



# Doing it together strengthens families and helps prevent substance use

*Where school-based prevention programmes disappoint, family interventions have a better record. According to an authoritative review, the one with the best record of all is the US Strengthening Families Programme now being tried in Britain. Where does it come from, and what is the evidence?*

A **FINDINGS** analysis  
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We are grateful for the assistance of Karol Kumpfer of the University of Utah, Richard Spoth of Iowa State University, Megan Marsh of Barnsley's Child and Adolescent Unit Mental Health Service, and Sara Lindfield of the Trust for the Study of Adolescence.

Though they have enriched it, they bear no responsibility for the final text.

The Strengthening Families Programme<sup>1</sup> is one of the few whose substance use prevention credentials have survived rigorous inspection by independent scholars, in this case a British team who singled it out as the most promising “effective intervention over the longer-term for the primary prevention of alcohol misuse”.<sup>1</sup> Their judgement carries considerable weight because it was based on one of the scrupulously scientific **Cochrane reviews**. An added attraction is that

Strengthening Families’ benefits potentially extend to youth crime and anti-social behaviour, educational attainment, and child welfare, consistent with advice that family interventions should not deal with drugs in isolation.<sup>2</sup> Though the programme and most of the research is US-based, at least one British centre is using it to gain these broader benefits (▶ *The British experience*) and at another an evaluation is under way (▶ *Accolade from Cochrane review*).

## Roots: drug using families and primary school children

Karol Kumpfer  
originated the  
programme



The study which caught the Cochrane reviewers’ eyes involved a version of the programme designed to be universally applicable to the families of secondary school children and tested on mainly rural, white, intact families.<sup>3,4</sup> However, its origins were in an attempt to help drug using parents do the best for their primary-school age children.<sup>5</sup>

Patients at a methadone clinic in Salt Lake City provided the impetus. By improving their parenting, they hoped to help their children avoid replicating their own fates and to achieve happiness and success. In response Karol Kumpfer, a developmental psychologist at the University of Utah, created an intervention to reduce the chances that the 6–10-year-old children of problem drug users would themselves later develop drug problems. She planned to achieve this by “improving parent-child relationships ... We try to change the family dynamics, to create a more democratic family where they actually have family meetings, talk together, and plan activities together.”<sup>6</sup>

### Careful construction

Work started in 1983 with a review of research on how family processes might lead to or protect against later drug problems and of existing family programmes which might divert this trajectory.

Based largely on the Utah team’s own research, a careful unpicking of how the drug problems of parents affect their children established that disorganised stress in the household often results in a lack of consistent and responsible parenting.<sup>7</sup> Parents spend relatively little time with their children, particularly ‘quality time’ enjoying joint activities. Stigma and fear of exposure lead to the social isolation of the family and of the child. To their peers, children from these families can seem ‘strange’, unable to engage in the normal give and take of social interaction or to share their

homes and their families with their friends.<sup>8</sup>

The result is an impoverished social environment which lacks adult supports. Family dysfunction takes its toll on the child in the form of emotional stress, low self-esteem, under-achievement at school, conflict at home, and avoidance of intimate relationships.

To meet these needs elements were adapted and blended from existing approaches.<sup>8</sup> Despite the achievements of some parent-only approaches, Dr Kumpfer believed that the best response would involve the whole family – parents and children. Ironically given its later transformation into an across-the-board (‘universal’) prevention programme, she was also convinced that there was a “qualitative difference” between trying to prevent drug *abuse* in these high-risk families and preventing recreational and experimental drug *use* by the children of more typical families.

What emerged was the first Strengthening Families Programme. Its basic format has remained unaltered. The weekly sessions last two to three hours. For about an hour parallel groups of children and parents from four to 14 families develop their understandings and skills led by two parent and two child trainers. In a second hour parents and children come together as individual family units to practice the principles they have learned.<sup>9</sup> The remaining time is spent in logistics, meals, and enjoyable family activities.<sup>5</sup>

Its tripartite nature (parents only, children only, then the whole family) departed from previous approaches as did the fact that parents put their learning into effect during the 14 sessions – an opportunity to receive immediate feedback from the trainers.<sup>8</sup> During parent-child play sessions parents are coached in how to enjoy their children and to reinforce good behaviour. At first the accent is on building up the positives before tackling the more incendiary issues of limit-setting and discipline. The programme is highly struc-



tured with detailed manuals, videos and activities, but also highly interactive and designed to be adapted sensitively to the participating families.<sup>5</sup>

### The first test: parents in drug treatment

The approach was first trialed in Salt Lake City on 90 families with parents in outpatient substance abuse treatment. Though its findings were convincing enough to generate further federal funding, the study was never fully reported in a scientific journal<sup>iii</sup><sup>10</sup> and the accounts we have seem inconsistent.<sup>iv</sup> Many studies followed but this remains one of the few to have randomised families to the programme, eliminating the risk that the apparent benefits arose simply because families who opted to undergo it differed from those who did not.<sup>5</sup>

Thirty families were randomly allocated to continue with the parent's normal substance abuse treatment (the controls)<sup>9</sup> while 20 each additionally received the Strengthening Families parents' sessions, these plus the children's sessions, or the full programme including the parent-child family sessions.<sup>11</sup> At issue was which approach would generate the greatest before-after improvements. The clear answer was the full programme.<sup>5,6,8,11</sup>

Compared to controls, families offered the full intervention improved in parenting, children's social skills and family relationships. Parents became less depressed and cut their drug use. Children became less aggressive, better behaved, said relationships with other children had improved, and felt more able to express themselves. Among older children could be seen a reduction in the use of tobacco, drugs, and alcohol. The differences were usually substantial and statistically significant.

