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To cite this article: Carmen Orte, Lluís Ballester, Joan Amer & Marga Vives (2017): Training of practitioners and beliefs about family skills in family-based prevention programmes, British Journal of Guidance & Counselling, DOI: [10.1080/03069885.2017.1343456](https://doi.org/10.1080/03069885.2017.1343456)

To link to this article: <http://dx.doi.org/10.1080/03069885.2017.1343456>



Published online: 24 Jun 2017.



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Training of practitioners and beliefs about family skills in family-based prevention programmes

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ABSTRACT

To ensure close adherence to the contents of a family-based cognitive-behavioural programme, and maintain a high standard of quality in its implementation, it is important that practitioners' attitudes and beliefs regarding family skills coincide with those of the programme. This paper describes and analyses (observed) potential changes in these beliefs, after training courses held prior to the application of a prevention programme for families: the Family Competence Programme. A questionnaire was devised to examine practitioners' beliefs regarding family skills; and completed both before and after the training course. The results point to significant changes in family dynamics, realistic expectations and active listening. Thus, it can be demonstrated that preliminary training courses promote practitioner attitudes and beliefs which are more coherent with a subsequent programme's approach.

ARTICLE HISTORY

Received 20 July 2016
Revised 10 February 2017
Accepted 11 June 2017

KEYWORDS

Family prevention;
facilitators; drug prevention;
fidelity; quality of
implementation

Introduction

Prevention programmes for families are based on different theoretical approaches. These determine the roles ascribed to the practitioners who implement them – the provider, trainer or facilitator who puts the specific contents of an evidence-based prevention programme for families into practice. It is the facilitator's adherence to the programme; their attitudes and beliefs about family skills; and their degree of motivation when dealing with families, which influence the quality of the programme's implementation (Brackett, Reyes, Rivers, Elbertson, & Salovey, 2012; Durlak & DuPre, 2008).

When considering practitioner profiles, there are two accepted approaches – research centred on aspects relating to the practitioners' specific traits and experience; and studies related to the characteristics of the programme to understand the practitioners' role (Orte, Ballester, Amer, & Vives, 2014). In this paper however, a third factor is considered: the importance of aligning practitioners' attitudes and beliefs with those of the specific prevention programme for families (of particular importance in matters concerning family skills). Shapiro, Prinz, and Sanders (2012) note that practitioners' *perceptions* of how family changes occur will determine a programme's implementation.

The *Substance Abuse and Mental Health Services Administration* (SAMHSA) emphasises the importance of a practitioner's experience and his willingness to be supervised and trained (www.samhsa.gov). Turner and Sanders (2006) define optimal practitioner characteristics as being experience in evidence-based programmes, confidence in their own skills, an awareness of implementation barriers, the quality of the training they receive and knowledge of the type of intervention programme.

Turner, Nicholson, and Sanders (2011) indicate that training is needed in relational and personal skills when seeking to improve practitioners' reliance on family support skills. Regarding the characteristics of implemented programmes, one important aspect is fidelity to its specific contents. For

example, Breitenstein et al. (2010) conclude that it is this fidelity that determines family engagement and participation.

In addition to these two areas, this paper will consider practitioners' attitudes and beliefs *prior* to the implementation of a family-based prevention programme. Shapiro et al. (2012) stress how important it is that practitioners both understand and identify with the appropriate theory of family change which they are proposing to use. According to Asgary-Eden and Lee (2011), a principle reason for practitioners failing to adhere to any programme is the low importance they attach to certain activities.

In this paper, an analysis is made of changes in the beliefs of implementing the Family Competence Programme 12–16 (FCP). The FCP is an adapted version of the Strengthening Families Programme (SFP) (Kumpfer & DeMarsh, 1985; Kumpfer, DeMarsh, & Child, 1989). This is a selective, multi-component, risk-prevention programme; originally designed to reduce the influence of family risk factors on the children of drug addicts while strengthening protective factors to boost resilience to drug consumption, or other possible problems. It is rated a model programme by the SAMHSA, whose quality criteria include the fidelity of the programme's implementation, process evaluations, measures of behavioural change and the validity of applied measurement techniques.

The FCP sets out to demonstrate how family communication plays a central role in positive family performance and better parent–child relationships (Orte et al., 2015), specifically the role played by parents in children's future decision as to whether to take drugs (Ebersole, Miller-Day, & Raup-Krieger, 2014).

The target group is families at risk with teenage children aged between 12 and 16. The risk factor may be due to one of the parents being a drug user, or because children may be prone to addictive or antisocial behaviour, owing to their parents' characteristics. The programme aims to improve family relationships, increase parenting skills, improve children's behaviour, increase social skills and reduce or prevent drug and alcohol abuse.

A preliminary training course for practitioners took place before the implementation of the FCP, delivered by the author of this article. The group of practitioners included four education scientists, two psychologists and three sociologists. The majority were university lecturers with a PhD, with one PhD candidate researcher. Everyone had experience both in delivering this training course, and as practitioners in the FCP.

The 20-hour training course consisted of four 5-hour sessions. The first session gave a detailed explanation of the objectives, structure and contents of the programme. It included the framework of different types of prevention, the experimental and theoretical basics of both the SFP and the FCP. A recent history outline included international experience, information about evidence-based programmes, the cultural adaptation of prevention programmes, the needs and family factors of the adolescents at risk, family-centric prevention interventions and adaptation for the Spanish population. The structure of the programme, based on explanations, debates and activities was described, as well as the format and content of the sessions.

The second session focused on the inclusion/exclusion criteria used in the recruitment of families, recommendations on the implementation of the programme, and ethics. The issue of attrition was addressed when discussing the selection of participants. The following was discussed in detail: teaching materials (handbooks, guides, visual materials); advice for improving implementation; a system of incentives for children, parents and families; incentives for practitioners and supporting organisations; and advice when faced with difficult scenarios. Specific recommendations regarding human resources included communicating with carers and volunteers; the coordinator of the application; external assessments, space resources, material resources and methods for monitoring family participation. Confidentiality, the obligation to report, family secrets and child abuse were discussed as part of the ethics session.

The third session dealt with group management, and included advice and roleplaying related to the subject matter of specific sessions. Topics included guidance on the communication styles of different trainers, how to create a positive environment, activities for reinforcing learning and

recommendations and criteria for group dynamics. The roleplay sessions addressed the topics of 'rewards' (parents' and family session); 'talking and listening' (children's session); 'communication' (family session); and 'solving problems' (children and family sessions).

The fourth session continued with roleplay on communication, and conflict and limits management, and considered evaluation techniques in detail including evaluation criteria, evaluation of the process itself and the evaluation of change observed in participants following the programme.

To ensure close adherence to the programme and optimal implementation, it is important that practitioner attitudes and beliefs about family skills coincide with the programme's approach. This paper aims to analyse to what extent the practitioners' beliefs about family and parenting skills change after they take part in a preliminary training course, prior to implementation of the FCP. On completion of the training course, these beliefs are expected to coincide more closely with the principles on which the programme and its theory of change are based.

Method

Sample

The sample used in this study was made up of 66 professionals, all certified practitioners of the FCP. Regarding gender, 83.5% were women and 16.7% men. Their academic backgrounds were diverse and included youth workers (31.8%), social workers (24.2%), educators (15.2%), psychologists (15.2%) and teachers (7.6%). The remaining 6% were from professions such as nursing, educational psychology, sociology and translation/interpretation.

Four applications of the FCP programme were held in the first round of implementation (corresponding to training course 1). Two were run directly by municipal social services; and two by bodies funded by *CaixaProInfancia*. *CaixaProInfancia* is an initiative aimed at supporting families at risk (CaixaProInfancia, 2016), and has been active in 11 of Spain's largest cities since 2008. Since the 2011–2012 academic year reforms have been made to several of its funded programmes, such as positive parenting skills, school support, educational and leisure time, and brief psychotherapy sessions, based on rigorous appraisals made in Spain. New programmes, including the FCP 12–16 are also part of this initiative, with the four applications in the second round also funded.

