

## Strengthening Families Program

Brief Description | Recognition | Program IOM | Intervention Type | Content Focus | Protective Factors  
Risk Factors | Interventions by Domain | Key Program Approaches | Outcomes | Evaluation Design  
Delivery Specifications | Intended Setting | Fidelity | Barriers and Problems | Personnel | Education  
Personnel Training | Cost | Intended Age Group | Intended Population | Gender Focus  
Replication Information | Contact Information

*Program developers or their agents provided the Model Program information below.*

---

### **BRIEF DESCRIPTION**

The Strengthening Families Program (SFP) involves elementary school children, 6 to 12 years of age, and their families in 14 family training sessions using family systems and cognitive behavioral approaches to increase resilience and reduce risk factors. It seeks to improve family relationships, parenting skills, and youth's social and life skills.

### **Program Background**

SFP was originally developed by Dr. Karol Kumpfer and associates with a grant from the National Institute on Drug Abuse (NIDA), National Institutes of Health, U.S. Department of Health and Human Services, from 1982 to 1986. It developed out of multiple existing science-based prevention programs. The Parent Training component includes basic behavioral parent training techniques developed by Dr. Gerald Patterson and used in many behavioral parent-training programs. The Children's Social Skills component took elements from Dr. Myrna Shure's *I Can Problem Solve*, which also is used in the Seattle Social Development Project and Second Step Program. The Family Skills Training component uses family communication exercises based on Dr. Bernard Guerney's *Family Relationship Enhancement Program*, family meetings used in many effective programs, and child and parent game techniques developed by Dr. Robert McMahon and Dr. Rex Forehand for the *Helping the Non-compliant Child Program*. A new 2001 version of SFP, available on CD-ROM, was modified based on practitioner feedback.

---

### **RECOGNITION**

Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services: Model Program

National Institute on Drug Abuse (NIDA), U.S. Department of Health and Human Services: Programs That Work



Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice, Strengthening America's Families Expert Review: Exemplary I (independently replicated) Program

The Strengthening Families Program is a combination of five model prevention and treatment programs shown in research to work with adaptations for substance-abusing parents or caretakers and high-risk ethnic, immigrant families. It is one of only seven parenting and family education programs at the Exemplary I Level. This is the highest level of evidence of effectiveness, meaning they have been implemented and evaluated by external researchers as well as the program developer (see OJJDP [www.strengtheningfamilies.org](http://www.strengtheningfamilies.org)).

OJJDP Blueprints for Violence Prevention (ISFP reviewed): Promising Program

U.S. Department of Education: Safe and Drug-Free Schools (ISFP): Exemplary Program

White House Office of National Drug Control Policy: Model Program

Centers for the Application of Prevention Technology (CAPTs): Model Program

SFP has been featured on radio and television, such as Indian Country Today, TVO Toronto, New York telecast, Center for Substance Abuse Prevention (CSAP) telecasts, and on NIDA's videotape showcasing three effective drug prevention programs, called "Coming Together on Prevention" available from the National Clearinghouse for Alcohol and Drug Information.

---

## **INSTITUTE OF MEDICINE CLASSIFICATION (IOM)**

UNIVERSAL, SELECTIVE

Developed for a selective audience, but two recent randomized control trials with universally recruited families from elementary schools and housing and faith communities demonstrated significant positive results with moderate to large effect sizes. Independent investigators (Harrison, Boyle, & Farley, 1999) also have published significant positive results when SFP is used by mental health centers with indicated populations of youth already having diagnosed conduct disorders or emotional problems.

---

## **INTERVENTION TYPE**

COMMUNITY-BASED

## **CONTENT FOCUS**

### **ACADEMIC ACHIEVEMENT, ANTISOCIAL/AGGRESSIVE BEHAVIOR, SOCIAL AND EMOTIONAL LEARNING**

The program does not specifically target any particular substances of abuse. It targets risk and protective factors that affect substance use, such as knowledge of negative consequences of drug abuse, causes of substance abuse, family discussions of expectations not to use, or family contracting to not use. However, numerous SFP studies have shown significant reductions in tobacco, alcohol, and drug initiation and use by the older children of drug abusers and in initiation and use of drugs among the parents. A new NIDA study suggests significant reductions in alcohol use among universal parents recruited from schools and housing communities even without being drug treatment clients.

The children's groups focus on social and life skills (e.g., peer-resistance skills, problem-solving, conflict resolution, decisionmaking, and communication skills).

The parent groups focus on increasing family strengths, appreciation of positive changes, holding family meetings, increasing positive family time together and unity, developing new family rituals and chore charts, effective discipline, and family resources for positive changes. The family group focuses primarily on practicing Child's Game (therapeutic child play or parent-child interactive therapy), Family Game (family meetings and fun family activities), and Parent's Game or parent instruction in traditional cultural or ethnic arts and practice in effective discipline.

#### **Parents are a primary target population:**

Parents or caretakers are a primary target population and included in all 14 sessions. Parents and their children are both primary targets of this program. Parents are involved in both parent training and a second hour of family skills training in a variety of structured parent-child interactions.

