infonova

> professional and academic journal of addictions

A space for open dialogue
about addictions

dianova

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LETTER FROM THE MANAGEMENT

Santos M. Cavero López

Managing director.
Asociación Dianova España

I am very proud to present the number 30 of the magazine INFONOVA, a publication that has been consolidated in a relevant position in the academic and professional area when dealing with the complex sector of the addictions. With a digital distribution of more than national and international 3.000 contacts and 1.200 printed copies, INFONOVA is already a point of reference to share the knowledge and the experience about addictions.

The present issue of INFONOVA is very special, not only because it is number thirty but also because this is our first bilingual edition, both in Spanish and English, with the aim of reaching a more wide and diverse public. This is why we have wanted to make to coincide INFONOVA #30's launching with the celebration of the International Day Against Drug Abuse and Illegal Trafficking, joining this celebration with our most ambitious number.

INFONOVA's intention has always been to turn the magazine into a space for dialog, both open and reflexive about addictions from all the possible perspectives, contributing from multiple disciplines to the comprehension of this problem. This understanding will favor all the potential that these combinations and interrelationships of disciplines possess at the moment of studying the addictions, their reasons, their consequences, and their treatments, from the health area, the social field, and the individual sphere.

The selected articles for this number are centered on the prevention area, being this the pillar on which the fight against addictions is based. Prevention serves two main aims: to raise awareness and to mobilize society to generate a culture of drugs rejection using the promotion of social values, and to inform and instruct people in order that they develop positive, healthy and autonomous ways of life.

I would particularly like to extend warm thanks to the Government Delegation for the National Plan on Drugs, which is the promoting and coordinating authority for the drugs policies in our country. Its financial and institutional support contributes to INFONOVA's continuation and promotion, turning it into a useful instrument to fight against addictions.

I am sure that you will find the reading of this INFONOVA's new edition quite fruitful. I also want to take the opportunity to ask for your contributions in the form of suggestions that can help us to improve this publication. Without you, INFONOVA would not be possible.

Thank you very much, and have a good reading.

EDITORIAL

Rosa Mª Frías Reina

Human Resources Manager.
Asociación Dianova España

In April 2016, a highly expected Special Session of the United Nations General Assembly (UNGASS) took place in New York, which assembled representatives from all the countries members to evaluate and to discuss the central aspects of the drugs policies that the different governments are carrying out.

Among this historical event's general conclusions there was the need to implement interventions based on the evidence, including treatment and reintegration, but mainly education and prevention, as indicated by the Spain's Action Plan on Drugs 2013-2016, part of the National Drugs Plan.

That is the reason why we have mainly focused the 30th number of INFONOVA, a professional and specialised publication in the area of addictions, on this topic. The articles included in the magazine revise methodological, scientific and technical aspects enlightening the actual condition of the main trends of research on the addictions prevention.

First of all, and in line with the 8th action of the Spain's Action Plan on Drugs 2013-2016 defined as "improvement project of the processes of detection and early intervention with minors at school, social and health levels ", INFONOVA presents in these pages its guide for early intervention. This is one of the tools included in the intervention program for the addictions selective prevention, aimed for parents, professionals and teenagers in risk situation or close to groups with risk behaviour.

Then, Francisco Jose Montero Bancalero, Psychology teacher at the University of Osuna, offers both an empirical analysis and bibliographical review of the prevention programs indexed in specific databases.

Finally, the therapeutic coordinator of Asociación Dianova España, Antonio Jesus Molina Fernandez, makes a review of the *Methodological Guide for the implementation of a preventive, selective and indicated intervention*, by Carmen Arbex Sánchez with the support of the National Drugs Plan. This guide proposes a methodological work aimed to facilitate the design, implementation and evaluation of preventive programs.

In summary, we offer you a deep and wide overview of the current state of research in addictions prevention. We hope that you find the contents in this number of INFONOVA of interest and that you enjoy the reading.

Kind regards.

INFONOVA IN THE CONTEXT OF THE NATIONAL PLAN ON DRUGS 2013-2016

Asociación Dianova España has a long experience in collaborating with the National Plan on Drugs of the Ministry of Health, Equality and Social Policy, administration that annually provides for the proper functioning of the entity by granting financial support to private non-profit organisations on a statewide level to accomplish supra community programs on addictions. This initiative is part of the mentioned administration's competences, as stated on its web page:

> *"It corresponds to the Government Delegation for the National Plan on Drugs the functions of managing, impulse, overall coordination and supervision of the different services responsible for the implementation of the National Plan on Drugs. Being one of its competences, the Ministry of Health, Equality and Social Policy, under the direction of the Government Secretary of Social Services and Equality, assumes the impulse of the consumption of drugs demand reduction policies and the programs of prevention, treatment, harm reduction and rehabilitation programs."*

Infonova magazine is a periodical publication edited by the Asociación Dianova España with the support of the Government Delegation on the National Plan on Drugs, as part of the statewide grants to private non-profit organizations, with special funds from confiscated assets in cases of drugs trafficking and related crimes, in application of the Law 17/2003, of May 29, for the accomplishment of supra communitarian programs on drug addictions in 2015, resolution of July 13rd, 2015, of the Secretary of the State of Social Services and Equality (BOE. n º 176, July 24, 2015).

Infonova is an initiative registered in the frame of the Action Plan on Drugs 2013-2016, as part of the work stream number 4 " Basic and applied knowledge improvement ", corresponding to the action number 27 " information system data dissemination improvement ", that targets professionals, NGOs, institutions and people in general.

DIANOVA EARLY INTERVENTION MANUAL
EARLY DETECTION OF PROBLEM DRUG USE AND OTHER ADDICTIVE BEHAVIOUR IN ADOLESCENTS AND YOUTH

Asociación Dianova España

ABSTRACT

In actual programmes about Prevention of drug use, we have to consider different theoretical models able to explain and make easier the approach to so complexes problems as binge use of alcohol and drugs, early apparition of psychological and psychiatric disorders (and their predictors), actual family models and their impact in prevention of addictive behaviours.

Design and implementation of Early Intervention Dianova´s program has been sustained in actual evidence-based models to develop a selective prevention program allows adolescents, their families and professional staff to have an efficient and actualized tool for early detection and intervention about the problems relationed with addictive behaviours.

KEYWORDS

Addictive behaviours, Risk/Protection Factors, Selective prevention, Early intervention.

INTRODUCTION: PREVENTION IN THE SPANISH NATIONAL PLAN ON DRUGS (PNSD)

""*The prevention of drug abuse, within a more global strategy for promoting health and well-being, is the primary objective of the National Plan on Drugs.*

As the highest body responsible for executing the PNSD, defining a global strategic policy – that, by general agreement, enables the stability of the preventative programmes and actions, their constant evaluation and progressive improvement – is a task that falls to the Government Delegation for the National Plan on Drugs.

The Autonomous Communities, in collaboration with the local public agencies, have the role of

planning and executing appropriate regional and local policies in this field, as well as their corresponding financial and technical supports.

Prevention is essentially aimed at:

- Raising awareness and mobilising society to generate a culture of rejection of drugs through the promotion of its own values and resources.

- Informing and educating our citizens, especially children and adolescents, in order to develop positive, healthy and independent lifestyles.

To achieve these objectives, different public agencies, social organisations, parents, educators, education facilities, and society as a whole, must work in a coherent and integrated manner. The universal, selective and recommended prevention actions and programmes are applied, among others, in the following fields: school, family, work, community, free time."Área de prevención, Plan Nacional sobre Drogas, PNSD.

Field of prevention, National Plan on Drugs (PNSD)

1. INTERNATIONAL CRITERIA FOR EARLY INTERVENTION

""Indicated prevention aims to identify individuals with behavioural or psychological problems that may be predictive for developing problem substance use later in life, and to target them individually with special interventions. Its subcategory 'early intervention' however focuses only and specifically on identifying substance-using individuals to prevent them from progressing into problem drug use. Identifiers for increased individual risk can be dissocial behaviour and early aggression, and alienation from parents, school and peer groups. The aim of indicated prevention is not necessarily to prevent the use of substances but to prevent the (fast) development of a dependence, to diminish the frequency and to prevent 'dangerous' substance use (e.g. moderate instead of binge-drinking)."

EMCDDA Preventing later substance use disorders in at-risk children and adolescents (2009)

"The aim of these principles is to help parents, educators and community leaders to analyse, plan and introduce drug abuse prevention programmes with scientific foundations at a community level. The references that follow each principle are representative of the current research".

Principle 1

Prevention programs should enhance protective factors and reverse or reduce risk factors.

- The risk of becoming a drug abuser involves the relationship among the number and type of risk factors (e.g., deviant attitudes and behaviors) and protective factors (e.g., parental support).

- The potential impact of specific risk and protective factors changes with age. For example, risk factors within the family have greater impact on a younger child, while association with drug-abusing peers may be a more significant risk factor for an adolescent.

- Early intervention with risk factors (e.g., aggressive behavior and poor self-control) often has a greater impact than later intervention by changing a child's life path (trajectory) away from problems and toward positive behaviors.

- While risk and protective factors can affect people of all groups, these factors can have a different effect depending on a person's age, gender, ethnicity, culture, and environment.

Principle 2

Prevention programs should address all forms of drug abuse, alone or in combination, including the underage use of legal drugs (e.g., tobacco or alcohol); the use of illegal drugs (e.g., marijuana or heroin); and the inappropriate use of legally obtained substances (e.g., inhalants), prescription medications, or over-the-counter drugs.

Principle 3

Prevention programs should address the type of drug abuse problem in the local community, target modifiable risk factors, and strengthen identified protective factors.

Principle 4

Prevention programs should be tailored to address risks specific to population or audience characteristics, such as age, gender, and ethnicity, to improve program effectiveness.

Principle 5

Family-based prevention programs should enhance family bonding and relationships and include parenting skills; practice in developing, discussing, and enforcing family policies on substance abuse; and training in drug education and information.

Family bonding is the bedrock of the relationship between parents and children. Bonding can be strengthened through skills training on parent supportiveness of children, parent-child communication, and parental involvement.

• Parental monitoring and supervision are critical for drug abuse prevention. These skills can be enhanced with training on rule-setting; techniques for monitoring activities; praise for appropriate behavior; and moderate, consistent discipline that enforces defined family rules.

• Drug education and information for parents or caregivers reinforces what children are learning about the harmful effects of drugs and opens opportunities for family discussions about the abuse of legal and illegal substances.

• Brief, family-focused interventions for the general population can positively change specific parenting behavior that can reduce later risks of drug abuse.

Principle 6

Prevention programs can be designed to intervene as early as infancy to address risk factors for drug abuse, such as aggressive behavior, poor social skills, and academic difficulties. (...)

