A framework for practitioners and policy makers

in effective alcohol, tobacco, and other drug prevention programming efforts

Best Practices in ATOD Prevention Handbook

Featuring:

- **Basic prevention principles, including points from the Center for Substance Abuse Prevention's Guidelines and Benchmarks for Effective Prevention Programming**
- **Key research results that discuss risk and protective factors and other recent prevention findings**
- **Application of basic principles, key reseach results, and other knowledge from research and experience to the details of conducting prevention programs**

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Best Practices in ATOD Prevention Handbook

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INTRODUCTION

? What constitutes *"best practice"* in the primary prevention of ATOD (alcohol, tobacco, and other drug) abuse?

The answer to this question is complex. To effectively answer it, many things must be considered, including:

- The criteria for success.
- The many levels of decision-making needed to move prevention efforts from concern about the problem to full implementation of effective action.
- That few generalities universally apply across the diverse situations associated with desired prevention efforts. Each community (urban, rural, stable, deteriorating, or growing) is unique and most have a variety of populations or situations within each.
- That every community has different strengths that can support the positive development of youth.
- That the identity and background of those pursuing prevention can be very diverse.
- That the amount of resources initially available to prevention in a given time and place can be tiny or immense and the nature of those resources (money, public interest, volunteer commitment, equipment, access to media, etc.) can also greatly vary.

About the Best Practices Handbook

This *Best Practices Handbook* was created to deal with the complexities of determining what constitutes best practice in prevention efforts in two ways.

1. The scope of issue is narrowed to some extent. As a document produced for the Division of Community Health and Prevention of the Illinois Department of Human Services (DHS), it is tailored to the issues addressed by the Illinois ATOD primary (Universal and Selective) prevention system. This system, established by the Prevention Division of the former Department of Alcoholism and Substance Abuse, directs most of its ATOD prevention efforts toward preventing use by youth. This complements the ATOD treatment system, which provides a range of (Indicated) interventions for youth and adult ATOD users. The rationale for focusing primary prevention efforts on youth (and those who influence youth) includes:
   - Nearly all adult substance abusers began use during adolescence or childhood, typically starting with “gateway” drugs (alcohol, tobacco, and marijuana).
   - The earlier in life a young person begins to use drugs, the greater likelihood of AOD problems in adulthood.

- Many of the methods of primary prevention (e.g., media campaigns, preventive education, etc.) are generally insufficient for stopping use that has already begun.
- Drug use during childhood and adolescence can have profound, life-long negative effects.

"The use of one or more classes of drugs between adolescence and young adulthood has been found to interfere with normal development by compromising physical and psychological health, the performance of traditional work and family roles, and the level of education achieved in young adulthood (Kandel et al, 1986 as discussed in Gerstein & Green, pp. 19-20).

- The vast majority of Americans agree that youth should not be using alcohol, tobacco, or other drugs.

2. Three different levels of analysis are used.

   A. The first level, "Basic Principles," features points from the Center for Substance Abuse Prevention's *Guidelines and Benchmarks for Effective Prevention Programming*. Also included are points from other sources.

   B. The second level, "Key Research Results," discusses risk and protective factors, the recent "National Structured Evaluation" on substance abuse prevention, and some other recent research relevant to prevention practice.

   C. The third level applies the first two sections and other knowledge from research and experience to the details of conducting prevention programs.

Rather than read the entire handbook, a reader may want to start with just Chapters 1-3 and then choose one or more of the remaining chapters that correspond to the prevention approach(es) relevant to their current situation.

The purpose of the *Best Practices Handbook* is to give prevention practitioners and policy makers a framework for examining what we know about effective prevention programming. There is no single "last word" about best practices in prevention, but the amount and sophistication of knowledge already acquired about prevention is extensive. This Handbook is intended to be an easy to understand, yet broadly illustrative guide, to research based prevention practices.

CHAPTER 1: BASIC PRINCIPLES

CSAP Guidelines

The federal government's Center for Substance Abuse Prevention published the following guidelines for effective prevention in 1997 (*Guidelines and Benchmarks for Prevention Programming).*

1. **Knowledge of the Target Population.** Base the prevention effort on a clear understanding and definition of the populations and groups to be influenced and a careful consideration of their patterns of substance abuse, cultures, value systems, and likelihood of responsiveness to the effort.

2. **Clarity and Realism of Expected Results.** Focus the prevention effort on specific, realistic goals. Consider the goals of a specific prevention effort in the context of the larger prevention goals of the community, State, or Nation.

3. **Corroborative Empirical Evidence of Potential Effectiveness.** When available, gather and use reliable, empirical evidence of effectiveness from comparable programs to select and guide the current effort.

4. **Conceptual Soundness.** Use a logical conceptual framework to connect the prevention effort with its intended results and ultimately with the overall goal of reducing substance abuse. Base the conceptual framework used to explain the prevention effort on existing knowledge and refine or revise as needed to reflect new learning from public health, behavioral sciences, and other fields.

5. **Inclusive Participation.** Include in the prevention effort activities that secure and maintain buy-in of key decision makers and leaders as well as of those organizations and individuals who directly or indirectly will be responsible for implementing the effort.

6. **System Integration.** Design and implement the prevention effort to build on and, in turn, support related prevention efforts. Design and implement the prevention effort with consideration for the strains that it may place on different parts of the system.

7. **Appropriate Structuring of the Effort.** Carry out the prevention effort through activities consistent with the availability of personnel, resources, and realistic opportunities for implementation. Create opportunities for the exercise of leadership across a broad range of participants.

8. **Appropriateness of Timing, Intensity, and Duration.** Time the prevention effort so that implementation coincides with a period of peak community concern or the target population's readiness for the change intended. Design the prevention effort for delivery with sufficient intensity (in exposure, breadth, and impact) to produce its intended results and apply the effort over appropriate duration so that results can be sustained.

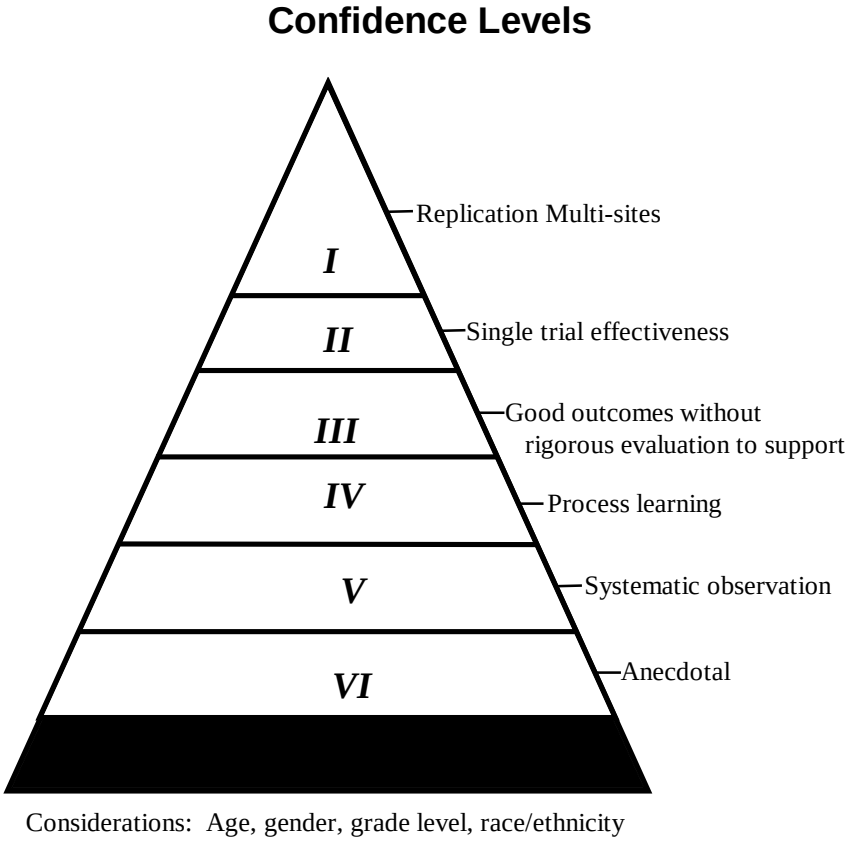
9. **Attention to Quality of Delivery.** Design and implement the prevention effort for the highest possible quality in each step of its execution.

10. **Commitment to Evaluation and Effort Refinement.** Pay adequate attention to monitoring and process and outcome evaluation.

In a separate document, titled "Science Driven," CSAP gives a list of six ways that prevention can be strengthened through application of scientific principles. The point is not that every prevention effort must have all six characteristics, but that each item on the list can be a way to apply scientific principles to prevention, and so increase the likelihood of ultimate success of a prevention initiative. The six items are:

- Randomized clinical trials
- Demonstration Projects (repeatedly documented in at least 3 projects under many environmental conditions)
- Theory Base in the Literature
- Follow substance abuse and/or other prevention principles established through science
- Process and outcome measures
- Technology Transfer – (practice application)

The following diagram shows how increasing the degree of scientific support for knowledge can increase confidence in the validity of the knowledge.



Other Basic Principles

1. No aspect of a prevention effort should encourage or condone illegal or unhealthy use of alcohol or other drugs.

2. Prevention efforts should conform to ethical guidelines.

3. The DHS funded ATOD prevention system is dedicated to community level (Universal Prevention) change rather than individual "indicated" client intervention. Providing direct, primary prevention services to groups of people (Selective Prevention) is acceptable, but best practice in this prevention system is to improve community systems and institutionalize those improvements. New approaches to direct group services may need to be piloted by prevention agencies, but ultimately the goal is to infuse such programs into communities.

CHAPTER 2: KEY RESEARCH RESULTS

This chapter highlights research findings that cut across prevention strategies. Research findings pertinent to particular approaches (e.g., preventive education) are presented in later chapters that discuss those approaches.

Risk and Protective Factors

ATOD risk factor research typically relates to the question:

> ? **What characteristics of youth, their families, and their communities tend to be more present in the backgrounds of teenage ATOD *users* than is the case with *non-users*?**

This research leads to clues about what conditions might contribute to the development of youth ATOD use.

ATOD protective factor research typically focuses on cases in which youth experiencing substantial risk of ATOD problems choose to avoid drug use, and asks:

> ? **What characteristics tend to be present in the backgrounds of those youth who remain ATOD *non-users* in spite of experiencing substantial risk factors?**

Risk and protective factor research provides valuable information for prevention practices, but it does not solve the problem of determining the best way to pursue ATOD prevention in a particular place and time, with particular resources. The outcome-based prevention planning and evaluation process used by the DHS ATOD prevention system helps apply risk and protective factor research by putting it in the context of a logical planning process.

Best practice in prevention includes helping communities increase youth exposure to protective factors (see Appendix B) and helping communities decrease risk conditions (see Appendix A). The particular list given in Appendix A differs from some others (such as those listed by Hawkins, Catalano, and Miller, 1992) in that it emphasizes societal (e.g. legal or normative) conditions and broad interpersonal conditions rather than individuals' vulnerabilities. Thus:

- Factors (e.g., deviant childhood aggression) irrelevant to community-wide primary prevention are not included.
- Factors (e.g., pro-ATOD media messages) that operate only on whole populations are included.
- Factors that can apply either to an individual or population-wide are included as population-wide conditions. So, for example, the question is not whether any particular

family has pro-ATOD norms, but whether there is sufficient number of such families to constitute a risk condition for youth in a community.

The use of ***risk conditions*** helps focus prevention on shared community problems that can be addressed by primary prevention strategies, rather than narrowing attention (and perhaps implicit blame) to one subgroup in a community. Risk factor research is **NOT** sufficiently predictive to justify exposure of people to primary prevention initiatives if there may be an associated stigma of "at-risk."

Avoiding this may sometimes be only a matter of how a program is described to participants and others, but in other situations may require delivering a prevention program to a mixed group of "at-risk" and other participants, or choice of a different program. Intervention programs that target youth or families who are already evidencing problems have greater latitude in this regard, but intervention programs are beyond the scope of this Handbook.

One of the implications of community risk conditions is that the amount of success to expect from a prevention initiative depends on how many risk conditions exist in a community and how many of those will be lessened (and to what extent) by the initiative. A community with multiple risk conditions will achieve only relative progress as each issue is addressed. A more dramatic cumulative effect becomes visible only after enough layers have been addressed to substantially affect large groups of youth.

CSAP's "National Structured Evaluation"

CSAP's "National Structured Evaluation" study focused on answering the question, What types of prevention initiatives, among those currently in use, produce measurable positive impact on ATOD outcomes? The study gathered all reported cases of U.S. prevention programs with measured outcomes relevant to AOD (tobacco prevention research was examined separately and discussed in an appendix to the evaluation report). The results of the "National Structured Evaluation" are discussed in Appendix C.

Patterns of Youth Substance Use

1995 data from a weighted random sample of 9174 Illinois youth in grades 7-12 was analyzed in a three-phase process to identify relevant patterns of use.
Results were:

1. Use rates for the twelve substances included in the survey fell into four factor categories or dimensions. Use of any drug in a category was correlated with use of other drugs in that category. The categories were labeled "gateway" (alcohol, tobacco, and marijuana), "pharmacological" (uppers, downers, and LSD), "high stigma" (cocaine, crack, heroin, PCP, and designer drugs), and "inhalants" (inhalants grouped with no other substance).
2. Given the above categories, six use pattern clusters, or groups, emerged. The largest group (67.7%) was composed of youth who either did not use any drugs or used at very low rates (e.g., tried once or twice). The next largest group (26.0%) was composed of youth who used gateway drugs but not much from the other three dimensions. Progression for each user seemed to go from non-users to gateway, and then either halt (in most cases) or progress to one of the other four drug use groups. Three of the other four groups were "hard-core" in that their use levels were high across all four dimensions.

The fourth group was "pharmaceutical" in that they tended to primarily use gateway and pharmacological drugs, and inhalants to a lesser extent.

3. Differentiation between the Low Use/No Use cluster and the Gateway cluster featured variables of peer approval for drug use, such as whether close friends would try to stop respondents' use of particular drugs. Differentiation between the Gateway cluster and the four other drug-using clusters included a variety of variables, with the first two being availability and then peer approval/disapproval.

Conclusions were:

1. Limiting availability is the single most powerful way of preventing drug use among youths.
2. Prevention initiatives which successfully interrupt the power of perceived peer approval for gateway drug use are key to success in lowering youth gateway drug use.
3. Programs which increase youths' perceptions of drug harm or which increase parents' capacity to successfully maintain drug-free family norms play some part in prevention, and may have the potential for more effect in the future.
4. Youth involvement in religion or sports may have some protective effect, but this effect is a weak one and is limited to a relatively small group of youth among those who are already using gateway drugs.
5. Primary ATOD prevention in Illinois should mainly focus on slowing the rate of progression of youth from Low/No Use to Gateway groups. Youths in the Hard-core and Pharmaceutical groups, as well as many youths in Gateway group, need a more intensive ATOD intervention and formal assessment of the need for substance abuse treatment.

The conclusions from the National Structured Evaluation, the "Patterns" study, and other research help point the way toward increasing the effectiveness of prevention programs. Application of this knowledge in particular communities, however, requires familiarity with the major risk conditions that may be present, and with the range of potential prevention approaches. The connection between community risk conditions and prevention program choices is discussed in Chapter 3.

CHAPTER 3: INTRODUCTION TO PREVENTION APPROACHES

Various definitions and classifications have been used to describe prevention approaches. The categories defined in this *Best Practices Handbook* are based on many existing ones, but differ in some ways from others. The categories used here have been selected to highlight differences of intended method of producing a preventive effect. This allows for discussion of differential effectiveness of different "approaches" to primary prevention of ATOD abuse.

One challenge of defining a classification system for prevention approaches is the growing recognition that the magnitude and success potential of a prevention initiative can be greatly increased by starting with the creation of a community prevention coalition rather than through independent efforts. Therefore, creation of a well functioning coalition becomes a key step toward achieving a variety of prevention goals. Accordingly, the first phase of the "Best Practices" effort, created in 1996 by the Center for Prevention Research and Development, University of Illinois, was the publication titled "Community Coalitions" which focused on creating and maintaining coalitions.

Prevention Initiatives for Coalitions

The remainder of this *Best Practices Handbook* focuses on eight categories of prevention initiatives that can be carried out through coalitions. In many cases, these initiatives can be implemented through partnerships rather than a formal coalition.

In implementing a prevention initiative, the following points are important to remember.

The key to success in prevention is knowing:

1. **Which approaches work and which do not, based on research.**
2. **Which approaches tend to be most effective, in proportion to the resources they require.**
3. **How to choose among the approaches that could work, given a particular local situation.**
4. **How to effectively carry out that approach.**

The following paragraphs briefly describe eight prevention approaches covered in this *Best Practices Handbook*, along with reference to the chapter in which each approach is discussed.

- **Chapter 4: Regulatory Strategies.** One of the strongest effects found in years of prevention research is a reduction in ATOD use as a result of decreased availability. When the number of sales outlets for alcohol or tobacco or dealers of illicit drugs decreases, ATOD use also decreases. When laws against underage purchases are

enforced, ATOD use decreases. When prices rise, ATOD use decreases, especially among youth.

- **Chapter 5: Mass Communication. The g**rowth of alcohol and tobacco use has been "fueled" by mass marketing, and decreasing use of those and other drugs depends to some extent on "counter-marketing." Counter-marketing includes informational campaigns, use of the media for advocacy, counter-advertising, and participatory campaigns. Media campaigns may be insufficient as a sole approach, but can be an important part of larger initiatives.

- **Chapter 6: Parent Programs.** Various kinds of parent programs can be effective in prevention,. The most effective programs help parents establish and support ATOD standards and issues, including parent advocacy initiatives, informational courses, parent communication networks, or support groups. In places where many parents are overwhelmed by problems such as poverty or illness, family support programs that furnish child care, job training, medical services, counseling, or other vital services may assist ATOD-focused prevention components. Similarly, if parents need help improving family management skills, courses that address this are part of the prevention mix.

- **Chapter 7: Preventive Education for Adolescents or Children.** Age-appropriate drug information is needed by youth, but knowledge alone has a small preventive effect. Younger children can gain from preventive education, but of a very different type than adolescent programs. Preventive education for adolescents or children can have a positive effect, particularly as part of a broader prevention initiative, but needs to be based on research and evaluation results that show what kind of programs are effective.

- **Chapter 8: Peer Influence Programs.** The distinguishing characteristic of peer influence programs is their attempt to establish or strengthen a drug-free peer subculture among target groups of youth. Peer leadership programs or other programs with a peer influence component can assist youth to be role models and support persons for same-aged or younger peers.

- **Chapter 9: Educational Enhancement.** Schools are complex institutions that can have many intended and unintended effects on youth. School failure and poor school "climate" are risk factors for youth ATOD use. School enhancement initiatives include assistance with school policy development and staff training to improve a school's capacity to support positive youth development. Educational enhancement can also include programs (e.g., tutoring, career exploration) within or outside of schools designed to decrease school failure or improve other educational outcomes.

- **Chapter 10: Mentoring.** Programs to provide mentoring to youth on a one-to-one basis are increasingly popular. Depending on the program, this may serve as a prevention program or a component of intervention. The intent of an effective mentoring program is to establish a positive and caring role model for youth who can supplement a parent's efforts to guide and encourage a youth's development.

- **Chapter 11: Supervised Youth Programs.** A number of different kinds of programs have been designed to provide supervised drug-free environments and activities for youth. Programs which consist solely of alternative activities have not demonstrated strong preventive effects. More successful are programs that manage to "bond " participating youth to a group (a group with explicitly drug-free norms), as with peer influence and mentoring programs.

This listing of ATOD prevention approaches may grow and change over time as research and experience provide further indications of effective approaches. In the meantime, it can be used as a foundation to draw from in addressing community risk conditions. To do so, specific outcomes needed to address identified risk conditions in specific communities should be matched to those prevention approaches most apt to have the desired effect.

The "Best Practices Table"

To demonstrate the practice of addressing identified risk conditions in specific communities and matching those risk conditions to prevention approaches most apt to have a desired effect, a "Best Practices Table" concludes this chapter. The table includes all fourteen community risk factors used by the Illinois DHS ATOD prevention system. For each risk factor the table lists examples of outcomes that local prevention planners may identify as crucial goals toward reducing that risk condition in their community. The outcome(s) selected for a community determine the range of approaches that might be most appropriate.

Each outcome in the table is matched to one or more approaches from the preceding list. The "Best Practices Table" is set up to identify recommended prevention approaches in the right hand column. For outcomes that have more than one approach listed, the question of which one or more of the listed approaches to use depends on a community's particular situation. For example, to get an increase in "skills to avoid and manage conflicts effectively" (with risk factor 3 in the table), education programs for youth, parents, or both might have an impact, depending on the local situation. Sometimes an approach other than those suggested may be appropriate, but the list gives an idea of the "theoretically most appropriate" in most cases.

In all cases, the presence of a community prevention coalition would tend to heighten the impact and chance of success of an initiative. In some cases the involvement of such a coalition may be essential for success, due to the scope or nature (i.e., if it involves a public policy issue) of the outcome. The word "**coalition**" in the right hand column denotes outcomes that are most likely to require use of a coalition. If the word "**coalition**" occurs without an associated approach, the recommended approach is public policy advocacy by a prevention coalition.

After you identify approaches that match the problems you face in a particular community, refer to the referenced content chapters to read more about implementation of those approaches. A bibliography at the end of the *Best Practices Handbook* lists further references that can provide you with additional information.

Remember: Using multiple, integrated approaches is generally better than depending on only one approach. The approaches are separated here only to facilitate clear consideration of the unique characteristics of each.

BEST PRACTICES TABLE

RISK FACTORS	OUTCOMES	BEST
1. Availability of ATOD	↑ In local ordinances prohibiting illegal sale of alcohol and tobacco	**Coalition** & Regu
	↑ In enforcement of laws prohibiting sale and provision of ATOD to youth	**Coalition** & Regu
	↑ In beliefs about individual and community responsibility for preventing illegal ATOD use	**Coalition**, Mass Programs
	↓ In parental provision of alcohol to youth	**Coalition**, Paren Communication
2. Stresses Associated with Transitions & Mobility	↑ In perceived family support	Parent Programs
	↑ In positive coping and stress management skills	Preventive Educa
	↑ In school personnel's knowledge of issues pertaining to transition stress	Educational Enha
	↑ In perceived social support from peers and community	**Coalition**, Peer I Communication
3. Unsafe Neighborhoods & Community Disorganization	↑ In pride of neighborhood and community	**Coalition** & Mass
	↑ In skills to avoid and manage conflicts effectively	Preventive Educa
	↓ In number of fights in neighborhoods	**Coalition** and Pe
	↓ In abandoned and/or condemned buildings	**Coalition**
4. Parental Drug Use & Pro-ATOD Family Norms	↑ In beliefs about appropriate consequences for underage alcohol and tobacco use among parents	Parent Programs
	↑ In parental role modeling of appropriate ATOD decision-making	Parent Programs
	↑ In parental communication about expectations regarding ATOD abstinence	Parent Programs
	↓ In sense of parental helplessness and lack of efficacy to impact their children's ATOD use	Parent Programs

BEST PRACTICES TABLE (CONTINUED)

RISK FACTORS	OUTCOMES	BEST A
5. Early Initiation of ATOD Use	↑ In resistance skills to reject underage ATOD use ↓ In supply of ATOD to underage youth by parents ↓ In supply of ATOD to underage youth by community members ↓ In number of offers to use ATOD among youth	Preventive Educat **Coalition**, Parent Communication **Coalition** Mass C Strategy, & Peer I Mass Communicat Youth Programs, &
6. Latch-key Status & Unsupervised Time Among Youth	↑ In availability of school and community resources providing supervised environments for youth ↑ In access to school and community resources providing supervised environments for youth ↑ In sense of safety in neighborhoods ↑ In exposure of youth to positive adult role models	Latchkey/Supervis Latchkey/Supervis Parent Programs & Mentoring & Educ
7. Lack of Family Resources & Supports	↑ In awareness of family support services/resources ↑ In availability of family support services/resources ↑ In family-friendly worksite policies ↑ In networks of families supporting each other	Mass Communicat **Coalition** & Paren **Coalition** & Paren Parent Programs
8. Family Management Problems & Stressful Home Environments	↑ In number and frequency of planned family activities ↑ In family time spent together in household management ↑ In parental knowledge of developmentally appropriate behaviors ↑ In employer support through family-friendly policies	Parent Programs Parent Programs Parent Programs **Coalition** & Paren

BEST PRACTICES TABLE (CONTINUED)

RISK FACTORS	OUTCOMES	BEST
9. Pro-ATOD Media Messages	↑ In awareness among media gatekeepers regarding ATOD message impact on communities	Coalition
	↑ In parental discussion with youth regarding ATOD media messages conveyed via advertising, television, music, etc.	Parent Programs
	↓ In pro-ATOD media messages	Mass Communic
	↓ In alcohol/tobacco company-sponsored festivals and events	**Coalition**
10. Community Laws & Norms Favorable to ATOD	↑ In correct perceptions of the extent of underage alcohol and tobacco use	Mass Communic
	↑ In perceived risk and harm associated with ATOD use	Mass Communic Peer Influence
	↑ In health positive messages communicated by adults and youth	Mass Communic Peer Influence
	↑ In attitudes of community leaders supporting anti-ATOD events	**Coalition**
11. Educational Readiness & School Success	↑ In parent communication with children about value of education	Educational Enha Programs
	↑ In parent involvement in children's education	Parent Programs Enhancement
	↑ In school attendance	Parent Programs Enhancement, &
	↑ In early referral of academically at-risk youth to community services	Educational Enha Programs
12. Lack of Child/Family Attachment to Schools	↑ In availability of school resources to parents	Educational Enha
	↑ In positive communication between parents and school personnel	Parent Programs Enhancement
	↑ In parent participation in school-sponsored activities	Parent Programs Enhancement
	↑ In youth participation in school-sponsored activities	Educational Enha Latchkey/Superv Parent Programs

BEST PRACTICES TABLE (CONTINUED)

RISK FACTORS	OUTCOMES	BEST
13. Develop-mentally & Physically Hazardous School Environments	↑ In youth coping and stress management skills ↑ In sense of safety in school among students, personnel and families ↑ In respect for culturally diverse backgrounds of students among school personnel ↑ In peer social support at school ↓ In exposure to weapons and violent acts at school	Preventive Educ Educational Enha Educational Enha Peer Influence & Enhancement Educational Enha
14. Anti-Social Youth Behavior	↑ In peer ability to mediate conflicts ↑ In clearly communicated standards for behavior by parents ↑ In clearly communicated standards for behavior by school personnel ↓ In aggression and negative interactions among youth ↓ In behavior-related youth detentions and suspensions	Preventive Educ Enhancement Parent Programs Educational Enha Peer Influence, L Programs, Paren Enhancement, & Educational Enha Parent Programs

CHAPTER 4: REGULATORY STRATEGIES

What Are Regulatory Strategies?

Regulatory strategies are policies adopted by communities, states, or the federal government regarding the sale or use of alcohol, tobacco, or other drugs. The most restrictive regulation is the prohibition of sale and/or possession of a drug, as is the case with federal "Schedule 1" drugs. Drugs on other federal schedules are "controlled," i.e. available for medical use by prescription only. Alcohol and tobacco are legally available to adults, but the conditions of their sale or use can be regulated at the federal, state, and local levels.

Regulatory approaches include strengthened enforcement against illegal sales or use (particularly sales to minors), taxation/price control, server intervention, and restrictions on times, places, or other conditions of sales. Server intervention and sales restrictions can be voluntarily implemented by individual retail outlets, but to have a community-wide impact, regulatory efforts must be codified in law (or local ordinances) and enforced.

Why Do Regulatory Strategies Work?

Regulatory strategies operate on at least two dimensions to reduce sales and use by decreasing opportunities for people to obtain or use a substance and by affecting social norms.

1. Regulatory strategies can be focused to decrease the opportunity for people to obtain or use a substance. This involves a reversal of the basic marketing premise that product use can be increased by making the product easier to obtain and use. Restrictions on sales, higher prices, and restrictions on use can all decrease use levels. Use by a particular individual may or may not be decreased in this way, but use levels among groups of people or communities will be affected.

2. Regulatory strategies can be focused to affect social norms. Less research has been done on this aspect of regulatory strategies, but the method of effect can be demonstrated by imagining an underage youth seeking to buy beer.

   In one scenario, the youth enters a store and makes a beer purchase. In a second scenario, purchase attempts at several stores are unsuccessful, and the youth instead locates an adult willing to buy the beer. In addition to extra time, money, and penalty risk incurred by the youth in the second scenario, he/she has experienced a stronger norm of youth non-use of alcohol than in the first scenario. An even stronger norm would be communicated if most adults declined to make the purchase for the youth.

How Effective Are Regulatory Strategies?

Well-enforced regulatory strategies have been shown to reduce use in a cost-effective manner.. **Compared to other options, regulation is extremely effective in decreasing use rates.** In other words, the notion that "they'll use it anyway" is misguided. Some youth will use alcohol, tobacco or other drugs in spite of laws or ordinances to the contrary, but with such regulations less youth will use and those who do use will use less.

Critics who suggest that youth will be more attracted to "forbidden fruit" may be unfamiliar with research on drug laws, alcohol and tobacco taxes, restrictions on youth alcohol and tobacco use, and/or restrictions on sales to minors. A "forbidden fruit" effect either does not occur or is far overwhelmed by the preventive impact of such regulations.

What Else Does Research Tell Us About Regulatory Strategies?

In addition to decreasing youth use of alcohol, tobacco, or other drugs, regulatory strategies can cut rates of drug related health problems and social problems. This has particularly been demonstrated with alcohol regulation and traffic crashes, but effects have also been shown for alcohol regulation and rates of: violence, vandalism, non-traffic trauma hospital admissions, suicides, and fetal alcohol syndrome [see Bowerman (1997), Cook & Moore (1993), Wagenaar (1993].

How Can You Help Your Community To Implement Regulatory Strategies?

Regulatory strategies should be an integral part of any community-based prevention effort.

The following checklist contains numerous action ideas. These ideas are largely based on the current and comprehensive research summarized in *Environmental Approaches to Prevent Problems Related to Alcohol Availability* (CSAP, 1996). Also included are prevention ideas related to tobacco. Work with your community to determine the actions best suited for their needs. Regulatory strategies can enhance any prevention effort — no matter what point a community is at in their prevention efforts.

The checklist is organized by these topics:

- *General Recommendations*
- *Decreasing Availability to Minors*
- *Taxes and Prices*
- *Responsible Alcohol Sales*
  - Enforcement Activities
  - Liability Activities
  - License Activities
  - Responsible Beverage Service Activities
  - Zoning Related Activities
  - Regulations at Special Events and Locations

General Recommendations

- ❒ Empower community members. Support grassroots advocacy for regulatory improvement. Encourage community members to pool their own resources to define and solve problems.
- ❒ Experiment. Encourage communities to attempt regulatory strategies that seem suited for their situation. If the effort does not work, seek expert advice and make adjustments. Document the process to educate others.

- ❒ Foster trust. Support collaboration between law enforcement, local businesses, merchants, and the entire community on alcohol and tobacco issues.
- ❒ Create awareness. Create ongoing public awareness about desired social behaviors and norms. For example, work with local TV, radio stations, and newspapers to deliver public service announcements.

Decreasing Availability to Minors

- ❒ Increase/enhance enforcement. Create linkages among several groups, including the Illinois Liquor Control Commission, local police, college administrations, and others that promote community values. Support enforcement of minimum-drinking age laws.
- ❒ Unite efforts. Help to create unity between local community laws, local community policies, and local prevention efforts.
- ❒ Anticipate crisis. Create community awareness about special events, high school and college activities, and holidays and their link to potential alcohol-related tragedies and crises.
- ❒ Educate minors. Provide minors with accurate information on legal consequences of alcohol, tobacco, or other drug use.
- ❒ Pressure problem outlets. Collaborate with local police and request aid with priority problem outlets. If problem outlets do not cooperate, hold a hearing about the outlet to identify problems and solutions. If problems are not resolved in a year, hold another hearing to recommend that the establishment be closed.
- ❒ Set up "stings." Work with law enforcement and other key community partners to conduct a study of local alcohol and tobacco retailers. Follow up if illegal sales are a problem.
- ❒ Reward appropriate behavior. Provide a reward for appropriate social behavior such as putting stickers in the windows of retailers who obey alcohol and tobacco-related laws.

Taxes and Price

- ❒ Prevent tax benefits erosion. Support a wide range of strategies and approaches to increase costs of alcohol beverages or tobacco products.
- ❒ Levy local taxes. Advocate, where State law allows, that local taxes (such as a nickel-a drink tax for on-sale purchases) and local license fees be used to finance local efforts to address alcohol and tobacco problems.
- ❒ Ensure tax benefits. Index state taxes to the consumer price index to help make public health gains of higher taxes permanent. This helps to prevent decreasing benefits of State tobacco or alcohol tax increases as inflation erodes the real value of the tax increase.
- ❒ Seek allies. Initiate partnerships with neighboring regions on cross-border shopping, cross-border drinking and driving, theft, black market sales, and taxing.
- ❒ Equalize taxes. Encourage law-makers to tax beverages differently so that retail prices of the most inexpensive form of each beverage are nearly equal. This may result in a higher tax level per unit of alcohol on beverages such as spirits, which are cheaper to manufacture and distribute.

Responsible Alcohol Sales

Enforcement Activities

- ❒ Enforce the law. