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FAMILY-BASED DRUG USE PREVENTION: THE "FAMILIAS QUE FUNCIONAN" PROGRAM

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"Families That Work" is a family-based drug use prevention program resulting from the adaptation to the Spanish context of the prestigious "Strengthening Families Program 10-14" implemented in the USA. The program was applied at four secondary schools in the Principality of Asturias (northern Spain). This article presents the results of the assessment of this application after a two-year follow-up, regarding its effectiveness in the reduction of drug use among adolescents and its effects on certain family risk factors. Consistent attendance on the "Families That Work" program proved effective for reducing both rates of increase in adolescent drug use (t = 2.73; p<.05 and t = -4.58, p<.005, for the 1- and 2-year follow-ups, respectively) and some family risk factors.

Key Words: *family-based prevention, drugs, "Familias que Funcionan", "Strengthening Families Program", adolescence, risk factors.*

"Familias que Funcionan" es un programa de prevención familiar del consumo de drogas, fruto de la adaptación a España del prestigioso programa norteamericano "Strengthening Families Program 10-14". El programa se aplicó en cuatro Institutos de Enseñanza Secundaria de Asturias con una muestra de 380 alumnos de 1º y 2º de ESO. Se presenta en este artículo la evaluación de tal aplicación tras dos años de seguimiento, referidos a su eficacia en la reducción del consumo de drogas entre adolescentes y a sus efectos sobre ciertos factores de riesgo familiares. Los resultados muestran que el programa «Familias que Funcionan» es eficaz para reducir el incremento en el consumo de drogas adolescente a partir de la asistencia a 7 sesiones, tanto en el seguimiento a un año (t= -2,73; p<,05) como a dos años (t= -4,58; p<,005) y para reducir algunos de los factores de riesgo familiares.

Palabras clave: *prevención familiar, drogas, "Familias que Funcionan", "Strengthening Families Program", adolescencia, factores de riesgo.*

The use of drugs among young people is one of today's most substantial social and public health problems (Gómez-Fraguela, Fernández Pérez, Romero Triñanes & Luengo Martín, 2008). A wide range of research has shown that programs for parents can be implemented in schools to help improve their parenting skills and their children's behavior (Kumpfer, 2004). Moreover, such programs tend to produce better long-term effects if they are family-based, that is, they involve and train both parents and children (Kumpfer, Alvarado & Whiteside, 2003).

"Familias que Funcionan" (*Families that Work*; FqF) is a family-based drug use prevention program for parents and their children aged 10 to 14, developed by the Addictive Behaviors Group at the University of Oviedo. It is a Spanish adaptation of the *Strengthening Families Program 10-14* (SFP 10-14), developed in the US by Drs. V. Molgaard and K. Kumpfer for the *National Institute on Drug Abuse* (NIDA).

The SFP 10-14 has been subjected to several rigorous evaluation studies in which it has demonstrated its positive effects in the prevention of drug use, justifying its repeated inclusion among the *model programs* at the *Center for Substance Abuse Prevention* (CSAP), a part of NIDA. The assessments carried out on the program have taken the form of randomized designs comparing drug use (measured before and after intervention) in a group of young people whose families had received the prevention program with that of a control group which met the requirements for a comparison group (Foxcroft, Ireland, Lister-Sharp, Lowe & Breen, 2003; Foxcroft , Lister-Sharp, Lowe, Sizer e Ireland, 2002; Gates, McCambridge, Smith & Foxcroft, 2006; Molgaard & Spoth, 2001; Molgaard, Spoth & Redmond, 2000; Redmond, Spoth, Shin & Lepper, 1999; Spoth, Goldberg & Redmond, 1999; Spoth, Guyll, Trudeau & Goldberg-Lillehoj, 2002; Spoth, Redmond & Lepper, 1999; Spoth,

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Redmond & Shin, 1998; Spoth, Redmond & Shin, 2000; Spoth, Redmond & Shin, 2001; Spoth, Reyes, Redmond & Shin, 1999).

The merits of the SFP 10-14 were highlighted in a systematic review carried out by the *International Cochrane Collaboration* (Foxcroft et al., 2002) and funded by the World Health Organization (WHO) and the *UK Alcohol Education and Research Council* (AERC). This review was presented at the Conference of EU Ministers and the WHO which led to the Stockholm Declaration on "Young people and alcohol". The *National Institute for Health and Clinical Excellence* (NICE) has also underlined the potential of the SFP 10-14 in its reports on the prevention of alcohol abuse. In 2006, another *Cochrane* review (Gates et al., 2006) referred to the potential of the SFP 10-14 for preventing drug abuse among young people.