---

## **PROTECTIVE FACTORS**

### **INDIVIDUAL, FAMILY, PEER, SCHOOL**

#### **INDIVIDUAL**

- Self-esteem
- Social and life skills
- Resistance to negative peer influences

#### **FAMILY**

- Parenting efficacy
- Family organization
- Effective communication
- Parent-child attachment
- Parental mental health

## PEER

- Prosocial friends
- Effective communication

## SCHOOL

- Grades
  - School bonding
- 

## **RISK FACTORS**

### INDIVIDUAL, FAMILY, PEER, SCHOOL

#### INDIVIDUAL

- Depression
- Conduct disorders
- Aggression, violence, delinquency
- Shyness and loneliness

#### FAMILY

- Family conflict
- Excessive punishment
- Child abuse and/or neglect
- Ineffective discipline
- Modeling of substance use by family members
- Family alcohol or drug abuse
- Differential acculturation

#### PEER

- Substance-using friends
- Negative peer influence

#### SCHOOL

- Tardiness
- Times absent
- Lack of school bonding

## **INTERVENTIONS BY DOMAIN**

### INDIVIDUAL, FAMILY, PEER

#### INDIVIDUAL

- Life and social skills training

#### FAMILY

- Family communication skills
- Parent education/parenting skills training

#### PEER

- Peer-resistance education
  - Social skills, communication
- 

## **KEY PROGRAM APPROACHES**

### BOOSTER SESSIONS, PARENT-CHILD INTERACTIONS, PARENT TRAINING, SKILL DEVELOPMENT

The program is delivered in 14 sessions consisting of 2 hours each for both parents and children. The first hour parents and children meet separately for skills training, and the second hour they meet together for structured parent child interactions that provide opportunities to practice the learned skills.

#### BOOSTER SESSIONS

Two booster sessions or family reunions at 6 and 12 months are encouraged to increase positive social networking and generalization and use of skills learned.

#### FAMILY SKILLS TRAINING (PARENT-CHILD INTERACTIONS)

Parents and children engage in structured family activities, practice therapeutic child play, conduct family meetings, learn communication skills, practice effective discipline, reinforce positive behaviors in each other, and plan family activities. Ongoing family support groups increase generalization and the use of skills learned.

#### PARENT TRAINING

Parents are taught how to increase desired behaviors in their children by using increased attention and rewards for positive behavior, as well as about clear communication, effective discipline, substance use, problem solving, and limit setting.

#### SKILL DEVELOPMENT

Children learn social and problem-solving skills. Parents learn disciplinary, and problem-solving skills.

## HOW IT WORKS

The SFP curriculum is a 14-session behavioral skills training program of 2 hours each. Parents meet separately with two group leaders for an hour to learn to increase desired behaviors in children by increasing attention and rewards for positive behaviors. They also learn about clear communication, effective discipline, substance use, problem solving, and limit setting.

Children meet separately with two children's trainers for an hour, to learn how to understand feelings, control their anger, resist peer pressure, comply with parental rules, solve problems, and communicate effectively. Children also develop their social skills and learn about the consequences of substance abuse.

During the second hour of the session, families engage in structured family activities, practice therapeutic child play, conduct family meetings, learn communication skills, practice effective discipline, reinforce positive behaviors in each other, and plan family activities. Booster sessions and ongoing family support groups for SFP graduates increase generalization and the use of skills learned.

Successful replication of SFP requires:

- Implementation of all 14 Parent, Child, and Family Skills Training sessions using SFP manuals and meeting once or twice per week. (Program manuals and other materials may be copied from an SFP CD-ROM.)
- An optimal family load of 4 to 14 families per group.
- Committed and experienced staff, including a part-time site coordinator and four group leaders (working 5 hours per week) who receive 2 to 3 days of training from SFP master trainers. (Warm, empathetic, genuine, and creative leaders are most effective.)
- Reunions or booster sessions of approximately 3 hours each every 6 months.
- Two large training rooms equipped with flip charts and extra space and tables for meals and childcare.
- Family meals, transportation, and childcare should be provided (reduces barriers to attendance).

---

## OUTCOMES

REDUCTIONS IN BEHAVIORS RELATED TO RISK FACTORS, IMPROVEMENTS IN BEHAVIORS RELATED TO PROTECTIVE FACTORS, DECREASES IN SUBSTANCE USE, OTHER TYPES OF OUTCOMES

Research has found consistent positive results with large to moderate effect sizes (ES = 1.30 to .20) for diverse families, and up to 5-year followup measures.

Percentage improvements for all the following outcomes can be found on the SFP Web site ([www.strengtheningfamiliesprogram.org](http://www.strengtheningfamiliesprogram.org)) for the following positive outcomes:

## REDUCTIONS IN BEHAVIORS RELATED TO RISK FACTORS

Parent Training results include statistically and clinically significant decreases in conduct disorders, aggression, delinquency, depression, overall internalizing and externalizing behavior problems, and (if measured) psychosomatic complaints in physically abused youth as measured by the Child Behavior Checklist (CBCL) and shyness on the Kellam Parent and Teacher Observations of Children's Activities (POCA and/or TOCA). Significant reductions in parents' depression, as measured by the Beck Depression Inventory (BDI), and significant reductions in parents' 30-day alcohol and drug use and stress, when measured, were revealed.

- Decreases family conflict and stress
- Decreased child depression and aggression
- Decreased substance use among parents and children

## IMPROVEMENTS IN BEHAVIORS RELATED TO PROTECTIVE FACTORS

Through Parent Training, significant improvements in parents' confidence in parenting and parenting efficacy, parenting knowledge, and positive parenting behavior skills (e.g., effective limit setting, discipline, and communication) and children's behaviors occurred.

Through Children's Skills Training, improved children's social skills and competencies such as communication, problem solving, peer resistance, and anger control, as measured by the Gresham and Elliott Social Skills Scale, resulted. An increase in the number of positive, prosocial friends and reports of reduced loneliness and isolation also were observed.

- Improvements in family environment and parenting skills
- Increased prosocial behaviors in children

## DECREASES IN SUBSTANCE USE

Through Family Skills Training, significant improvements occurred with small-to-moderate effect sizes in family conflict, organization, communication, and cohesion as measured by the Moos Family Environment Scale (FES).

