Canada

Overview

Their drug prevention strategy (2007 – 2012) intends to work on the risk and protective factors in youth before they initiate substance use and spreading to the community about "evidence-based drug prevention messages" (Government of Canada, 2009). It is a response towards a national priority identified by the "National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada, 2005" (National Framework, 2005). The strategy summarizes three major approaches to reduce youth drug use: (1) Media/Youth Consortium, (2) Establishing Canadian National Standards for Prevention, and (3) Sustainable partnership. Currently, their support for family or parents focuses mainly on providing information in toolkits, and emphasizes the importance of parents to communicate with their children on drugs. It is primarily the National Crime Prevention Centre (NCPC) who provides grant that emphasize the use family-focused, "crime-prevention" model program, and Health Canada provide funding resources on

health promotion and prevention projects. Participation of parents and evidence-based family training is one of the many elements embedded in the larger school environment within the Canadian National Standards for School-based Prevention. The upcoming establishment of Canadian National Standards for community-based and family-based preventions reflects their approach in combating drugs would be further strengthened in the community and the family.

2.3.4.1 Media / Youth Consortium

To raise public awareness of the harms of illicit drugs, it is mainly an advertising campaign using TV, internet, radio, print media, and advertisement in transportations. The websites under Canadian Center on Substance Abuse (CCSA), Health Canada, "Xperiment.ca" and "not4.me.ca", contain easy-to-access-information and tools for both parents and teenagers on drug-related information, tips on talking to teens, and drug-refusal skills. The website "Xperiment.ca" was carefully created by, and created for, youth through significant testing using youth surveys and focus group. For the tools for parents, it also aims at convincing parents that they have great influences towards their children, and the importance of constant communications with them. While the media would focus on teens and their parents, the Consortium also hopes to target a larger group of 10-24 years old and the high-risk populations. It will also work with youth-serving organizations to

embed the campaign message into their program materials and provide positive youth engagement in order to promote alternative healthy lifestyle and make informed and responsible choices about illicit drugs. The creation of the innovative Xperiment.ca website and the inclusion of youth representatives in the Youth Substance Abuse Prevention (YSAP) National Advisory Group are a few examples that they attempt to engage youth in a meaningful way (CCSA, 2010a).

2.3.4.2 Canadian Standards for Youth Substance Abuse Prevention

The Canadian government recognizes the need to establish national standards for the design and delivery of substance abuse prevention program across Canada in the settings where children grow up: schools, communities, and families. School-based Standards is the first one that was established in May 2009 and an updated version in June 2010 (CCSA, 2010b). There will be upcoming Standards for Community- and Family-based Youth Substance Abuse Prevention Standards in the summer and fall of 2010 respectively. The ultimate goal is to strengthen the quality of youth-oriented drug prevention programs in Canada and provide a means for communities, schools and families to access and implement evidence-based programs.

The established standards are used in elementary (starting at 6 years old) and

secondary schools. In their "Building on our strengths: Canadian Standards for school-based substance abuse prevention", it calls for a comprehensive health-promoting school approach that includes strong parent and community connections. Substance abuse efforts in Canadian Standards are also regarded as "initiatives" rather than "program or project", which means they should be infused into school's daily work and should not be treated as a separate, time limited "add-on". It involves an ongoing process rather than just running an individual program, and substance abuse prevention is only one piece of a bigger puzzle of an ultimate aim of promoting the well being of the children.

The 17 Standards involves four phases (which is somewhat similar to the SAMHSA's SPF):

1. Assess the situation.

2. Prepare a plan and build capacity.

3. Implement a comprehensive initiative.

4. Evaluate the initiative.

In other words, schools are required to examine the current protective and risk factors of students in their own schools, determine current substance use pattern, engage students in the design of the initiatives, conduct professional (teachers) development, connect with parents and communities, deliver

developmentally appropriate instructions, implement and maintain such initiatives

and policies, and have regular evaluations of such initiatives. Two databases are

developed by CCSA to encourage schools to update the Canadian Standard:

"Database of prevention resources" on world-wide prevention resources (catalogued

by the Standards they reflect), and "Database of Canadian Prevention Initiatives" on

examples of Canadian-specific prevention initiatives and programs that has been

assessed against the Standards, which is currently under construction.

One of the aspects mentioned is the importance of school-based drug

prevention education to be connected with parents and community initiatives. As

parents are key influencers of family cohesion, stability, sense of belonging,

communication styles, etc. that can affect family health have significant impact on

child and youth health. Community norms and leisure options, which also have

impact on children's decisions on substance abuse, are also outside school

boundaries. Therefore, a concerted attention to engaging and supporting parents

(such as through evidence-based family training) particularly in the early school years

can provide significant protections to children. Such protections can snowball and

provide ongoing benefits in extended areas when the children grow up.

2.3.4.3 Sustainable Partnerships

New and existing partnership between the government and organizations with various strength and areas of expertise would guide the implementation of the strategy. In particular, the National Advisory Group on Youth Substance Abuse Prevention (YSAP), composed of 35 experts in the drug prevention field and several youth participants, was established to design a nationwide consultative process to ensure the communities achieve the Strategy's objectives successfully. CCSA's Health, Education and Enforcement in Partnership (HEP) Program, Scientific Advisory Council, and Canadian Network of Substance Abuse and Allied Professionals would all bring together their expertise in carrying out the strategy.

Specifically, in 2008 YSAP identified seven priority areas for action on youth substance abuse:

■ Family support

■ Risk and protective factors

■ Special populations (e.g., developing gender/diversity-based analysis, which is currently the focus)

■ Youth engagement

■ Evidence-based prevention messages

■ Translating research into practice

■ Alcohol

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It is important to note that during their last meeting, the YSAP National

Advisory Group approved a re-focus on parenting nurturing – instead of merely

creating a toolkit, it will take a "systems approach", but no specific action or

elaboration has yet been mentioned (CCSA, 2009).

2.3.4.4 Major Funding: Drug Strategy Community Initiatives Fund and Public Safety

Canada – National Crime Prevention Centre

The following two paragraphs described the funding that support

communities in their anti-drug prevention work.

The Drug Strategy Community Initiatives Fund (DSCIF)

Funded through Health Canada, these are community projects aiming at

health promotion and prevention targeting youth aged between 10 to 24. The

projects engage intermediaries (parents of youth, educators, health service providers,

social service providers, recreation and sport service providers, enforcement officials,

etc.), and stakeholders (all orders of government, NGOs, professional associations

and private sector interested in address drug use in youth). They can focus either on

universal prevention that does not distinguish the level of risk within the target

populations (e.g. general parents , students), or on selected / indicated prevention

strategies that target populations demonstrating higher risk factors with illicit drug

use (e.g., drug-using parent, dysfunctional families, lesbian /gay /bisexual /

transgendered/ aboriginal youth etc.) (Health Canada, 2009).

Each province decides which population or sector has the greatest needs to receive the service and priorities would be given to projects that match those target audience. The projects need to achieve one of the following outcomes:

■ Increased awareness and understanding of healthy lifestyle choices, and of illicit drugs and their negative consequences

■ Acquired/improved capacity (knowledge and skills development) to avoid illicit drug use.

■ Increased engagement of community structures, and networks in activities to promote healthy lifestyle choices & prevent illicit drug use among youth.

However, unlike the U.S.'s SPF – State Initiative Grant where the programs need to adhere to the SAMHSA's strategic framework, the programs funded under Canada's DSCIF do not need to adhere to specific framework although they still need to submit a process evaluation and outcome evaluation of the project. Yet with the Canadian Standard for Communities-based prevention being established soon, this (no) requirement may change in the future.

<u>Public Safety Canada – National Crime Prevention Centre (NCPC) and Crime</u>

<u>Prevention Action Fund (CPAF)</u>

Substance abuse has strong association with delinquency. In Canada, the Public Safety Department's National Crime Prevention Center (NCPC) emphasizes tremendously the relationship between families and juvenile delinquency. The NCPC, through their Crime Prevention Action Fund, financially support initiatives that are directed at preventing and reducing substance-related crime among at-risk populations under Canada's National Crime Prevention Strategy (NCPS). Specifically, they highly encourage the province or territory applying for their funding to utilize evidence-based "model" or "promising" programs that are found to be empirically effective in prevention. NCPC provides a list of programs (based on information from various resources including OJJDP, SAMHSA, Blueprints for violence prevention and other anti-crime specific bodies) that address risk and protective factors of at-risk youth, parental training, family issues, school-based programs, etc. NCPC also develop and disseminate crime prevention related knowledge through their publications in a few areas: Families, children and youth at risk, general crime prevention, high crime neighborhood, youth gangs, and aboriginal people. NCPC also publishes a list of school-based drug abuse prevention model programs that they encourage schools to adopt, and explains in details the risk and protective factors for

drug use in such publications (Public Safety, 2010).

Another source of major funding comes from Department of Justice, but they focus on treatment and rehabilitation.

2.3.4.5 Drug Education and Drug Testing

As mentioned, the new Canadian Standards for School-based Youth Substance Abuse Prevention provides guideline for designing initiatives within school related to substance abuse. The topics of drug are usually covered in health and physical education curriculum (e.g., starting in Grade 2 [about 8 years old] in Ontario). As for drug testing, it is quite uncommon in Canadian schools; the latest Canadian Standard for School-based Substance Abuse Prevention does not provide guideline on this subject (CCSA, 2010b).

2.3.4.6 Support for Young Parents

Young Parent Programs (YPP) in Canada is partnership between and across community and public sector services. NGOs, Public Health, Board of Education , child care providers and in some instances secondary schools collaboratively provide young parents a chance to improve parenting capacity, further their education and increase employability in a supportive environment (BC Council for Families, 2009). Initiatives include but not limited to childcare, antenatal and postnatal health education, nurse home visit, life skills training, and parenting education and support

while young mothers finish their high school educations or upgrade their skills. Individualized, self paced programs for young parents to take regular or modified Grade 11 and 12 courses are provided. Licensed on-site child care at NGO, parenting and child development credit course, healthy nutrition and lifestyle credit courses are also provided, which also includes provide healthy snacks and meals daily. Bus pass assistance and support and advocacy of a full-time Youth and Family Worker are also available (Vancouver School Board, 2009). In addition, Young/Single Parent Support Network (YSPSN) is partnership of four agencies at Ottawa and they target support services to pregnant teens, as well as to young and single parents and their children aged birth to five years. They provide numerous programs and support services including a residential program, counseling, education, housing, support, parenting training and child care, anger and stress management, and life skills training (YSPSN, 2009).

2.3.4.7 Canada Summary

Currently, as a national strategy they emphasize youth's active participation, and not merely their presence, in their anti-drug prevention efforts as this serves as the best way to exemplify meaningful youth engagement. In terms of support for family and parents, support are mainly through: information dissemination to parents via online toolkits, reinstating to parents about the importance of

communication, and providing the information about negative drugs effects for the community so as to help youth stay informed and make their own smart choice. In terms of parent training or tools to build family cohesion, it is mainly led by the National Crime Prevention Centre under the National Crime Prevention Strategy who provides grants for such programs. Although preventions focusing on risk and protective factors are considered important in Canada's overall drug strategy, and the use of evidence-based prevention programs are strongly encouraged, the use of family as the platform is not as salient as countries such like U.K. and Australia. Yet recently YSAP's national advisory group has re-focused on risk and protective factors and family functioning. Also, in the near future there is the establishment of Canadian Standards for Community- and Family-Based substance abuse prevention. Implementation of these standards via various programs would likely join the forces of family and community at large to combat the substance abuse issues.

2.3.5 Taiwan

Overview

School is the major platform used by Taiwan in their anti-drug effort. Mandatory and punitive drug test for targeted, at-risk students is the main tool used to identify drug-using students. Counseling would be offered to them and family

members, with the aim of deterring them from further drug use. At the community level, Taiwan provides education seminar and launching of healthy activities to promote healthy lifestyle in youth (Ministry of Education, Ministry of Justice, Ministry of Foreign Affairs, Department of Health Executive Yuan, 2009).

2.3.5.1 Drug testing and counseling in school

Taiwan government regards mandatory drug testing in school as an important means to deter illicit drug use among students. Taiwan subsidizes the rapid drug screening in schools, and students identified as needing "intense care" (verbatim) are required to take urinalysis drug test. Those students needing "intensive care" actually means "at risk" students whom they suspect may have taken drugs. Seminars are organized through schools and professionals are invited to explain the legal implications and drug testing procedures in schools. The after-school counseling committee, parents, and the police's juvenile delinquency prevention brigade would be notified should the student refuse to take the drug test (Ministry of Education, 2008).

"Spring Sun" working group – a group that provide counseling in schools and help students on issues including illicit drugs, alcohol, tobacco, HIV, and betel nuts, will be set up in schools within three days when there are cases of drug use in

schools. Follow-up counseling sessions would be provided to students who have positive test results via the group, counseling teachers, and parents, volunteers for "Spring Sun" working group, and "student counseling center" with professional counseling. The student would be tested again in three months. If the follow-up tests for the individual is still tested positive, those using Category 1 and 2 drugs (heroin, amphetamine, etc) will be reported to the juvenile court on top of receiving counseling help and professional healthcare for treatment; for Category 3 and 4 drugs users (ketamine, diazepam, etc.), students would be required to undergo counseling sessions again, and will be tested again afterwards. If the test result is still positive, they will be sent to juvenile court, together with requiring the family to attend mandatory "health and counseling education" sessions.

"Spring Sun" working group from different schools meet regularly by organizing sharing sessions and workshops to share the skills and best practices used in different schools on anti-drug efforts. They also form teams to spread anti-drug messages in the community. Workshops on drug and legal knowledge and refusal skills are organized.

Teacher Training and Drug Education in School

Teachers in the elementary, middle and high school need to take courses and

complete drug education materials within three years. Ministry of Education also requires elementary school, middle school and high school to have at least one class in each school term in the health curriculum to include anti-drug class. Age-appropriate education is currently being developed by teachers to complement the health curriculum on drug education. Furthermore, Spring Sun project training program are given to train teachers in high schools, vocational schools, middle schools, and elementary schools. Extra-curricular activities with anti-drug theme such as drama contests, poster design competitions, and writing contests are also organized.

In addition, after-school counseling programs also assist school counselors and police to do after-school patrol (involving teachers, instructors and police) in places such as internet café, clubs and karaoke; the students found in those places will be asked to take the drug test when they return to schools (Ministry of Education, 2008).

Involvement of parents or families

After-school student counseling committees in school provide parent-student symposium which educate parents on drug, current teenage sub-cultures and their slangs used. Before long school vacation, schools are also encouraged to provide

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reminders for parents to care about the children's activities during the period, and

encourage schools to organize healthy activities for them to engage. Schools are also

encouraged to organize parent-student leisure activities such as parent-student

hiking, singing contests, painting to promote closer relationship among students,

school and families. Direct intervention (i.e., counseling) would be used when

necessary (Ministry of Education, 2008).

2.3.5.2 Community Level

The community-based prevention is done by working with NGOs to

incorporate anti-drug education element into the activities that they organize. These

include community traditional culture activities, evening art performance, setting up

drug-information booths major music festivals, etc. NGOs and schools are

encouraged to organize attractive, healthy activities for young people to participate

to engage them meaningfully and promote healthy lifestyle. Educational seminars

(mainly involve drug information dissemination and law education) are held in

schools and the communities. Outreach services are done by NGOs to reach the

vulnerable youth and family and provide counseling and support. Local drug

prevention centers are established to enhance the anti-drug collaborations among

medical, education, vocational training, and legislation sectors.

Community counseling station for drug abuse preventions are set up in the community. Community Pharmacists are stationed at the stations to provide anti-drug education and counseling service so that the public has constant, easy access to the service. The Ministry of the Interior has also established anti-drug ambassadors to go to schools and organizations to promote anti-drug information. They train teenagers and general public to become volunteers and educate the public (Ministry of Education, Ministry of Justice, Ministry of Foreign Affairs, Department of Health Executive Yuan, 2009).

2.3.5.3 Youth between school and work

"Youngsters' On Light" is a project coordinated by NGO and government to train teenagers between 15 – 19 who are out of school and out of work for them to "keep learning" in a four-month career-exploratory, experiential learning. They also provide two-month on the job training for those who decide to work (Younger, 2010).

2.3.5.4 Media

Taiwan also makes great use of the media, slogan, short films, using celebrities to participate in anti-drug advertisement, print media, internet that contains drug information and internet games for teenagers, anti-drug helpline, and distribution of anti-drug information and games VCD for use in the family (Ministry of Education, Ministry of Justice, Ministry of Foreign Affairs, Department of Health

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Executive Yuan, 2009).

2.3.5.5 Taiwan Summary

School is the major platform emphasized by Taiwan to fight the anti-drug battle. The government encourages drug test in school as a screening tool to prevent students from using drugs. Drug testing is combined with law enforcement (if the drug is tested positive after counseling). There seems to be little concern in Taiwan regarding the labeling effect or stigma associated with drug-testing in schools. "Spring Sun" working group in schools and "after-school programs" team have an important role to play in anti-drug effort. Prevention efforts that involve families and parents are driven also by school programs. At the community level, it involves providing educational seminar on drugs and laws to the community, and organizes healthy activities for young people to engage in. There is yet little to be done to conduct the long-term effect on behavioral change and sustainability of such efforts. Certain scholars in Taiwan have called for the need to address risk and protective factors and family-focused approaches to deal with the root cause of drug abuse in Taiwan (Executive Yuan Report, 2005).

2.3.6 PRC

Overview

In the mainland, drug prevention rests primarily on "education", and it is believed that school should be the major platform for drug-education, probably because of the great diversity in the parents' levels of literacy and resourcefulness. The nine years of free education when children need to stay in school is regarded as the best opportunity to promote a healthy lifestyle and resist drugs. And it utilizes schools as the basis and community education as assisting the overall drug education (Narcotics Control Bureau & Ministry of Education, 2006).

2.3.6.1 Drug education in school

As a national strategy, starting in 2003 the Ministry of Education requires primary 5 to secondary 2 students to receive two hours (originally one hour) of drug-education per academic year. The content covers the effects of drugs, refusal skills, and related laws and regulations. They particularly emphasize secondary 2 students as they believed that it is the most critical year in determining if students would take drugs based on their physical and psychological needs and the school curriculum arrangement. Schools are also encouraged to use interesting and interactive ways to strengthen students' anti-drug knowledge and nurture good self-management and social skills so that students can live a healthy life. Schools are required to collaborate

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with parents and encourage them to receive drug-information education and assist

them on how to help their children to resist drugs (Narcotics Control Bureau &

Ministry of Education, 2002).

Apart from the mandatory drug education nation-wide, individual municipals

and counties varies with the way they carry out the school and drug education,

although all education materials and curriculum need to be approved by China

Narcotics Control Foundation and the Ministry of Education. For example, in the city

of Shanghai, the Shanghai Museum of Anti-drug Scientific Education was revamped

and opened in 2009. Primary and secondary school students are required to visit

there four times per year as part of their anti-drug education curriculum (Shanghai

Museum of Anti-drug Scientific Education, 2009).

PRC also encourage schools to organize activities and seminars for parents on

drug information, so that parents can teach the children to stay away from drugs,

monitor their children, and collaborate with school on anti-drug effort. Volunteers

from schools, universities, communities are recruited year-round to spread anti-drug

messages by distributing pamphlets are also popular. The youth website and the

Narcotics Control Bureau also provide drug and legal information (Narcotics Control

Bureau, 2010).

The government encourages each province and city to integrate effort from various sectors such as legal, media, social work, medical, mental health, teachers with drug-education expertise, rehabilitated drug-users, etc. to produce anti-drug educational resources and spread the anti-drug message in their community. It is noteworthy that PRC has strict law with regards to drugs, and capital punishment is allowed. Whether these laws are strictly enforced is yet another question.

2.3.6.2 PRC Summary

Although certain scholars and even the government acknowledge the importance of parents and families to prevent children from trying drugs (Yuan, 2004), currently the emphasis is to use school as the main interface, supplemented with media campaigns, education seminars, use of celebrity to spread anti drug messages.

2.3.7 Singapore

Singapore's drug abuse prevalence rate is among the lowest internationally – with over five million populations in Singapore, the number of new abusers in 2009 was 553 (Central Narcotics Bureau, 2010; Statistics Singapore, 2010).

Their prevention strategy mainly targets educating students on the danger and consequences of drug abuse, especially on school dropouts who are considered high risk. Prevention efforts include assembly talks in schools by officers from the Central Narcotics Bureau, the Police, anti-drug exhibitions, inter-school dance competitions "DanceWorks!". For high-risk youths, Volunteer Guidance Officers under a program by Singapore Anti-Narcotics Association (SANA) would befriend and encourage dropouts to return to school or acquire specific skills. For prevention efforts at the community level, community education, parent-kid camps, mass media, exhibitions and celebrity were used to spread the anti-drug message. The activities are tailored to meet the languages and other needs of different ethnic group in Singapore. Media campaign is also used.

As for the support for parents and families, the National Council against Drug Abuse (NCADA) provides communication skills tips for parents through the website; a counseling hotline is also run by SANA (NCADA, 2010).

Similar to PRC, Singapore also has strict law enforcement on drugs. Strokes of cane can be used, and capital punishment is allowed for illegal traffic of certain illicit

substance such as cannibals and cocaine; possession or consumption of ketamine can lead to up to 10 years of imprisonment or a fine or SGD 20,000 or both. And if necessary, known drug offenders are detained without trial to prevent them from "contaminating others" (verbatim).

2.3.7.1 Singapore Summary

Singapore being one of the countries with the lowest drug abuse prevalence would not be possible without the efficient and effective anti-drug and drug prevention strategies. High-risk youths such as school dropouts are always considered as the targets. Through the mass media and different means of propaganda, the anti-drug messages are widely spread in Singapore irrespective of ethnicity and language. On the other hand, the support of parental and communication skills for high-risk and drug abuse families and strict law enforcement on drugs are of prime importance.

2.3.8 Summary

Few points are evident from the review of the substance abuse prevention practices across different countries (see Appendices A and B).

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First, initiatives in countries such as the U.K., U.S., Australia, and Canada focus tremendously on addressing the risk and protective factors in causing youth substance abuse. Instead of merely focusing on the drug issue per se, efforts are made to enhance protective factors, such as strengthening the attached bonding and relationships with adults through family-based intervention like parental or family training, provision of nation-wide meaningful youth engagement, and reduce risk factors such as normalizing the lives of children suffering from parental drug use.

Second, the prevention efforts address the needs of not only the adolescent themselves, but also the young adults, their families and the broader community. Best practices from some countries show they utilize an ecological framework to both understand and tackle the substance abuse issue, although the emphasis in each country may be different. U.K. and Australia acknowledge the importance of supporting parents and the families to build healthier family at an early stage so that the children and youth can benefit from growing up in a positive environment, thereby naturally build resistance against delinquent behavior including substance abuse. Both countries currently target at collaborating different service platform (NGOs and government) to assist at-risk families, so as to minimize drug and other social problems being spread inter-generationally. U.S.'s public health approach

emphasizes the mobilization of different sectors of the community to address the drug issue. The use of the Communities that Care systems invite members in the community to identify and change the environmental context in which the young people live in. Canada emphasizes youth-focused community prevention initiatives involving different partners. Their current projects in establishing the school-based, community-based and family-based Canadian Standards again shows that anti-drug efforts are not limited to working in one setting alone but also the broader environment surrounding young people. Asian countries such as Taiwan, PRC and Singapore place more emphasis on information dissemination, school drug education and law enforcement and have less to do with risk and protective factors or the ecological framework of drug use. In the U.S. and Canada, the increased non-medical use of prescription drugs is also of concern to the government.

Third, use of parenting or training that strengthen family functioning are common in U.K., U.S., Australia and Canada, although they are conducted under different government authorities – some countries place them under their department of family affairs while others are under the crime prevention bureau. In any case, these countries believe the same "basket" of factors is responsible for causing not only substance abuse but also other adolescent behavioral issues. Thus

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tackling the same risk and protective factors mean not only a reduction in substance

abuse but multiple problems as well. Fourth, although the strategies to support

parents varies, most countries acknowledge the importance of communication

between parents and their children and the benefit of parents being the "first

person" to talk to their children about negative consequences on drug use. Fifth,

western countries provide more concrete assistance to teenage and young parents

encompassing health, emotional, educational and financial support. This is one of the

steps they take to prevent intergeneration transfer of poverty and improve the health

and well-being of both the children and the young parents.

2. 4. Key Issues and the way forward

In the first section, we examined the adolescent drug use and the current

prevention efforts in Hong Kong. In the second section, we highlighted the common

framework used in understanding adolescent drug use problem, namely, the

Bronfenbrenner's ecological systems theory, the public health model, and the

Hawkins and Catalano's social development model. We explored how these theories

are applied in previous studies relating family and adolescent drug use, including

family in various contexts. In the third section, we examined the current and

prospective anti-drug efforts from a few countries: the U.K., the U.S., Australia,

Canada, Taiwan, PRC and Singapore, and explored the best practices from them. A

few lessons are salient:

(1) **Ecological understanding and tackling problems are essential.** Adolescent substance abuse involves a combination of factors encompassing different layers of internal and external influences. And as Randall and Cunningham (2003) suggested, if adolescent is influenced by peers, family, school, and neighborhood factors, then it is essential to change the environmental contexts that they live in. Therefore prevention and intervention efforts needs to be "ecologically valid" in order to be effective.

(2) **Reducing risk factors and enhancing protective factors are imperative**. Both the theories and the best practices from the leading countries demonstrated that prevention efforts that focus on training refusal skills and drug knowledge dissemination are insufficient, because they do not sufficiently address the underlying cause of the issues of drug use. Countries such as the U.K., U.S., Australia and Canada not only emphasize universal prevention strategies such as the media campaign, national hotline, one-off educational seminars or isolated leisure activities that promote positive youth engagement. They also prioritize their resources by focusing on selected and indicated prevention strategies. These include targeting on assisting families-at-risk to prevent inter-generational

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transfer of social problem; cross-agencies collaboration to help the most

vulnerable families and children suffering from substance abuse within the family;

and requiring the communities to identify the elevated risk factors and depressed

protective factors within their community and address those factors using

evidence-based programs. Positive and meaning engagement is also very

important in providing youth the alternatives to healthy lifestyle. As evidenced

from the best practices overseas, these engagements should not be one-off

events but should have the ultimate goal to steer towards education or

employment opportunities. Preventions and early interventions efforts should

also extend beyond adolescents to include young adults so that substance use

would not become a habit when they become mature adults. Last but not least,

prevention and intervention initiatives should be systematically and regularly

evaluate to examine their effectiveness.

(3) **Family intervention is the key.** Family interventions are found to be most

effective in addressing significant risk factors for substance abuse (UNODC, 2009;

Spooner, Hall, and Lynskey, 2001). Such interventions focus not only on the issue

of substance abuse, but on a broader topic such as maintaining good familial

bonds and setting clear standards. Healthy parent-child attachment, good

parental modeling, effective parental monitoring can have huge, positive impact

on adolescent attitudes towards drug and adolescent peer selection – all these

can reduce the likelihood that youth to experiment drug. Such positive impact is

sustainable since these factors facilitate youth in being nurtured in a healthy and

positive environment, thereby building their natural resistance against delinquent

behavior. In addition, as we found that most countries acknowledge the

importance of communication between parents and their children, we should

also equip parents in Hong Kong to do this job. Since various adolescent

behavioral problems are often caused by a series of similar risk and protective

factors, family interventions that sufficiently address these factors may reduce

not only substance abuse but also other problematic behavior. Also, the best

practices from other countries, like frameworks for engaging parents in

preventive work (Randolph, Fincham & Radey, 2009)show that it is critical that

prevention and intervention efforts to be based on evidence (Social Care Institute

of Excellence, 2009a and 2009b) as guided by some principles of effectiveness

(Small, Cooney & O'Connor, 2009). They also need to be systematically and

regularly evaluated.

As mentioned, adolescent drug abuse is a manifestation of deeper family

issues and a symptom of an ongoing pattern of youth development problems (Hong Kong Narcotics Division, 2008a; CAPT, 1999). For prevention efforts to be effective and sustainable, it is essential to have an ecological understanding of the drug use issue and focus on the underlying factors causing youth substance use. Various theories and models attempt to explain the combination of factors influencing youth initiation and use of substance, and comprehensive approach involving communities, schools, peers, and families are necessary to tackle the issues. Yet parental and family factors still have the key role to play – especially in the long run – leading adolescents to or preventing them from substance abuse (SAMHSHA, 2009; UNODC, 2009; Vellenman et al., 2005). Despite the importance of peer influence, it works more as a contributing factor near the time when they start using substance (UNODC, 2009). Positive, supportive family environment is the underlying reason youth do *not* engage in a variety of disruptive behaviors, including substance abuse (Gardner et al., 2006; Kumpfer et al., 2003). Although peer influence should not be undermined, it is imperative to note that young people's choice of friends are largely influenced by their relationships with their parents, as poor parent-child bond was found to be associated with drug-use peer (Brook et al., 2009). In other words, those who have a positive and healthy relationship with their parents are likely to also choose peers who also have positive influences (UNODC, 2009).

While using family intervention as a universal prevention strategy may induce high cost and self-selection (i.e., "the worried well") issues, it is a promising form of early intervention if they are used as a selected or indicated strategy targeted for at-risk families (Spooner et al., 2001). They are a cost-effective tool if they are considered in bringing multiple benefits to children on co-occurring delinquent behaviors, rather than treating it as merely a drug prevention program (Spooner et al., 2001).

We need to be mindful that using such family interventions or by appropriately addressing risk and protective factors may not bring us immediate results in the short run. Yet previous studies repeatedly demonstrated that they can bring about significant, observable and sustainable effects on substance abuse in the long run (Hawkins et al., 2009). Effective prevention initiatives should therefore take a long-term perspective. Such initiatives should include family to play an active role in early prevention and intervention, go beyond the universal prevention strategies, and sufficiently address the underlying risk and protective factors for drug use.

CHAPTER 3:   SECONDARY DATA ANALYSIS

3.1 Overview & Data

Variables definition

Regular use of alcohol (drinking): Self-reported habitual alcohol use of every week

Regular smoking: Self-reported current smoking (included occasional smoking and at least one time every week)

Ever drug use: Self-reported use of drugs (included ice, marijuana, ecstasy, ketamine or other drugs which are not prescribed by doctors)

Parental relationship: How do you think about the relationship between your father and mother? 5-point scale (1=very bad, 5=very good)

Happiness about family life: Do you feel happy about your family life? 5-point scale (1=very unhappy, 5=very happy)

Good relationship with father: rating "good" or "very good" to the question "Your relationship with father is…" 4-point scale (1=very unhappy, 4=very happy)

Good relationship with mother: rating "good" or "very good" to question "Your relationship with mother is…" 4-point scale (1=very unhappy, 4=very happy)

Acceptance to father's parenting: rated "accept" or "very accept" to question "Do you accept your father's parenting?" 4-point scale (1=very unhappy, 4=very happy)

Acceptance to mother's parenting: rated "accept" or "very accept" to question "Do you accept your mother's parenting?" 4-point scale (1=very unhappy, 4=very happy)

Impulsiveness: 7-item about impulsiveness from Eysenck and Eysenck (1978)

I usually act without careful thought
I am an impulse person
I usually speak out without careful thought
I usually give promise but failed to commit them
I need to be very self-restraint to avoid running into trouble
I enjoy excitement, but would not think about the consequences
I always run into trouble because I usually act without thinking about the consequence

Depressive symptoms: 10-item related to depressive symptoms (CESD-10)

Could not shake off the blues even with the help of family and friends
Feeling depressed
Feeling that everything done was much effort
Life has been in failure
Feeling fearful
Feeling lonely
Feeling that people are unfriendly
Feeling sad
Feeling that people dislike me
Appetite is bad

Social support: 4-item related to social support from friends

Do you consider yourself as important to your friends?

Do you have any friend who can support you and help you make important decisions?

When you feel annoyed or angry, do you have any friend who can cheer you up?

Do you have any friend you can spend time with?

3.2 Descriptive analysis

This section demonstrates the prevalence of substance abuse and characteristics of family structure and relationship with basic descriptive statistics. For the prevalence of substance abuse, all data from in-school survey (Form 1 to 7) and out-school survey (aged 18-27) would be used. For the cross-tabulation showing the association between family quality and drug use, data from in-school survey of Form 3 to 7 and out-school survey would be used.

3.3 Statistical methods

The descriptive analysis generates some basic statistics showing the prevalence of substance abuse with regard to different characteristics of family structure, relationship and acceptance to parenting. The prevalence of three specific patterns of substance abuse was studied: The regular drinking (Drink alcohol for at least one day every week), current smoking (Occasional smoker or smoke at least 1 cigarette every week) and drug use (Ever used either psychotropic substance or inhalant). In all the cross-tabulations, chi-square testing was conducted to compare drug users and non-drug users regarding to categorical family-related characteristic, while independent sample t-test was used for comparing scale variables between drug users and non-drug users.

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Group 1 (Form 3-7) the demographic analysis and prevalence by drug users and non-drug users and by sex

Prevalence of psychotropic substance and inhalant use

The prevalence of psychotropic substance use, inhalant use and use of either one of them for junior boys (Form 1 to 2) were 2.4%, 3.3% and 5.0% respectively. The prevalence rates for older boys were 5.6%, 2.7% and 6.9% respectively. Junior boys have significantly lower prevalence of using psychotropic substance than older boys (Form 3 to 7) (2.4% vs 5.6%). Among in-school boys, Form 5 students have the highest prevalence of using psychotropic substances, inhalant and both drugs among all grades.

The prevalence of psychotropic substance use, inhalant use and use of both for junior girls (Form 1 to 2) were 2.1%, 1.4% and 3.2% respectively. Such prevalence rates for older girls were 2.0%, 2.4% and 4.2% respectively. Junior girls and older girls have similar prevalence of using psychotropic substance and inhalant as shown in Table 3.

Among those Form 1 to 2 respondents who reported psychotropic substance use in life time, 7 males (63.6%) and 4 females (44.4%) of them reported they used

the substances in the past 30 days. Among those Form 3 to 7 respondents who reported psychotropic substance use in life time, 34 males (57.6%) and 13 females (50%) of them reported they used the substances in the past 30 days.

