Evidence-based Practice and Training Needs in Drug Prevention: the interest and viability of the European Prevention Curriculum in prevention training in Spain

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BACKGROUND: The EUPC training series has been pilot-implemented in nine European countries under the UPC-Adapt Project. The pilot implementation of the curriculum in Spain has raised two questions: (1) what the training prevention needs are, according to the Spanish prevention agents; and (2) how the training prevention needs can be addressed via evidence-based practice. **AIM:** With the aim of analysing the interest and viability of the implementation of a prevention curriculum in the training of prevention professionals, a study was conducted with a twofold objective: 1 to explore how the prevention training has been developed in Spain and 2 to know which training needs prevention practitioners have. **METHOD AND SAMPLE:** The study was carried out through discussion groups and interviews with prevention professionals, policymakers, researchers, and students. The study involved 36 participants (61% of them women), distributed in three focus groups and seven interviews. **RESULTS:** The analysis of the information provided by drug prevention organisations, academics, and students reveals common agreement upon the lack of recognition of prevention agents and the need for definition of their skills. In relation to training, they shared the idea that a broader perspective should be incorporated, a perspective that considers the role of consumption embedded in youth cultural values and specific social settings (such as nightlife). With regard to evidence-based practice, the participants highlighted that this is not still mainstream. **CONCLUSIONS:** Taking into account the backgrounds of drug prevention professionals and stakeholders, the current research acknowledges the need to forge a common curriculum on drug prevention. Therefore, the EUPC may fit in with this need in Spain.

Keywords | Universal prevention – Training of prevention agents – Drug prevention curriculum

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1 INTRODUCTION

Evidence-based prevention intervention programmes are highly developed in the United States of America and the trend towards these programmes is coming to Europe (Axford et al., 2012). Some authors (e.g. Borntrager et al., 2009) believe that in Europe educational and healthcare services are of high quality and available to all citizens. For this reason, European countries do not need so many complementary programmes as is the case in the United States.

However, authors such as Cuijpers (2003) and McGrath et al. (2006), question whether evidence-based programmes developed in a specific context (i.e. North America) may be applicable to other contexts (i.e. Europe) because of variables such as manualisation, replication, context, and external validity and/or culture (Burkhart, 2013). Other barriers to this implementation may be the few evidence-based approaches used in everyday practice (Riemer et al., 2005), the lack of knowledge among policymakers and practitioners regarding evidence-based programmes, and a lack of funds (Axford et al., 2012).

Such obstacles can turn into effective prevention elements when there is evidence that these programmes can be implemented in real-world settings (Axford et al., 2012), when they are able to achieve the desired outcomes, and when they provide information regarding what works and for whom (Bernat et al., 2006). This evidence can be understood as proving that they are effective via rigorous evaluation (Chorpita et al., 2009). In fact, 'understanding what works for whom will enable practitioners and policy makers to tailor their efforts more effectively for the populations they are serving' (Bernat et al., 2006, p. 15). In this regard, the European Monitoring Centre for Drugs and Drug Addiction – the body in charge of providing an overview of European drug problems and the data that policymakers need to draw up laws and strategies or that practitioners require to know best practices – disseminates the results of evidence-based programmes that have been thoroughly evaluated and shown to be effective (EMCDDA, 2009, 2010). Some examples of North American evidence-based programmes implemented in Europe (Burkhart, 2013) are the Strengthening Families Programme in France, Portugal, and Spain, Communities That Care in Croatia, England and Scotland, and the Netherlands, and the Life Skills programme IPSY (Information + Psychosocial Competence = Protection) in Germany and Italy.

Durlak and DuPre (2008) highlight the fact that the maintenance of programmes is sometimes difficult, and therefore it is most important to pay attention to different phases such as addressing individual and local needs, preferences, and norms (Durlak et al., 2008; Kumpfer et al., 1995), cultural adaptation (González et al., 2010; Orte et al., 2015; Resnicow et al., 2000), programme dissemination (Durlak et al., 2008), implementation (Dane et al., 1998), trainers (Lewis et al., 1990; Uhl et al., 2010), and policies and political support (Elias, 1995; Kronsbein et al., 2011).

