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An analysis of family dynamics: a selective substance abuse prevention programme for adolescents

Un análisis de la dinámica familiar: un programa selectivo de prevención del abuso de sustancias para adolescentes

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ABSTRACT

Adolescence is a particularly vulnerable time in terms of the possible onset of drug abuse, with an increased risk in the case of minors from socially disadvantaged families. Selective family-based drug prevention programmes seek to empower families by providing the necessary tools and skills for parents to manage relations with their adolescent children. The aim of this study was to analyse the resulting dynamics of 69 vulnerable families who completed a Family Competence Programme (FCP) for adolescents aged between 12 and 16. For this purpose, a k-means cluster analysis was conducted, leading to the identification of four clusters characterised by different types of family dynamics, based on the scores of the KK-Children Questionnaire and BASC (Behaviour Assessment System for Children). Each cluster was named accordingly: improvable skills, poor organisation, poor communication, and competent. From the analysis, it can be concluded that the observed differences in family dynamics are not dependent on the families' level of vulnerability or structure, but rather on their acquired skills. In conclusion, the profiles and family dynamics of families at risk with access to programmes like the FCP are dependent on their parental and family skills.

RESUMEN

La adolescencia es un momento particularmente vulnerable en cuanto a la posible aparición del uso indebido de drogas, con un mayor riesgo en el caso de los menores provenientes de familias socialmente desfavorecidas. Los programas selectivos de prevención de drogas basados en la familia buscan capacitar a las familias proporcionándoles las herramientas y habilidades necesarias para que los padres gestionen las relaciones con sus hijos adolescentes. El objetivo de este estudio fue analizar las dinámicas resultantes de 69 familias vulnerables que completaron el Programa de Competencia Familiar (PCF) para adolescentes de entre 12 y 16 años. Para ello, se realizó un análisis de conglomerados k-means, que condujo a la identificación de cuatro conglomerados caracterizados por diferentes tipos de dinámicas familiares, basados en los puntajes del KK-Children Questionnaire y BASC (Sistema de Evaluación del Comportamiento para Niños). Cada grupo fue nombrado en consecuencia: habilidades mejorables, organización deficiente, comunicación deficiente y competente. A partir del análisis, se puede concluir que las diferencias observadas en la

KEYWORDS
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dinámica familiar no dependen del nivel de vulnerabilidad o estructura de las familias, sino de las habilidades adquiridas. En conclusión, los perfiles y las dinámicas familiares de las familias en riesgo con acceso a programas como el PCF dependen de sus habilidades parentales y familiares.

Introduction

Very often social work practice is responsible for achieving prevention of drug abuse in young people. This is a great challenge, because adolescence is a stage characterised by numerous changes at a biological, emotional and social level, and this makes these youngsters particularly prone to risk-type behaviours (Kim-Spoon & Farley, 2014). Indeed, adolescence has been pointed out as being a critical point in the possible initiation of substance abuse, both in Spain (Plan Nacional Sobre Drogas, 2015) and abroad (The European School Survey Project on Alcohol and Other Drugs [ESPAD], 2015; National Institute on Drug Abuse [NIDA], 2014). Three landmarks have been identified when parents and families should be particularly alert in case youngsters decide to try out drugs. They are the change from primary to secondary school, youngsters' relations with their peers, and their first nights out (Van Ryzin, Fosco, & Dishion, 2012).

According to social learning theories and systemic family approaches, family interaction is bidirectional and thus the behaviour of each of its members impacts on the rest (Eddy, Martinez, Metzler, & Heyman, 2014). The family plays a fundamental socialising role in the learning and social development process, and it serves as a model for many types of behaviours and attitudes, not just in relation to drugs (Cerutti, de Ramos, & Argimon, 2015) but also in terms of psychosocial development (Orte et al., 2015a). Studies like those of Reeb et al. (2015) have associated certain family dynamics with the onset of delinquent behaviour. According to these authors, perceived close family links, a strong bond and family support are protective factors in preventing delinquent behaviour and they are even more influential than a person's socioeconomic status. Family cohesion has also been positively related to psychological wellbeing and a lack of cohesion highlighted as a risk factor in the onset of family conflicts (Li & Warner, 2015).

