

How Can Fathers be More Actively Engaged in the Drug Education of their Children?

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Craigie SHS (Material Evaluation)
Ballajura Community College (Material Evaluation)
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Yuluma Primary School (Material Evaluation)

Formative Consultation Interview Venues/Contacts

Wanneroo Markets
Anna Wood Foundation
Lifeline Lone Fathers Support Centre

Sporting Venues/Clubs

Wanneroo Netball Centre
Joondalup Netball Centre
Wembley Downs Football Club
Wembley Downs Soccer Club
North Beach Soccer Club

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EXECUTIVE SUMMARY

This one-year study investigated the feasibility of providing fathers with a variety of strategies that could be used to increase fathers' discussion of drug-related (and other) issues with their children. The father-based communication information materials developed for this project were the result of consultation with health and education professionals with experience in parent and drug education, interviews with fathers, fathers focus groups and pilot-testing of materials with fathers from three metropolitan schools. A literature review was also conducted to determine evidence-based practices and current gaps in efforts to engage fathers in health promotion (especially drug education) strategies.

Fathers of nine to 14 year old children and key health and education stakeholders favourably reviewed the subsequent *'Dads, Kids and Drugs'* information materials. This evaluation has found that these materials may be a promising intervention strategy to increase fathers' involvement in the drug education of their children.

The study consisted of five major stages including, literature review, Advisory Panel consultation, formative consultation interviews, focus group discussions and an evaluation of the information materials.

A literature review revealed that although parents play a significant role in the development of children's knowledge, attitudes and skills regarding drug-use, mothers (70-90%) have been the principal participants and respondents in all parent-directed program activities implemented by the Western Australian Centre for Health Promotion Research. A model, depicting variables that potentially predict fathers' involvement, was designed to highlight areas for intervention. Substantial literature suggests that fathers can influence adolescent behaviour significantly, and that absence of a father figure is associated with increased incidence of cigarette smoking and other drug-use problems among teenagers. Consequently, the provision of effective drug education programs involving fathers of young adolescents has the potential to reduce drug-related harm in the community.

Consultation with the Advisory Panel and a review of the literature determined that very few evidence-based intervention programs were available that target fathers. A combination of central intercept interviews at sporting groups and surveys distributed through schools were used to recruit fathers. The Advisory Panel and research evidence suggested that the materials developed would be most appropriate in the form of a take-home package that focussed on communication strategies. As recommended, formative consultation interviews with fathers were conducted through sporting venues. These revealed that while only 30% (n=50) of respondents talked with their child about drug-related issues on a regular basis, 50% (n=81) liked talking with their children because it strengthened their relationship. Focus group discussions (with fathers recruited from intercept interviews and via schools) revealed that fathers felt they had little influence on their child's alcohol and tobacco use once they reached their teenage years. Fathers also reported feeling they had limited knowledge of drug-related issues and how to talk with their children about these issues.

Take-home drug information materials (*'Dads, Kids and Drugs'*) focusing on communication and parenting issues for fathers, were developed incorporating formative data gathered in previous stages. These materials targeted fathers with nine to 14 year old children.

Pilot testing of the materials developed was conducted with the fathers involved in the focus groups and fathers recruited through six school classes (one Year 6, two Year 7 and Year 8, and one Year 9 class). This testing indicated the materials were interesting and appropriate for fathers of children aged eight to ten. Recommendations from these groups are addressed in this report.

1 INTRODUCTION

1.1 Definitions

For the purpose of this report the term ‘drug’ includes alcohol, tobacco and other psychoactive drugs. The term ‘Fathers’ in this report includes all men who care for children including step-fathers, grandfathers and significant male figures in children’s lives. The term ‘children’ refers to young people between the ages of nine and 14 years.

1.2 Fathers’ involvement in the drug education of their children

It is widely recognised that most health-related behaviours are adopted during the formative years of childhood and adolescence.¹⁻⁵ Alcohol, tobacco and other drug-use are no exceptions. While schools provide a logical setting for drug education of young people, it is clear that parents should also be targeted with drug education information and skills. Parents provide primary role models for children and as such, play a significant role in the development of children’s knowledge, attitudes and skills regarding drug-use. Unfortunately, in all parent-directed interventions developed by the Western Australian Centre for Health Promotion Research (Child Pedestrian Injury Prevention Project, Friendly Schools Project, School Bicycle Helmet Project, and Drug Education Strategies for WA Parents) mothers (70-90%) have been the principal participants and respondents. There is, however, substantial literature that suggests that fathers can influence adolescent behaviour significantly.⁶⁻¹¹ Convincing evidence from many studies suggests that the absence of fathers increases the incidence of drug-use problems in adolescence including cigarette smoking,¹²⁻¹⁵ increases the likely severity of drug-related problems¹⁶ and increases risk of suicide.^{17,18} The provision of effective drug education programs for fathers of young adolescents has the potential to reduce drug-related harm in the community.

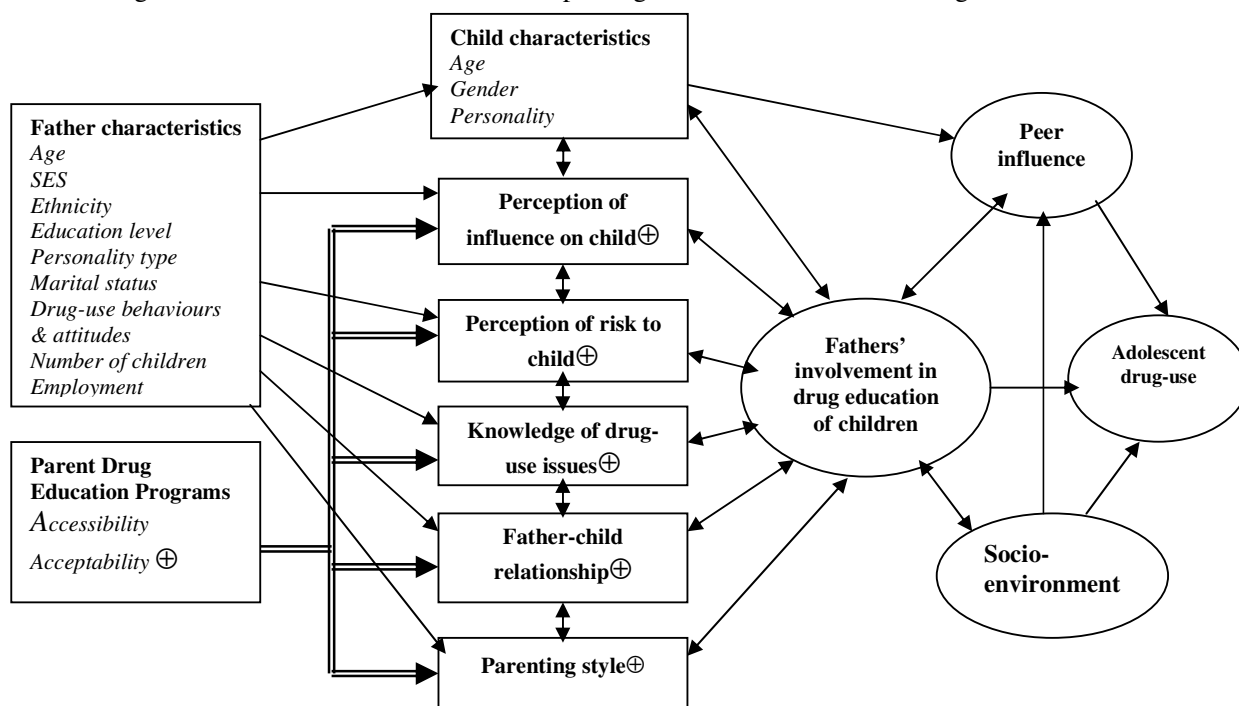
Since 1998 Shelley Beatty has conducted an extensive literature review to determine effective drug education strategies that encourage active involvement of parents. Review of current evidence-based practice in parent education programs revealed there are a limited number of parent education programs that address drug education or communication strategies that specifically target fathers. Despite limited research specific to fathers, trends found in research on parent and family dynamics have been transferred to the current study. Research focusing on improving fathers’ communication skills with their children has provided insights regarding father-child relationships.^{7,8,19,20} Subsequently, a number of variables have been identified as potential predictors of fathers’ involvement in the drug education of their children. These variables include fathers’ characteristics,^{8,10,21-29} children’s characteristics,^{3,5,6,10,12,23,28-30} perception of influence on child,^{5,6,11,31,32} perception of risk to their child,^{3,4} knowledge of drug issues,^{5,32,33} level of bonding and open communication,^{6,11,34} parental style^{2,3,6,7,12,14,26,35,36} and accessibility and acceptability of parent education programs.^{8,10} Peers^{2,3,9} and other socio-environmental factors^{9,36-38} may also influence fathers’ involvement and their children’s drug-use. These are represented in the model illustrated in Figure 1. This model was intended to depict areas for intervention within this project and is not

intended to be a comprehensive depiction of all variables that might predict fathers' involvement in the drug education of their children.

1.2.1 Fathers' characteristics

Holden, Lavigne and Cameron as cited in Meyers,⁸ suggest that social status and ethnicity may be key variables to fathers' involvement in parent drug education programs. Some researchers have indicated that fathers of middle-class income are more willing to be involved than lower income, single or step-parent families.²¹ This may be because single parents/fathers may have limited time and energy to participate in drug education programs,²² particularly if they are fathers of a large number of children. The socio-economic trend may also be related to the education level of the father, with fathers of higher education generally earning higher income.²³ Fathers' occupation may also pose time and scheduling barriers to involvement.²³ Fathers who are absent due to work or family separation may be unable to attend drug education programs or be involved in the drug education of their children. Unfortunately the literature indicates that children of lower-social-status and those who are separated from their fathers are at a greater risk of drug-use than those of higher-social-status fathers and whose fathers are accessible.¹⁰ Therefore it is critical to help fathers to become involved in the drug education of their children.

Figure 1 Theoretical model underpinning fathers' involvement in drug education.



⊕ = Variables underpinning the hypothesised intervention

Children of single-parent and step-parent families may also be at more risk of adolescent drug-use than children of nuclear families.^{24,25} Kumpfer,²⁶ however, reported structurally non-traditional families such as single and step-parent families do not necessarily indicate a high-risk family, but rather the relationship and parenting style may be more important predictors of adolescent drug-use. Selnow¹³

also reported parent/father-child relationships to be better predictors of adolescent drug-use than the number of parents at home.

Fathers' own drug-use behaviours and attitudes may influence their children's drug-use,²⁷ and may also influence their involvement in their children's drug education. There is some evidence to suggest that perceived stigmatisation of parents who use substances might be a barrier to parents' involvement in drug education programs.²² Fathers who use alcohol, tobacco or other drugs may be apprehensive about attending drug education programs for fear of stigmatisation by other parents, or perceiving themselves as being hypocritical.²²

Age and personality of the father may also influence the involvement of fathers in the drug education of their children.^{29,39}

1.2.2 Children's characteristics

Drug-use tends to increase as children get older.⁶ However, as the age of children increases parents may feel less influential in their lives.²³ It has been shown that younger children tend to talk more and spend more time with their parents as compared to older children (Jessor & Jessor as cited in Klitzner, Gruenwald and Bamberger.³⁰) Many parents/fathers believe they have little influence on their teenagers' drug-use.²³ For this reason, parent/father drug education programs need to start early so that by the time their children are exposed to drug-use they have an open and trusting relationship and communication strategies are well established.⁵ Strong parent-child relationships may also reduce adolescents' susceptibility to the influence of their peers.³

Some research has investigated the level of parental involvement based on the gender of their child.¹² In one study fathers were more involved with sons than daughters.²⁰ In another study, girls reported greater involvement with parents than boys.³ It seems unclear whether parents/fathers are more involved in the drug education of their boys or girls.

The child's personality may also influence their fathers' involvement in the drug education of their child.^{29,39}

1.2.3 Perception of influence on child

There is some evidence to suggest that parents are generally unaware of the extent of their influence on their children, particularly in drug education.^{31,32} Many parents feel they exert little influence and are therefore reluctant to discuss drug-related issues with their children.^{31,32} While parents may feel their influence diminishes as their children get older it has been reported that young people view parents as very important and necessary sources of drug-related information.⁵

Parents, and in particular fathers, need to be aware of their important influence on their adolescent children. Likewise, empowering parents to be more actively involved in the drug education of their children is an important health promotion strategy.^{31,32} Fathers should be alerted to the research that suggests that the closeness of father-child relationships may have greater influence on a child's drug-

use than mother-child relationships.^{6,11} Such information could assist to empower fathers to be more actively involved the drug education of their children.

1.2.4 Perception of risk to child

It seems that many parents/fathers underestimate their child's exposure to drugs and have an inaccurate perception of the number of their child's peers who may be using drugs.³ Research has reported that many children have tried alcohol and cigarettes by the time they are 12 years old.^{40,41} Assisting parents/fathers to appreciate the importance of open communication and to be involved in the drug education of their children before their children reach this age is therefore important.

1.2.5 Knowledge of drug issues

Previous research has suggested that parents/fathers are often misinformed about drug-use issues⁵ and as a result may be unsure and confused about how to discuss these issues with their children.³² Many parents reported feeling afraid that talking about the issue will make it seem that they condone drug-use. Parents also requested updated information on drug-use issues and 'how to talk' with children about these issues.⁵ Assisting parents/fathers to talk about drug-use issues with their children may increase their confidence in this aspect of their parenting.^{32,33}

1.2.6 Father-child relationship

Research has suggested that positive parent-child relationships have a positive influence on the prevention of drug-related harm.^{11,34} Some research also suggests that father-child relationships seem to have more pronounced effects on children's drug-use than mother-child relationships.^{6,11} For example, one study reported that fathers of non-drug-users were more actively involved in the family and that non-drug-users typically felt closer to their fathers, and were more dependent on them for advice and guidance than those who used drugs.⁶ When compared to those who didn't, fathers who developed and maintained a close relationship with their young children, had greater influence on drug involvement of their children during adolescence.⁶

Furthermore, the quality of the parent/father-child relationship appears to be more important than the number of parents in the home.³ A single or absent father can therefore influence their child's drug-use by developing and maintaining a strong and open relationship with their child.^{5,26}

1.2.7 Parenting style

Research has suggested that parenting style has a considerable influence on adolescent drug-use (Jessor et al., as cited in Brody et al.,^{2,3,6,12,14,35}). Programs that teach parents how to communicate clearly and set clear goals for their child's behaviour are more likely to reduce alcohol and other drug-use among their children than parents who don't.^{7,12,26,36}

1.2.8 Peer influence

Peer influence has been established as a factor related to the onset of adolescent drug-use, however the influence of peers is often overestimated because the quality of parent/father-child relationship and parents' role in peer selection has been left out.⁴² The quality of the parent/father-child relationship in early to middle childhood, appears to mediate adolescent susceptibility to peer influence.³ For example, adolescents who experience non-supportive family relationships were more likely to affiliate with and be influenced by, their peers than children who have a strong open relationship with their family (Jessor et al., as cited in Brody et al.,²).

Parents who also have a positive relationship with their adolescent's peer group are reported to be more likely to provide an important support base for adolescents who are making decisions about drug-use.⁹ It is therefore important to assist parents to appreciate that while peer influence certainly increases as children get older, parental influence need not diminish. Providing parents with strategies to maintain their connections with their fast-changing adolescents is also warranted.

1.2.9 Socio-environment

When considering variables that may influence fathers' involvement in the drug education of their children it is important to include social and environmental factors. Not only does the family influence a child's drug-related decisions but so too does the local community and the society in which they live.^{37,38} For example, children who are involved with individuals and social groups who are opposed to hazardous and harmful drug-use are less likely to engage in such behaviours.³⁷ The type of school a child attends may be an indicator of the society, in which the child lives and may also influence the social groups with which the child interacts. A study by Carlson and associates³⁶ found that the effects of their intervention designed to increase parent-child communication regarding alcohol use, differed by school setting and race.

1.2.10 Parent drug education programs

Evidence of drug education specifically targeting fathers appears to be sparse. In one study, the adaptation of parent education programs to meet the needs of fathers was investigated and recommended that programs must be structurally amenable and functionally pertinent to men.⁸ Another investigation concluded that attention to the differences that set fathers apart was a key factor in reaching fathers.¹⁰ It therefore seems important to appreciate fathers' ideas and listen to their concerns and acknowledge their value as role models for their children. For this reason, the current study focused on formative consultation with fathers to determine effective ways to recruit men to participate in drug education programs and develop an intervention specific to the needs and concerns of fathers.

1.3 Literature summary

Parents can have a strong and enduring influence on their children's drug-use behaviours. Research has shown that mothers tend to be more involved in the drug education of their children despite some evidence, suggesting fathers in some instances have a greater influence.

The belief that they have little influence on their children appears to be common among fathers. As a result many fathers may not be fully involved in the drug education of their children. The literature also reveals fathers' lack of involvement may be due to a lack of knowledge about drugs and a consequent lack of confidence. Fathers who enjoy open communication and a close relationship with their children appear to be more involved with their children and as a result, more inclined to be involved in parent education programs than fathers who do not. However, the accessibility and acceptability of these programs for fathers may also be a key influence on the likelihood of their involvement in the drug education of their children.

These variables appear to be areas where intervention may be necessary in order to increase fathers' involvement. Empowering fathers to become more involved in the drug education of their children is important. Optimal father education strategies would likely include increasing fathers' potential to influence their children and making this information accessible and based on the expressed needs of fathers.

This project aimed to determine ways to encourage fathers' involvement. By consulting with experts and fathers, this project aimed to identify strategies to actively engage fathers in the health promotion (and especially drug education) of their 9 to 14 year old children.

2 OBJECTIVES

The aim of the *'Dads, Kids and Drugs'* Project was to develop and evaluate materials based on effective intervention strategies to actively engage fathers in the promotion health (and especially drug education) of their 9 to 14 year old children.

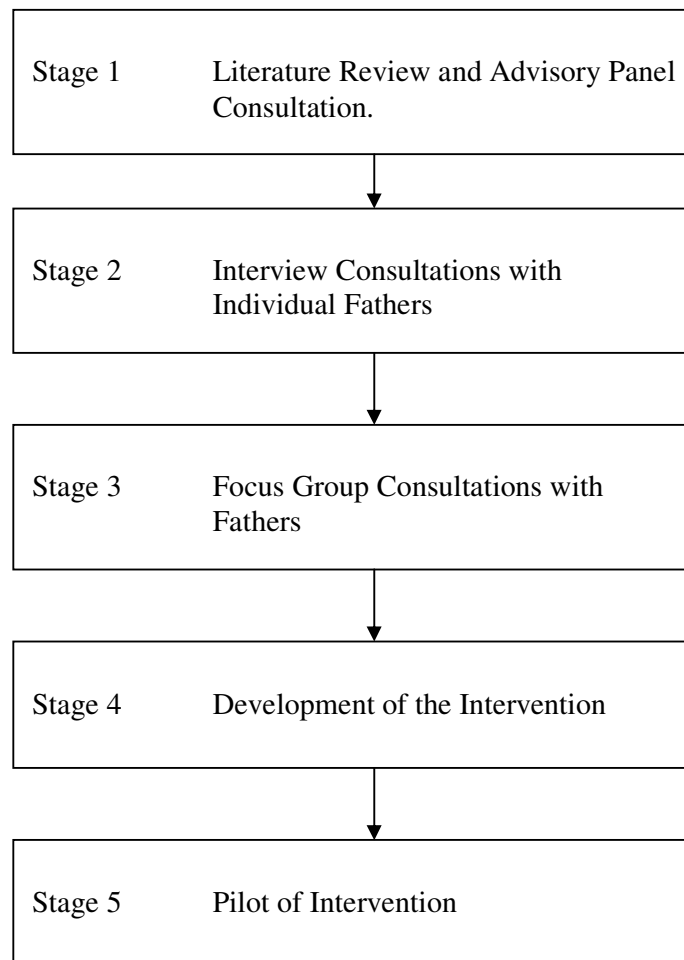
The specific strategy objectives were to:

- Establish an Advisory Panel comprising individuals interested and experienced in the areas of parent (especially fathers) education, parent/child communication and drug education, to develop criteria to determine best practice in these areas;
- Consult fathers via focus groups to determine effective ways to recruit men to participate in drug education programs with their children;
- Conduct an extensive national and international literature and resources review of current evidence-based practises to engage fathers in the drug education of their children;
- Develop and evaluate an intervention which incorporates evidence-based activities to help fathers to communicate more effectively and frequently with their children about drug-related issues; and
- Assess the feasibility, acceptability, appropriateness and usefulness of the proposed information material for encouraging fathers to communicate more frequently with their children about drug-use issues.

3 METHODOLOGY

The study was conducted in four distinct stages (see Figure 2). The first stage involved a comprehensive review of relevant literature and consultation with key stakeholders in drug education. Stage two involved formative consultation interviews and surveys, completed by fathers recruited from sporting venues and two high schools. This survey was used to recruit fathers willing to attend follow-up focus group discussions. The third stage involved the collection of qualitative responses from five focus groups. The final stage of the project involved the evaluation of intervention materials, produced as a result of formative consultation with the focus groups, the Advisory Panel and fathers of children in six school classes (ranging from Year 6 to 9).

Figure 2 Data Collection Stages.



3.1 Stage 1: Literature Review and Advisory Panel Consultation

A comprehensive review of parent and child drug education literature, particularly as it related to fathers, was ongoing throughout the project. The key factors identified as associated with fathers' involvement in the drug education of their children include fathers' characteristics,^{8,10,21-29} children's characteristics,^{3,5,6,10,12,23,28-30} father's perception of influence on their child,^{5,6,11,31,32} fathers' perception of their child's risk status,^{3,4} knowledge of drug-use issues,^{5,32,33} level of bonding and open communication,^{6,11,34} parental style^{2,3,6,7,12,14,26,35,36} and accessibility and acceptability of parent education programs.^{8,10} Peers^{2,3,9} and other socio-environmental factors^{9,36-38} may also influence fathers' involvement and their child's decision about drug-use. These variables were illustrated in the hypothesised model illustrated in Figure 1.

The key stakeholders in drug and parent education were identified from a network of government and non-government organisations. This network contained representatives from the Western Australian Department of Health, the Western Australian Department of Education, the Western Australian Drug Abuse Strategy Office, the Western Australian Council of State Schools Organisation, the Western Australian Catholic Education Office, the Western Australian Association of Independent Schools, Wesley College, Holyoake, Shenton College, the Western Australian Alcohol Advisory Council, the Australian Council on Smoking in Health, the Anna Wood Foundation, Curtin University of Technology, the South Metropolitan Community Drug Service Team, South East Metropolitan Community Drug Service Team, Lions Drug Education Foundation, Next Step Drug and Alcohol Service and Local Drug Action Groups.

These key stakeholders were invited to attend a meeting to determine what, if anything in Western Australia was being done to encourage fathers to get involved in the drug education of their children. This meeting was also used to identify other health programs that were aimed at men, and what the stakeholders thought were the best ways to target fathers. The questions used for the expert panel appear as Appendix A. The content and presentation of a drug education program specifically for fathers were also discussed.