The characteristics of the principal longitudinal study of the SFP 10-14, which was assessed by means of Iowa State University's *Project Family*, are as follows (Spoth, Redmond, Trudeau & Shin, 2002): the sample was made up of 446 families from areas with high percentages of population with economic difficulties; participants were assigned at random to the intervention conditions and comparisons were made between those receiving the program and the control families; the study monitored the young people and their parents from 6th through 12th grade of the US educational system. The results of the study showed that the young people on the program presented significantly lower rates of alcohol, tobacco and marijuana use than those who were not on the program. The differences between the young people who received the program and the control group increased over time, indicating that the skills learned gain more and more influence. Furthermore, the youngsters on the program presented significantly lower rates of problem behaviors at school, compared to those from the control group. Parents attending the program showed an increase in positive feelings toward their children. Moreover, these parents showed improvements in the general supervision of their children and in specific parenting skills, such as setting appropriate limits, building positive relationships with their children, making rules, applying consequences, effective supervision and consistent and appropriate discipline.

The chief risk factors in which SFP 10-14 intervenes are individual (depression, behavior disorders, violent behavior and isolation), family-related (family conflict, excessive punishment, child neglect or abuse, ineffective discipline and bad example by family members in relation to drug use), school-related (lack of punctuality and truancy) and peer-related (negative influence of exclusively drug-using friends and acquaintances). On the other hand, the protective factors SFP 10-14 sets out to enhance are individual (self-esteem and social skills), family-related (effectiveness of the parent-child relationship, family organization, effective communication, parent-child bonds and parents' ability to manage stress), school-related (good school performance and bonds with school) and peer-related (resistance to the negative influence of peers, prosocial development of friendships and effective communication).

In the wake of the Cochrane review referred to above (Foxcroft et al., 2002), various research groups in different European countries expressed their interest in adapting the SFP 10-14 to their own cultural context. Clearly, adapting a drug use prevention program involves more than merely translating it; rather, it is necessary to analyze each element so as to evaluate how it fits into a given sociocultural reality. In sum, it is a question of staying faithful to the active ingredients that work in the SFP 10-14, but modifying the examples, the roleplays, the games, the activities, etc. in which such ingredients are presented so that they are appropriate and relevant to a particular society, in this case that of Spain.

This adaptation process is always a complex one. Indeed, in many cases it may be more costly to adapt a program that has demonstrated its efficacy in one particular cultural context than to develop a totally new one. The translation of any assessment or intervention instrument is only the first in a series of steps aimed at ensuring that the tool acquires in another language or culture the functions it has in its original form (Hambleton & De Jong, 2003). Furthermore, some research suggests that certain aspects of the adaptation of a program are critical in relation to the recruitment and retention of participants, increasing adherence rates by as much as 40% in some cases (Catalano, Hawkins & Krenz, 1993; Kumpfer & Alvarado, 1995). As a general principle, cultural adaptations should employ processes sensitive to cultural and socioeconomic differences, remaining at all times faithful to the core of the original program (Barrera & Castro, 2006).

It was in such a context that the "Familias que Funcionan" (FqF) program was developed, a universal and selective prevention program comprising seven principal sessions and four maintenance sessions. For the adaptation, we first produced a translation of the program's written and audiovisual materials with the permission of its authors and under their close supervision. We next adapted the content of some examples and activities to the Spanish culture, in

accordance with the criteria of a group of expert judges. Finally, we developed the written materials and made the program DVDs with the newly-adapted content. These materials were tested using a series of focus groups which received the program and judged its viability. All the *feedback* received during the application of the program sessions was considered in the design of the definitive version. The resulting material was published in two volumes and on twelve DVDs.

We now present a first evaluation of the results of the FqF program applied in Spain to a small sample of families who were followed up at 1 and 2 years after their participation.

METHOD

Participants

The initial sample was made up of 380 families whose children attended one of four public secondary schools in the region of Asturias (Spain). The schools were located in Cudillero, Gijón, Pola de Siero and Oviedo. Program sessions were to be attended by the pupils accompanied by one or both of their parents.