For this reason, the family is considered to be a potential risk factor and protective factor in substance abuse throughout the whole lifecycle. For instance, parental supervisory and organisational tasks, such as overseeing the children's activities, setting rules, defining limits, applying reinforcement methods and punishments, designing a behaviour management plan, planning quality time with the family and forging prosocial bonds with family members, might help to reduce the children's exposure to risk situations (Higgins, McCann, McLaughlin, McCartan, & Perra, 2013; Kumpfer & Alvarado, 2003; Orte et al., 2015a; Van Ryzin et al., 2012). Adequate family communication has also been identified as a protective factor in adolescence, while communication of a critical or negative kind and a lack of parental support have been associated with a greater likelihood of risk behaviours. Many research studies highlight the importance of an affective bond between parents and children in the prevention of mental health and behavioural problems (Kostelecky, 2005; Savelieva et al., 2017; Shimura et al., 2017; Smorti & Guarnieri, 2015; Van Ryzin et al., 2012).

Kumpfer, Alvarado, and Whiteside (2003) believe that drug consumption by adolescents is a family problem and so prevention programmes should be aimed at empowering families. According to these authors, the most successful programmes in recent years are those that bring about changes in family dynamics (Orte et al., 2015a). But unfortunately more resources continue to be invested in dealing with the consequences of drug consumption by young people than in prevention, even though prevention programmes are designed to reduce possible risk factors by boosting protective ones through improved relations between parents and children, efficient communication, efficient adequate behavioural management etc. (Small & Huser, 2014).

Prevention based on families at risk

In academic literature, different types of families at risk have been described, albeit not in any close way with their family dynamics or participation in prevention programmes (Kolthof, Kikkert, & Dekker, 2014). Types can be found associated with the family's social and economic status or level of social integration, with drug consumption patterns, and certain family structures, among others. Hidalgo, Lorence, Pérez, and Menéndez (2012) conclude that the families most at risk are those with the lowest levels of social support and they found no connection with any particular type of family structure. The link between the family structure and the children's educational performance has also been explored (Martín, Alemán, Marchena, & Santana, 2015). On the other hand, authors like Crawford and Novak (2008) claim that the type of family structure does influence relations between parents and children and whether the latter's peer group takes drugs. For instance, single-parent families have a more liberal approach to bringing up their children, and this increases the likelihood of inadequate or risk-type behaviours. When children live with a non-biological parent (a stepfather or stepmother), this increases the risk of family conflicts. In other words, some family structures bring about changes in family dynamics, interactions, educational styles and socioeconomic vulnerability. In a recent study (Sharma, Sharma, & Barkataki, 2015), a positive relationship was found between young drug takers and coming from a broken home while, in contrast, there was a negative relationship between an intact family structure and drug consumption. The authors also pointed out that delinquent behaviour and drug taking in adolescents were positively associated with a previous history of delinquency in the family. Delinquent adolescent behaviour was also positively correlated with a history of drug consumption by the parents. Poor relations between parents and children also lead to an increased risk of cannabis consumption through increased relations with friends who take drugs (Hemovich, Lac, & Crano, 2011; Hoffmann, 1995). As for the association between descriptions of family types and drug consumption, Jaaskelainen, Holmila, Notkola, and Raitasalo (2016) identify five types of families, also tied in with financial difficulties, broken homes, mental health problems, and educational levels. Doba and Nandrino (2010) stress that the common denominators to the type of family most at risk are a low level of social cohesion and a tendency to avoid conflict.

Turning the spotlight on the social vulnerability of families at risk (Krakouer, Mitchell, Trevi, & Kochano, 2017), initiatives have been proposed aimed at boosting family resilience (Kumpfer, Fenollar, & Jubani, 2013), From a systemic relational point of view, families are conceived as functional units whose dynamics are affected by changes and, particularly, by stressful crisis points, like a divorce, the loss of a job or home, or a serious illness. Resilience processes are particularly important in the case of vulnerable families, since the latter are either exposed to higher levels of everyday stress or else they have fewer skills and resources to be able to tackle day-to-day problems. A resilient family is not only able to manage change better and to adapt more successfully as a group, but this resilience also has an individual impact on how all its members deal with issues (Walsh, 2012). Family resilience and other aspects like social capital (Belcher, Peckuonis, & Deforge, 2011; Wen, 2017) or the level of social and community support (Krakouer et al., 2017; Tilbury, Walsh, & Osmond, 2016) might affect family participation in prevention programmes. Some studies have indicated that a family's dynamics prior to taking part in a programme can determine how much advantage is taken of it or their level of participation (Guyll, Spoth, Chao, Wickrama, & Russell, 2004; Rosenman, Goates, & Hill, 2012), but it is not clear whether families can be classified into groups with specific dynamics.