3.2 Stage 2: Formative consultation interviews

3.2.1 Instruments

A formative consultation survey (see Appendix B) was developed to identify fathers willing to participate in a follow-up discussion group that focussed on drug-related issues. Face and content validity were assessed for the instrument via the Advisory Panel of health and education consultants. The survey also aimed to reveal how fathers currently communicate with their 12 to 15 year old children, when and where were the best times to talk and what topics were discussed.

3.2.2 Participants

The screening survey was sent to two metropolitan high schools, selected randomly and representing a medium to high socio-economic stratum and a low socio-economic stratum (determined by postcode from the 1996 Census data).

Central intercept interviews using the survey were also conducted with fathers at various sporting venues. Five venues were selected, representing different metropolitan areas and sports, catering for both girls and boys. Fathers were interviewed at games played at the Wanneroo and Joondalup Netball centres, the Wembley Downs football and soccer clubs, and the North Beach soccer club.

3.2.3 Procedure

3.2.3.1 School procedure

The Principal of the two schools selected was contacted and asked if their school would like to participate. The project coordinator briefly outlined the project to the Principal, then faxed or posted a letter providing more detailed information (see Appendix C). School Principals were contacted a few days after receiving this information to clarify any questions and to confirm whether their school would participate in the data collection. After obtaining consent from the Principal, the survey was sent home with all students from one class in each of Years 8 to 10 for their fathers to complete and return to the class teacher. Incentives were used to encourage the return of the surveys.

3.2.3.2 Central intercept interviews

The survey was also used in a central intercept format. Staff and volunteers from the Western Australian Centre for Health Promotion Research were trained in the data collection protocol (see Appendix D) and conducted interviews with fathers at a number of sporting venues (see 3.2.2). This procedure was also used at the Wanneroo markets and at an Anna Wood Foundation parent drug education course.

3.2.4 Data collection and analysis

All data collected from schools, sporting venues, markets and at the Anna Woods Foundation was returned to the Western Australian Centre for Health Promotion Research for preparation for data entry.

Completed surveys were entered and univariate analysis were conducted using SPSS for Windows, Version 10. Open-ended responses were entered into a Microsoft Word Document and common themes identified.

3.3 Stage 3: Focus Groups

3.3.1 Instruments

The aim of the focus groups was to elicit detailed information on drug-related issues, to explore the type of father-child interaction about drug-related issues fathers report, and to determine types of information fathers would like in an intervention (see Focus Group Moderator's Guide in Appendix E). Fathers were also asked about their preferred format and content of a drug or communication education program aimed at fathers, and the way they would prefer it delivered.

3.3.2 Participants

Five focus groups were conducted, with approximately 12 fathers invited to each group to allow for non-attendance. Attempts to stratify according to gender and age of the child proved difficult. The participants, however, were divided amongst the groups so that friends or acquaintances were in different groups.

3.3.3 Procedure

All focus groups were conducted in the evening, for approximately two hours. With participant permission, all groups were audiotaped for subsequent transcription and analysis. In addition to the trained moderator, a scribe was also present.

3.3.4 Data collection and analysis

Transcriptions were analysed for recurring words and common themes.

3.4 Stage 4: Evaluation of the information materials

3.4.1 Instruments

Findings from the formative consultation interviews, the focus group discussions, consultation with Advisory Panel and current literature were used to develop take-home drug information materials for fathers that focussed on communication and parenting issues (see Appendix F).

The text of each information sheet was subject to readability analysis to ensure that the maximum proportion of fathers would be able to comprehend the content. That

is, the readability levels were kept as low as possible. Flesch-Kincaid Grade Level Index scores and Flesch Reading Ease scores⁴³ were calculated for each sheet of the information materials. These analyses indicated an average education level between US grade-levels of 7-9 was required to comprehend the materials (7-8 is reported to be the optimal score for most documents⁴³). The actual score may have been lower due to the use of tables in the materials rather than full sentences. The Flesch Reading Ease scores (on a 100-point scale) were between 51 to 69%. The recommended optimal level is between 60% and 70%.⁴³

An evaluation survey (see Appendix G) was developed to assess the appropriateness of the drug information materials for fathers. The survey contained items related to demographics, readability, usefulness, age appropriateness of the materials, and improvements that could be made to the materials. The survey was addressed to 'men who raise children' to be inclusive of all men who care for children including step-fathers, grandfathers and significant male figures in children's lives. The survey also acknowledged that some families do not include a male adult and as a result, did not disregard the importance of a mother's perspective on the information materials. Specific questions were targeted at women who were completing the survey including relevance and usefulness of information to a mother, suggestions about the materials and whether directing the materials to fathers was offensive to mothers. Some questions were adapted from instruments previously used by the Western Australian Centre for Health Promotion Research and were therefore previously tested for reliability and validity. Face and content validity were assessed for each instrument via the Advisory Panel of health and education consultants.

The survey included a cover page stating completion of the survey would take approximately 10 minutes, participation was voluntary and all answers provided would remain strictly confidential. All recipients were supplied with an envelope in which to place their completed survey and seal. If recipients of the survey did not want to participate they were instructed to return the survey unanswered. The option of phone or email feedback was provided on the cover page. Recipients were offered incentives for the return of surveys.

3.4.2 Participants

A convenience sample from three large Metropolitan schools, one secondary school, one combination (K-12) school and one primary school, were chosen to participate in this pilot study.

This sample consisted of one Year 6, two Year 7 and 8 classes, and one Year 9 class. Approximately 175 students (31 Year 6 students; 60 Year 7 students; 53 Year 8 students and 31 Year 9 students) were recruited for the pilot study. Fathers were recruited by sending a package, including the materials and survey, home with their children in these classes.

An additional 54 fathers from the focus groups and 31 Advisory Panel members agreed to also review the intervention materials in this phase of the project. Feedback from the Advisory Panel was voluntary and informal.

Twelve clients of the Lifeline Lone Fathers Support Centre for single fathers, and approximately 30 other fathers accessible to the project investigators also participated in this phase of the project.

3.4.3 Procedure

3.4.3.1 Focus group participants

During the formative consultation interview, fathers were asked if they would like to be further involved in the project and if so to provide contact details. These men were contacted and asked if they would like to participate in the review of these materials. The project coordinator briefly outlined the procedure (including return date), the contents of the survey and the incentives offered for participation (see Telephone Interview, Appendix H). Of the 71 fathers who provided contact details, 14 were unable to be contacted, three did not want to be involved, but overall 54 men agreed to review the educational materials. These men were asked to provide a postal address to which the materials and a survey could be sent in the following two weeks. Participants given a reply-paid envelope in which to place their completed survey, seal and post to Curtin University by the return date specified on the survey.

3.4.3.2 School participants

Once three schools had been selected, each school Principal was contacted and asked if their school would like to participate. The project coordinator briefly outlined the project to the Principal, then faxed and posted a letter providing more detailed information (see Appendix I). Each school was asked for two particular Year levels to be involved, but the choice of class was to be identified by the Principal or teacher involved. School Principals were contacted a few days after receiving this information to clarify any questions they had and to confirm whether their school would be participating in the data collection.

One secondary school declined due to the number of other projects in which it was involved. A second high school recruited through the same process, agreed to participate. Once confirmation from each school was received, a class list from each of the two participating classes was requested from each school, as well as an appropriate time to visit the classes. The class list enabled the allocation of a unique identification code for each participating student.

The project coordinator visited each class at an arranged date and time to distribute the materials to the students from all three schools. A standardised set of instructions was developed (see Appendix J). The project was explained to the students, and envelopes distributed containing the materials and the survey. The students were instructed to address the envelope to their father, or 'another man in your life who has raised you, such as a stepfather, grandfather, uncle or your mother's partner'. If students did not have access to these people, they were asked to address the envelope to their mother. The technique of asking students to address the envelope themselves was used to help encourage more fathers to respond to the survey. Students were instructed to take the envelope home to the person they identified.

When the survey was completed the respondent was instructed to give it to his/her child then return to the classroom teacher. Students were offered incentives for the return of the survey by the due date.

Teachers were provided with a summary of instructions (see Appendix K), a fax-back form and a return envelope with a class list attached. The return envelope provided was to be placed in the reception for collection two weeks from the delivery date. Teachers were also given a small gift for their participation.

3.4.3.3 Advisory Panel participants

The Advisory Panel members were sent a copy of the materials, without the survey, and were asked that if they would like to provide feedback they could contact the project coordinator (see Appendix L).

Copies of the materials and surveys were also distributed to 12 clients of the Lifeline Lone Fathers' Support Centre for single fathers, as well as another 30 fathers accessible to the project investigators.

3.4.4 Data collection and analysis

All data collected were returned to the Western Australian Centre for Health Promotion Research at Curtin University of Technology.

Completed surveys were coded and univariate analysis conducted using SPSS for Windows, Version 10. Open-ended responses were entered into a Microsoft Word Document and common themes were identified. Informal responses from the Advisory Panel were also entered in a Word Document.

4 RESULTS

The following section is presented in four sections including a summary of information from the initial Advisory Panel consultation, formative consultation interviews, focus groups and evaluation of information materials including informal feedback from the Advisory Panel.

4.1 Advisory Panel Consultation

The following is a summary of the input provided by the attendees to the Advisory Panel meeting. A total of 16 members attended the focus group meeting and were asked in small groups a number of questions related to parents and drug education, and specifically how to target fathers with these programs.

4.1.1 Groups involved in father-based intervention programs

The members reported a number of different father-based intervention programs or organisations that may be able to provide resources. School Drug Education Project, Family and Children Services, Relationships Australia and men's groups were reported most frequently.

4.1.2 The 'best' ways to recruit fathers

Workplaces, sporting groups, central intercept interviews, schools and parent groups were the most commonly suggested methods of recruiting fathers for both the focus groups and intervention.

4.1.3 Strategies to actively engage fathers

There were a variety of suggestions to actively engage fathers including one-off short presentations, discussions and social activities. The most common themes were a take home intervention/activity or bulletin, monthly, weekly or via email.

4.1.4 Content of father-based drugs/communication intervention

The Advisory Panel members indicated that the intervention should focus more on the communication styles than on the drug issues and focus on the role of the father. These suggestions were consistent with the hypothesised intervention model (see Figure 1). The content should also be specific; activity-based; and focus on listening and common interests of fathers and their children.

4.2 Formative consultation interviews

A total of 167 surveys were completed by fathers, and of these 71 (42.5%) agreed to be involved in a follow-up group. No surveys were returned from the parenting class, as no one in the class had children of an age to meet the inclusion criteria.

Recruitment of fathers was the most successful at sporting venues, particularly netball (39%) and soccer (15.6%), while nearly a quarter of fathers also responded to the survey sent home from one of the secondary schools (22.2%).

The demographic characteristics of respondents are provided in Table 1. The most commonly identified relationship was between child and father, with a small number of stepfathers and uncles present. The majority of respondents had two or three children in the family and most had a girl within the selected age range of 12-15 years (67% girls and 33% boys). While all ages within this range were covered, the largest number was in the age group of 13 years. The majority of children were the oldest or youngest in the family. The age of most respondents was between 35 and 54 years. The majority of respondents were from the highest SES tertile (49%) while the number of respondents in the lower and middle strata was about equal (22% and 23% respectively). Ten postcodes were for suburbs that did not exist when the 1996 SEIFA was constructed and therefore they were not categorised.