The professionals undertaking the training course were classified into five groups: those from social services (21.2% of the sample), those from bodies funded by *CaixaProInfancia* (42.5%), those from the University of the Balearic Islands (30.3%) and a mixed group from other organisations (6%). Table 1 shows the different roles played by the professionals as part of the course (practitioner, replacement practitioner, coordinator, collaborator and others) by application. The majority of the sample were practitioners (39.4%). Each application had a coordinator responsible for its implementation. Collaborators and other professionals oversaw external assessment (fidelity).

Measures

The instrument was a self-administered questionnaire entitled 'Family Competence Questionnaire about Families with Adolescents'. Constructed specifically for this research study, it featured 62 statements requiring a binary response (true or false).

The high number of questions (62) ensured that the different aspects of the FCP were all represented. The questionnaire was created as follows (Crocker & Algina, 1986; Muñoz, 2003):

- (a) An explanation of how the questionnaire considered the 14 sessions of the FCP and its contents.
- (b) A protocol to determine the time, length and conditions governing responses, together with instructions for the evaluator.

Table 1. Sample.

ROUND			Role within the programme				Total
			Practitioner	Replacement practitioner	Coordinator	Collaborator	
1	<i>Caixa Prolinfancia</i> 1	<i>N</i>	5	0	2	1	8
		% of the application	62.5	0.0	25.0	12.5	100.0
	<i>Caixa Prolinfancia</i> 2	% of the total	7.6	0.0	3.0	1.5	12.1
		<i>N</i>	3	0	2	1	6
	Social services 1	% of the application	50.0	0.0	33.3	16.7	100.0
		% of the total	4.5	0.0	3.0	1.5	9.1
	Social services 2 and <i>Caixa Prolinfancia</i> 3 ^a	<i>N</i>	3	0	1	0	4
		% of the application	75.0	0.0	25.0	0.0	100.0
	Social services 2 and <i>Caixa Prolinfancia</i> 3 ^a	% of the total	4.5	0.0	1.5	0.0	6.1
		<i>N</i>	6	3	1	4	14
Social services 2 and <i>Caixa Prolinfancia</i> 3 ^a	% of the application	42.9	21.4	7.1	28.6	100.0	
	% of the total	9.1	4.5	1.5	6.1	21.2	
2	<i>Caixa Prolinfancia</i> 4	<i>N</i>	3	2	1	2	8
		% of the application	37.5	25.0	12.5	25.0	100.0
	<i>Caixa Prolinfancia</i> 5	% of the total	4.5	3.0	1.5	3.0	12.1
		<i>N</i>	3	2	1	3	9
	<i>Caixa Prolinfancia</i> 6	% of the application	33.3	22.2	11.1	33.3	100.0
		% of the total	4.5	3.0	1.5	4.5	13.6
	Social service professionals	<i>N</i>	3	0	1	2	6
		% of the application	50.0	0.0	16.7	33.3	100.0
	Social service professionals	% of the total	4.5	0.0	1.5	3.0	9.1
		<i>N</i>	0	0	0	11	11
Social service professionals	% of the application	0.0	0.0	0.0	100	100.0	
	% of the total	0.0	0.0	0.0	16.7	16.7	
Total	<i>N</i>	26	7	8	14	66	
	% of the total	39.4	10.6	12.1	21.2	100.0	

^aIn this case (in the same town) the social services oversaw the first application, and a body funded by *CaixaProlinfancia* oversaw the second.

- (c) The formation of a panel of experts, i.e. the members of our research group. The panel's role was to define the items, review the questionnaire, gauge the questions' level of difficulty and check the results of empirical tests.
- (d) Define some structured criteria for associating items with the programme contents; and provide an assessment of each items' coherence with the programme contents (i.e. an analysis of the aggregation process and final questionnaire).

Different recommendations can be found on the design of multiple-choice test questions (Haladyna, Downing, & Rodriguez, 2002; Moreno, Martínez, & Muñoz, 2004). Following these recommendations, Thurstone (true/false) tests were selected, as these are based on an easy response system, with equivalent levels of difficulty guaranteed. Thurstone tests are a basic test of knowledge and attitudes, not focused on the individual evaluation of the participants, but on the changes that take place in the group. Considering the training given to the practitioners, the validity of the questionnaire needed to be defined by both the level of coverage of the contents of the FCP; and by the clarity of each question.