In intervention work with families at risk, a series of factors will inevitably affect the related programme's efficiency and impact on social work practice (Dolan, Shannon, & Smyth, 2017; Vermeulen-Smit, Verdurmen, & Engels, 2015). On many occasions, financial difficulties, social handicaps, or the families' dysfunctional nature interfere in the participants' involvement in tasks aimed at boosting parenting skills and this is also reflected in their attendance of the intervention programme and the benefit they reap from it. Strategies used to modify family dynamics in evidence-based programmes include work on conflict management and parental supervisory skills, guidelines on warm effective communication between parents and children, activities

aimed at forging a solid emotional bond, and skills in handling emotions and disruptive behaviour (Kumpfer et al., 2003; Orte et al., 2015a). When the main aim is to prevent drug consumption in adolescents at risk, a good option is a family-based multi-component programme, since this type of programme has been demonstrated to have a greater success rate by taking a psychosocial approach and including strategies designed to encompass a wide range of behaviours (Foxcroft & Tsertsvadze, 2011).

Reynolds and Crea (2016) drew up a model of parental psycho-social wellbeing in which financial hardship and a precarious social support network are considered to heighten the probability of psycho-social stress and the tendency to take a more coercive, inconsistent or negligent approach to parenting. At the same time, adolescence is the target age group for many preventive intervention programmes precisely because of the implications that adolescence has on the onset of a multitude of behaviours related to health in adult life. Many of the intervention programmes at this stage are aimed at avoiding the emergence of risk-type behaviours and at promoting healthy habits, focusing on avoiding initial contact with drugs or on modifying the adolescents' behaviour. When families at risk are used as a basis in prevention programmes for adolescents, a holistic approach must be taken to the programme's objectives, the specific strategies used to achieve these goals and the different social agents that are involved.

The Family Competence Programme (PCF) 12–16 is an example of a multi-component selective prevention programme for particularly vulnerable families with adolescent children, aimed at tackling the problem of substance abuse. This is the Spanish adaptation of the Strengthening Families Program (SFP, Kumpfer & DeMarsh, 1986), and its main aim is to modify family dynamics and to strengthen the family relations of socially or financially disadvantaged households or families at risk (i.e. ones dealing with drug problems, psychosocial or family stress, financial problems, abuse etc.). It also seeks to improve parenting skills and the children's behaviour, to boost their social skills and to reduce or prevent the consumption of drugs. To achieve this goal, 14 sessions are held on a weekly basis, each lasting for two or three hours, working with groups of about 7 to 12 families. The programme is divided into three sub-programmes, the first two of which are held simultaneously. They consist of (a) parental sessions, (b) adolescent sessions, and (c) family ones. The same subject matter is dealt with at each type of session, but aspects specific to each group are worked on, taking into account the participants' age and level of development. A cognitive behavioural approach is taken to the course contents, based on active meaningful learning. Before the sessions or on their conclusion, refreshments or dinners are organised in order to forge closer family ties and the creation of a social support network with families in similar circumstances.

In this paper, through a family vulnerability index, attempts are made to establish links between vulnerability and the parents' employment situation, their level of education and the type of family structure (Orte et al., 2015b). The aim of the study is to identify and describe the types of families at risk who have taken part in the Family Competence Programme 12–16, based on their family dynamics, since most studies of this type of prevention programme only report group measures, without breaking them down into different levels. In this study, we attempt to test the hypothesis that there are different types of benefit or use that can be made of the programme. In this way, it is possible to give attention to families that have less benefits, despite their attendance and participation in the programme. The first hypothesis is that the programme is completed by different types of families in terms of their parental and family skills and hence they have heterogeneous risk profiles. The second hypothesis concerns family vulnerability, and it aims to find out whether families with positive and negative dynamics can be found regardless of the level of family vulnerability, suggesting that vulnerability does not play a decisive role in family dynamics. And the third hypothesis is that positive family dynamics can be found, regardless of the family structure. That is, there is no relation between the type of family structure and a specific kind of family dynamics.