Table 1 Demographic characteristics of formative consultation interview respondents

		n=167	
		n	%
Relationship with child	Father	156	94
	Stepfather	4	2.4
	Grandfather	1	.6
	Uncle	3	1.8
	Carer	0	0
	Other	2	1.2
Age of respondent	<25 years	9	5.4
	25-34 years	75	44.9
	35-44 years	74	44.3
	45-54 years	8	4.8
	55+ years	1	.6
Number of children in the Family	1	7	4.2
	2	78	46.7
	3	47	28.1
	4	22	13.2
	5	6	3.6
	6	4	2.4
	7	1	0.6
	8	1	0.6
Age of the child	12 years	37	22.2
	13 years	60	35.9
	14 years	36	21.6
	15 years	34	20.4
Sex of child	Male	55	32.9
	Female	112	67.1
Child's position in the family	Oldest	67	40.1
	Middle	30	18.0
	Youngest	57	34.1
	Other	13	7.8
Socio-economic status	High	81	48.5
	Middle	39	23.3
	Low	37	22.2
	Missing	10	6

Respondents were asked a number of questions about discussions they have had with their children. The topics that most commonly discussed with their teenagers were school (71.1%) and sport (53.6%), but drugs were very high on the list with 30% of fathers saying they talk with their children about them (Table 2).

Table 2 Topics fathers talked with their teenagers about on a regular basis (n = 166)

THEME	%
School – school work, homework, Problems at school	71.1
Sport	53.6
Interests – music, fashion, films, TV, cars, computers, fishing, pets	32.5
Drugs	30.1
Sexuality/relationships	17.5
Social activities	15.7
Feelings, motivations, attitudes, hopes	15.7
Friends	14.4
Family matters, issues	13.8
Routine activities - Washing dishes, cleaning room etc.	12.6
News/current affairs	7.2
Behaviour	5.4
Problems - peer pressure etc.	4.8
Health issues	4.2
Work (teenagers)	3.6
Money/finances	1.8
Church/religion	1.8
Work (fathers)	1.2

Many respondents (49.4%) said they liked to talk with their teenagers because they could share ideas and interests or that they enjoyed their company (14%) (see Table 3). The reverse was true when they were asked what they thought their teenagers liked about talking with them. However, trust and acceptance were also thought to be important to their teenagers and that they had someone who would listen to them (see Table 4).

Table 3 What fathers like about talking with their teenager (n = 164).

THEME	%
We share things - ideas, interests, feelings, problems, “get to know how she is feeling about things in general”, builds our relationship, develop a closeness/bond, “feel good as a father”, “communication”, “interaction”, (general characteristics of the relationship)	49.4
Specific topics e.g. sport, money, school	23.2
I enjoy their company - “they are open, honest, easy to talk to”, “he has a positive attitude”, “full of ideas”, “educates and entertains me”, (general characteristics of the teenager)	14.0
Other – “everything”, “anything”, “difficult at times, but rewarding”, “being creative”, “doesn’t listen”, “don’t communicate much”	12.2
I can influence them – morality, values, provide direction, help them	10.4
I receive information – e.g. what they are doing, who with, where they are going, who are their friends	3.6

Table 4 What fathers think teenager's like about talking with them (n = 163)

THEME	%
We share things - interests, ideas, feelings, problems, have fun, develop a bond/closeness, "spend time together", "like friends", "builds our relationship"	30.5
Specific topics e.g. school	26.2
Get feedback/direction – information, advice, guidance	21.3
There is acceptance and trust, someone who listens, honesty	20.7
Other – anything, "when he wants to talk", "not much", "being independent", "clams up", "has to drag information out"	14

When fathers were asked what things they found hard about talking to their teenager, many were confused by the question (see Table 5). They returned to specific topics, particularly feminine issues with teenage daughters. However, some said they found the normal adolescent development problems difficult to talk about (moods etc) and related to this, issues of independence and discipline. However a large proportion (45.1%) said they found nothing hard about talking with their teenagers. This was also the case when they were asked what they thought their teenagers found hard about talking with them. Again a considerable percentage (23.7%) said nothing (see Table 6).

Table 5 What do fathers find hard about talking with teenagers (n = 164).

THEME	%
Nothing	45.1
Personal matters – female hygiene, sex, relationships, drugs, problems that may lead to embarrassment	28.0
Getting past the normal adolescent development problems - their moods, they think they know everything, they are not realistic, they think for now, not later, difficulty translating thought into words – "understanding what they are thinking", "age gap"	12.8
Initiating the conversation and keeping it going	6.7
Other – "divorced, try not to be negative towards ex-partner", other specific topics e.g. school, "everything", "doesn't like talking to him", "doesn't listen", "limited contact time makes it hard to talk and bond – e.g. in a divorce"	6.1
When there are issues of discipline	4.2

Table 6 What fathers think teenagers find hard about talking with them (n = 160)

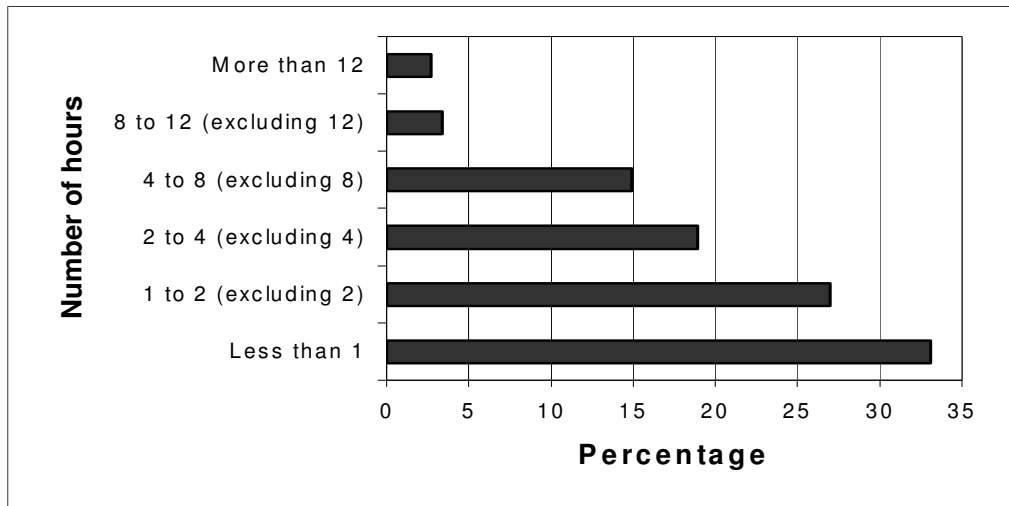
THEME	%
Personal matters - female hygiene, sex, relationships, drugs, problems that may lead to embarrassment	41.8
Nothing	23.7
Getting past the normal adolescent development problems - saying what they really feel and believe, they think they know everything, difficulty asking for help, difficulty in living up to expectations – “doing what my parents want me to do”, “age gap”	11.2
Other – “separated, relationship with mother affects our relationship”, “school issues”, “most things”, “everything”, “mistakes”, “general life”, “we are on different wavelengths”, “think I don’t understand”	10.6
Discipline issues - their expectation of a certain response, being lectured	8.1
Getting my attention – work issues, “believes I don’t listen”, “occupied with other things”	4.3

In terms of when and where fathers talk with their teenagers, there was great variation. Many reported over dinner, in the car, at a specific time of the day at home, at sporting or other activities and on weekends or holidays. The amount of time they talk with their teenagers was a difficult question for many and varied widely from five minutes to 16 hours a week. These data were collapsed into categories and are displayed in Figure 3. Most respondents indicated that they spent less than 2 hours a week (60%) talking with their teenagers.

Table 7 Times and places fathers feel are best to talk with their teenager (n = 161)

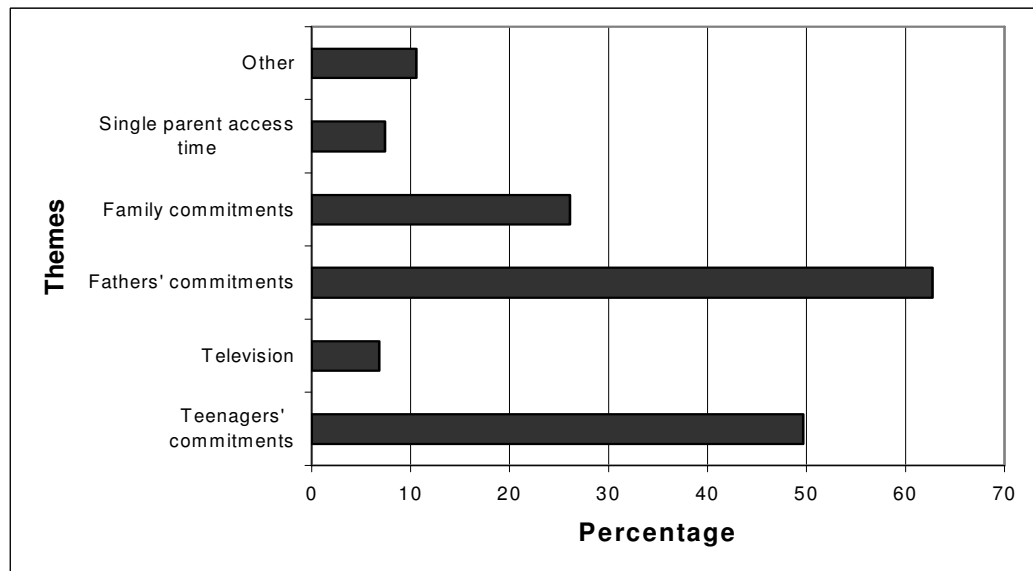
THEME	%
Specific time of day at home - last thing at night, early morning, after school in the afternoon	28.6
In the car	28
Whenever we are together, anytime on our own, anytime they want to talk	20.5
At sporting activities/other activities they enjoy away from home e.g. walk, out to dinner, picnics, shopping	18
Home, one-on-one, no specific time	16.8
Dinnertime/mealtimes	16.8
Weekends/holidays	11.8
Watching TV	6.2
Other – “hard to find time”, “not during the news”, “family orientated situations”, “when mum’s not there”, “not when she is interested in something else”	3.1
Access visits/on the phone	1.2

Figure 3 The time fathers feel they spend in a week talking with their teenager, in a one-on-one situation (n = 148)



Finally, the factors that limit their communication with their teenager were mainly the teenagers’ commitments, fathers’ work or commitments, family routine and commitments with other siblings. Access time for single parents was also listed (see Figure 4). The theme termed “other” included comments such as “when she doesn’t want to talk”, “too busy”, “don’t get along”, “nothing, I allow the time”, and “their attention span”.

Figure 4 What factors fathers think limit their time to talk with their teenager (n=161)



4.3 Focus groups results

Of the 167 surveys that were completed, 71 fathers said they would attend a follow-up group. When contacted with a specific date and time, 50 fathers committed themselves to one of five focus groups. The final number of fathers who attended in each group varied from five to seven.

The following is a summary of the responses given by fathers who attended the focus groups.

How does the list of topics that fathers talk about with their teenagers on a regular basis sound, what other things (if any) do you talk with your teenager about on a regular basis?

Overall the focus group participants agreed with the list of topics that fathers talk about with their teenagers on a regular basis, though one remarked that they thought the topic of drugs would be further down in terms of frequency. This list was taken from the topics reported in Table 2.

How much influence do you think you, as a father, have over your teenager's life?

In all groups fathers felt that they did not have a huge influence once children reached their teenage years. From this point their influence diminished rapidly. However, a lot remarked that perhaps the influence is unseen until later, when children are older. For example:

“It has only been in last 12 months that my older one is always telling us how we did influence her when we thought we weren't. They actively watch you, observing your life.”

Fathers tried to give their children a set of values rather than instructions, and felt that consistency was very important.

All groups mentioned communication and the relationship between themselves and their children as vital. That you need to know your children and spend time with them to have any influence.