Each question dealt with beliefs about different aspects of family skills, with the respondents deciding whether the statements were true or false. Correct responses coincide with the theories of the FCP on good practices in family skills.

Examples of these true/false items are: 'It is important for parents to manage stress so as to avoid hurting their children' (true); 'Any moment is fine to talk, provided that what needs to be said is important' (false); 'Unlike adolescents, adults do not need to be recompensed/rewarded' (false); 'Rewards are only useful when a new type of behaviour must be learned' (false); 'Objectives should be clearly understandable for children' (true); 'There are so many basic norms in communication that it is better not to take advice and to be natural' (false); 'To improve family relations, parents' communication skills should be improved' (true); 'Family meetings are recommended for unstructured families, but not for other types' (false) (see [Table 2](#) for more examples).

These items were classified into several factors: differential attention, communication, stress control, family performance, active listening, realistic expectations, risk and protection factors, emotional management, conflict and limits management, behavioural objectives, and programmes and rewards.

Procedure

The 62-item questionnaire was given out at the beginning and end of each training course, to gauge change in the practitioners' beliefs about family skills. For the data analysis process, SPSS 22 was used. A score was awarded, based on the number of correct answers to the true/false statements. Answers to the 62 questions were then grouped into 12 factors, according to the pattern of responses.

The questionnaire was tested for its validity and reliability. Regarding the statistics of the factorial analysis, the values of Kaiser–Meyer–Olkin (KMO) between 0.5 and 1 determined that it was accurate to apply the factorial analysis to the study data. Here, KMO was 0.872. Bartlett test (1539.264; $p = .000$; $p < .001$) which allows rejecting the null hypothesis of a matrix of correlations as an identity matrix, confirming that there were significant correlations among variables. [Table 3](#) shows the grouping of items in different factors. Both relevant and secondary elements for each of the factors were identified. Overall, the solution of 11 factors represented 58.182% of the communality (?)/common variance, and, after considering former research about the curricula of the Family Competence Program, the 11-factor solution was considered accurate. Results are consistent for the latter analysis.

Results

The results analysed here relate to the two training courses for practitioners previously described; held September 2015 and February 2016. Both took place immediately before the implementation of FCP applications in the field (with four applications taking place between October 2015 and January 2016, and four between February 2016 and June 2016).

This paper aims to demonstrate the benefit of training courses for the facilitators of family-based cognitive-behavioural programmes in bringing beliefs into line with a programme's underlying theories. As [Table 4](#) shows, some significant changes occurred between the pre-test and post-test stages. Active listening ($p = .006$), family performance ($p = .040$) and realistic expectations ($p = .006$) showed a significant improvement after training. In the case of stress control, there was a distinct trend *toward* significance, even though this was not significant ($p = .054$). Other factors that showed improvement (albeit not significant) were communication, and conflict and limits management. All other factors remained the same, or showed a reduced significance.

However, the three factors that saw significant change are important ones for the FCP, as they are associated with communication (active listening), family interaction (family performance) and objectives (realistic expectations). These factors are all considered both within the FCP and in the preliminary facilitators course.

In addition to these *significant* changes, other results can be highlighted as having relatively important positive changes. Some scales with a high pre-test score, albeit with a sizeable standard deviation, achieved a higher post-test score and more homogenous results (a greater agreement among practitioners). This is demonstrated in the case of both communication (scale 3, pre-test

Table 2. Factors and questionnaire items (true/false statements).**Factor 1. Stress control**

It is important for parents to manage stress to avoid hurting their children (true)
 What we think about a situation determines whether we feel stressed or not about it (true)
 'I am very anxious' is a correct form of describing a problem (false)

Factor 2. Differential attention

Differential attention implies paying attention to adolescents that behave well and punishing those that misbehave (false)
 Adolescents that are often punished may think that they do not know how to do anything right (true)
 The practitioners should not intervene in family communication so as not to undermine parental authority (false)