Principle 15

Prevention programs are most effective when they employ interactive techniques, such as peer discussion groups and parent role-playing, that allow for active involvement in learning about drug abuse and reinforcing skills.

Principle 16

Research-based prevention programs can be cost-effective. Similar to earlier research, recent research shows that for each dollar invested in prevention, a savings of up to $10 in treatment for alcohol or other substance abuse can be seen."

NIDA InfoFacts: Lessons from Prevention Research

2. HISTORICAL BACKGROUND

"Classic drug addiction was a result of a subject encountering a drug. Therefore, there was first the act of choosing said drug as a result of a chance discovery or a deliberate intention, and then the subject and the chosen drug come together, like a true marriage, entailing the fidelity of the drug addict and evolving from the allure of the first days to the bitterness of the last, whilst experiencing many crises, break-ups and the rekindling of passions. All this drama occurred within the family and great care was taken, like in the most bourgeois marriages, that nothing became public. However, the traditional fidelity of the drug addict to their drug no longer exists because there is a new problem: that of encountering new drugs. In the constant search for new sensations and different experiences, the least predictable and most reckless combinations are encountered".

Velasco, 2008: 17

A At the end of the 1970's, and as a result of the alarm created by the consumption of heroine amongst young people, the first responses to substance use were created that, catering to the social demand of the time, were support-oriented.

The objective of any strategy, whether public or private, had to be aimed at treating addiction and, in particular, the physical and social consequences. At the time, the use of legal drugs (alcohol and tobacco) among adolescents was scarcely worthy of mention, compared to the personal, family and social drama that emerged from heroine consumption as well as other illegal drugs.

As a result, throughout the 1980s, prevention of drug dependence was characterised by the abundance of sporadic initiatives lacking continuity, the majority of them being informative, and that were generally directed at this type of substances. The creation of the National Drug Plan (PNSD), along with the consolidation and diversification of available care, and the very evolution of the drug use problem (in terms of the changes in substances, profiles of users and styles of use), paved the way for interest in prevention and in the qualitative improvement of prevention strategies. Incorporating health education as a framework for preventive action, and a more holistic view of the problems related to drug use and prevention, has made it possible to approach prevention as a global strategy that is deeply rooted in the social fabric.

The creation of the PNSD, made into a ministerial department in 1986, was unanimously welcomed as an integrating public response to the severe social problem of drug dependence, and in particular intravenous heroine addiction among a group of very young people who were beginning to use heroine during adolescence. In addition to this youth phenomenon was the issue of drug-related crime linked to this drug use. In fact, in that same year, 1986, drugs became the second problem for Spaniards according to the Sociological Research Center (CIS, 1986).

In the 1990's, the idea that the prevention of drug use should also involve legal drugs (alcohol and tobacco) is clearly reflected in the fact that the majority of prevention programmes in Spain mainly focus on these substances. This is justified if we take into account that, during adolescence, illegal drugs affect a very small number of individuals, and in some cases also prevents the counter-prevention phenomenon (E. Becoña, 1995). This continues to be shown today in data from different ESTUDES household surveys and EDADES school surveys carried out by the PNSD (1994-2013), in which the huge difference between legal and illegal drug use is apparent.

1. 1. CURRENT CONCEPTS ON THE PREVENTION OF DRUG USE AND OTHER ADDICTIVE BEHAVIOURS: HEALTH EDUCATION

"(All authors) agree upon the need to use the programme results as tool to assess their effectiveness, that is, base interventions on scientific evidence and not political ideology, calling for this scientific evidence to be the grounds for developing policies and not the other way around." (Laespada and Iraurgi, 2012: 15).

1.1.THEORETICAL FRAMEWORK

CWhen we approach drug dependency or we refer to other types of addiction, such as so-called behavioural addictions (pathological gambling, mobile phones, the Internet, etc.), we accept the previous definition of "illness" as "the disruption of the biopsychosocial balance, based on an integral model". Moreover, we normally define drug dependence and addiction as a "multifactorial phenomenon" (Martín and Lorenzo, 2003), where individual aspects are combined with factors of the primary social context (essentially family and partner), to which the elements of the macro-social context (social and cultural surroundings, including the socio-economic context) are added. These factors interact with each other, sometimes causing protective situations and sometimes risky

situations for the people in which these elements come together.

It is within this context that we include the family as a risk or protective factor. The family functions as the primary social structure for adolescents, both positively and negatively. It is in the family system that teenagers learn and "mature" their values, emotions, attitudes and behaviours (Becoña, 1999), especially by comparing them to complementary social structures such as peer groups and school context.

In general, the aim of the prevention of drug dependence and other addictions is considered "preventing young people from starting to use substances, including legal drugs (tobacco, alcohol and medicines) and illegal drugs (cannabis, cocaine, heroine, synthetic drugs, etc.)"

Specific aims include:

- Delay the age at which drug use starts.
- Limit the number and type of substances used.
- Prevent the progress from experimenting with drugs to drug abuse and from abuse to dependence.
- Reduce the negative consequences of use (associated risks).
- Educate so that young people can have a mature and responsible relationship with drugs.
- Strengthen the protective factors and reduce the risk factors.
- Change the conditions of the socio-cultural surroundings and promote alternative uses of free time.

Martín y Lorenzo 2003
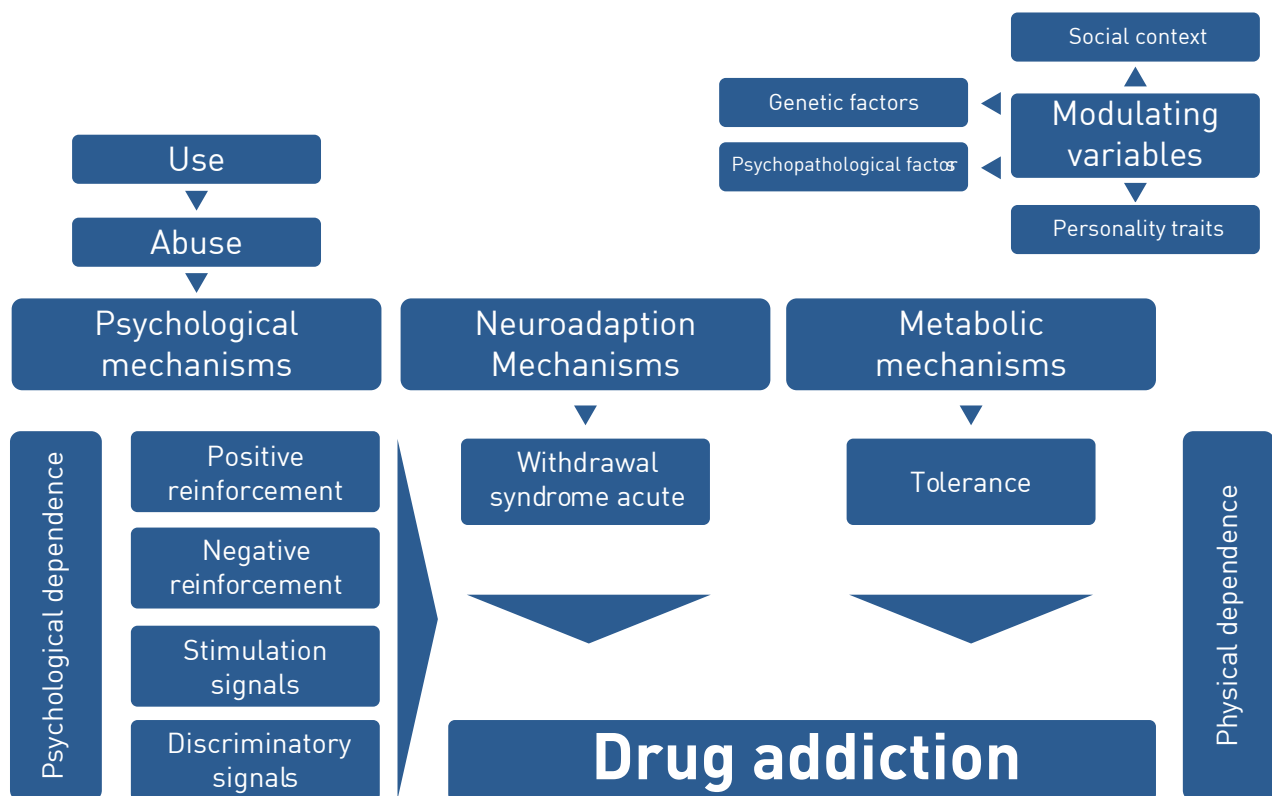
1.2.FROM SCIENTIFIC EVIDENCE TO IMPLEMENTATION.

Scientific research and the implementation of prevention have traditionally operated in different spheres, often separated by objectives, strategies and funding channels (Bumbarger and Campbell, 2011). It seems fundamental for the development of prevention and early intervention strategies to implement applied research groups, with efficient information and programme design transfers, which streamlines the transition from the research field to intervention, and from intervention to research. In order to do so, design and implementation systems for said programmes must be developed: they must be initiated in an organised and planned manner, whilst considering the psychosocial and socio-demographic characteristics of the target population; they must be provided in adequate language for these people, and offer efficient and effective solutions, based on concrete and specific activities.

Furthermore, up-to-date and relevant information on current behavioural risks for adolescents and young people in Spain is used. Said information is not solely based on substance use, but also has a multifactorial purpose in which personal, micro-social and macro-social aspects are integrated. Within these factors, there was particular focus on the combination of the neurodevelopmental aspects and their correlation to the social behaviour of adolescents and youth, especially in the current social contexts. It is in these contexts, with a low perception of risk in the use of certain addictive behaviours (alcohol, cannabis, ICT, etc.) and high accessibility to substance use and other addictive behaviours, that we must act and assess the risk and/or protective factors.

1.3. DIANOVA Y LAPREVENCIÓN BASADA EN LA EVIDENCIA.

Dianova Spain provides services that support and are committed to social actions that help people in need, whether due to their vulnerable social situation, social exclusion or risk, through innovative programmes and projects conducted by professionals and in which quality, assessment, control and transparency are intrinsic factors to their intervention and philosophy as an organisation.

Dianova Spain is a non-profit NGO that does not belong to any political party and is not governed by any ideological or corporate ties, but rather its fundamental purpose and action is to work for the public interest and well-being of people.