In order to encourage practitioners and policy makers to commit to [and consequently seek to fund] evidence-based practices, we can provide them with knowledge on the programme through the following successive and effective phases (Durlak et al., 2008): dissemination concerning the programme's existence and the value of the programme to the community, and adoption of the programme into the community and its implementation and sustainability over time. We can also help them by identifying cost-effectiveness via great accountability regarding the cost of social, therapeutic, and rehabilitative services vs. the cost of effective prevention programmes or strategies (Nation et al., 2003). In fact, we know that effective prevention strategies and programmes can be useful not only for reducing drug use, but also for modifying possible risk factors (such as delinquency, violence, unsafe sexual practices) (Blake et al., 2001).

Agents involved in the fields of education, social work, and healthcare usually show greater interest in implementing evidence-based programmes (Borntrager et al., 2009; Webb, 2001), probably because their development has an impact on the health and wellbeing of citizens (Durlak et al., 2008). In addition to this engagement, national and international stakeholders should create an environment that promotes the successful implementation of these programmes (Kronsbein et al., 2011). Here, trainers also play a very important role in maximising effectiveness. According to Uhl and Ives (2010), the motivation, empathy, and charisma that one possesses contribute to the programme's effectiveness. Therefore, there is a focus on soft skills; that is, interpersonal qualities and personal attributes (Robles, 2012). Trainers must be sensitive, competent, well trained to support the programme, and fluent in the implementation of the intervention (Lewis et al., 1990; Nation et al., 2003). Training also helps to improve the operation of the programme, to internalise objectives, to understand the theories underlying the programmes, and to generate changes from the perspective of prevention science (Shapiro et al., 2012).

1. 1 The Need for a Universal Prevention Curriculum

According to the EMCCDA (2004), universal prevention models are based on programmes that target families and school and general populations. In Spain, for example, universal prevention is mainly implemented in the educational sector through the development of personal and family competences and skills (EMCDDA, 2017) because programmes that only focus their attention on the risks of drug use are not effective in preventing drug use (Barrera et al., 2017).

Taking into account the fact that substance use is a public health problem, Bernat and Resnick (2006) suggest addressing this serious problem by bringing together scholars and practitioners. There is little evidence of effective programmes in colleges (Bernat et al., 2006) concerning what works, with whom, and why, but the implementation of evidence-based prevention programmes in universities and

other educational centres will benefit individuals, groups, and society as a whole by: (i) reducing substance use; (ii) reducing violence; (iii) improving learning; (iv) achieving better academic success, and (v) creating a better classroom and organisational climate (EMCCDA, 2017).

In order to meet health needs and the social challenges to improving the coverage and quality of universal prevention work (Bernat et al., 2006; EMCDDA, 2017), Applied Prevention Science International (APSIntl) developed the Universal Prevention Curriculum (UPC) training series (Colombo Plan International Centre, 2015). Specifically, the UPC training series aimed at helping reduce substance use and its related health, social, and economic problems. To do so, it follows the International Standards on Drug Use Prevention (UNODC, 2009; 2015) and the European Drug Prevention Quality Standards (EMCDDA, 2011).

In Europe, the UPC-Adapt training series were initially pilot-implemented in nine countries (Belgium, Estonia, Germany, Italy, Poland, the Czech Republic, Spain, Slovenia, and Croatia). To do this, the European Commission, under the Directorate-General for Migration and Home Affairs, provided the necessary financial support, and the EMCDDA (European Monitoring Centre for Drugs and Drug Addition), EUSPR (European Society for Prevention Research), and UNODC (United Nations Office on Drugs and Crime) provided the scientific rigour and logical rationale of the original UPC training series.

In the frame of the UPC-Adapt project, there were three work packages dedicated to piloting the training modules: WP 2 piloted an online training module (targeting decision, opinion, and policy makers – DOPs), WP 3 piloted a short training model (also targeting DOPs), and WP 4 piloted an academic training model (targeting students in universities or university colleges). For more information on the UPC-Adapt project, see http://upc-adapt.eu/project/

The EUPC was born in the scope of the UPC-Adapt project, at the end of the project. The E was added to it, referring to 'European', since it was adapted to the European context and aligned with the objective of the EMCDDA of taking the lead in spreading the curriculum (as a handbook) and coordinating the training, as a derivative from this European Prevention Curriculum handbook (standardised curriculum).