Method

Participants

The sample used in this study is made up of 68 adolescents and 70 parents. Between 2015 and 2016, a total of $N = 69$ families took part in and completed nine different applications of the FCP. There are 69 families and 68 teenagers, because one of the adolescents left the programme but his family (his mother and his sister) continued to attend right through to the end. Out of the parents who completed the programme, 15 were men (21.43%) and 55 were women (78.57%). The average age of the parents was 41.46 ($SD = 7.56$), while the adolescents who finished the programme had an average age of 13.71 ($SD = 1.19$), with 33 of them being male (48.53%) and 35 female (51.47%). Data were gathered on the structure of the families, finding that 39.13% ($n = 27$) of the families who completed the programme were single-parent ones, 34.78% ($n = 24$) were two-parent ones, 11.59% ($n = 8$) were blended families, and 14.49% ($n = 10$) had another kind of structure. To conduct the analysis, the results for just one child per family were taken into consideration, even though more than one might have taken part. When there were siblings of the right ages to be accepted on the programme (12–16 years old), the child for whom the family had requested support was included in the assessments. The aim was to assess changes in the family as a whole, in the parents and also in the child identified as the 'appointed patient' (Boszormenyi-Nagy & Framo, 2013).

The study was conducted in the Balearic Islands (Spain), a tourist region with a population of 1,150,000 people, where tourism has a special impact on families since the characteristics of employment make it hard to reconcile work with private and family life (Murray, Yrigoy, & Blázquez-Salom, 2017). The study is based on applications developed with the Social Services and NGOs, taking a joint collaborative approach. The programmes were implemented by NGOs working in the field of poverty and with families at risk, except for two cases directly implemented by the Social Services. The latter also contributed through the recruitment of families.

All the participants had to meet a series of criteria for their inclusion or exclusion: (1) the families had to be in touch with a network of support services; (2) they had to be considered vulnerable or at risk; (3) they had to be willing to attend the programme, be available to do so, and meet other associated requirements (a reasonable level of attention and cooperation, parents with adolescent children aged between 12 and 16 and, in the event of drug consumption, the participant had to be undergoing treatment and be in a stable condition etc.).

As for the family drop-out rate, during the whole of the programme only 14.81% of the families ($n = 12$) failed to finish it. Some of the reasons that were given were incompatibility with their children's timetables or activities, a change in the parent's employment situation or reasons relating to the programme (a lack of motivation regarding the programme or assessment processes).

Instruments

The Spanish version of *Kumpfer's KK-Children Questionnaire* (Kumpfer, 1998) was used for the SFP to assess the change in the families. This is made up of two self-report questionnaires – one for the parents and one for the children – with 135 items and 13 scales (positive parenting and parental involvement, family conflicts, family organisation, clear rules on drugs, drug consumption, parental supervision, parental effectiveness, communication and parenting skills, family cohesion and strength, learning skills and social skills, impulsiveness, concentration problems/depression and aggressiveness). The instrument's reliability was assessed using the Cronbach α (Wagner, 2016), with a score of .91 in the case of the parents and .89 for the adolescents (Orte et al., 2015b).

The questionnaires from the multi-dimensional *Behaviour Assessment System for Children* (BASC) by Reynolds and Kamphaus (1992) were also used, taking the version validated for the participants of Spanish programmes by González, Fernández, Pérez, and Santamaría (2004). This includes a children's

self-report (negative attitudes to school, negative attitudes to teachers, social stress, anxiety, depression, interpersonal relationships, relations with parents and self-esteem) and questionnaires for parents and teachers (aggressiveness, hyperactivity, behaviour disorders, attention problems, learning problems, depression, anxiety, adaptability, social skills and study capabilities). This questionnaire has a Cronbach α of .89 for the adolescents, .85 for the parents, and .82 for the teachers. The questionnaires are administered taking into account the age of the participants and recommendations regarding their application and processing, based on scales defined by the authors, in order to ensure the fidelity and validity of the tools

The **Family Vulnerability Index** (FVI) is made up of three indicators, based on family information regarding the parents' employment situation, their level of education and the family structure. Each family's situation is assessed prior to their participation in the programme and, again, at the end of it, since changes in the benchmark situation could have occurred. The index ranges from 0 to 20 points, calculated by taking the average scores of the three aforementioned indicators, weighted as follows: job situation 40%, parents' level of education 30% and family structure 30%. Vulnerability situations are cumulative and so the higher the score, the higher the relative vulnerability.