Role modelling by the parents was seen as critical to any influence, that actions influenced more and most felt teenagers were very quick to pick up any contradictions between “*what I say and what I do.*”

Fathers were very conscious of peer influence, and felt it outweighed the influence from parents. Some fathers were also worried about the influence of other parents on their children. One father said:

“I see them cycling out without their helmets on, I would say at least 50% of them without their cycle helmets on ... sometimes I feel like I'm surrounded by people who don't want to have to do anything and

sometimes I think, well, am I the only one, am I banging my head against a wall?”.

Some also seemed unhappy with the idea of giving a drink over dinner to an underage child, however, this was not universal.

What influence do you think you have on his/her decisions about smoking cigarettes?

Many fathers were not sure they had any influence on their child's decision about cigarette smoking. Overall, the feeling was that once children reach a certain age and stage, peers and social situations influence their children to smoke, *“everything else goes out the window”*.

Peer influence was seen as a more powerful influence than that of parents as illustrated in the following comment:

“We have a non-smoking household – produced kids who smoke...totally inconsistent with all things he had been saying as a kid growing up...All his mates smoke, so he smokes”.

Many fathers were worried about negative influences such as dad being a smoker, and what fathers did when they were teenagers (if they smoked). There was a significant proportion of smokers present at the focus groups, but many felt their attempts to give up smoking were a positive influence on their children. Many fathers also felt that their child's interests in sport would steer them, particularly boys, away from smoking. Other positive influences include the advertising of public health messages on the television campaigns and the school education curriculum.

The continuation of smoking, rather than just experimentation, was viewed as part of a wider issue for teenagers involving other factors such as an addictive personality, other problems in their life, escapism, stress, school problems etc. Teenagers were seen as vulnerable. There was also concern about conflict between the parent's values and the friend's values.

Issues to do with self esteem were mentioned such as *“certainly the more self-esteem they have the less they tend to be impacted by peers”*.

What influence do you think you have on his/her decision about drinking too much alcohol?

With this question fathers were strongly of the view that they had little influence over their children when it came to drinking alcohol and binge drinking.

Peer pressure was seen as far more influential than parents with regard to drinking too much alcohol. Fathers felt they had very little control if their teenagers really wanted to binge drink. They were worried about their teenagers losing control at parties or when they were out, even if they appeared sensible at home. They felt that

teenagers viewed themselves as immortal, which was perceived to have a huge effect on their behaviour. For example:

“Kids don’t think about the end result, they don’t think in 10 years I’ll be a junkie or whatever, they think it feels good, my friends are doing it, I’ll try it”

However, while fathers thought they had no influence, many were adopting protective behaviours. Many reported attempting to know where their teenagers were, what they were doing, and try to know who their friends were. Monitoring their children was important for many fathers. They also thought that knowing their child’s friends better and whether they had values similar to them was important. They considered they had a role to play in peer selection. For example, they could subtly encourage some friendships and not others in a subtle way.

Standards set by other parents was a worry to some, particularly allowing drinking underage at home or at the “footy club”.

There was some feeling that there is a lack of support from the law, that teenagers are able to drink underage, e.g. at Rottneest or at the beach. Fathers felt the type of alcohol consumed was also an issue. Spirits, particularly the cans of ready-mixed drinks were very conducive to binge drinking. They felt girls were more attracted to that type of alcohol than boys. However, many felt boys would not drink low-alcohol beer, wanting the full strength alternatives because they weren’t drinking for the taste, but for the effect.

Campaigns that try to teach teenagers to respect themselves were seen as a positive influence on teenagers. Many fathers felt they needed to teach their children to drink responsibly but needed a few practical suggestions about how. It came back to their own actions, that again were seen as very important. They felt they needed to set a standard and act as role models for their children.

What influence do you think you have on his/her decisions about using marijuana and other drugs?

Many fathers felt they had some influence in this area, but again it may not be seen until some time in the future. Many felt a lot of children try illegal drugs, but not many go on to have serious problems.

Issues related to children’s self esteem and strength of character were perceived by fathers to influence whether they go on to problematic use. They thought some children were despairing in our society and the suicide rate was mentioned as evidence of this major problem.

Peer influence was again seen as a huge influence, together with the influence from older siblings, either good or bad.

Modelling behaviour by the parents was again seen as very important. For example, *“It’s what you say and do”, “you can warn them about the errors of smoking dope and smoking and drinking too much alcohol and set an example at home”*.

Fathers believed their teenagers knew more than they did about illegal drugs, but felt that their teenagers could also see the inconsistencies between illegal drugs and legal and prescribed drugs. For example, children couldn't understand why alcohol and cigarettes were legal while marijuana wasn't.

What sorts of opportunities have you had to discuss drug-related issues with your teenager and how have you approached the drug-related topic?

Most fathers said they have had opportunities to talk with their teenagers about drugs. It was often prompted by an external event, material seen or sent home. For example, television advertisements and programs (Neighbours), children expelled from school for possessing drugs, children finding a needle, school project or newsletter, tonight's meeting, government drug education booklet, movies, Anna Wood's death, when teenagers go out to places where drugs may be present. Fathers felt strongly that they had to be there for these opportunities to turn into a discussion.

Sometimes teenagers brought up the topic, other times the fathers would initiate. Examples include:

"If I was concerned, if I thought one of my daughters was in trouble, I would certainly initiate the conversation and ask".

"Definitely need an external prompt, something from school or an event like Anna Wood's death. I read the book that my daughter brought home from school in an afternoon and we talked about it".

Some fathers reported having difficulty answering questions about illegal drugs. The following is an example of a situation reported by a father:

"As we walked up the alleyway to get to the restaurants there is a toilet block and its got bright lights and its got a little syringe disposal box out the front. This is a classic question. As we were walking back, [daughter] said, "Dad, wouldn't that encourage people to shoot up more often?...I don't know. Does it or doesn't it? That was a good prompt, she initiated it and we actually had a good discussion about it."

Communication with their teenager was important to the fathers, but often it is not structured and they reported needing skills to keep the conversation going. Fathers thought they had to be aware and use the moment or occasion to talk, particularly about the issue of drugs. Many fathers said they would wait until their teenager raised the topic and therefore there is some spontaneity in the conversations and they do a lot more listening than talking.

The self esteem of their teenager was seen as very important to many fathers. Fathers felt they should try to build self esteem in their children, but they felt they had to have a relationship to do this. They reported that *"knowing each other, and asking their advice sometimes"* were ways to build such relationships. Other strategies fathers had used included:

- *“Something that will give them confidence so that they don’t feel like they have to smoke or do drugs”.*
- *“Some sort of mastery that makes them feel like they’re worth something. It could be dancing or soccer, something they are good at”.*
- *“Something positive, an actual physical thing and not an absence of something”.*
- *“Look at their competencies and somehow steer them in that direction”.*

Fathers felt that to nurture their relationship they needed to talk with their teenager in a relaxed situation, some said over an evening meal, others a quiet space in the teenager’s bedroom away from the other members of the family, or doing something special together e.g. play basketball or go fishing. Teenagers could then talk with them if they felt like it.

Fathers thought it was important to have a strong community network so that the children had another options to go to when they couldn’t go to mum and/or dad. One father suggested that this included:

“A wider community of responsible people, our friends, not peers. They really do need someone to pay them some attention”.

Most discussions were reported to take place in the teenagers’ time frame. For example, they *“tell me to chill out, if they are not interested”*. Fathers felt their teenagers decided on their own terms and fathers had to accept this. Fathers felt they needed to ask *“open-ended questions, not be too judgmental, or too shocked with what they told me and to not overreact”*.

Messages like *“it’s okay to say no”* and *“try to tell them they don’t need it to have a good time”* were viewed as good messages to give to their children, Others also indicated that the authority message like *“If I ever catch you taking drugs I’ll knock the hell out of you”* doesn’t work. Rather, *“teens need to feel respected and accepted because they are finding it hard to accept themselves.”*

Fathers felt they had difficulty, because they did not know much about illegal drugs and the scene today. Many fathers said they felt inadequate and sensed that the older siblings could educate the younger ones better than the parents.

If you have talked with your teenagers about tobacco, what do you generally talk about?

Many fathers felt that the drug messages from school and from the television campaigns, particularly those related to smoking, were passed on by the children to a smoking parent very strongly. For example, *“My kids see their father smoking... My kids influence me, tell me where I am going wrong”*.

Fathers felt the teenagers understood the messages. They also commented that rather than between the parents and the teenager, often a lot of conversation on drug-use issues occurred between the siblings.

If you have talked with your teenagers about alcohol, what do you generally talk about?

Fathers overall thought it depended on the child's age, but they talked about their children's choices, the cost, health issues, and sexuality issues, "*not the drug itself but the behaviour*". Fathers felt they were competing with the pro-drug messages found in movies and magazines.

If you have talked with your teenagers about illegal drugs, what do you generally talk about?

A lot of fathers felt they did not know much about illegal drugs. For example, "*I didn't experience them so I feel less able to talk to my children about them*". Most felt that the next generation of fathers would have more experience.

Fathers reported mixed responses to the federal government drug education program. Some thought the booklet was a good prompt and gave them some information, others felt it was too directed and assumed it was an easy topic to bring up and discuss with their teenager. They felt there was not enough information on *how* to talk about the topic with their children.

How do the discussions normally go?

There was an overall feeling that it is the teenagers' agenda. For example, "*if they want to talk to Dad, you have to be there and listening, other times they might tell you to butt out*".

Many felt it depended on the child's age, but that "*sometimes they just like to think someone is interested in them or is on their team*".

Some fathers expressed concern that by talking about drugs "*sparks an interest in them, go out and experiment, trigger their curiosity*". Again it was thought that children are able to see the double standards between legal and illegal drugs.

Many fathers perceived children these days are under greater pressure to use drugs.

Think of a drug-related discussion that went well. What do you think made it successful?

Fathers struggled to answer this question. They felt discussions just happen, some felt a useful conversation was when the teenager was really giving a glimpse of him or herself and what they really thought and believed.

What extra information would you like to know more about to help you to discuss drug-use with your teenager?

Fathers provided many ideas, the most common included:

- Communication techniques for parents;
- Development of self-esteem in children and parenting tips;

- How to teach teenagers moderation with alcohol and other drugs;
- How to start and keep the conversation going;
- Information on indications or signs and symptoms of drug problems. For example, “*things I should look for*”;
- More information on illegal drugs because “*I don’t know what to say to them*”;
- Words used by young people when talking about illegal drugs, “*the language of the drug culture*”;
- The timing of these sorts of conversations, in terms of the age of the children, what to talk about when;
- More accurate information, for example, “*all sides of the story, harm minimisation programs compared to other types*”. Many fathers felt their own information from when they were young, and from the media, is inaccurate;
- Health and psychological risks;
- Information on community services if their teenagers get into trouble; and
- Information on what really is happening with teenagers and drugs.

What would be the best place and time for you or other fathers you know to receive information that would help you talk to your teenager about drugs? And if you were to be involved in a program that provided this information, how would you like it to be presented (format of the program)?

There were two prime suggestions, meeting at a venue or having some material come home. Across the focus groups, both ideas were mentioned although all stressed the need to make the contact personal.

The venue suggestions included:

- School drug information nights;
- Share experiences with other fathers by getting together, learn from others, in a group setting – “*dad’s forum*”;
- Get a well-known speaker if doing it at a venue or a video, so fathers will feel more relaxed initially. Use the speaker as the draw-card, and then recruit into smaller groups;
- Speakers could also be fathers who can talk of their own experiences;
- Direct mailing to each dad from school lists as an invitation to a venue;
- Through sporting associations or other interest groups for fathers – organise a meeting after the sport or activity has finished or at a later date and time. Educate at the club by using posters, make it part of the coaching course, have meetings and speakers. Make it a whole club activity;
- Leaflets down at the pub, to recruit them or just talk to them;
- Might need cash incentives to get fathers at a venue, “*hardest thing is to get fathers through the door the first time*”, “*Could have a few beers and a BBQ afterwards*”; and
- Add some humour.