Nowadays the programme belongs to the EMCDDA and it is being further developed under a new EU project named ASAP for decision, opinion, and policy makers. Further information is available on the ASAP website: http://asap-training.eu/project/

Regarding prevention systems, ASAP aims to build on existing training tools (such as EDPQS and the EUPC) to bring them to a wider public in the prevention science and professional community. Related to e-learning, ASAP is developing an instrument, a virtual community of practices, to support the sharing of practices, sharing of experiences, and interaction at a distance about problems and solutions.

The EUPC training series is intended for prevention coordinators who work at the community level, are involved in the assessment and planning of prevention, select evidence-based interventions and apply them in practice, monitor and assess the process and outcomes, can supervise other specialists, and have, at least, a bachelor's degree and two years of experience in the field of prevention. It is also aimed at decision, opinion, and policy makers.

The EUPC, as a standardised curriculum, is composed of the following ten chapters: (i) Introduction; (ii) Epidemiology; (iii) Prevention Science; (iv) Evidence-Based Prevention Interventions and Policies; (v) Monitoring and Evaluation; (vi) Family-Based Prevention; (vii) School-Based and Workplace-Based Prevention; (viii) Community-Based Prevention; (ix) Environment-Based Prevention; (x) Media-Based Prevention, and (xi) Advocacy for Prevention. Nevertheless, there are different delivery modes – a short module, an extended academic module, and an online module with an e-learning basis – that bring together the areas of academia, civil society, and policy makers. The training structure has been built up as a cascade TOT model, in which trained trainers can disseminate this European prevention curriculum. Full information about the adaptation to the academic field of the EUPC and UPC may be found in Miovsky et al. (2019) and Henriques et al. (2020).

The pilot implementation in Spain raised two questions: (1) what the training prevention needs were according to Spanish prevention agents; and (2) how, that being the case, these needs could be addressed through evidence-based practice. Therefore, the contribution of this paper is twofold: it explores, via prevention practitioners, coordinators, policy makers, researchers, and students, how prevention training is developed in Spain and it identifies training needs in the target populations.

The objectives of the article were to discover the training needs of prevention agents in Spain, and to find out their opinions regarding the role given to evidence-based practice in the field of prevention. As for the specific objectives linked to these general objectives, we aimed to determine the recognition of prevention agents in Spain, the deficiencies in their training, the role afforded to evidence-based practice, and also the characteristics and possibilities of implementing specific training in prevention.

2. METHOD

2.1 Participants

The study had a total of 36 participants (61% of them women), divided into three focus groups and seven interviews. The first focus group took place in Madrid on June 2017 and was attended by 13 prevention professionals from all over Spain (53.8% of them women). The inclusion criterion for this group was that they were working in the specific field of prevention for the public administration (46.1% of the participants in this focus group) or for a third sector organisation

Professionals			Academics			Students	
	FG	INT		FG	INT		FG
Organisations	7		Nursing and physiotherapy	1		Doctorate	3
Administration	6	3	Psychology	2	3	Master's	3
			Education	3		Last year of degree	5
Men	6	2	Men	5	2	Men	1
Women	7	1	Women	1	1	Women	10

Table 1 | Participant details (N=36)
FG = focus group. INT = interview

(53.9%). These organisations were selected following the criteria of their participation in drug prevention interventions and their significance in prevention work in Spain. Interviews were carried out with those participants who were not available to attend the focus group. The second focus group took place in Palma in July 2017 and brought together seven academics (14.2% of them women) from different disciplines (health sciences, psychology, and pedagogy). The inclusion criterion was that they were working in prevention, either in research or in teaching. The third focus group also took place in Palma in July 2017 and was participated in by 11 students (90.9% of them women) doing their PhD or Master's degree or in their final undergraduate year. The inclusion criterion was that they had studied a subject with contents related to drug prevention. There were three people doing a PhD in education, three doing a Master's degree in socio-educational intervention, three in the last year of pedagogy, one in the last year of social education, and one in the last year of social work. Additionally, interviews were conducted in order to complement the information gathered in the focus groups. A total of six interviews was conducted (33.4% women), with three academics and three people in charge of prevention within the public administration. (*Table 1.*)