Article 5 of Dianova Spain's bylaws in effect set forth its social purpose, and aims to develop actions and programmes that actively contribute to personal autonomy and social progress, such as:

a. Promoting social and professional integration of people in situations of social exclusion and/or social vulnerability, especially minors, families, the elderly, women, victims of violence, immigrants, ethnic minorities, the unemployed, people and families who have lost their homes, through all types of actions and programmes, and promoting intercultural coexistence.

b. Investing in the comprehensive help, reception and integration of immigrants or nationals from developing countries, providing humanitarian aid, international protection, right to asylum, shelter, statelessness, temporary protection and return, and contributing to the fight against human trafficking, promoting respect and effectiveness of the universally recognised human rights and individual and civil liberties.

c. Stimulating employment through the promotion and development of programmes and projects with the aim of contributing to people's social and professional integration.

d. Stimulating and promoting culture and entrepreneurial activity, as well as social entrepreneurship.

e. Creating and developing programmes and

projects in the areas of family, minors, youth and education.

f. Promoting and strengthening worldwide development cooperation.

g. Promoting equal opportunities, gender equality, and promoting and defending women's human, social and professional values.

h. Promoting and strengthening compassionate volunteering.

i. Health education and promotion.

j. Medical treatment of mental health, including drug dependence and other addictions.

k. Prevention, intervention and integration in different spheres related to addictions and their consequences.

The current Dianova early intervention manual uses consolidated theoretical models. Bearing mind the theoretical and practical knowledge that Dianova has collected over the last 30 years, said models must evolve in order to adapt them to the requirements of the current agents involved. This commitment, which is both organisational and technical, involves an effort to technically consolidate a revisable and comparable model that is a driving force to be shared among other entities.

1.4. CONCEPTS AND DEFINITIONS.

Health. "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". (WHO)

Illness. "Alteration or deviation of the physiological state in one or several parts of the body, due to causes that are generally known, which manifest through characteristic symptoms and signs, and the evolution of which is more or less predictable". (WHO)

Addiction. "Addiction is defined as a chronic, relapsing brain disease that is characterised by compulsive drug seeking and use, despite harmful consequences. These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors". (NIDA)

Prevención. Measures taken to prevent the occurrence of disease (risk factor reduction) and arrest its progress and reduce its consequences once established. (WHO)

Promoción de salud. Process of enabling people to increase control over, and to improve, their health. (Ottawa, 1986)

Addiction is a complex bio-psycho-social disease. In other words, there are multiple causes of addiction and they interact in a complex manner to produce the addictive disorder. Its linear, multifactorial and systematic aetiology makes it difficult to understand it linearly or simplistically as a cause and an effect.

1.5. SOMATIC-MARKER THEORY (DAMASIO, 1994; VOLKOW, 2000).

Substance use was traditionally linked to pleasure theory, especially to mechanisms linked to satisfaction being triggered. Since 1994, especially starting with NIDA's studies in the late 90s, a great deal of importance has been placed on neuropsychological mechanisms – especially cognitive and emotional factors – in the onset, maintenance and consolidation of addictions.

This hypothesis was confirmed through the theoretical work of Robinson and Berridge (2000, 2003). Based on a series of experiments conducted on animals, they demonstrated that compulsive drug use was connected to a motivational mechanism ("wanting"), but not a hedonic one ("liking"). In other words, through a process of neuromodulation which they termed "incentive-sensitisation", drugs take on the ability to hyperactivate motivational systems, even in the absence of any pleasant effects. Simply put, you keep "wanting" to use drugs even when you no longer "like" taking them.

We are therefore faced with two types of models:

1. Those based on an imbalance between the motivational system and the executive system, and

2. those based the reward system losing its central role and giving way to the learning of automatic habits.

Later on, different studies carried out on the neurobiology of cocaine (Verdejo, Pérez García, *et al*., 2007) revealed factors and problems that had not been made explicit in classic approaches to addiction: the so-called "moral brain" (Volkow, 2006), alterations in the control and expression of emotions, low control over impulses and the resulting deficit in decision making among the drug-dependent population.

Based on these different studies, the conventional terms used with drug addictions started to be called into question, and it was suggested that we should substitute the classic addiction-related concepts of tolerance, dependence, habituation, etc. with another set of definitions, such as amotivational syndrome, emotional blocks, impulsiveness, alterations in the system of short-term rewards/gratification, executive planning, decision making and problem solving (or lack thereof).

Moreover, to further complicate or clarify the issue of addictions and neurobiological and genetic determinism, in use since 1997 in analyses of drug dependence and addiction, just recently, in 2015, the prestigious journal "The Lancet Psychiatry" published a review article called, "The brain disease model of addiction; is it supported by the evidence and has it delivered on its promises?", which criticises the excessive biology-centric reductionism and determinism applied to addiction. In this article, the group led by Prof. Hall from Australia's University of Queensland criticises the limited access to psychosocial programmes that has resulted from the medicalisation of addiction. They call for a return to a broad, multicomponent framework that includes psychosocial, socio-economic, epidemiological, pharmacological, neuropsychological and other aspects, in order "to integrate emerging insights from neuroscience research with those from economics, epidemiolo-

gy, sociology, psychology, and political science to decrease the harms caused by drug misuse and all forms of addiction" (Hall *et al*., 2015:108).

2. CURRENT FAMILY INTERVENTION MODELS FOR ADOLESCENTS WITH ADDICTION PROBLEMS: ADOLESCENTS AND THEIR CONTEXT TODAY

2.1.THEORIES USED ON ADDICTIVE BEHAVIOUR AND YOUNG PEOPLE.

The classic theories used to explain substance use in young people have focused their attention on the substances and their consequences. The most widely used are the following:

Problem-behaviour theory (Jessor and Jessor, 1977). This theory is in turn based on the theory of risk factors and protective factors. It makes reference to the fact that experimental drug use takes place during adolescence, where it functions as a repudiation of conventional norms, reinforces integration with the peer group, etc. The goal when working with this theory is to prevent maladaptive behaviours on a global level, making the person see that it is a mistake to think that the benefits of drug use outweigh the risks it entails. This theory is based on the idea that risk behaviours do not usually occur in isolation, but rather go hand in hand with others, such as experimenting with drugs, risky sexual behaviour, truancy, rebelliousness, etc. These subjects have lower performance at school, take part in fewer pro-social activities, and are more likely to engage in other risk behaviours (delinquency, risky sexual behaviour, etc.) than non-users.

A risk factor is any factor associated with the increased likelihood of a behaviour that usually has negative consequences. A protective factor is any factor that reduces the impact of a risk behaviour. A protective factor helps individuals to not engage

in potentially harmful behaviour, and/or promotes an alternative pathway (Spooner, Hall and Lynskey, 2001). Studies have identified specific risk factors and protective factors in order to determine how drug abuse begins and progresses.

While this is difficult to determine, a number of studies have come to the same conclusions:

1. There is broad consensus among specialists in the field of prevention and drug dependence treatment regarding the multifactorial nature of drug use.

2. There are factors stemming from individuals and their relationship with their surroundings (intrapersonal and interpersonal) and environmental or context-based factors.

3. Risk factor and protective factor are not two ends of a continuum. In other words, the absence of a risk factor does not constitute a protective factor, and vice versa. However, the greater the concentration of factors, the greater the risk or protection. What's more, many studies have suggested that the power of both types of factors increases exponentially in combination.

4. There are different risk factors for different drugs; a person with depression is likely to use drugs that depress the central nervous system, whilst someone who is high-energy will tend to use drugs that stimulate the central nervous system.

5. Certain risk factors influence a person throughout the course of their development, whilst others have a stronger influence at a given age (age itself, for example, is a risk factor during adolescence because it increases minors' susceptibility to peer pressure).

6. Certain risk factors and protective factors are common to different problematic behaviours (academic failure, unplanned pregnancy, violence, etc.).

The first experiences with drug use tend to occur during adolescence. This state of development is considered by all fields to be a special moment for the consolidation of the individual's independence.

The ecological model. The main point of reference for this model is environmental psychology. At the level of prevention, the strategy would consist of intervening in the person-environment relationship, bearing in mind the risk and protective factors that affect how the person acts. Therefore, the goal is getting the family, school, peer group and society to work together in coordination, in order to help promote the individual's health.

The transtheoretical model of Prochaska and DiClemente. The transtheoretical model helps to understand processes of change, and how people, with or without professional help, get involved in these processes. This model incorporates stages, processes and levels of change. The stages indicate when the person decides to undergo changes that will modify their behaviour. The processes of change indicate how these changes are carried out when going from one stage to the next. The levels point out what the person needs to change in order to carry out the change, once they have made up their mind. Therefore, this model is very good at explaining the stages that a person goes through when they begin to quit using. The stages are: pre-contemplation, contemplation, preparation, action, relapse and maintenance.

Theory of reasoned action: Fishbein and Ajzen. This theory is based on the different beliefs that the person has about their behaviour, examined by evaluating their current behaviour. Along with these beliefs, the theory also looks at predisposition to follow rules, and the expectations created around the possibility of gaining control of their behaviour. As such, the theory of reasoned action takes into account beliefs, predisposition and expectations surrounding the use of rules in order to be able to manage behaviours.

Comprehensive models: Social development theory. This theory emphasises the concept of self-efficacy as one of its central components, and as the most important element for explaining how behaviours are acquired, maintained and chan
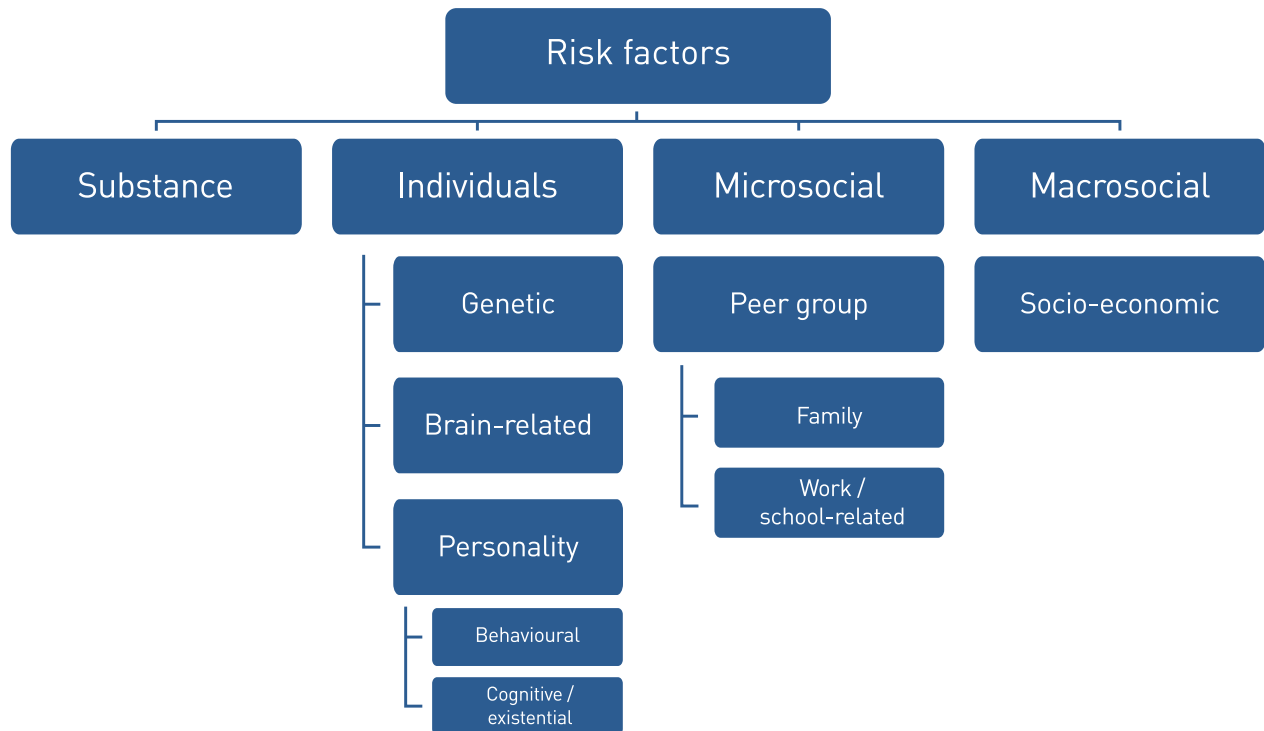
Risk factors according to Jessor and Jessor

ged. This theory takes into account learning factors, cognitive processes, and the portion of society in which the person lives and develops.