### Reductions in Youth and Parent Substance Abuse:

The original NIDA research and several CSAP replications showed significant reductions in tobacco, alcohol, and drug initiation and use among the older children of drug abusers and in initiation and drug use among the parents. The new NIDA study suggests significant reductions in alcohol use among universal parents recruited from schools and housing communities even without being drug treatment clients. Similar results were found in several CSAP grants. The SFP for 10- to 14-year-olds has longitudinal followup studies up to 5 years that demonstrate significant reductions of 30% to 60% in alcohol, tobacco, and marijuana initiation and use by the ninth grade. These reductions in substance use are maintained to the 12th grade. These positive results found in students from 33 schools in southern Iowa produced a substantial cost/benefit ratio of \$9.60 per \$1 spent on SFP (Spoth, Redmond, & Lepper, 2001; Spoth, Gyll, & Day, 2002).

## OTHER TYPES OF OUTCOMES

At 5-year followup:

- 92% of families still used parenting skills, and 68% still held family meetings

## EVALUATION DESIGN

SFP has been evaluated more than 17 times on Federal grants and 150 times on State grants by independent evaluators. The original study involved a true pretest, posttest, and followup experimental design with random assignment of families to one of four experimental groups: 1) parent training only; 2) parent training plus children's skills training; 3) the complete SFP including the family component; and 4) no treatment besides substance abuse treatment for parents.

SFP was then culturally adapted and evaluated with five Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention (CSAP) High Risk Youth Program grants by independent evaluators using statistical control group designs that involved quasi-experimental, pre-, post- and 6-, 12-, 18-, and 24-month followup.

Recently, SFP was compared to a popular school-based aggression prevention program (*Can Problem Solve*) and found highly effective (effect sizes = .45 to 1.38) employing a true experimental pre-, post-, 12-, and 24-month followup design in two Utah school districts.

A NIDA effectiveness research study of 195 African American and White families in Washington, DC, randomly assigned to parent training only, children's skills training only, the full SFP, or minimal contact control, suggests very positive results in reducing children's behavior problems (e.g., aggression and conduct disorders) and improving children's social skills.

---

## DELIVERY SPECIFICATIONS

5–24 WEEKS

**Amount of time required to deliver the program to obtain documented outcomes:**

The curriculum consists of 14 2-hour sessions for groups of 4 to 14 families preceded by a half-hour family meal. The first hour parents and children meet separately. The second hour they meet together. Training groups meet once or twice a week. Sometimes, SFP is delivered twice a week to finish in 7 weeks for homeless shelters, drug treatment centers, pre-release jail centers where parents could leave in 2 months. It is generally run on a Monday and Thursday night or Saturday morning.

Booster sessions, called family reunions, occur every 6 months for 3 hours.

The SFP curriculum requires 14 behavioral skills sessions of 2 hours each plus reunions or booster sessions of approximately 3 hours each every 6 months.

---

## INTENDED SETTING

RURAL, URBAN, SUBURBAN, TRIBAL RESERVATIONS

Originally developed on a NIDA research grant (1982–1986) for use with children of parents in substance abuse treatment and mental health centers in an urban western setting, new culturally sensitive versions have been developed and evaluated largely with CSAP funding. They have been found effective with families from diverse backgrounds living in urban, suburban, rural communities and American Indian reservations from Alaska to Florida.



## FIDELITY

Components that must be included in order to achieve the same outcomes cited by the developer:

Full implementation of 12 to 14 parent, child, and family skills training sessions using the SFP manuals. Low-risk families can improve with 12 sessions, but high-risk families or immigrant and refugee families need at least 14 sessions. In some cases, 16 sessions are provided for these families with additional time to understand the material covered.

Implementing in groups of 4 to 14 families.

Trained and experienced staff consisting of a part-time site coordinator and four group leaders (two for parents, two for children).

Three-hour booster sessions every 6 months.

Family meals, transportation, and child care should be provided to reduce barriers to attendance.

---

## BARRIERS AND PROBLEMS

**Recruitment Issues and Solutions:** Agencies or schools with no prior experience in providing services for families or no existing client base may find recruitment to be difficult. Solutions to improving recruitment include removing barriers to attendance such as providing meals prior to training, babysitting, and transportation when needed. Researchers have found recruitment is easier if families trust and are already receiving services from the person suggesting they sign up for the family program. Drug treatment clients in residential treatment sign up at higher rates than intensive outpatient clients who sign up at higher rates than weekly outpatient clients.

**Retention Issues and Solutions:** Once families attend one session the completion rate averages about 70% for universal families in schools to 85% for drug treatment clients. Retention can be lower for the first two groups (45% to 65%), but should be up to 70% to 85% by the third time the same group leaders run an SFP group. The first groups are pilot training groups and experienced group leaders have higher retention rates. Hence, hiring excellent group leaders who understand the local culture increases retention, as does an agency climate that is very committed to strengthening families.

**Funding Issues and Solutions:** Locating funding for a fully paid staff and implementing SFP at about \$7,500 per group of 4 to 14 families can be daunting for local agencies. Most agencies write grants to Federal or State agencies to get funding for SFP to do two groups per year. Some agencies have continued SFP after their grant funds have ended by working with community coalition volunteers, probation and parole officers, school teachers and counselors, or church volunteers supervised by an agency staff member. Some clinically licensed agencies bill Medicaid for mothers in drug treatment or mental health treatment as a family group therapy. LutraGroup staff can help with grant writing.