Design

The original study was quasi-experimental in design, with a pre-test and post-test evaluation of the experimental and control groups. Mixed methods were used, although this study focuses specifically on the cluster analysis. For further details of the general approach that was taken, including the qualitative part (see Orte, Ballester, Pascual, Gomila, & Amer, 2018).

Procedure

Relevant literature on family prevention programmes was identified by carrying out a bibliographic search, using international databases such as the Web of Science, SCOPUS, Psycinfo, PubMed, EBSCO, ERIC or Sciencedirect.

The study began with nine applications of the FCP 12–16 (7–10 families per application), held at the centres of different social organisations and bodies in the Balearic Islands between 2015 and 2016. The families and children who took part in the programme had requested some kind of assistance from the organisations where the applications were run. Each application's planned schedule was followed and each one lasted for between 14 and 16 weeks (depending on possible holiday periods). Certain variables that might distort the measurements were controlled, e.g. through the application of inclusion/exclusion criteria when recruiting the families, by assessing the fidelity of the applications, through specific training for instructors, etc. Attempts were made to eliminate other variables that might interfere in the process, e.g. by overcoming possible transport problems or providing a nursery service for young children too small to take part in the programme etc. The coordinators of the applications always ensured that they were put into practice under the same conditions (the length of the sessions, the structure of the contents, the instruments and materials, the environmental conditions in the room, etc.).

Three steps were taken for the study's ethical approval: first, the proposed study was assessed and approved by the University of the Balearic Islands' Ethical Committee; second, to be granted research funds by the Spanish government, a research ethics form had to be filled in; and third, during the field study and implementation stage, all the families signed a standard consent document to be included in the study and also relating to confidentiality of their data.

Data were collected at two points in time: at the start of the application and just after the programme ended. The k-means cluster method was used to generate groups, based on statistically significant variables, in order to try and detect different types of family dynamics, based on the scores of the different family skills indicators. For the analysis of the data, the SPSS 24.0 statistical software package was used.

Results

From the *K-means* cluster analysis, four different clusters were identified (see Table 1), reflecting four different types of family dynamics. The clusters were formed by taking the significant results of the variance analysis (ANOVA, with Tukey-b contrast). The scales used to discriminate the clusters were resilience, parent–child relationships, family cohesion and family organisation. Two scales were significant but not relevant in the clusters' discrimination. They were family involvement and family conflict management. Table 2 shows the clusters' centre scores for the measured variables, the number of families in each cluster, and the percentage of families in each one.

As for the results of the variables for each of the clusters, the scores were interpreted and the clusters were named as follows: improvable skills, poor organisation, poor communication, and competent (see Table 3). For brief descriptive purposes and ease of understanding, each cluster was given a representative name.

- Competent: This group, with 18 families in total, achieved good scores for four statistically significant variables (resilience, parent–child relationship, family cohesion, and family organisation).
- Poor organisation: This group (29 families) achieved medium or mid-to-high scores for all the variables, except for family organisation whose score was poor or weak
- Poor communication: This group of families (nine) had medium or mid-to-high scores for all the variables, except for communication.
- Improvable skills: This group of families (13) had a good score for the relationship between parents and children but they needed to improve their resilience, communication and organisation.

56 of the 69 families obtained good results, with high or mid-to-high scores for the statistically significant variables. Most families – 29 out of 69 (42.03%) – can be seen to be in cluster 2, which was named 'poor organisation', characterised by an average resilience, marginally good parent–child relationship, average level of family cohesion and slightly below average organisational capacity. Of the participating families, 26.04% were categorised as forming part of the 'competent' family cluster, since they achieved better scores for all the considered factors.

No significant pattern was found between the family dynamics at the end of the programme and the family structure (single parent, nuclear or blended families or other forms of cohabitation): $\chi^2 = 8.929$ ($df = 9$); $p = .444$ ($p > .05$). This is the assumption put forward in hypothesis 2. As for the FVI, the participating families had a $M = 12.26$, with a $SD = 2.975$, $Min = 5.800$ and $Max = 17.20$. Nor was any

Table 1. Results of ANOVA.