Table 3. Prevalence of psychotropic substance and inhalant use among in-school respondents

Boys

		N	n	(%)	95% C.I.	n	(%)	95% C.I.	n	(%)	95% C.I.
			Psychotropic substance use			**Inhalant use**			**Either drug type**		
Grade	1	224	5	1.9	(0.9, 5.4)	7	3.1	(1.5, 6.6)	11	4.9	(2.7, 8.9)
	2	234	6	2.7	(1.2, 5.7)	8	3.4	(1.7, 6.8)	12	5.1	(2.9, 9.0)
	3	276	12	4.3	(2.5, 7.7)	7	2.5	(1.2, 5.3)	16	5.8	(3.6, 9.5)
	4	240	14	5.8	(3.5, 9.8)	6	2.5	(1.1, 5.6)	18	7.5	(4.7, 11.9)
	5	251	21	8.4	(5.5, 12.8)	11	4.4	(2.4, 7.9)	25	10.0	(6.7, 14.7)
	6	134	7	5.2	(2.5, 11.0)	2	1.5	(0.4, 6.0)	8	6.0	(3.0, 11.9)
	7	151	5	3.3	(1.4, 8.0)	2	1.3	(0.3, 5.3)	6	4.0	(1.8, 8.8)
F.1-2		458	11	2.4	(1.3, 4.3)	15	3.3	(2.0, 5.4)	23	5.0	(3.3, 7.6)
F.3-7		1052	59	5.6	(4.3, 7.2)	28	2.7	(1.8, 3.9)	73	6.9	(5.5, 8.7)

Girls

		N	n	(%)	95% C.I.	n	(%)	95% C.I.	n	(%)	95% C.I.
			Psychotropic substance use			**Inhalant use**			**Either drug type**		
Grade	1	211	2	0.8	(0.2, 3.8)	2	0.9	(0.2, 3.8)	4	1.9	(0.7, 5.1)
	2	224	7	3.0	(1.5, 6.6)	4	1.8	(0.7, 4.8)	10	4.5	(2.4, 8.3)
	3	276	4	1.4	(0.5, 3.9)	7	2.5	(1.2, 5.3)	11	4.0	(2.2, 7.2)
	4	245	7	2.9	(1.4, 6.0)	5	2.0	(0.8, 4.9)	12	4.9	(2.8, 8.6)
	5	341	9	2.6	(1.4, 5.1)	15	4.4	(2.7, 7.3)	23	6.7	(4.5, 10.1)
	6	222	2	0.9	(0.2, 3.6)	2	0.9	(0.2, 3.6)	4	1.8	(0.7, 4.8)
	7	189	4	2.1	(0.8, 5.6)	1	0.5	(0.1, 3.8)	4	2.1	(0.8, 5.6)
F.1-2		435	9	2.1	(1.1, 4.0)	6	1.4	(0.6, 3.1)	14	3.2	(1.9, 5.4)
F.3-7		1273	26	2.0	(1.4, 3.0)	30	2.4	(1.6, 3.4)	54	4.2	(3.2, 5.5)

Comparison of drug users and non-drug users

All respondents

Table 4 shows that adolescents whose parents were married had a lowest likelihood of reporting drug use in lifetime (4.4%). The prevalence of drug abuse

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among respondents whose parents were separated or divorced was 8.8%. Those adolescents whose mother or both parents passed away had an even higher prevalence of drug use, 16% and 66.7% respectively.

The associations of other variables related to family relationship and drug use were significantly present with chi-square tests as shown in Table 4.1. In short, those who had very poor parent's marital relationship, very unhappy family life, bad relationship with parents, being refused to accept parenting would had a higher prevalence of drug use.

Table 4. Cross tabulation of family antecedents and substances use among Form 3 to 7 respondents (both sexes)

		Row total	Drug users	
			n	%
Parents' marital status	Married	1935	85	4.4
	Separated/divorced	239	21	8.8
	Father passed away	97	7	7.2
	Mother passed away	20	3	15.0
	Both parents passed away	9	6	66.7
	Others	18	5	27.8
	Chi-sq test			**
Relationship between parents	Very poor	71	9	12.7
	Poor	177	12	6.8
	Fair	721	34	4.7
	Good	646	25	3.9
	Very good	600	34	5.7
	Chi-sq test			*
Happiness about family life	Very unhappy	62	12	19.4
	Unhappy	204	17	8.3
	Fair	783	40	5.1
	Happy	767	33	4.3
	Very happy	471	18	3.8

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	Chi-sq test			**
Good relationship with father	Yes	1609	72	4.5
	No	343	32	9.3
	Chi-sq test			**
Good relationship with mother	Yes	1959	90	4.6
	No	140	19	13.6
	Chi-sq test			**
Accept father's parenting	Yes	1491	58	3.9
	No	504	46	9.1
	Chi-sq test			**
Accept mother's parenting	Yes	1773	77	4.3
	No	321	32	10.0
	Chi-sq test			**

Remarks: Numbers in brackets represent sizes of respondents in the category. Percentages shown are proportions of substance use within the row categories

**. Association is significant with chi-square test at the 0.01 level (2-tailed).

*. Difference is significant with chi-square test at the 0.05 level (2-tailed).

Table 4.1 Mean score for scales for both sexes

	Drug users	
	Yes	No
Impulsiveness	17.72*	16.12*
CESD-10	7.79**	5.64**
Social support	11.89	11.73
Age	16.71*	16.34*

**. Difference is significant with independent sample t-test at the 0.01 level (2-tailed).

*. Difference is significant with independent sample t-test at the 0.05 level (2-tailed).

Boys

Parents' marital status has a close relationship with boys' initiation of substance abuse. Boys whose father or/and mother passed away had much higher prevalence of drug use than those whose parents were married. Boys whose parents were divorced or separated or father passed away had slightly higher prevalence of drug use than those whose parents were married.

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Relationship between parents perceived by adolescents was not quite associated with initiation of substance abuse. Feeling happy about family life is associated with reduction of likelihood of substance abuse among boys. The prevalence of ever using drugs among those who felt very unhappy about family life was 21.2%, while the corresponding figure for those who felt very happy was 1.4% respectively.

Good relationships with father or mother were also protective factors to current smoking and using drugs. Table 5 shows that 11.2% of those who did not have good relationship with father and 19.7% of those who did not have good relationship with mother reported ever use of drugs, compared to about 6% among those who had good relationship with parents. 10.8% of those who did not accept father's parenting and 12.1% of those did not accept mother's parenting reported ever use of drugs, compared to less than 5% among those who accepted parents' parenting.

Acceptance to parenting is highly associated with lower prevalence of drug use. Those who did not accept their father's or mother's parenting have a higher proportion of having initiation of regularly using alcohol, cigarettes and drugs.

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Generally, there is no significant difference between male substance users and male non substance users in impulsiveness, depression symptoms and social support, except that drug users are shown to be more depressed than non drug users as presented in Table 5.1. Male users of various kinds of substance tend to have an older age than non substance users.

Table 5. Cross tabulation of family antecedents and substances use among Form 3 to 7 boys

		Row-total	Drug users	
			n	%
Parents' marital status	Married	875	47	5.4
	Separated/divorced	105	9	8.6
	Father passed away	44	6	13.6
	Mother passed away	5	1	20.0
	Both parents passed away	8	6	75.0
	Others	8	3	37.5
	Chi-sq test			**
Relationship between parents	Very poor	31	4	12.9
	Poor	70	5	7.1
	Fair	297	19	6.4
	Good	320	13	4.1
	Very good	271	20	7.4
	Chi-sq test			
Happiness about family life	Very unhappy	33	10	30.3
	Unhappy	79	10	12.7
	Fair	372	21	5.6
	Happy	328	16	4.9
	Very happy	211	12	5.7
	Chi-sq test			**
Good relationship with father	Yes	714	40	5.6
	No	161	18	11.2
	Chi-sq test			*
Good relationship with mother	Yes	871	48	5.5
	No	61	12	19.7
	Chi-sq test			**
Accept father's parenting	Yes	642	31	4.8
	No	241	26	10.8
	Chi-sq test			**

Accept mother's parenting					
	Yes		751	37	4.9
	No		173	21	12.1
	Chi-sq test				**

Remarks: Numbers in brackets represent sizes of respondents in the category. Percentages shown are proportions of substance use within the row categories

**. Association is significant with chi-square test at the 0.01 level (2-tailed).

*. Difference is significant with chi-square test at the 0.05 level (2-tailed).

Table 5.1 Mean score for scales for boys

	Drug users	
	Yes	No
Impulsiveness	18.52**	16.06**
CESD-10	8.09**	6.11**
Social support	12.07	12.20
Age	16.52	16.40

**. Difference is significant with independent sample t-test at the 0.01 level (2-tailed).

*. Difference is significant with independent sample t-test at the 0.05 level (2-tailed).

Girls

Those female respondents whose parents were divorced or separated or having their mother passed away had a higher prevalence of drug use than those who have married parents. About 3% of those whose parents were married were drug users, but those whose parents were separated or divorced had a prevalence of 9% of ever using drugs. 13.3% of those whose mother had passed away were drug users.

Relationship between parents and happiness about family life were not highly associated with drug abuse among girls. From chi-square tests, relationship between parents and happiness about family life were not associated with drug use among girl respondents.

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Having good relationship with father and mother is slightly protective against drug abuse among girls. Among those who did not have good relationship with father, 7.7% of them reported that they were drug users respectively, compared with 3.6% among those had good relationship with mother.

Compared with boys, acceptance of parenting has a moderate influence to use of drugs among girls. Among those who did not accept father's parenting, the prevalence of drug use was 7.6%. The corresponding figures for those who accept father's parenting were 1.4%, 2.6% and 3.2%. Among those who did not accept mother's parenting, the prevalence of using drugs was 7.4%. The corresponding figures for those who accept father's parenting was 3.9%.

The differences of impulsiveness and depression symptoms between female substance users and non users were noticeable among boys and girls. Female regular users of alcohol, current smokers and drug users were shown significantly to have higher impulsiveness and depression symptoms on average as shown in Table 6.1. Differences in age and amount of social support were not significant.

Table 6. Cross tabulation of family antecedents and substances use among Form 3 to 7 girls

		Row-total	Drug users n	Drug users %
Parents' marital status	Married	1060	38	3.6
	Separated/divorced	134	12	9.0
	Father passed away	53	1	1.9
	Mother passed away	15	2	13.3
	Both parents passed away	1	0	0.0
	Others	10	2	20.0
	Chi-sq test			*
Relationship between parents	Very poor	40	5	12.5
	Poor	107	7	6.5
	Fair	424	15	3.5
	Good	326	12	3.7
	Very good	329	14	4.3
	Chi-sq test			
Happiness about family life	Very unhappy	29	2	6.9
	Unhappy	125	7	5.6
	Fair	411	19	4.6
	Happy	439	17	3.9
	Very happy	260	6	2.3
	Chi-sq test			
Good relationship with father	Yes	895	32	3.6
	No	182	14	7.7
	Chi-sq test			*
Good relationship with mother	Yes	1088	42	3.9
	No	79	7	8.9
	Chi-sq test			*
Accept father's parenting	Yes	849	27	3.2
	No	263	20	7.6
	Chi-sq test			**
Accept mother's parenting	Yes	1022	40	3.9
	No	148	11	7.4
	Chi-sq test			*

Remarks: Numbers in brackets represent sizes of respondents in the category. Percentages shown are proportions of substance use within the row categories

**. Association is significant with chi-square test at the 0.01 level (2-tailed).

*. Difference is significant with chi-square test at the 0.05 level (2-tailed).

Table 6.1 Mean score for scales for girls

	Drug users	
	Yes	No
Impulsiveness	17.31**	16.09**
CESD-10	6.77*	6.54*
Social support	11.54	12.6
Age	16.7	16.4

**. Difference is significant with independent sample t-test at the 0.01 level (2-tailed).

*. Difference is significant with independent sample t-test at the 0.05 level (2-tailed).

Group 2 (out school, aged 18-27) the demographic analysis and prevalence by drug users and non-drug users and by sex

<u>Prevalence of psychotropic substance and inhalant use</u>

Generally, the prevalence for inhalant use is relatively lower than use of psychotropic substances among young adults. There is an apparent contrast of prevalence of using psychotropic substances between studying and working young adults. The prevalence for studying and working males were 3.8% and 21.5%, while the prevalence for females were 2.2% and 9%.

Among those who reported psychotropic substance use in life time, 10 males (17.2%) and 5 females (11.9%) of them reported they used the substances in the past 30 days.

Table 7. Prevalence of psychotropic substance, inhalant use and either drug type among young adult respondents

<u>Male</u>

		N	n	(%)	95% C.I.	n	%	95% C.I.	n	%	95% C.I.
			Psychotropic substance use			**Inhalant use**			**Either drug type**		
Grade	Studying	255	10	3.8	(2.1, 7.3)	0	0.0	N/A	10	3.8	(2.1, 7.3)
	Working	350	48	21.5	(10.3, 18.2)	4	1.1	(0.4, 3)	49	14.0	(10.6, 18.5)
Overall		605	58	5.9	(7.4, 12.4)	4	0.7	(0.2, 1.8)	59	9.8	(7.6, 12.6)

<u>Female</u>

		N	n	%	95% C.I.	n	%	95% C.I.	n	%	95% C.I.
			Psychotropic drug use			**Inhalant use**			**Combine 2 drugs**		
Grade	Studying	225	5	2.2	(0.9, 5.3)	4	1.8	(0.7, 4.7)	7	3.1	(1.5, 6.5)
	Working	343	31	9.0	(6.4, 12.9)	2	0.6	(0.1, 2.3)	31	9.0	(6.4, 12.9)
Overall		568	36	6.3	(4.6, 8.8)	6	1.1	(0.5, 2.4)	38	6.7	(4.9, 9.2)

<u>Comparison between drug users and non-drug users</u>

The drug prevalence for respondents whose parents were married was 7.2%.

Such prevalence surged to 15.8% for those respondents whose parents were

separated or divorced. The drug prevalence for respondents whose father or mother

passed away were 8.7% and 11.8% respectively.

The chi-square tests show that the relationship with mother, relationship

between parents and happiness about family life were associated with adolescent

drug use. Those respondents who had poor relationship with mother, poor parental

relationship or unhappy family life had a higher prevalence of drug abuse. When the

analysis is separated by sex, the association between family relationship and drug

use is less significant for males, while the association is much higher for females.

Drug users had a higher score of impulsiveness and depressive symptoms

than non drug users. Also, drug users tend to be older than non drug users.

Table 8. Cross tabulation of family antecedents and substances use among out-school respondents (both sexes)

		Row total	Use of psychotropic substances or inhalant Yes		
			n	%	
Marital status of parents	Still married	904	65	7.2	
	Separated/ divorced	158	25	15.8	
	Father deceased	92	8	8.7	
	Mother deceased	17	2	11.8	
	Both deceased	2	0	0.00	
	Chi-sq test				*
Relationship with father	Very Poor	25	5	20.0	
	Poor	91	10	11.0	
	Good	579	44	7.6	
	Very good	356	24	6.7	
	Chi-sq test				
Relationship with mother	Very Poor	7	2	28.6	
	Poor	41	7	17.1	
	Good	523	44	8.4	
	Very good	548	40	7.3	
	Chi-sq test				*
Relationship between parents	Very Poor	51	9	17.7	
	Poor	74	9	12.2	
	Average	302	31	10.3	
	Good	343	24	7.0	
	Very good	344	18	5.2	
	Chi-sq test				**
Happiness about family life	Very unhappy	20	4	20.0	
	Unhappy	69	9	13.0	
	Average	375	42	11.2	
	Happy	446	27	6.1	
	Very happy	257	17	6.6	
	Chi-sq test				*

Remarks: Numbers in brackets represent sizes of respondents in the category. Percentages shown are proportions of substance use within the row categories

**. Association is significant with chi-square test at the 0.01 level (2-tailed).

*. Difference is significant with chi-square test at the 0.05 level (2-tailed).

Mean score for scales for both sexes

	Drug users	
	Yes	No
Impulsiveness	16.95**	14.75**
CESD-10	7.00**	4.94**
Social support	12.17	12.35
Age	22.57*	21.94*

**. Difference is significant with independent sample t-test at the 0.01 level (2-tailed).

*. Difference is significant with independent sample t-test at the 0.05 level (2-tailed).

Table 9. Cross tabulation of family antecedents and substances use among out-school male respondents

		Row total	Use of psychotropic substances or inhalant	
			Yes	
			n	%
Marital status of parents	Still married	467	39	8.4
	Separated/ divorced	78	15	19.2
	Father deceased	43	4	9.3
	Mother deceased	6	0	0.0
	Both deceased	0	0	0.0
	Chi-sq test			*
Relationship with father	Very Poor	12	2	16.7
	Poor	51	6	11.8
	Good	283	23	8.1
	Very good	184	14	7.6
	Chi-sq test			
Relationship with mother	Very Poor	4	0	0.0
	Poor	20	3	15.0
	Good	283	28	9.9
	Very good	258	23	8.9
	Chi-sq test			
Relationship between parents	Very Poor	27	4	14.8
	Poor	31	3	9.7
	Average	148	18	12.2
	Good	186	13	7.0
	Very good	170	13	7.7
	Chi-sq test			
Satisfaction with family life	Very unhappy	11	2	18.2
	Unhappy	35	2	5.7
	Average	201	27	13.4
	Happy	227	14	6.2
	Very happy	114	12	10.5
	Chi-sq test			

Remarks: Numbers in brackets represent sizes of respondents in the category. Percentages shown are proportions of substance use within the row categories

**. Association is significant with chi-square test at the 0.01 level (2-tailed).

*. Difference is significant with chi-square test at the 0.05 level (2-tailed).

Mean score for scales among males

	Drug users	
	Yes	No
Impulsiveness	17.44**	15.05**
CESD-10	7.19**	4.97**
Social support	12.44	11.93
Age	22.42	21.90

**. Difference is significant with independent sample t-test at the 0.01 level (2-tailed).

*. Difference is significant with independent sample t-test at the 0.05 level (2-tailed).

Table 10. Cross tabulation of family antecedents and substances use among out-school female respondents

		Row total	Use of psychotropic substances or inhalant	
			Yes	
			n	%
Marital status of parents	Still married	437	26	6.0
	Separated/ divorced	80	10	12.5
	Father deceased	49	4	8.2
	Mother deceased	11	2	18.2
	Both deceased	2	0	0.0
	Chi-sq test			
Relationship with father	Very Poor	13	3	23.1
	Poor	40	4	10.0
	Good	296	21	7.1
	Very good	172	10	5.8
	Chi-sq test			
Relationship with mother	Very Poor	3	2	66.7
	Poor	21	4	19.1
	Good	240	16	6.7
	Very good	290	17	5.9
	Chi-sq test			**
Relationship between parents	Very Poor	24	5	20.8
	Poor	43	6	14.0
	Average	154	13	8.4
	Good	157	11	7.0
	Very good	174	5	2.9
	Chi-sq test			**
Happiness about family life	Very unhappy	9	2	22.2
	Unhappy	34	7	20.6
	Average	174	15	8.6
	Happy	219	13	5.9
	Very happy	143	5	3.5
	Chi-sq test			**

Remarks: Numbers in brackets represent sizes of respondents in the category. Percentages shown are proportions of substance use within the row categories

**. Association is significant with chi-square test at the 0.01 level (2-tailed).

*. Difference is significant with chi-square test at the 0.05 level (2-tailed).

Mean score for scales among females

| | Drug users | |
	Yes	No
Impulsiveness	16.30*	14.46*
CESD-10	6.72*	4.93*
Social support	11.81*	12.78*
Age	22.77	21.99

**. Difference is significant with independent sample t-test at the 0.01 level (2-tailed).

*. Difference is significant with independent sample t-test at the 0.05 level (2-tailed).

3.4 Framework of the study: Proposed pathways between family quality and drug use

Background

The relationship between family antecedents and initiation of substance use has been studied. Family antecedents include family structure, quality of relationship and parenting practices.

3.4.1 Family structure

Brown (2004) found that children with step parents or single parents are more likely to be troubled by behavioral and emotional problems than those who are borne by couples in a traditional marriage relationship. Past longitudinal studies further pointed out that adolescents who did not reside with both parents had a higher likelihood of developing drug use problems (Hemovich and Crano, 2009; Hoffmann, 2002; Hoffmann and Johnson, 1998; Lansford et al., 2001), whereas such difference of drug prevalence was not evident in those who live with foster parents and biological parents (Lansford et al., 2001). However, the impact arising from

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family structure on adolescents' drug use behavior may not be as conspicuous when other family variables are also taken into consideration. Carlson and Corcoran (2001) identified the predictive effect of family structure on behavioral problems of children, but the effect is shown to be confounded by other variables like family economic status and mother's psychological functioning.

The risk of adolescent drug use is not necessarily the same among families which exhibit disrupted relationships. For instance, girls who live only with their fathers are at significantly greater risk for illicit drug use than girls living only with their mothers (Hemovich and Crano, 2009). Also, a strong bonding with the mother serves as a stronger protective factor for adolescent drug use than that with the father (Bahr et al., 1998). These two findings suggested that the gender of parents would pose a moderation effect on the relationship between family structures and adolescent drug use. This result corresponds with the *maternal hypothesis* that youths who live with mothers and cultivate a closer relationship with mothers are less likely to be involved in delinquent behavior than those who live with fathers (Eitle, 2006). Although there has never been consensus on *the* gender that would provide better parenting to children, these findings have highlighted the fact that

while disrupted family structure is a risk factor for adolescent drug use, parenting style and parent-child relationship could serve as strong moderating factors.

3.4.2 Family relationships

Further to the conclusion just drawn, numerous studies have found that the effect of disrupted family structure on adolescent drug use is indeed confounded by the quality of family relationships. A better relation between couples and more parent-child discussions have been found to reduce the influence of marital disruption on adolescent drug use (Sun, 2001). Children who exhibit stronger bonding with parents would also have stronger protection against adolescent drug use (Bahr et al., 1998). In contrast, children in families with a high degree of conflict and low family bonding are more prone to have drug use experiences (Guo et al., 2002). Moreover, hostile parent-child relationships pose a direct impact on children's problematic behaviors (Buehler, 2006). In a survey targeting run away and homeless youngsters in Taiwan, those who left home because of unsatisfactory family relationships had a higher risk of illegal drug or inhalant use compared to those who left home simply because of seeking for excitement (Wang et al., 2010).

3.4.3 Parenting practices

In particular, positive parenting practice has been identified as an important protective factor for adolescent drug use. Adequate parental monitoring on

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children's behavior mediates the effect of parent-child relationships on children's problematic behavior (Buehler, 2006). Clearly specified behavioral expectations from parents and parents' reinforcement by praise and encouragement also reduce the risk of adolescent drug use (Coombs and Landsverk, 1988). In addition, effective supervision and monitoring in middle childhood by parents or guardians might induce a delay or prevent onset of drug use among youths (Chilcoat and Anthony, 1996). However, a high level of parental monitoring cannot guarantee a low level of peer drug use for their children, which is a strong risk factor for initiation of drug use (Bahr et al., 1998). As a result, despite parents' close monitoring on children's behavior, drug use due to peer influence within the social network is hardly avoidable.
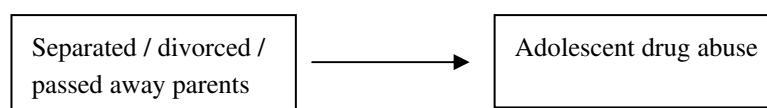
As opposed to positive parenting practice, negative parenting practice would lead a higher risk of adolescent drug use. Aggravation in parenting, such as experiencing feelings of hardship when taking care of the children as well as feelings of being bothered by the children's behavior, predicts behavioral and emotional problems of children (Brown, 2004). A local large scale study found that adolescents who experienced physical punishment (體罰) by family members, were more likely to be current users of psychoactive substances and heroin (Lau et al., 2005).
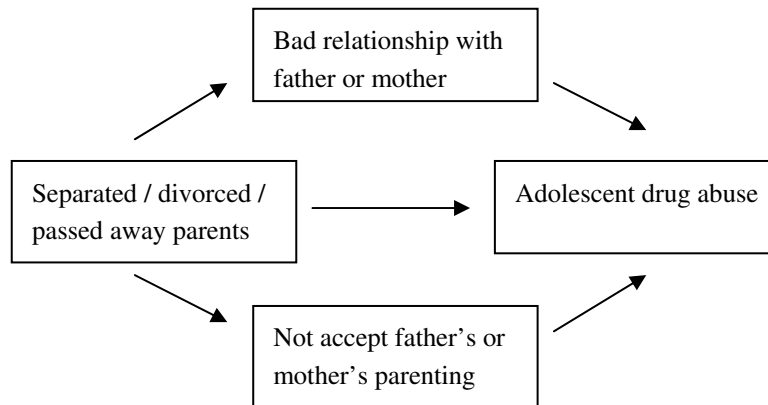
3.5 Research questions

There is a local research gap about how the above family antecedent factors interacted with each other and protect the adolescents from substance abuse. The relationship between children's acceptance of parenting and adolescent drug use among local adolescents has not been studied thoroughly with quantitative study in a large representative sample, to the best of research team's knowledge.

The key research questions in this quantitative research are whether local adolescents with disrupted family structure are more prone to be drug abusers and whether parenting style and parent-child relationship could serve as strong moderating factors. Two streams of the countervailing hypotheses are therefore set:

(1) one-parent or no parent family structure (where parents are divorced, separated or passed away) has *direct influence* on substance abuse, adjusted for variables of family relationship and acceptance to parenting.

```
┌─────────────────────┐          ┌──────────────────────┐
│ Separated / divorced /│  ──────▶ │ Adolescent drug abuse │
│ passed away parents  │          │                      │
└─────────────────────┘          └──────────────────────┘
```

(2) one-parent or no parent family has _indirect influence_ on substance abuse, where

family relationship and acceptance to parenting act as mediators.

```
                    ┌─────────────────────┐
                    │ Bad relationship with│
                  ↗ │ father or mother     │ ↘
                 ╱  └─────────────────────┘  ╲
┌──────────────────┐                      ┌──────────────────────┐
│ Separated / divorced / │ ───────────→   │ Adolescent drug abuse │
│ passed away parents │                   └──────────────────────┘
└──────────────────┘  ╲                  ↗
                 ╲    ┌─────────────────────┐ ╱
                  ↘   │ Not accept father's or│
                      │ mother's parenting    │
                      └─────────────────────┘
```

There is no absolute parenting style which can prevent from delinquent

behavior, but children's acceptance towards parenting seems to play an important

role in determining their compliance to rules and respect towards parents, hence

may serve as a mediator between family structure and adolescent substance abuse,

and between family relationships and adolescent substance abuse.

On the other hand, according to the maternal hypothesis, the role of mother

tends to be more important than father to protect adolescents from substance

abuse. This part of the work also attempts to specify the influence from father's

parenting and mother's parenting on initiation of substance abuse. Further analysis

focuses on whether father's influence is directly associated with substance abuse

among adolescents, and how it is correlated with mother's influence and indirectly

influence substance abuse problem.
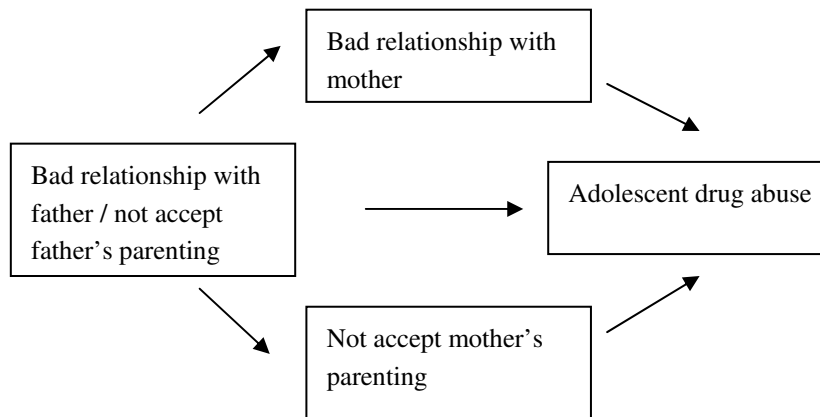
3.6 Hypothesis

Based on the two streams of the countervailing hypotheses and the maternal

hypothesis are proposed in the previous section, 14 sub-sets of the hypotheses are

further detailed and verified as below:

Direct influence of family structure, family relationship and parenting on

adolescent drug abuse:-

1. Adolescents having their parents divorced or separated are more likely to have
   drug abuse problem than those who have married parents

2. Adolescents whose either or both parents passed away are more likely to have
   drug abuse problem than those who have married parents

3. Adolescents having better satisfaction to their family life are less likely to have
   drug abuse problem than those who have less satisfaction

4. Adolescents whose parents have better relationship are less likely to have drug
   abuse problem than those who have worse relationship

5. Adolescents having better relationship with their parents are less likely to have drug abuse problem than those who have worse relationship

6. Adolescents who accept parents' parenting are less likely to have drug abuse problem than those who do not do so

Indirect influence of family structure on adolescent drug abuse:-

7. The relationship between having parents divorced or separated and initiation of drug abuse can be mediated by non-acceptance to father or mother's parenting

8. The relationship between having parents divorced or separated and initiation of drug abuse can be mediated by bad relationship with father or mother

9. The relationship between having parents passed away and initiation of drug abuse can be mediated by non-acceptance to father or mother's parenting

10. The relationship between having parents passed away and initiation of drug abuse can be mediated by bad relationship with father or mother

Maternal hypothesis:-

11. Good relationship with mother can mediate the relationship between good relationship with father and initiation of drug abuse

12. Good relationship with mother can mediate the relationship between acceptance to father's parenting and initiation of drug abuse

13. Acceptance to mother's parenting can mediate the relationship between acceptance to father's parenting and drug abuse

14. Acceptance to mother's parenting can mediate the relationship between good relationship with father and initiation of drug abuse

3.7 Statistical methods

The analysis is divided into 3 parts: (1) Investigate the univariate impact of each family factor (2) Multivariate impact of all family factors, and (3) Mediation analysis. In the first part, Multiple logistic regressions is conducted to explore the risk or protective effect of each family characteristic towards drug abuse, controlled with age, impulsiveness, depressive symptoms, social support. Each family characteristic is entered into the model separately to study their univariate impact on substance abuse. Adjusted odds ratios with p-values and 95% confidence intervals are obtained to compare the influence of the family characteristics. The odds ratio is the ratio of the odds of an event occurring in one group to the odds of it occurring in another group. An odds ratio greater than 1 indicates that the condition or event is more likely to occur in the first group (Bohrnstedt and Konke, 1994).

In the second part, all family structure and relationship variables and controlled variables were incorporated into a single logistic regression model in an exploratory manner. A backward elimination is applied to remove those variables with less explanatory power towards the outcome, according to their p-values. The final model would be noted when all remaining family factors are significant.

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Mediation analysis is a kind of path analysis to examine the presence of mediator between the risk/protective factors and the outcome variable. Mediation is assessed by using 3 rounds of regression models according to 3 criterion suggested by Baron & Kenny (1986).

Figure 8. Procedures for mediation analysis
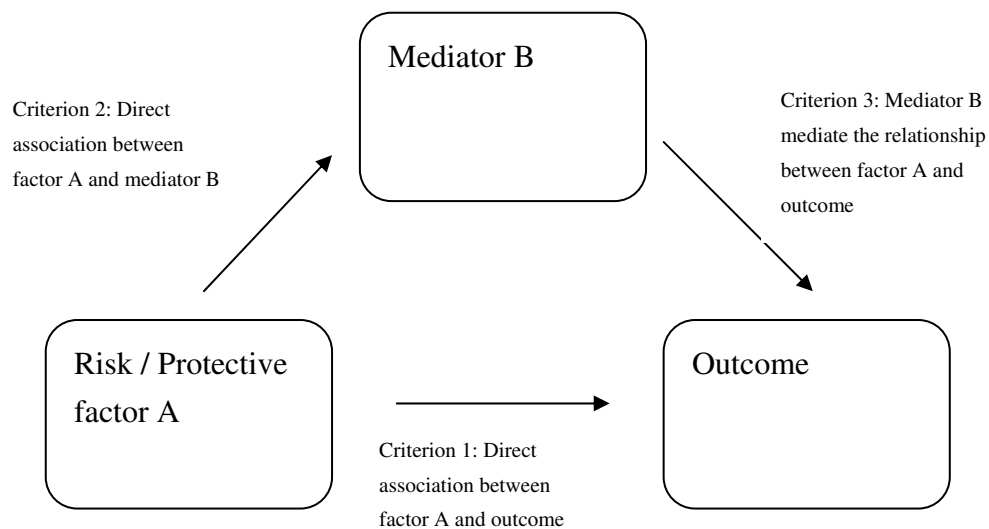
Univariate analysis of risk and protective factors for drug abuse among youths

Figure 8 shows the procedures for the mediation analysis which consists of three criteria: (1) the risk or protective factor A correlates with the outcome with a regression model (criterion 1); (2) the risk or protective factor A correlates with the potential mediator (factor B) with the second regression model (criterion 2); and (3) when factor A and factor B are in the same regression model for the outcome, factor (B) is significantly predictive to the outcome (criterion 3). If factor A is no longer significant to predict the outcome in the third regression model and the factor B is still significant, this criterion is fulfilled and then factor B would be proved as a

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mediator fully mediating the association between the factor A and the outcome. If both factor A and factor B are significantly predictive to the outcome in the third regression model, there would be a partial mediation effect from factor B.

From the study of odds ratios of logistic regression models, there is significant association between family structure and drug abuse among boys. The adjusted odds ratios showed that, compared to those who have married parents, boys whose either or both parents has passed away were more likely to be drug users (OR=5.003, CI=2.451, 10.212), whereas girls whose parents were divorced or separated were more likely to be drug users (OR=2.367, CI=1.178, 4.759) (Table 11).

Good family relationship and acceptance to parents' parenting are also significant protective factors to drug abuse among boys. The adjusted odds ratios of happiness about family life, acceptance to father's control and acceptance to mother's control were significantly lower than 1 for all outcome variables. Good relationship with father and mother is protective to ever drug use.

Among girl respondents, the associations between family antecedents and initiation of drug abuse were less apparent as boys. When family factors were

controlled with other covariates in the regression models, the influence from family towards drug use was reduced. Girls whose parents were divorced or separated were more likely to have drug use (OR=2.399, CI=1.199, 4.799), and acceptance to father's parenting reduced the risk of being drug use (OR=0.475, CI=0.251, 0.90) (Table 15).