Without family sessions there had been gains in parenting and child social skills but these had not gelled into improved family relationships. It was the package 'wrapped up' by parents and children coming together which had made the difference.<sup>5</sup>

### Adapted for new populations

A series of trials followed in which Strengthening Families was adapted for and tested on high-risk families with pre-teenage children from disparate backgrounds.<sup>5,12</sup> Except for two as yet unpublished studies,<sup>11,13</sup> none were randomised and only one has been published in a scientific journal.<sup>14</sup>

Results from one of the randomised studies are still being analysed. It involved not just US but also Canadian families, probably culturally closer to Britain.<sup>13</sup> Participants were families with children aged 9–12 one of whose parents had a drink problem. They were randomly assigned to a minimal contact control group or to Strengthening Families. An initial report on 365 families who completed before-and-after interviews found significant extra parenting gains in the Strengthening Families group, particularly when the child was a boy.

One of the largest of the non-randomised studies involved a mainly poor, multi-ethnic sample of 421 parents and their 703 youngsters aged 6–13.<sup>5</sup> Strengthening Families was compared with a local variant which omitted the joint parent-child sessions found so important in the original study. Again their importance was shown when the full programme led to significantly better family environment, parenting, and child behaviour/emotion outcomes. A five-year follow-up of just the Strengthening Families sample found that the gains had largely persisted, but without a control group this finding can only be considered suggestive.

In Hawaii an attempt was made to disseminate the programme throughout schools, churches, and public service organisations.<sup>5</sup> Though multiply-flawed, a local evaluation which compared a longer 'culturally appropriate' version against the original came up with the interesting finding that the customised version was less beneficial – a warning that though they improve recruitment, such modifications can also undermine the programme by departing from core content or principles. In this case a shift from behavioural training to 'family values' sessions could have been the culprit.

Hawaii also demonstrated that the prospect of multiple benefits can stimulate support from disparate agencies, enabling large-scale implementation.<sup>v</sup> It also underlined the importance of skilled trainers, good facilities and a realistic group size (with these big families numbers were best kept low) if drop-out is to be minimised.

### Rural black mothers benefit

For America with its large black drug treatment caseload, whether the programme would work with these families was a major issue. An adapted

Strengthening Families received a boost when a [Cochrane review team](#) led by Professor David Foxcroft [singled it out](#) as the most promising "effective intervention over the longer-term for the primary prevention of alcohol misuse".<sup>1,33</sup>

Foxcroft's team examined over 600 reports of studies of psychosocial or educational interventions intended to prevent alcohol use or misuse by young people. Just 56 were relevant and rigorous enough to be included in the review, and just three reported alcohol use or misuse reductions which persisted over a follow-up period of at least three years. One was the seriously flawed study of Life Skills Training<sup>34</sup> analysed previously in [FINDINGS](#)<sup>35</sup> and another investigated an approach tailored for Native Americans.<sup>36</sup>

That left Strengthening Families, specifically the study in Iowa where the seven-session version was offered across the

►►► *This systematic review points to the potential value of the Strengthening Families Program ... for the primary prevention of alcohol misuse.*<sup>1</sup>

board to families with children in the early years of secondary school.<sup>4</sup> This featured a "strong design, and ... a consistent pattern of effectiveness across the three drinking behaviour variables". Unusually, its effectiveness "seemed to increase over time, reflecting the developmentally orientated ... model on which the intervention is based".

To the original analysis David Foxcroft added one accounting for children not re-interviewed at the last follow-up. This assumed that their behaviour matched that of children from control group families. The result was an estimate that for every nine children whose families had been offered the Iowa programme, one was prevented from starting to drink, to drink without permission, or getting drunk; the last two were statistically significant. These ratios were around twice as good as those for the other two programmes and more consistent across different drinking measures. It was enough to persuade Professor Foxcroft to call for a project to "translate, develop and pilot the Strengthening Families Programme in the United Kingdom".<sup>37</sup>

One such trial is under way, but using it to help troubled families rather than as a universal intervention. Run by the Trust for the Study of Adolescence, the project's main aim is to test whether involving young people in a family programme is more effective than parenting programmes focused on parents or carers. Participants will be drawn from families referred by the courts because of the behaviour of their children. One of the five services in the study is using Strengthening Families as an example of a whole-family approach. [The project](#) ends in August 2004.<sup>38,39</sup>

## Golden Bullets

### Practice points from this article

- 📌 Strengthening Families' 14-session version has been tested mainly on high-risk families with primary school children, the seven-session version as a universal substance use prevention programme for secondary school children, but both have been used in other roles.
- 📌 For both there is evidence of improved family, parental and child functioning and of a retardation in the uptake of substance use and a reduction in its severity.
- 📌 For drinking in particular, the seven-session programme is considered the most promising approach we have, but research on this version is confined to a few studies in US rural communities, while most research on the 14-session version has consisted of uncontrolled studies.
- 📌 Nevertheless the consistency and bulk of positive findings warrants serious consideration of the approach not just for substance use prevention but as a means of promoting pro-social child development in general. It is feasible to implement in Britain and a formal evaluation is under way.