	Cluster		MSError			
	MS	df	MSE	df	*F*	*p*
Resilience	330.8	3	28.21	66	11.72	<.001**
Parents-child relationship	14,846.01	3	24.28	66	611.53	<.001**
Family cohesion	86.91	3	12.60	66	6.9	<.001**
Family organisation	57.26	3	15.4	66	3.72	.016*

Notes: The four discriminating factors. $N = 69$ families; MS = Mean Square; MSE = Mean Square Error.
*$p < .05$; **$p < .001$; ***$p < .001$.

Table 2. The clusters' centre scores.

	1	2	3	4
Resilience	35.69	42.40	45.11	46.78
Parents-child relationship	72.08	87.50	16.56	98.28
Family cohesion	20.00	22.73	24.33	25.67
Family organisation	17.00	18.23	18.89	21.39
Number of families	13	29	9	18
% of families	18.84	42.03	13.04	26.09

Table 3. Clusters by family dynamics (or family dynamics of the families that completed the programme).

Interpretation of scores	Improvable skills	Poor organisation	Poor communication	Competent
Resilience	Low	Medium	Medium-High	High
Parent-child relationship	Medium-High	Medium-High	Low	High
Family cohesion	Low	Medium	Medium-High	High
Family organisation	Low	Low-Medium	Medium	High
Number of families	13	29	9	18

Table 4. ANOVA family competence.

Family competence	SS	Df	MS	*F*	*p*
Among groups	40,593.929	3	13,531.310	23.968	<.001***
Within groups	32,179.382	57	564.551		
Total	72,773.311	60			

Note: SS = Sum of Square.
*$p < .05$; **$p < .001$; ***$p < .001$.

pattern observed between the family dynamics and scores obtained in the FVI $\chi^2 = 5.293$ ($df = 6$); $p = .507$ ($p > .05$). In turn, no significant link was found between family vulnerability and family competence at the end of the application: $\chi^2 = 0.242$ ($df = 59$); $p = .063$ ($p > .05$).

In contrast, depending on the family dynamics displayed at the end of the programme, significant differences could be seen in the level of family competence, $F = 23.968$ ($df = 3$) $p < .001$*** (see Table 4).

Conclusion

The results highlight the existence of different groups or clusters that achieve different scores for the resilience, parent–child relationship, family cohesion and family organisation factors. At the end of the family skills programme, different patterns could be observed in the way the family's function, as demonstrated by the scores of the measured factors, with four types of families being identified, characterised by differing dynamics. One of them clearly accounts for the largest number of families ($n = 29$), conspicuous for their poor organisational skills.

From the classification of the families, certain heterogeneity can be observed in the families at risk that took part in the programme. This suggests that it is wrong to believe that all families at risk who are referred to the social services and are in need of or request access to intervention programmes have the same family dynamics (Hidalgo et al., 2012).

In contrast with what was expected, the data shows that there is no significant link between the vulnerability index and the resulting dynamics at the end of the programme. This could be due to the fact that all the families participating in the programme had a certain degree of vulnerability, since this is one of the criteria for inclusion. Thus, once families have been rated as being vulnerable, this index is not useful in differentiating how they function as families. There is no link between the level of family skills and vulnerability at the end of the programme. Positive family dynamics can be observed in families with a high level of vulnerability and negative ones in families with a low level of social vulnerability. Similarly, positive or negative family dynamics can be found, irrespective of the type of family structure. Hence, it can be affirmed that the family structure (single-parent, two-parent or other types of families) does not determine the type of family dynamics seen at the end of the programme.

The type of family structure or level of vulnerability might have some impact on family dynamics, but they do not determine participation in the programme (Crawford & Novak, 2008; Hidalgo et al., 2012; Orte et al., 2015b). In general, the families who complete the FCP 12–16 have a high level of family dynamics. The clusters that contain the highest number of families (poor organisation and competent) are the ones with the highest scores for the four discriminating factors. This coincides

with studies like those of Rosenman et al. (2012), which suggest that family dynamics prior to the programme are linked to how much advantage is taken of it. They found that the families with the lowest and highest family dynamics at the start of the programme tend to be less involved and are therefore more likely to drop out. The drop-out rate by families with a high level of family dynamics is an important aspect to bear in mind in the case of universal programmes. However, in the case of selective ones, the aim is to retain families with a low level of family dynamics (since it has been shown that they tend not to wish to participate). In turn, Rosenman et al. (2012) maintain that the programme is effective regardless of the initial level at which family's function and even though their willingness to participate may differ.

There is some evidence that the long-term effectiveness of prevention programmes does not depend on the initial level of family dynamics (Guyll et al., 2004). Furthermore, families with a low level of family dynamics are those most in need of such programmes but those least willing to take part in them. If the families most in need of such programmes drop out, one conclusion that can be drawn is the ensuing impact on the efficiency and cost–benefit ratio of the intervention programme. Positive results are achieved by families taking part in selective prevention programmes regardless of their initial level of family dynamics. Families with poor dynamics can take advantage of the programme to improve the strategies they use, and families with better dynamics can also benefit from them. In our case, the families that function the worst account for 18.84% of all those that completed the programme and they are characterised by a low resilience, low level of cohesion and poor organisational capacity: scores associated with a higher risk (Doba & Nandrino, 2010; Kumpfer et al., 2013). An analysis of the profiles of families that manage to complete the programme would improve the selection and retention process and, by extension, the efficiency of social work practice (Tilbury et al., 2016).

This study highlights the presence of different family profiles among the families that took part in the programme, based on the scores they achieved for a series of parental and family skills. By gaining a closer insight into the families that use prevention services, applications of programmes can be better adapted to suit their needs (Tilbury et al., 2016). The strategies that are devised should take into account the fact that there is not just 'one type' of family at risk, but that diversity is the norm as opposed to the exception. These results offer an insight into the needs of the families that finished the programme. This information is important so as to improve further programmes and pinpoint possible strengths and weaknesses, especially when dealing with families in a vulnerable situation.

The relevant implication for social work practice is to find out what level to use the programme at, what kind of skills vulnerable families need to strengthen, and whether different support is needed for families with a low level of performance in this type of prevention programme. This information is also useful in improving the efficiency and effectiveness of family prevention programmes. An awareness of the different ways in which more vulnerable families function is an important factor in social work practice, since it can serve to improve the efficiency of the services that are provided (Dolan et al., 2017) and ensure that resources are more efficiently used. Likewise, a higher degree of involvement in programmes and lower drop-out rates can be achieved, and new hypotheses can be posed on the relationship between the different family dynamics of families at risk and how each type might benefit from certain components of evidence-based programmes or strategies used in them. We already know that families at risk and adolescents have higher associated problems (behavioural problems, a greater likelihood of drug consumption, more possibility of coming from a broken home and greater socioeconomic handicaps) and so any related risks need to be minimised, their social and personal resources boosted, more intensive programmes applied, and some universal prevention strategies used as a support (Schiettecat, Roets, & Vandenbroeck, 2014; Vermeulen-Smit et al., 2015).

Evidence-based family prevention programmes are a good way of bringing about positive changes in family dynamics and reducing risk factors in adolescence (Orte et al., 2015b). Because they work on developing pro-social behaviour, such as how to spend more positive time together as a family, this improves family dynamics and strengthens affective ties. As Burkhart points out

(2013), the SFP contains all the necessary ingredients to ensure an effective intervention programme (joint family sessions with parents and children, positive interaction during learning experiences, forging communication links and effective forms of discipline, strengthening affective ties, etc.). Recent reviews of selective prevention programmes, such as that of Bröning et al. (2012), point out that the SFP is effective for at-risk populations precisely because it includes parents. When we work with families at risk, it is our duty to find out which type of intervention works best with them (Gottfredson et al., 2015), and an evidence-based study is a good way of assessing and improving social care strategies.

The most important limitation to this study is the low sample size, preventing our conclusions from being generally extrapolated to populations at risk. Nevertheless, if we take into account the fact that this is a selective intervention programme where participation tends to be lower anyway, we are dealing with a low but relevant number of participants. For the purposes of future research, it would be interesting to develop a predictive model for improving family skills, based on factors able to discriminate between different levels of related skills. It would also be useful to discover whether the way in which a family functions – assessed by taking into account different factors – determines their degree of involvement in the programme and their continuance and commitment to it. Likewise, it could be ascertained whether different family dynamics have significant effects on the efficiency of certain components or strategies designed for families at risk and on their completion of programmes, such as strategies like long-term monitoring processes or incentives to take part in programmes.

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