**Culturally Matched Staffing Issues:** We recommend having culturally matched group leaders and a male trainer in each pair of group leaders. Finding culturally matched men can be difficult, so agencies advertise or hire from other agencies, schools, parks and recreation, or faith communities to locate qualified men on contract for evening work. For ideas on hiring and supervision of SFP staff, see Aktan (1995) article in *International Journal of Addictions*.

## **PERSONNEL**

### **PART TIME, PAID, VOLUNTEER**

A part-time site coordinator or program coordinator (.50 FTE) is generally hired from the agency staff to supervise the four group leaders and all other needed services (e.g., food, transportation, babysitting, etc.). If more than one group or cohort is being run at a time, the job should be full time.

Four group leaders (two for children, two for parent training) are generally hired on contract for about 5 hours per week. Warm, empathetic, genuine, and creative leaders are most effective.

Community or church volunteers are often used to provide the meals, transportation, and babysitting for infants and preschoolers. Also 12- to 16-year-old youth from the attending families are sometimes interviewed and used as assistants in the children's and babysitting groups. Some agencies with a youth leadership training focus used coalition youth as training assistants in the children's groups.

---

## **EDUCATION**

### **SPECIAL SKILLS**

Four group leaders who are enthusiastic about SFP and positive changes in the families, warm, empathetic, genuine, and creative, each working 5 hours per week (two group leaders for children and two for parents).

---

## **PERSONNEL TRAINING**

**Type:** SEMINAR/WORKSHOP, **Location:** ONSITE/OFFSITE (trainer location),  
**Length:** BASIC (2 to 3 days)

Staff must receive 2 to 3 days of training from SFP-certified trainers. Two LutraGroup-certified trainers generally offer SFP training for group leaders. Costs can be reduced by cost sharing with other agencies or inviting local referral or sponsoring agencies to also send trainees. Sometimes individuals wanting training join an already sponsored training workshop in their area. To reduce cost, the training host generally supplies copies of the training manuals to all trainees once a single set is purchased on a CD-ROM.

Training addresses content and process issues for implementing the three training manuals and includes videos, games, role plays, group discussion or recruitment, retention, and cultural adaptation issues as well as didactic presentations on the risk and protective factors for drug abuse addressed by family programs and SFP research outcomes. The agenda for either a 2- or 3-day training, as well as information about what must be supplied by the training site, is available on the SFP Web site ([www.strengtheningfamiliesprogram.org](http://www.strengtheningfamiliesprogram.org)).

**COST (estimated in U.S. dollars)**

\$5,001–10,000

Cost considerations for implementing this Model Program for one cohort of 10 families as recommended by the developer:

Four group leaders x 14 weeks x \$14/hour x 3.5 hrs/week . . .	\$2,744
Food (14 sessions x 10 families x \$10/family) . . . . .	\$1,400
Child care x 14 weeks x 2 staff x \$10/hour x 3 hours . . . . .	\$840
Supplies (paper products and toys) . . . . .	\$300
Completion incentives (\$50 x 10 families) . . . . .	\$500
Manual duplication (\$15 parents = 15 children x \$4) . . . . .	\$120
Manual duplication (4 trainers x 6 manuals x 4 trainers) . . . . .	\$96
Per booster session (trainers, food, child care, and incentives) . . .	\$856

**TRAINING**

2-day training . . . . .	\$2,700 plus travel expenses
3-day training . . . . .	\$3,700 plus travel expenses

(recommended for groups over 25 and evaluated grants)

**MATERIALS**

Multicultural SFP 6-manuals, plus evaluation package on CD with limited site license to photocopy as many manuals as needed for agency . . . . .	\$200
SFP 6-manual, plus evaluation, hard copy (all of the below materials) . . . . .	\$200
Family Skills Training Group Leader’s Manual . . . . .	\$35
Parent Skills Training Group Leader’s Manual . . . . .	\$35
Children’s Skills Training Group Leader’s Manual . . . . .	\$35
Parent’s Handbook . . . . .	\$35
Children’s Handbook (6–12 years) . . . . .	\$35
Implementation Manual . . . . .	\$35
SFP Evaluation Package (pretests, posttests, followup tests, instructions) . . . . .	\$35
SFP for Spanish-speaking Families (CD with 6-manuals and evaluations in Spanish including site license to photocopy manuals for own agency use) . . . . .	\$200
Strengthening African American Families (each manual listed above, no CD) . . . . .	\$35

Strengthening American Indian Families (on CD) . . . . . \$200  
Strengthening Hawaiian Families (contact Coalition for Drug-free Hawaii)  
Strengthening Families for 10 to 14 Year Olds (contact Iowa State University,  
[vmolgaard@iastate.edu](mailto:vmolgaard@iastate.edu), (515) 294-8762)

---

**INTENDED AGE GROUP**

CHILDHOOD (5–11), EARLY ADOLESCENT (12–14)

The basic SFP targets elementary school-aged children, 6 through 11 years of age. Mature 5-year-olds or developmentally young 12-year-olds have been successfully included in some sites. The junior high school version of SFP, called *Strengthening Families of 10 to 14 Year Olds*, distributed by Iowa State University, can be used with the older youth in the families or they can be hired to work as assistants in the children’s groups. Younger preschool children in the family are provided services in a separate group.

---

**INTENDED POPULATION**

AFRICAN AMERICAN, AMERICAN INDIAN/ALASKA NATIVE, ASIAN AMERICAN,  
HISPANIC/LATINO, WHITE, NATIVE HAWAIIAN

Culturally sensitive versions have been developed and tested by independent investigators and found effective for all major ethnic groups. Spanish language versions of SFP are available. Specific SFP versions have also been developed and evaluated for Canada and Australia. The American Indian version is called *Five Feathers*. The African American version is called *Strengthening African American Families*; the Spanish-language version is *Strengthening Spanish-speaking Families*; the Asian American/Native Hawaiian version is called *Strengthening Hawaiian Families*.