Table 11. Univariate odds ratios of regular drinking, regular smoking and ever drug use from multiple logistic regressions

(Adjusted for age, impulsiveness, depressive symptoms, social support)

Boys

	Ever drug use			
	OR	p-value	95% C.I.for OR	
			Lower	Upper
Parents are divorced or separated	1.796	.128	.844	3.822
Either parent are passed away	**5.003**	**.000**	**2.451**	**10.212**
Parents relationship	.914	.491	.706	1.182
Happiness about family life	**.684**	**.004**	**.528**	**.886**
Good relationship with father	**.493**	**.031**	**.259**	**.937**
Good relationship with mother	**.216**	**.000**	**.100**	**.463**
Acceptance to father's parenting	**.467**	**.013**	**.255**	**.853**
Acceptance to mother's parenting	**.335**	**.000**	**.181**	**.617**

Girls

	Ever drug use			
	OR	p-value	95% C.I.for OR	
			Lower	Upper
Parents are divorced or separated	**2.367**	**.016**	**1.178**	**4.759**
Either parent are passed away	.799	.766	.183	3.498
Parents relationship	.912	.510	.694	1.199
Happiness about family life	.878	.412	.644	1.197
Good relationship with father	.715	.373	.342	1.495
Good relationship with mother	.421	.057	.173	1.026
Acceptance to father's parenting	**.475**	**.022**	**.251**	**.900**
Acceptance to mother's parenting	.628	.216	.300	1.313

Multivariate analysis of risk and protective factors to drug abuse (With backward elimination)

In the process of backward elimination, a number of variables have been filtered as they have less explanatory power to the drug use outcome variable. 4 variables related to family structure and family relationship was left in the final reduced model: *Parents divorced or separated (OR=2.277, p<.01), either or both parents passed away (OR=3.13, p<.05), good relationship with mother (OR=.417, p=.01) and accept father's parenting (OR=.60, p<.05)* (Table 12)*. Such findings supported that both family structure and family relationship played an important roles in adolescent drug use. Also, positive impact from both father and mother are important protective factors of drug use.]

Table 12. Interaction effect between variables among females

| | OR | p-value | 95.0% C.I.for OR | |
			Lower	Upper
Female	0.634	0.050	0.402	1.001
Age	1.019	0.785	0.890	1.168
Impulsiveness	1.039	0.058	0.999	1.080
CESD-10	1.008	0.682	0.970	1.047
Social support	1.063	0.226	0.963	1.172
Parents divorced or separated	**2.277**	**0.009**	**1.224**	**4.236**
Either or both parents passed away	**3.130**	**0.015**	**1.252**	**7.829**
Good relationship with mother	**0.417**	**0.010**	**0.214**	**0.810**
Accept father's parenting	**0.600**	**0.038**	**0.371**	**0.971**
Constant	0.078	0.074		

In addition to the main effect of each variable, interaction effect between variables of family structure and relationship were tested in the regression model.

3.8 Mediation analysis

Firstly, the mediation analysis attempted to test whether the relationship between family structures can be mediated by relationship with parents and acceptance of parents' parenting. As shown in the first set of mediation models, either parents passed away is significantly associated with drug use, so the Baron and Kenny's criterion 1 was met. However, *either parent passed away* was associated with *good relationship with mother* only, but not with other variables. The Baron and Kenny's criterion 2 was met for this variable only. In the final model incorporated *either parents passed away* and *good relationship with mother*, the former is no longer significant but the latter remains significantly associated with drug use, so the Baron and Kenny's criterion 3 was met. Therefore, *good relationship with mother* mediate the relationship between *either parent passed away* and drug use (Path diagram A as illustrated in Figure 9).

In the second set of mediation model, *separated or divorced parents* was the origin explanatory variable, while other family relationship variables were the potential mediators. With the similar procedure as the previous analysis, *good relationship with father* and *acceptance of father's parenting* partially mediate the association between *divorced or separated parents* and drug abuse. On the other

hand, *good relationship with mother* and *acceptance of mother's parenting* did not

mediate the association between *parents' divorce or separation* and drug abuse

(Path diagram B as illustrated in Figure 10).

The third set of mediation analysis investigated whether *acceptance to*

mother's parenting is a mediator between *acceptance to father's parenting* and

initiation of drug abuse among boys and girls. The results show that all Baron and

Kenny's criterion were fulfilled in these four mediation models for boys only.

Therefore, interaction with mother acts as good mediator between interaction with

father and the drug abuse (Path diagram C as illustrated in Figure 11).

Table 13. Mediation models 1 and 2. Results from the mediation analysis through multiple logistic regressions (All respondents)

| Risk or protective factor(A)	Risk or protective factor/potential mediator (B)	Outcome (C)	Adjusted OR for factor (A) in the first model	Adjusted OR for factor (A) in the second model	Adjusted OR for factor (A) and (B) in the incorporated model		Mediation present?
					Factor (A)	Factor (B)	
Either of both parents passed away	Good relationship with father	Use of drugs	3.081**	.556	2.868**	.610*	No
	Good relationship with mother			.487*	2.495*	.325**	Yes
	Accept father's parenting			.703	3.088**	.490**	No
	Accept mother's parenting			.655	2.868**	.477**	No
Parents divorced or separated	Good relationship with father	Use of drugs	2.359**	.315**	2.234**	.610*	Yes
	Good relationship with mother			.659	1.721	.325**	No
	Accept father's parenting			.436*	2.531**	.490**	Yes
	Accept mother's parenting			.919	2.116**	.477**	No

Table 14. Mediation model 3. Results from the mediation analysis through multiple logistic regressions

|	Risk or protective factor(A)	Risk or protective factor/potential mediator (B)	Adjusted OR for factor (A) in the first model	Adjusted OR for factor (A) in the second model	Adjusted OR for factor (A) and (B) in the incorporated model		Mediation present?
					Factor (A)	Factor (B)	
Boys	Good relationship with father	Good relationship with mother	.493*	13.705**	.657.	.324*	Yes
	Good relationship with father	Accept mother's parenting	.493*	3.480**	.591	.485*	Yes
	Accept father's parenting	Good relationship with mother	.467*	4.974**	.596	.382*	Yes
	Accept father's parenting	Accept mother's parenting	.467*	11.922**	.679	.434*	Yes
Girls	Good relationship with father	Good relationship with mother	.715	1.828*	.710	.648	No
	Good relationship with father	Accept to mother's parenting	.715	2.848**	.851	.542	No
	Accept father's parenting	Good relationship with mother	.475*	1.864*	.503*	.463	No
	Accept father's parenting	Accept mother's parenting	.475*	6.424**	.453*	.970	No

Figure 9. Path diagram (A)
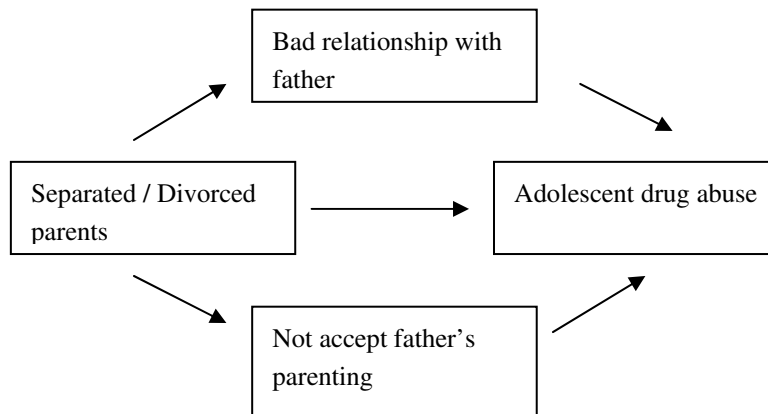
Figure 10. Path diagram (B)
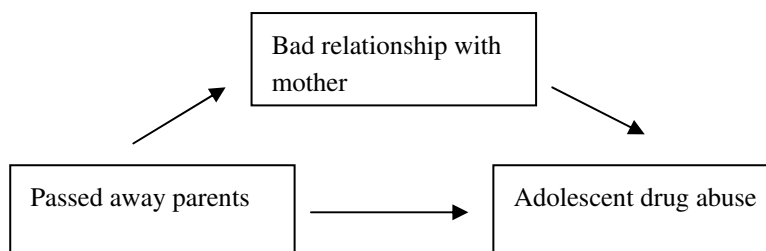
Figure 11. Path diagram (C) (for boys only)
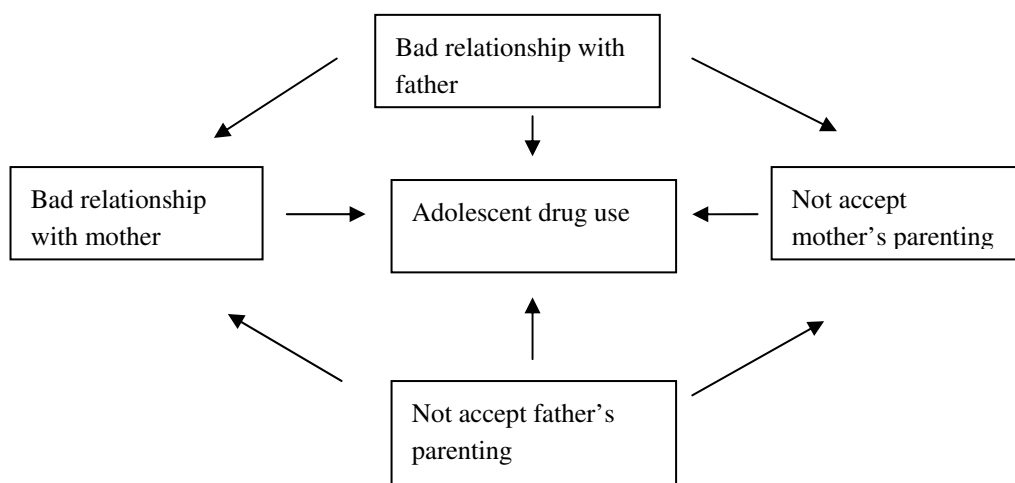
3.9 Conclusion

Among boys, use of psychotropic substance becomes more prevalent in older adolescents (Form 3-7) than younger adolescents (Form 1-2), and exceed the prevalence of using inhalant. The prevalence of using psychotropic substance and inhalant is quite similar for girls.

The drug prevalence for in-school adolescents is about 5% to 7% for boys and 3% to 4% for girls. The figure for working young adults soars up to 14% for males and 9% for females.

Parents' divorce, separation or passing away has a high influence on substance abuse among adolescents. Perceived between-parent relationship is not very important predictor. Feeling happy about family life, good relationship with parents and acceptance to parenting are significant protective factors to substance abuse. However, the influence from family on substance abuse is more evident among boys than girls. It may be due to the lower prevalence of girls and thus lower statistical power in the analysis for girls.

Pass away of parent or parents has a direct influence to adolescents' substance abuse, and it did not necessarily lead to destruction of family relationship. On the other hand, divorce or separation of parents is associated to worse family relationship, worse relationship with father and less acceptance to father's parenting among boys. These factors pose a mediating effect to substance abuse among adolescents.

Role of father has an indirect influence to substance abuse. Better relationship with father or better acceptance to father's parenting is associated with better relationship with mother or better acceptance to mother's parenting, and role of mother mediate this effect to substance abuse.

Table 15. Univariate odds ratios of regular drinking, regular smoking and ever drug use from multiple logistic regressions (Adjusted for age, impulsiveness, depressive symptoms, social support)

Boys

	Regular use of alcohol				Current smoking				Ever drug use			
			95% C.I.for OR				95% C.I.for OR		OR	p-value	95% C.I.for OR	
	OR	p-value	Lower	Upper	OR	p-value	Lower	Upper			Lower	Upper
Parents are divorced or separated	.702	.461	.274	1.796	**2.085**	**.026**	**1.090**	**3.985**	1.485	.297	.706	3.122
Either parent are passed away	**2.398**	**.028**	**1.097**	**5.242**	**3.121**	**.002**	**1.501**	**6.489**	**4.633**	**.000**	**2.294**	**9.355**
Parents relationship	.894	.374	.698	1.144	.843	.159	.665	1.069	.914	.491	.706	1.182
Happiness about family life	**.711**	**.009**	**.551**	**.917**	**.691**	**.004**	**.539**	**.886**	**.684**	**.004**	**.528**	**.886**
Good relationship with father	.701	.304	.356	1.380	**.431**	**.008**	**.232**	**.804**	**.493**	**.031**	**.259**	**.937**
Good relationship with mother	.478	.100	.199	1.151	**.163**	**.000**	**.078**	**.344**	**.216**	**.000**	**.100**	**.463**
Acceptance to father's control	**.468**	**.009**	**.266**	**.825**	**.311**	**.000**	**.179**	**.541**	**.467**	**.013**	**.255**	**.853**
Acceptance to mother's control	**.320**	**.000**	**.181**	**.567**	**.280**	**.000**	**.157**	**.499**	**.335**	**.000**	**.181**	**.617**

Girls

	Regular drinking				Current smoking				Ever drug use			
			95% C.I.for OR				95% C.I.for OR		OR	p-value	95% C.I.for OR	
	OR	p-value	Lower	Upper	OR	p-value	Lower	Upper			Lower	Upper
Parents are divorced or separated	1.894	.224	.676	5.306	2.078	.065	.956	4.515	**2.399**	**.013**	**1.199**	**4.799**
Either parent are passed away	NA	NA	NA	NA	.878	.863	.201	3.830	.681	.608	.157	2.957
Parents relationship	.765	.152	.530	1.104	.855	.303	.634	1.153	.912	.510	.694	1.199
Happiness about family life	**.587**	**.013**	**.386**	**.894**	.791	.165	.569	1.101	.878	.412	.644	1.197
Good relationship with father	.457	.113	.174	1.204	.602	.205	.275	1.319	.715	.373	.342	1.495
Good relationship with mother	1.817	.571	.231	14.310	**.212**	**.000**	**.091**	**.492**	.421	.057	.173	1.026
Acceptance to father's control	.492	.128	.197	1.226	.542	.094	.264	1.109	**.475**	**.022**	**.251**	**.900**
Acceptance to mother's control	**.338**	**.019**	**.137**	**.836**	.628	.262	.278	1.417	.628	.216	.300	1.313

CHAPTER 4:   Qualitative study - focus groups

4.1.   Background

The research team employed both qualitative and quantitative (i.e., phase I on secondary analysis of relevant population data) research to produce systematic, credible data and richer results on drug use among youths and its impacts on family (and vice versa). Phase II of the study provided stand alone qualitative information on drug abuse among youths and family in the context of Hong Kong, as well as enhancing the methodology of the present wider study.

The specific aims of the phase II focus group study are to:

1. examine the underlying causes of young drug abusers and their relationship with family and assess the impacts of drug using on the family as a whole and individually

2. identify risk and protective factors of the drug abuse problem – emphasis on the voices of young drug users and their family members to share their insiders' stories in relation to their personal experience into drug abuse; and

3. identify problems and needs that young drug abusers see as relevant to the road to recovery

This stream of work was led by Dr. Samson Tse, Prof. Karen Laidler and assisted by Ms Garlum Lau and Mr Kender Wu. It was expected that eight to ten focus groups would be held for different profiles of youngsters such as current juvenile drug abusers, non-drug users, professionals, the juvenile drug abusers' parents or siblings and teachers and for different age

spectrums such as teenagers (i.e. age 12-17), young adults (i.e. age 18-24), and adults (i.e. age 25-34).

4.2. Methodology

The main task of Phase II involved interviewing a range of people in a focus group format. The main benefit of focus groups is to provide an initial, general scoping picture of the issues and problems, which can be used in improving the researchers' understanding of the topics, and giving directions for future investigation. The group format also offers the advantage of discovering, for the researchers and the participants, the points of similar and unique experiences different participants have encountered. During the focus group, the facilitators or researchers should pay attention to the interactional dynamics of group members, the intensity and flow of discussion generated in the group rather than treating each group member as an individual who happens to talk about their experience in a group setting. Although focus groups are extensively used in research, they have their limitations, particularly with participants who are reluctant to disagree in public or share their personal experience. While collecting data in group format is considered to be very useful; the confidentiality of issues discussed needs to stay within the group session. The protection of participants' identity and privacy in focus groups has to be managed very carefully within the present study. Another limitation lies in our teenage sample. Teenagers, in our study tended to show additional hesitancy to share and talk about private issues in the group, especially when other group participants were total strangers. Relatively, young adult respondents seemed to have fewer problems in this regard, perhaps because of their age, and were more willing to speak openly and contribute to group discussion.

The organizations (e.g., social service agencies, drug rehabilitation centers) and/or individuals were approached by the project team in the planning stage of the project and all agreed to take part in study. In order to provide a comprehensive analysis and overview of the topic under study, two basic data collection methods were employed:

- Focus groups involving eight separate groups of individuals:

    1. Teen non-drug users (12-17 years old)

    2. Teen experimental drug users

    3. Teen regular drug users

    4. Adult non-drug users (18-24 years old)

    5. Adult experimental drug users

    6. Adult regular drug users

    7. Parents of loved one with drug addiction problems

    8. Professionals working with clients affected by addictions

Administration of a one-page questionnaire on participant demographic information prior to the commencement of the group discussion.

4.2.1   Recruitment process

The following inclusion/exclusion criteria were developed for phase II:

Inclusion criteria

- Individuals who were able to give informed consent;

- Individuals who aged 16 years or above (for those who were under age, consents were sought from their caregiver/ guardian)

- Individuals who were able and willing to reflect on their experiences in providing and/or using problem gambling intervention services.

Exclusion criteria

- Individuals who were at immediate risk of harm to self or others;

- Individuals who were not interested in participating in the research process;

- Individuals who were not able to engage in a 20-60 minute interview.

Convenience sampling was used during the recruitment stage, an email note was sent or a phone call was made to relevant agencies and individual social workers to request assistance with participant recruitment. Eligible participants were given a one-page study summary or explained verbally by the agency workers and asked if they were interested in participating. If the participant expressed interest, they would be referred to the research field worker, who would answer any questions she or he may have and provide the written information sheets. The individual then indicated their consent by signing the consent form (or alternatively not consent to participate) at the beginning of the data collection process. After obtaining the consent, a focus group session was completed. Participants were involved in focus groups at a location convenient to them, social agencies concerned and the researchers. The focus group usually took about 90 minutes. To maximize reliability and strengthen the interaction between researchers and research participants, the focus groups were conducted in the participants' native language which was Cantonese. Qualitative focus groups were audio-taped after obtaining the group members' permission and field notes were written as well. All the participants, including agencies practitioners, clients with or without personal experience of addictions and family

members/significant others were reminded that their participation *was voluntary.* The participants were reminded that *complete confidentiality and anonymity is promised.* The participant names will not be used and their data would be identified by codes only. If the information they provide is reported or published, this will be done in a way that does not identify them as its source.

4.2.2   Participants: Sample size and distribution

Three groups of people were involved in this study:

1.   Teenagers and young adults who have or have not used drug before

2.   Family members of loved one with addiction problems and were interested in sharing their understanding of the issues, and

3.   Social work or human services practitioners

Table 16 summarises the distribution and background of research participants. Altogether 46 individuals participated in this study.

Table 16 Focus group: Summary of focus group participants

	Date (conducted in 2010)	Group membership	Number of participants (male)	Researchers involved
1.	21st May	Teen (12-17 years), non-users	7 (4)	GL & student helper
2.	26th May	Adult (18-24 years), non-users	7 (4)	GL & student helper, observer KC
3.	30th May	Family members	6 (2)	ST, GL & student helper, observer KC
4.	1st June	Teen, experimental users	6 (5)	ST, GL, KC & student helper, observer A*
5.	3rd June	Adult, experimental users	4 (3)	ST, GL, KC & student helper, observer B*
6.	9th June	Teen, regular users	6 (4)	GL, 2 observers C & D*

7.	9th June	Adult, regular users	6 (4)	GL, 2 observers C & D*
8.	30th June	Professionals working in drug rehabilitation field	4 (3)	GL, KC & student helper, observers E & F[#]
		Total number of participants=	46 participants 29 (63%) were males	

Notes:
- GL, ST, KC and student helper were members of the HKU research team
- * A, B, C & D were the agency staff members who sat in to observe in the focus group
- #E & F were social work students who sat in to observe in the focus group

4.2.3   Data collection: Semi-structured focus group guideline

Semi-structured interview schedules were developed for use with young people, professionals and family members. These schedules were based upon the reviewed literature. Details are attached in Appendix E.

4.2.4   Data analysis

Data collection and analysis took place concurrently. Analysis commenced following the first few focus group discussions. Qualitative data in the form of detailed information provided by the research participants were formed into categories and analyzed thematically (Creswell, 1994; Patton, 1990). Initial data and the research objectives were used to create a preliminary framework within which emerging topics were identified and addressed in subsequent focus groups. In other cases, as the findings emerged, the researchers modified the interview guidelines or searched for unique individuals, for example, who reported coming from a good, stable family but still used drug regularly. Data were analyzed using a general inductive approach to identify key themes relevant to the research objectives (Thomas, 2006). The steps were: 1) Initial reading of participants responses or the transcripts from individual focus groups, 2)

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Identifying text segments specifically related to the research objectives, 3) Labeling segments of text to create themes and sub-themes, 4) Creating new themes and sub-themes if findings evident in later focus group discussions did not readily relate to the existing framework and; 5) Reducing overlap and redundant themes and sub-themes. Importantly, the research team has taken care to accurately capture and interpret the views of the research participants while maintaining their privacy and confidentiality.

4.2.5   Research rigor

The research rigor for phase II can be summarized as follows

Table 17 Research rigour in phase II study

Category	Activities/ remarks
Triangulation of data sources	• Used quantitative and qualitative data emerged from the phase I and II of the present study • Collected data from multiple sources namely, young people from two broad age groups, individuals who did not use drug versus those who experimented or used drug regularly; professionals who worked in drug rehabilitation field and family members/ parents
Data verifications	• All focus groups were audio-taped (after obtaining the participants' permission), all the tapes were transcribed and the notes were available for checking and re-checking, copy and paste to create themes and sub-themes • Individual researchers who had been involved in the focus groups prepared their notes independently on what they considered as the major themes of the findings, then the notes were compared between the researchers to improve the validity of the data interpretation • Presented the preliminary findings in various project team meetings to verify the accuracy of data interpretations
Instrumentation	• The project team members provided input and steered the development of the semi-structured focus group guideline

4.3. Results

Summaries of the Focus Groups

Below we provide a summary of the main personal characteristics and familial relations of the young persons and family members. Here we also include a summary of discussions with professionals.

Group 1 – Teen (12-17 years), non-users
Overview:
1. This group ranged in age between 13 to 16 and from F.2 to F.4 students. All were born in Hong Kong except one male, born in Shenzhen and came to HK in 1999.
2. They all came from a band-1 secondary school in Kwai Chung, lived in Kwai Ching area, referred by an alumnus of the school in consultation with his former school teacher.
3. In specific, two girls from F.2 were distinct academic achievers and received awards at school from time to time. Another boy from F.4 was a prefect at school and was planning an exchange year to a US high school next year.

Individual Group Members:
4. Generally, these seven participants showed great interests in schooling (they said they were busy all the time for study and activities) and every one had strong affiliation with various extracurricular activities.
5. One of the boys was a Christian whose attachment with church was strong (weekly visit), though the religious bond was not a family-initiated one (he was the only Christian in his family). All other six had no religious attachment.
6. Only one girl was the only child in her family. The other six participants had siblings.
7. One boy lived with his mother, not father (but also with his grandparents), the other six were living with both parents (half together with grandparents too).
8. Only one of the boys had a domestic helper at home, all other participants had none.

Family Relationships:
9. One participant described his family relationship as "very good" and half of the remaining group described as "good" and "quite good" respectively.
10. The former expressed that there will always be activities with mother, father and siblings on Sunday. Fishing and hiking was their favorite pastimes.
11. The latter two groups did not have weekly outdoor/sports activities as such but Sunday dinner or Yum cha gatherings were common.
12. Most of them expressed that they could see their family members quite often and would have nightly dinner together with parents.
13. Participants generally showed caring attitude towards family. They were willing to talk a lot about their family life.

Attitudes Towards Drugs:

14. They had never used any illicit drugs, thus are total abstainers of drugs. None of them had smoked and only two boys tried a drink of beer.

15. None of them had been offered any type of drugs in their lifetime.

16. All of them held negative impression to drugs. Most of them thought the term "drug" is an all embracing term (i.e., that any drug is "drug"). One would see cough mixture, which is not "illegal", as a less serious type of drug.

17. They learned their knowledge about drugs chiefly from mass media, talks and seminars at schools. Yet, one boy expressed that he was "bored" by the drug education. He even mentioned that the more the government and the society tell teens about drugs, the more some might get curious about drug. From his standpoint, in the end, it would be a bad idea if someone tries drugs because of such curiosity.

18. All participants told us that they did not see any drug user at their school and believed that there should be no drug user at school. Only one girl recalled a primary school classmate talked about drug use in her blog. This was the only acquaintance that she knew who might be drug using.

Prevention Programme and Health Promotion:

19. When asked whether they would try drugs in the future, four of them said they would never but three were uncertain, chiefly because they said they wouldn't know what would be ahead of them and somehow at some points in their life, they might try it.

Group 2 - Adult (18-24 years), non-users

Overview:

1. This group aged between 18 and 23 years old. All were single adults with no child. Four of them were F.7 students and three were working young adults.

2. Two were born in mainland China and came to HK in mid 1990's and the other five were born in HK.

3. The four students came from a band-1 secondary school in Kwai Chung, lived in Kwai Ching area, and referred by our student helper.

4. The three working adults were friends of friends of our Department colleague.

5. Working adults obviously showed different lifestyle and routine from the younger students. On average, the three working adults had to work ten or up to 12 hours a day which took up most of the time they had whereas the students spent much of the time on internet surfing, internet socializing and sometimes online game playing because schooling and exams had all been over.

6. Unlike the non-user teens (group 1), the young adult students in this group showed little interests in extracurricular at school and were more likely to arrange activities on their own and according to their own schedule. Working adults seemed to have showed no keen interests in a hobby or outside activities. One working adult though expressed he took part in football playing on a weekly or fortnightly basis.

Individual Group Members:
7. Only one working adult was a Christian whose attachment with church was quite strong (weekly visit). All other six had no religious attachment.
8. All of the participants had siblings; four of them were the youngest child.
9. Only one was living in a single-mother family and all others were living with both parents, no one lived outside of the family.

Family Relationships:
10. Most participants described their family relationship as "good" and one described as "quite good" as she thought the views of her family members were always in conflict. Still, she believed they love each other.
11. Unlike the non user teen group, it was rare for participants to have frequent family gatherings/outings. Sunday dinner or Yum cha was relatively common.
12. One female working adult expressed that her father insisted that dinner at home every night was important and she was not allowed to go home later than 11 pm. Still, she had not much complaint about this curfew.
13. The other two working adults admitted that, with their long working hour, they could only leave little time to their family.

Attitudes Towards Drugs:
14. They had never used any illicit drugs, thus are total abstainers of drugs and none of them were smokers.
15. All of them held negative impression to drugs. The most common type of drug they quoted for perceived popular choice of drug in HK was Ketamine and Ecstasy. They learned their knowledge about drugs chiefly from mass media.
16. Most of the participants believed peer pressure was a common factor in explaining one's drug use. One working adult suggested access to drinking/party setting might be the first step for one to get in touch with drug.
17. Most were not certain of what protective factors facilitate abstinence, but one thought it might be because of the family socialization of moral rights and wrongs, in explaining their abstinence. For her, she believed taking drug was wrong. One thought the actual family relationship status and stability mattered. Others thought the negative effects of the drugs they learned from media deter them to try.
18. When asked whether they would try drugs in the future, five of them said they would not but two were uncertain. One explained if he was given an opportunity, he might try. Another explained that there might be uncertainly ahead, if in the future, the high from the drugs could outweigh the side-effects of a drug, he might try it.

Group 3 - Family members
Overview:
1. This group consisted of six parents from six different families, whose sons/daughters were currently in a residential drug rehabilitation centre.
2. Except for one parent's daughter who was arrested for theft, the children of the five parents were all sent to the centre due to drug use, possession or trafficking of dangerous drugs.

3. The interview day was the monthly parents' day of the centre and these six parents were referred by a teacher of the centre who recruited randomly.
4. The group had to be held within a short period of time because parents could only spare about an hour before meeting their children.

Individual Group Members:
5. Six parents aged from 36 to 58, 3 were born in mainland (but came to HK in 1950's/60's) and one out of three came to HK in 1990's. The others were born in HK.
6. Most of them had junior education and one illiterate.
7. Three were divorced/separated and three were married.
8. One was unemployed and other five were employed in various occupations: from waitress, technician to insurance agent.
9. Three parents stated they were Christians and others had no religious attachment.
10. In specific, one parent emphasized that her background was middle class whereas the others showed that they made less than 10K a month.

Awareness of Child's Drug Use:
11. Most parents came to be aware of the child's drug use after their child was arrested. One parent's son was charged with trafficking of drug. Otherwise it took between one to two years to get the loved one accepting help after the drug use was revealed.
12. One parent claimed that she noticed some signs beforehand, like going out late, getting home late, asking for more money etc.
13. Three children were living in single-parent families at the time they started using drug.
14. Not all parents told us the choice of drug of their children but at least three told us that their children were using Ketamine.

Impact on Family and Help Seeking:
15. Most parents said they were shocked after knowing about their children's drug use. Most of them gone through a period of confusion and disappointment. Most expressed that their children's drug use caused great turbulence to their family. Had different impacts at different stages e.g. shocking, confusion at the beginning, self-denial and self-doubt of previous parenting skills and effort, after two to three years, the emotions settled again.
16. Two parents explained that they sought help from social workers, doctors and other professionals before coming to centre.
17. Yet, not all parents saw the fact that their children's drug use as totally negative. One especially expressed that the family bonding between parents and sibling was even stronger after the turbulence. It was apparent that addiction within family was not a good thing at all, but the transformation (e.g. being more respectful to parents, more discipline life-style) occurred after seeking help (e.g. from centre) was surely positive.

Impact of Intervention on Family:
18. When participants were asked to rate their family relationship for now, from 0-10, most rated it as 7-8, one as 9 and one as 5, just a pass, this was because he actually lived alone without his daughter's presence at home.

19. Most parents had very high comments on the service provided by the centre. One even expressed that most previous treatment and assistance was not much effective but it was this centre that really transformed their children.
20. Most parents showed great support to centre and thought that the government should pay more efforts and spend more resources on solving youth drug use problem. Service like this was rare and resources were too limited.
21. The middle-class parent especially pointed out that she even had friends who are from upper, very well off families whose children were also using drugs. Services to serve the needs of this social class were especially lacking.

Group 4 – Teen, experimental users

Overview:
1. This group consisted of six teens referred by a community centre. Our recruitment criteria required participants to have tried drugs in their lifetime and have used drug in the past two years.
2. They aged from 15 to 17 years old.
3. Four of them were born in China and came to HK from mid to late 90's, soon after they were born, two others were born in HK.
4. Three of them were the youngest child in the family, two were single children and one had a younger brother.
5. Four of them were living in Eastern District, one in Tuen Mun, and one was unknown.
6. Four were current secondary school students and two had left school.

Individual Group Members:
7. Among the two dropouts, one had just quit work but expressed that he was not actively seeking employment. Another used to work in various occupations like computer repair and tutoring but was now waiting to turn 18 and move on to other jobs.
8. Only two of them were currently living with both parents. One was living with a relative, and one was living with mother only. It is noted that one was now living in a dormitory provided by a social service centre and the only girl in this group was independently living on her own. Her mother owned the flat but they were not living together, her mother, however, financially supported her.
9. Also note that two respondents were/are being supervised under the Police Cautioning Scheme.
10. One claimed that he is Catholic, three Christians, one Buddhist, and one no religious belief.

Drug Experiences:
11. Two of them tried drugs but didn't use any in the past one year. They tried ice and cannabis respectively.
12. Four had used drugs in the past one year. All of them named Ketamine as their choice of drugs. Other drugs mentioned included Ecstasy, Cannabis, Cocaine and Cannabis flower.

13. Among the six, four declared in the group that they had "stopped" using drug (they didn't use the term 'quit')
14. They quite commonly believed that peer influence explained their initial and continuation of drug use. One also thought lack of self-control was important.

Role of Family Relationships and Other Factors in Drug Use:
15. Yet, when they were asked whether family or their family relationship had a role in it, four of them believed not. They didn't see a negative family environment would explain their own or others' drug use. These four participants seemed to see drug use as a matter of personal choice related to peer pressure.
16. Only two believed that family played a role. The girl started using drug only after she lived on her own. In this way, lack of parental supervision may be a factor. Another boy explained good/positive family relationship should be helpful to protect one teenage from drug use.
17. None of the respondents were currently seeing/receiving any drug treatment and they didn't feel they need to.
18. Especially about the boy who is now living dormitory, he described his family relationship as bad as he from time to time had a fight (physical too) with his step-father, so he preferred living at the dormitory where he could hang out with friends and he could have more freedom.
19. The girl was reluctant to tell us the reason why she had to live alone, but she said she might be able to see her mother once in a week when she put money for her use at home.
20. Another boy lived with both parents. Although this boy had first tried cannabis with peers, his mother thinking he had never tried it, taught him about smoking cannabis. She believed that this would better prepare in the future. Still, the boy explained that his mother was not a regular drug user. He further described his family relationship as quite a materialistic one by quoting "講金 o 吾講心", meaning "money matters more than love".
21. Three boys told us that their family members knew about their drug use. With two being either observed or caught by their mother and another being arrested for possession of Ketamine.

Family Reactions to Drug Use:
22. Family responses varied. The mother of a boy started to keep calling him after school to check on him. Another was somehow "lectured" by his mom and whenever she noticed that he was high, she kicked him out of home. He felt bad about being kicked out and so he quit. Both boys felt the strategies worked.
23. One boy expressed that he felt that he could stop using drug whenever he wanted to, and there was no need for intervention. Especially, he felt that he used drugs just for socializing purpose; it was just like him being offered alcohol in drinking setting. He further explained that he used to help with business meetings for the family business, in which drug was being offered just like alcohol, and these were the occasions in which he used drugs.

Strategies on Parental Response:
24. They offered suggestions if a parent found out their children was using drug. One suggested that the parent should let the child take drugs to the extreme, almost letting him die, and

then the child would know he/she has to stop. He also suggested that isolated residential drug rehab could help. Another suggested that parents closely monitor and observe the child. Another suggested that kicking the child out of the house would allow him to understand his wrongdoings. Another boy thought that more social activities that the whole family could take part in should be conducted to mend the broken family relationship, so as to help the drug using child.