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Kaplan's self-rejection theory. This theory is based on the idea that adolescents seek acceptance and approval for their behaviours. When their behaviour deviates from the behaviours expected by their family, teachers and other important figures, this situation becomes a source of psychological discomfort that must be resolved. When they lose the favour of the adults who provide them with affection and from their authority figures, the following arise:

- Attitudes toward behaviour.

- Normative beliefs.

- Predisposition to the norm.

- Control expectations.

- Control frequency.

- Subjective norm.

- Behaviour.

- Perceived control.

- Behavioural intention.

- Behavioural beliefs.

- Evaluation of outcomes.

- Feelings of self-rejection that require a corrective or compensatory response.

2.2. THE MATURITY MODEL ON DRUG USE.

Labouvie (1996) proposes a model based on self-regulation, where some of the key elements are self-control and efficacy. When these fail, individuals respond to their immediate needs and to si-

tuational pressures. Moreover, they are unlikely to have personal goals, or tend to have goals that are unimportant, or that are difficult, costly or improbable to achieve. This can lead to alienation and depression. Her studies confirm that as time passes, there is a decrease in substance use by these individuals and their friends, and an increase in the number of couples who marry, both among subjects themselves and their friends. All of this indicates, according to the author, that there is an increase in the direction of greater conventionality, among both males and females (Becoña, 1999).

Becoña (1999) himself proposes a comprehensive and sequential model of phases for drug use, which is essentially a compilation of the main contributions in the field of drug use aetiology. Among the many phases he includes, it is worth mentioning the sequence between perceiving risk and making decisions about whether or not to continue using a substance (1999).

Some authors (Calafat et al., 2004: 109) hold that interactive programmes are the only ones that have been proven to be effective, but even non-interactive ones have produced a percentage of change, as can be seen in the article by Ennett (Ennett et al., 1994). Catalano and Hawkins (1996) see a clear relationship between antisocial behaviour, petty crime and drug use.

2.3. FACTORS THAT AFFECT PREVENTION.

2.3.1 Factors that have a positive effect on prevention:

- Some community and school programmes, although unable to stop the onset of substance use (Becoña, 2002: 88), are able to prevent it from intensifying.

- Working on the social environment, personality and risk factors all together yields better results than working on just one of them (Becoña, 2002: 100).

- One of the best risk factors for predicting drug

abuse is starting to use at an early age.

- The perceived risk associated with use: there is a high inverse correlation between perceived risk and use (Bachmann et al. 2002).

2.3.2 Factors that do not contribute to prevention.

- In prevention it has become clear that whilst information is a necessary prerequisite for any programme, it is not enough to change attitudes and behaviours. In fact, drug users often have more information than non-users.

- According to the same authors, the information gathered is information that does not compromise the target audience (Calafat et al., 2004).

- Programmes based on generating messages of fear and public concern are not seen as effective (Becoña, 2002).

- Improving values and self-esteem have yielded little success (Becoña, 2002).

- There is not always a connection between knowledge, attitudes and behaviour (rational models) (Becoña, 2002).

- Simultaneously offering a broad variety of prevention-related activities does not improve effectiveness (Becoña, 2002).

- • Activities that are preventive for alcohol may not be for other drugs (Becoña, 2002: 131).

As we can see, very few of these theories prioritise sociological explanations. Instead, they are more deeply rooted in psychological, educational and healthcare models. Regarding cultural aspects of drug use, or cultural nuances and differences, they are not an integral part of hardly any explanations we have found.

3. WHAT IS ADOLESCENCE? EXPECTATIONS AND RESPONSES REGARDING DRUGS (AND OTHER ADDICTIVE BEHAVIOURS)

3.1. TYPES OF ADOLESCENCE: DEVELOPMENTAL ASPECTS OF ITS DIFFERENT STAGES.

In talking about adolescence we tend to refer to a broad age group, spanning from 12/13 (preadolescence) up to 22/23 (youth). In this space of time people undergo enormous changes, both physical and psychological, which will have a determining effect on how they position themselves in the social sphere.

The need to establish one's own identity in the face of these fast changes, and the search for autonomy and independence from the adult world, stimulates adolescents to engage in risk behaviours, which can include drug use and anti-social behaviour. By bearing in mind the unique features of the psychological changes that take place during adolescence, we can better understand the function of drug use at these ages. Due to its very nature, this transitional stage generates a great deal of uncertainty connected to the need to relieve stress by experimenting with new "sensations" and behaviours that allow them to assert themselves.

Moreover, the cognitive changes that take place in adolescence cause adolescents to perceive the world around them differently. This is marked by their egocentricity and sense of invincibility, which, although necessary conditions for establishing their own identity, can also be at the root of certain risk behaviours. On the other hand, the influence of the peer group is a decisive factor, bearing in mind that they are especially relevant in the process of constructing one's own identity because they allow adolescents to compare themselves with others and get to know themselves better. They also increase their perception of vulnerability when they face situations involving peer pressure.

The group of friends takes on more and more influence as a decisive source of habits, attitudes, values and ways of life. The search for an identity that is different from that of their family context pushes adolescents to share experiences with their friends, and to turn to them for assurance and support. Thus, the group becomes one of the main contexts for socialisation. The first contacts with drugs are connected to social situations, and it is very rare for them to start experimenting on their own. The group of friends and the contexts where they spend their free time are the spheres where drug use tends to arise.

Thus, in adolescence we find people who want to manifest their independence, are sensitive to the influence of their group of friends, and are cognitively prepared to downplay the standards and knowledge transmitted to them by their family.

3.2. COGNITIVE AND EMOTIONAL CHARACTERISTICS OF ADOLESCENCE: EMOTIONAL MODULATION.

Since 2004 other theories have emerged that are closer to social neuroscience. They have proposed a "profile of the adolescent with a neurodevelopmental disorder", as a combination of:

- problematic use of at least one "traditional" substance (alcohol, cocaine, cannabis, benzodiazepines, heroine, etc.), plus

- at least one behaviour problem (social networks, sports betting, gambling, compulsive shopping, bigorexia, orthorexia, etc.), plus

- at least one diagnosed mental disorder.

These disciplines have established a clear parallel between the incidence of drug use and a young person's neurological maturity, holding that these two aspects are intertwined with physiological/cognitive/emotional/personality transitions, as well as the structural consolidation of the prefron-

tal cortex with motivation (striatum and basal ganglia) and emotion (amygdalae and insulae).

According to this theory, instead of describing addiction as a "chronic, relapsing brain disease", we would describe it as an "adolescent neurodevelopmental disorder" that turns into a habitual alteration in behaviour. To justify this approach, a variety of studies on premorbid or vulnerability factors have been used, as well as definitions of the so-called "endophenotype" (predisposing characteristic), which has been generally accepted as impulsiveness/lack of inhibitory control. The combination of impulsiveness + imbalance in the motivational system + regulatory deficit = vulnerability factor.

The combination of these factors would then be what facilitates the onset and consolidation of the addictive disorder. According to these theories, the following may all be considered neurocognitive predictors:

- Neurobehavioural disinhibition.

- Academic failure.

- Run-ins with the juvenile justice system.

- Families from all social strata and classes.

Thus, using this framework, we would move from "drug dependence problems" toward a neuropsychological definition of "drug use + conflictive behaviours", with correlations between different factors, such as:

- neurobehavioural disinhibition between the ages of 10 and 12 leads to a greater risk of intense drug and alcohol use (16-17 years of age) and to subsequent early diagnosis of dependence (19 years of age).

- the correlation between early age of use and academic failure, despite young people's views on the pointlessness of studying, means that we must include alternative education strategies in prevention programmes and plans.

The strategy through which the adolescent par-

ticipants were chosen was indicated prevention and early intervention with young people and their families. This involves specific programmes where one intervenes directly with an adolescent engaged in problem drug use (or other addiction issues) and with their family. These programmes do not work exclusively on the addictive behaviour itself, but rather aim to analyse and resolve the causes and consequences that the problem of substance use has had on the adolescent, and on their immediate context: aggressiveness, lack of communication, academic failure, domestic and behavioural habits, etc. This is the reason why the participation of the entire family unit is crucial in order to carry out the activities and reach the objectives. These are not therapy programmes of the sort traditionally used with adults, but rather are programmes combining education and therapy for the adolescent and their family, the goals of which are:

- to provide adolescents with the resources they need in order to strengthen their protective factors in risky situations; and

- to promote the changes that need to be made in the family in order to accommodate for the adolescents' needs and foster their comprehensive development (values, emotions, attitudes, behaviours, etc.).

3.3. ADOLESCENCE IN SOCIAL DEVELOPMENT: THE REFERENCE GROUP AND RESILIENCE.

We should also make reference to the most common features of drug use among adolescents. These include its social (group use) and recreational (in free-time contexts) nature. Studies have shown that legal substances (tobacco and alcohol) are usually the first step toward using other substances such as cannabis and synthetic drugs, in some cases continuing on from there to cocaine and other drugs. Another proven fact is that the more someone experiments with drugs, the more likely they are to progress into harder substances.

This is why delaying the onset is one of the main goals of prevention. Delaying the first contact with tobacco and alcohol reduces the likelihood of a problematic use of this or other substances, as well as other addictive behaviours.

3.4. ADOLESCENCE AS A RISK FACTOR: ASSOCIATED BEHAVIOURS (SEXUALITY, AGGRESSIVENESS, ETC.)

We must act on a high percentage of compulsive or out-of-control behaviours, which is a behavioural pattern that is heavily based on disorderly conduct and short-term rewards. The problem may not reside in the social networks or telephones, but rather in why and how they are used, and the consequences they have for those who use them.