The basic multicultural version of SFP is used by most agencies when serving a mixed ethnic population or White families. This is the version available on CD that is used by most agencies implementing SFP.

---

**GENDER FOCUS**

BOTH GENDERS

Developed for both male and female elementary school-aged students. A Latino Girls and Mothers SFP was tested on a CSAP Adolescent Female grant and found effective.

## REPLICATION AND ADAPTATION INFORMATION

SFP has been replicated and evaluated in several new Phase IV Special Population Replication research studies using randomized control trial designs, namely: (1) Project SAFE, the CSAP Predictor Variable study (Kumpfer, Alvarado, Tait, & Turner, 2002) in several school districts in rural Utah, and (2) the Strengthening Washington, D.C. Families Project, the NIDA-funded study (Gottfredson, Kumpfer, et al., submitted) of over 700 African American families and White families in the Washington, D.C. metropolitan area in the District of Columbia, Maryland, and Virginia. The importance of these research studies is that they tested SFP and found it effective with universal populations of families recruited through schools and communities, whereas earlier studies targeted selective high-risk populations primarily. SFP is also being replicated in multiple sites through CSAP funding to Parenting and Family Strengthening grantees, Family Strengthening and Mentoring grantees, and CSAT funding to Adolescent Residential Treatment grantees. Also, many States have authorized SFP implementation on State Incentive Grant (SIG) funding or allocated special legislative or Governor's drug prevention funding specifically for SFP implementation (Arizona, New Jersey, Maryland, Texas, Tennessee, Virginia, North Carolina, Florida, Washington, and Wyoming). The cross-site results of these replications have still not been submitted in final reports, but preliminary results look promising.

### CONTACT INFORMATION

**Strengthening Washington D.C. Families Project.** Implementers included the Washington, D.C. Council of Government, Director, Dave Robbins; Project Director: Carol Small (410-280-2927); Project Coordinator: Susie Johnson, M.S.W., (202-962-3200); Evaluation Director: Denise Gottfredson, Ph.D., Department of Criminology, University of Maryland. Site coordinators were also from Rockville Social Services and Montgomery County Pre-release Center, Prince George's County, Alexandria, and Marshall Heights Housing Community in the District of Columbia. Karol Kumpfer, Ph.D., Department of Health Promotion and Education, is the principal investigator on this NIDA research grant (801-581-7718). Preliminary research results are submitted and available from Dr. Kumpfer by e-mail at [karol.kumpfer@health.utah.edu](mailto:karol.kumpfer@health.utah.edu).

**Project SAFE.** Positive results published in the December 2002 issue of *Journal of the Psychology of Addictive Behaviors* (Kumpfer, Alvarado, Tait, & Turner, 2002). Project Director: Rose Alvarado, Ph.D., Department of Health Promotion and Education, 250 South 1850 East, Rm. 215, University of Utah, Salt Lake City, UT 84112 (801-581-8498), e-mail: [rosemary.alvarado@health.utah.edu](mailto:rosemary.alvarado@health.utah.edu).

**CSAP Parenting and Family Strengthening Program Grantees.** The CSAP Project Officer of these SFP replications, Nikki Bellamy, Ph.D., [nbellamy@samhsa.gov](mailto:nbellamy@samhsa.gov), has the most recent information on contact sites and results.

## TARGET SETTINGS

### Additional target settings where the Model Program has been replicated:

Because about 50 SFP trainings of group leaders are conducted each year for more than 450 agencies and 1,000 new group leaders each year, it is difficult to know about all the new populations to which SFP is being applied. Hence, the descriptions listed below include only a sample of new SFP target populations.

**Universal Populations.** As mentioned above, SFP has recently been tested in randomized control trials by researchers in new *universal populations of families (elementary schools and housing communities)* with comparable statistically significant results although the effect sizes are somewhat smaller because general population families have fewer problems to improve. State and other Federal grants are funding SFP to be used in schools and communities with good effects.

New **Selective Populations** have been used to replicate and evaluate SFP's effectiveness; such high-risk families were recruited from faith communities in Detroit, MI; Ft. Wayne, IN; Joplin, MO; South Miami, FL; Harrison, AR; Minneapolis, MN; and other communities.

*Children of criminally involved parents* are a new target population. For example, more than 400 families with parents on probation or parole for drug abuse violation in Maricopa County, Phoenix, AZ, have been enrolled in SFP in the past 2 years. Completion of SFP was included as a required component of their drug treatment. The Governor's Office is funding replications of SFP in many sites in Arizona. Parents in the Montgomery County, MD, pre-release center were enrolled voluntarily in the Strengthening Washington, D.C. Families Project as an indicated population contrasting to the other universal families.

*Child Protective Services Agencies* are now employing SFP to reduce child abuse and neglect among reported parents. Parents who complete SFP show significant reductions in child abuse and physical punishment. Parents are less willing to give up children to relatives or the foster care system, hence reducing foster care costs in States.

*Welfare to Work Programs* in New Jersey are using SFP to improve belief in personal change and readiness for change in drug-abusing mothers who have not found jobs and refuse drug treatment. They are finding that graduation from SFP reduces depression and increases personal efficacy and confidence in ability to change, so that more mothers are entering drug treatment and then getting jobs. State Family Services agencies are using SFP to improve the chances of grandparents to qualify for kinship care foster care.