Factor 3. Communication

Any moment is fine for talking, if what needs to be said is important (false)
 You should stare at your son/daughter so that he/she feels observed (false)
 To improve family skills, parental communication skills should be improved (true)
 The practitioners should not shepherd the use of communication skills, as these will be learned slowly (false)
 There are so many basic norms in communication that it is better not to take advice and to be natural (false)
 Feedback on the use of communication skills is fundamental to ensure that these skills are learnt (true)
 Differential attention can be applied to all types of negative behaviours by adolescents (false)
 'I am very anxious' is a correct way of describing a problem (false)

Factor 4. Active listening

To demonstrate active listening, it is advisable to interrupt and ask questions about things that have not been understood (false)
 Giving examples of the use of active listening with parents and adolescents helps teenagers to incorporate this skill (true)
 Non-verbal communication plays an important role in demonstrating that we are listening (true)

Factor 5. Family performance

Adolescents should be trained in communication skills in order to have proper family conversations (true)
 Family meetings are highly recommended for unstructured families, but not for other family groups (false)
 It is good practice for families to have a meeting every day, to discuss an issue about which they concerned (false)
 An adolescent living alone with his/her mother is more likely to have a behavioural problem than an adolescent that lives with both parents (false)
 All children from a drug-using family have the same risk of drug abuse (false)
 Family habits are important in the development of family identity (true)

Factor 6. Risk and protection factors

Adolescents should understand the importance of seeking help, either for themselves or for their friends (true)
 Action by parents and other agents (teachers, relatives and community members for example) may reduce the adolescent risk of drug abuse (true)
 Practitioners should understand that some adolescents may be more familiar with drug consumption than others (true)
 No time should be dedicated to finding out the children's risk level, as if these risks are highlighted, their problems may increase (false)
 When parents are unable to help children in certain situations, the adolescents should talk to another adult whom they trust (true)

Factor 7. Realistic expectations

Understanding the characteristics of adolescent development helps parents to form realistic expectations of what their children can or cannot do (true)
 To allow adolescents to develop it is better for them to have no responsibilities (false)
 All adolescents of the same age know and can do the same things (false)

Factor 8. Rewards

Unlike adolescents adults do not need to be rewarded (false)
 Rewards are only useful when a new behaviour needs to be integrated (false)
 When acknowledging a particular behaviour we should specify what we liked about it (true)
 Praising adolescents that listen actively will increase the probability of this skill being used (true)

Factor 9. Emotional management

When a particular behaviour is ignored, parents should explain why so that their children are aware that they do not like what they have done (true)
 It is important for family members to talk about signals so as to be able to interpret other people's feelings (true)
 When a person is angry it is not relevant to know who he or she is angry with (true)
 When criticism is given you should try to be understanding, but it is not necessary to say something positive as it will sound insincere (false)

Factor 10. Conflict and limits management

'Throwing the children out of the house' could be one solution when there are difficulties (false)
 If children keep getting into trouble, parents should use further severe punishments to avoid risks (false)
 Parents should set limits for their children without taking into account other issues. If the rules are clear, they should be applied (false)

Limit-setting techniques can be used in any situation and with any negative adolescent behaviour (false)

Communication skills should not be mixed with procedures for setting limits, as one may be taken into account less than the other (false)

Factor 11. Behavioural and programme-related objectives

The more generally an objective is defined the better, as it encompasses a larger range of behaviours (false)

Objectives must be clearly comprehended by children (true)

Clear instructions will help children to know exactly what their parents' expectations are (true)

Warnings are used as behavioural signals (true)

Parents must give complex instructions otherwise their children will believe that they are being treated like a child (false)

To design behavioural programmes, parents should know how to define goals and objectives (true)

The following objective is well defined: 'I want Sandra (13 years old) to not make me hysterical over and over again' (false)

Table 3. Factorial analysis.