Group 5 – Adult, experimental users
Overview:
1. This group consisted of four young adults referred by a social worker from a community centre.
2. Our recruitment criteria required adult participants (aged between 18 and 24) to have tried drugs in their lifetime and have used drug in the past 2 years.
3. They aged from 18 to 22 years old.
4. All of them were born in Hong Kong.
5. Three of them were the youngest child in the family.
6. Two of them were living in the Tin Shui Wai, one in Southern District, one in Kwun Tong.
7. Three were students; two were F.5 students and one in Community College. One was unemployed.
8. One respondent's parents were divorced, one widowed (mother passed away) and the other two were still married and living together with children.
9. The two respondents whose parent(s) divorced/passed away were raised by single parent and now living with their single parent and sibling(s).

Individual Group Members:
10. Three of them had institutional experiences in centers run by the Correctional Service Department (CSD).
11. One claimed that he is Catholic, one Christian, one Buddhist and one had no religious belief at all.

Drug Experiences:
12. All of them reported trying Ketamine. Other drugs which they had tried in their lifetime include Ecstasy, Ice, Cannabis, Cocaine, O Chai and 5 Chai.
13. All of them also reported using drug(s) in the past one year.
14. Two used Ketamine in the past year whereas one used Ice and cough mixture and another one used Ice specifically.
15. Parent(s) of three of them were aware of their drug use.
16. In recent months, one expressed that he only used Ketamine, whereas another one thought he had somehow been dependent on Ice and Ketamine previously but had quit for three months. Another one, on the other hand, had quite strong desire to use Ice but his supplier was now in jail so he used cough mixture occasionally as a substitute. The only lady in our group used Ice at drinking/disco settings and had sometimes used to use it daily but had stopped using it for a month because she wanted to pass through the drug test of CSD officers to avoid recalling into the institution again. Yet she admitted she still wanted to use Ice.

17. No one was now on rehab or any medical treatment about their drug use nor saw their drug use problematic.

Role of Family Relationships and Other Factors in Drug Use:

18. Like the previous group, peer influence was a commonly quoted reason for their drug use. One in specific said curiosity a reason because his first drug use was initiated after he picked up coincidentally a pack of cigarettes with cannabis joints inside.

19. One who lived in single parent family believed that it might be quite different to his family if both parents were in the family which he believed would provide him more time and guidance. Still, he was not sure his single parent status directly explained his drug use.

20. Another believed that the economic status of family did not explain youngsters' drug use but negative peer influence, e.g. triads, peers.

21. One respondent expressed that he once thought that if his family were rich and he had a well-off status, he might be able to diversify his hobbies and drug use might not be on the top of his hobby list. Yet, some other respondent disagreed, but thought that a well-off background would also facilitate a teenager to use higher-end type of drug and not necessarily keep a teenager away from drug.

22. Most ex-boyfriends of the lady were using drugs while they were together and she didn't see her boyfriends were the ones who introduced drugs to her but more likely that they started using drugs together, thus somehow enhanced the frequency and extent of her drug use.

23. In one respondent's single parent family, he thought he did not have much communication with his mother and his father left the family when he was young, which he saw had great negative impact to his family as his sister and mother felt very sad about it.

24. Although another respondent's family was relatively more intact, with both parents present, one time his father had extra marital affairs, which he didn't approve of. In a way the family relationship was not satisfactory at that time.

25. Another respondent told us his mother passed away when he was small and his father was relatively of old age (now aged 70). Their family was on CSSA for years. He did think many of his family problems centered on lack of money/resources. His family experiences were generally not happy.

26. The young woman didn't reveal much about her family relationship but did indicate that she was not in good terms with his brother and that relationship deteriorated after her drug use was made known to him.

Family Reactions to Drug Use:

27. Family responses towards their drug use varied. One respondent's father was of the view that his son's arrest would help him to grow, meeting obstacles in life and thus lessons learned. Another's father suspected his son's drug use but couldn't prove it so far. Another respondent's mother complained about his drug use all the time but couldn't do much as her son rarely listened to her. The female respondent's family responses were very negative especially from her brother who had just about cut off communication with her after her arrest.

28. One respondent expressed that he thought an intact family relationship with both parents at home would mean a lot of support to a drug-using kid so as to prevent him/her from relapse.

Strategies on Parental Response:
29. When they were asked what suggestions they would make to improve family relationship, two respondents came up with the idea that "Parents should learn how to be friends of their children".

Group 6 – Teen, regular users
Overview:
1. This group consisted of six teenagers referred by a residential drug rehabilitation centre. They were all on residential rehab on an isolated island at the time of interviewing. The residential program has a 2-year stay minimum requirement.
2. Our recruitment criteria required participants to age between 12 and 17 and to have used drug(s) as frequently as daily to weekly, 1 year prior to admitting to the centre.
3. They aged from 15 to 17 years old and included four males and two females.
4. All of them were born in Hong Kong.
5. Four of them were the youngest child in the family whereas two of them were the eldest. No one was single child.
6. All were students and had quit school previously. Now they were F.2 or F.3 students and at the college.

Individual Group Members:
7. Four respondents' parents were divorced and the other 2 were still married.
8. Four claimed that they were Christian and two held no religious belief.

Drug Experiences:
9. All of them expressed that they had tried Ketamine in their lifetime. The second common type of drug quoted was Ecstasy. Other drugs which they had tried include Ice, Cannabis, Cocaine and 5 Chai.
10. As all of them had been on rehab for months or even years, they expressed that they had not used any drug(s) in the past one year.

Role of Family Relationships and Other Factors in Drug Use:
11. The most commonly quoted reason for initial drug use was peer pressure. None of them related their drug use with their family relationship. They thought they were all introduced by peers to use drugs, no matter how their family was, they believed they would end up using it.
12. Yet, another common experience they shared was parental absence at home. Most of them did not describe negative family relations but the parents' physical absence was felt and three respondents stated that their parents worked long hours.
13. One girl expressed that she felt bored at home, so she went out with friends and began using drugs. Another boy said he rarely talked with his mother because she was busy working. Another said his parent usually left money for him even when they couldn't meet. They also rarely sat down and dined together.
14. Another boy, on the other hand, had an elder sister who also used drugs though it was not her introducing the drug to him, they did have some occasions using drugs together.

15. One girl, however, described her relationship with family as very good. She used to chat with her mother a lot and go shopping all the time. Yet, her parents didn't like her going out with friends as she grew up. The more they were against it; the more she wanted to do it. So in the end she went out with friends frequently and there she got in touch with drugs. She later even used drugs at home and her family somehow tolerated it. She left home, became to sell drugs and then got arrested.

16. All in all, inevitably, they expressed that when they felt unhappy at home, they sought support from friends where drug use was not uncommon, thus explaining their initial drug use. Such drug use, for all of the teen respondents in this group later turned into addiction and problems.

Impact on Family and Help Seeking:

17. While some parent(s) didn't know about their children's drug use until an arrest by the police, others reported otherwise. One female's parents knew about her drug use at home way before her arrest, they talked to her but in vain. In another case, one boy's mother learned of his drug use when she learned of his stealing from home to finance his drug use. Another boy's mother also knew about his drug use before the arrest and kicked him out of the home. He spent some weeks at his friends' place but finally when he was out of money, he begged to return home. Still, he confessed that he cheated money from his mother to buy drugs without letting her know.

18. They all rated their family relationship below 5 (Fail) at the time they took drugs.

Impact of Intervention on Family:

19. Yet, special notes should be taken that; after rehabilitation at the centre, all of the respondents expressed that their family relationship improved a lot (even up to 8 or 10).

20. One boy described, after his drug addiction, the family relationship was broken. Yet, most of the other respondents could really mend the broken relationship after getting into the centre. Only one boy's mother did not make up well with him because she thought it was a "ball" who introduced drug to his elder brother, who is now still using it.

21. However, interesting about this group of teenagers was that all of them now expressed that they wanted to mend their relationship.

22. One boy told me that, he now learned how to communicate mutually with parents but in the past, there used to be only one-way communication. He further added that his mom and dad also had better relationship because while he was on rehabilitation that could leave more time for the parents to communicate and leave them room to have a break.

23. Another agreed that he was now more willing to communicate.

24. One added that, especially when he could only meet his parent once a month, he treasured the opportunity and thus was eager to communicate.

25. A girl said she now wanted to express her feelings to her parents so much. When she found them understand her feelings, their relationship naturally improved.

Strategies on Parental Response:

26. When asked for suggestions to improve family relationships, one girl said she hoped parents could learn how to allocate time and balance work and family. Another boy suggested that

children should be taught about good and bad from an early age and which should continue through adolescence. One girl suggested that parents learn to balance a child's need for freedom, but at the same time, but not excessively. One boy proposed that parents should also tell feelings to their children, so in the same way, children will share feelings with them, thus having effective communication.

Group 7 – Adult, regular users

Overview:

1. This group consisted of six teenagers referred by a residential drug rehabilitation centre. They were all on residential rehab on an isolated island at the time of interviewing.
2. Our recruitment criteria for this group required participants to age between 18 and 24 and to have used drug(s) as frequently as daily to weekly, 1 year prior to admitting to the centre.
3. They ranged in age from 18 to 23 years old; four male, two female.
4. Three of them were born in Hong Kong, three were not: one in Thailand, one in Shanghai, one in mainland China (city not specified).
5. Three of them were the eldest child in the family (all had one younger brother) whereas two of them were single children, one was the youngest in the family.

Individual Group Members:

6. All were students and had quit school previously. Now four were F.5 students, one was in F.3 and one in F.2.
7. Two respondents' parents were divorced and the other three were still married, one respondent's father passed away when she was small.
8. Five claimed that they were Christian and one held no religious belief.

Drug Experiences:

9. All of them reported trying Ketamine in their lifetime. The second and third common types of drug quoted were Ecstasy and Cannabis. Other drugs tried include Ice, Cocaine and Cough Mixture.
10. As all of them had been for rehabilitation on the island for months or even years, they expressed that they had not used any drug(s) in the past one year.

Role of Family Relationships and Other Factors in Drug Use and Impact on Family:

11. Unlike the teenage groups, this group was able to articulate the family relationships and personal drug use. According to a male respondent, he explained that an unhappy/unsettled/troubled family experience did not explain his initial drug use which he thought was more largely a result of peer influence. Still, it was the negative experience at home that pushed children away from home and allowed peers to win over their parents. In the long run, successive negative experience at home, he explained, could also be an excuse for a youngster to continue using drugs. When he made such a comment, all others agreed.
12. Another female's experience also cast a new way of looking at single parenting. In her case, her father passed away when she was very small. In this way, she didn't feel uncomfortable without him because she didn't have to adjust to his absence, unlike divorced marriage in other families. She further added that as her mother told her that her father had been a triad

member, if he was still alive, she thought that might even cause more trouble to the family. To her, her mother being widowed at her young age seemed to be more easily acceptable to her than seeing parents' divorce in other families.

13. Another female respondent had a different story. She used to "dislike" her mother. She couldn't tell exactly why but she really didn't like her. In a way, she was more attached with her father and brother. However, her thoughts about her mother caused problems in their relationship. In her teenage time, her mother and father were in conflicts too. When her drug addiction was later known to them, the conflicts intensified and contributed to their divorce. The divorce further deteriorated her experience at home and thus contributed to her drug use.

14. There was another similar story. One male respondent used to "hate" his mother because he always thought his mother was pretentious and hypocritical. This also distorted how he viewed his family. Moreover, he also noted that he was raised by a domestic helper, rather than his parents, and felt close to the helper than to his mother before his primary school years. He thought he didn't know much about his parents before that and he added, a helper wouldn't teach him what rights and wrongs were and this somehow affected his value in life.

15. Economic deprivation did not seem to explain why another relatively well-off respondent took drugs. He admitted to being spoilt, having everything since he was small. If he wanted to smoke cigarette, his mother would buy it. Later, when they knew about his drug use, they also kept offering him money, knowing, in the end, it would be used to buy drugs. His family had also sought professional help from clinics/doctors after they knew about his drug use, but all failed.

Impact of Intervention on Family:

16. Like previous group, most rated their family relationship below 5 (Fail) at the time they took drugs. After the rehab, all of the respondents expressed that their family relationship improved a lot and even rated it up to 9.

17. One explained might present a clear picture of how the family relationship improved. He believed that, after his admission into the centre, he himself changed a lot, when his parents saw his changes, his parents also changed as a result. This was how transformation took place.

18. Another girl agreed. As she at first thought she'd rather choose to go to CSD institutions (which was shorter in time) after the arrest. But her mother strongly encouraged her to come to the centre, and she thought the family support was right and now she thought she changed for the better.

Strategies on Addressing Drug Use:

19. When they were asked what government could do to deal with drug abuse among youth, almost all of them suggested more rehab centers should be built. One thing was religious faith that they thought could transform youngsters. The other thing was that they felt such organization of rehab centre could really help improve family relationship and thus this would fundamentally help youngsters to cope with drug temptation and relapse.

Group 8 – Professionals working in Drug Rehabilitation Field

Overview:

1. This group consisted of four professional workers in the field of drug rehabilitation and/or drug counseling. Three were social workers; one was a teacher/principal at rehabilitation centre.

Factors Affecting Family Relationships:

2. First of all, all of the participants expressed that family value now was quite distorted. One especially pointed to the change of value system and the rise of materialism. He thought that parents were too much concerned with money and materials. As a result, parents inevitably had to spend a lot of time on work and thus sparing little time to their children.

3. One added further that some of her clients' family were simply in lack of materials/money, and consequently had to work very hard to catch up with the larger value system. Most of her clients were from less well-off or even lower class family, or were new arrivals. She thought such relative low education background pushed parents to work very long hours at low hour wages, in this way, parents were almost like absent at home, not to mention parenting.

4. Another worker also pointed to another important direction that not only economic deprivation put family in a less privileged position thus exposing children to risks of drug use, but even middle class family might also have difficulties in dealing with this risk. Spoiling was also another risk factor. Especially when parents spent a lot of time on work for more materials and make more money but less time on children, they offered more monetary rewards to compensate such absence at home, and eventually spoiling might put children more at risk.

5. One worker commented that parenting today usually did not involve much fun. In a way, communication between parents and children were usually centered on academic achievement and rewards, which he thought was a distorted, unhealthy family relationship.

Youth Drug Use:

6. Another issue is that some clients had a very pragmatic view on their drug use. For example, one social worker's clients thought pleasure from drugs was good and desirable, though he knew he had to pay a price, e.g., by a few years of jail time, which he thought was worthwhile, because he had plenty of time. With such a distorted cost-benefit calculation, the worker believed somehow his parents in some way shared similar view. In this way, such parenting style could perfectly explain why the kids would follow suit.

Socialization and Discipline in Family:

7. When talking about family, we would also like to include siblings in the discussion, but most respondents told us that their clients usually lived in nuclear family in which extended family relationship were uncommon. Therefore, family support or disciplining by elder siblings was not possible even when parents went to work.

8. About parenting and disciplining, all respondents pointed to one thing that children today were "smarter" than parents. They commented parents' disciplining did not have much success because parents sometimes did not know how to or were even not sure of the moral rights and wrongs. One worker also agreed that many parents they came across were not

sure how to explain how "wrong" drug use was; sometimes it was even the children to teach or socialize the parents about drugs. Parents may be unaware or have limited drug knowledge and methods for addressing adolescent drug use.

9. One worker further commented that schools/education in general had a responsibility to socialize what is right, what is wrong to teenagers, but the education system is unable to do so because of the focus on exam preparations for children to survive.

10. A constructive and positive value system for youngsters, which was used to be instilled by parenting, was generally lacking.

Role of Domestic Helpers in Family Relationships:

11. Another issue raised was the presence of a domestic helper in the household. A worker commented that some of his students felt bad when they were raised/taken care of by helpers when they were small because it was like changing "moms" every three years (helpers contracts end and new helper comes). Effective parenting and disciplining can be disrupted with periodic changes at work in the home.

12. Strategies on Addressing Drug Use:

13. In some ways, if support/training could be provided for parenting would surely help but all workers understood this was not easy to implement. One worker suggested ways like family conferencing to enhance communication between parents and children. Another proposed enhancing residential drug rehab service cum education so that more quality socialization could be allowed for drug-using youngsters.

4.4. Discussion and recommendation

4.4.1   Underlying Causes of Young People's Drug Use

The underlying causes of young people's drug use in relation to their relationship with family were one of the core results we aimed to examine.

4.4.1.1 First Impression - Peers, Personal Choice and Curiosity

Although we had anticipated a more direct connection between youth's initial drug use and family relationships, most young respondents perceived their introduction to drug use as being related to peer influence or as a matter of personal choice. Curiosity factor was also often mentioned:

"Drug use, I'm not saying it's totally unrelated to family, but I think using drug is with a group of friends. Yeah, it takes a group of friends. So it's more about myself, not really relevant to my family…" (YL, regular user, adult, #140)

"I think, peer influence (matters more). I don't think my mom understands me, so I hang out with my friends. That's better. I do think my friends understand me much better…" (CY, regular user, teen, #275,277)

"(family) It's not that relevant. I think it's peers (that matter). I mean, it's like a group of people, hanging out together. We persuaded one and other to take it (drug). Everybody was ready for it. It depended on whether you had the guts to do it or not. So I said, 'ok, I'll try.'" (B, regular user, teen, #283, 285)

However, a teen regular drug user expressed at the end of a discussion session:

"I figure, perhaps there was little communication between me and my family, and I felt that there was no one in the family who cared about me, but my friends could always be with me and it might be this kind of feeling that…so we tried these (drugs) together." (PY, regular user, teen, #299)

In a way, when youth were asked about their initial drug experience, it might be common

for them to explain their use out of personal choice, peer pressure and curiosity. Yet, what pushed from young people to the first trial of drug, to the continuous use of it, and later an addiction, this was somehow instigated by family experiences.

4.4.1.2 Dysfunctional Communication in Family

Youth's Perspective

Young people in the focus groups commonly reported that their parents' paid little attention to them. Likewise, communication with young people in their families was either lacking or ineffective, and sometimes resulted in extreme negative experiences.

For instance, one young adult user told us that *"I hated my mom" (adult regular user, CF, #108)*. He described his mom as hypocritical. Such extreme negativity towards his parent further set the child apart from their family. He further expressed that *"I felt that no one raised me, but my Filipino maid did" (#417).*

Another factor in well-to-do family relating to youth's drug use could be spoiling. One adult respondent confessed that his parents spoilt him both emotionally and financially. For example, his mother bought him cigarettes when he was too young to buy them legally. Likewise, when his parents found out his drug use, money was still provided, which helped finance his drug use (TL, Group 7).

In some relatively economically-deprived families, the picture was quite different. Parents had to work long hours, thus giving little time to attend to youngsters at home. For instance, Apple (Group 4), a teenager from the experimental user group had to take care of herself. Her mother only left money weekly at home and Apple lived on her own. In the cases of PY and Joe (Group 6) in teen regular user group, parent(s) rarely dined with children, not to mention talking to them. It was apparent that young people in such circumstances did not enjoy staying at home. In this way, such negative experiences at home pushed young people out of it and thus in a way exposed children to negative peer influence as discussed above. Whether due to long working hours or other commitments, these young people felt there was neither little time spent together nor little communication.

Parents' Perspective

Similarly, the voices of parents echoed with the young people when it came to the discussion about lack of attention and communication in family. S, a parent of a drug-using daughter confirmed that lack of time to spend with children contributed to lack of understanding her daughter. She recalled,

> "Two years ago, (after her husband passed away), I had to start working. I didn't know what she (her daughter) was doing outside home. When I came back at night, sometimes I found that she wasn't home, I was so scared. So I called her cell phone, but she didn't answer. When she was still not home, I felt so nervous that I called the police. But after calling the police, I was also scared of what would happen." (parent, S, #108)

Professionals' Perspective

While both parents and youth were the core players within a family, it was not easy for insiders to evaluate the situations they were in. Professionals like social workers and teachers for drug-using youngsters provided us different lens to look into the issue.

Their views largely echoed those of parents and youth. Professionals, however, tend to make sense of the issue in terms of social structures. All of them believed that materialism was affecting the value system of both parents and young people. This echoed one comment from a teen experimental user's on his parent, *"money matters more than love"* (講金 o 吾講心) (experimental user, teen, CL #184).

M of the professional group told us,

"I think…nowadays, we have many more materials to satisfy the kids, somehow these mean temptations, and this also makes the parents not really knowing how to care about their kids…I think the parents simply don't know how to." (professional, M, #119)

Professionals further added that disregarding one's socio-economic status, with keen competition in society, parents tended to work hard and thus likely to work long hours to ensure their family's living standard. Parents' absence at home for long hours was common. Parents, especially from low SES background, had to work longer hours, further disadvantaging their

children in terms of family socialization and communication, not to mention fostering an enjoyable and fun atmosphere at home.

"Yeah, I do think this point matters…I mean long working hours, I really do think it's long. It's more like the general societal atmosphere, everybody wants to make more money, like P told us…I would like to share my experience here…my mother was like this. She wanted to take care of us (when J was young) and she had rather chosen to make less money, but at least provided us basic needs, and in the meantime she could have more time to keep an eye on/take care of us. That was what she chose. Like what we said about long working hours…I think if parents try to come back home earlier, say one hour earlier to have meals with the kids, or even see the kids come back home from school…though it means making less money for an hour. Is that important? I think it's really a matter of choice." (professional, J, #121)

"Yeah, minimum wage (could help)." (professional, H, #124)

"Plus maximum working hour (could help)" (professional, J, #127)

Herein lies a critical paradox as parents aspire to facilitate their family's economic wellbeing, and in the process, find themselves sacrificing family development and relationships. Worse still, with the changing family structure in Hong Kong, professionals found out that social

support from extended family was rarely available. Well-to-do families however turned to rely on domestic helpers. Yet, professionals put forward the "changing mom" concept,

"One of the most significant things is, the 'mom' is changing every 3 years. Once the contract of a helper ends, the 'mom' changes. How do you think the kid could adjust and understand?" (professional, P, #146)

In many respects, professionals' comments went along with the youth's voices. For example, professionals echoed youths (Point 15, Summary of Group 7) that parents spoiled children by materials or money, even after they found out their children's drug use. What is more, professionals found that some parents had little knowledge and misled views about drugs. Some could be easily influenced by children's opinions thus delaying the decision to seek help.

"I think it's realistic, in this society, the so-called "critical thinking" means there is no black and white, yes and no answer. Everything has its pros and cons. 'Shit, then how should I teach my son? Using drug is not right, but it does have its pros, just like we said, the drug really works (it makes the users happy) !" (professional, J, #268)

"If we want to find the root (of drug use), I think the kids nowadays know how to manipulate the parents" (professional, J, #192)

All in all, views of youth, parents and professionals gathered from the focus groups converged to a large extent. Lack of effective communications and lack of appropriate strategies available to parents became the most commonly cited theme in understanding young people's drug use whereas how the parents deal with the drug use was found to determine the drug use would later develop.

4.4.2   Consequences of Drug Use on the Family

Immediate Consequences on Family

Consequences of young people's drug use on the family could be understood in terms of different stages. Immediate effects on parents include such emotional ones like worrying, shocking and overwhelming, negative moods, and also physical ones like weight lose. Ongoing impacts include confusion of why children used drugs, uncertainty on where and from whom to seek help, worsening of family and spouse relationship. In some cases, children's drug use became triggers or excuses for further arguments at home, thus further worsening the family relationship, as in B's case,

"One night, when I came back home, my dad was waiting for me…then he asked me, with his knees down. He was crying and asked me not to do it again (take drugs). My mom was sick, he was afraid that I would agitate my mom to death." (regular user, teen, B, #269)

While young people recalled the negative emotions their parents experienced, another parent confirmed this.

"No matter how I cried and cried, how I collapsed and knelt down, he (her child) still went out and left home" (parent, P, #42)

Emotional distress was not easy to handle with, but the lack of helping hands to deal with children's drug use posed further problems.

"Shall I call police? Or shall I send him to the hospital?"(parent, P, #34)

"So, how can I help my son? Where I can seek help from?"(parent, N, #144)

"Psychologist, social workers…I have also thought of (getting help from) them. But I think, are they good? I don't resent them, but I think it's useless. My hutch is…I mean, these are all superficial…I'm not sure…" (regular user, adult, CF, #340-6)

The above reactions seemed to reflect some parents in Hong Kong could be easily baffled and experienced difficulties in coping and seeking help when they discovered their children's drug use.

Multi-directions of Consequences on Family

Drug use of a young member in the family posed consequences to their family members, not only across time, but also laterally, extending to other siblings. TT from regular user group told us how her drug use affected her brother's view on her.

"My second elder brother…he was at that time at school, and I was so bad (doing drugs), some of his classmates knew about this, then he didn't like it. More or less, I affected him (negatively). I suppose he might think, 'it's so pathetic to have a sister like you, it's a shame to the family'. (TT, regular user, #282)

Worse still, TT added,

"So the family relationship became worse and worse, as a result…we just had quarrels at home. Yeah we did, quite badly" (TT, regular user, #284-286)

In Ball's case (teen, regular user), on the contrary, he believed his drug addiction had led to his drug addiction.

"My mom thinks that I made my elder brother used it (drug), so my relationship with mom was like…broken (#221)…he (Ball's brother) used to take it in toilet or his room, but now he even used it in the living room. He just put a line of it (ketamine/cocaine) on the table and snorted it. Everyday he was just like this. It's (his life) just so messy. I see my mom blame herself. She just kept telling me about blaming herself, and also me. She asked me why I made my brother took it in the beginning." (#379)

Consequences on Family after Treatment Services

For young persons (Group 6 and 7) who were undergoing drug treatment services at the time of interview, such residential drug rehabilitation service seemed to have significantly changed the family dynamics. Below is a table showing how respondents in regular user teen groups in treatment evaluated their general satisfaction of the relationship within family before and after receiving drug treatment:

Table 18 Changes in satisfaction score on family relationship before and after receiving treatment service, Regular Teen Users

Respondents	Before admission to drug treatment service	After admission to drug treatment service
S	About 5	10
PY	Around 4 or 5	7
B	Around 2 or 3	Around 5
J	5	8
WL	Around 2 or 3	8
CY	Sometimes 4，Sometimes 7	8

Notes: scoring from 0-10, 0 denotes the lowest whereas 10 denotes the highest satisfaction in family relationship, 5 denotes a pass

It is important to note that all respondents in this group found the relationship improved significantly after the treatment services. The reasons for this could be multiple. S, a regular teen drug user, told us some special moments of experiencing parents' love and affection after his arrest that changed how he viewed his mother differently. In this case, treatment might not be the only lubricants between parents and children, but the arrest could be too.

"When I was arrested, it took 50K for the bail. And then my mom said, 'no matter how much it cost, I have to bail him out', I was deeply moved. (regular user, teen, S, #265)

CF, an adult regular user, further explained how transformation of him at treatment centre inspired his parents to change and thus helping to improve the family dynamics.

"At first, it was me who turned bad. This made them (parents) want to make me change and be good again, by all means. They first started to change. Then when I got into here (Drug Rehab), I kept changing. So it was more like both me and they changed together" (regular user, adult, CF, #389)

Similarly, mother F expressed positive comments on their family relationship/solidarity after her son entered into treatment service.

"I had very bad relationship with my ex-husband. Really, it was all because of my son...I mean, now, two of us (F and ex-husband) could talk about many things. So our

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relationship improved. Even we couldn't be a couple again, but at least in front of the son,

we're doing good…our relationship improved a lot"(parent, F, #208)

F further added,

"Umm…how should I put…basically the (family) relationship was so bad when things (drug use) happening to my son. But when he changed so much and is now so much better, actually, the energy of the whole family is very important. Coz the whole family (F's family and F' ex-husband's family) is so supportive, I mean supporting him to come to here (Drug Rehab) and we support him every step he makes in the future…My mom (i.e., son's grandmother) hasn't seen him for half a year and she came all the way to see him. It becomes…my own family and my ex-husband's family have become more connected and the relationship is more consolidated" (parent, F, #225)

Effective residential rehabilitation services not only assisted drug users, but also their family in a way that family members could have a break away from their child and they could adjust to the changes happened.

"Ummm…I think, it must take the rehab centre to play a part to make things work…and I think this is very very good. For sure, for my daughter, and including my family, if you ask me about the role of the rehab centre (in helping her daughter), I'll say 90% or above is about the centre. It takes the centre to complement. I mean the environment here, all

these things make her change, or let her have chances to grow up. This made me feel

safe…this actually means some adjustments to our family. It even helps us adjust our

family relationship…or if there are different things, and we (parent and daughter) could be

in different locations and to really think things over. Over here, there are teachers,

instructors, principals…all are so good and they adopt various methods, to make things

work…I think it's really good (weeping)." (parent, N, #240)

"Half of the change is because of myself, another half is because of what I learned here"

(about the effectiveness of rehab centre) (regular user, adult, WL, #429)

4.4.3   Parents' Responses to Young People's Drug Use

Family relationships and structure was not only linked to drug use, but also found to

determine how drug use of young family members was dealt with. A functional family with more

stable structure and strong relationships dealt with the suspected addiction much more

decisively and promptly.

N, a mother of a drug-using girl, told us that she immediately sought professional help

from a counselor after she discovered her daughter's addiction. Medical check-ups and a

cognitive function examination were also carried out (#49-65).

On the contrary, S, a previously teen regular user told us,

"After I took drugs and fell asleep, my parent came home, so they knew about my use

finally. They kept scolding me even if I was sleeping. I didn't know what they scolded about,

I only knew they were scolding, but I just let them do it while I was sleeping…after that, they didn't scold me much, because they knew if they did so, I wouldn't listen to them for anything, that would be worse" (#187-189)

Parents' responses to children's drug use varied. This ranged from scolding (S, Group 6), spoiling (YL, Group 7), calling police (a case reported by J, Group 8) to seeking help from medical professionals (N, Group 3). These were immediate responses.

Other long-run strategies reported by the professionals might provide some clues. P and M of the professional groups told us that they witnessed some parents who tried to set an example to their drug-using children by paying efforts on quitting smoking, gambling (#196-199) and getting sex services (#214-6) so as to inspire their children the need and determination to quit. Generally, they found family re-socialization and modeling strategies work.

4.4.4   Other Empowering Factors for Parents

It is easy to say that if parents acted promptly, properly and decisively enough, that might affect the pathway of their children's drug use, and thus shape the consequences of drug use. However, professionals pointed to other factors that could emotionally and practically equip parents better if they are to assist their drug-using children.

First of all, M in the professional group did not think family alone could change.

"In my opinion, I mean, it's difficult to ask one's family alone to initiate change, because everything is connected. It has to be a system. Let's say, I suppose the government should prioritize what to be done first. For example, there are many programs and strategies which are 'scratching the surface' only...say, the government is telling people not to take drug, not to get in touch with it, but they usually stay on a remedial approach. Perhaps they don't know about the problem deep enough. They might think kids take drugs because of curiosity, so they provided support, some activities to prevent, yet without examining the essence of the problem. What we talk about today, like consumerism, the government might have overlooked this, so that the strategies they launched are usually piece-meal, but not in a systematic, holistic approach. If I am a parent (of a drug-using kid), I see there're a lot of programs available, but it's more like some fragmented medicine prescription but not a therapy that could be sequential."(professional, M, #328-330)

In P's words, lack of holistic youth policy, dysfunction of education and distorted information on anti-drug campaign had to be taken note of.

"Don't you know that? There's no youth policy in HK!... One more thing, the government anti-drug publicity has to be upgraded. The advertisement always says 'I need to get off the bus every 15 minutes (after long-term use of Ketamine). But my clients immediately pointed out, 'when I used Ketamine, I won't go out but stay home, I don't need to get off the bus every 15 minutes!" (Professional, P, #332)

"The definition of 'education' is very narrow here, that means the place where teaching takes place. But a school is where a teenager grows up in. So far, social workers at school…it's been a while, but there's no review, say how to be a social worker? There's no way out. Some breaking news come, today it's fighting, tomorrow it's drug dealing, are you going to do conferencing every day? There's still need for other task. But… I think the platform of school has to be reformed….If there's positive atmosphere in schools, positive experiences or a replacement…I mean…God provided music as an art, it's for fun. I used to lead a ball team in secondary school, there were 3 matches in one season only. It's humiliation! There're so few chances. In high schools in other countries, there were at least 20 or so matches for warming up before getting into finals, I mean for some average teams. Actually, students in Hong Kong are really bored! (laugh) (professional, P, #359)

In this way, strengthening the family is one of the many strategies needed to deal with drug use of youth, however, other structures, like the provision of holistic youth policy; the assistance of effective mass media messages and positive experiences in education might all contribute to keep youth away from drugs.

4.4.5 Risk and Protective Factors of Youth's Drug Use

4.4.5.1 Risks Within Family: Failing Family Dynamics, Single Parenting, Economic Deprivation & Dysfunctional Communication

Single parenting, nevertheless a factor which has been commonly believed to be a key risk factor to youth's deviance, is found to be in need of careful examination in our study. GU, an

adult experimental user who grew up in a single-parent family expressed that he had asked himself, if he were not raised in a single parent family, would he grow up differently? He thought it might be true in a way that a greater deal of parental supervision could be provided with both parents at home, which might in turn steer him away from drugs.

Another participant CZ, who grew up in a two-parent family, questioned this assumption that the presence of both parents in a family would necessarily ensure sufficient parental supervision and effective guidance. To him, even if a family consists of both parents, but the lack of effective guidance and communication from parents would still pose risk on children.

Chuen, another young adult experimental user, however, thought single parenting did account for the relatively low SES status of his family which in a way increased his chances of being at risk of using drugs. Chuen, whose family is a CSSA recipient, believed that it was economic deprivation that aroused further conflicts between his father and his step-mother which annoyed him and thus driving him to drugs (adult experimental user group, p.11). He told us,

> *"I think if a family is more intact. And if life is easier, with more money, I don't think I would get in touch with this stuff (drug).] (Experimental user, adult, Chuen #328)*

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Yet, participants in this group further discussed and expressed they had witnessed other well-to-do families whose children also took drugs, although the choice of drug would be some high-end ones like Cocaine (#305).

Likewise, N, a full-time mother from middle-class background expressed that she had difficulties in accepting the fact her daughter was addicted to drug because she would not believe this would happen to a family of her background.

"My daughter…she used it (drug) for fun. When she felt unhappy…her classmates were all doing this (taking drugs), so it was nothing special. And I realized that she also felt that everybody was doing it. Then I thought…it was so shocking to me. I immediately asked myself 'Why?' To us (the whole family)…we're from middle class background, and we went to church since she was small, and we all went together…it was such a shock" (parent, N, #59

Professionals' opinions revealed that, middle class family had concerns other than insufficient economic resources which posed barriers in establishing happy family life. For instances, the focus on success and achievement of children inevitably imposed pressures on both parents and youth, thus heightening tensions within family. Materialistic concerns might also imply longer working hours of parents and thus less time to be spent with children, further exploiting the chances of effective communication, increasing the risks of young people's drug use.