## The British experience



Megan Marsh (left) and Sara Male consider their British pilot a success.

Parent training coordinators Megan Marsh and Sara Male at the Barnsley Child and Adolescent Unit Mental Health Service scouted round for an approach to fill a gap in their work with families of troubled young teenagers.<sup>40</sup> A literature search identified the Strengthening Families Programme and they visited the Iowa centre for training.

How they set up their pilot programme illustrates that the approach can draw support from well beyond substance misuse circles. Apart from their own service, workers came from "the education service behaviour support team, the youth offending and the intensive prevention teams". A school made available two classrooms and a third which could be used as a creche. Such cooperation was important because "One agency would find it difficult to provide all the resources necessary to run the groups".

The Barnsley centre is using the seven-session (plus boosters) 10–14 version of the programme for referred families whose children evidenced a variety of problems. For these families they found it an attractive and feasible option but also that they needed more than the recommended number of group leaders – for ten families, two for the parents and four for the children. They trained 30 multi-agency professionals in the city as group leaders and the five facilitators of the pilot programme received training to be trainers for the UK. Neither recruitment<sup>41</sup> nor retention were a problem.

In their experience the 15 families who attended the first two groups showed substantially improved parenting in the targeted areas leading to improved general child management. "For example, there was standard setting, monitoring, effective discipline, together with a greater quality of affection between parent and child."

start by selecting out less committed families, and neither had a control group who did not go through the programme. Without this we cannot know whether in these families the improvements would have occurred anyway<sup>15</sup> or after any reasonable intervention. Also, extra gains in the high drug use families may have been partly due to their benefiting more from the other treatments they were receiving. Such limitations apply to most of the work on high-risk families, a by-product of concerns over depriving at-risk youngsters of help in order to create a control group.

Rather than a few rigorous studies, it is the accretion of low-level research from disparate investigators and disparate groups which testifies to the effectiveness of the intervention with high-risk families. Appropriately, Karol Kumpfer warns against placing too much store by these studies. They show that the programme "can be implemented by others with integrity and fidelity"<sup>5</sup> but when it comes to the effects, her generalised claims are limited to intermediate variables such as "family-focused risk and protective factors or processes and children's behaviors".<sup>18</sup> These can be expected to lead to reduced drug problems, but the brevity of the studies and the youth of the children would generally have made such reductions hard to detect. Where it was feasible to find them, they have been substantial.

Extended to families across the board A big step was taken by Karol Kumpfer and colleagues when they moved away from high-risk families to offer the programme to the full range of families with primary school children. In recruitment terms it was not a success, but the study did suggest yet again that the full intervention works best.<sup>16</sup>

The location was 12 rural schools in the Rocky Mountains. Families of all 1110 first-grade children (aged 6–8) were invited to participate. Typically those who agreed were white, middle class families, few of whose children had recognised special educational needs. Classes were randomly allocated to act as controls or to one of three interventions. The first was a classroom-based curriculum teaching children problem solving and critical thinking. Other families were in addition offered the Strengthening Families parent sessions and others the full programme. Just a quarter took up these offers.

This left 56 children whose families went through the full programme and 21 the parent-only component. The analysis is confined to these unusually committed participants, making it difficult to determine to what degree the outcomes were due to the programme as opposed to the types of families who agreed to undergo it.<sup>8</sup>

Before and after questionnaires completed by children, parents and teachers were used to assess the outcomes. Given methodological problems, not too much can be read into

version was tested on 62 black, single-mother families in rural Alabama in a study which featured a one-year follow-up.<sup>5 11 12</sup> Four results echo other work on the programme.

First, recruitment beyond women already in treatment at a mental health centre proved difficult. The solution was to employ a recruiter from the same background who enrolled participants from venues such as housing estates, churches, and classes for problem children. 'Indigenous' recruiters also proved valuable in later trials. Secondly, over 80% of the recruited families virtually completed the 14 sessions, typical (perhaps after teething problems) of the programme.

Thirdly, the most at-risk families made the greatest gains – in this case mothers who used illicit drugs as well as alcohol. Here there was more scope to normalise the children's and the parents' functioning, including their drug use. Children of less at-risk families improved only in the areas where they happened to be problematic in the first place. The implication is that the programme works by helping families with relatively severe problems move closer to the normal range. For those already within this range, it makes less difference.<sup>vi</sup>

Lastly, the degree to which parents spoke up in the group sessions made no difference to how much they and their children profited from them<sup>12</sup> – a finding later replicated.