*Youth Services Agencies* in a number of States are using SFP with high-risk youth in low-income neighborhoods. Foundations, such as the Hedge Funds Care Foundation in New York City, have selected SFP as a Model Program and are providing funding to existing SFP sites in settlement houses in New York City, such as Boys and Girls Harbor in Harlem, and Johnathan's Place in Dallas, TX. They are conducting fundraising activities in New York City, Dallas, San Francisco, Chicago, and other cities to raise funds for SFP implementations.

*Urban and Rural American Indian Tribes or First Nations Families.* A number of culturally adapted versions of SFP have been developed and tested for more than 30 different tribes in the mainland United States, Alaska, Hawaii, First Nation's families in Canada, and indigenous peoples in Australia with positive evaluated results in several randomized controls trials or quasi-experimental studies.

**Indicated Populations.** In addition, a number of CSAP-funded grantee sites or SIG State sites have used new populations that include indicated populations, such as children with severe mental health problems and diagnosed conduct problems. The National Mental Health Association in Alexandria, VA, the SFP National Partner, has funded State mental health associations to replicate SFP with parents with mental health problems through community mental health services agencies in several areas, such as Chicago and New York.

**Treatment and Aftercare Populations.** New CSAT-funded research has begun to test SFP's effectiveness in improving treatment outcomes and preventing relapse after Residential Adolescent Treatment with American Indian youth through Raindancer Youth Services in St. George, UT (southern Utah), New Mexico, Arizona, and Colorado.

## DELIVERY LOCATIONS

### **Additional intervention sites for which the Model Program was replicated:**

See descriptions above of new intervention sites, such as faith communities, criminal justice settings such as probation and parole, jails or pre-release centers, child protective services, youth services agencies, settlement houses, mental health centers, to name a few. Tribal social services agencies are also adapting and replicating SFP with indigenous, First Nation's families from more than 30 tribes in the United States, Alaska, Canada, Hawaii, and Australia.

## PERSONNEL CAPACITY AND TRAINING

### **Changes in personnel capacity, qualifications, or training required for the replication:**

There have been very few changes in the required personnel and staffing or training with one exception. We are currently evaluating the use of community coalition youth leaders who are highly trained in group facilitation skills to be youth aides or volunteers in the Children's Social Skills Training groups. Observations of African American youth in Hampton, VA, suggest high effectiveness in relating to the children and high levels of fidelity and enthusiasm.

## RACIAL/ETHNIC COMPOSITION OF PARTICIPANTS

### **Describe any additional racial/ethnic populations with which the Model Program has been replicated:**

No new racial/ethnic populations have been used in SFP replications, because SFP had specifically developed culturally adapted versions for all major racial groups before selection by CSAP as a Model Program. What has occurred is additional ethnic subgroup versions have been developed, such as for the multiple Spanish-speaking populations that include Dominican families in Bronx, NY; Cuban families in South Miami, FL; South and Central American families in Minneapolis; Mexican border community families in Nogales, El Pasco, and Anthony, NM; and Cape Verde families in Boston, MA. SFP has been replicated with over 30 Indian tribes or First Nation's families with several specific tribal versions, such as the Shoshone/Bannock Five Feathers SFP, the Ojibwa Tribe version with their own SFP board game marketed by the tribe.

## COST ESTIMATES

### **Describe any changes in cost estimates incurred with replications of the Model Program:**

Some sites or agencies are reporting being able to implement SFP for as little as about \$2,300 per group with the use of volunteers and church support. Some other sites are reporting having to pay more than \$14/hour for contracted staff in areas with high costs of living. Some sites have found very creative ways to locate funding or reduce costs. Some sites are billing third-party insurance companies and Medicaid if they are using licensed clinical staff, because since SFP uses therapeutic techniques used in standard clinical practices such as parent training, family therapy, and therapeutic child play or parent-child interactive therapy.

## OTHER DIFFERENCES BETWEEN THE DEVELOPER'S IMPLEMENTATION OF THE MODEL PROGRAM AND SUBSEQUENT REPLICATIONS

### **Describe any other features of the Model Program that were altered or affected by the implementation:**

**Cutting number of sessions for universal populations.** In practice, many sites cut the number of sessions to 8 to 12 sessions rather than the complete 14 sessions, particularly if they are working with universal families with lower risk. Higher-risk families need the complete 14 sessions to get good outcomes. Because there are several sessions that are repeated, such as three sessions on Limit Setters, some sites combine these into two sessions. The number of Family Communication sessions is sometimes cut to one session. The Generalization and Maintenance session is sometimes omitted or conducted in abbreviated version prior to graduation to combine sessions 13 and 14. Whenever SFP has been cut to any fewer than 12 sessions with high-risk populations for immigrant populations, the results have been less positive and the agencies have revised the program to return to the 14-session SFP version.

**Cutting length of sessions.** A number of sites are implementing SFP with a half-hour meal, 1 hour of the Parent or Children's Skills Training groups, and only a half hour, rather than an hour, of the Family Skills Training. The implementation sites find that keeping the children for longer than 1.5 hours in groups is difficult and children often need to get home earlier. Also, it is possible that some sites have staff with less background and comfort in running multiple family groups of four to five families each.

**Cutting the number of months to complete from 4 to 2 months.** In treatment programs or shelters where families are likely to stay only about 2 months, SFP has been implemented twice a week rather than once a week to allow the families to graduate before leaving the shelter and increase retention. In a residential wilderness camp in Alaska, the program was infused into the daily activities of the camp, with parents conducting Child's Game (fun family time together) and Parent's Game (instruction in new skills and discipline) during chore time.