KMO and Bartlett's test			
KMO test for sampling adequacy			0.872
Bartlett's test of sphericity	Approx. χ^2		1539.264
	Sig.		.000
Total variance explained (58.182)			
Community: sum of the squared factor loadings			
Factors	Total	% of variance	% accumulated
1	7.354	13.371	13.371
2	7.130	12.964	26.335
3	2.464	4.480	30.815
4	2.292	4.168	34.983
5	2.292	4.167	39.150
6	2.174	3.953	43.103
7	1.881	3.420	46.523
8	1.684	3.062	49.585
9	1.581	2.875	52.461
10	1.574	2.862	55.323
11	1.573	2.859	58.182

Note: Method: ACP.

Table 4. Practitioner beliefs about family skills.

	Pre-test/ post-test	N	Mean	SD	t	d.f.	Sig.	95% CI	
								Lower	Upper
1 Stress control	Pre-test	63	8.35	2.15	-1.945	115	.054	-1.440	0.013
	Post-test	54	9.07	1.76					
2 Differential attention	Pre-test	63	6.66	2.99	0.234	115	.816	-0.922	1.168
	Post-test	54	6.54	2.66					
3 Communication	Pre-test	63	7.96	1.84	-1.602	115	.112	-1.102	0.117
	Post-test	54	8.45	1.41					
4 Active listening	Pre-test	63	8.09	1.96	-2.783	115	.006**	-1.568	-0.264
	Post-test	54	9.00	1.53					
5 Family performance	Pre-test	63	6.92	1.75	-2.079	115	.040*	-1.225	-0.030
	Post-test	54	7.55	1.48					
6 Risk and protection factors	Pre-test	63	9.68	0.74	0.355	115	.723	-0.242	0.348
	Post-test	54	9.63	0.88					
7 Realistic expectations	Pre-test	63	9.36	1.68	-2.779	115	.006**	-1.086	-0.182
	Post-test	54	9.99	0.00					
8 Rewards	Pre-test	63	7.22	0.91	0.265	115	.791	-0.300	0.392
	Post-test	54	7.18	0.98					
9 Emotional management	Pre-test	62	9.80	0.82	0.205	114	.838	-0.258	0.318
	Post-test	54	9.77	0.73					
10 Conflict and limits management	Pre-test	63	7.59	2.19	-0.878	115	.382	-1.102	0.425
	Post-test	54	7.93	1.94					
11 Behavioural and programme-related objectives	Pre-test	63	7.74	1.49	0.806	114	.422	-0.310	0.735
	Post-test	53	7.53	1.32					

* $p < .05$.

** $p < .01$.

mean 7.96, pre-test SD 1.84, pre-test CV 23.09, post-test mean 8.45, post-test SD 1.41, post-test CV 15.79), and conflict and limits management (scale 10, pre-test mean 7.59, pre-test SD 2.19, pre-test CV 28.87, post-test mean 7.93, post-test SD 1.94, post-test CV 23.51). In both cases, there is greater unification in the criteria adopted by the practitioners. The preliminary course therefore made a positive impact.

Other scales – differential attention and rewards – did not demonstrate the expected improvements, with high mean scores but a slight drop in the post-tests (pre-test differential attention mean: 6.66; post-test differential attention mean: 6.54; pre-test rewards mean: 7.22; post-test rewards mean: 7.18). There was no notable progress in the level of agreement among the practitioners (pre-test differential attention SD 2.99, post-test differential attention SD 2.66, pre-test differential attention CV 45.27, post-test differential attention CV 40.20, pre-test rewards SD 0.91, post-test rewards SD 0.98), and the coefficient of variation for the differential attention scale was very high.

Regarding the different types of practitioners and their diverse scores in the preliminary course, a cluster analysis (Tables 5 and 6) identified three levels at the pre-test stage (low, intermediate and high) and another three levels at the post-test stage (intermediate, upper-intermediate and high). At the pre-test stage, 10 scales were discriminating, at the post-test stage just 7. The aggregation per level does not refer to single scores for a specific scale, but to the whole group.