2.2 Instrument

A semi-structured interview was employed, using active and methodical listening (Bourdieu, 1999), along with the focus groups (Ballester et al., 2014). The questions were aligned with the research aims. In the script, including both the focus groups and the interviews with professionals, academics, and students, questions were asked regarding the professional category of the prevention agents, training needs, their opinion concerning evidence-based practice, the likelihood of implementing a prevention training agenda in the academic field, and the specific odds of doing so in their institution, the requirement or otherwise of prior training in order to gain admission to this training proposal, and the obstacles to and conditions for success.

2.3 Procedure and information analysis

A qualitative design was used with the focus groups and interviews with the three types of informants for methodological triangulation. The script for the focus groups and interviews was the one used in the framework of the European UPC-Adapt project for the validation of standardised training in the field of prevention in the European Union. Contact was made with the participants, appointments were arranged, and the interviews and focus groups were conducted. One focus group was carried out with professionals, another with academics, and one with students. Of the three focus groups, the one with the professionals was held in Madrid (at the headquarters of the *Plan Nacional Sobre Drogas*), to enable the attendance of expert professionals from all over the country. The other two took place in Palma (on the campus of the University of the Balearic Islands). In the case of the interviews, except for one that was face to face, all were held via videoconferencing.

As for the analysis of the information, the methodological proposal used was qualitative content analysis. For the extraction, the information from the transcriptions of the interviews and focus groups was classified using the NVIVO11 qualitative data analysis program. The information collected was categorised on the basis of the issues that arose in the study participants' answers. The scripted questions from the interview/focus group structured the prior categories, whereas the information that went beyond the questions posed in the script was collected as emerging categories.

Correspondence analysis and concordance analysis were also performed. First, in the correspondence analysis developed here, the expertise of the informants (nominal variable) in the interview or focus group was related to their identification of the need for training in prevention (ordinal variable). This is a relationship that can be studied according to the specific relationships between each of the levels of expertise (objective position) and the identification of training needs (interpretative position). The existence of a relationship or otherwise between the variables was investigated using Pearson's Chi-square hypothesis test.

Second, concordance analysis was conducted. The aim was to check the concordance that had been observed internally, group by group, and between the three types of informants, in relation to the key question of training needs. After the presence of correspondences between the informants and their assessment of the need had been demonstrated, concordance analysis between the diverse informants was performed.

Item	Main ideas
Professional category	Professional activity in the field of prevention needs objectives and competences to be defined. There are two main types of professionals in prevention: one aimed more at coordination and the other at implementation.
Recognition	Lack of specific recognition. Difficulty of obtaining recognition given the demand for results in the short term.
Specific training	Professionals from very different backgrounds. Heterogeneous needs. Global vision of prevention: consumption perspective and weight of cultural values and of agents such as the environment or advertising. Given the diversity of the agents' professional backgrounds, the need to build a common scope and curriculum on prevention.
Evidence-based programmes	Training in how to implement on the basis of evidence Demand for greater centrality of these programmes. Link theory with current empirical research.
Possibilities of implementation and benefits	Need for greater transversality of university studies in order to implement the training. Difficulties in the field of undergraduate and postgraduate studies given the academic structure. Demand for advocacy. A closer relationship between institutions, universities, and professionals in prevention as a benefit.
Obstacles to and conditions for success	Cognitive, cultural, academic, and institutional obstacles. Conditions for success: quality, funding, and student satisfaction.