**Black drug using fathers queue up to join**  
The replication came in research on black fathers with 6–12-year-old children. In preparation the Alabama manual was tailored for the inner city and renamed the 'Safe Haven Programme'.<sup>5 12</sup> It was trialed on the residents of a Salvation Army drug treatment centre in

Detroit, using drug counsellors as leaders.<sup>14</sup>

Again the recruiting agent was crucial, a charismatic ex-addict drug counsellor. Another typical feature was the integration of the programme into the life of ordinary community venues (local churches at night), destigmatising participation and enhancing sustainability. Also typical was the provision of child care, meals, transport, and other basic supports, much from church members or the treatment agency. These promoted recruitment and retention as did the advent of the specially tailored programme.<sup>vii 11</sup>

At first low, the retention rate rose to 80% where it remained for four years as applicants came to exceed capacity. Within two years, 88 families had entered the programme. Most had below-poverty incomes and half the children had fallen seriously behind at school, but still 58 families came to at least 10 of the 12 sessions.<sup>11</sup>

For the analysis they were split into families whose adults (not just the father) consumed higher versus lower amounts of alcohol and illicit drugs. Before-to-after gains were concentrated in the high drug use families where there were substantial improvements in family and parental illicit drug use, parental depression, confidence in parenting ability, time spent with the children, in the children's delinquency, aggression, and withdrawn or compulsive behaviour, and some improvements in family 'atmosphere'. Parents also reported significant improvements in their child's relationship with school.

### Feel the weight

Though encouraging, in both studies of black families parents chose to commit to the sessions,<sup>viii</sup> giving the intervention a head



the finding that compared to controls, only families given the full programme significantly improved on all outcome measures including parenting and family relationships.

Another (but as yet unpublished) randomised trial of the programme for across-the-board prevention involved primarily

black families.<sup>11</sup> 715 were randomly allocated to a minimal contact control group, to the Strengthening Families parents' sessions, to its child training sessions, or to the full programme. The latter created extra significant post-programme gains in parenting, child social skills and sociability, school progress,

and family organisation and harmony.

These studies show that families committed to improving their functioning through this type of intervention get most out of the full programme, but among the general population, only a minority of may be sufficiently committed.

## New programme for families with secondary school children

A still bigger step was taken when Richard Spoth's team at Iowa State University developed a version of the programme for universal application to families with children in the early years of secondary school.<sup>17</sup> With Dr Kumpfer they cut it to seven sessions and substantially revised it for rural families from the poor Midwest areas where the study was to be conducted. However, the 'Iowa Strengthening Families Programme' retained the three-strand format of the Utah original and, as before, the aim was to prevent substance use by improving family functioning.<sup>3</sup>

Twenty-two schools were randomly assigned to the Iowa programme or to act as controls. Of the 873 families with sixth-grade children (age 11–12), 446 agreed to participate in the study (which they knew might involve evening intervention sessions) and completed baseline measures. Before-and-after questionnaires completed by parents and observations of the family confirmed that the four targeted parenting behaviours had indeed improved: communicating rules about substance use; managing the child's anger; involving the child in family activities and decisions; and communicating understanding of the child as well as the parent's wishes.<sup>18,19,20</sup> In turn these led to generalised improvements in the parents' management of the child and in the emotional quality of the parent-child relationship.

Other papers assessed whether these (or other) changes really had helped retard substance use or abuse. Such an effect was evident in the two years following the end of the programme when fewer pupils from Strengthening Families schools started to drink, smoke, get drunk, or to progress to regular/heavy smoking or drinking.<sup>4,21</sup>

A later follow-up tracked outcomes for drinking, smoking and cannabis use three

and a half years after the end of the programme when the children were roughly aged 15–16.<sup>3</sup> On most measures drug use was significantly and substantially less in pupils whose families had been offered the programme. Among children yet to have done these things before its start, 40% had begun to drink alcohol without their parents' permission compared to 59% of controls, 26% had now got drunk versus 44% of controls, 33% versus 50% had tried smoking, and 7% versus 17% had tried cannabis. The Cochrane review used these figures to estimate that for every nine offered the intervention, one child was prevented from beginning to drink, drink without permission, or to get drunk [▶ Accolade from Cochrane review.](#)

### Benefits despite minority participation

The benefits were not confined to one-off experimentation. At the last follow-up 30% fewer Strengthening Families children had drunk alcohol in the past month and 46% fewer had smoked cigarettes. They had also used less often – on average drinking once and smoking less than one cigarette in the past month, 32% and 51% less than control group children.<sup>3i</sup> On both uptake and frequency measures, far from fading away, the gap between Strengthening Families and control group children seemed to widen the older they got [▶ charts below.](#)

On the basis of these figures, Richard Spoth estimated that the programme saves nearly ten times its costs by averting alcohol-related harm.<sup>22</sup> Savings in relation to smoking may also be substantial. Also reduced on some measures were incidents of hostility directed to the parents and aggressive behaviour outside the home.<sup>23</sup>