Prior to the preliminary course (pre-test, Table 5), 33.87% were in the low and middle levels. Subsequently (post-test, Table 6), only 7.41% were in these levels. There were two exceptions. The first was the scale 'emotions management', with relevant scores at a pre-test level, but post-test scores that do not allow for discrimination among the clusters. The second exception was 'differential attention', where the upper-intermediate level group was resistant to change (perhaps because they did not share the approach to the issue).

Discussion and conclusion

Practitioners' beliefs on family skills influence the implementation of the programme, its evaluation and the outcome (Brackett et al., 2012; Durlak & DuPre, 2008). The results of this paper demonstrate that it is *active listening*, *family performance* and *realistic expectations* which improve after the pre-implementation training course.

Within the FCP, communication is an important issue explored during two family sessions, two parental sessions and two adolescent sessions. This is addressed in the preliminary training for practitioners, with two roleplaying sessions used to practise communication skills.

Family interaction is dealt with as a crosscutting topic within the FCP and specific sessions are also devoted to this subject (i.e. family meetings and family learning). In the preliminary course, family interaction is again addressed through roleplaying. One family session and one parental session of the FCP are devoted to setting goals, although no session is dedicated to this in the preliminary course.

Table 5. Practitioner beliefs, cluster analysis, pre-test.

	Cluster		
	Low level	Mid-level	High level
1 Stress control	6.66	7.03	9.18
2 Differential attention	2.22	3.70	8.28
3 Communication	3.33	6.94	8.78
5 Family performance	4.45	6.12	7.54
6 Risk and protection factors	8.00	9.56	9.85
8 Rewards	4.17	7.50	7.38
9 Emotions management	7.50	10.00	9.88
10 Conflict and limits management	1.33	6.89	8.39
11 Behavioural and programme-related objectives	5.24	7.71	7.95
Mean	4.54	7.42	8.66
Number of practitioners	3	18	41
%	4.84	29.03	66.13

Table 6. Practitioner beliefs, cluster analysis, post-test.

	Cluster		
	Mid-level	Upper-intermediate level	High level
2 Differential attention	7.49	3.52	8.12
3 Communication	6.56	7.78	9.06
4 Active listening	9.99	8.14	9.37
5 Family performance	6.26	7.05	7.98
6 Risk and protection factors	8.50	9.78	9.69
10 Conflict and limits management	4.00	8.11	8.31
Mean	7.19	7.71	8.87
Number of practitioners	4	18	32
%	7.41	33.33	59.26

No significant change was observed in the other factors, perhaps due to the time restrictions impacting the length of the preliminary course (20 hours). However, from our experience of this type of training, it is not advisable to extend the course, given practitioners' time constraints and the course's length in comparison with the FCP (this lasts for 28 hours – fourteen 2-hour sessions – in addition to preparation and evaluation of each session, and meeting with families).

It is accepted that this study may be limited by a need to be politically correct when completing the questionnaires, which may affect results. Questionnaires based on self-declarations must be acknowledged to run this risk.

Regarding the practical implications, family skills training programmes such as the FCP promote prosocial behaviour, and it is therefore important for practitioners to share the programme's underlying principles. By observing the level of change in the practitioners' beliefs after the preliminary training course, it is possible to ascertain whether these beliefs can be aligned with prosocial *attitudes* so that prosocial *skills* can be taught more convincingly.

Bearing in mind the fundamental role of practitioners in the quality of family programmes, it is positive that other research work on this subject is already underway. In addition to the beliefs held by practitioners, their experience and skills are additional attributes which influence implementation (Shapiro et al., 2012). In future papers, we aim to present research into the facilitators' perceptions of their skills before and after the implementation of the FCP, through qualitative interviews and focus groups. Specific areas to be explored include practitioners' skills when working with parents and children, skills in managing groups and engaging families, self-confidence in ability, and their beliefs about the programme's theory of change.

Preliminary training courses for practitioners should not only be aimed at boosting facilitator skills, but also at fostering an in-depth knowledge of the contents of the FCP. This will support the alignment of practitioners' beliefs about family competence with those of the programme and its theory of change.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

This work was supported by the Spanish Ministry for Economic Affairs and Competitiveness (research projects EDU2010-20336, EDU2013-42412-R and EDU2016-79235-R).

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