Table 2 | Tabular summary of the results

3 RESULTS

From the content tree structuring the script of the interviews and focus groups, the information from the results was arranged in different blocks relating to: i) the professional category of those working in prevention; ii) recognition for the professional in prevention; iii) specific training of professionals in prevention; iv) opinions concerning evidence-based programmes; v) the possibilities of implementing specific training in prevention and its benefits; vi) the obstacles to and conditions for success. (*Table 2.)*

First of all, as far as the professional category in prevention is concerned, the participants in both the interviews and focus groups stressed the non-existence of a recognised professional category. In order for there to be one, its competencies and objectives must be delimited. In addition, it must distinguish between one line that is more related to coordination and another line more oriented towards implementation. Currently, what do exist, according to the interviewees, are heterogeneous profiles of professionals in prevention.

Second, regarding the specific recognition of the figure of an agent in prevention, this needs to be valued, as claimed in the interviews and focus groups. It is a figure that has emerged from the health sector and from professions such as medicine, nursing, and psychology, but which is expanding its trajectory towards professions such as social education and social work. This lack of recognition is linked to the difficulty of carrying out preventive work in a social context that demands short-term results. According to what was explained in the interviews, recognition will improve if quality prevention underpinned by evidence-based practice – or, in other words, with proven results – is carried out.

The science of prevention is now being developed. This brings us all together. From health professions to social education professionals, evidently psychology... and those not strictly linked to health. From the perspective of a professional profile, it doesn't exist. People don't recognise it as a profession in prevention. It would be really good if this profile were to come in as we could carry out interdepartmental training activities in this field. (Academic. Man. Education sciences. Focus group among academics.)

Third, in relation to training needs, the people participating in the fieldwork stated that it is a job or occupation with professionals from many different disciplines, which means that the training needs are exceedingly heterogeneous, and that a common field must be forged. They considered that is necessary to improve training whilst taking into account the diversity of profiles, depending on who the training is aimed at (technicians/coordinators, facilitators/trainers, mediators – teachers, families, coordinators of activities, etc. – policy makers). Various training models were also distinguished, depending on the type of prevention: selective, indicated, and universal. There were also different training needs contingent on the field of application (family, school, work, community).

Along the same lines, demands were voiced for training in the spheres of undergraduate degrees (with emphasis on both the theoretical basis and on giving more weight to practice), postgraduate degrees (combination of a homogeneous curriculum and some specific pathways), and ongoing training (online courses, summer courses, short training courses for professionals, and accreditation courses, amongst others).

In the interviews and focus groups, the training elements that could remedy the existing deficiencies were raised, ,

such as higher-quality basic training, including theoretical models of prevention and medical, psychological, and educational bases:

All the biological, psychological frameworks, models, and so on are explained, but they do not tie in afterwards with how this has to implemented, in what way, what we are talking about, or how to work. A theoretical part is taught, but this is not linked to what actually works and how to put it into practice. The proposal must be theoretical and practical. The academic methodology itself must enable work that is more closely linked to professional practice. (Professional. Woman. Third sector organisation. Focus group among professionals.)

The interviewees, speaking from the perspective of consumption and including agents such as the environment, social relations, and advertising, among others, pointed out the importance of making a transition from a strictly clinical vision to a more global vision. This implies emphasising these issues in training in prevention. Training is required in order to gain a better understanding of the contexts of young people, their social dynamics, and the cultural meanings they attach to substance use:

I believe this vision is necessary, beyond 'say no'; professionals must have skills to promote critical thinking. Drugs exist, they're here, they make up part of society ...we're going to see them from a multidisciplinary viewpoint, rather than from a more global perspective. Yes, there are many theoretical concepts, but they are still talking about dependency on drugs, about addictions from a perspective that is closely linked to illness. If you talk to a person who is a professional working with young people and whose speciality is prevention, they will talk to you about consumption, about substances, about relationships, about the environment, about critical thinking, about where drugs come from, about advertising; there are other things. (Professional. Woman. Public administration agency. Interview.)

Fourth, opinions regarding evidence-based programmes were collected. In this sense, the importance of placing value on evidence-based practice was highlighted; investing in what works as an efficient, effective way of investing resources. And this evidence-based practice must form part of the training content, linking theory with current empirical research. In other words, as well as the biological, psychological, and social frameworks and models specific to training in prevention, training is required in how to implement by drawing from evidence:

Often, interventions are carried out that are very counter-preventive because there is no knowledge of prevention and things are implemented on the basis of 'I believe'. And enough is enough. There is evidence, there is knowledge, there are programme assessments, we know what works, or what doesn't work. (Professional. Woman. Public administration agency. Focus group among professionals.)