The main factor taking the shine off these findings is that they derived from just over a

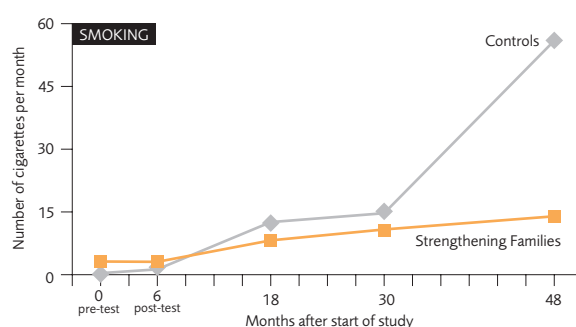
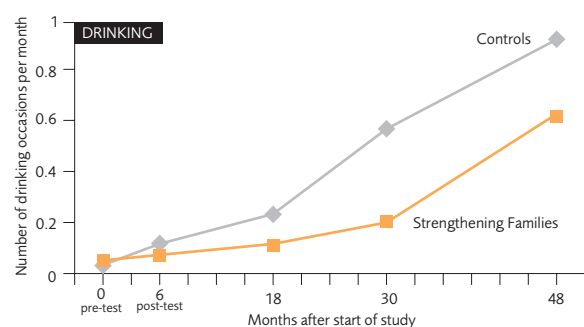
third of the families asked to participate in the study. The remainder either refused to do so or their children did not complete the follow-up assessment. Results from these families may be a poor guide to the programme's impact on children in general, even in the same schools. Generalising the results beyond the rural, white, intact families in the area to the rest of the USA would be even more risky, still more so to the UK with its different legal controls and cultural attitudes to alcohol and under-age drinking.

Still, the results were impressive. For families prepared to enter a study with fairly onerous research and intervention requirements, the programme prevented many of their children from an early introduction to smoking, cannabis, and alcohol use and abuse, and the indications were that the impacts would persist and grow at least to the end of secondary schooling.

### Fascinating footnotes

From this study there were two intriguing secondary findings. The first arises from the fact that it included not just the Iowa programme but also an alternative family skills programme. This ran over five rather than seven sessions and in just one did children participate as well as their parents. As its title (*Preparing for the Drug-Free Years*) suggests, it was also more directly aimed at preventing substance use. Yet, in contrast to the less substance-focused Strengthening Families, at the last follow up it had failed to prevent children starting to use any of the substances included in the analysis and only with respect to drinking had it significantly reduced frequency of use.<sup>3</sup>

The second is that whether families actually attended Strengthening Families' sessions seemed not to matter. At the two-year follow



Far from fading away, in a study of families with secondary school children the gap between Strengthening Families and control group children seemed to widen the older they got.<sup>3</sup>





up it made no difference to drinking outcomes whether children had attended at least half the sessions,<sup>21</sup> and at the four-year follow-up whether they had attended any at all made no difference to any of the substance use measures.<sup>3</sup> The presumption was that though just a third of their year group, the influence of children and families who went through the programme had spread to other children and families at the same schools via reduced 'peer pressure' to start using.

### Latest incarnation for 10–14s

With a little revision to for more ethnically diverse and urban populations, the Iowa Strengthening Families Programme became the Strengthening Families Programme: for Parents and Youth 10-14 – the numbers designate the intended age group.<sup>17</sup> The core seven-session format was retained but after its delivery in the first years of secondary schooling families are invited back the next year for four 'booster' sessions.

The new version's most well documented outing was in a study which tested whether using it to supplement the Life Skills Training drug education curriculum improved outcomes compared either to Life Skills alone or to an 'education as usual' control condition.<sup>24</sup> The programmes were offered to grade seven pupils (aged 12–13) and their families in 36 schools in the rural US Midwest which were randomly allocated to the three groups. Questionnaires completed by pupils a month after the core sessions were used as the baseline from which to assess a year later how many had started to drink, smoke or use cannabis. Only 38% of families allocated to these attended any of the Strengthening Families sessions but results are reported for all the families.

A year after the interventions about 26% of the Strengthening Families children went on to start drinking compared to 35–37% not offered the programme. Only with respect to cannabis use did Life Skills Training on its own improve on 'education as usual'. On this measure, adding the family sessions did not further improve outcomes, but the numbers were too small to be relied on. There were no statistically significant results for tobacco.

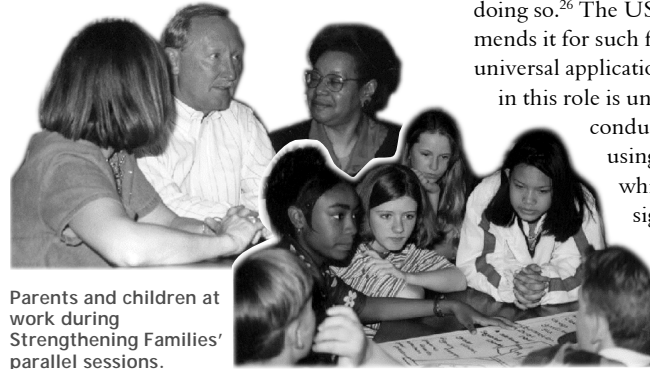
### Stringent test

This was a stringent test of Strengthening Families since the curriculum to which it would have to add value was itself well constructed and extensive and, unlike the voluntary evening sessions, it was experienced by nearly all the children. Yet compared to normal education this had little impact on drinking, while family sessions attended by only about a third of pupils/parents had a significant effect across the group as a whole.