The take-home material suggestions included:

- School newsletters:
 - Direct mailing to each dad with a newsletter/activity sheet/newspaper;

- Use a school project that is interactive with the teenager, they have to sit with the parents, *“bit of sharing, not talking down to them”*. It is still their agenda and prompted by the school. Learn together;
- Has to be brief, few practical tips, some quizzes, and some activities to do together;
- Add some humour; and
- *“Send a survey to mums and fathers, which they fill in every week, which might trigger something. Over an 8 week period it may become a habit”*.
- School project - encourage teenagers to go and talk to dad, and find out what he thinks.

Other suggestions included:

- Web page, “drugs, sex, rock and roll.com” or general broadcast through email;
- Develop a database of information and helpful tips or a resource kit;
- Workplace, with meeting or newsletters;
- TV ads make it cool for fathers to hang out with their children;
- *“Don’t send it in the mail”*; and
- Different groups need different approaches.

How much time would you be prepared to spend doing the program, regardless of how it is presented?

Most fathers felt it depended on how busy they were at the time, and what their children were doing. Fathers felt that if their children were not at risk, they would not devote much time.

Some fathers felt that it had to be a well-defined time, probably around six to eight weeks, that 10 weeks was too long and that fathers should be made very aware of its length. Other suggestions included one to two hours per session once a week if it was at a venue. But if it was brought home, it had to be shorter and more directed.

How could we encourage you, or fathers you know, to read and use a program that provided information to help talk with your teenager about drugs?

Fathers emphasised the need for information and encouragement:

- Provide facts so that they know there is a problem and that many families are affected. If fathers think it is only 5-10%, they won’t pay attention. One father suggested that:

“If we [fathers/parents] had some numbers of people who are smoking pot and going on heroin, you know so in the end the parents are going to sit there and say, ‘Well hang on am I going to be just that 10% who gets away with it or should I really pay attention to this?’ I really think that almost every family will be affected. Especially in the next generation.”

- Need to be careful not to criticise their parenting but encourage them.
- Provide information.

What things might discourage or prevent you or fathers you know from being involved?

Barriers to participating in programs included:

- Work, wanting to spend more time at home (which is the down-side of having a meeting in a venue);
- Being divorced or separated;
- Sex of the child, girls tend to want to talk to mums, boys to fathers;
- Mums spend more time with the children, more time to bond;
- Drug-using parents;
- If inflammatory topics are discussed;
- Using government channels, government policies sometimes put people off;
- Prospect of involvement is enough to turn people away; and
- Lots of fathers feel that it is out of their hands, it's too hard. They need to be encouraged to be knowledgeable about it, to talk about it and have an opinion.

What could people developing this information for fathers do to help address these problems?

Fathers emphasised promoting the role of fathers and encouraging them to be good parents:

- Don't focus on the drug issue, focus on communication, bonding with your child, make it a "*fathering/parenthood issue*";
- "*How to be a better dad*", or "*how to stay friends with your kids*", rather than drugs and your children; and
- Need a relationship first, before you can talk about drugs.

Other recommendations for design and content of the fathers' intervention are summarised in Appendix M.

4.4 Evaluation of the information materials

A total of 234 surveys and materials were distributed to fathers in this phase, 90 to fathers through schools, 53 to the initial focus groups members, 12 to single fathers and approximately 30 packages were distributed to a convenience sample available to the Principal Investigators. Of these 234 surveys, 128 were returned completed and 23 not completed (55% response rate).

The demographic characteristics of respondents are presented in Table 12. Of the respondents, 77% identified as fathers, 5.6% as stepfathers and one respondent as a family friend. Although the surveys and materials were aimed at fathers, 16.4% of respondents were mothers. No respondents reported being related to the child as an uncle, grandfather or mother's partner. Most of the respondents (93.6%) were aged between 35 and 54 years. The family structure generally consisted of two to three children (51.2%, and 24.8% respectively). Most of the respondents' families comprised of children who were all older than 12 years (40%), with 28.8% of families consisting of only children under the age of 12 years.

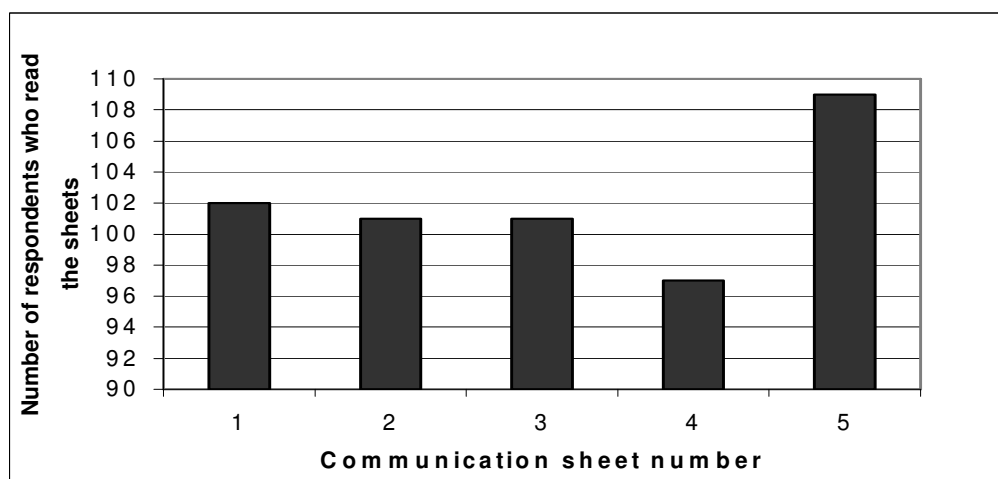
The majority of respondents were from the middle SES tertile (51.6%) while 32.8% and 11.7% of respondents were in the higher and lower strata, respectively. Five postcodes were for suburbs that did not exist when the SEIFA 1996 was constructed; and therefore they could not be categorised.

Table 8 Demographic characteristics of respondents who evaluated information materials

		n=128	
		N	%
Relationship with child	Father	97	77.0
	Stepfather	7	5.6
	Uncle	0	0
	Grandfather	0	0
	Mother	21	16.7
	Mother's partner	0	0
	Other	1	0.8
Age of respondent	<25 years	0	0
	25-34 years	6	4.8
	35-44 years	75	60.0
	45-54 years	42	33.6
	55+ years	2	1.6
Number of children in the family	1	16	12.8
	2	64	51.2
	3	31	24.8
	4	10	8.0
	5	2	1.6
	6	2	1.6
Age of the children	All under 12 years	36	28.8
	Mix (U12 & 12 +)	39	31.2
	All over 12 years	50	40.0
Socio-economic status	High	42	32.8
	Middle	66	51.6
	Low	15	11.7
	missing	5	3.9

Each respondent was randomly allocated to read two of the five '*Dads, Kids and Drugs*' information sheets provided. Twenty percent of respondents read the two sheets allocated to them, 68.5% read all five sheets and only one respondent reported not reading any of the sheets. As a result, each sheet was read by between 97 to 109 participants. Sheet five was read the most (n=109). This sheet contained information about men as role models for their children and included checklists for fathers to describe their own use of cigarettes and alcohol by ticking a "yes" or "no" response. Figure 5 indicates the number of respondents who read each sheet.

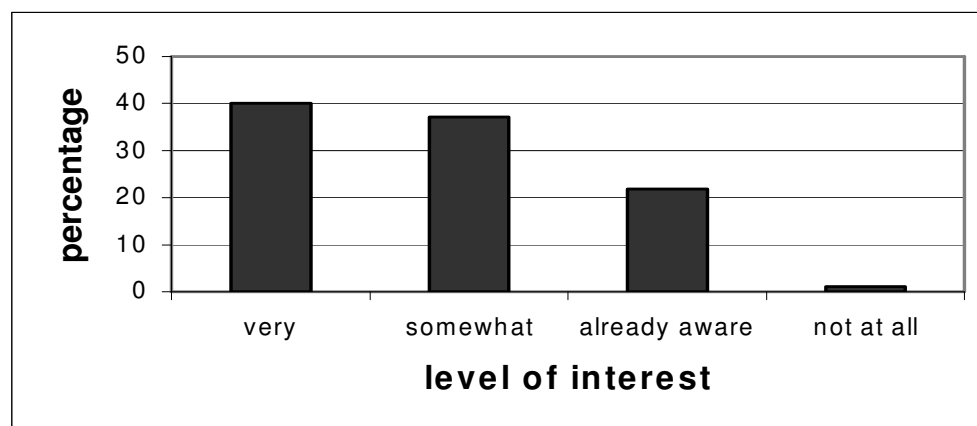
Figure 5 Number of respondents who read each sheet (n=126)



Interest

Forty percent of respondents (n=42) reported that they found the information provided in the sheets very interesting (see Figure 6). The general themes that arose when asked to comment further were that the information was useful and highlighted improvements that they could make to how they currently communicate with their children. Some respondents also commented that the information provided reinforcement of current practices. For example, one respondent wrote “*it reinforces values I hold and things I can be better at*”. A summary of the qualitative responses can be found in Appendix N.

Figure 6 Level of interest in the information materials (n=105)



Approximately 37% of respondents reported that the information provided was somewhat interesting. It appears that when asked why, these respondents were already aware of the information and the materials simply confirmed their current practices. An additional, 23% also indicated they were aware of the information provided. Only one respondent found the materials not at all interesting, as it was “*all about common sense. You have got to be thick to need them.*”

Readability

The majority of respondents (85.8%, n=91) reported that the materials were very easy to read, and 13.2% (n= 14) believed they were somewhat easy to read. Reasons for the materials being easy to read were that the layout was simple and well explained, easy to understand and they did not contain jargon. Other comments referred to the use of point form, tick boxes and that the information “*doesn't try to tackle too much at once. Has one idea and expands on that*”. Other respondents' comments related to readability can be found in Appendix N.

Tips

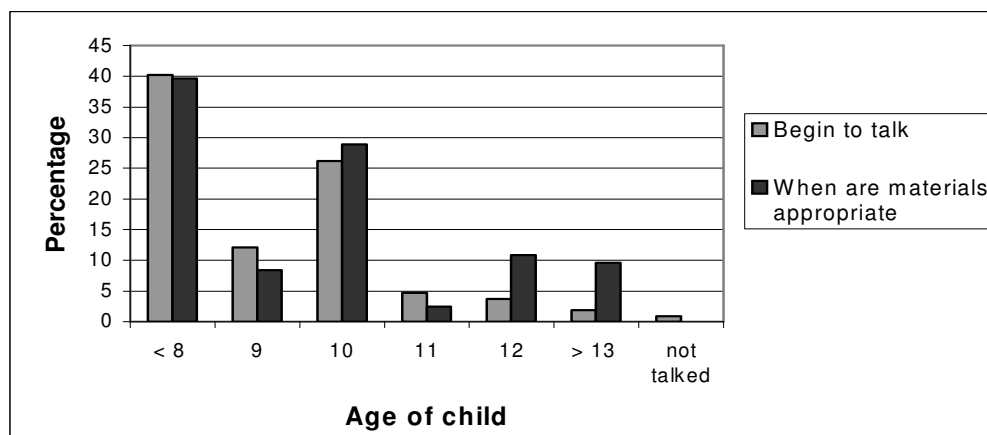
The tips provided on the sheets were also generally reported to be very easy to use (66%, n=68), and were also reported to be “*easy to read and clearly set out*” due to the use of checklists. Of the 33% (n=34) of respondents who reported that the tips were somewhat easy to use, the most common comment was summarised by one respondent in saying “*[it] depends on the child and the age of the child as to how you pose these questions*”. One respondent also commented that “*[the sheets] could possibly have ideas on how to broach the topics of discussion*”. Only one respondent indicated that the tips were not easy to use and no explanation was provided.