Emphasis must be placed on the need to value the evidence-based programmes that have been validated. Evidence-based programmes and instruments that enable good change assessments to be conducted, whatever. (Academic. Man. Education sciences. Academic focus group.)

The training processes for prevention agents must place quality at the centre, and continuously relate the theoretical content to the intervention being assessed. Evidence-based practice also has its detractors, as was pointed out by the professional and academic participants in the study. Technicians in prevention need to abandon prior positions that were not based on evidence. The interviewees confirmed the heterogeneous nature and diversity of intervention proposals in operation even without being accredited as effective, when there are catalogues indicating which programmes work.

Right now you go doing...you work on life skills, circumstances, risks, you do a lot, but in the end it's a question of faith. Because you don't know to what extent, whether in three years this will have served the kids in any way. As the instruments haven't been validated and there's no follow-up, they're not even expected. (Academic. Man. Psychology. Academic focus group.)

In fifth place, in relation to the possibility of implementing specific training in prevention and its benefits, information was mainly gathered from the field of undergraduate and postgraduate degrees. This was information provided by the academic participants in the study through a focus group. No mention was made of the possibility of applying other formats, such as online courses or continuing education courses. Greater transversality was proposed in undergraduate and postgraduate degrees by way of modules, some of the subjects, and activities. Meanwhile, the difficulty caused by the configuration of the studies and the academic structure was confirmed. The interviewees also indicated the need for political advocacy on behalf of both professionals and academics in order to be able to manage to develop and implement specific training. As a benefit of specific training in prevention, it was emphasised that this would draw universities, institutions, and professionals together.

In sixth and last place, in fieldwork, reference was made to the obstacles to, and conditions for, the success of specific training in prevention. Some obstacles were detected: cognitive (resistance to incorporating new knowledge), cultural (little value placed on prevention), academic (prevention science does not have the central importance it does in the Anglo-Saxon context), and institutional (the need for political advocacy in order to develop master's-type training programmes). Regarding the conditions for success, they stressed the importance of funding quality preventive training programmes, inspired by evidence-based practice and programmes. Further on, student satisfaction should play a key role in the sustainability of these training proposals:

Enthusiasm, motivation. Perhaps I'm saying this because for me it's a bit of a concern. When students start they're enthusiastic and in the third year they just want to finish. It has to be made somewhat more dynamic, to speak to them, to connect them with reality, so that they see that this is useful. (Academic. Woman. Social Work. Interview.)

		Contribution of the points to the inertia of the dimension		
Expertise	Mass	Dimension 1	Dimension 2	Inertia
Professionals	**0.444**	**0.553**	0.003	0.204
Academics	**0.278**	**0.177**	**0.545**	0.093
Students	**0.278**	**0.270**	**0.452**	0.122
Total	1.000	1.000	1.000	0.419

		Contribution of the points to the inertia of the dimension		
Training needs	Mass	Dimension 1	Dimension 2	Inertia
There are needs	**0.750**	**0.176**	**0.074**	0.069
Doubts	**0.028**	0.073	**0.899**	0.072
No needs	**0.028**	0.094	0.003	0.035
Expresses no opinion	**0.194**	**0.657**	0.024	0.243
Total	1.000	1.000	1.000	0.419

Table 3 | Correspondence analysis. Contribution of the points to the inertia of the dimension

A significant associative relationship was seen between expertise and the position expressed with respect to the training needs in prevention (Chi-Square=15.067; p=0.020; p<0.05). For the correspondence analysis, *Table 1* and *Table 2* showed the coordinates of each of the categories in both dimensions: the position of the categories on the X-axis (Dimension 1) and Y-axis (Dimension 2). Dimension 1 was the most important and was defined in particular by the expertise of the professionals (0.553), as well as by the general identification of the training need (0.176) and by silence concerning the needs (0.657). Dimension 2 was defined by the expertise of the academics (0.545) and students (0.452) and by the doubts (0.899). It should be noted that, in the variable 'training needs', the levels 'doubts' and 'no needs' had a low response rate and caused a certain anomaly. (*Table 3.)*