Given the age group targeted by the prevention program in question, we chose years 1 and 2 of the *E.S.O.* educational stage of the Spanish system, whose pupils are aged 12-13 and 13-14, respectively). We should point out that circumstances unrelated to the research itself made it impossible to work with the 13 to 14-year-olds at the Pola de Siero school. The families with pupils at the participating schools could be categorized as lower-middle socioeconomic class.

As is customary with such programs, participation was very low with respect to the total number of families given the opportunity to take part. Thus, of the total of 380 families contacted, only 26 attended one or more of the program sessions – just 6.84% of the complete sample. Even so, of these 26 families who attended at some point, 17 (65.38%) attended the principal maintenance sessions with the desired regularity.

Instruments and variables

The total sample of school pupils was assessed in the following variables:

Drug use. This was assessed using the items employed by the Spanish National Plan on Drugs (*Plan Nacional sobre Drogas*) for evaluating drug use over the previous month in secondary school students (ESTUDES). It comprises 10 items, each referring to a different substance, and respondents are required to state on how many of the previous 30 days they have used 10 different types of drug: tobacco, alcohol, tranquillizers or sleeping pills, hashish and marijuana, cocaine, heroin, speed and amphetamines, hallucinogens, solvents, and ecstasy and other designer drugs.

Furthermore, given that the FqF program aims to intervene in family functioning, it was considered pertinent to assess the principal family risk factors associated with drug use in order to determine the program's effects on them.

Family risk factors. We drew up the "Cuestionario de Factores de Riesgo Familiares" (*Family Risk Factors Questionnaire*; CFRF), made up of four scales from the *Centre for Substance Abuse Prevention's* (CSAP) *Core Measures*, developed by Arthur, Hawkins, Catalano and Pollar (1999), in addition to some items from a questionnaire applied in Spain by Luengo, Villar, Gómez-Fraguela and Romero (2003), with a view to identifying the most relevant family risk factors.

Both instruments were applied to the participants on three occasions: prior to the application of the prevention program, at the follow-up one year after implementation of the principal program sessions, and at the two-year follow-up. The third of these assessments was carried out only at the schools in Cudillero, Gijón and Pola de Siero.

Procedure

For the application of the prevention program we initially selected a series of schools with the appropriate sociodemographic characteristics (pupil numbers, social class of intake, etc.). Next, in accordance with the availability and disposition to cooperate of the schools in question, we chose those located in Cudillero, Gijón, Pola de Siero and Oviedo to take part in the study. Each school sent information to parents informing them that the prevention program was to be implemented, and later, at a meeting between the parents and their children's class teachers, the team of specialist monitors that would run the program sessions was presented. The following week the principal sessions of the program began with all the families (parents and children) who turned up at the appointed time and place.

Each session, including the seven principal sessions and the four maintenance ones, lasts around two hours, and are made up of two parts: a first hour in which the parents' group and the children's group meet separately, each with their respective monitor, and a second hour in which the whole families come together to carry out a series of activities.

The FqF sessions took place weekly, and it was decided to schedule them for the same day and the same time as

the other weekly meetings organized by the school over the course of the academic year.

A summary of the objectives and content of each session can be found on the website of the University of Oviedo's Addictive Behaviors Group (Grupo de Conductas Adictivas, 2008).

During the final sessions of the program, parents were informed about its continuation through the implementation of four maintenance sessions involving review of the content and the solution of any doubts that may have arisen. Two months later, those pupils that had participated in the program received a letter from their school with information about the maintenance sessions.

Data analysis

We carried out comparisons of means analyses (*t*-tests) to explore the possibility of significant differences in the adolescents' mean scores on the drug use scale and the family risk factors scales as a function of their attendance at the FqF program sessions. This comparison was carried out in accordance with the dichotomous grouping variables created from the continuous variables for program attendance. Thus, these comparisons were made according to the number of sessions attended by the families, that is, from attendance at more than one session (i.e., at least two) through attendance at more than 10 sessions, which would imply their having attended the full 11 sessions of the program, including the maintenance sessions.

Likewise, we carried out difference of means analyses (one-factor ANOVA) to determine whether there were previous significant differences in the family risk factors and drug use factors among the pupils from the four secondary schools involved in this study. The statistical package used was SPSS v14.0.