When asked if any of the respondents had used the tips provided (before or after receiving the materials), 50.5% (n=53) reported having used some of the tips, and 21.9% (n=23) indicated they used a lot of the tips provided. Eleven percent of respondents indicated that they already used the techniques provided in the information materials.

Age fathers begin to talk about drug issues

Approximately two-fifths (n=43) of respondents indicated that they began talking about drug issues when their child was under the age of eight years (see Figure 7). Twenty-six percent (n=28) began talking about drug issues when their children were 10 years of age. Ten percent of respondents had not yet talked about drug issues with their children.

Figure 7 Children's age when fathers began to talk with them about drug issues (n=107)



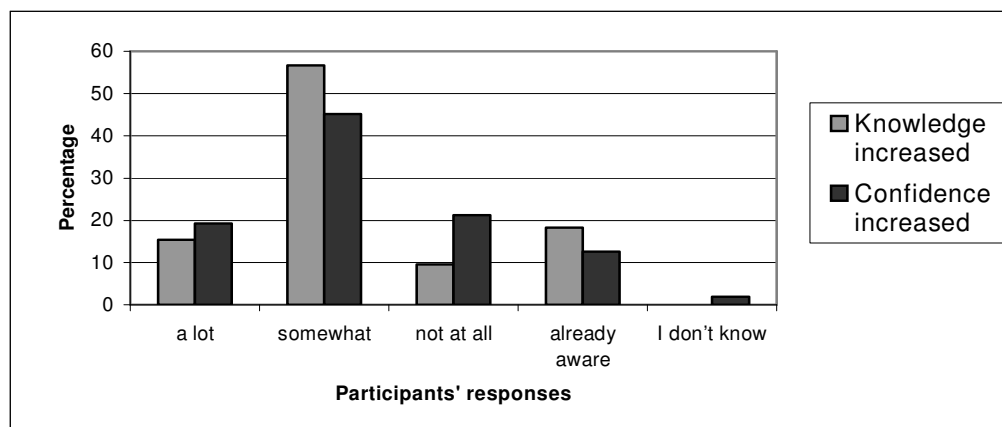
Respondents were asked at what age in their child's lives would these communication sheets have been most useful to them. A variety of different ages ranging from two to 17 years were reported, however it appears that respondents generally think these materials would be useful for children aged eight to 12 years. One comment by a respondent appeared to mirror the comments of others in saying "10 years is an optimum age to engage kids in more serious discussions". Other common themes included "the earlier the better," and "going into high school".

Increase in knowledge and confidence

Seventy-two percent of respondents indicated that their knowledge had increased as a result of reading these materials (a lot, n=16 and somewhat, n=59). Eighteen percent of respondents indicated that they were already aware of the information provided and therefore had no increase in knowledge as a result of reading the materials. As with many studies which involve passive consent, these participants are not likely to be fathers of children at high risk of drug-related harm, but rather may already have better communication skills and relationships with their child than non-participants.

Approximately 64% of respondents reported an increased capacity to talk about drug issues with their child, after reading the materials. Interestingly, 21.2% of respondents reported that they did not feel more able to talk with their child about drug issues. Twelve percent of respondents reported already feeling able to influence their child about drug issues.

Figure 8 Effects of materials on knowledge and confidence levels of fathers (n=104).



Recommendation to other fathers/parents

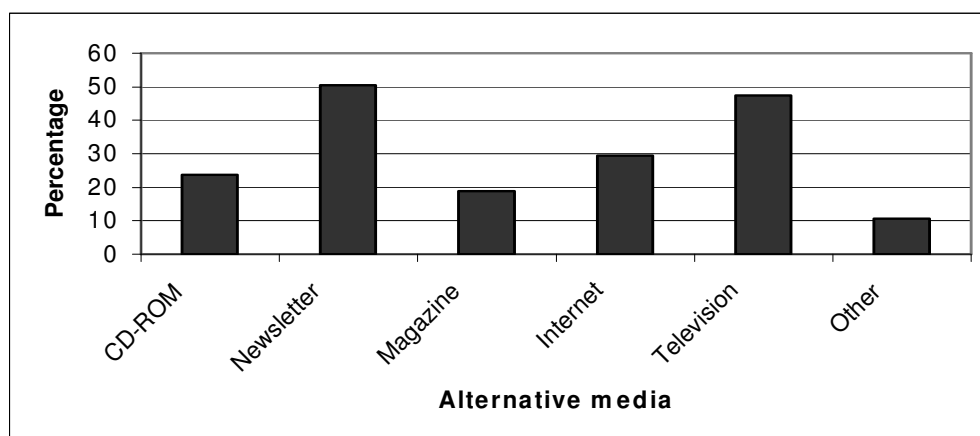
When asked if respondents would recommend these materials to other fathers/parents the responses were very positive with 98% of respondents reporting they would do so. The majority of respondents commented that "any information is beneficial" and that they contain "practical information that not many fathers are aware of". Respondents who indicated that "maybe" they would recommend the materials had reservations about interfering with other people's parenting. One

respondent believed that they would only recommend the materials “*if they were thick enough to need them*”.

Other ways of receiving the information

The most popular alternative medium for these materials was in the form of a newsletter (50.5%, n=49), with television being the second most popular (47%, n=39). Seventy six percent of respondents indicated that did not want the materials in the form of a CD-ROM, similarly 73% did not want the information available on the Internet (see Figure 9). Other suggestions for receiving the information were through school information, forums/presentations, radio and discussion papers with children.

Figure 9 Suggestions for alternative media for receiving this information (n=97).



Mothers' perspectives on materials

Approximately 17% (n=21) of survey respondents were mothers. The investigators believed it was important to ascertain whether directing the materials to men would offend mothers and whether they had any suggestions for encouraging fathers to talk with their children about drug-use issues. Five women who responded to the survey found the materials offensive. The common response was that the materials should be directed at ‘parents’ per se. One mother commented that “*the hurt some children could feel, knowing their father is not around through separation or death*” was the reason she found it somewhat offensive. Mothers who did not find the materials offensive acknowledged that:

“1 in 3 families are split... So men as parents have much more involvement today”... “it is just as important for male carers to communicate with children as it is for females, regardless of whether parents/carers live together”.

Suggestions for encouraging the involvement of fathers in discussing drug-use issues were to “*put it in a current affair context*”, “*don’t pretend you know everything – learn from kids as well. Be a mentor not an expert on life*” and “*read this series*”.

Seventy-four percent (n=17) of respondents indicated that the activities provided in the materials were relevant for mothers. The remaining respondents reported that they were already aware of the activities provided. None of the respondents indicated that the activities were irrelevant to mothers.

Informal Advisory feedback

Very few of the Advisory Panel provided informal feedback, however the feedback received was generally very positive. The only suggestion made were minor recommendations about wording or structure. Their comments can be found in Appendix O.

5 LIMITATIONS

This study comprised small convenience samples from which conclusions can not be generalised to the Western Australian population of fathers. As participation was voluntary, participants are likely to be significantly different from non-participants. For example, the participants are less likely to be fathers of children at highest risk of hazardous and harmful drug-use, but may already have better communication skills and relationships with their child as compared to non-participants.^{30,44} There was also a relatively low response rate from fathers who were invited to evaluate the information materials developed (50%).⁴³ Given a larger budget, more comprehensive follow-up and the provision of more incentives would have been used to increase response rates.

Although selection bias is a threat to the external validity of this study every effort was made to reduce this bias within the means of the project funding. Although the participants were conveniently sampled, they were selected from various clusters such as sporting venues, markets, schools and the Lifeline Lone Fathers group in order to sample from different populations.⁴³

Given the data were collected using self-report questionnaires, some social desirability bias may have occurred. Some parents may have over-reported their parent-child communication or involvement.

Internal validity may be threatened by limited testing for reliability and validity of the instruments used in the evaluation of the materials.⁴³ In addition, to increase response rates, questions regarding income, marital status and education level were excluded from the survey. These indicators may have highlighted areas for improvement or acceptability of materials across socio-economic and cultural groups. These variables should be included in any future larger empirical trial of the Fathers' materials.

6 DISCUSSION

The results from this study and their implications for education programs that address communication about drug-related issues for fathers require consideration. Due to the nature and limited amount of data collected, it was difficult to analyse data for trends or correlations but comparisons can be made with other research findings. It is important to note, however, that many of the variables found to influence father involvement in the drug education of their children are similar to those found in other research. Results and implications will be summarised under the variables highlighted in the hypothesised model underpinning the intervention (see Figure 1). The final section outlines recommendations resulting from this research.

Fathers' characteristics

A total of 295 fathers, 11 stepfathers, three uncles and one grandfather, participated in this study. The majority of these participants (90%) were between the ages of 35-54 years. Most respondents also had families of two to four children, who were 12 years or older.

According to postcode information, fathers in this study (formative consultation, focus groups and final evaluation) were generally of middle (35.5%) to high socio-economic backgrounds (41%). This may indicate a similar trend to that reported by Holden, Lavigne and Cameron, (as cited in Meyers⁸) and Spoth and Redmond²¹ who reported fathers of middle-class incomes were more willing to participate or complete parent education programs than of lower-income families. The literature indicates that adolescent children of fathers of lower socio-economic status (or lower parental education) are at increased risk of smoking onset.⁴⁵ It is important to note that this may reflect low suitability of those programs to the needs of lower socio-economic status fathers rather than a lower interest in their child's drug-use.⁸

Within the focus group discussions it was revealed that fathers who were smokers felt uncomfortable talking to their children about drug-use and in many cases did not do so. This appears supportive of Cohen and Linton²² who found parents who use alcohol, tobacco or other drugs had greater difficulty communicating with their children that such use was unacceptable, as they believed they would face criticism from their children.

Other factors reported by fathers as preventing greater involvement in their children's drug education were consistent with the hypothesised model developed from the literature review. For example, Miller²⁵ reported family disruption such as divorce, separation or one or both parents absent reduced the involvement of parents in their children's drug education. This was reported by four percent of the current formative study respondents. Research by Spoth and Redmond²³ indicated work-related time and scheduling barriers were a common barrier to parental participation in prevention programs. The current study found likewise. That is, 62.7% of fathers reported work/commitments restricted the time they spent talking with their children. Fathers in the formative consultation also reported their teenagers' commitments limited the time available to spend with their teenager (49.7%)

Children's characteristics

Children's characteristics were not a target of this intervention, however some observations were made. Children whose fathers participated in this study were generally 12 years of age or older. The initial proposal of this research was to sample from fathers of 12 to 15 year olds. However it was later (Stage 4) deemed necessary to adopt a more primary preventive approach and target fathers whose children were younger, as some children have already tried alcohol and/or other drugs by the time they are 12 years old.^{40,41} Further support for targeting fathers of younger children came from fathers in the focus groups who felt they had more influence on their child before the child reached adolescence.

Fathers of daughters were more likely to participate in the survey in both the formative consultations (67%) and the evaluation (51%). This may be indicative of a higher perception of risk or a greater involvement of fathers with daughters than with sons. It is important to acknowledge, however, that the highest percentage of fathers recruited for the formative consultation, were fathers who were attending netball venues (39%), which is usually entirely a female sport at this age. This study did not find evidence for higher involvement of fathers with their daughters over their sons as suggested earlier by both Cohen and Rice⁴⁶ and Montemayor²⁰.