We have to analyse and mitigate the risk factors, especially when it comes to controlling schedules, behaviours, homework and video games. In other words, we must prevent behaviour from becoming totally chaotic, which means we have to consider behavioural restructuring strategies. Most of all, the huge difference in risk behaviours for health between some young people and others makes it necessary to recommend programmes based on controlling damage and preventing relapse, especially to avoid the most serious social and health consequences of drug use.

But we cannot focus this behavioural pattern solely on matters of conduct. The prevalence of emotional factors, the need for rewards, the repercussions for social, family and romantic relationships, controlling rage and negative emotions, etc., leads us to infer that there is an emotional discomfort that is somehow compensated for, whether through outbursts with the close social circle, or through physical or emotional isolation. Addictive/compulsive behaviours are highly efficient at achieving this: they isolate you, cut you off from reality, and help you to avoid facing your own problems..

3.5. BEHAVIOURAL ASPECTS OF ADOLESCENCE: CHALLENGE, RISK AND REBELLION.

On disobedience as a predisposing factor, this theory indicates a profile of vulnerability, mainly with males, who engage in behaviour that goes "against the rules", followed by acts of "vandalism" and aggression toward others. Of course, one cannot deny the increase in criminal acts carried out by boys and girls at increasingly early ages, acts which are recurring, violent, and carried out by larger and larger groups of perpetrators. In particular, we are talking about acts related to the use of social networks: cyberbullying, online sexual harassment, etc. In many cases we are faced with people who have low social and academic skills, as well as early-onset psychopathological disorders, especially features of cluster B/emotional personality disorders (borderline, narcissistic, antisocial, histrionic).

More and more, we find a small percentage of young people who flirt with a broad range of disruptive, aggressive and, at times, antisocial behaviours. The social problem is not just in this group, but also in the fact that this group is presented all too often as "young people and drugs". Whilst there are more and more young people who do not abuse substances (and who do not exhibit any other type of risk behaviours), nevertheless there is still a clearly identifiable psychosocial profile of young people who use more and more types of substances, have worse behaviour management, less control over their impulses, and engage in behaviour that is increasingly dangerous (ESTUDES 2013).

The correlation between early age of use and academic failure, despite young people's views on the pointlessness of studying, means that we must include alternative education strategies for these youths.

Specialists in early intervention, teaching and research would qualify this: the typical style of intervention is based on "traditional substances" and

the language used is more closely accessible to a "conventional addict"; these young people need different intervention models because of their level of cultural knowledge, their access to ICT, their family systems, etc. As for assessments, especially clinical assessments, specialists point out that the tools typically used emerged with the heroine and cocaine epidemics. Since the year 2007 no new multifactorial assessment tools have emerged. Phenomena arising after 2007 are therefore not reflected in their assessments. In this sense, they see the current study as a way to reveal a reality that till now had been kept beyond their reach: the influence of ICT on addiction, for good and for bad.

If we are to analyse multifactorial problems (as in this case, young people + substance abuse), we need a theoretical model that is multifactorial. As we mentioned before, we need to shift our focus away from "drug dependence in young people" and towards "drug use + conflictive behaviour". These people employ drug use as a trigger that sets off a much deeper set of explosives, tied up with family and social discomfort. In intervention and prevention one has to look at these problems and conflicts, not just from the individual point of view, but through a group approach that encompasses the social structure/system. In practice, empowering the subject is effective in the short term, but really it is the social system itself that needs adjusting. Informing about the risks of addictive behaviour is part of the solution, but as patterns evolve this information fails to stay up to pace. ICT may be part of this solution, due to its effectiveness and the sense of cultural identification it has for this generation of young people.

4. TRAINING PARENTS TO PREVENT AND DETECT RISK FACTORS

4.1. PREVENTION MODEL.

Current drug use prevention programmes, as we have already mentioned, must consider different theoretical models that are able to explain and aid in tackling problems as complex as teen binge drinking and/or drug use, early onset of psychological and psychiatric problems (and their predictors), today's family models and their impact on preventing addiction, etc.

In particular, in our sessions we use the general underlying model or theory of risk and protective factors. In part 2 we discussed the theoretical framework of this model, and now we will proceed to explain its more practical applications.

We will define a risk factor as "any factor associated with the increased likelihood of a behaviour that usually has negative consequences". Therefore, a protective factor is "any factor that reduces the impact of a risk behaviour".

According to risk and protective factor theory, a protective factor "helps individuals not to engage in potentially harmful behaviour, and/or promotes an alternative pathway" (Spooner, Hall and Lynskey, 2001). A number of studies have identified specific risk factors and protective factors in order to explain and define how drug abuse begins and worsens.

To generalise, with the due caution and care required by each case, we can determine that:

1. There is broad consensus regarding the multifactorial nature of drug use.

2. There are factors stemming from individuals and their relationship with their surroundings (intrapersonal and interpersonal) and environmental or context-based factors.

3. Risk factor and protective factor are not two ends of a continuum. In other words, the absence of a risk factor does not constitute a protective factor, and vice versa. However, the greater the concentration of factors, the greater the risk or protection. What's more, different studies have argued that both risk and protective factors are cumulative, meaning their effects increase exponentially in combination.

4. There are different risk factors for different

drugs, especially those connected to the effects of drug use on the brain, adverse neuropsychological effects, and related cognitive and behavioural issues.

5.Certain risk factors influence a person throughout the course of their development, whilst others have a stronger influence at a given age, such as peer pressure during early adolescence.

6. Certain risk factors and protective factors are common to different problematic behaviours (academic failure, unplanned pregnancy, violence, etc.) and their biopsychosocial consequences, in terms of lifestyle.

4.2.THE BIOPSYCHOSOCIAL PERSPECTIVE.

For years now, in the field of prevention and intervention in drug use and other addictive behaviours (for example the so-called "non-substance abuse addictions" to pathological gambling, mobile phones, the Internet, etc.) we have reached the consensus of avoiding reductionist approaches and dealing with this type of problems from a biopsychosocial perspective.

"When discussing drug use we are dealing with three interacting elements: the substance(s) being used, the person using them, and the context in which use takes place. To overlook this fact, by assigning a disproportionate importance to any one of these three elements, would involve the a priori alteration of any rigorous analysis of the problem and any solution we might try to implement" (Becoña and Martín, 2004).

We believe early detection to be especially important, all the more so when it is aimed at early intervention with young people and/or their families. This involves preparing specific actions that work directly with a group of adolescents engaged in drug use (or other addiction issues) and/or with their families. These programmes are not based exclusively on the addictive behaviour itself, but rather aim to analyse and resolve the causes

and consequences that the problem of substance use has on the adolescent, and on their immediate context: aggressiveness, lack of communication, academic failure, domestic and behavioural habits, etc.

During the development of both minors and the families in which they are raised, there are structural, relationship and individual factors at play. These generate a wide array of situations that give rise to difficulties and vulnerabilities, which must be addressed. In most cases where a minor has a substance abuse problem, domestic and communication problems have also been detected, along with a difficulty in taking on rules and limits in the family sphere.

This is the reason why the participation of the entire family unit is crucial in order to carry out the activities and reach the goals.

These are not therapy programmes of the sort traditionally used with adults, but rather programmes combining education and therapy for the adolescent and/or his or her family. The goal is to provide adolescents and/or their families with the resources they need in order to strengthen their protective factors in risky situations, as well as to promote the changes that need to be made in the family in order to accommodate for the adolescents' needs and foster their comprehensive development (values, emotions, attitudes, behaviours, etc.).

We must highlight the fact that the family is the environment in which we develop as people. In general terms it is considered the primary social structure in which we learn rules, limits, responsibilities, everyday activities, emotions, models, etc. Unfortunately, all too often we are faced with situations in which this context does not constitute a protective factor, due to the conflicts and problems that later on can facilitate the development of behavioural and/or addictive disorders.

Following Del Nogal's outline (Del Nogal, 2012), we should pay attention to the following variables:

Microsocial (family) variables::

- Parenting style (authoritarian vs. permissive).
- Values regarding drug use.
- Models of use vs. models of non-use.
- Family support and care.

Como variables personales:

- School attendance.
- Ability to perceive risks.
- Models.
- Adverse emotional states.
- Positive expectations regarding use.
- Search for new sensations.
- Psychological disorders.
- Truancy.
- Social reinforcement.
- Social skills.
- Impressionability.
- Impulsiveness.
- Antisocial behaviour.
- Mental and physical state.
- Information.

Prevention is an attempt to influence adolescents' conduct, which is why, in order to achieve this, we must take into account a number of influences that affect them, including friends, school, social context, etc. Parents need to be equipped with knowledge and attitudes in order to evaluate the context/environment where the adolescent will be carrying out their daily activities, be it the school environment, peer group or surrounding social context (neighbourhood, town, city).

4.3. EARLY DETECTION AND INTERVENTION.

In early detection and intervention programmes, the most effective way to design and address the content is through a participation-based methodology, working through the topics actively and in-depth, clarifying any doubts and queries, encouraging active participation (and avoiding the "passive student" style) by means of discussion groups about the sessions' topics, and presenting on specific cases and practical examples, using techniques such as modelling, moulding and role playing.

It is very important for parents to be able to engage in creative and constructive analysis of their own behavioural patterns, and especially to be able to adapt these patterns and modify them based on the needs that arise in the various situations (moulding). Being able to change one's strategy, role or worldview at a given moment is a healthy exercise that facilities emotional connectedness in a moment as complex as early action against addictive behaviour.

It is also very important to be able to act as role models, in terms of both words and actions. This skill with modelling can also be worked on through active participation, focusing on coherence between words and actions, identifying their own strengths and weaknesses, and bringing out their positive resources whilst mitigating the negative aspects. In any case, the methodology should be one of active participation. This programme is more than just the group sessions. Since it is an early intervention programme, participating parents are invited to attend in-person tutorial classes (or Internet-based, as mentioned previously) for better counselling and orientation in those cases where the more informative part of the programme is not enough.

To do so, we hold a series of discussion groups with parents to look at the content in depth, make sense of it, and offer them guidance in covering their needs, whether they are at risk, or are part of groups where risk behaviours have already begun.

4.4. PREVENTION IN THE FAMILY SPHERE.

Using the framework of the family to prevent all sorts of risk behaviours is, first and foremost, a matter of family values, examples and dialogue.

Three conditions must be met in the day-to-day life of the family:

- A warm emotional relationship that provides a sense of security and stimulates the adolescent's independence.

- Discipline that shows how to respect rules and limits.

- Having adults on hand to establish constant communication, and to turn to when needed.