Interestingly, GU of experimental adult group (Group 5) reiterated that if he had the economic resources, he would turn to other hobbies and interests instead of drugs. In this way, GU and Chuen both tended to believe that economic deprivation was pushing them towards drug use.

From the above discussion, the interaction of the three factors: single parenting, economic deprivation and dysfunctional communication became revealing. Single parenting disadvantaged a family in terms of economic resources and emotional support. Yet, internally, when parents have difficulties in establishing effective parenting methods and style, even with the presence of both parents in family and the advantage of abundant economic resources, such privileged predisposition could still be translated into lack of parental supervision and guidance, thus fostering unhappy family life, which equally posed youth to higher risks towards such deviant acts as drug use.

4.4.5.2 Risks Outside of Family - Easy access to Drugs in Immediate Neighborhood

Other risk factors like drug use of parents and/or siblings (CU of Group 4; WL of Group 6) as well as the use of drug of male partner influencing female respondent (Mary of Group 5) had emerged once or twice in our data set but no patterns were found. However, easy access to drugs within immediate neighborhood was another commonly mentioned risk factor.

In a way, it could be understood that negative experiences in unhappy family life pushed youth away from home, and exposed them to peers influence. When readily availability of drug in neighborhood was at work, it pulled youth towards the initial use of it. It is also important to note that such initial use of drugs always took place in forms of groups of peers, thus enhancing the first experience.

Respondents' drug choices ranged from sniffing solvents, drinking cough mixture, smoking cannabis, to such most common ones as snorting Ketamine and taking Ecstasy, and even escalating to smoking Ice and Cocaine. Drug dependence was more prominent among regular users (who were in drug rehabilitation) whereas experimental users expressed that they used drugs occasionally only. Importantly, both regular and experimental users expressed that availability and supply of drugs, especially Ketamine and Ecstasy, was rarely a problem. Ketamine, in specific, was reported to be easily accessible at schools, classrooms and also generally in the neighborhood like karaoke, parks etc.. What is more, such drug as Ketamine was found to be relatively affordable. Respondents usually reported financial problem only when dependence developed. In other words, social and occasional use of it was not likely to burden youth financially, hence allowing the continuous use of it.

4.4.5.3 Risks Outside of Family - Negative Experiences at Schools

It is equally worth noting that negative experiences not only originated from unhappy family relationship but also from schools. Most of our drug-using respondents were not academic achievers. Dropping out of schools was common, sometimes by choice, sometimes due to police

arrest or dependence of drug. Disinterests in schooling and the associated activities further put them at risk. As a teacher of a treatment rehabilitation centre commented,

"Students in Hong Kong are really bored! (Laugh)" (professionals, P, #359)

Protective Factors

4.5.4   Protection within Family - Functional Family Communication

The importance of functional and effective family communication became apparent when drug-using respondents were compared to non drug-using ones. In both non drug-using teen and young adult focus groups, it was not uncommon to find respondents used such adjectives as "*positive"* and *"warm"* to describe their family relationship. Non drug-using teens also tended to have more regular family activities and gathering (*e.g. Yum-cha*). It was also common to find them having close ties not only with parents but also with siblings.

For instance, father of TL (Group 1) had to work late in weeknights and it was not easy for them to have dinner together. However, Sunday outings were regular family gatherings every week that he could not miss. Parents, young sister and TL went hiking, fishing and dinner together. He expressed that he enjoyed every moments and always looked forward to it.

C (Group 1), an academic achiever at school in the non-drug using teen group further explained how her family communicated.

"Ummm…I like my mom and dad…I'm quite busy all the time, and we couldn't spend much together in weekdays…and they (mom and dad) like…um, they're not annoying, but they

always asked me questions. Like 'do you have to go to school tomorrow?'…they kept

asking me whether I have to go to school on Saturday…as I always went out. Even if I

didn't go out, I still have to work (do homework) at home, very busy…then they would

always talk and talk at home, because they like to talk to each other. Coz mom and dad

had little time to themselves either, they would squeeze time to talk…but sometimes I

found them quite noisy…(laugh)" (#648)

Participants of the young adult experimental users group proposed an idea of "re-socialization of parents". All of the participants agreed that parents should learn all over again on how to communicate with children.

"Researcher: Does Chuen mean parents should learn how to be parents again?

"GU: I think it's about parents learning how to be friends (with children)."(All nodded their

heads) (#582-3)

4.4.5.5 Protection within Family - Accommodating Family Atmosphere

Communication time would be limited for most families in Hong Kong, but if parents were willing to squeeze time to make quality time together, communication could be effective enough to make children "*like*" their parents, thus fostering a happier family life and protecting youth from risks of drug use.

Another non drug-using adult described her family relationship as not perfect, but she said,

"I felt that we love each other and care about each other. But I don't think it's easy to change one's value, so we do have some conflicts sometimes, it's unavoidable, but we do care about each other." (non drug-using adult, K, #396)

In a way, a tolerating and accommodating atmosphere could promote senses of love and care, even when conflicts arise in family.

4.4.5.6 Protection within Family - Effective Family Socialization

V, a young working adult from the non-drug using group told us his father insisted that dining together at night had been very important.

"He wanted to keep our family in harmony by this (dining together) (#336).

V's parents also provided deliberate guidance about negative effects of drugs and reminded her of such effects from time to time. Plus, strict discipline like curfew was required for V. Most importantly, V, as a working adult, did not show resentment to such measures.

4.4.5.7 Protection within Family - Ability to Notice "Early Warning Signs"

Ability of parents to take notice of early warning signs of drug use was found to be a protective factor to guard against youth's drug use to develop into addiction.

"My mom…took notice of how I acted…she saw me…when she talked to me…she said I was very slow. She also told me I used to be like 'retarded' and something like that. Then she asked me, is that the drug that made me like this. She also said I lost temper easily, coz I used to keep scolding her…and when she rang me, when I was on high, I talked more than usual. I talked about this and that, about myself, which I wouldn't be so in other times. But when I found myself talked too much, I hung up the phone…" (JY, regular user, adult, #260)

In other words, whether parents could take notice of such early signs of behavioral changes as turning up late for dinner irregularly, leaving home early and returning late, asking for more money, retarded reaction, bad temper, unstable moods etc., could better prepare parents and youth to face with problems associated with drug use. Still, if school teachers and other professionals in the society could also lend a helping hand earlier to assist parents to take notice of the children's drug use, the positive impact would be multiplied.

4.4.5.8 Protection outside of Family - Having Motivations, Aspiration and Life Goals

Teens in non-drug using group had a heated discussion about their dreams. One wanted to be a medical doctor, another wanted to finish reading a Chinese Classical Writing so as to predict the world future with the philosophy, one even wanted to investigate the possibility of time travel. These goals seemed far but they were not shy to talk about.

More importantly, teens in this group had strong affiliations and attachment with various kinds of extra-curricular activities (e.g., church activities, sports games etc.). Unlike drug using

teens who usually showed anxiety on inability to "kill" time, non-drug using teens expressed that their life was fully occupied and they had not enough time. "*Busy"* was always the adjective to describe their daily life.

4.5. Conclusion and recommendation

Although the focus group method is limited as it provides a "snapshot" of a diverse group of individuals, this diversity can be beneficial as it reveals the complexity of a particular social issue, as in this case, the relationship between drug use and family relationships. The focus groups included a range of youth experiences in different age/life stages and family relations (and structures). Professionals provide additional insight as well as a way of confirming the discussions among young persons.

The key themes and sub-themes include:

1. *Underlying Causes of Young People's Drug Use*

    a. First Impression - Peers, Personal Choice and Curiosity

    b. Dysfunctional Communication in Family: Youth's Perspective; Parents' Perspective; and Professionals' Perspective

2. *Consequences of Drug Use on the Family*

    a. Immediate Consequences on Family

    b. Multi-directions of Consequences on Family

3. *Consequences on Family after Treatment Services*

4. *Parents' Responses to Young People's Drug Use*

5. *Other Empowering Factors for Parents*

6. *Risk and Protective Factors of Youth's Drug Use*

   a. Risk factors

      I.   Risks Within Family - Failing Family Dynamics, Single Parenting, Economic Deprivation & Dysfunctional Communication

      II.   Risks Outside of Family - Easy access to Drugs in Immediate Neighbourhood

      III.   Risks Outside of Family - Negative Experiences at Schools

   b. Protective Factors

      I.   Protection within Family - Functional Family Communication

      II.   Protection within Family - Accommodating Family Atmosphere

      III.   Protection within Family - Effective Family Socialization

      IV.   Protection within Family - Ability to Notice "Early Warning Signs"

      V.   Protection outside of Family - Having Motivations, Aspiration and Life Goals

There are several themes running throughout the focus group discussions. First, that young people's initial drug use must be understood in the context and primacy of their peers. Second that both young people and their children recognize the lack of communication in the family, and want to develop the ability to have meaningful interactions. Third, that youth and their family relationships are heavily shaped by parents' work and other commitments in a culture which is perceived to place heavy emphasis on materialism. This can add further pressure on parents and their children. Fourth, those at the community and education levels, young people tend to thrive in an environment of creativity. We identify the following primary needs:

1. *Family/ parents*

    a. Family's strength, support & care including grandparents

    b. Improved family relationships (e.g., less arguments) also helped

    c. The space, the distance & separation (that they were at ZSC- safe and receiving education)- the need for residential rehabilitation facility

2. *Young people*

    a. Own willingness to change

    b. Both parties (parents & children) change

    c. Family's tireless love (did not feel before admitting to ZSC),

    d. Re-learned how to communicate (both parties- listen & talk)

    e. Need for Effective Residential rehabilitation facility

SPECIFIC RECOMMENDATIONS BASED ON FOCUS GROUPS

1. *Young people*

    a. Learn to communicate with family members

2. *Family- stability & relationship*

    a. Spend time together e.g., dinner, doing fun things, let children enjoy being at home

    b. Learn to communicate with children

    c. Equip with parenting skills

    d. Seek help promptly & decisively

    e. Support "at risk" families (e.g., single parenthood, family members abuse drugs [or history of])

3. *Services provision*

   a. Accessible, meaningful interventions

   b. Residential rehabilitation services

4. *Professionals*

   a. Wider context: Family, society, culture & youth policy

   b. Replacement, satisfying & meaningful activities for young people

   c. Residential rehabilitation facility

   d. Family conferences

   e. Re: prevention & health promotion- more relevant and in-depth

5. *Wider context*

   a. Youth policy: Youth engagement through meaningful "youth led" programs in and out of

   school.

CHAPTER 5: IN DEPTH CASE STUDIES OF YOUTHS WHO DO NOT MATCH A DIAGNOSIS OF SUBSTANCE –RELATED DISORDER

5.1 Background

It has been suggested that the most salient change in the pattern of drug use among young people around the world since the 1990s has been the rapid ascent in popularity of party drugs, such as ecstasy and ketamine, commonly used in rave parties, discos, and clubs (Joe Laidler, 2005). Parker and colleagues (2002) proposed the normalization thesis that attempts to describe and explain the popularity and the changing nature of drug use among young people in the context of the post-modern and risk-laden society. The normalization thesis points at three major aspects of the normalization phenomenon, namely, *a rapid increase of the prevalence of drug use in young people*, *the widespread popularity of recreational drug use*, and *a receptive attitude towards drug use as a normal part of leisure* (Parker, 2003).

Cheung and Cheung (2006) studied the normalization thesis in the Hong Kong setting and found that the normalization of drug use among young people has occurred in Hong Kong, but the extent of normalization is smaller than those in Western societies like the United Kingdom. They suggested that the possible reason that explains the cultural differences is that youths in Hong Kong adopt a collectivism mentality that as long as the youths possess family and school social capital, youths are unlikely to engage in drug use behavior. In other words, youths who have less parental and school support, and with socially and educational disadvantages

experiences, the so-called marginalized youths, are much more likely to develop drug use behavior.

The normalization of drug use has also brought challenges to the professionals, especially psychiatric and psychological professionals, in identifying and intervening youths with drug use behavior. One of the most difficult challenges in identifying these youths is that many young people taking party drugs may not fit the clinical diagnostic criteria for substance abuse (Parker, 2003). The clinical definition of substance abuse is used that does not meet criteria for dependence but that still leads to clinically significant impairment or distress including failure to fulfill major role obligations (at school, work or home), recurrent use in physically hazardous situations, recurrent substance-related legal problems and persistent or recurrent interpersonal problems related to substance use (DSM-IV-TR, American Psychiatric Association, 2000). However, because of the normalization phenomenon, youths who take party drugs recreationally and occasionally may not show obvious significant bio-psycho-social impairments which leaves many of their drug use habits unknown and unidentified by their older counterparts, especially, families and professionals (Usher, Jackson, & O'Brien, 2005). Moreover, the harmful effects of party drugs are relatively less severe or have yet to be found as potent as with other conventional drugs (Chu et al., 2008), young people taking party drugs may not actively seek for professional help because they are less likely to perceive their addiction as out of control (Chung & Shek, 2008).

There is increasing evidence that the family plays a key part in both prevention and intervention, both through inducing risk, or encouraging and promoting protection and resilience.

According to a review paper on the role of family on youth drug use problem by Velleman and colleagues (2005), a large number of family processes and structures (i.e., family cohesion, communication, management and attitudes, parental modeling of behavior, parental supervision, parent influences) are identified to be associated with young people commencing substance use and later misuse. These processes, alternatively, can also serve to increase young people's resilience in resisting or recovering from substance use. In Hong Kong, parenting styles, family functioning, and parent-adolescent conflicts were found to be significantly related to adolescent problem behavior, including drug use (Shek, 1997, 2002, 2005). Nevertheless, there is a paucity of qualitative studies being conducted in Hong Kong to study the role of family in adolescent drug use (i.e., Sim, 2006, 2007; Sim & Wong, 2008).

In the light of the impact of the normalization of youth drug use pattern, the significant role of families in drug use problem, and the obstacle of identifying and intervening youths taking party drugs, the present exploratory study aims to qualitatively uncover factors evolving under the three identified observations of the current pattern of drug use by youth in Hong Kong. Specifically, we aim to investigate the role of family both as a potential root cause and solution to the problem of drug use by youth who do not match a diagnosis of substance-use disorder, and the role of non-psychiatric medical services in the intervention of the problem.

5.2 Methodology

5.2.1 Respondents

A qualitative research design was used in attempt to uncover factors deserving of further research. Four youths who were known to have taken party drugs (regardless of their severity) were recruited for participation in the present study. The four respondents were recruited through medical professional (i.e., pediatrician) and social workers who have been helping these young individuals. The study was designed and approved for four participants because we pre-selected two selection criteria: a) whether the family member knew about their drug use behavior, and 2) whether the youths were receiving non-psychiatric medical services for their drug use habits) (see the matrix of the four cases based on the selection criteria in Figure 12).

Figure 12. Character categorization of 4 case studies

Case 1: An adolescent ***agreed*** to receive the non-psychiatric medical service that his/her drug use behavior ***is*** known to one or both of his/her parent(s). The adolescent and her father attended the interview.	Case 3: An adolescent ***did not*** receive the non-psychiatric medical service and his/her drug use behavior ***is*** not known to any of his/her parent(s). The adolescent attended the interview by herself.
Case 2: An adolescent ***agreed*** to receive the non-psychiatric medical service that his/her drug use behavior ***is*** known to one or both of his/her parent(s). The adolescent attended the interview by himself.	Case 4: An adolescent ***did not*** receive the non-psychiatric medical service that his/her drug use behavior ***is*** known to one or both of his/her parent(s). Both parents and the adolescent attended the interview.

5.2.2 Semi-structured interviews

We adopted a semi-structured interview procedure in the present study. We interviewed the adolescent, her parent, the responsible social worker, the nurse, and the occupational therapist, and the pediatrician in Case 1; the adolescent, the responsible social worker, the nurse, and the occupational therapist, and the pediatrician in Case 2; the adolescent, the responsible social worker in Case 3; and the adolescent, her parents, and the responsible social worker in Case 4.

All participants including youths and his/her parents were asked to give their consent to participate in the study. A semi-structured interview was conducted addressing their experiences of commencing drug use, family dynamics contributing to their behavior, and the experiences of using non-psychiatric professional services (details about the services can be found in Appendix F). Each interview lasted for about one hour and thirty minutes. The questions used in the interview are listed in Appendix G. All interviews were video-and/or-audio-taped and transcribed verbatim for purposes of data analyses. Each transcript was reviewed sentence by sentence by another researcher to ensure inter-rater reliability. Content analysis was used for finding the themes and patterns of the cases.

Another set of questions were used with the semi-structured interviews with the non-psychiatric medical and social work professionals. The study was first introduced through telephone calls and both verbal and written consents were sought. The questionnaire (Appendix H) was then sent and collected through e-mails. Follow-up phone interviews were conducted to clarify and gather further information. Two pediatricians, three social workers, one occupational

therapist, and one nurse were interviewed. Information gathered from these professionals was included in the thematic analysis.

5.3 Analysis

5.3.1 Socio-demographics

Four adolescents (one male and three females, age ranges from 15 to 17) and two of the youths' families participated in the research study conducted in May and June 2010. Two respondents were recruited from the Substance Abuse Project of Tseung Kwan O Hospital while two were referred by Evergreen Lutheran Center. Table 19 summarizes the socio-demographic characteristics of the respondents at the time of the interview. There are three two-parent families and one single mother-headed family. Of the single parent family, the child was looked after by her maternal grandmother when young. Two adolescents grow up in single child families while two have sibling(s). One family has both parents working while one has both parents non-working .There is one family where the mother and child are immigrants from mainland China. In the single parent family, the mother is a full time housewife living on Comprehensive Social Security Assistance. In another family, both parents held full-time jobs with long working hours till 2006 when the mother suffered a stroke and has been staying at home thereafter.

5.4 Results

5.4.1 Socio-demographics

Four adolescents (one male and three females, aged between 15 ans 17) and two of the youths' families participated in the research study conducted in May and June 2010. Two respondents were recruited from the Substance Abuse Project of Tseung Kwan O Hospital while

two were referred by Evergreen Lutheran Center. Table 19 summarizes the socio-demographic

characteristics of the respondents at the time of the interview.

Table 19. Socio-demographic Background

Case No.	Case 1	Case 2	Case 3	Case 4 (Immigrant)
Age	15	15	16	17
Gender	Male	Female	Female	Female
Education Level	F.1 repeated twice	F.3	F. 4 dropout	F. 2 dropout
Family Structure	Two parent family	Two parent family	Single mother headed family	Two parent family
Siblings	Two elder brothers (24 &20)	Nil	One younger brother (10)	Nil
Parents' Occupation	F: Renovation sub-contractor M: Janitor	F: Exp. delivery M: Housewife (trainer before heart stroke)	M: Housewife on CSSA	F: Retired M: Housewife
Significant Events	The elder brothers are triad members.	In 2006, mother had a stroke and depression Around same time, maternal grandma passed away followed by grandpa.	Dad left 8-9 years ago while mom went bankrupt.	Nil

5.4.2 Thematic analysis

The analysis of the data revealed five clinical themes characteristic of the four

respondents under study: 1) family crisis; 2) attachment with parents/significant others; 3)

factors contributing to drug use; 4) factors conducive to drug withdrawal; 5) issues in tackling

drug use.

<u>Theme 1: family crisis (as a triggering event for the commencement of drug use behavior)</u>

Two girls experienced distinctive family crisis, and reported very little happy scenario in family life. One occurred when the mother suffered a serious heart stroke and then depression. Both the father and the girl mentioned that it was during the period when her needs were not met in the family that she turned to elsewhere for attention.

Youngster: *Due to mother's illness, no one looked after me. My birthday was seven days before my mother had the stroke. My birthday was on the 20th. The maid was fired, and left. And I became the only one staying at home. Mom stayed in the hospital while Dad went to work. When I went home after school, it was only about 4:00pm. It was boring to go home that early. There was no one to keep me company. So [I said to myself] why go home so early.*

Father: *At that time, I had to look after my wife. Therefore, there was not much time left to take care of her [the daughter]. That's why I neglected her.*

The mother had several unsuccessful suicidal attempts (e.g. cutting wrist, drug over dosage etc.). She became obese and was now socially withdrawn. The father was very stressful in caring for the whole family, in particular, his wife whom could not accept the disabilities due to the stroke. The mother lost her job and income. The family then relied only on the father's income and experienced a certain degree of financial difficulty. This created considerable stress and conflicts among the family members.

Youngster: *He [father] was emotional as well. He scolded us: "I am being driven crazy by you two women. You fight with each other endlessly. I could hardly sleep. I have already been*

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under a lot of stress at work." In fact, all three of us were fighting against each other. Usually, when I saw daddy start to grumble, I would shut up because I was afraid that I might upset him so much that even he might abandon me.*

Father: *Yes, I really couldn't cope with the situation. Therefore, during that time, I had to drink a lot to get relaxed.*

In another case, parents had a lot of conflicts over money and father's affairs before the father left the family. The father suddenly disappeared when the girl was about 7. He also left certain amount of debts for the mother to bear. Eventually, the mother went bankrupt. The mother was unhappy, and so did the girl. This obviously created an unhappy childhood for the girl. The girl had gone out for fun since she was very young at age, and during which she started to be acquainted with undesirable peers.

Interviewer: *What happened when your mother knew* [daddy had two other families outside]?
Youngster: *She appeared as if it was nothing in front of me.*
Interviewer: *But you know mommy is*?
Youngster: *I saw her crying.*
Interviewer: *It was very unhappy, right*?
Youngster: *Well, at that time, I did not know how to comfort her so I just ran away.*

Theme 2: attachment with parents/significant others

In three out of the four families, there was a close mother-child relationship with father at the periphery in each of them. In the other family, the relationship between father and daughter was close. All four cases showed some degree of strong tie between the adolescent and one of the parents, in particular the mother. As for the girl who was taken care of by her maternal

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grandmother with supports from uncles and aunts, the relationship between the girl and these relatives was close. The grandmother was nurturing and the girl developed a positive bonding with her.

Theme 3: factors contributing to drug use

(a) Parental monitoring

In all four cases, there were signs of parental incompetence and/or non-acceptance of parenting which contributed to the drug use by the youths. In case 1, the father seemed to be a peripheral figure that seldom involved in disciplining the child. The mother, who had a close relationship with boy, was found not exercising her authority. The mother knew about his drug use behavior but failed to stop him

> Interviewer: *How did you know your mom was aware* [that you have been taking drugs]?
> Youngster: *Sometimes, how to say it? I returned home only half consciously*.
> Interviewer: *Oh yes, that really happened. I mean after you had taken drugs, you might be partially out of your mind. You might not be aware of this but actually your family members noticed it, didn't they*?
> Youngster: *Yes*.
> Interviewer: *Did she ask you directly*?
> Youngster: *No. It would be so embarrassing to ask such kind of questions. She knew that I had a very bad temper*.

In case two, the father was a nurturing figure with close relationship with the girl while the mother used to discipline their only child. When the mother had a heart stroke and could no longer function as a mother and the father had to be occupied with taking care of his wife, the girl lost the necessary guidance from her parents. The mother in case 3 seemed to be unable to

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function as a mother after her husband had left. The duty of looking after the girl was passed to the maternal grandmother, uncles and aunt. It is noted that the grandmother seldom exerted any parental authority.

In case 4, the father surrendered his disciplinary role very early while the mother tended to control by nagging. However, her way of parenting by nagging seemed to be ineffective. The more she nagged, the farther she drove away the daughter. In the eyes of the father, the mother was over-protective. She took too good care of the daughter in the daily routines that made her becoming dependent. He attempted to influence his wife but was unsuccessful. This might contribute to his withdrawal from participating in disciplining the child. In this family, the mother was over-involved and father was sidelined in parental functioning.

(b) Pro- attitude towards deviance

In two cases, the adolescents reported examples of inappropriate modeling and/or pro-deviance attitude in their family. In case 1, both of the boy's elder brothers were members of triad gangs and had antisocial behaviors including drug abuse.

> Interviewer: *When you were seven or eight years old, what did you see about your second elder brother's situation*?
> Youngster: *More or less similar to me*.
> Interviewer: *Did he use Ketamine*?
> Youngster: *I think so*.
> Interviewer: *How did you know*?

> Youngster: *I saw it*.
> Interviewer: At home?
> Youngster: *I did see it*.

Youngster: *He was* [my eldest brother] *even worse. It is difficult to describe. He was more defiant than both of us* [the second elder brother and I].

In this family, the second elder brother attempted to control the boy's deviant behavior. However, it was unsuccessful because he himself was associated with undesirable peers, and conflicts between them ensued. As revealed, the elder brother did not model what he preached and thus, lost his persuasive power in preventing his younger brother from mingling with the undesirable peers.

The girl in case 3 also grew up in a family with undesirable examples from her maternal uncles and aunts who led a lifestyle that did not provide a good model for the child. According to the girl, her uncle took her to disco and bars in Shenzhen and in Hong Kong. Moreover, the relatives took an accepting attitude towards her deviant behavior.

> Youngster: *My aunt said that it was no problem of trying such experience but I should know how to set the limits*.

(c) Being excluded in the school system

None of adolescents reported any positive or supportive experience in school. This becomes a contributory factor to the youth's commencement and continuation of drug use. All adolescents in these cases have experienced different degrees of academic failure. Two youths repeated in F.1

or F.2. Another two youths were school dropouts. They also had other kinds of delinquent behaviors at school such as fighting, bullying and/or possession of drugs. One girl was expelled from the school due to bullying and other behavioral problems.

All four adolescents did not reveal any positive or supportive relationship with peers or teachers in school. The boy reported experience of being stigmatized. He opined that he had been labeled as a troubled student and had been prejudiced against by the teachers.

Youngster: *They thought that I was a deviant. How could I have good relationship with them? That was it.*

According to the boy, he had been beaten by several schoolmates near school during his first year in F. 1. He was the victim. Yet, the teachers considered that it was he who provoked others.

Interviewer: *How did the teachers intervene that made you feel that they labeled you*?
Youngster: *They always thought that I was among those trouble makers.*
Interviewer: *That means they did not consider that you were the victim.*
Youngster: *No, they said that I had provoked others to get being beaten up.*

(d) Undesirable peer influence

All four adolescents had their first experience of drug use associated with peer influence. They took drugs with friends in the park, at home, in disco, on the beach or in the backstairs of the residential flats. They took a variety of drugs including Ketamine, marijuana, and cocaine, etc. The age of first drug taking ranged from 10 to 13. The durations of drug usage varied from 2 to 4 or 5 years. They usually took drugs out of boredom or sometimes when they were unhappy.

Youngster: *It was boring and I had nothing to do. I was bored and had nothing to do. I saw my friends taking drugs. Then, I saw them all lying on the ground. It was awkward to be just sitting there. So naturally you would want to join them and try to see how it felt. Then, trying and trying and the dosage increased.*

Theme 4: factors conducive to drug withdrawal

(a) Family factors

While the family can be a source of trouble that contributes to the adolescent's taking refuge in drugs, it can also be a source of strength that helps the adolescent quitting drug use. In each of the four cases, we can find some positive parent-child relationship. As revealed, the girl in case 4 attributed her decision of quitting drug use directly to the influence by her mother because she did not want to break her heart.

Furthermore, the discovery of drug use by parent(s) in two families and the positive ways they handled the crisis had a deterring effect on the adolescents' drug use. Both of the parents sought outside help to stop their child from self-harming, and they voiced a clear and strong objection to their child's continuation of drug use. In case 2, the father thought that he was no longer capable of controlling the child after she had run away from home. He then proceeded to seek external professional assistance from social worker and police.

The mother in case 4 made it very clear to her daughter that she would send her to drug rehabilitation center if the daughter continued her drug use. This had a positive effect on stopping the adolescent's drug use.

Youngster: *Well, she* [mother] *said if I continued to play [with drugs], she would send me to the drug rehabilitation center*

The discovery by the mother about the girl's drug use is a turning point in the child's drug addiction problem. The mother was tearful. She was sad. She was heart-broken. It was because of her mother, she quitted. She went to the urine test to prove to her mother that she had quitted. The main reason for the child to quit drug use was not to upset her parents, in particular her beloved mother.

Youngster: *That's all. If it had not been for my family members, I would not have quitted* [using drugs]

(b) Peers

By the time of the interview, all the adolescents claimed that they had quitted drug use. The undesirable negative consequence of drug use as shown by the peers appeared to have sounded the alarm in one girl. She had witnessed her friend died out of over-dosage and another one lost his / her mind and turned violent after taking drugs.

Youngster: *That one was really horrendous. At one time, after he/she had taken drugs, he/she chased us with a knife. Then I told my friends that if we could not escape from him/her, he/she would really chop us to death.*

This girl also revealed that the demand from her boy friend as the main factor that had caused her to abandon taking drugs. One respondent revealed that a stable job (positive peer influence from colleagues and boyfriend) could also contribute to protect her from drug use.

(c) Interventions from Medical and Allied Health Professionals and Social Workers

(i) Assessment by medical and allied health professionals

The pilot project on helping youths with party drug use behaviors initiated by the Tseung Kwan O Hospital (TKOH) involves a multi-disciplinary team – pediatricians, nurses, occupational therapists, and social workers. Occupational therapists mainly conduct memory and fine motor assessments that aim to reflect the side effects of substance use in functional aspect in daily life to the youths. The results of the assessment are discussed with the youths, pediatricians, and social workers. Nurses arrange the registration, pre-consultation observation measurement (i.e., body weight, body height, blood pressure, ECG), arranging video viewing and appointment booking. Social workers accompany the youths to the hospital that aims to minimize the chance of default appointment by the youths. He or she also sits in the interview with other professionals where s/he provides information about the youths and ensures that the youths would utilize the information outside the hospital setting. Pediatricians provide medical consultations.

This multi-disciplinary pilot project appeared to be an effective tool in convincing the adolescents about possible damages done to them due to drug use. One youth said that he had found it most scary when the doctor told him about the possibility of becoming slow in responding and the likely damage done to the bladder that might cause him to go to toilet every 15 minutes. He also associated his stomach ache with drug use.

Interviewer: *What was the scariest thing that really made you feel alarming? What did they say*?

Youngster: *How to say it? Retardation in response. Those that would cause problems to the brain. Those were more frightening.*

Interviewer: *Who told you so? The doctor?*

Youngster: *Probably.* [He said] *things like: "You might have to go to toilet every fifteen minutes." It was scary.*

Another adolescent was shocked to notice that she could suddenly lose part of her memory of an immediate event. The terribly poor result in an eye-hand coordination test conducted by an occupational therapist had also raised a big alarm in her.

Youngster: *I remembered very clearly the first time that the occupational therapist asked me to thread the beads. I could only thread a few. In fifteen seconds, I could only thread about five beads. The first time, I could only thread three and then five. My co-ordination ability was horrible.*

Youngster: *I thought the occupational therapist fooled me. What? How come? I remembered the occupational therapist marked on the report and passed it to me. He/she marked a tick in the category of "ordinary" regarding my hands co-ordination ability. Adjacent to that, he/she made a remark – "terribly poor". Then, I said: "What's the matter?"*

Youngster: *It told me how critical I was. Sometimes, you did not know without going through an examination. You could never tell. Perhaps even when you collapsed, you still could not be aware that it was drug related. You could not know you had physical problems. You did not know that you were so poor in limbs co-ordination.*

As revealed, these two adolescents realized the harm and seriousness of drug use only

after going through their own body check and other tests.

(ii) Work done by social workers

All four youth participants received social work services. One participant received help provided by Social Work Department, one by the Hong Kong Federation Youth Group, and two by the Evergreen Lutheran Centre. Two major approaches have been used to initiate the contacts with the youths – 1) out-reaching by social worker and followed up by individual counseling and 2) referral by peers to join a "Beauty and Fashion Group" that involves drug prevention elements followed by individual counseling. It should be noted that two youths received help from more than one social worker (i.e., school social worker, and social worker in a rehabilitating centre) and two received help from one social worker.

According to the participating social workers, they had clear treatment goals with the youths, namely eliminating of drug use behavior, managing school/work problems, and dealing with emotional problems. Although the participating social workers recognized that family was a significant factor that helped initiating and stopping the youths' drug use behavior, they faced several difficulties in engaging the youths' parents: 1) youths did not permit the social worker to reveal the drug use behavior to the parents; 2) they were afraid that breaching the confidentiality between them and the youths would destroy the rapport; 3) some parents, especially fathers, seemed to be uninvolved in dealing with their children's drug use behavior.

After all, all respondents reported positive impacts arising from interventions by the social

workers. For the social workers who could engage the adolescents, they had been experienced by the clients as someone who was capable of providing guidance and showed understanding and genuine concern. One girl had very positive feedbacks about her experience in a residential care service center. She experienced the care and concern from the warden and the discipline from the social worker. Her school life there appeared to have a positive impact on her quitting of drug use.

Youngster: *She [warden] showed super concern over people in respect of everything.*
Youngster*: She [social worker] disciplined me.*

When the interviewer asked what kind of help the boy received from the social worker, he mentioned as follows:

Youngster: *Whatever issue it is, I can consult him.*
Interviewer: *Such as*?
Youngster: *Such as issues at school or concerning friends*.
Interviewer: *What sort of advice is normally given by this social worker*?
Youngster: *Good advice*.
Interviewer: *What advice did he give you*?
Youngster: *He told me to reduce the dosage or to stop altogether*

Theme 5: other Aspects of Service delivery systems

(a) Promotional materials

None of the adolescents believed the messages delivered in public education or other publicity programs. They were not convinced that the drugs would cause permanent or serious bodily harm. They considered that the information in such program was highly exaggerated. They seemed to believe that information even if it was true, did not apply to them.

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Youngster: *The promotional materials said that you had to go to toilet every fifteen minutes. Were you trying to fool me? How could this be possible? I thought it was not possible that one would have to take a urinal bag unless one was deeply poisoned. May be this would happen to people who have been using drugs for ten or twenty years. Yes, I never thought that this would happen to me.*

Some of them believed that they could quit drug use easily.

Youngster*: I thought I did not belong to the category of severe drug abuser. I thought I could quit once I made up my mind. I have never thought that I could be terribly poor [in hands coordination]. My speech and memory abilities were also in critical condition, it was only one step away from hospitalization*.

(b) Family involvement in drug treatment

While the social workers have done a lot of positive works in helping the adolescents in quitting drug use, none of them seemed to have provided services to the family as a whole or had intervened at the family level. In case 2, the father took the initiation to find assistance from social workers to help her daughter and participated in activities organized by the social worker. However, it appears that the focus of service remained to be on the adolescent.

