

Vista Community Clinic Jr. REACH Research Study

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Introduction

The Vista Community Clinic (VCC) Health Promotion Center developed a novel, experimental intervention for youth in 4th, 5th, and 6th grade who are 9-12 years old and their parents/guardians. The intervention will be delivered within the context of VCC's preexisting after-school program called Junior (Jr.) REACH. "Jr. REACH" stands for Recreation, Employment Readiness, Academic Achievement, Communication Skills, and Healthy Lifestyles; it is a comprehensive, youth development after-school program offered by VCC at two Oceanside Parks and Recreational Centers. VCC provides Jr. REACH to north San Diego County communities containing multiple census tracts identified as "Teen Birth Rate Hot Spots" by the California Department of Health Services. This novel experimental intervention includes classes for youth and parents or other adult caregivers offered in parallel that focus on abstinence, puberty and parent-youth communication. VCC has adapted and combined three independently tested curricula ("Sex Can Wait" for youth; "Can We Talk" and "Guiding Good Choices" for parents/guardians) supplemented with additional material. The youth component consists of thirty-one (31) sessions that will be delivered for one hour, four times a week. Sessions include lectures and interactive lessons which will cover seven topics: (1) Self-Esteem; (2) Values; (3) Goals; (4) Puberty; (5) Decision Making; (6) Communication and Relationships; and (7) Consequences. The parent component consists of eight (8) two-hour weekly sessions. Both components intend to improve parent-youth communication, teach parents what youth are learning about sexuality and puberty in schools, and bring greater awareness of the myriad of risks and protective factors related to teen pregnancy as well as the initiation of substance use and abuse. VCC's intervention is designed to provide a holistic approach to promote abstinence among youth, delaying onset of sexual activity, thus ultimately reducing teen pregnancy.

Methods

The behavioral intervention under study is being developed and tested in two stages: Phase I and Phase II. Phase I is the pilot test completed in June 2008 that is the subject of the findings presented here. Phase II is the efficacy trial launched in October 2008 that employs a quasi-experimental, longitudinal study design to compare outcomes of intervention youth and matched comparison youth recruited from other after-school programs in the area. Youth will be matched on gender, age and race/ethnicity. We expect the proposed intervention to increase parent-child communication overall and with respect to abstinence, increase parental involvement in the lives of their children, enhance youth self-esteem and increase youth intention to remain abstinent.

Outcomes are measured using self-administered baseline and follow-up behavioral assessment tools. The youth behavioral assessment tool consists of two components: the Adolescent Family Life (AFL) Prevention Programs Core Questionnaire (OMB NO.: 0990-0290, expired 9/30/08) and the Jr. REACH supplemental questionnaire. The constructs being measured by this tool are: (1) parent-youth communication, (2) parental involvement, (3) youth self-efficacy to remain abstinent, and (4) attitudes and peer norms regarding abstinence. The parent behavioral assessment tool is composed of items from three different sources: (1) adapted items from the youth AFL Core Questionnaire; (2) items from the *Can We Talk* program survey; and (3) items

from the *Guiding Good Choices* program survey. Both youth and parent self-esteem will be measured by the Rosenberg Self-Esteem Scale. In Phase I the surveys were administered at pretest and posttest. Due to the small sample size, analysis was limited to simple descriptive statistics to assess trends. In Phase II data will be collected at four points in time: pretest, posttest, 12 months after pretest and 24 months after pretest. Matched comparison youth and their parents will complete surveys at the same intervals. Outcomes will be evaluated based on repeated measures using SAS software version 9.1.3 (SAS Institute, Inc., Cary, NC).

Results

Phase I allowed the study team to test curricula, protocols and procedures with a limited number of youth and their parents at one intervention site. Qualitative data collection included staff observation, youth and parent class evaluation forms, and focus groups at the end of each curriculum. Six of 15 parents and eight of 14 youth enrolled in Phase I participated in the parent and youth focus groups, respectively. Participants recommended that the parent and youth classes continue to be offered concurrently to reinforce parent-youth communication. Parents and most youth reported increased parent-youth communication. Parents reported that exposure to material about puberty and abstinence helped open family discussions about these delicate issues. Parents requested more printed material to use as guides. They also identified the need to expose their youth to gang and/or substance abuse prevention messages in addition to abstinence messages. Participants also expressed a desire for more interactive programming.

Quantitative data was collected through the parent and youth behavioral assessment tools. Of the 14 children enrolled in Phase I, matched pre/post data was available for 11 children (78.6%). Of the 11 youth with matched data, 4 (36%) had at least one parent who participated in the parent component. The results reported here reflect the responses for matched cases only. The sample of youth consisted of 6 females (54.5%) and 5 males (45.5%). Eight participants were 10 years of age (72.7%) and three participants were 11 years of age (27.3%). Seven were of Hispanic or of Latino origin (63.6%) and four were Native Hawaiian or Other Pacific Islander (36.4%). Key questions were selected for analysis. Evaluation findings include: (1) an increase in the percentage of youth reporting that youth should be 16 years or older to go alone on a date; (2) an increase in youth self-efficacy according to three measures (increased percentage who disagreed with the statements: “I don’t have enough control over the way my life is going”; “I can’t do things as well as most other people”; “My plans hardly every workout”); (3) an increase in the percentage of youth reporting that “I can say “no” to activities that I think are wrong”; and (4) an increase in the percentage of youth reporting that they have talked to their parents about “puberty”, “how girls get pregnant”, “why people your age should not drink or do drugs”, “why people your age should not have sex” and “how to say “no” to alcohol, drugs or sex”. Overall nearly all youth agreed with the statement “I know adults who often cheer me on” (90.0%) at baseline, and nearly all youth reported that they did not smoke cigarettes, drink alcohol or use marijuana. This may reflect the young age of the children involved in the study.

Discussion

Phase I provided an important opportunity to pilot test the intervention with a small sample of parents and youth from the target population. Due to the small sample size, data presented are suggestive and conclusive findings will not be available until completion of the Phase II efficacy trial. However, focus groups suggest that the curricula fostered parent-youth communication. Analysis of selected youth survey responses appears to substantiate these findings. Youth

reported increased communication with their parents/caregivers about key topics introduced in the class, including puberty and why youth should remain abstinent. The key recommendations for curricula improvement included additional printed material, more interactive programming and an expansion of content to include gang and substance abuse prevention that reflect the range of concerns among parents in the area. Based on participant feedback staff modified study protocols and curricula content for Phase II.

Implications

Pilot test findings suggest that the intervention is acceptable to the target population and may increase parent-child communication about the topics introduced in the youth and parent classes. Valuable modifications were made in response to participant feedback. Phase II will determine the potential efficacy of the proposed intervention to increase parent-youth communication and increase youth intention to remain abstinent.

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