All training aimed at prevention in the family sphere must highlight the importance of a healthy emotional relationship, and the ability to communicate limits. This combination of factors is the foundation of "positive authority", not to be confused with authoritarianism. In other words, in order for minors to develop properly, the family unit must provide care, recognition, appreciation, coherent and open communication about feelings, sincerity, listening and acceptance, in addition to setting limits and rules. The latter provide a structure or set of guidelines to channel and strengthen protective factors.

Setting limits on behaviour is crucial in order for minors to acquire the ability to self-regulate, gain self-control, take on responsibilities, learn to deal with frustration, and accept that they cannot always get what they want, or get what they want right away.

Putting this style of upbringing in place constitutes preventive behaviour, since it fosters children's psychological and emotional development by providing them with tools against risky situations.

Positive authority is characterised by being present for children's growth, being sensitive to their needs, consistently offering them attention, and expressing unconditional support. In short, it is a preference for reinforcement and motivation of appropriate behaviour over punishment for inappropriate behaviour. If a punishment is necessary, it is related to the bad behaviour being punished, and violence is never used.

Parents should be coherent and consistent in their own behaviour and attitudes, and must not forget that they are role models for their children. When the verbal messages and non-verbal messages do not match up, i.e. when there is dissonance between what adults say and what they actually do, minors are most likely to internalise the non-verbal message. In other words, what they are likely to take in is the information from the behaviours they observe. Thus, if minors move in circles where drug use takes place, and their role models offer permissive models regarding use, this is bad news for prevention.

Training in this parenting style is oriented toward children developing greater self-esteem and feeling more satisfied with themselves, and fosters their decision-making skills, independence, and social skills. On the other hand, other relationship patterns in the family can prevent children from acquiring healthy skills, thereby putting them at risk. Thus, a rigid, authoritarian, controlling parenting style – in which love is tied to results or expectations, in which emotions are not expressed and there is no communication, just rules – favours, on the one hand, the development of minors who are insecure, dependent, incapable of making decisions and defending their needs, and on the other, children who are disobedient, problematic and act out aggressively.

On the other hand, a permissive parenting style – in which there are not clear and stable limits, in which there is a lack of attention or guidance from the adults, in which the children are allowed to govern their own behaviour and do as they please – puts minors in control of their parents, taking on a role that is not right for them and that in fact will prevent them from developing their emotional skills; on the contrary, they are likely to exhibit immaturity, insecurity, difficulty socialising, low self-control, aggressiveness, etc.

As such, when working on prevention from inside the family, on the one hand parents must be attentive to their own behaviour and how they relate and interact, and on the other must be attentive to their children's behaviour and emotions. This is will facilitate early intervention.

Knowing the specific characteristics of adolescence, and being attentive to certain variables – impulsiveness, intolerance to unpleasant feelings, inappropriate style of dealing with difficulties, low spirits, lack of social relations, weak family ties, etc. – are tools that are oriented towards early intervention. Once certain risk factors have been detected, training mechanisms can then be put into place in order to minimise them.

In this way, if one observes that a minor is sad, cuts themselves off from others, is irritable, etc., it is important to find a way to approach them, whilst respecting their space and showing care and support. Using good communication, parents should find out the reasons behind the minor's behaviours and emotions, what is causing them to persist, and offer alternatives. Such alternatives include promoting healthy and alternative uses of free time, encouraging social contact, recognising their skills, their achievements and their strengths, helping them feel secure when making decisions, making the most of their conflict-resolution skills, getting involved in their free time and academic performance, etc. In short, the family must set into motion skills that help minors attain personal and social maturity, bring out their talents for facing the problems in their everyday life, and promote their personal independence.

It is important to avoid viewing the adolescent as "the problem", since they will only feel misunderstood, and be pushed to cut themselves off even more, or intensify their risk behaviours or aggressiveness. The focal point should be looking after family relationships, communicating in a caring manner, offering support, listening, mutual support, acceptance and care, and setting limits.

Parents engage in prevention when they pay attention to their children's lives, when they are familiar with their world and their friends, and when they take an interest in their free-time activities. This does not mean interrogating them on a daily basis; rather, by simply communicating with them, parents get to know their reality. Neither overprotection nor conflict avoidance will ensure proper protection or prevention.

By the same token, parents engage in prevention by educating their children about drug use, and speaking with them truthfully and naturally about the subject.

There is a common misconception that education amounts to encouragement, but this is far from true. To educate is to prevent. Firstly, it is important to learn what the adolescent knows about drug use, what beliefs they have about it, and what their opinions are, and then offer them information adapted to their level, along with guidance and alternatives. This should never take the form of an imposition, threat or prohibition. Indeed, the outcome of this type of behaviour will be just the opposite of the intended effect. The adolescent will close up and cease to communicate. When discussing the consequences of drug use, adopting an unflaggingly alarmist tone is not necessarily going to ensure that the adolescent stays away from them. In fact, we must keep in mind that in this phase of their life cycle, adolescents do not perceive risk in the same way as adults, and so they tend to downplay these consequences.

In order to carry out this process of education and information with their children, parents must first learn about the different drugs and their effects, and be familiar with signs that their children may have started to use them. This knowledge will allow them to address the topic more confidently, and with a greater level of objectivity.

4.5. RULES AND SIGNS FOR PREVENTION.

There are a number of signs to warn us that problematic substance use may have started, as well as other types of behavioural problems. Among

them, we may consider the following (Del Nogal, 2012):

- A drop in academic performance or a change in attitude towards school.

- School/work absenteeism.

- Disciplinary problems.

- Family conflicts.

- Lack of interest in activities or hobbies they used to enjoy.

- Sudden changes in behaviour or mood.

- Changes in sleep habits.

- Frequent complaints of illness or fatigue.

- Changes in appetite and weight (especially a loss of either).

- Changes in their group of friends and attempts to keep parents from meeting the new ones.

- Arguments, rows, fights, vandalism.

- Coming home later than before.

- Money or objects going missing.

- Changes in money habits: having more than usual or asking for it all the time.

As Del Nogal says, these signs are all clues or indicators that something is afoot. Often, they have to do with the use of addictive behaviours, but they may also have to do with other types of problems (or a combination of factors, as presented in section 2).

As for rules to tackle this problematic situation, we will likewise follow the instructions of Del Nogal, who highlights the following:

- Wait for the right moment to bring it up.

- Don't criticise, judge or blame.

- Don't use an accusing tone.

- Make explicit the consequences that have arisen from their use of substances.

- Make explicit the change in their patter of use over time.

- Don't use labels.

- Stand by their side.

- Don't give ultimatums or make promises we won't be able to keep later on.

- Use "I messages".

- Use the formula "you and I both know".

- Change strategies.

- Don't feel guilty, it is their decision.

We must avoid at all costs falling into the so-called "perverse triangle" of overprotection, criticism and hostility, which has been heavily analysed in the field of psychosis. We must also avoid playing the "nice guy" with "good intentions" if we hope to achieve a change in behaviour, attitudes, aptitudes and lifestyles. Thus, the situation must be faced responsibly and calmly.

Lastly, we should mention the participation of the families within the community as another way to engage in prevention and mitigate risk factors. Getting involved in social programmes offered by different public and private organisations (neighbours' associations, charities, etc.) aimed at fighting the problem of drug addiction and promoting social support structures and alternative uses of free time, helps to improve contextual conditions and helps adolescents to take on both responsibilities and adaptive and functional models.

5. ACTION PLANS FOR PREVENTION AND PROTECTIVE FACTORS

5.1. DESIGNING AND IMPLEMENTING PREVENTION PLANS IN THE FAMILY SPHERE.

In order to adapt the strategies and techniques to each participant's needs, we create individualised education programmes (IEPs). They involve specific analysis, designing action plans and methodologies on a case-by-case basis, following a single-case design framework using standar-

dised instruments to improve assessment when necessary (such as T-ASI or SDQ). The individualised education programme or IEP is a technical document whose primary function is to aid and channel each minor's individualised attention. To prepare the IEP, the participant's needs must first be assessed (as well as those of the family and social context, if possible). Next, the primary goals to work on must be singled out and formally programmed, stating the goal in operational terms and specifying the resources, activities and timetable to carry them out.

Lastly, a monthly assessment should be carried out in order to determine whether progress has been made in reaching the proposed goals. Here we can incorporate new goals that have arisen over time, as well as check off or update goals that have already been met during the period, if applicable.

In short, the individualised education programme (IEP) is a dynamic, flexible tool intended to progressively systematise social and educational actions. As such, it should be constantly revised in order to ensure a response that is suited to each minor, meaning it is permanently open to changes and adaptations.

The IEP includes the assessment, the diagnosis, and the individualised intervention plan. The goals are marked by area, and follow-up sessions are held. Annex I includes the IEP template used by Dianova Spain in its prevention programmes with at-risk youth.

In the assessment phase we detect needs, weaknesses and strengths in different areas: family, personal life, social sphere, free time, school and work. Based on this evaluation, the action plan is put into place, in a state of constant revision, with set goals and a specific methodology to reach them.

5.2. ACTION PLANS.

5.2.1. In the **family action plan**, goals are set that have to do with family communication, sharing quality time together, behaviour-management skills and conflict-resolution skills. The parenting style and relationship dynamics involved in the workings of the family are also evaluated, including attention, sense of security, care and setting limits. Each of the specific needs is dealt with using a methodology that allows for reflection and for work to be done on new patterns, along with empowerment and the acknowledgement of the family's strong points.

5.2.2. In the **social action plan**, the minor's social skills are evaluated, paying attention to their own personal resources that can aid in development and socialisation.

Among the goals, they work on skills and behaviours that will allow them to cope with a wide range of situations, allow them to improve their interpersonal relationships, and provide them with self-confidence when solving problems.

The activities are flexible, participative and dynamic, and work on different areas:

- Self-image and self-esteem.
- Emotional regulation, managing emotions: anxiety, rage, sadness.
- Communication skills. Empathy and assertiveness.
- Conflict resolution and controlling impulses.
- Pro-social values.

5.2.3. The **free-time plan** establishes goals aimed at encouraging the minor to participate in healthy free-time activities that are an alternative to drugs and alcohol. By increasing their knowledge about the different resources in the area where they live, they come away with a broader range of opportunities. Likewise, we promote creativity, play and coexistence as key elements in this area.

To work toward the goals, we set activities centred on different areas related to free time:

- Playful group games.
- Sport activities.
- Cultural activities, such as cinema, music or

- photography.
- Artistic and creative activities.
- Activities related to new technologies.

5.2.4 The **socio-occupational training and orientation plan** takes into account skills for the learning process and for entering the workforce.

The specific goals are aimed at developing basic learning skills, focusing on cognitive, procedural and instrumental content, as well as orientation toward performance at work. In other words, we carry out activities centred on motivating the minor and guiding them in the decisions they make in the realm of education and work.

The different areas that we work on are:

- Study strategies and habits.
- Evaluating needs in the socio-occupational sphere.
- Occupations and job profiles.
- Resources, educational organisations.
- Employment.