Father: *In the activities for families [organized by the social worker], we [father and daughter] would communicate with each other when we met. In addition, we might sometimes talk over the phone*.

In case 4, the girl introduced the social worker to her mother and the mother would seek advice from the social worker on issues such as how to handle the drugs discovered at home. Again, it seems that the focus was still on the girl but not on the family.

Mother: *I called the social worker. She told me that she knew roughly what it was based on my description. I told her that I wanted to bring it to her. The social worker told me not to do so. She was worried that I might run into a police officer. She asked me to see her in person. I then went to see her immediately.*

5.5 Discussion

5.5.1 Limitations

This is a formative qualitative study of the family involvement in drug use behavior among youths who do not match a diagnosis of substance-use disorder in Hong Kong. We studied four young people and conducted in-depth interviews with them. We also interviewed some of their parents and the helping professionals involved. This study has several limitations that should be noticed. Since the purpose of formative qualitative research is for description and hypothesis generation rather than generalization, the present findings are meant to be exploratory rather than representative of the majority of youths with party-drug use behavior. Although internal validity is supported, given the relatively homogeneous sample of interest, these preliminary findings may not be generalized to dissimilar populations. Also, although two reviewers engaged in a consensus process to derive themes from the data, the use of more reviewers may have fostered a more thorough analysis.

Based on the thematic analysis, we have identified a number of risk and protective factors around five themes: 1) Family crisis; 2) Attachment to family members; 3) Factors contribute to drug use; 4) Factors conducive to drug withdrawal; and 5) Issues in tacking drug use. Although the number of youths participated in the study is very modest, these youths seem to share a very

similar trajectory regarding their drug use behavior. These youths started to experiment with drugs after there was a family crisis (i.e., presence of parent's physical illness, parents' relationship problems), then the parental monitoring became very weak, and the youths disliked school life and did not get along well with teachers and schoolmates. They felt bored and started to hang out with friends outside their schools. Subsequently, they were offered free drugs by these friends (either as a gesture of friendliness or as a form of reward for their participation in triad activities). With the help of the attached parent(s) or significant others and efforts from professionals, the four cases were able to stop using drugs. This trajectory portrays a similar pattern as described in Cheung and Cheung's (2006) earlier empirical study in which they indicated that marginal youths possessed less family and school social capital, suffered more educational disadvantages, and had involvement with drug-taking peers and started to take drugs.

Regarding their termination of drug use, it is interesting to learn that all four cases were able to stop using drugs quite easily, relatively speaking when compared with those who are taking "hardcore drugs". It is acknowledged that this finding may be biased by our sampling methodology because all of them have been receiving some form of medical and/or social services. Having said that, it seems that when their drug use behaviors were known to either family members or social workers, these youths could stop using drugs with little well-known withdrawal symptoms.

Some interesting findings are also noteworthy about the abandonment of their drug use behavior. First, unlike conventional belief, all four cases showed some degree of strong tie between the adolescent and one of the parents. As soon as their parents became more involved

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with their lives, some of these youths would stop using drugs because they did not want to disappoint their parents or to be a burden to their families. Second, the services provided by the social workers seem to be effective in helping the young drug abusers to deal with their problems including drug use. Although we have found that the works provided by social workers varied significantly in terms of length and frequencies, these youths found that the trusting relationships with the social workers were helpful. Third, it is noted that a positive relationship with a certain significant other is a strong motivational factor in quitting drug use. In these four cases, such a significant other could be a social worker, a boy friend or one of the parents. Fourth, the non-psychiatric medical service, i.e., regular physical assessment provided by occupational therapist and nurse, and the consultation provided by pediatricians have helped the drug-taking youths to have a better understanding of the physical harmfulness of drug use on them. They have also provided a platform for multi-disciplinary effort in dealing with recreational drug-taking youths who have yet to develop substance-use disorders that require psychiatric service.

5.3.2 Family – a risk and a protective factor for youth drug use

In the past, peer influences have always been regarded as the strongest predictors of drug use during adolescence and they represent a key construct in numerous theories of the etiology and maintenance of adolescents' drug use (Kandel, 1980a, 1980b). It has been suggested that peer variables not only dominate the prediction of drug use but mediate the effects of other variables (Beauvais & Oetting, 1986). Beauvais (1992) suggested that peers initiate youth into drugs, provide drugs, model drug-using behaviors, and shape attitudes about drugs. The role of

parental influence in youth drug use behavior has been studied recently and studies seem to find

consistent findings to suggest that parental influence play an important role on drug use behavior

as much as peer influence (Baumann, Spitz, Predine, Choquet, & Chau, 2007).

Baumrind (Baumrind, 1996) suggested that although it is normative for youth to

experiment with alcohol and drugs, substance use may be attenuated by parent-adolescent

relationship quality. Brook and colleagues (1983) found that the presence and quality of an

affectionate and non-conflicted parent-adolescent relationship protects the child from substance

use, but that poor parenting practices, high levels of conflict in the family, and a low degree of

bonding between children and parents appear to increase risk for problem behaviors, including

the abuse of alcohol and other drugs. Our findings are in line with these studies. Learning from

the four case studies, poor parental relationship seems to be the "origin" of their drug use

behavior. It is clear to see that the initiation of drug use was introduced by the peers of the four

cases; however, if there were no family crisis initially or there was an affectionate bonding

between the youths and their parents, the non-school peers might not have the opportunity to

introduce the street drugs to these youths. It is interesting to have found that parents have also

played a very significant role in the termination of the drug use behavior of the four cases. In

future large-scale studies, it will be useful to investigate the parental influence/involvement prior

to youths' experimentation and termination of drugs. If the links between these two variables are

found, the information will be very useful for parent education on prevention of youth drug use

behavior.

5.3.3 The role of non-psychiatric medical and social services

The pilot project initiated by the Department of Pediatrics, TKO Hospital seems to have motivated some of our participants to terminate their drug use behavior. The efficacy of the social services provided by a number of committed social workers is remarkable. It has been widely discussed and believed that the help provided to adolescents need to be differentiated from adults and young children due to the unique developmental transformations they are going through. Additionally, adolescents tend to mistrust professionals and often manifest this reaction crudely, intensely, provocatively, and for prolonged periods (Katz, 1997). Also, the harder the professional pushes to resolve the problem of a youth, the worse the situation becomes (Lambie, 2004). As found from the four participants, they claimed that one of the reasons responsible for their termination of drug use was contributed by the work of the non-psychiatric medical and social work professionals. It seems that these professionals have helped the four participants to feel that they were choosing to do something for their own self-interests, rather than taking a confrontative approach. It is, therefore, suggested that future intervention studies may involve a larger number of participants and may attempt to adopt a similar approach but with more engagements with parents.

5.6 Recommendation

Despite the limitations of this small-scale qualitative study, we have identified a number of observations that may hold promise for generating further qualitative and quantitative research

questions and hypotheses. First, as mentioned above, all adolescents seem to be able to quit drug quite easily. This creates a sharp contrast with the image of traditional drug (e.g. heroine) addicts who struggle extremely hard with drug quitting. Indeed, as commented by one of the youths in the study, the existing advertisement on drug prevention not only made no impact on his drug use behavior, but also created an impression in him that the government has been ignorant about the current situation of drug use by youth. Hence, there may be a need to rethink about the framework / paradigm of public education.

Second, it also appears that money is not an issue for these adolescents when they initiated their drug-taking behavior. Moreover, none of our participants has reported involvement in illegal activities for the sake of obtaining drugs. The party drugs that these youths took were either given by their drug-taking peers or purchased with part of their pocket money. Normalization may have weakened the specific relationship between drug use and offence. Hence, one of the most important drug prevention initiatives for Hong Kong is to identify and eliminate the sources of party-drugs smuggling into Hong Kong (if they are made outside Hong Kong).When the supply of party drugs can be reduced significantly, this may eventually lead to an increase in their prices so that the youths cannot afford to settle the bill with their pocket money (whether this will lead to an increase in other offences will become another potential topic for future study).

Third, three of the four youths in the study have identified that they have turned their party drug use habit to frequent alcohol consumption. This means that the adolescents might still

not have learnt the problem solving skills and have relied on substance abuse to stay away from their core problems. Also, the habit of drinking would keep them staying in an undesirable environment such as bars that may be filled with temptations to lure them back into drug use. Underage excessive drinking will likely to be another up-and-coming social problem that our society needs to combat with.

Fourth, we learned that the social workers who have been helping the four youths have adopted an individual treatment modality with little or no family involvement. It is beyond the scope of this study to comment on the effectiveness of family interventions for youth drug use behaviour; however, there is increasing evidence to suggest that family interventions lead to positive outcomes for both mis-users and family members. Some recent interventions have widened the scope to include other members of the user's social networks and have focused on a range of treatment goals (Copello, Templeton, & Velleman, 2006). Recent studies have continued to show that family and network approaches either match or improve outcomes when compared with individual interventions (Velleman, et al., 2005). However, because of practical issues, despite most evidence support interventions with family involvement in youth drug prevention and treatment work, they are not used routinely in practice (Sim & Chiyi, 2009). Research studies and policy initiatives need to focus on dissemination of family approaches and their integration into treatment services.

Last but not least, boredom seems to be a major cause of party drug use for marginalized youths. Because many schools adopt a low- or zero-tolerance to drug use, this may not be helpful as it encourages school-aged youths to conceal, rather than to deal with their drug use. This is

not to suggest, however, that party drug use is a problem-free activity and should be endorsed by schools or it is merely prejudiced against by the society. However, the impacts of our education system and schools on youth drug use behavior remains to be ascertained.

CHAPTER 6:   CONCLUSIONS AND POLICY RECOMMENDATIONS

In Hong Kong, there is about 5% prevalence of drug abuse among our youth of aged 15-24. A higher prevalence was not found among school children but those who are working or school drop-out and unemployed. The drug abusers also have similar risk profiles with other deviant behaviors, e.g. deliberate self harm, smoking and drinking. From the experiences of front-line social workers and research studies, Hong Kong experiences the "normalization" of drug use, especially among marginal youth. The major problem is that they do not consider themselves as having problems or in need of help.

Factors contributing to adolescent drug abuse and the family relationship:

Based on the results of the secondary data analysis, focus groups and case studies, Hong Kong adolescents with a dysfunction family and a poor family relationship are more likely to hazard to take drugs which validate the research questions as posed in Chapter 1.   More specifically, a common trajectory of the youths taking drug is ascertained in this study. Drug use like other adolescent behavioral issues involves a number of factors, some of which *interact or operate jointly*.

1. Dysfunction families due to unstable family (poor marital relationship, family crisis, rising number of divorce, single-parent family), low income and long working hours of family members (limited family time, little attention to young people, poor attachment with parents/significant others), poor/ineffective communication between youth and his/her family (inadequate/poor parenting and bad relationship with parents);

2. Easy access to drugs within immediate neighborhood (convenient supply and relatively cheap cost);

3. Failure of school achievement, feeling boredom and undesirable peer influence;

4. Intergenerational addiction and peer's negative influence (e.g. boy friend who abused drug).

Risk factors

- Parents' divorce, separation or passing away

- Poor and inefficient parenting practices, high levels of conflict in the family, and a low degree of bonding between children and parents

- Felt bored, possessed less family and school social capital, suffered more educational disadvantages, and had involvement with drug-taking peers

- Risks Within Family - Failing Family Dynamics, Single Parenting, Economic Deprivation & Dysfunctional Communication

- Risks Outside of Family - Easy access to Drugs in Immediate Neighbourhood

- Risks Outside of Family - Negative Experiences at Schools

Protective Factors

- Feeling happy about family life, good relationship with parents and acceptance to parenting

- The presence and quality of an affectionate and non-conflicted parent-adolescent relationship

- Protection within Family - Functional Family Communication

- Protection within Family - Accommodating Family Atmosphere

- Protection within Family - Effective Family Socialization

- Protection within Family - Ability to Notice "Early Warning Signs

- Protection outside of Family - Having Motivations, Aspiration and Life Goals

However, with the help of the attached parent(s) or significant others and efforts from professionals, case studies demonstrated that the participants were able to stop using drugs. More importantly, the non-psychiatric medical services have helped the drug-taking youths have a better understanding of the physical harmfulness of drug use on them. They have also provided a platform for multi-disciplinary effort in dealing with recreational drug-taking youths who have yet to develop substance-use disorders that require psychiatric service.

Limitations:

This study used the quantitative and qualitative research methods to examine the underlying causes of the youth drug abusers and its family relationship and to identify problems and needs that young drug abusers are facing in Hong Kong. The source of the secondary data is based on the 2006 Youth Sexuality Study provided from the Family Planning Association. Although it is one of the longest running community-based sexuality surveys in Hong Kong, it only covers three aspects of family antecedents, namely, family structure, quality of family relationship and parenting practices. Therefore, it is imperative to have a longitudinal study to understand the family dynamics and its impact on the adolescents' deviant behaviors, including drug abuse, smoking, drinking, deliberate self harm and casual sex, etc. More socio-economic and family background information should be obtained so that it can properly study how different socio-economic classes and family relationship are related to on the adolescents' deviant

behaviors. Although the Hong Kong Narcotics Division has conducted 2004 Survey and the 2008/2009 Survey on drug use among students, the surveys only asked one family-related question (i.e. are your parents living with you?) which is not sufficient to understand the mechanism of the family dynamic behind why a teenager is more prone to drug taking. Focus should cover not only the school-aged students, but also the school drop-outs, unemployed and marginal youngsters.

Secondly, the qualitative research consists of focus groups and cases studies. Although they are extensively used in research as highlighted in Chapters 4 and 5, they have their limitations, particularly with participants who are reluctant to disagree in public or share their personal experience. Another limitation lies in the teenage sample. Teenagers, in this study tended to show additional hesitancy to share and talk about private issues in the group, especially when other group participants were total strangers.

Similarly, the participant in the case studies also worried about the confidentiality and trust of issues which prevented them speaking openly. In addition, the participants for the qualitative research are convenience samples which were recruited from the NGOs and different stakeholders, e.g. school teachers, social workers, medical social workers, medical doctors, etc. who have already developed consistent contacts with the participants. The present study is meant to be exploratory rather than representative of the majority of youths with party-drug use behavior. Caution should be made when the results are interpreted. For future study, it is

necessary to enlarge the sample size of those youth drug abusers with different socio-economic background who didn't seek clinical and non-clinical professional help.

Overseas experiences:

Based on the overseas experiences in dealing with drug taking among youngsters, there are several strategies and interventions as listed below:

In the U.K., the U.S., Australia, and Canada

• Identifying and reducing the risk factors relating to youth substance use;

• Enhancing protective factors and strengthening the family functioning and attached bonding, maintaining effective communications and harmonized relationships with adults through family-based intervention like parental or family training, provision of nation-wide meaningful youth engagement;

• Addressing the needs of not only the adolescent themselves, but also the young adults, their families & the broader community;

• Acknowledging the importance of supporting parents and the families to build healthy families at an early stage so that children and youth can benefit from growing up in a positive environment, thereby naturally building resistance against delinquent behavior (in the U.K. and Australia);

• Collaborating with different service platform (NGOs and government) to assist at-risk families, so as to minimize drug and other social problems being spread inter-generationally (in the U.K. and Australia);

• Mobilizing different sectors of the community to address the drug issue (in the U.S.);

•	Emphasizing youth-focused community prevention initiatives involving different partners (in Canada).

Taiwan, Mainland China and Singapore: placing more emphasis on information dissemination, school drug education and law enforcement and little to do with risk and protective factors or the ecological framework of drug use.

Local service gaps for combating adolescent drug abuse:

Hong Kong has developed an anti-drug policy which encompasses five areas: (1) preventive education and policy, (2) treatment and rehabilitation, (3) legislation and law enforcement, (4) external cooperation, and (5) research. Over 70 recommendations in a Task Force Report were proposed in 2008 and over 300 preventive programs were subsidized by "the Hong Kong Beat Drug Funds" in the last decade. However, among them, less than 20 programs have parents as their primary target. These programs are typically isolated. Systematic evaluations for the existing anti-drug programs are of dearth. School is mostly considered as an important platform to spread anti-drug messages through drug-testing, recreational activities, and classroom education; these are methods similar to that in Mainland China and Taiwan, but far from effective and satisfactory.

Policy recommendations:

Since most local anti-drug policy and preventive programs are not in view of parents and family as their primary target, a public health approach with a multi-layered intervention in

relation to overseas experiences and the key findings of the secondary data analysis, focus groups and case studies should be introduced:

i. **Empowering young lives and their families** to combat the rise and the spread of drug abuse for Hong Kong population: Drug use like other adolescent behavioral issues involves a number of factors, some of which interact or operate jointly. Efforts on preventions and interventions should be made to enhance protective factors through family-based intervention like parental or family training, provision of nation-wide meaningful youth engagement, and reduce risk factor, instead of focusing on the drug issue per se and individual. The target would not only cover among the school youths, but also drop-out, unemployed or working youngsters.

ii. **Theme: youth-centered** (for, with, and by the youth), family-focused (equal-finality proposition), **community-sensitive** (ecological, public health, social development, broken window (early intervention); cultural/contextual); and **government-led** (top-down directives especially for cross-departmental collaborations) approach focusing on transitional periods and developmental stages:-

iii. **Identify and support high risk families:** single-parent, inter-generational addiction (drug/gambling/drinking), poorer SES (receiving CSSA), having frequent family crises involving school-age children, out of school youths & working youths through the cooperation of different sectors of the community (i.e. outreach social workers, non-clinical & clinical professionals, teachers & schools, police) & link with referral of family services (e.g. in-home family support);

iv. **Nurture positive family relationship:** a family-friendly working environment should be promoted and reinforced in Hong Kong, e.g. a 5-day work for all sectors (including non-civil servants); annual family-recreation and travel coupon: HK$500 per family; offer free and regular parenting and communication skill trainings at the district level, schools and universities, in different workplaces and community centers (e.g. Family Parent Association); at least 1-week paid paternal leaves for any following reasons such as childbearing (for father), sick children and elder parents (both for father and mother); reduce the long working hours (e.g. 12-hour work for 6-day in a week to meet ends for low income families is NOT conducive for promoting positive family relationship at all);

v. **Enhance community-based involvement and neighborhood responsibility:** especially for poorer household income and at-risk districts - open school and other premises in the district (e.g. library, playground); frequent friendly police patrols after school and white-collar drug bars (the visit by the police within the neighborhood is excellent how we can mobilize the existing resources for prevention. The community suicide prevention work in the Eastern district and Cheung Chau are good examples); cooperate with business sectors to offer free quarterly or bi-annually family recreational activity tickets (such as Disneyland, Ocean Park, museums, swimming pool and sport centers etc.); weekly family-discount transport ticket; organize more family-based overnight outreach programs through NGOs and partnership with district councilors;

vi. **Curb drug sources:** assign more sniffer dogs and make random drug tests at the border between Mainland and Hong Kong to handle cross-border drug (the measure of imposing

drug tests at school might not be effective); liaise with the Mainland authority in making it more difficult for our young people to get hold of the drug;

vii. **Extend professional trainings:** develop a manual to work with children and parents in dysfunctional families; provide more trainings, seminars & workshops for identifying at-risk families and suggesting measures to strengthen family protective factors that can be held at the district level & school-based with the support of the Parent association in the school; family and school doctors as trusted professionals in the neighborhood and in the workplace to provide family parenting education and early identification and help family to develop resiliency;

viii. **Launch evaluations for existing anti-drug programs:** collaborate with universities for systematic evaluations to examine how different programs modify the youth's drug-related attitude and behavior in the long run;

ix. **Reform the mindset in the educational system:** make school curriculum more attractive and develop interactive joint parental activities; internalize the importance of family values; reshape the belief of the success (should not rely only on good results, but also more importantly developing a full competent, self-regulated and caring person); more diversity in multi-talented program should be embraced and alternative boarding schools should be offered;

x. **Others:** disseminate credible anti-drug and family-harmonized environment messages/slogans and appoint youth-respite and drug-free ambassadors through public events.

REFERENCES

For Chapter 2

Ackard, D., Neumark-Sztainer, D., Story, M., and Perry, C. (2006). Parent–child connectedness and behavioral and emotional health among adolescents. *American Journal of Preventive Medicine, 30* (1), 59 – 66.

Ali, R. (2010). Taking risks by examining our practice: Encouragement to address the couple relation. *Clinical Child Psychology and Psychiatry, 15* (2), 147 – 150.

British Columbia Council for Families, Canada (2009). *Young Parents: The Importance of Support and Recognition.* Retrieved June 15, 2010, from http://www.bccf.ca/all/resources/young-parents-importance-support-and-recognition

Bamberg, J., Toumbourou, J., & Marks, R (2008). Including the siblings of youth substance abusers in a parent-focused intervention: a pilot test of the BEST Plus program. *Journal of Psychoactive Drugs, 40* (3), 281–291

Bancroft, A., Wilson, S., Cunningham-Burley, S., Backett-Milburn, K., & Masters, H. (2004). *The effect of parental substance abuse on young people.* University of Edinburgh: Centre for Research in Families and Relationships. Retrieved May 22, 2010, from http://www.jrf.org.uk/publications/effect-parental-substance-abuse-young-people

Barnabas Charitable Service Association. (2010). Survey report on the drug-taking attitude of senior primary school students. 高小學生嗦 K 態度問卷調查結果. Hong Kong: Author. (In Chinese)

Barnard, M. (2005). *Drugs in the family: the impact on parents and siblings.* UK: Centre for Drug Misuse Research, Glasgow University. Retrieved May 22, 2010, from http://www.jrf.org.uk/publications/drugs-family-impact-parents-and-siblings

Baumrind, D. (1996). Parenting: The discipline controversy revisited. *Family Relations, 45*, 405 – 414.

Belsky, J. (2001). Developmental risks still associated with early child care. *Journal of Child Psychology and Psychiatry, 42* (7), 845–60.

Billing, A., Ehrle, J., and Kortenkamp, K. (2004). Children cared for by relatives: What do we know about their well-being? Washington, DC, Urban Institute, *Assessing the New Federalism Project, 2002.* Retrieved May 20, 2010, from http://www.urban.org/publications/310486.html

Bittman, M. (1999). Social participation and family welfare: The money and time costs of leisure. *Discussion Paper No. 95. Sydney: University of New South Wales Social Policy Research Centre.* Retrieved May 31, 2010, from http://www.sprc.unsw.edu.au/media/File/dp095.pdf

Booth, A., Scott, M., and King, V. (2010). Father Residence and Adolescent Problem Behavior: Are Youth Always Better Off in Two-Parent Families? *Journal of Family Issues, 31* (5), 585–605.

Boyle, M., Sanford, M., Szatmari, P., Merikangas, K., & Offord, D. (2001). Familiar influences on substance use by adolescents and young adults. *Canadian Journal of Public Health, 92* (3), 206 – 209.

Bradford, K., Burns Vaughn, L., and Barber, B. (2008). When there is conflict: Interparental Conflict, Parent–Child Conflict, and Youth Problem Behaviors. *Journal of Family Issues, 29* (6), 780-805.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Bronte-Tinkew, J., Moore, K., and Carrano, J. (2006). The father-child relationship, parenting styles, and adolescent risk behaviors in intact families. *Journal of Family Issues, 27* (6), 850 – 881.

Brooks-Gunn, J., Han, W., and Waldfogel, J. (2002) Maternal Employment and Child Cognitive Outcome: The NICHD Study of Early Child Care. *Child Development, 73* (4), 1052 – 1072.
Ann Arbor, MI: Society for Research in Child Development.

Brook, J., Brook, D., Zhang, C., and Cohen, P. (2009). Pathways from adolescent parent-child conflict to substance use disorders in the fourth decade of life. *American Journal on Addictions, 18* (3), 235-242.

Bry, B., Catalano, R., Kumpfer, K., Lochman, J., and Szapocznik, J. (1998). Scientific findings from family prevention intervention research. *National Institute on Drug Abuse, Research Monograph Series 177: Drug Abuse through Family Interventions*. US Department of Health and Human Services, National Institute of Health.

Cabinet Office Social Exclusion Task Force, U.K. (2008). *Think Family: Improving the life chances of families at risk.* Retrieved May 7, 2010, from http://www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/think_families/think_family_life_chances_report.pdf

Canadian Centre on Substance Abuse (CCSA), Canada (2009). *Communiqué: A drug prevention strategy for Canada's youth. National Advisory Group on Youth Suhbstance Abuse Prevention (YSAP).* Retrieved May 3, 2010, from http://www.ccsa.ca/2009%20CCSA%20Documents/YSAP-comm-1n3-2009-e.pdf

Canadian Centre on Substance Abuse (CCSA), Canada (2010a). *Youth Drug Prevention.* Retrieved May 3, 2010, from
http://www.ccsa.ca/Eng/Priorities/YouthPrevention/Pages/default.aspx?print=true

Canadian Centre on Substance Abuse (CCSA), Canada (2010b). *Building on our strength: Canadian Standards for Youth Substance Abuse Prevention, version 2.0.* Retrieved June 19, 2010, from
http://www.ccsa.ca/Eng/Priorities/YouthPrevention/CanadianStandards/Pages/default.aspx

Catalano, R., Oxford, M., Harachi, T., Abbott, R., & Haggerty, K. (1999). A test of the social development model to predict problem behavior during the elementary school period. *Criminal Behavior and Mental Health, 9*, 39 – 56.

Central Narcotics Bureau, Singapore (2010). CNB news release: *Vigorous enforcement keeps drug and inhalant abuse situation in 2009 under control.* Retrieved May 2, 2010, from
http://www.cnb.gov.sg/Libraries/CNB_MediaLibrary_Files/Drug_Situation_Report_2009.sflb.ashx

Chan, H. (2005). Live-in foreign domestic workers and their Impact on Hong Kong's middle class families. *Journal of Family and Economic Issues, 26*, 509 – 528.

Cheung, N., and Cheung, Y. (2006). Is Hong Kong experiencing normalization of adolescent drug use? Some reflections on the normalization thesis. *Substance Use & Misuse, 41*, 1967 – 1990.

Children's Workforce Development Council (CWDC), U.K. (2009). *CWDC takes on parenting programme work from National Academy for Parenting Practices.* Retrieved May 8, 2010, from http://www.cwdcouncil.org.uk/news/2854.

Choi, Y., Harachi, T., Gilmore, M., & Catalano, R. (2005). Applicability of the social development model to urban ethnic minority youth: Examining the relationship between external constraints, family socialization, and problem behaviors. *Journal of Research on Adolescence, 15*(4), 505-534.

Chow, N., and Lum, T. (2008). *Trends in family attitudes and values in Hong Kong. Final report submitted to Central Policy Unit, Hong Kong SAR Government.* Retrieved July 7, 2010, from
http://www.familycouncil.gov.hk/english/research/research_value.htm

Coley, R., Votruba-Drzal, E., and Schindler, H. (2008). Trajectories of parenting processes and adolescent substance use: Reciprocal effects. *Journal of Abnormal Child Psychology, 36*, 613 – 625.

Committee on Home-School Cooperation. (2010). Website, retrieve on 2 July 2010 at
http://chsc.edb.hkedcity.net/en/aboutus_chsc.php

Community Drug Advisory Council (CDAC), Hong Kong (2010). Community Drug Advisory Council website, Hong Kong. Retrieved April 21, 2010, from http://www.cdac.org.hk/

Community Anti-Drug Coalitions of America (CADCA), U.S. (2008). *The Coalition Impact: Environmental Prevention Strategies. Beyond the Basics: Topic-Specific Publications for Coalitions.* Retrieved May 21, 2010, from
http://www.cadca.org/files/Beyond_the_Basics_EnvironmentalStrategies.pdf

Community Anti-Drug Coalitions of America (CADCA), U.S. (2010). *Analysis of Blueprint for Reform – Successful, Safe and Healthy Students Proposal.* Retrieved May 31, 2010, from
http://www.cadca.org/files/policy_priorities/Analysis%20of%20Blueprint.pdf

Cummings, E, Davies, P., and Campbell, S. (2000). *Developmental psychopathology and family process: Theory, research, and clinical implications.* New York: Guildford Press.

Dawe, S., Frye, S., Best, D., Moss, D., Atkinson, J., Evans, C. et al. (2006). *Drug use in the family: Impacts and implications for children.* Australia: Australian National Council on Drugs.

Deng, S., and Roosa, M. (2007). Family influences on adolescent delinquent behaviors: Applying the Social Development Model to a Chinese sample. *American Journal of Community Psychology, 40* (3-4), 333 – 344.

deToledo, S. and Brown, D. (1995). *Grandparents as parents: A survival guide for raising a second family.* New York: Guildford.

Department for Children, School and Families (DCSF), U.K. (2008). The DSCF website. Retrieved May 5, 2010, from
http://www.dcsf.gov.uk/everychildmatters/healthandwellbeing/commonhealthissues/substancemisuse/substancemisuse/

Department for Children, School and Families (DCSF), U.K. (2007a). *The Children's Plan: Building brighter futures – Summary.* Retrieved May 15, 2010, from
http://publications.everychildmatters.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=00999%2FCPS&

Department for Children, School and Families (DCSF), U.K. (2007b). *Targeted youth support – A guide.* Retrieved May 3, 2010, from
http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00206/

Department for Children, School and Families (DCSF), U.K. (2008a). *Background to Every Child Matters.* Retrieved May 5, 2010, from
http://www.dcsf.gov.uk/everychildmatters/about/background/background.

Department for Children, School and Families (DCSF), U.K. (2008b). *Parenting Early Intervention Programme: Guidance for Local Authorities.*

Department for Children, School and Families (DCSF), U.K. (2008c). *Government Response to the report by the Advisory Group on Drug and Alcohol Education.* Retrieved May 5, 2010, from http://publications.everychildmatters.gov.uk/eOrderingDownload/Government.pdf

Department for Children, School and Families (DCSF), U.K. (2009a). *The Children's Plan: Progress Report 2009.* Retrieved May 6, 2010, from http://publications.dcsf.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-01162-2009

Department for Children, School and Families (DCSF), U.K. (2009b). *The Teenage Pregnancy Independent Advisory Group.* Retrieved June 16, 2010, from http://www.dcsf.gov.uk/everychildmatters/healthandwellbeing/teenagepregnancy/tpiag/tpiag/

Department for Children, School and Families (DCSF), U.K. (2010a). *Think Family.* Retrieved May 5, 2010, from http://www.dcsf.gov.uk/everychildmatters/strategy/parents/ID91askclient/thinkfamily/tf/

Department for Children, School and Families (DCSF), U.K. (2010b). *Think Family Pathfinders – Research update.* Retrieved May 5, 2010, from http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00681/

Department for Education and Skills, U.K. (2004). Drugs: *Guidance for schools.* Retrieved May 4, 2010, from http://publications.teachernet.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DfES+0092+2004

Department for Education and Skills, U.K. (2005). *Every Child Matters: Change for Children, Young People and Drugs.* Retrieved May 1, 2010, from http://www.dcsf.gov.uk/everychildmatters/healthandwellbeing/ahdc/earlysupport/inpractice/ecm/ecm/

Department of Education, U.S. (2010). Successful, Safe and Healthy Students. Retrieved June 3, 2010, from http://www2.ed.gov/policy/elsec/leg/blueprint/successful-safe-healthy.pdf

Department of Education, Science and Training, Australia (2004). *Principles of Drug Education in School.* Retrieved May 22, 2010, from http://www.deewr.gov.au/Schooling/Programs/REDI/readingroom/profile/Pages/principles_school_drug_ed.aspx

Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), Australia (2008). *Helping families affected by drug abuse.* Media releases of the Australia Minister for Families, Housing, Community Services and Indigenous Affairs dated April 23, 2008. Retrieved June 2, 2010, from

http://www.jennymacklin.fahcsia.gov.au/mediareleases/2008/Pages/helping_families_23apr08.aspx

Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), Australia (2009a). *National Illicit Drug Strategy (NIDS) - Strengthening and Supporting Families Coping with Illicit Drug Use.* Retrieved June 2, 2010, from http://www.fahcsia.gov.au/sa/gamblingdrugs/progserv/nids/Pages/default.aspx

Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), Australia (2009b). *A departmental discussion Paper – Developing a Family Support Program.* Retrieved May 14, 2010, from http://www.facs.gov.au/sa/families/progserv/familysupport/Pages/DepartmentalDiscussionPaper-FSP.aspx

Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), Australia (2009c). *Family Support Program – Kids in Focus – Family Drug Support.* Retrieved May 15, 2010, from http://www.fahcsia.gov.au/sa/gamblingdrugs/progserv/kidsinfocus/Pages/default.aspx

Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), Australia (2009d). *Kids in Focus – Application Guidelines.* Retrieved May 15, 2010, from http://www.fahcsia.gov.au/sa/gamblingdrugs/progserv/kidsinfocus/application_guidelines/Pages/Section1.aspx

Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), Australia (2009e). *Family Relationship Services Program (FRSP).* Retrieved May 11, 2010, from http://www.facs.gov.au/sa/families/progserv/FRSP/Pages/frsp-main_types_frsp_services.aspx#4

Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), Australia (2009f). *Local Answers Funding Rounds.* Retrieved May 21, 2010, from http://www.fahcsia.gov.au/sa/communities/funding/localanswers/Pages/default.aspx

Department of Health, Hong Kong. (2009). *Adolescent Health Program Student Health Services.* Government of the Hong Kong Special Administrative Region, P.R.C. Retrieved May 31, 2010, from http://www.ahpshs.gov.hk/english/abo_us/abo_us.html

Department of Health, U.K. (2009). *The Family Nurse Partnership. Changing the world – one baby at a time.* Retrieved June 16, 2010, from www.liv.ac.uk/ssp/duncansociety/FNP_slides_11.11.09.ppt

Department of Health and Human Services, U.S. (2001). *Youth Violence: A Report of the Surgeon General.* U.S.: Public Health Services. Retrieved May 13, 2010, from http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssurggen&part=A12974

Department of Health and Human Services, U.S. (2006). *About The Temporary Assistance for Needy Families (TANF) program.* U.S.: Administration for Children and Families, Department of Health and Human Services. Retrieved June 10, 2010, from http://www.acf.hhs.gov/programs/ofa/tanf/about.html

Department of Health and Ageing, Australia (2004). *Positive Parenting for Young Parents: Child, Youth and Women's Health Program, ACT Community Health.* Retrieved June 11, 2010, from http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1157353867&sid

Department of Health and Ageing, Australia (2007). *About the National Drugs Campaign.* Retrieved May 21, 2010, from http://www.health.gov.au/internet/drugs/publishing.nsf/Content/campaign-resources/$FILE/About%20the%20National%20Drugs%20Campaign%20Fact%20sheet.pdf

Dembo, R., Williams, L., Wothke, W., Schmeidler, J., and Brown, C. (1992). The role of family factors, physical abuse, and sexual victimization experiences in high-risk youths' alcohol and other drug use and delinquency: A Longitudinal model. *Violence and Victims, 7* (3), 245-266.