In this study all the targeted children participated in the baseline survey and follow-up rates were high, increasing confidence that the outcomes would generalise

across the schools and communities sampled. The decision to use not pre-intervention but immediate post-intervention measures as the baseline is unusual, but unlikely to have materially affected the conclusions.

Though the new programme had been revised to embrace ethnically diverse and



Parents and children at work during Strengthening Families' parallel sessions.

urban populations, all but a handful of the families recruited for this study were white and from rural areas. However, research is under way on African-American families<sup>25</sup> and Iowa State University says that a variety of US groups have successfully used the programme, including families with children already experiencing problems or at risk of doing so.<sup>26</sup> The US government recommends it for such families as well as for universal application,<sup>27</sup> but how well it works in this role is unclear. Many groups have conducted pre- and post-tests using the programme's forms which apparently recorded significant gains in targeted behaviours,<sup>25</sup> but these often small local initiatives have not been funded to conduct scientific trials.

## It's not easy ... but they're worth it

If Strengthening Families is one of the most promising prevention programmes, it is also harder to implement than one aimed at the 'captive' school audience – a reason why its potentially wide appeal is important.<sup>28</sup> More hands dipped into more purses and a larger pool of staff to draw on aid dissemination.

For both major versions, detailed manuals and videotapes facilitate implementation,<sup>20</sup> but the programmes' interactive natures demand committed and skilled group leaders who will not just follow the manual but intuitively react to events. For the version for primary school children, they should be "warm, empathetic, genuine, and creative",<sup>9</sup> while for the 10–14 version they must have "strong presentation and facilitation skills ... and the ability to be flexible".<sup>20</sup> Just organising the sessions with rooms, transport, child care and meals, and orchestrating multi-agency and volunteer inputs, is a major task requiring administrative support.

### The trick is to get them in

To achieve acceptable recruitment and retention rates a run-in period is required during which local supporters are found and motivated to provide resources and to recruit families. The latter is perhaps the key task. Once recruited, given good leaders and facilities, the great majority attend most sessions. Both sets of US researchers have developed a tool kit of recruitment strategies. These have a strong track record in recruiting identified at-need families, where an 'indigenous' local champion seems the key factor.

But when the programme has been offered across the board to all families, only around a third have been drawn in. In the small, rural communities where a 'diffusion' effect seems to have been identified, the minority who participate may strongly influ-

ence the remainder, but this cannot be assumed in more socially fragmented settings.

US research suggests that time constraints and scheduling conflicts are the main blockages to participation.<sup>29</sup> However, British experience is that factors such as poor contact with the school, lack of commitment to parenting, or inability to attend, create a serious risk of missing out on the families in greatest need.<sup>2,30</sup> Unless this perception can be overcome, British funders may be reluctant to support Strengthening Families as an across-the-board programme.

Another risk is that attempts to make the time commitment acceptable and the programme applicable to families at different risk levels encourages a lowest common denominator approach which mitigates against effectiveness. It would probably be a mistake, for example, to short-change on the second hour of the sessions where the families come together. When the target is narrowed to high-risk families or those where problems are already apparent, there is less temptation to cut back and the approach can be both intensive and individually tailored.<sup>31</sup>

### Grass roots appeal

Strengthening Families is not the only family/parenting intervention to have demonstrated its value in preventing substance use or misuse,<sup>32</sup> but it is hard to think of another which has done so across such a spectrum. Most impressive and perhaps too most instructive, it does so by defocusing almost entirely from substance use to concentrate instead on the processes which sustain family life and promote healthy development. In the process it recommends itself not just (or not even primarily) as a substance use programme, but as a generic approach of equal interest to mental health, crime prevention,



education, child welfare, and family services.

However, the research behind the programme is often far from 'hard' science, conducted by community groups or agencies neither funded for nor primarily interested in research of the kind which would satisfy a peer-reviewed journal. The original randomised trial was for this reason never fully documented in a scientific journal.

Later trials have been, and some were also randomised and used control groups, but these tested the programme as a universal prevention initiative rather than one for at-risk families. Most of these trials had low research and/or programme recruitment rates, raising question marks over the generalisability of the results. One which did not still found substantial short-term benefits in reduced uptake of drinking.<sup>24</sup>

In David Foxcroft's words, Strengthening Families is certainly a "promising" programme, and workers and families across the USA and now too in Britain believe their experience and in-house evaluations prove its value. It would be good to see Professor Foxcroft's call for a well designed trial in Britain come to fruition.