6. SKILLS AND ABILITIES FOR PARENTS

6.1. BEHAVIOUR-MANAGEMENT SKILLS.

We have repeatedly stressed the importance of setting limits and creating discipline in the family sphere, which promotes a coherent and structured environment that provides the adolescent with a sense of security. For this reason, it is important to develop contingency-management skills. In other words, it must be clear what the consequences are of following or departing from the established rules and responsibilities. The aim should be for behaviours directed at following them to be kept in place, whilst reducing or eliminating those that depart from them.

The basic idea to bear in mind is that we tend to

repeat behaviours that have had pleasant consequences for us, and tend to leave behind those that have had unpleasant consequences, or no consequences at all.

Therefore, given that we prefer to repeat behaviours that are followed by positive consequences, what parents should consider is that if they want their child to increase what they believe is a good behaviour, they need to make sure that the child receives reinforcement after carrying it out. On the other hand, if there is a behaviour they would like to see happen less often, before eliminating the positive consequences that are maintaining it, we should look for a way to offer them those same consequences but through a more appropriate path.

There are a variety of techniques related to managing contingencies: modelling, moulding, behaviour contracts, extinction, over-correction, punishment, etc.

But in order to develop any of them, adults need to be consistent and not give mixed messages about following the rules and limits. On the other hand, they should be clear and realistic, and parents should explain and think through them beforehand with their children, who should know exactly what consequences to expect when they follow or break them.

6.2. COMMUNICATION SKILLS.

Good communication skills within the family will enable parents to grow closer to their children, and relieve tensions. It is important for parents to invest time, patience and a lot of listening in order to discover who their children are, along with their preferences, abilities, limitations, qualities, defects, etc., and be able to transmit this to them in such a way that they come to accept themselves unconditionally and bring out the best of themselves, whilst being aware of their limitations.

As their children grow, parents must continually mould their forms of communication. These

should be open forms that allow for debate, discussion of different points of view, acceptance and listening. If they step down from the position of supreme, all-knowing authority, adults will find that minors become more receptive. This form of communication does not mean adopting the position of the adolescent's peer, which would not be healthy. Parents are the role models and they are the ones who must show the way. But if we propose a form of communication based on dialogue and on paying attention to emotions, when we ask questions it is to understand, not to determine the truth or to bring into question.

When communicating with adolescents it is wise to avoid preaching or imposing unsolicited advice. It is better to focus on listening, proposing, and respecting privacy and confidentiality.

According to Giorgio Nardone (2006), there are a number of forms of communication – point-making, laying blame, criticising, pointing out the bad things, saying "I told you so", preaching instead of proposing and constructing – that all generate rejection and the desire to break rules, whilst blocking possibilities and cancelling out growth and potential.

This is why it is important to work on assertive communication skills that allow parents to grow closer to their children, and promote positive relationship patterns.

6.3. CONFLICT-RESOLUTION AND NEGOTIATION SKILLS.

The ability to dialogue and negotiate opens up possibilities for finding effective solutions to conflicts that arise in the family. Apart from resolving certain interpersonal problems, training in these skills and putting them to work is a way of showing one's children an adaptive way of facing conflicts.

Often, parents use tactics based on punishment and coercion, which end up generating more tension and unpleasant situations in the family environment.

We should remember that, although adults are indeed the ones who should set the rules at home, it is important to have minors participate in these rules by allowing them to take an active role, explaining the rules to them, reasoning with them, asking for their opinions, and at times even negotiating with them and reaching a consensus, even though there are some rules that will never be up for debate.

When facing the various conflicts that arise in everyday life, reliance on negotiation will involve analysing the problem, learning the causes and the feelings that it produces in each of the parties involved, addressing possible alternative solutions, and reaching agreements that benefit the shared domestic sphere. Of course this must all be done in an environment of dialogue and respect.

6.4. EMOTION-MANAGEMENT SKILLS.

In the words of René Diekstra, "We are preventing optimal development in children when we deprive them of social and emotional education".

Emotions carry out a key function and role in our lives. They enable us to express our needs, reveal the meaning and value that the situations we are living through, and regulate our relationships with others.

Parents can learn to recognise their emotions, and to manage them. Likewise, they can learn to identify their children's emotions, act according to them, and teach their children to identify and regulate them themselves.

Sometimes there are emotional reactions that are hard to manage. They are too intense, too frequent, out of context, or highly unstable. A proper emotional education can help to express them more appropriately.

Not knowing how to manage emotions such as fear, distress, rage, emptiness, powerlessness or shame, in conjunction with other factors, can lead

people to employ harmful coping strategies such as using substances.

Relaxation and full-attention techniques, tools for controlling rage and techniques that boost positive emotions (optimism, creativity, etc.), will help in acquiring emotional regulation skills.

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PROGRESS AND CHALLENGES IN THE PREVENTION OF ADDICTIONS IN SPAIN.
A SYSTEMATIC REVIEW.

Francisco José Montero Bancalero

PhD, Huelva University.
Professor at Osuna Universtity (Spain).
Editor of www.adiccionyciencia.info.

ABSTRACT

This article consists of a systematic review of a set of addiction prevention programs carried out in the last years in Spain. Only studies that included a control group were considered. It has been noted that programs that enhanced personal skills are more effective than informative ones, and for the specific case of smoking, the evidence of its impact is contradictory. More studies validated methodologically and more visibility of the positive results of preventive programs are required.

KEYWORDS

prevention; addictions; Spain; drugs; alcohol, tobacco

1. INTRODUCTION

A systematic review is a modality of scientific research based on checking scientific sources from a specific topic and a clear purpose and using a systematic procedure of selection and critical analysis of information to get valid conclusions in response to the initial objective (Meca, 2010). Accordingly, the present work has been carried out by using a procedure with these characteristics to analyze different prevention programs in the area of the addictions.

The word prevention has its origin in the Latin language. The Royal Spanish Academy (RAE) gathers several meanings for this definition, emphasizing among them "preparation and disposition that is done at early stages to avoid a risk or to execute something" (Royal Spanish Academy, 2014). In a more specific way, the World Health Organization (WHO) speaks of "taking measures so that the disease does not appear (to reduce the risk factors) and to stop its advance and to attenuate its consequences once established" (World Health Organization, 1998). On the other hand, it is considered as a risk factor

any individual, social or environmental particularity that increases the possibility of occurrence of an event (Luengo Martín, Romero Tamames, Gómez Fragüela, Guerra López, & Lence Pereiro, 1999).

As for the addictions, these they are described as a pathological process of chronic and repeated character that affects, among other organs, the brain, and which is expressed at the behavioral level as the search and compulsive use of drugs, in spite of their harmful effects (American Association of Psychiatry, 2014). The three principal addictions considered in the prevention area are tobacco, alcohol, and drugs, and nowadays they have become part of the parents and teachers basic education (Pichardo Pimentel, 2014). Since the addictions prevention programs are intended to affect the risk factors to delay or diminish the appearance of addictions, in this systematic review there will be taken into consideration different studies in which the impacts of such programs have been evaluated.

2. METHODOLOGY

2.1. PROBLEM FORMULATION

To know what strategies are effective for the prevention of addictions in Spain, and so, to identify the advances obtained and the outstanding challenges.

2.2. STUDIES SEARCH

The search was done using formal sources from investigations in PsycInfo, Pubmed, Scopus and Dialnet databases.

2.3. INCLUSION CRITERIA

It was proposed to include experimental and quasi-experimental studies with a control group, with large samples of Spanish children and young people, describing the statistical procedure realized to determine the effect size of the prevention program. The studies were written in English or Spanish, and they were published between 2010 and 2015.

2.4. CODING OF STUDIES

An independent review organization (MJCH) was in charge of the studies codification, and it was used a quality scale, more concretely, the PEDro-Spanish Scale.

3. RESULTS

The results, from the methodological point of view and using some items from the PEDro Scale as a reference, can be seen in Table 1. As it can be stated, a total of 8 studies with quasi-experimental design were compiled.

The first study was carried through with 744 Andalusian young women in Secondary Education using several experimental conditions and control group, unrandomized, but with internal controls. It was intended to contrast the use of alcohol, tobacco, and cannabis among teenagers who had taken part in the preventive program "Prevenir para Vivir" ("Prevent to Live") and the control group. The "Prevenir para Vivir" program is designed by the Fundación de Ayuda contra la Drogadicción or FAD (Aid against Drug Addiction Foundation) and tries to stimulate several competencies related to self-control, self-esteem, social skills, as well as the healthy attitudes. It was observed that those who had been receptors of the prevention program did not always show

Ítem	Number of investigations
Total:	8
Existence of control group	8
The selection criteria were given	8
Randomly assigned subjects	0
Secret asignment	0
The results from statistical comparisons among groups were shared	8
The research provides variability and one-off measures for at least one key result	8
The assessors who measured the results were blinded	1

Table 1. A methodological analysis of the studies included in the review.
Source: Prepared by the authors on the basis of the PEDro Scale.

a smaller use of substances (Jiménez-Iglesias, Moreno, Oliva, & Ramos, 2010).

A second study evaluated the effect of problem-solving and social skills training in the framework of alcohol and other substances consumption prevention program at school (Programa Saluda) aimed at 341 subjects between 12 and 15 years old from the region of Murcia, by means of the design with four experimental conditions (one of them, the control group) and pre-test, post-test and follow-up evaluations. The results showed that the minor consumption of alcohol after one follow-up year occurred in the group that took part in the prevention program of prevention. This difference was statistically significant with regard to the control group. (Espada, Griffin, Pereira, Orgilés, & García-Fernández, 2012)

On another occasion, it was valued the efficiency of a program aimed at decreasing both the presence and the new appearance of new cases of smoking in Compulsory Secondary Education (ESO) students from Catalonia. A controlled test randomized by conglomerates was carried out, and there was a follow-up during the 4 Secondary Education years period. The educational program activities over the 4 ESO courses included role- play workshops, debates,

the creation of a machine that simulates to be a cigar and its effects, the design of bookmarks with slogans to help a friend or a relative quitting tobacco, directives to stop smoking, guides about the local resources that help to quit tobacco, advertising analysis, social and Internet networks analysis, the creation of a Facebook ©group with the participants in the study, workshops on cancer of larynx and tongue patients' vital experiences, etc. Even though the group that took part in this preventive school program registered a small number of prevalence and incidence figures of smokers' cases than the control group, these differences among groups were not statistically significant (Valdivieso-Lopez et al., 2015).