**Adding new, but similar experiential activities that are culturally appropriate.** To culturally adapt or locally adapt SFP, the sites are encouraged to change some of the suggested experiential activities to those that they have used before successfully with their ethnic families. For instance, problem solving or Saying No to Drugs can be taught in several different ways—some more didactic and some more experiential and culturally relevant. The best sites are adding their own puppets for role-plays based on group dynamics, cultural folklore stories, and culturally sensitive family activities, such as parents teaching ethnic dancing, clothes-making, drums, flutes, songs, shields, storytelling, etc., for children to prepare for an ethnic performance for the graduation party. A big and formal graduation party is encouraged with families performing cultural arts.

**Adding additional children’s groups for older and younger children in families.** A number of sites are adding more structured children’s skills training activities for the children in babysitting, by having the two child care leaders find Head Start or Dare To Be You activities that match the topics in the elementary school version of SFP. Also, the sites are using the van drivers or other community volunteers to run a youth group for the older children in junior high or high school. Some sites are using the seven-session SFP for 10- to 14-year-olds. For the other seven sessions they are including a counselor or speakers to discuss topics of interest generated by the older youth as important topics for discussion, adding field trips or recreational and tutoring activities.

#### ADAPTATIONS OF THE MODEL PROGRAM

**Describe changes made to the Model Program in order to enhance program delivery and outcomes:**

The Strengthening African American Families curriculum was adapted by the State of Alabama Department of Mental Health and Mental Retardation in Alabama to include all graphics of African Americans and new cultural pride information, plus wording changes to reflect rural South, African American language and low reading level. The Detroit Salvation Army and Detroit Department of Health adapted SFP to urban drug abusers in treatment by including local videotapes. This version is called the Safe Haven Program. The Strengthening Hawaii’s Families Program was adapted by Coalition for Drug Free Hawaii to include more local family values. Iowa State University has developed a seven-session junior high school version with videotapes and a specific Ojibwa Indian version with an SFP board game the tribe markets. A more generic Strengthening American Indian Families version was developed for the Shoshone/Bannock tribe with cultural modifications such as talking circles, cultural family activities, and involving Indian storytellers and elders. The Strengthening Hispanic Families version was developed in Denver, but a new version on CD-ROM is now available from the program developer at the University of Utah with all manuals in Spanish. For a summary of all cultural adaptations and results, see the Kumpfer, Alvarado, Smith, & Bellamy (2002) article in the fall issue of *Prevention Science*.

Specific adaptations made in the cultural versions of SFP are mentioned above as well.

**Available products:**

See list of available modified versions in list of costs above.

## GENERAL SUMMARY DESCRIPTION OF EACH ADAPTATION

### Describe the adaptation and the reason for the change:

Most of the adaptations were made to create greater acceptance by local and ethnic families by using local values, language, and examples. Recruitment and retention were found to be higher when culturally adapted versions were used, but the program outcomes are not improved according to current SFP research (Kumpfer, Alvarado, Smith, & Bellamy, 2002). The junior high school version was developed to improve age-appropriate activities and focus on a universal school-based population (Kumpfer, Molgaard, & Spoth, 1996).

## CONTACT INFORMATION

There are too many agencies with multiple sites locally to list here for contact persons. Probably more than 3,000 sites are replicating SFP or have replicated SFP over the past 20 years. The best people to contact about contact information on SFP replications with similar target populations or those in your area are the program developer, Karol Kumpfer, Ph.D., at [karol.kumpfer@health.utah.edu](mailto:karol.kumpfer@health.utah.edu) or SFP Training Coordinator, Henry Whiteside, Ph.D., who is managing partner of LutraGroup at [hwhiteside@lutragroup.com](mailto:hwhiteside@lutragroup.com).

## IOM LEVEL OF PRIMARY PREVENTION

Universal populations (e.g., recruited from schools, communities, community coalitions, health clinics), selective populations (e.g., high-risk populations of children of parents with mental health and substance abuse problems, parents on probation or parole, children in foster care or kinship care, children with physically abusive parents reported to protective services), and indicated populations (e.g., recruited from referrals from counselors, psychologists, mental health centers, school psychologists because child is already manifesting diagnosed risk factors for later tobacco, alcohol, or drug abuse, such as conduct or behavior problems, delinquency, shyness, or mental health problems).

## TARGET SETTINGS

See above description under Replications.

## DELIVERY LOCATION

SFP has been implemented in about 3,000 sites nationally and internationally. There are SFP sites in almost all mainland States in the United States, Alaska, Hawaii, and Canada (primarily Toronto, Ontario, sites conducting the Canadian SFP version on a National Institute on Alcohol Abuse and Alcoholism grant and in British Columbia). SFP materials have been purchased in a number of foreign countries and some countries are seeking European Community grants to conduct a multination study in Sweden, Finland, Switzerland, and Italy. Governmental agencies and nongovernment organizations in Majorca, Spain, Saudi Arabia, Iran, Russia, and Rumania are also seeking funding to implement SFP. South American agencies in Chile and Costa Rica are implementing SFP versions. Australia has sites implementing the Strengthening Australian Families version that was tested and implemented in multiple sites with a grant from the Queensland government.

## TARGET AGE

Preschool versions are being developed in several sites, and Iowa State University developed the junior high school version. A high school version is being developed as well by several sites to improve parenting skills among high school students and particularly teen mothers.

## GENDER

A Latino Girls and Mothers version has been tested on a CSAP High-Risk Youth grant by Centro de la Familia in Salt Lake City, UT, and found to be effective. Contact Dr. Rose Alvarado at [rosemary.alvarado@health.utah.edu](mailto:rosemary.alvarado@health.utah.edu) for curriculum and results.