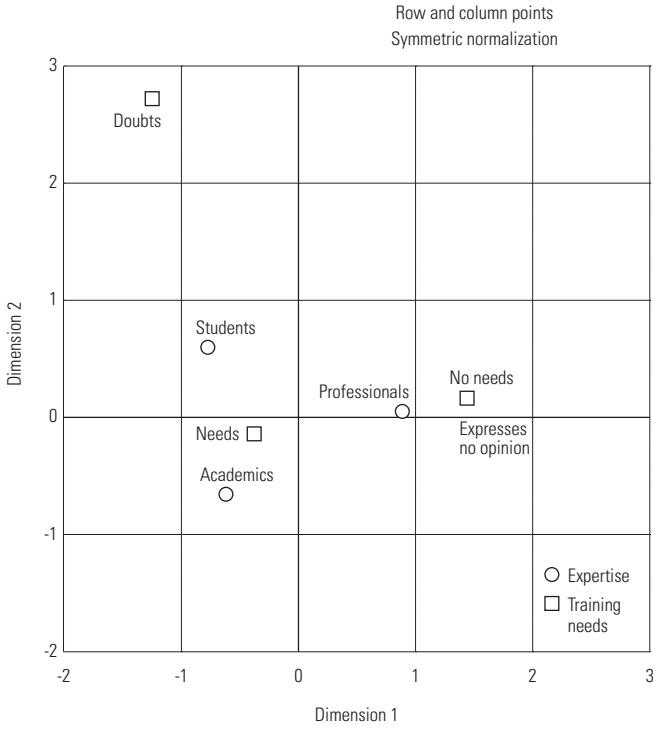

Figure 1 | Correspondence analysis

In *Figure 1*, the absolute contributions were interpreted on the basis of their weighting, as their position – the distance between each level of the variables – was weighted according to their mass. Thus, as well as observing the coordinates, we considered the number of elements included in each modality – their mass. In Dimension 1, the most important one (88.8%), it could be observed how the difference in mass explained that the points that fall far away from the centroid (such as doubts) made small absolute contributions (without importance), and vice versa, that points nearby, with low points on the coordinate, achieved high contributions in explaining the dimension, such as the training needs.

Lastly, concordance analysis was performed (*Table 4*). High percentages of coincidence were observed in each group with respect to the needs, altering the dominant explanation regarding the needs, because of the high proportion of professionals who expressed no opinion (43.75%).

DISCUSSION AND CONCLUSION

The participants identified certain lines of action in accordance with the following definition of needs:

(1) the need to harmonise the two basic areas (health and social) from which substance use prevention interventions are developed, by taking into account the economic element (cost-benefit relationship, appropriate investment) as the guiding principle for defining prevention policies and designing intervention programmes;

(2) the need to generalise a mentality and a context focused on prevention science at all levels which will guarantee the development and implementation of initiatives whose effectiveness has been proven;

Expertise								
Training needs	Professionals	%	Academics	%	Students	%	Total	%
There are needs	8	50.00	10	100.00	9	90.00	27	75.00
Doubts	0	0.00	0	0,00	1	10.00	1	2.78
No needs	1	6.25	0	0.00	0	0.00	1	2.78
Expresses no opinion	7	43.75	0	0.00	0	0.00	7	19.44
Total	16	100.0	10	100.00	10	100.00	36	100.00

Table 4 | Concordance analysis

(3) the need to motivate and stimulate engagement and the coordinated work of all the agents involved in prevention – politically, technically, and academically – in order to carry out a joint effort that will enable the aim indicated in need 2.

The study participants referred to the need to break with the dynamics with which work has been carried out to date in the field of prevention, in order to make it possible to create a culture of effective prevention. Two of the obstacles identified were (1) the great heterogeneity of professional profiles and, with this, the heterogeneous nature of their needs (training, for instance) and action models; (2) the lack of recognition and value of prevention science at the academic, labour, and professional levels. The latter obstacle coincides with what Axford et al. (2012) stated concerning resistance to the development of prevention based on scientific evidence in certain fields, such as, for instance, the social one. The invisibilisation and lack of awareness of the theoretical basis and methodology of evidence-based prevention, especially on the part of policy makers and professionals, underpins this idea, which is intimately related to the lack of funding for programmes whose effectiveness has been proved for the sake of programmes that do not comply with the requirements, as regards design and assessment, of evidence-based initiatives (Axford et al., 2012; Durlak et al., 2008).