A different research evaluated the effect of the EX project in the consumption prevention quitting tobacco between teenagers. The EX project is a program adapted to Spanish from the original USA program; it supports the positive role of motivational factors, personal competencies and coping strategies in the consumption stopping (Espada et al., 2015)). This program is structured in eight sessions, and it was evaluated using a controlled randomized test in a sample of 1546 Spanish students, with six experimental conditions (three

of intervention and three as control group). The results showed that the group of participants in the program registered a major decrease in the intention of smoking and the carbon monoxide concentration, measured in parts for million (Espada, Gonzálvez, Guillén-Riquelme, Sun, & Sussman, 2014).

In some other case, it was analyzed the efficiency of a cannabis consumption prevention program among 4848 young women in Secondary Education. The program used was the "Xkpts.com", which includes information about general concepts and the cannabis effects on the organism, decision-making processes, discussion based on a video dealing with the group social pressure, a training workshop on different everyday situations where cannabis might appear, and finally, activities on the consequences of the consumption. A quasi-experimental design was set and after 15 follow-up months it was perceived a statistically significant reduction of 29% in the cannabis consumption of cannabis in the last month when compared the intervention group and the control group (Ariza et al., 2013).

On the other hand, two interventions directed to the prevention of addictions were compared, the Programa Saluda and the Programa de Entrenamiento en Habilidades para la Vida (Life Skills Training) among 13 pupils in the 3rd year of Secondary Education. The study used a quasi-experimental design that included five conditions, the Programa Saluda, the Life Skills Training, a Programa de Educación para la Salud (Health Education Program), an Attention-Placebo group condition and, finally, the control group with no intervention carried out. The groups Programa Saluda and Life Skills Training got better results in the intention of alcohol consumption in comparison with the groups of Attention-Placebo and control group without intervention. By contrast, the Programa Saluda offered the best values regarding attitude changes when dealing with drugs in comparison with the rest of (Espada Sánchez, Hernández Serrano, Orgilés Amorós, & Méndez Carrillo, 2010).

A different research valued the impact of a preventive educational program on the attitudes towards drugs consumption in 141 young women from Asturias. The intervention design was established on the base of a quasi-experimental study with four different experimental conditions and a condition for the control group. The first experimental condition consisted of information meetings, groups' dynamization targeted parents actions at the same time. The second condition was based on an addictions expert informative activities. The third condition consisted of informative activities of a specific type. Finally, the fourth condition dealt with demystifying and sensitizing informative actions, as well as the practice of social skills to face the group pressure. The post-treatment measures and of follow-up actions showed that the teenagers who were part of the intervention group registered opposite attitudes towards the use of alcohol and other drugs, which meant that awareness was being increased, and there was a less mythologized and a more realistic perception of the effects and consequences of the consumption. On the other hand, it was also perceived a better impact of an empowerment intervention in contrast with the strictly informative programs (Moral Jiménez, Sirvent Ruiz, Ovejero Bernal, & Rodríguez Díaz, 2004).

Finally, it was analyzed the effect of a three years intervention program on smoking in a population of 417 young people from Zamora and Salamanca, by means of quasi-experimental design with a control group. The preventive program included several actions such as the development of a specific library on smoking, the use of smoking banning and prevention smoking posters, as well as the start of school activities, extracurricular and community activities. In addition, teachers created cross-curricula contents about smoking, and smoking issues were included in the tutorial and guiding actions. After the intervention, the different amount of smoking pupils from the intervention group and the control group was not significant. As for the cognitive factors affecting the smoking behavior, there were only significant

differences between the experimental conditions and control conditions when dealing with the behavior perceived from brothers, equals, and teachers. The authors of the study conclude that it is very important to replace the clinical criteria with the pedagogic ones (Gómez Cruz, Barrueco Ferrero, Aparicio Coca, Maderuelo, & Torrecilla García, 2009).

4. CONCLUSIONS: PROGRESS AND CHALLENGES IN THE PREVENTION OF ADDICTIONS PROGRAMS

The above results are the basis for drawing several conclusions to study the advances attained and the outstanding challenges regarding the prevention of addictions programs:

• • Though not in all the cases, there is more evidence towards the positive effects of the addictions preventive programs.

• The multicomponent programs that promote the personal empowerment (especially the social skills and problem-solving attitudes) seem to be more effective than the merely informative ones.

• The implication of parents and teachers in the preventive programs is essential, as well as the application of this prevention at early ages.

• Regarding the specific prevention of smoking, the efficiency of the preventive programs is contradictory.

• It is compulsory to grant major visibility to the achievements of the preventive programs so that they don´t go unnoticed, and by doing this, to raise more awareness about the preventive function regarding addictions.

• It is important to promote the development of preventive programs methodologically valid, with pre and post treatment measures, control group, and with a random assignment of the subjects to the different conditions if possible.

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Review
"METHODOLOGICAL GUIDE FOR THE IMPLEMENTATION OF A PREVENTIVE, SELECTIVE AND INDICATED INTERVENTION. (ADES, 2013)"

GUÍA METODOLÓGICA PARA LA IMPLEMENTACIÓN DE UNA INTERVENCIÓN PREVENTIVA SELECTIVA E INDICADA

Antonio Jesús Molina Fernández

Psychologist.
Therapeutic coordinator,
Asociación Dianova España.

" The basic aim of prevention should consist of helping minors and teenagers so that they are not started off in drugs consumption, and if they have already begun, to prevent them from developing disorders, being the progression towards dependence one of them. Nevertheless, the general objective of drugs prevention is much wider as it is a question of accomplishing a positive and balanced development in children and teenagers so that they develop their potentials and become persons incorporated into their community and their society."

In 2013, in collaboration with the National Drugs Plan, Carmen Arbex Sanchez elaborated this Methodological Guide to facilitate the design, implementation, and evaluation of preventive programs, mainly selective and indicated prevention ones. It is an essential and applicable monograph, developed from the technical perspective of an expert person both on documentary review and the evaluation of programs and in the design and implementation of preventive actions.

"The effective drugs prevention contributes in a significant way to this positive integration of children and teenagers in their families, schools, workplaces and community. This document is focused on the prevention of the starting age of drugs consumption, as well as on the prevention of the transition towards the drug consumption disorders among minors and young people classified as being of major risk or more vulnerable, that is to say, those in whom come together a major number of risk factors and a minor proportion of protective factors. No other types of interventions, such as the treatment of drug dependence, are approached in this paper. It is not meant that these efforts are not important, in this regard it is fundamental to underline that no prevention intervention can be developed or implemented in isolation if it is intended to be effective, given the complex interaction of factors that make children and young people vulnerable to the use of substances and other conducts of risk."

The theoretical basis and the models based on the scientific evidence which are more applicable in the prevention of addictive behaviors (and other

risk behaviors) in young people are explained in this guide in a clear and brief way. Even though the subsequent examples are based on programs that work fundamentally on drugs consumption, the frames of reference (risk factors and protection and social learning mainly) are applicable for another kind of risk behaviors.

"Some years ago, drugs prevention merely warned young people about the danger of using drugs, with the result of modifying their behavior very little or nothing at all. In most recent years, professionals and citizens have placed a greater emphasis on recognizing the necessity that prevention interventions have to be as effective and efficient as possible. "

Apart from setting the theoretical models, the practical application is fundamental in this guide: Sections IV and V mainly refer to the Planning and Implementation of preventive actions (both in Selective Prevention and Indicated Prevention), as well as to the Evaluation and Quality Standards in Prevention, not only in Evaluation of Process but also in Results and Social Impact. A series of quality standards are also established as essential for the drugs consumption prevention programs.

Finally, Annexe 4 includes a series of cards with samples of Good Practices in Selective and Indicated Prevention, with European examples from prevention programs evaluated and verifiable. The documentary bases are very complete, including references from Spain and several European countries: Germany, Portugal, Netherlands, Turkey, Great Britain, Poland…

A valid, applicable, useful, easy, very well made, and very complete tool. A reference for the production of preventive programs in Spain. An obligatory monograph on a type of programs that need both investigation and implementation, which demand an update in concepts and methodologies, and require clear criteria on what parts of the preventive programs have to be promoted. To correct and eliminate. As stated in the prologue by Mr. Francisco de Asís Babín Vich, Delegate for the National Plan on Drugs.

"This guide is originated in this concern for stimulating and improving the quality of the selective and in-

dicated interventions. With this purpose, it offers an updated and wide review of different aspects to the professionals in this field that are basic for the design of this type of programs; from the risk and protection factors associated with the consumption of drugs, up to the theoretical models which sustain the selective and indicated programs and the quality criteria, as well as recommendations which are to be taken into account when designing implementing this kind of programs.

The work of Carmen Arbex, who is a recognized expert on this topic and to whom is compulsory to be grateful for this review, is a significant contribution in this field of prevention. We hope it helps to facilitate the work of all the professionals who devote themselves to work with this group of minors in situations of special vulnerability, at initial stages when it is possible to modify vital paths which otherwise might turn doomed to personal and collective suffering. "

PEOPLE COLLABORATING IN THE PRESENT ISSUE

ANTONIO JESÚS MOLINA FERNÁNDEZ

Therapeutic coordinator, Asociación Dianova España.

Associated professor in Faculty of Psicology, Universidad Complutense de Madrid.

Master in Social Problems.

Professional certificate as European Specialist in Clinical Psychology and Health.

FRANCISCO JOSÉ MONTERO BANCALERO

PhD, Huelva University.

Professor at Osuna University (Spain).

Editor of Addiction and Science Journal.

IF YOU ARE INTERESTED IN PARTICIPATING

Infonova Nº 31 / Second semester, 2016

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AUTHOR'S GUIDE

REVISTA INFONOVA: professional and academic magazine on addictions.

Infonova is a biannual publication edited by the Asociación Dianova España, with the support of the Ministry of Health, Equality and Social Policy and its National Plan on Drugs, dependent on the Spanish Government. The magazine is published in two formats: physical for national distribution and digital, accessible from our website (www. dianova.es).

The aim of this publication is to help to promote the latest breakthroughs and scientific studies relevant in the area of intervention among the professionals and researchers working in the field of addictions or any other person with an interest in this field. It is meant to spread good practices, identify trends and create a space for professionals working in different areas (educational, academical, professional, social, sanitary, etc.) to exchange knowledge and experiences.

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Papers will be between four thousand (4.000) and six thousand (6.000) words long, including the bibliographical references and the abstract.

Documents will be A4-size paper, with double line spacing, and text set in 12 point Times New Roman type, with numbered pages in consecutive order in the top right part. The title will be centered in bold capital letters in Spanish and English.

All contributions will include an abstract both in Spanish and English, no more than one hundred words, and five keywords (Spanish and English).

Book citations and bibliographical references will follow the American Psychologist Association (APA) standards.

Authors will send a brief Resume (in a separate document) including all this information: full name and surname, place of birth (city and country), academic degrees including the university's name, place of work; position, four publications maximum (if any), email, address, and if the paper is part of an institutionally formalized investigation it is compulsory to indicate the project's title, starting date, finishing date and the name of the organization financing it.