Perception of influence on child

As mentioned above, fathers in the focus groups felt their influence had decreased, as their children became teenagers, particularly in terms of alcohol and cigarette consumption. They believed that role modelling by the parents was very important as reflected in the following parental comment: "*its what you say and do*".

The communication sheets included information, that aimed to increase fathers' awareness of their influence and empower them to discuss drug-use issues with their children. Many of the fathers (64.4%) reported feeling more able to talk to their child about such issues after reading the materials. Additionally, 72.4% of fathers reported using the tips provided in the materials. Perhaps these are indicators of an increased perception of their influence on their children as a result of reading the materials.

Perception of children's risk status

The majority of fathers involved in the focus groups and the evaluation of the materials indicated they were aware of the risks their children may face in future years with drug-use and that they were aware of this prior to their children reaching 12 years of age. Forty percent of the evaluation respondents indicated they began talking with their children about drug-use issues when they were under the age of eight years with a further 26% beginning when their children were 10 years old. This may indicate an understanding of the importance of communicating about drug-use issues prior to children's exposure to cigarettes, alcohol and other drugs.

A number of fathers (10%) involved in the study indicated after reading the materials that they had not yet talked about drug-use issues with their children.

Many of these children were 12 years or older, and may already be making decisions about drug-use. The number of father non-respondents may indicate a perception of their children being at low-risk of drug use or drug-related harm. This was consistent with the findings of Cohen and Linton²² who reported that non-attending parents were more likely to underestimate the number of their child's peer group who are using drugs. These authors surmised that "*denial that the problem of drug-use personally threatened their children, was likely to be one of the most important barriers to parental attendance (p. 167).*"

Knowledge of drug issues

Fathers in the focus group reported feeling they had difficulty talking about drug issues because they did not know much about illegal drugs and how they are used these days. Many said they felt inadequate and sensed that their older children could educate the younger ones better than the parents. Fathers appear to underestimate the positive influence they have over their children's drug-use.^{31,32} They also reported feeling their children knew more about drugs (particularly marijuana) than they did. Consequently, fathers wanted more information on drugs (particularly illegal drugs); how to sense when their children might be in trouble; as well as information about drug-related health and psychological risks. Fathers felt they needed to teach their children about drug-use issues and strategies to reduce the likelihood of drug-related harm. They also reported feeling unsure as how to do this. Fathers who received and evaluated the information materials reported an increase in such knowledge as a result of reading the materials (70%).

Twenty-eight percent of fathers in the formative consultation interviews reported finding talking about drugs, sex and other personal issues with their teenagers difficult. Some fathers in the focus groups expressed concern that talking about drugs might "*spark and interest in them (the children), go out and experiment ... trigger their curiosity*". This is a common misconception as there doesn't appear to be evidence support this belief.⁴⁷ To the contrary, recent unpublished research on a school-based smoking cessation program conducted at the Western Australian Centre for Health Promotion Research reported less cigarette smoking experimentation as a result of implementing a broad-based harm minimisation program.⁴⁷

Research recommends correcting such common myths and providing fathers with the knowledge and skills to talk about drug-use issues with their children and in doing so, fathers' confidence may also be enhanced.^{6,11,31} Findings of this study are consistent with previous research in that the materials appeared to increase fathers' knowledge as well as their confidence. For example, after reading the materials 62% of respondents reported an increase in confidence related to talking about drug-use issues with their children.

Interestingly, 20% of respondents did not feel more able to talk with their children after reading the materials. Future research could therefore attempt to ascertain the possible reasons why these fathers did not feel more able to discuss drug-related topics. One explanation may be that the materials did not assist fathers with particular characteristics (for example, fathers with low self-confidence). It may also be that fathers whose children have already reached adolescence might find it

more difficult to initiate discussion without having established communication strategies when their children were younger. Consequently, it is important to determine whether the reasons why fathers did not feel more able to discuss these issues were due to limitations of the materials or mediating factors about which data were not collected.

Father-child relationship

Fifty percent of the fathers involved in the formative consultation reported they liked to talk with their teenager because they could share interests or because they enjoyed their company. A high percentage of these fathers (45%) also reported they were comfortable talking with their teenagers and believed that their teenagers were comfortable talking with them (24%). This supports other research findings regarding children wanting and enjoying these discussions with parents.⁵

Fathers involved in the focus groups reported that communication and their relationship with their teenager was important to them. Although fathers felt that as their children move through adolescence they have less time with them, they still found it important to use opportunities, when they arose, to talk about issues such as drugs. Fathers, however, reported feeling it was less about drug issues and more about the relationship. For example, one father commented “*You need a relationship before you can talk about drugs*”. This perception of fathers is consistent with research discussed earlier.^{6,34}

Parenting style

Research into adolescent drug-use has indicated parenting style may strongly influence the extent of adolescent drug-use.¹⁴ While fathers in the focus groups felt that they had little influence over their teenagers, some reported parenting in the ways research indicates as being influential.^{7,36,46} That is, fathers reported already undertaking parenting actions suggested as protective of drug-related harm such as monitoring, providing guidelines and communicating. Furthermore, these protective parenting techniques were discussed in the materials and received favourably by fathers.

Peer influence

Peer influence was reported to be a major concern of fathers who participated in the focus group discussions. They believed it diminished anything they might say. It seems that fathers could benefit from knowing that while peers become more important in their children’s lives as they get older, the influence of parents continues and that a strong father-child relationship can reduce their children’s susceptibility to health-compromising peer influences.³ While this was emphasised in the information materials, changing beliefs such as this may be harder or take more time than increasing fathers’ knowledge about protective parenting skills.

Socio-environment

Due to the nature and limited amount of data collected no comparisons were made between type of schools or ethnicity. It did appear that the majority of fathers (53.6)

were from the middle socio-economic status tertile and 11% of fathers were from the lower socio-economic status tertile. Nonetheless it is difficult to make conclusions due to the convenience sampling method used.

Parent drug education programs

Information gleaned from the literature review, consultation with the Advisory Panel and focus group discussions with fathers, provided insights regarding the intervention design and content preferred by fathers (see Appendix M and O). Carlson and associates³⁶ piloted an educational print intervention designed to increase parent-child communication about alcohol avoidance. It was concluded the intervention increased parent-child communication and was an efficient and relatively inexpensive method of brief intervention for parent drug education purposes. Parents reported that posted written materials were more convenient than telephone interviews or meeting-based interventions. Werch and associates⁴⁸ also reported that parents preferred printed materials or activities, that could be completed at home.

This preference for written materials was also consistent between recommendations made by the Advisory Panel and those of fathers who attended the focus group discussions. As a result, information materials titled '*Dads, Kids and Drugs*' were developed and favourably reviewed by both the Advisory Panel and the fathers who participated in this research. In addition, over 70% of father respondents reported using the tips or activities provided in the '*Dads, Kids and Drugs*' information materials. This implementation rate supports using activity-based materials that require father-child interaction. The father-oriented information and activities developed and trialed in this research were reported to be easy to use and successful in terms of encouraging fathers talk with their children about drug-use issues.

Summary

As a result of consultation with fathers and health education professionals, fathers favourably received the educational materials. These materials appear to have the potential to encourage active involvement of fathers in the drug education of their children by increasing knowledge and confidence. The provision of these materials to fathers of children aged 9 to 12 would seem a feasible approach to decreasing the prevalence of adolescent smoking and other harmful drug-use.

Recommendations

The use of conveniently-selected small samples means these findings only represent the views of men (and women) who responded and participated in this study. Replication of this study with a larger randomised sample order for the findings to be more generalisable is therefore recommended. A larger sample would also facilitate more rigorous analyses of variables that may predict fathers' involvement in the drug education of their children. Further process evaluation of the diffusion process is also warranted.

7 EFFECTS OF RESEARCH ON PROFESSIONAL DEVELOPMENT

This project has provided learning opportunities for a number of students at Curtin University. One student is currently completing a Master of Public Health with research from this project. This student was the project coordinator during the intervention development and piloting stages. She gained valuable experience in project management as well as data collection, entry and analysis and report writing skills. Undergraduate students also completed volunteer work on the project, which provided opportunities to develop and demonstrate important research competencies such as training in central intercept interviewing and focus group scribing, to complement the competencies gained from their formal education.

This project also provided an opportunity for research staff at Curtin University of Technology, Edith Cowan University and the University of Western Australia to work collaboratively and improve research networks.

8 IMPLICATIONS FOR HEALTH PROMOTION/ LINKING RESEARCH TO HEALTH OUTCOMES

Few if any drug education programs for children that actively involve parents have focussed on the father's contribution, nor is there evidence of school-based interventions which actively and selectively encourage fathers to participate in the drug education (especially smoking and alcohol education) of their children. Yet the impact of fathers on the behaviour of children is reportedly significant. This study developed tailored communication-related information materials for use by fathers with their school-aged children. The materials were designed to improve fathers' knowledge, ability and confidence regarding participation in the drug education of their children.

This research provided important qualitative data from fathers, as well as mothers, on what types of information fathers may need to help them to communicate more effectively with their children. Information was gathered regarding appropriate strategies to provide fathers with such information. Their perceptions of what fathers required to increase their involvement in the drug education of their children provide important insights regarding the development of health promotion information materials, and how they can better target the needs of fathers and other men who raise children.

It is anticipated the data collected in the current study will form the basis of a larger empirical trial of the effectiveness of involving fathers in the drug education of their children. This trial will include a larger randomised sample to develop specific father-friendly strategies.

9 COMMUNITY BENEFITS FROM THE RESEARCH

This research has added to current knowledge of best practise regarding the provision of drug education for fathers of school-aged children. In particular, this research has resulted in the:

- Provision of criteria to assess father-based drug education programs that target communication with high school-aged children;
- Development of health promotion strategies to actively encourage communication about drug education issues between fathers and their children which may be utilised state-wide, nationally and internationally;
- Assessment of methods to empower and encourage fathers to play a critical role in their children's drug education through more frequent and tailored communication; and
- Enhanced knowledge of strategies to engage parents in health promotion activities associated with their children's and their own health.

10 PUBLICATIONS

Beatty, S., and Cross, D. (In Press). Engaging Parents in the Drug Education of Children: Practical Problems and a Promising Program. *In The Proceedings of the Inaugural Alcohol and Other Drug Symposium*. Inaugural Alcohol and Other Drug Symposium, August 22-23, Fremantle, WA.

Additional papers are currently being prepared for publication by Shelley Beatty (Edith Cowan University) and Donna Cross (Western Australian Centre for Health Promotion Research).

11 SEMINARS

Shelley Beatty presented a paper written by herself, and Donna Cross titled "Engaging Parents in the Drug Education of Children: Practical Problems and a Promising Program" at the Inaugural Alcohol and other Drug Symposium on August 22-23 in Fremantle.

The abstracts of two papers will be submitted (by 13 September 2002) to the organising committee of the International Alcohol and Other Drug Research Conference scheduled for Perth 2003.

Shelley Beatty has also presented keynote sessions at three School Drug Education Regional Organising Committee Network Conferences.

There will also be a presentation of study findings to the Advisory Panel later in this year (2002).

12 FURTHER DISSEMINATION

A systematic plan for dissemination of the findings of this project will be developed in association with key collaborators from Family and Children's Services, Police Service, Health and Education Departments as well as professional organisations and non-government organisations such as the TVW Telethon Institute for Child Health Research. A brief summary of the results will also be disseminated to all participating schools and a seminar to disseminate the formative findings to the Advisory Panel and other interested groups will be arranged for later this year.

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APPENDICES