Table 1
Evolution of mean scores on the family risk factor scales

Family risk factors	Range Min-Max	Baseline Age 12 - 14	Post 1 yr. Age 13 – 15	Post 2 yrs. Age 14 - 16
		Mean scores		
Parenting style	15 - 60	25.19	25.51	25.91
Family conflict	8 - 32	14.71	15.38	15.75
Parental attitudes ATOD	3 - 12	11.50	11.11	10.72
Affective bonds between parents and children	4 - 16	07.33	07.71	08.38
Family communication	7 -28	12.35	13.18	13.50

Note: The higher the score, the higher the level of family risk factors, except in the case of the "Parental attitudes ATOD" scale, for which the direction of the scores is reversed.

Table 2
Percentage (%) of tobacco and alcohol use

Frequency	Baseline Age 12 - 14	Post 1 yr. Age 13 – 15	Post 2 yrs. Age 14 - 16
Tobacco			
Never	94.3	90.4	81.0
1 to 2 days	02.4	05.0	07.0
3 to 5 days	01.2	01.1	03.5
6 to 9 days	0.8	0.2	01.6
10 to 19 days	0.4	0.4	02.3
20 or more 00.8 02.8 04.7			
Alcohol			
Never	81.0	67.6	50.0
1 to 2 days	12.7	17.7	27.1
3 to 5 days	03.0	07.7	13.6
6 to 9 days	01.6	04.2	04.7
10 to 19 days	0.8	01.8	02.7
20 or more	0.8	01.1	01.9

RESULTS

Baseline

No pre-intervention statistically significant differences were found between the groups making up the sample in any of the CFRF scales that measured family risk factors, nor in that which measured drug use.

As Table 1 shows, in general, the parents were characterized by having negative attitudes toward the use of alcohol and other drugs, adequate levels of family communication and "reasonable" levels of family conflict. Likewise, we can observe that, over time, the scores related to risk factors increase (remember that such scores are based on the children's perception of their parents' behavior).

As regards the adolescents' drug use, it was constituted mainly by tobacco and alcohol across all three time points at which the assessments were made (Table 2). Frequency of use of the remaining substances was clearly lower, as is the case of tranquillizers and cannabis derivatives, and even anecdotal in the cases of cocaine, heroin, speed and amphetamines, hallucinogens, solvents, and ecstasy and other designer drugs.

Drug use

We assessed the difference in "drug use" among our sample of adolescents between the pretest (baseline) and the follow-ups at one and two years, and between the 1-year and 2-year follow-ups.

As can be seen in Table 3, statistically significant differences were found in the three variables as a function of attendance at more than seven sessions of the FqF program. Similarly, we found statistically significant differences between the posttest and the 2-year follow-up, and between the 1- and 2-year follow-ups, as a function of attendance at more than 8 and more

than 9 sessions, which represent attendance at 72% and 81% of the program, respectively.

Family risk factors

The variables examined for the assessment of the family risk factors were the same ones as in the previous section, except that drug use was substituted by the corresponding risk factor. Statistically significant differences were found for the scales "perceived parental attitudes toward young people's use of alcohol" and "parent-child bonds".

Thus, as can be seen in Table 4, the difference in "affective bonds between parents and children" between the pretest and posttest (two years after the intervention) emerged as statistically significant as a function of attendance, from attending at least two program sessions to attending at least 10 sessions. Statistically significant differences were also found in this family-related variable between the 1-year follow-up and the 2-year follow-up, as a function of attendance at more than one, two, three, four, five, six and seven sessions of the FqF program.

As regards the variable "perceived parental attitudes toward young people's use of alcohol" (Table 5), the difference between the pretest and 1-year follow-up was statistically significant as a function of attendance at more than one, two, three, seven and ten program sessions. Statistically significant differences were also obtained in this family-related variable between the 1-year follow-up and the 2-year follow-up, as a function of attendance at all the program sessions.

DISCUSSION AND CONCLUSIONS

The objective of the present study was to assess the functioning of the family-based drug use prevention program "Familias que Funcionan" (FqF) – a Spanish adaptation of the SFP 10-14. The results provide clear indications that continuous attendance at the majority of FqF sessions is effective for reducing the increase in the use of tobacco, alcohol and other drugs commonly observed in adolescence. This result appears reasonable, since in order to modify certain parenting styles or to learn new behaviors related to supervision, communication, reinforcement or punishment with regard to children, it is necessary to rehearse such situations, review possible doubts and undergo some kind of consistent training, as occurs in protocolized programs that also include maintenance sessions, such as FqF.