## PARENT INVOLVEMENT

Parents or caretakers are involved in all program versions adapted. Fatherhood versions have been developed and tested with positive effects. Female caretakers and male caretakers are encouraged to attend in all cases; however, in about 60% to 70% of the attending families only the mother attends, sometimes accompanied by a grandmother or aunt. For SFP “family” means whoever is the primary caretaker of the child and can include many different types of “families,” including adoptive, foster, step, live-in friends, lesbian or gay parents, or long-term child mentors.

## FIDELITY

Program fidelity has been very high in all research studies where fidelity is required by the grants. In the field, adaptations are encouraged as long as the content (session topics or goals) is not rearranged, at least 12 sessions are completed, all topics are covered in the correct order, and sessions including the parent, children, and family groups are no less than a total of 1.5 hours long.

Adaptations are expected so that the program can be made more locally and culturally sensitive and effective. Additionally, we have found that by allowing the new group leaders to add their own special family activities, puppets, training exercises, songs, cultural stories, music, etc., the group leaders are more committed, invested, and enthusiastic and convey an atmosphere of real hopefulness for positive change. In short, they become “True Believers” in the program. They make learning and behavior change fun and exciting for their families. These are the best group leaders to hire.

## PERSONNEL CAPABILITY

**Parent Volunteers.** As mentioned above under adaptations in staffing, some sites are using volunteers for the second group leader in each group, including parents who have completed SFP in earlier groups and want to become certified as a group leader. Hence, these sites are watching for the most promising candidates to be group leader assistants in the next group and to be sent for SFP Group Leader Training the next time the workshop is available in their agency or area. If the agency has enough funding, they are paid for their work.

**Youth Leaders Volunteers.** Community coalitions are also interviewing and hiring dynamic and self-confident community youth leaders from their coalitions as a third assistant in the children’s groups after attending the SFP Training Workshops.

## PERSONNEL TRAINING

### Training requirements to become an SFP group leader of families:

No changes in the training requirements of 2 to 3 days by an SFP-certified trainer. LutraGroup generally arranges trainings at the site of the agency so that enough staff can be trained as well as backup staff to fill in for sick or traveling group leaders. Training agency directors, supervisors, and any referral staff from other agencies by having them attend the first half day of training is recommended as well.

### **Training requirements to become an SFP-certified trainer:**

To become an SFP-certified trainer, a person attends the SFP Group Leaders Workshop, delivers SFP as a co-group leader with a more senior group leader at least once with positive feedback or results from families. At this point, the person can be called by LutraGroup to co-train with another SFP-certified trainer during a paid apprenticeship (\$500/day). Once they are considered qualified to be the lead trainer, which can take one to five SFP Group Leader Workshops, they can train others in SFP Group Leader Trainings under LutraGroup's management.

### **List of Certified LutraGroup SFP Trainers:**

Only the following LutraGroup-certified SFP trainers are authorized to conduct SFP training workshops. Currently there are certified SFP trainers in the following cities or States:

- Washington, D.C. (Dr. Jeanie Ahearn Greene and Ronald F. Bates)
- New York City, NY (Maria Bernalles)
- Philadelphia, PA (Wadine Toliaferro)
- Rhode Island (Lorraine Kaul)
- Maryland (Sue Henry)
- Florida (Doris Carroll)
- Chicago, IL (Dr. Crystal Shannon Morla)
- Connecticut (Dr. Connie Tait)
- Plano/Dallas, TX (Laurel Jackson)
- Houston, TX (Marsha Baker and Rudy Garcia)
- Scottsdale/Phoenix, AZ (Cathy Rosick)
- Montana (Leslie Boone)
- Salt Lake City, UT (Dr. Karol Kumpfer, Dr. Henry Whiteside, Dr. Rose Alvarado)

### **BARRIERS/PROBLEMS AND SOLUTIONS**

See above. Need for Spanish-speaking SFP trainers. LutraGroup is getting many more requests for trainings to be conducted in Spanish; hence, there is a need to find and develop new certified SFP trainers who are fluent in different types of Spanish: Cuban, Mexican, South American, Central American, Puerto Rican, etc. Those who are interested should contact Dr. Henry Whiteside at [hwhiteside@lutrargroup.com](mailto:hwhiteside@lutrargroup.com).

## **CONTACT INFORMATION**

### **ABOUT THE DEVELOPER**

The developer is Karol L. Kumpfer, Ph.D., psychologist, associate professor of health promotion and education at the University of Utah, and former director of CSAP in Washington, D.C. Henry O. Whiteside, Ph.D., managing partner of LutraGroup, runs the training system.

### **FOR INFORMATION, CONTACT**

Karol L. Kumpfer, Ph.D., Associate Professor  
Department of Health Promotion and Education  
250 South, 1850 East, Room 215  
University of Utah  
Salt Lake City, UT 84112-0902  
Phone: (801) 581-7718  
Fax: (801) 581-5872  
E-mail: [karol.kumpfer@health.utah.edu](mailto:karol.kumpfer@health.utah.edu)  
Web site: [www.strengtheningfamiliesprogram.org](http://www.strengtheningfamiliesprogram.org)

Henry O. Whiteside, Ph.D., Managing Partner  
LutraGroup, Inc.  
5215 Pioneer Fork Road  
Salt Lake City, UT 84108  
Phone: (801) 583-4601  
Fax: (801) 583-7979  
E-mail: [hwhiteside@lutrargroup.com](mailto:hwhiteside@lutrargroup.com)