#### NOTES

- i Apologies to US readers for adopting the English spelling of 'programme'.
- ii Similar processes were highlighted in *Hidden harm* (2003), a report from the British Advisory Council on the Misuse of Drugs.
- iii At the time Karol Kumpfer was not an academic but working for Utah's alcohol and drug service.
- iv This account of the study's design is from the latest document received from the Utah team reference 11.
- v Politicians, government, schools, community services agencies, health services and voluntary bodies all joined in.
- vi Perhaps why replications with the weakest results in-

involved families with non-drug-abusing parents or whose children did not exhibit significant problems.

- vii Though compared to the unadapted programme it did not improve outcomes once families had been recruited.
- viii And only those who attended nearly all of them were included in the study but this was the great majority.
- ix Of course, for many agencies these 'intermediate' processes will be the outcomes they are looking for.
- x Another methodological problem was that classrooms were allocated to the interventions but the results analysed in terms of individual children.
- xi Differences were not significant for past-year cannabis use and a skewed distribution precluded testing effects on cannabis use frequency.

#### REFERENCES

- 1 Foxcroft D.R. *et al.* "Primary prevention for alcohol misuse in young people (Cochrane Review)." In: The Cochrane Library: 2002, 4. Oxford: Update Software.
- 2 Velleman R. *et al.* *Taking the message home: involving parents in drugs prevention*. DPAS, 2000.
- 3 Spoth R.L. *et al.* "Randomized trial of brief family interventions for general populations: adolescent substance use outcomes 4 years following baseline." *Journal of Consulting and Clinical Psychology*: 2001, 69(4), p. 627–642.
- 4 Spoth R.L. *et al.* "Assessing a public health approach to delay onset and progression of adolescent substance use ..." *J. Consult. Clinical Psych.*: 1999, 67(5), p. 619–630.
- 5 Kumpfer K.L. "Selective prevention interventions: the Strengthening Families Program." In: Ashery R.S. *et al.*, eds. *Drug abuse prevention through family interventions*. NIDA Research Monograph 177. [US] National Institute on Drug Abuse, 1998, p. 160–201.
- 6 Wyman J.R. "Multifaceted prevention programs reach at-risk children through their families." *NIDA Notes*: 1997, 12(3).
- 7 Kumpfer K.L. *et al.* "Family environmental and genetic influences on children's future chemical dependency." *J. Child Cont. Soc.*: 1985, 18(1-2), p. 49–91.
- 8 DeMarsh J. *et al.* "Family-oriented interventions for the prevention of chemical dependency in children and adolescents." *J. Child Cont. Soc.*: 1985, 18(1-2), p. 117–151.
- 9 [US] Center for Substance Abuse Prevention. *Strengthening Families Program*. SAMHSA Model Program. <http://modelprograms.samhsa.gov>, accessed November 2003.
- 10 Personal communication from Dr Kumpfer, Dec. 2003.
- 11 *Table 1: Study design and outcomes for Strengthening Families Program studies*. Received Dec. 2003 from Dr Kumpfer.
- 12 Results pages of [www.strengtheningfamiliesprogram.org](http://www.strengtheningfamiliesprogram.org) accessed Nov. 2003.
- 13 Safyer A. *et al.* "The impact of a family-based alcohol prevention program on parenting." Abstract for SSWR presentation. 2003.
- 14 Aktan G.B. *et al.* "Effectiveness of a family skills training program for substance use prevention with inner city African-American families." *Substance Use & Misuse*: 1996, 31(2), p. 157–175.
- 15 Kumpfer K.L. *et al.* "The Strengthening Families Program for the prevention of delinquency and drug use." In: Peters R. *et al.*, eds. *Preventing childhood disorders, substance abuse, and delinquency*. Thousand Oaks, CA: Sage, 1996.
- 16 Kumpfer K.L. *et al.* "Effectiveness of school-based family and children's skills training for substance abuse prevention among 6–8-year-old rural children." *Psychology of Addictive Behaviors*: 2002, 16(4 suppl.), p. S65–S71.
- 17 Molgaard V.K. *et al.* "Competency training. The Strengthening Families Program: for parents and youth 10–14." *Juvenile Justice Bulletin*: August 2000, p. 1–11.
- 18 Spoth R. *et al.* "Direct and indirect latent-variable parenting outcomes of two universal family-focused preventive interventions ..." *Journal of Consulting and Clinical Psychology*: 1998, 66(2), p. 385–399.
- 19 Redmond C. *et al.* "Modeling long-term parent outcomes of two universal family-focused preventive interventions: one-year follow-up results." *Journal of Consulting and Clinical Psychology*: 1999, 67(6), p. 975–984.
- 20 Molgaard V. *et al.* "The Strengthening Families Program for young adolescents: overview and outcomes." In: Pfeiffer S.I. *et al.*, eds. *Innovative mental health interventions for children: programs that work*. Haworth Press, Inc, 2001, p. 15–29.
- 21 Spoth R. *et al.* "Alcohol initiation outcomes of universal family-focused preventive interventions: one- and two-year follow-ups of a controlled study." *Journal of Studies on Alcohol*: 1999, suppl. 13, p. 103–111.
- 22 Spoth R.L. *et al.* "Universal family-focused interventions in alcohol-use disorder prevention. Cost-effectiveness and cost-benefit analyses of two interventions." *Journal of Studies on Alcohol*: 2002, 63(2), p. 219–228.
- 23 Spoth R.L. *et al.* "Reducing adolescents' aggressive and hostile behaviors. Randomized trial effects of a brief family intervention 4 years past baseline." *Arch. Pediatr. Adolesc. Med.*: 2003, 154, p. 1248–1257.
- 24 Spoth R.L. *et al.* "Longitudinal substance initiation outcomes for a universal preventive intervention combining family and school programs." *Psychology of Addictive Behaviors*: 2002, 16(2), p. 129–134.
- 25 Project Family web site Dec. 2003.
- 26 ISU Extension web site Dec. 2003.
- 27 [US] Center for Substance Abuse Prevention. *Strengthening Families Program for Parents and Youth 10–14*. SAMHSA Model Program. <http://modelprograms.samhsa.gov>, accessed Dec. 2003.
- 28 Gilvarry E. *et al.* *The substance of young needs: review 2001*. Health Advisory Service, 2001.
- 29 Spoth R. *et al.* "Project Family prevention trials based in community-university partnerships ..." *Prevention Science*: 2002 3(3), 203–221.
- 30 Home Office Drugs Prevention Initiative. *Developing local drugs prevention strategies*. HMSO, 1998, p. 21–25.
- 31 Kumpfer K.L. *Strengthening America's families: promising parenting strategies for delinquency prevention. User's guide*. U.S. Department of Justice, 1993.
- 32 *Preventing substance abuse among children and adolescents: family-centred approaches. Reference guide*. [US] Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, 1998.
- 33 Foxcroft D.R. "Longer-term primary prevention for alcohol misuse in young people: a systematic review." *Addiction*: 2003, 98, p. 397–411.
- 34 Botvin G.J. *et al.* "Long-term follow-up results of a randomized drug abuse prevention trial in a white middle-class population." *JAMA*: 1995, 273(14), p. 1106–1112.
- 35 Stothard B. *et al.* "Education's uncertain saviour." *Drug and Alcohol Findings*: 2000, 3, p. 4–7, 16–20.
- 36 Schinke S.P. *et al.* "Preventing substance use among Native American youth: three-year results." *Addictive Behaviours*: 2000, 25, 387–397.
- 37 Foxcroft D.R. *Alcohol misuse prevention for young people: psychosocial and educational interventions*. Alcohol Concern, 2003.
- 38 Personal communication from Sarah Lindfield, Trust for the Study of Adolescence, December 2003.
- 39 Trust for the Study of Adolescence. *Parenting and Youth Justice Team. Involving Young People in Parenting Programmes*. Project description.
- 40 Marsh M. *et al.* "Chat back." *Young Minds Magazine*: 2003, 66, p. 26–27.
- 41 Personal communication from Megan Marsh, Nov. 2003.