Demuth, S. and Brown, S. (2004). Family structure, family processes, and adolescent delinquency: The significance of parental absence versus parental gender. *Journal of Research in Crime and Delinquency, 41,* 58 – 81.

Doherty, W., and Needle, R. (1991). Psychological adjustment and substance use among adolescents before and after a parental divorce. *Child Development, 62* (1), 328 – 337.

Ebbeck, M. and Gokhale, N. (2004). Child-rearing practices in a selected sample of parents with children in childcare in Singapore. *Contemporary Issues in Early Childhood, 5* (2), 194 – 206.

Education Bureau, Hong Kong (2004). *Understanding Adolescent Project (Primary).* Government of the Hong Kong Special Administrative Region, P.R.C. Retrieved April 22, 2010, from http://www.edb.gov.hk/index.aspx?nodeID=1989&langno=1

Education Bureau, Hong Kong (2006). *Enhanced Smart Teen Project.* Government of the Hong Kong Special Administrative Region, P.R.C. Retrieved April 22, 2010, from http://www.edb.gov.hk/index.aspx?nodeID=926&langno=1

Eggert, L. L., Seyl., C.D., and Nicholas, L.J., (1990). Effects of a school-based prevention program for potential high school dropouts and drug users. *The International Journal of Addictions, 25* (7), 773 – 801.

Engels, R., Vermulst, A., Dubas, J., Bot., S., and Gerris, J. (2005) Long-term effects of family functioning and child characteristics on problem drinking in young adulthood. *European Addiction Research, 11*, 32 – 37.

Epstein, J., Williams, C., and Botvin, G. (2002). How universal are social influences to drink and problem behaviors for alcohol use? A test comparing urban African-American and Caribbean American adolescents. *Addictive Behaviors, 27* (1) , 75 – 86.

Fagan, A. and Najman, J. (2005). The relative contributions of parental and sibling substance use to adolescent tobacco, alcohol, and other drug use. *Journal of Drug Issues, 35* (4), 869 – 883.

Fleming, C., Catalano, R., Oxford, M., & Harachi, T. (2002). A test of the generalizability of the social development model across gender and income groups with longitudinal data from the elementary school development period. *Journal of Quantitative Criminology, 18* (4), 423 – 439.

Fuller, E. (Ed.). (2009). *Smoking, drinking and drug use among young people in England in 2008.* U.K.: National Centre for Social Research and the National Foundation for Educational Research. Retrieved May 21, 2010, from http://www.ic.nhs.uk/webfiles/publications/sdd08fullreport/SDD_08_%2809%29_%28Revised_Oct_09%29.pdf

Frederick, L. (2010). Older relatives raising adolescents: The relationship between age of caregiver and youth delinquent acts. Presentation paper at the 9th Global Conference on violence: Probing the boundaries. US: Texas A&M University – Kingsville.

Frye, S., Dawe, S., Harnett, P., Kowalenko, S., and Harlen, M. (2008). *Supporting the families of young people with problematic drug use.* Australia: Australian National Council on Drugs.

Gardner, F. , Burton, J., and Klimes, I. (2006). Randomised controlled trial of a parenting intervention in the voluntary sector for reducing child conduct problems: outcomes and mechanisms of change. *Journal of Child Psychology and Psychiatry, 47* (11), 1123-1132.

Gordon, R. (1987). An operational classification of disease prevention. In Steinberg, J. A. and Silverman, M. M. (eds.), *Preventing Mental Disorders*, Rockville, MD: U.S. Department of Health and Human Services, 1987.

Government of Canada (2009). *The National Anti-drug strategy.* Retrieved May 3, 2010, from http://www.nationalantidrugstrategy.gc.ca/nads-sna.html

Gregg, M., and Toumbourou, J. (2003). Sibling peer support group for young people with a sibling using drugs: A pilot study. *Journal of Psychoactive Drugs, 35* (3), 311 – 319.

Griffin K, Botvin G, Scheier L., et al. (2000). Parenting practices as predictors of substance use delinquency and aggression among urban minority youth moderating effects of family structure and gender. P*sychology of Addictive Behaviors, 14*, 174–84.

Grodzicki, J. & Galanter, M. (2005). Spirituality and addiction. *Substance Abuse, 26* (2), 1-4.

Hair, E., Moore, K., Hadley, A., Kaye, K., Day, R., and Orthner, D. (2009). Parent marital quality and the parent-adolescent relationship: Effects on adolescent and young adult health outcomes. *Marriage & Family Review, 45* (2 & 3), 218 - 248

Hand, K. (2005). Mother's views on using formal child care. *Family Matters, Australian Institute of Family Studies, 70*, 10-17.

Harachi, T. W., Ayers, C. D., Hawkins, J. D., & Catalano, R. F. (1996). Empowering communities to prevent adolescent substance abuse: Process evaluation results from a risk- and protection-focused community mobilization effort. *Journal of Primary Prevention, 16* (3), 233-254.

Hawkins, J.D., Lishner, D.M., Jenson, J.M., & Catalano, R.F. (1987). Delinquents and drugs: What the evidence suggests about prevention and treatment programming. In B.S. Brown & A.R. Mills (Eds.), Youth at high risk for substance abuse (DHHS Publication No. ADM 87-1537, pp. 81-133). Washington D.C.: U. S. Government Printing Office.

Hawkins, J.D., Catalano, R.F., & Miller, J.Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. Psychological Bulletin, 112, 64 – 105.

Hawkins, J.D. & Catalano, R.F. (2005). Investing in your community's youth: An introduction to the Communities That Care System. Retrieved May 17, 2010, from http://download.ncadi.samhsa.gov/Prevline/pdfs/ctc/Investing%20in%20Your%20Community's%20Youth.pdf

Hawkins, J.D., Brown, E.C., Oesterle, S., Arthur, M.W., Abbott, R.D., & Catalano, R.F.. (2008). Early Effects of Communities That Care on Targeted Risks and Initiation of Delinquent Behavior and Substance Use. Journal of Adolescent Health, 43, 15–22.

Hawkins, J.D., Oesterle, S., Brown, E.C., Arthur, M.W., Abbott, R.D., Fagan, A.A. & Catalano, R.F. (2009). Results of a Type 2 Translational Research Trial to Prevent Adolescent Drug Use and Delinquency: A Test of Communities That Care. *Archives of Pediatrics & Adolescent Medicine, 163* (9), 789 – 798.

Health Canada (2009). *The Drug Strategy Community Initiatives Fund (DSCIF) – At a glance.* Retrieved May 13, 2010, from http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/dscif-ficsa/index-eng.php

Hemovich, V. and Crano, W. (2009). Family structure and adolescent drug sse: An exploration of single-parent families. *Substance Use & Misuse, 44* (14), 2099 – 2113.

Hoare, J. (2009). *Drug misuse declared: Findings from the 2008/09 British Crime Survey, England and Wales.* Home Office Statistical Bulletin. U.K.: Home Office.

Home Affairs Bureau, Hong Kong (2009). *SHA: Territory-wide programme against youth drug abuse launches in August.* Government of the Hong Kong Special Administrative Region, P.R.C. Retrieved May 2, 2010, from
http://www.hab.gov.hk/file_manager/en/documents/publications_and_press_releases/20090731SHA_against_e.pdf

Home Office, U.K. (2007). *Communications and campaigns strategy: FRANK.* Retrieved May 4, 2010, from http://drugs.homeoffice.gov/uk/communications-and-campaigns/frank-campaign/Strategy/ and http://www.talktofrank.com/

Home Office, U.K. (2008). *Drug strategy overview.* Retrieved May 4, 2010, from
http://drugs.homeoffice.gov.uk/drug-strategy/overview/?version=2

Home Office, U.K. (2009). *Blueprint Drugs Education: The response of pupils and parents to the programme. Executive Summary.* Retrieved May 23, 2010, from
http://www.drugsandalcohol.ie/12373/1/Home_Office_Blueprint_drugs_education_evaluation_summary.pdf

Home Office, U.K. (2010). Positive Futures website site. Retrieved May 21, 2010, from
http://www.posfutures.org.uk/index.asp?m=793&t=Home

Hong Kong Census and Statistics Department (2009). *Hong Kong Annual Digest of Statistics, 2009 Edition.* Hong Kong: Government of the Hong Kong Special Administrative Region.

Hong Kong Christian Service (2002). Survey results on the caregiving styles of parents and Filipina domestic helpers on children's self-care abilities. Retrieved April 26, 2010, from
http://www.hkcs.org/commu/2002press/press26.html.

The Hong Kong Federation of Youth Groups (2008). Party drugs: a problem in Hong Kong and overseas. *Youth Matters, Issue 124*, published April 18, 2008, Hong Kong.

The Hong Kong Federation of Youth Groups (2010). *Anti-drug resource kit for school.* Retrieved May 13, 2010, from http://antidrug.u21.hk/

Hong Kong Special Administrative Region Government (2010). *The Budget, 2010 – 2011.* Government of the Hong Kong Special Administrative Region, P.R.C.

Hill, T., Burdette, A., Weiss, M., and Chitwood, D. (2009). Religious Involvement and Adolescent Substance Use. In C.G. Leukefeld et al. (eds.) *Adolescent Substance Abuse: Evidence-Based Approaches to Prevention and Treatment.* U.S.: Springer Science and Business Media LLC.

Hospital Authority, Hong Kong (2010). *2010 Outstanding Teams Award - UROK clinic.* HAS Link Special Issue, April 2010. Retrieved July 1, 2010, from
http://www3.ha.org.hk/ehaslink/issue48/chi/urok.htm

Huxley, A. and Foulger, S. (2008). Parents who misuse substances: implications for parenting practices and treatment seeking behavior. *Drugs and Alcohol Today*, 8 (3), 9 – 16.

Ip, H.M., Cheung, S. K., McBride-Chang, C. & Chang, L. (2008). Associations of warmth and control of Filipina domestic helpers and mothers to Hong Kong kindergarten children's social competence. *Early Education & Development, 19* (2), 284 – 301.

Joe Laidler, K. (2005). The rise of club drugs in a heroin society: The case of Hong Kong. *Substance Use & Misuse, 40*, 1257 – 1278.

Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2009). *Teen marijuana use tilts up, while some drugs decline in use.* University of Michigan News Service: Ann Arbor, MI. Retrieved May 23, 2010, from http://www.monitoringthefuture.org

Kaminski, Ruth A.; Stormshak, Elizabeth A. (2007). Project STAR: Early Intervention With Preschool Children and Families for the Prevention of Substance Abuse. Preventing youth substance abuse: Science-based programs for children and adolescents. In Tolan, Patrick (Ed); Szapocznik, José (Ed); Sambrano, Soledad (Ed). (2007). *Preventing youth substance abuse: Science-based programs for children and adolescents.* Washington, DC, US: American Psychological Association.

Kelling, G., and Wilson, J. (1982). Broken Windows – The police and neighborhood safety. Retrieved July 5, 2010, from http://www.theatlantic.com/magazine/archive/1982/03/broken-windows/4465/

Kerr, M., Stattin, H., and Burk, W. (2010). A reinterpretation of parental monitoring in longitudinal perspective. J*ournal of Research on Adolescence, 20* (1), 39 – 64.

King, V., and Sobolewski, J. (2006). Nonresident fathers' contributions to adolescent well-being. *Journal of Marriage and Family, 68*, 537 – 557

Koenig, H. (2009). Research on Religion, Spirituality and Mental Health: A Review. *Canadian Journal of Psychiatry, 54* (5), 283 – 291.

Krohn, M., Hall, G., and Lizotte, A. (2009). Family transitions and later delinquency and drug use. *Youth Adolescence, 38*, 466–480.

Kumpfer, K. (1989). Environmental and family-focused prevention: The Cinderellas of prevention want to go to the ball, too. In K. H. Rey, C. L. Faegre, & P. Lowery (Eds.), *Prevention research findings: 1988.* [OSAP Monograph #3, DHHS Publication No. ADM-89-1615], (pp. 194-220). Washington, DC: Government Printing Office.

Kumpfer, K., Alvarado, R. and Whiteside, H. (2003). Family-based interventions for substance use and misuse prevention. *Substance Use and Misuse, 38* (11) 1759-1789.

Labour Department, Hong Kong (2009). Youth Pre-employment Training Program (YPTP) and Youth Work Experience and Training Scheme (YWETS). Government of the Hong Kong Special Administrative Region, P.R.C. Retrieved April 30, 2010, from
 http://www.yes.labour.gov.hk/ypyt/home.aspx?lang=en

Lai, M. (2009). Surrogate mothering and conjugal insecurity: Indonesian domestics reenvisioning the family in Hong Kong. *Women's Studies, 38* (5), 559 — 576

Landry-Meyer, L., and Newman, B. (2004). An exploration of the grandparent caregiver role. *Journal of Family Issues, 25*, 1005–1025.

Latimer, W., Floyd, L., Kariis, T., Novotna, G., Exnerova, P., and O'Brien, M., (2004). Peer and sibling substance use: Predictors of substance use among adolescents in Mexico. *Pan American Journal of Public Health, 15* (4), 225 – 232.

Lau, J., Kim, J., Tsui, H., Cheung, A., Lau, M., Yu, A. (2005). The relationship between physical maltreatment and substance use among adolescents: A survey of 95,788 adolescents in Hong Kong. *Journal of Adolescent Health, 37*, 110–119.

Lau, Y. (2009). The impact of fathers' work and family conflicts on children's self-esteem: The Hong Kong case. *Social Indicators Research, 95* (3), 363-376.

Lee, F. W. L. (2000). Teens of the night: The young night drifters in Hong Kong. *Youth and Society, 31* (3), 363 – 384.

Life Education Activity Programme, Hong Kong (LEAP) (2010). *Life Education Activity Program website.* Retrieved April 30, 2010, from http://www.leap.com.hk/

Lindsay, G., Davies, H., Band,S., Cullen, M.A., Cullen, S., Strand, S., Hasluck, C., Evans, R., and Stewart-Brown, S. (2008). *Parenting Early Intervention Pathfinder Evaluation.* U.K.: University of Warwick and Kings College, London.

Lindsay, G., Davis, H., Strand, S. Cullen, M.A., Band, S., Cullen, S., Davis, L., Hasluck, C., Evans, R. and Stewart-Brown, S. (2009). *Parent Support Advisor pilot evaluation – final report.* U.K.: University of Warwick and Kings College, London.

Lloyd, (1998). Risk factors for problem drug use: Identifying vulnerable groups. *Drugs: Education, Prevention, and Policy,* 5, 217 – 232.

Lockman, J. and Steenhoven, A. (2002). Family-based approached to substance abuse intervention. *The Journal of Primary Prevention, 23* (1), 49 – 114.

Ma, J. L. C., Wong, T. K. Y., Lau, L. K., and Pun, S.H. (2009). Perceived family functioning and family resources of Hong Kong families: Implications for social work practice. *Journal of Family Social Work, 12*, 244 – 263.

Mallick, J., and Stein, G. (1999). Parents and drug education: Parents' concerns, attitudes and needs. *Early Child Development and Care, 151*, 1-9.

Mayer, M. (2002). Grandparents Rearing Grandchildren: Circumstances and Interventions. *School Psychology International, 23*, 371 – 385.

Melby, J., Conger, R. D., Conger, K. J., & Lorenz, F. O. (1993). Effects of parental behavior on tobacco use by young male adolescents. *Journal of Marriage and the Family*, 55, 439–454.

Miller, W. (1998). Researching the spiritual dimensions of alcohol and other drug problems. *Addiction, 93*(7), 979-990.

Miller-Day, M. (2008). Talking to youth about drugs: What do late adolescents say about parental strategies. *Family Relations, 57* (1) , 1-12.

Narcotics Division, Hong Kong (2007). Central registry of drug abuse fifty-sixth report. Security Bureau, Government of the Hong Kong Special Administrative Region, P.R.C.

Narcotics Division, Hong Kong (2008a). *Task force report on youth drug abuse.* Security Bureau, Government of the Hong Kong Special Administrative Region, P.R.C.

Narcotics Division, Hong Kong (2008b). *Path builders. S*ecurity Bureau, Government of the Hong Kong Special Administrative Region, P.R.C.. Retrieved May 13, 2010, from
 http://www.nd.gov.hk/Path_Builders/en/home/index.html

Narcotics Division, Hong Kong (2009a). *Central registry of drug abuse fifty-eighth report.* Security Bureau, Government of the Hong Kong Special Administrative Region, P.R.C.

Narcotics Division, Hong Kong (2009b). *The Trial Scheme on School Drug Testing in Tai Po District.* Retrieved May 3, 2010, from
http://www.nd.gov.hk/en/school_drug_test_tp.htm

Narcotics Division, Hong Kong (2010a). *The 2008/09 Survey of drug use among students.* Security Bureau, Government of the Hong Kong Special Administrative Region, P.R.C..

Narcotics Division, Hong Kong (2010b). *Hong Kong Narcotics Division's website.* Retrieved May 13, 2010, from http://www.nd.gov.hk/tc/antidrugstrategy.htm

Narcotics Division, Hong Kong (2010c). 大埔區校園驗毒試行計劃最新進展. Retrieved May 31, 2010, from http://www.info.gov.hk/gia/general/201005/25/P201005250209.htm

National Centre for Social Research, U.K. (2010). *ASB Family Intervention Projects: Monitoring and Evaluation.* Retrieved May 10, 2010, from http://publications.dcsf.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-RR215&

National Center on Addiction and Substance Abuse at Columbia University, U.S. (2001). So help me God: Substance abuse, religion and spirituality. New York, NY: Columbia University.

National Council against Drug Abuse (NCADA), Singapore (2010). National Council against Drug Abuse website. Retrieved May 2, 2010, from http://www.drugfree.org.sg/

National Framework, Canada (2005). *The National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada.* Retrieved May 3, 2010, from http://www.nationalframework-cadrenational.ca/index_e.php?orderid_top=2

National Institute on Drug Abuse, U.S. (1997). *Drug abuse prevention: What works.* National Institute of Health, U.S. Department of Health and Human Services.

Northeast Center for the Application of Prevention Technologies (CAPT), U.S. (1999). *Strengthening Families and Protecting Children from Substance Abuse.* Education Development Center, Inc.

Ng, T. K. SWD. "Preventing drug abuse among young people – community-based programs in Hong Kong". Retrieved May 21, 2010, from http://www.nd.gov.hk/en/conference_proceedings/Drugs_proBK_Part3/Drugs_proBK_NgTK.pdf

Ng, W. and Bernier, S. (2009). A state of work-life balance in Hong Kong survey: Assessing the impact of economic downturn – 2009 a summary of research findings. Hong Kong: Community Business Limited.

Nurse Family Partnership (2009). *Nurse Family Partnership website.* Retrieved June 10, 2010, from http://www.nursefamilypartnership.org

Office of National Drug Control Policy (ONDCP), U.S. (2009). *Applicant eligibility requirements for the Drug-Free Communities Program.* Retrieved May 11, 2010, from http://www.ondcp.gov/dfc/cer/html

Office of National Drug Control Policy (ONDCP), U.S. (2010). Community-based prevention strategies fact sheet. Retrieved May 28, 2010, from http://www.whitehousedrugpolicy.gov/strategy/Prevention_factsheet.pdf

P.A.T.H.S. to Adulthood (2005). P.A.T.H.S. to Adulthood website. Retrieved April 22, 2010, from http://www.paths.hk/index/

Paglia-Boak, A., Mann, R.E., Adlaf, E.M., & Rehm, J. (2009). *Drug use among Ontario students, 1977-2009: OSDUHS highlights.* (CAMH Research Document Series No. 28). Toronto, ON: Centre for Addiction and Mental Health.

Parsai, M., Marsiglia, F., and Kulis, S. (2010). Parental Monitoring: Religious involvement and drug use among Latino and Non-Latino youth in the Southwestern United States. *British Journal of Social Work, 40* (1), 100-114.

Pasch, K., Stigler, M., Perry, C., and Komro, K. (2010). Parents' and children's self-report of parenting factors: How much do they agree and which is more strongly associated with early adolescent alcohol use? *Health Education Journal 69* (1), 31–42.

Patin, H., Schwartz, S., Sullivan, S., Coatsworth, J., & Szapocznik, J. (2003) Preventing substance abuse in Hispanic immigrant adolescents: An ecodevelopmental, parent-centered approach. *Hispanic Journal of Behavioral Sciences, 25* (4), 469-500.

Peterson, J. (2010). A qualitative comparison of parent and adolescent views regarding substance use. *Journal of School Nursing, 26*, 53 – 64.

Petrie, J., Bunn, F., and Byrne, G. (2006). Parenting programmes for preventing tobacco, alcohol or drugs misuse in children <18: a systematic review. Health Education Research, 22 (2), 177 – 191.

Pilowsky, D., Wickramaratne, P., Nomura, Y., and Weissman, M. (2006). Family discord, parental depression, and psychopathology in offspring: 20-year follow up. *Journal of the American Academy of Child and Adolescent Psychiatry, 45* (4), 452 – 475.

Poelen, E., Engels, R., Vorst, H., Scholte, R., & Vermulst, A. (2007). Best friends and alcohol consumption in adolescence: A within-family analysis. *Drug and Alcohol Dependence, 88*, 163 – 173.

Public Safety, Canada (2010). *Public Safety Canada's National Crime Prevention Centre.* Retrieved May 14, 2010, from http://www.publicsafety.gc.ca/prg/cp/ncps-fndsndx-eng.aspx

Radio Television Hong Kong (RTHK) (2010). 校園驗毒計劃推行後求助青少年增加. Retrieved June 2, 2010, from
 http://www.rthk.org.hk/rthk/news/expressnews/20100306/news_20100306_55_652010.htm

Randall, J., Cunningham, P. (2003). Multisystemic therapy: A treatment for violent substance-abusing and substance-dependent juvenile offenders. *Addictive Behavior, 28*, 1731 – 1739.

Randolf, K. A., Fincham, F., & Radey, M. (2009). A framework for engaging parents in prevention. *Journal of Family Social Work, 12,* 56-72.

Repetti, R. L., Taylor, S. E., and Seeman, T. E. (2002). Risky families: Family social environments and the mental and physical health of offspring. *Psychological Bulletin, 128*, 330–366.

Roche, A., Pidd, K., Bywood, P., Duraisingam, V., Steenson, T., Freeman, T., and Nicholas, R. (2008). Drug testing in schools evidence, impacts and alternatives. Canberra: Australian National Council on Drugs.

Rothrauff, T., Cooney, T., and An, J. (2009). Remembered parenting styles and adjustment in middle and late adulthood. *The Journals of Gerontology, 64* (1), 137 – 146.

Royal Children's Hospital, Australia. (2010). *Implementing Communities That Care in your community.* Melbourne, Australia. Retrieved May 17, 2010, from
 http://www.rch.org.au/ctc/index.cfm?doc_id=13444

Sawyer, T., and Stevenson, J. (2008). Perceived parental and peer disapproval toward substances: Influences on adolescent decision-making. *Journal of Primary Prevention, 29*, 465–477

Scaife, V. (2008). Maternal and paternal drug misuse and outcomes for children: Identifying risk and protective factors. *Children and Society, 22*, 53 –62.

Shek, D.T.L. (2000). Parental marital quality and well-being, parent-child relational quality, and Chinese adolescent adjustment. *The American Journal of Family Therapy, 28* (2), 147 - 162

Shek, D.T.L. (2002a). Family functioning and psychological well-being, school adjustment, and problem behavior in Chinese adolescents with and without economic disadvantage. *The Journal of Genetic Psychology, 163* (4), 497 – 502.

Shek, D.T.L. (2002b). Parenting characteristics and parent-adolescent conflict: A longitudinal study in the Chinese culture. *Journal of Family Issues, 23*, 189 – 208.

Shek, D.T.L. (2005). Paternal and maternal influences on the psychological well-being, substance abuse, and delinquency of Chinese adolescents experiencing economic disadvantage. *Journal of Clinical Psychology, 61* (3), 219 – 234.

Shek DTL (2008) Special Issue: evaluation of the Project P.A.T.H.S. in Hong Kong. Scientific World Journal, 8:1-94.

Shek, D.T.L. (2007). Tackling adolescent substance abuse in Hong Kong: Where we should and should not go. *The Scientific World Journal: TSW Child Health & Human Development, 7*, 2021 – 2030.

Siggins Miller. (2009). *Evaluation and Monitoring of the National Drug Strategy 2004-2009. Final Report.* Retrieved May 12, 2010, from http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/consult-eval

Skeer, M., McCormick, M., Normand, S., Buka, S., & Gilman, S. (2009). A prospective study of familial conflict, psychological stress, and the development of substance use disorders in adolescence. *Drug and Alcohol Dependence, 104,* 65–72.

Small, S.A., Cooney, S.M., & O'Connor, C. (2009). Evidence-informed program improvement: Using principles of effectiveness to enhance the quality and impact of family-based prevention programs. *Family Relations, 58,* 1-13.

Smith, G., and Palmieri, P. (2007). Risk of psychological difficulties among children raised by custodial grandparents. *Psychiatric Services, 58* (10), 1303 – 1310.

Social Welfare Department (SWD), Hong Kong (2010). *District Youth Outreaching Social Work Service.* Government of the Hong Kong Special Administrative Region, P.R.C. Retrieved May 21, 2010, from http://www.swd.gov.hk/en/index/site_pubsvc/page_young/sub_seryouthrisk/id_districtyo/

Social Care Institute for Excellence. (2009a). At a glance 11: Reaching parents: implementing parenting programmes. Retrieved on August 7th 2009 at http://www.scie.org.uk/publications/ataglance/ataglance11.asp

Social Care Institute for Excellence. (2009b). Report 21: Follow up work to support implementation of the NICE/SCIE guidance on parenting programmes, Retrieved on August 7th 2009 at http://www.scie.org.uk/publications/reports/report21.asp

Spooner, C., Hall, W., and Lynskey, M. (2001). *Structural determinants of youth drug use.* Australia: Australian National Council on Drugs.

Statistics Singapore (2010). Retrieved May 27, 2010, at http://www.singstat.gov.sg/stats/latestdata.html#12

Stevens, K., Dickson, M., & Poland, M. (2005). *Focus on families: Reinforcing the importance of family. Families with dependent children – Successful outcomes project.* New Zealand: The Families Commission.

Statham, J., and Mooney, A. (2003). Across the spectrum: An introduction to family day care internationally. *In A. Mooney & J. Statham (Eds.), Family day care: International perspectives on policy, practice and quality.* London: Jessica Kingsley

Stein, J., Milburn, N., Zane, J., and Rotheram-Borus, M. (2009). Paternal and maternal influences on problem behaviors among homeless and runaway youth. *American Journal of Orthopsychiatry, 79* (1), 39-50.

Stormshak, E., and Dishion, T. (2009). A school-based, family-centered intervention to prevention substance use: The Family check-up. *The American Journal of Drug and Alcohol Abuse, 35* (4), 227 – 232.

Strohschein, L. (2005). Parental divorce and child mental health trajectories. *Journal of Marriage and Family, 67* (5), 1286–1300.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. (2004). SAMHSA's Prevention Platform. Retrieved May 18, 2010, from
 http://prevention.samhsa.gov/about/spf.aspx

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. (2007). The National Survey on Drug Use and Health (NSDUH) Report: Religious involvement and substance use among adults. Retrieved June 10, 2010, from
http://www.oas.samhsa.gov/2k7/religion/religion.htm

Swenson, C., Schaeffer, C., Tuerk, E., Henggeler, S., Tuten, M., Panzarella, P., Lau, C. et al. (2009). Adapting Multisystemic Therapy for co-occurring child maltreatment and parental substance abuse: The Building Stronger Families Project. *Emotional & Behavioral Disorders in Youth*, *Winter,* 3 – 8.

Tam, V. C.W. (2001). A family ecological analysis on child care use in Hong Kong. *Children and Society, 15*, 181–192.

Tan, J., Buchanan, A., Flouri, E., Attar-Schwartz, S., and Griggs, J. (2010). Filling the parenting gap? Grandparent involvement with U.K. adolescents. *Journal of Family Issues, 20* (10), 1 – 24.

Tangenberg, K. (2005). Faith-based human services initiatives: Considerations for social work practice and theory. *Social Work, 50* (3), 197 – 206.

Tsang, S.K.M. (1996). *Father-Adolescent conflict in Chinese families in Hong Kong*. Unpublished Ph.D. Dissertation, Department of Social Work and Social Administration, The University of Hong Kong. Hong Kong: Author.

Tsang, S.K.M. with T.W.G.Hs (2008). *Engagement of parents in anti-drug work: Research Report and four program manuals on implementation guidelines, prevention programmes for general parents, parents with at risk children and parents with drug-taking history.* Commissioned by Narcotics Division, Hong Kong SAR Government. *http://www.nd.gov.hk/pdf/EPA_Full_Report.pdf*

Tung Wah Group of Hospitals (TWGHs)' CROSS center, Hong Kong (2009). 「家・心・關懷」家長抗毒支援熱線. Retrieved May 2, 2010, from http://crosscentre.tungwahcsd.org/news.html

Tsang, S., and Leung, C. (2005). Developing a database for evaluating the effectiveness of parent education and support programs: Results of a pilot study. *Illinois Child Welfare Journal, 21 (1 & 2)*, 77 – 89.

United Nations Economic and Social Council (2001). *World situation with regard to drug abuse, with particular reference to children and youth.* Vienna: Commission on Narcotic Drugs. Retrieved May 12, 2010, from http://www.unodc.org/pdf/document_2000-12-06_1.pdf

United Nations Economic and Social Council (2002). *Prevention of the recreational and leisure use of drugs among young people: Report of the Executive Director.* Vienna: Commission on Narcotic Drugs. Retrieved May 12, 2010, from www.unodc.org/pdf/document_2001-12-21_1.pdf

United Nations Office on Drugs and Crime (UNODC) (2009). *Guide to implementing family skills training programmes in drug abuse prevention.* Vienna: Commission on Narcotic Drugs. Retrieved May 1, 2010, from http://www.unodc.org/unodc/en/prevention/familyskillstraining.html

Vancouver School Board (2009). *Tupper young parents program.* Retrieved June 11, 2010, from http://www.vsb.bc.ca/programs/tupper-young-parents-program

Velleman, R, Templeton, D.B., Copello, L. and Alex, J. (2005). The role of the family in preventing and intervening with substance use and misuse: a comprehensive review of family interventions, with a focus on young people. *Drug and Alcohol Review, 24* (2), 93–109.

Vimpani, G. (2005). Getting the mix right: family, community and social policy interventions to improve outcomes for young people at risk of substance misuse. *Drug and Alcohol Review*, *24* (2), 111-25.

Vorst, H., Engels, R., Meeus, W., Dekovic, M., and Leeuwe, J. (2007). Similarities and bi-directional influences regarding alcohol consumption in adolescent sibling pairs. *Addictive Behaviors, 32*, 1814 – 1825.

Walton, E. (2007). Evaluating faith-based programs: An introduction from the guest editor. *Research on Social Work Practice, 17* (2), 171 – 173.

Wall, M. (2001). Resilience in ecosystemic context: Evolution of concept. *American Journal of Orthopsychiatry, 71* (3), 290 – 297.

Walsh, C. MacMillan, H., & Jamieson, E. (2003). The relationship between parental substance abuse and child maltreatment: Findings from the Ontario Health Supplement. *Abuse and Neglect, 27* (12), 1409 – 1425.

Welford, R. (2008). *Work Life Balance in Hong Kong Survey Results*. Hong Kong: The University of Hong Kong and Corporate Social Responsibility in Asia.

Wharton, A. and Blair-Loy, M. (2006). Long work hours and family life: A cross-national study of employees' concerns. *Journal of Family Issues, 27*, 415 – 436.

White, C., Warrener, M., Reeves, A. and La Valle, I. (2008). *Family Intervention Projects: An Evaluation of their design, set-up and early outcomes.* U.K.: National Centre for Social Research.

White House, U.S. (2010a). *National Drug Control Strategy Executive Summary.* Retrieved May 31, 2010, from http://www.whitehousedrugpolicy.gov/strategy/2010StrategyExecutiveSummary.pdf

White House, U.S. (2010b). *National Drug Control Strategy.* Retrieved May 31, 2010, from http://www.whitehousedrugpolicy.gov/publications/policy/ndcs10/ndcs2010.pdf

Williams, N. (2010). Establishing the boundaries and building bridges: A literature review on ecological theory: Implications for research into the refugee parenting experience. *Journal of Child Health Care, 14* (1), 35 – 51.

Wills T., Gibbons F., Gerrard, M., Murry, V., and Brody, G. (2003). Family communication and religiosity related to substance use and sexual behavior in early adolescence: A test for pathways through self-control and prototype perceptions. *Psychology of Addictive Behaviors, 17* (4), 313-323.

Windle, M. (2000). Parental, sibling, and peer influences on adolescent substance use and alcohol problems. *Applied Developmental Science, 4*, 98 – 110.

Wong, H. (2004). Social capital of the marginal communities. *Hong Kong Journal of Social Work, 38*, 53–71 (in Chinese).

Wood, M., DeJong, W., Fairlie, A., Lawson, D., Lavigne, A., and Cohen, F. (2009). Common ground: an investigation of environmental management alcohol prevention initiatives in a college community. *Journal of Studies in Alcohol and Drugs, Supplement 16*, 96–105.

Yen, J.Y., Yen, C.F., Chen, C.C., Chen, S.H., and Ko, C.H. (2007). Family factors of internet addiction and substance use experience in Taiwan adolescents. *Cyberpsychology & Behavior, 10* (3), 323 – 329.

The Young/Single Parent Support Network of Ottawa (YSPSN), Canada, (2009). *YSPSN website.* Retrieved June 15, 2010, from http://www.ottawayoungparents.com/yspsn.htm

Yuan, Y. (2004). 關於青少年毒品預防教育的思考. Journal of Beijing Youth Politics College, 13 (1), 36 – 39. (In Chinese).