The results show a generalised agreement that training is the cornerstone of overcoming these obstacles and enabling changes to be brought about in prevention science (Shapiro et al., 2012). Nevertheless, defining a training model that will create competent professional profiles in order to develop evidence-based prevention initiatives is a more complex task. The heterogeneity of professionals, disciplines, and fields from which prevention intervention is approached in Spain requires a flexible training model, with common, interdisciplinary areas, which will encourage transversality between the different training modalities, and which will be sustainable over time.

Following one of the main ideas mentioned at the beginning, the study participants pointed to the need for a qualitative transformation of the current training model, based on the inclusion of theoretical prevention models that would afford a much more global, rather than exclusively clinical perspective. The emphasis on social and personal competencies in the training of the people directly involved in prevention (whether practitioners, professionals, stakeholders, etc.) (Uhl et al., 2010; Robles, 2012 Lewis et al., 1990; Nation et al., 2003; Shapiro et al., 2012) must not lead to neglecting other aspects that were also indicated as basic in this training process, such as the inclusion of multiple fields in which it is possible to intervene, interdisciplinary collaborative work, and the dissemination and advertising of evidence-based prevention.

Dissemination is a key element in order to raise awareness of public opinion and generate greater political involvement, in terms of both planning and funding. This is why training in this field is a recurring theme in debates with professionals: 'How to get the message across' is the key question in the debate on prevention in Spain. Without forgetting the need to build a body of trained, competent, and motivated professionals capable of correctly implementing initiatives based on scientific evidence, it is also necessary for these professionals to be able to disseminate and spread prevention practice. In this sense, it would be necessary to make known the successful initiatives applied today (good practices and experiences) in the field of substance use prevention in Spain as a way of getting this message across.

For professionals (current and future) working in prevention, the training model proposed by the EUPC seems to be a decisive step towards greater effectiveness in preventive action in the European context. The fact that policy makers are included in this training activity is particularly interesting, since they form an essential link in the process of achieving greater commitment to an effective prevention model. The arguments imply clear lines of intervention and policies, ranging from raising public awareness to greater investment, better training – which also includes policy makers – and better planning and coordination of interventions.

Perhaps a more detailed analysis of the training options that exist in this field in Spain could have allowed the analysis of the needs to be contrasted with the practices and real offer, and to determine more accurately the gaps in training that need covering. Inevitably, designing a training model that enables transformation towards an effective preventive policy will at some time require this analysis. This paper therefore opens a line of future research and assessment of training in the field of prevention in Spain in line with international organisations.

As a conclusion, despite the fact that the study highlights the lack of a common, standardised training curriculum

that provides common criteria to develop and regulate prevention interventions, the results of the analysis of the focus groups and interviews showed, above all, a generalised interest in a standardised prevention curriculum. This interest was expressed as a demand to clearly define quality prevention models with internationally accepted unified standards.

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Ethical requirements: The paper has fulfilled all the ethical requirements. A written informed consent was asked for from all participants, also including their permission to record the discussion groups and interviews. The participants received feedback through a report of the results of the analysis in order to validate it.

Ethical particulars: Research and fieldwork of this article proposal is on training needs of prevention professionals and the creation of a prevention curriculum. It does not involve patients, so no informed consent was required.

Role of authors: Carmen Orte, Joan Amer, Maria Antònia Gomila and Belén Pascual designed the study and proposed study design. Joan Amer designed the initial form of the manuscript. Annemie Coone ellaborated the background of UPC, UPC-Adapt, EUPC and ASAP Project. Maria Antònia Gomila and Belén Pascual were involved in the field work. Carmen Orte supervised the results and discussion/conclusion section. All authors contributed to the emergence article and approved the final version of the manuscript.

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