#### For more information

On the programme for families with primary school age children

► The [Strengthening Families web site](http://www.strengtheningfamiliesprogram.org) at the University of Utah offers a guide to using the programme from age three to young adulthood but concentrates on the 14-session version for families with 6–11-year-old children. From here you can also order CD manuals. Visit [www.strengtheningfamiliesprogram.org](http://www.strengtheningfamiliesprogram.org) or contact the Department of Health Promotion and Education, 250 South 1850 East, Room 215, University of Utah, Salt Lake City, Utah 84112, USA. Also contact [Karol Kumpfer](mailto:Karol.Kumpfer@health.utah.edu) at [Karol.Kumpfer@health.utah.edu](mailto:Karol.Kumpfer@health.utah.edu).

► Particularly valuable for its account of the unpublished as well as the published research is: Kumpfer K.L. "Selective prevention interventions: the Strengthening Families Program." In: Ashery R.S. *et al.*, eds. *Drug abuse prevention through family interventions*. Download from [www.nida.nih.gov/DrugPages/Prevention.html](http://www.nida.nih.gov/DrugPages/Prevention.html).

On the programme for families with secondary school age children

► The seven-session version for 10–14-year-old children has been developed as part of Project Family at Iowa State University. For background visit [www.projectfamily.isbr.iastate.edu](http://www.projectfamily.isbr.iastate.edu).

► To order programme materials, organise training, and for implementation tips, visit [www.extension.iastate.edu/sfp](http://www.extension.iastate.edu/sfp) or contact Catherine Webb, Iowa State University, 2625 N. Loop Drive, Suite 500, Ames, IA 50010-8296, USA, [cwebb@iastate.edu](mailto:cwebb@iastate.edu).

► The US Department of Justice has published a useful practical guide to the research and to what it takes to implement the programme: Molgaard V.K. *et al.* "Competency training. The Strengthening Families Program: for Parents and Youth 10–14." *Juvenile Justice Bulletin*: August 2000. Download from [www.ojjdp.ncjrs.org/pubs/generalsum.html#182208](http://www.ojjdp.ncjrs.org/pubs/generalsum.html#182208).

**Notes** 9.10 7.11 3.15  
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