Youth Action and Policy Association, Australia (2007). *Young Parents Early Intervention Parenting Program (YPEIPP).* Retrieved June 11, 2010, from http://www.yapa.org.au/youthwork/stories/youngparents.php

林國強 (2010) 。香港教育局健康校園政策。Retrieved May 31, 2010, from http://www.antidrug.u21.hk/resources/seminar/policy.ppt

麥偉強 (2010) 。破窗理論對校園禁毒工作的啟示。

台灣行政院研究發展考核委員會 (2005) 。毒品問題與對策 (修訂稿) 。

台灣行政院研究發展考核委員會委託研究。台灣：國立中正大學。

台灣行政院教育部 (2008) 。防制毒品進入校園實施策略，行政院教育部防制學生藥物濫用三級預防。Retrieved May 20, 2010, from http://www.edu.tw/military/itemize.aspx?site_content_sn=7767&itemize_sn=2529

台灣教育部、 法務部、外交部、行政院衛生署 (2009) 。 98 年反毒報告書. Retrieved May 18, 2010, from http://140.111.34.206/internet/main/01news/01edu_view.aspx?uid=684&docid=321

台灣桃園縣少年輔導委員會 (Younger) (2010) 。 Youngsters' On light. Retrieved May 18, 2010, from http://www.younger.nat.gov.tw/newsdetail/show/news_part/109/lang/big5.html

中國國家禁毒委員會辦公室、教育部辦公廳 (2006) 。 禁毒辦通〔2006〕26 號。Retrieved May 19, 2010, from http://www.chinabaike.com/law/zy/bw/sort0970/1416319.html

中國國家禁毒委員會辦公室、教育部辦公廳 (2002) 。中央關於進一步加強中小學生毒品預防教育工作的通知。 Retrieved May 11, 2010, from http://www.moe.edu.cn/edoas/website18/32/info432.htm

國家禁毒委員會(2010) 。 2010 中國禁毒報告。 Retrieved June 30, 2010, from http://china.rednet.cn/c/2010/06/25/1991969_2.htm

上 海 市 禁 毒 科 普 教 育 館 (2009) 。禁 毒 有 我 。 Retrieved May 21, 2010, from http://shjdg.org/detail.asp?id=443

For Chapter 3

Bahr, S.J., Maughan, S.L., Marcos, A.C., Li, B., (1998). Family, Religiosity, and the Risk of Adolescent Drug Use. *Journal of Marriage and Family,* 60, 979-992.

Bohrnstede G.W. and Knoke D. (1994). *Statistics for Social Data Analysis*. Third Edition. F. E. Peacock. Chapter 5, page 155-188.

Brown, S.L., (2004). Family Structure and Child Well-Being: The Significance of Parental Cohabitation. *Journal of Marriage and Family,* 66, 351-367.

Buehler, C., (2006). Parents and Peers in Relation to Early Adolescent Problem Behavior. *Journal of Marriage and Family,* 68, 109-124.

Chilcoat, H.D.S.D., Anthony, J.C.P.D., (1996). Impact of Parent Monitoring on Initiation of Drug Use through Late Childhood. *Journal of the American Academy of Child & Adolescent Psychiatry,* 35, 91-100.

Coombs, R.H., Landsverk, J., (1988). Parenting Styles and Substance Use during Childhood and Adolescence. *Journal of Marriage and Family,* 50, 473-482.

Eitle, D., (2006). Parental gender, single-parent families, and delinquency: exploring the moderating influence of race/ethnicity. *Social Science & Medicine,* 35, 727-748.

Guo, J.P.D., Hill, K.G.P.D., Hawkins, J.D.P.D., Catalano, R.F.P.D., Abbott, R.D.P.D., (2002). A Developmental Analysis of Sociodemographic, Family, and Peer Effects on Adolescent Illicit Drug Initiation. *Journal of the American Academy of Child & Adolescent Psychiatry,* 41, 838-845.

Hemovich, V., Crano, W.D., (2009). Family Structure and Adolescent Drug Use: An Exploration of Single-Parent Families. *Substance Use & Misuse,* 44, 2099-2113.

Hoffmann, J.P., (2002). The Community Context of Family Structure and Adolescent Drug Use. *Journal of Marriage and Family,* 64, 314-330.

Hoffmann, J.P., Johnson, R.A., (1998). A National Portrait of Family Structure and Adolescent Drug Use. *Journal of Marriage and Family,* 60, 633-645.

Lansford, J.E., Ceballo, R., Abbey, A., Stewart, A.J., (2001). Does Family Structure Matter? A Comparison of Adoptive, Two-Parent Biological, Single-Mother, Stepfather, and Stepmother Households. *Journal of Marriage and Family,* 63, 840-851.

Lau, J.T.F., Kim, J.H., Tsui, H.-Y., Cheung, A., Lau, M., Yu, A., (2005). The relationship between physical maltreatment and substance use among adolescents: A survey of 95,788 adolescents in Hong Kong. *Journal of Adolescent Health,* 37, 110-119.

Sun, Y., (2001). Family Environment and Adolescents' Well-Being before and after Parents' Marital Disruption: A Longitudinal Analysis. *Journal of Marriage and Family*, 63, 697-713.

Wang, S.-H., Chen, W.-C., Lew-Ting, C.-Y., Chen, C.-Y., Chen, W.J., (2010). Running away experience and psychoactive substance use among adolescents in Taiwan: multi-city street outreach survey. *BMC Public Health*, 10, 1-9.

For Chapter 4

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks: SAGE Publications.

Patton, M. Q. (1990). *Qualitative evaluation and research methods.* Newbury Park, CA: SAGE.

Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation, 27*(2), 237-246.

For Chapter 5

Baumann, M., Spitz, E., Predine, R., Choquet, M., & Chau, N. (2007). Do male and female adolescents differ in the effect of individual and family characteristics on their use of psychotropic drugs? *Eur J Pediatr, 166*(1), 29-35.

Baumrind, D. (1985). Familial antecedents of adolescent drug use: a developmental perspective. *NIDA Res Monogr, 56*, 13-44.

Baumrind, D., & Moselle, K. A. (1985). A development perspective on adolescent drug abuse. *Adv Alcohol Subst Abuse, 4*(3-4), 41-67.

Beauvais, F. (1992). The consequences of drug and alcohol use for Indian youth. *Am Indian Alsk Native Ment Health Res, 5*(1), 32-37.

Beauvais, F., & Oetting, E. R. (1986). Drug use in an alternative high school. *J Drug Educ, 16*(1), 43-50.

Brook, J. S., Cohen, P., & Gordon, A. S. (1983). Impact of attrition in a sample in a longitudinal study of adolescent drug use. *Psychol Rep, 53*(2), 375-378.

Cheung, N. W., & Cheung, Y. W. (2006). Is Hong Kong experiencing normalization of adolescent drug use? Some reflections on the normalization thesis. *Subst Use Misuse, 41*(14), 1967-1990.

Chu, P. S., Ma, W. K., Wong, S. C., Chu, R. W., Cheng, C. H., Wong, S., et al. (2008). The destruction of the lower urinary tract by ketamine abuse: a new syndrome? *BJU Int, 102*(11), 1616-1622.

Chung, Y. Y., & Shek, D. T. (2008). Reasons for seeking treatment among young drug abusers in Hong Kong. *Int J Adolesc Med Health, 20*(4), 441-448.

Copello, A. G., Templeton, L., & Velleman, R. (2006). Family interventions for drug and alcohol misuse: is there a best practice? *Curr Opin Psychiatry, 19*(3), 271-276.

Joe Laidler, K. A. (2005). The rise of club drugs in a heroin society: the case of Hong Kong. *Subst Use Misuse, 40*(9-10), 1257-1278.

Kandel, D. B. (1980a). Developmental stages in adolescent drug involvement. *NIDA Res Monogr,30*, 120-127.

Kandel, D. B. (1980b). Drug use by youth: an overview. *NIDA Res Monogr, 38*, 1-24.

Katz, P. (1997). Adolescence, authority, and change. *Adolescent Psychiatry: Developmental and Clinical Studies, 21*, 49–65.

Lambie, G. W. (2004). Motivational Enhancement Therapy: A tool for professional school counselors working with adolescents. *Professional School Counseling, 7*(4), 268–276.

Parker, H. (2003). Pathology or modernity? Rethinking risk factor analyses of young drug users. *Addiction Research & Theory, 11*(3), 141-144.

Parker, H., Williams, L., & Aldridge, J. (2002). The Normalization of 'Sensible' Recreational Drug Use: Further Evidence from the North West England Longitudinal Study. *Sociology, 36*(4), 941-964.

Shek, D. T. (1997). The relation of family functioning to adolescent psychological well-being, school adjustment, and problem behavior. *J Genet Psychol, 158*(4), 467-479.

Shek, D. T. (2002). Family functioning and psychological well-being, school adjustment, and problem behavior in chinese adolescents with and without economic disadvantage. *J Genet Psychol, 163*(4), 497-502.

Shek, D. T. (2005). Paternal and maternal influences on the psychological well-being, substance abuse, and delinquency of Chinese adolescents experiencing economic disadvantage. *J Clin Psychol, 61*(3), 219-234.

Sim, T. (2006). Adolescent Drug Abuse in Chinese Families: An Insider Perspective. *Journal of Constructivist Psychology, 19*(4), 321-341.

Sim, T. (2007). Structural Family Therapy in Adolescent Drug Abuse. *Clinical Case Studies, 6*(1), 79-99.

Sim, T., & Chiyi, H. U. (2009). Family Therapy in the Forbidden City: A Review of Chinese Journals From 1978 to 2006. *Family Process, 48*(4), 559-583.

Sim, T., & Wong, D. (2008). Working with Chinese Families in Adolescent Drug Treatment. *Journal of Social Work Practice, 22*(1), 103-118.

Usher, K., Jackson, D., & O'Brien, L. (2005). Adolescent drug abuse: helping families survive. *Int J Ment Health Nurs, 14*(3), 209-214.

Velleman, R. D., Templeton, L. J., & Copello, A. G. (2005). The role of the family in preventing and intervening with substance use and misuse: a comprehensive review of family interventions, with focus on young people. *Drug Alcohol Rev, 24*(2), 93-109.

APPENDIX A: MAJOR ANTI-DRUG WEBSITES (REFER TO CHAPTER 2)

Some of the websites that provide drug-related information to youth and parents.

Australia
National Drugs Campaign
http://www.drugs.health.gov.au/

Drug Information Clearing House
http://www.druginfo.adf.org.au/druginfo/drugs

Canada
Xperiment
http://xperiment.ca/

National Anti-Drug Strategy's Youth Drug Prevention for Parents
http://www.nationalantidrugstrategy.gc.ca/parents/parents.html

Not4me
http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/youth-jeunes/index-eng.php

Hong Kong
Narcotics Division
http://www.nd.gov.hk/tc/index.htm

Community Drug Advisory Council
http://www.cdac.org.hk/eng_news.htm

Life Education Activity Programme Hong Kong
http://www.leap.com.hk/

Hong Kong Education City Anti Drug Blog
http://www.hkedcity.net/article/special/drugs/

PRC
青少年遠離毒品網
http://cyc90.cycnet.com/cycnews/jindu/index.jsp

Narcotics Control Bureau of the Ministry of Public Security
http://www.mps.gov.cn/n16/n80209/index.html

Beijing
http://www.bjjdzx.org/index.htm

Shanghai

http://shjdg.org/index.asp

Singapore
National Council Against Drug Abuse
http://www.drugfree.org.sg/

Central Narcotics Bureau
http://www.cnb.gov.sg/

Taiwan
On-line museum of anti-drug resources
http://antidrug.fda.gov.tw/

Ministry of Justice Refrain Drug Information
http://refrain.moj.gov.tw/html/helpme.php

U.K.
FRANK – a national helpline, website and media campaign on drugs
http://www.talktofrank.com/

U.S.
Above the Influence
http://www.abovetheinfluence.com/

The Partnership for a Drug Free America
http://www.drugfree.org/

Parents. The Anti Drug.
http://www.theantidrug.com/

APPENDIX B: ANTI-DRUG INITATIVES IN MAJOR COUNTRIES (REFER TO CHAPTER 2)

	Parent Ed / Parenting Support	Home School Collaboration	Community Education	Media	Voluntary Service	School Drug Education	Others
United Kingdom: Think family	-FRANK (media campaign) -Think Family Pathfinder* -Parenting Early Intervention Project (use Triple P, Incredible Yrs, SFSC, SF 8-14, FAST)* -Family Intervention Project (FIP)* to reduce nuisance caused to neighbor - CWDC's parenting academy* - Parent Support Advisor* (*not drug specific)	Parent Support Advisor (PSA)	FRANK	FRANK	Minimal	- Mandatory drug ed in Science and Citizenship, start at Key Stage 1 (age 5) - plan to make Personal, social & health ed (PSHE) compulsory - "Blueprint" earlier that emphasize parent component	-Positive Futures -Allow sniffer dog and drug testing in school -Targeted Youth Support (TYS) to identify vulnerable youth, intervene early, integrated services to youth -Support the grandparents/carers of children with incarcerated parents - Family Nurse Partnership*, integrated support* by L.A. for young parents; Sure Start Centers* for disadvantaged groups (*not drug specific)
	Parent Education / Parenting Support	Home School Collaboration	Community Education	Media	Voluntary Service	School Drug Education	Others

	Parent Education / Parenting Support	Home School Collaboration	Community Education	Media	Voluntary Service	School Drug Education	Others
United States: Community-based	- National Youth Anti-Drug Media Campaign "Above the Influence" to provide info and resources to parents --SAMHSA's educational websites such as "Building Blocks for a Healthy Future" (age 3-6) and "Family Guide" (age 7-18)* (*not drug specific)	/	- Prevention Prepared Communities (PPC), - Communities that Care (CTC), - DFC (federal funding to community level) - SPF-State Incentive Grant	-Strengthen the National Youth Anti-Drug Media Campaign ("Above the Influence") - NineLine 1-800-999-9999	/	- No "national strategy" on drug education - Increase law enforcement officers participation in community prevention programs in school, community coalitions, etc.	- Random student drug testing (non punitive)** - Support SA prevention on college campuses - Expand research on new drugs: inhalants, "study" drugs, painkillers - Increase collaboration between Justice and prevention organizations - Support mentoring children with incarcerated parents - Nurse Family Partnership* support for young parents; Temporary Assistance for Needy Families (TANF)* program for minor parents (*not drug specific)
	Parent Education / Parenting Support	**Home School Collaboration**	**Community Education**	**Media**	**Voluntary Service**	**School Drug Education**	**Others**
Australia: Kids in Focus	-Family Support Program (FSP), "Kids in Focus" -Info on National Drugs Campaign website, Counseling Online (both direct phoneline and text counseling), Lifeline* (suicide prevention), Kids helpline*, Raising Children Network* - Family Relationship Education and Skills Training (FREST)* (*not drug specific)	/	- National Drug Campaign - Community Investment Program*, Local Answers* - Communities that Care (CTC) (pilot stage) *not drug specific	- National Drug Campaign - info hotline	/	- Principles of Drug Ed in School (2004) encourage drug education to be more than health education	- Against school drug testing - For young parents: Young Parents Early Intervention Parenting Program (YPEIPP) * (*not drug specific)
	Parent Education / Parenting Support	**Home School Collaboration**	**Community Education**	**Media**	**Voluntary Service**	**School Drug Education**	**Others**

	Parent Education / Parenting Support	Home School Collaboration	Community Education	Media	Voluntary Service	School Drug Education	Others
Canada: Youth active participation	- web and print info from Canadian Centre on Substance Abuse and Health Canada on drug info, communication skills, importance of family cohesion, and build resilience in child - Community projects from Drug Strategy Community Initiatives Fund -National Crime Prevention Centre's funded initiatives for at-risk families - upcoming: Canadian Standard for Family-based youth substance abuse prevention	- Canadian Standard for school-based youth substance abuse prevention encourage family engagement	- Media/Youth Consortium - Community projects from Drug Strategy Community Initiatives Fund - upcoming: Canadian Standard for Community-based youth substance abuse prevention	- Media/Youth Consortium - Xperiment.ca and not4me.ca - National Kids Help Phone	/	- Mostly covered in health and physical education curriculum - Canadian Standard for School-based youth substance abuse prevention as guiding principles (revised version in summer 2010)	Positive engagement such as: - Youth-led creation of youth website - Youth representative in National Advisory Group of Youth Substance Abuse Prevention (YSAP) - Support for young parents: Young Parent Programs (YPP)*, Young/Single Parent Support Network (YSPSN)* at Ottawa (*not drug specific)
	Parent Education / Parenting Support	**Home School Collaboration**	**Community Education**	**Media**	**Voluntary Service**	**School Drug Education**	**Others**
Taiwan: School-based	-Through parent-student school activities organized by schools - Drug and law seminars organized by govt and NGO -National drug-specific helpline	-Activities organized by schools -Outreach, counseling service for "high risk" families and out of school children	- Drug and law seminars organized by govt and NGO -National drug-specific helpline -community pharmacist at community counseling station	TV, internet, VCD, print material	Anti-drug ambassadors from Ministry of Interior	- At least one class in each school term in the health curriculum need to include anti-drug material - Teachers undergo drug-material training and finish within 3 years - "Spring Sun" working group provide counseling for students who tested positive in drug tests.	- Mandatory and punitive# drug test in school for those needing "intensive care" - After-school patrol teams to check students in café and clubs, etc. and identify students that need to take drug-test afterwards - Encourage healthy activities in school and community for youth participation
	Parent Education / Parenting Support	**Home School Collaboration**	**Community Education**	**Media**	**Voluntary Service**	**School Drug Education**	**Others**
School-based	Through school program (minimal), leisure activities, information on internet	Through school program	Seminars on drug and legal information	TV, internet, celebrity	Recruit volunteer from school and community	Mandatory drug education in curriculum from p5 to F2, 2 hours per year	- Law enforcement include death penalty - Encourage healthy activities in school and community for youth participation

	Parent Education / Parenting Support	Home School Collaboration	Community Education	Media	Voluntary Service	School Drug Education	Others
Singapore: Education	Leisure activities, information on internet	/	Anti-drug exhibitions, seminars	TV, internet, celebrity	Volunteer Guidance Officers to befriend with high-risk youths	School assembly talks by Central Narcotics Bureau and Police	Law enforcement include death penalty and stroke of canes

Notes

** U.S.: Drug test can be conducted among students who participate in competitive extracurricular activities that they voluntarily participated in. The exact protocol is determined by each State, but typically repeated positive drug test of the students would lead to suspension of extracurricular activities, but not academically and without legal implications (i.e., no imprisonment / sending to juvenile court as a result of the positive drug test would occur).

Taiwan: If the test for the student is still tested positive after three months' follow up, those using Category 1 and 2 drugs (Heroin, Amphetamine, etc) need to be reported to the juvenile court; those using Category 3 and 4 drugs (Ketamine, Diazepam, etc.) need counseling and will be tested again; yet if it is still tested positive after further counseling, need to be sent to juvenile court, together with requiring the family to attend mandatory "health and counseling education".

APPENDIX C: THE DISTRIBUTION OF DRINKING AND SMOKING HABITS BEHAVIORS IN GROUP 1 PARTICIPANTS IN FOCUS GROUP (REFER TO CHAPTER 3)

1. Drinking habit

Among Form 1 and 2 respondents, 1.1% of boys and 0.5% of girls were daily drinkers. 6.3% of boys and 5.5% of girls reported that they drank alcohol weekly.

Distribution of drinking alcohol pattern among Form 1 and 2 respondents

	Boys	Girls
Yes, daily	1.1	0.5
Yes, I drink 3 to 6 days a week	1.5	2.3
Yes, I drink 1 to 2 days a week	3.7	2.7
Yes, but I drink less than a day per week in average	26.7	21.5
No, I do not drink at all	66.3	72.8
No response	0.7	0.2
Total %	100.0	100.0
Total respondents	460	437

Among Form 3 to7 respondents, 1.3% of boys and 0.1% of girls were daily drinkers.

7.1% of boys and 2.2% of girls reported that they drank alcohol weekly.

Distribution of drinking alcohol pattern among Form 3 to 7 respondents

Drinking status	Boys	Girls
Yes, daily	1.3	0.1
Yes, I drink 3 to 6 days a week	1.1	0.1
Yes, I drink 1 to 2 days a week	4.7	2.0
Yes, but I drink less than a day per week in average	34.3	30.4
No, I do not drink at all	58.3	67.3
No response	0.3	0.2
Total %	100.0	100.0
Total respondents	1052	1277

2. Smoking habit

Among Form 1 and 2 respondents, 5.5% of boys and 1.1% of girls smoked more than

six cigarettes a week. 7.4% of boys and 3.4% of girls reported that they were current

smokers, including those who use cigarette occasionally.

Distribution of smoking habits among Form 1 and 2 respondents

	Boys	Girls
Never	72.2	83.3
I have smoked once or several times*	14.6	9.6
I used to smoke but have quit	3.7	2.1
I sometimes smoke but less than one cigarette a week	1.3	0.9
I smoke one to six cigarettes a week	0.9	1.4
I smoke more than six cigarettes a week	5.2	1.1
No response	2.2	1.6
Total %	100.0	100.0
Total respondents	460	437

Among Form 3 to 7 respondents, 6.3% of boys and 1.7% of girls smoked more than

six cigarettes a week. 8.2% of boys and 3.5% of girls reported that they were currently using

cigarettes, including occasional smokers.

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Distribution of smoking habits among Form 3 to 7 respondents

Smoking status	Boys	Girls
Never	71.3	78.1
Had tried smoking	16.5	15.0
Used to smoke	3.6	3.2
Smoke occasionally	1.1	1.1
Smoke 1-6 cigarettes per week	0.8	0.7
Smoke more than 6 cigarettes per week	6.3	1.7
No response	0.4	0.2
Total %	100.0	100.0
Total respondents	1052	1277

3. Prevalence of regular drinking and current smoking

Overall, junior boys (Form 1 to 2) and older boys (Form 3 to 7) have similar prevalence of regular drinking (6.3% vs 7.1%) and current smoking (7.4% and 8.2%). Junior girls significantly had a higher prevalence of regular drinking than older girls (5.5% vs 2.1%), but they had similar prevalence of current smoking.

Prevalence of regular drinking and current smoking among in-school respondents

Boys

		N	Regular drinking			Current smoking		
			n	%	95% C.I.	n	%	95% C.I.
Form	1	224	15	6.7	(4, 11.1)	17	7.6	(4.7, 12.2)
	2	234	14	6.0	(3.5, 10.1)	17	7.3	(4.5, 11.7)
	3	276	16	5.8	(3.6, 9.5)	23	8.3	(5.5, 12.5)
	4	240	18	7.5	(4.7, 11.9)	22	9.2	(6.0, 13.9)
	5	251	25	10.0	(6.7, 14.7)	28	11.2	(7.7, 16.2)
	6	134	9	6.7	(3.5, 12.9)	9	6.7	(3.5, 12.9)
	7	151	7	4.6	(2.2, 9.7)	4	2.6	(1.0, 7.1)
F.1-2		458	29	6.3	(4.4, 9.1)	34	7.4	(5.3, 10.4)
F.3-7		1052	75	7.1	(5.7, 8.9)	86	8.2	(6.6, 10.1)

Girls

		N	Regular drinking			Current smoking		
			n	%	95% C.I.	n	%	95% C.I.
Grade	1	211	10	4.7	(2.5, 8.8)	4	1.9	(0.7, 5.1)
	2	224	14	6.3	(3.7, 10.6)	11	4.9	(2.7, 8.9)

3	276	9	3.3	(1.7, 6.3)	10	3.6	(1.9, 6.7)
4	245	4	1.6	(0.6, 4.4)	11	4.5	(2.5, 8.1)
5	341	10	2.9	(1.6, 5.5)	19	5.6	(3.6, 8.7)
6	222	2	0.9	(0.2, 3.6)	3	1.4	(0.4, 4.2)
7	189	2	1.1	(0.3, 4.2)	2	1.1	(0.3, 4.2)
F.1-2	435	24	5.5	(3.7, 8.2)	15	3.4	(2.1, 5.7)
F.3-7	1273	27	2.1	(1.5, 3.1)	45	3.5	(2.6, 4.7)

APPENDIX D: THE DISTRIBUTION OF DRINKING AND SMOKING HABITS BEHAVIORS IN GROUP 2 PARTICIPANTS IN FOCUS GROUP (REFER TO CHAPTER 3)

1. Drinking habit

Respondents are divided into studying and working young adults. Studying subjects are respondents who reported that they were full time studying students (including self-study students), while working respondents were those who reported that they were currently working or looking for jobs, but excluding those who were house workers.

Among young adult respondents, 1.1% of males and 1.3% of females were daily drinkers. 10.0% of males and 4.8% of females reported that they drank alcohol weekly.

Distribution of respondents by drinking among young adult respondents

Drinking status	Males	Females
Yes, everyday	1.1	1.3
Yes, 3-6 days a week	2.5	0.8
Yes, 1-2 days a week	7.4	2.7
Yes, but less than a day per week	47.3	34.3
No	40.6	59.9
No response	1.1	0.8
Total %	100.0	100.0
Total respondents	611	594

2. Smoking habit pattern

Among the young adult respondents, 22.8% of boys and 8.9% of girls reported that they smoked every day.

Distribution of respondents by smoking among young adult respondents

Smoking status	Males	Females
Never	58.6	76.8
Ex-occasional smoker	9.3	6.9
Ex-daily smoker	1.3	2.2
Occasionally	6.5	4.4
Daily smokers (subtotal)	22.8	8.9
Daily (1-5 cigarettes per day)	4.6	2.4
Daily (6-15 cigarettes per day)	12.1	5.4
Daily (≥16 cigarettes per day)	6.1	1.1
No response	1.5	0.8
Total %	100.0	100.0
Total respondents	611	594

3. Prevalence of regular drinking and current smoking

The prevalence of regular drinking for studying and working young males were 5.9% and 14.9% respectively. The prevalence of current smoking were 12.2% and 42% respectively. The prevalence of regular drinking for studying (Need a definition!) and working young females were 4% and 5.5% respectively, while the prevalence of current smoking were 3.6% and 19% respectively.

Males have significantly higher prevalence of regular drinking and current smoking than females. Working males have significantly higher prevalence of regular drinking and current smoking than studying males. Working females have significantly higher prevalence of current smoking than studying females.

Male

		N	Regular drinking			Current smoking		
			n	%	95% C.I.	n	%	95% C.I.
Grade	Studying	255	15	5.9	(3.5, 9.8)	31	12.2	(8.5, 17.3)
	Working	350	52	14.9	(11.3, 19.5)	147	42.0	(35.7, 49.4)
Overall		605	67	11.1	(8.7, 14.1)	178	29.4	(25.4, 34.1)

Female

		N	Regular drinking			Current smoking		
			n	%	95% C.I.	n	%	95% C.I.
Grade	Studying	225	9	4.0	(2.1, 7.7)	8	3.6	(1.8, 7.1)
	Working	343	19	5.5	(3.5, 8.7)	65	19.0	(14.9, 24.2)
Overall		568	28	4.9	(3.4, 7.1)	73	12.9	(10.2, 16.2)

APPENDIX E: GENERAL GUIDELINES: KEY TOPICS FOR DISCUSSION (REFER TO CHAPTER 4)

1. Roles of family plays in young people's life and in relation to drug abuse

2. Coping with drug abuse within the family

   a. How does family cope with the loved one who used drugs?

   b. How does family member who used drug deal with family reactions to his/her addictive behaviours?

   c. What are the impacts of drug addiction on all family members?

Prompts for specific groups:

1.   SIX groups: Youth's voice and perspectives

Teens: 12-17 yrs old	Adults: 18-24 yrs old
TWO groups: Non-users • How can family protect its members from addiction problem? • Under what circumstances, family may increase young people's risk for addiction?	
TWO groups: Experimenting drug user • How can family protect its members from addiction problem? • Under what circumstances, family may increase young people's risk for addiction? • How can family be better supported to detect drug abuse in family? What were the critical warning signs? How was it discovered? How did the process look like? How was it dealt with immediately?	

- How did family cope with the aftermath of finding someone abusing drug occasionally? How were the interactions among family members affected? What were the major concerns? What were the sources of strengths for family to battle against experimentation of drug use? How was the family balance/ harmony regained (if applicable)?

- What strategies have the family found helpful in managing someone using drug occasionally? How helpful was it and for who?

- What strategies have the family tried that did not work in counselling the loved who used drug occasionally?

- How did the services affect the family's coping with irregular drug abuse within the family?

- How can family be supported to counsel its members against drug abuse at the early phase of addiction?

- How did friends, relatives, and professionals might affect family's ability to cope with occasional drug abuse within the family?

APPENDIX F: DETAILS OF THE PILOT PROJECT (REFER TO CHAPTER 5)

The project was initiated by the Department of Pediatrics, TKO Hospital and a number of NGOs which aims to:

1. Provide integrated physical and psychosocial assessment for adolescents with substance use problem through a fast and coordinated referral system;

2. Provide feedbacks to adolescents in terms of their physical and cognitive functional impairment in relation to substance use;

3. Provide health education and counseling to adolescents so as to motivate them to change their drug use behavior; and

4. Adopt multidisciplinary approach to address the psychosocial needs of those teens with substance use in order to change their drug use behavior.

Setting:

(1) Out-patient clinic

(2) In-patient service for those with major complications and psychosocial needs

Referral system:

Direct referral from NGOs, school social workers, other community health professionals or A&E

Multidisciplinary Service

1. **Assessment**

2. **Intervention**

3. **Evaluation**

Service	Disciplines involved
I. Assessment (Physical and Psychosocial)	
1. Drug screening – urine test	Pediatrician
2. Physical check up	Pediatrician
3. Cognitive assessment – Tools for testing memory and motor coordination	Occupational therapist Nurse
4. Psychosocial assessment (HEADSS) – Identification of other risk behaviors – STDs screening – School and family issues – Mental health co-morbidities	Pediatrician Refer to child psychiatrist for mental health problems if appropriate
II. Intervention	
1. Health Education on substance abuse	Pediatrician
2. Psycho-cognitive rehabilitation – Feedbacks to adolescents after assessment – Motivation enhancement	Pediatrician Social worker
3. Social rehabilitation – Restoration of schooling – Vocational training – Family intervention	Social worker
4. Follow up – Follow up for adolescent health issues – Follow up for behavioral modification	Pediatrician Nurse Social worker
III. Evaluation	
Outcome measures – Change of physical and cognitive function – Behavioral change – Engagement in other risk activities	Pediatrician Social worker

APPENDIX G: YOUTH AND/OR FAMILY INTERVIEW QUESTIONS (REFER TO CHAPTER 5)

The content of the family interview would include problems and difficulties encountered by these families, perception of drug abuse, attempted solutions towards the drug abuse, parental functioning, parent-child relationship, and family dynamics.

Family Composition and Dynamics

• Ask the child or family members to describe their family to the researcher, e.g. the number of family members, age and sex, who are living together, their education and employment, significant others in close contact, families of origin, past and current important life events, adaptation to these changes, what they like to do together as a family, who is close to whom, who does what activities with whom, etc.

Perception of Adolescent's Drug Abuse Problem

• What is the drug abuse pattern of the adolescent?

• When, how and by whom was the problem discovered?

• What are the parent(s)' responses to the problem? Who is most worried?

• Who referred the adolescent for treatment? Who in the family agreed/disagreed most with having the referral? Is the treatment effective?

• What do different family members do to help the adolescent to tackle the drug problem? What does the adolescent do in response? Does the help make it easier

or harder to manage the problem? Who is in charge of the problem?

Role of the professionals involved

- What other agencies or professionals have been involved with you or your family in the past or currently?

- Who are the professionals involved, for how long and what are the issues that you are trying to resolve with them? Have you resolved the problems with them? If yes, how? If not, why not?

- What has been your experience with the other professionals? What was useful and what was not useful?

Parental functioning

- How do the parents function as the executive system in the family? Can they exercise their authority? Are they in-charge?

- Do they have the power as parents over their child?

- Do the parents have expectations of their child in particular areas?

- What are the parental differences, and how do parents resolve the conflicts?

Any Other Problems/Concerns Encountered by the Family

- Does the adolescent have other problems? What are they? Does the adolescent perceive the problems the same or differently? How do the parents deal with it? Outcome?

- Do other family members have problems? What are the problems? Do they

perceive the problems the same or differently? How does the family tackle the problems? Outcome?

Adolescent's Peer Network

- What is the peer network? What is the relationship with peers?

Tackling Drug Abuse in Future

- What individual and environmental changes are needed to help the adolescent tackle the drug abuse problem?

- Who is going to do what in order to be effective?

- Are there any foreseeable difficulties?

- How does the family plan to resolve the problems?

APPENDIX H: INVOLVED CLICIANS/PROFESSIONALS INTERVIEW QUESTIONS (REFER TO CHAPTER 5)

Perception of Adolescent's Drug Abuse Problem

- What do you think as the core reason(s) for the adolescent's drug use behavior?

- What is the drug abuse pattern of the adolescent?

- What are the roles of the adolescent's parent(s) play for the adolescent's drug use behavior?

- What are the roles of the adolescent's school play for the adolescent's drug use behavior?

- What are the roles of the adolescent's peers play for the adolescent's drug use behavior?

Service utilization pattern

- How the drug use behavior was discovered?

- Who was the first professional/clinician/worker provided the help/treatment? Did he/she notify the adolescent's parents? If yes, how did they respond? If no, why not?

- Then, how many professionals were/are involved in this case?

- How many times have you seen this adolescent? Has he/she ever missed any appointment with you?

- What are your treatment goals of this adolescent?

- What did you do with him/her?

- How likely will this adolescent reach the treatment goals?

- Who are the professionals involved, for how long and what are the issues that you are trying to resolve with them? Have you resolved the problems with them? If yes, how? If not, why not?

- What has been your experience with the other professionals? What was useful and what was not useful?

- What made a successful treatment? What made a rather less successful treatment?

Role of the adolescent involved in the pilot project

- Was/is he/she very committed during the treatment?

- How did he/she behave?

Role of the families involved in the pilot project

- Were/are they very committed during the treatment?

- How did they behave?

- What do different family members do to help the adolescent to tackle the drug problem? What does the adolescent do in response? Does the help make it easier or harder to manage the problem? Who is in charge of the problem?

Any Other Problems/Concerns Encountered by the Family

- Does the adolescent have other problems? What are they? Does the adolescent perceive the problems the same or differently? How do the parents deal with it?

Outcome?

- Do other family members have problems? What are the problems? Do they perceive the problems the same or differently? How does the family tackle the problems? Outcome?

Tackling Drug Abuse in Future

- Who is going to do what in order to be effective?

- What individual and environmental changes are needed to help the adolescent tackle the drug abuse problem?

- Are there any foreseeable difficulties?