Likewise, significant differences were found after the application of FqF in two of the scales measuring family risk factors related to drug use: "perceived parental attitudes toward young people's use of alcohol" and "parent-child bonds". The important role of parents as models and transmitters of values and attitudes in their

Table 3
t-test for the variable "Drug use"

	Differences								
	Pretest - Posttest 1			Pretest - Posttest 2			Posttest 1 - Posttest 2		
	n	M	*t*	n	M	*t*	n	M	*t*
Attendance									
More than 7	366_a	-.42	-2.73*	203_a	-1.07	-4.58**	194_a	-.89	-3.53**
	12_b	.00		11_b	-.09		10_b	-.10	
More than 8				205_a	-1.06	-4.93**	195_a	-.89	-4.18**
				9_b	.00		9_b	.00	
More than 9				206_a	-1.06	-4.54**	196_a	-.88	-3.84**
				8_b	.00		8_b	.00	

Note: n_a = non-attendance. n_b = attendance; * p<.05; ** p<.005

Table 4
t-test for the variable "Bonds between parents and children"

	Differences					
	Pretest - Posttest 2			Posttest 1 - Posttest 2		
	n	M	t	n	M	t
Attendance						
More than 1	184_a	-.99	-2.74**	182_a	-.67	-2.11*
	15_b	-2.73		15_b	-1.86	
More than 2	185_a	-1.01	-2.49*	183_a	-.67	-2.01*
	14b	-2.64		14_b	-1.85	
More than 3	187_a	-1.03	2.06*	184_a	-.67	2.05*
	12_b	-2.50		13_b	-1.92	
More than 4	188_a	-1.04	2.03*	185_a	-.68	1.95*
	11_b	-2.54		12_b	-1.91	
More than 5	189_a	-1.03	2.29*	186_a	-.68	2.15*
	10_b	-2.80		11_b	-2.09	
More than 6	189_a	-1.03	2.29*	186_a	-.68	2.15*
	10_b	-2.80		11_b	-2.09	
More than 7	192_a	-1.05	5.47**	189_a	-.69	2.21*
	7_b	-3.14		8_b	-2.37	
More than 8	193_a	-1.06	4.78**			
	6_b	-3.00				
More than 9	193_a	-1.06	4.78**			
	6_b	-3.00				

Note: n_a = non-attendance. n_b = attendance; * p<.05; ** p<.005

children's upbringing is well known (Secades Villa, Fernández Hermida & Vallejo, 2005). Thus, the children participating in the program perceive greater disapproval in their parents of the use of psychoactive substances, which in turn makes these adolescents less likely to use drugs. Furthermore, the fact that the program improves or increases the affective bonds in the family not only protects against the use of drugs and reduces the probability of their use, but also represents an important protective factor for other problematic behaviors commonly found in adolescence.

One of the limitations of the present study is the small size of the experimental sample: although 380 families were invited to take part, scarcely more than 6% of these actually did so. This is indeed customary in the case of family-based prevention programs, which tend not to have the luxury of a "captive" population in which to implement their interventions. Therefore, it is necessary to replicate the study with a larger sample size.

An essential ingredient for the success of family-based preventive interventions against drug use is that parents attend the programs, and that they do so motivated by a concern for the wellbeing of their children. Despite the fact that the vast majority of parents claim to be prepared to take part in such prevention programs, the reality is that there is a strong self-selection process with the result that participants tend to be basically mothers who are worried about their children's wellbeing (Pinazo & Pons, 2002). In this regard, it is essential to develop strategies for increasing the participation of families in prevention programs, particularly those families with a high risk profile for drug use (Al-Halabí, Secades Villa, Errasti, Fernández Hermida, García Rodríguez & Carballo, 2006).

Table 5
t-test for the variable "Perceived parental attitudes toward young people's use of alcohol"

	Differences					
	Pretest - Posttest 1			Posttest 1 - Posttest 2		
	n	M	t	n	M	t
Attendance						
More than 1	360_a	.42	2.35*			
	21b	.00				
More than 2	361_a	.42	2.24*			
	20_b	.00				
More than 3	362_a	.42	2.13*			
	19_b	.00				
More than 7	370_a	.41	2.78*			
	11_b	.00				
More than 10	371_a	.41	2.55*	192_a	.50	2.45*
	10_b	.00		8_b	.12	

Note: n_a = non-attendance. n_b = attendance; * p<.05; ** p<.005

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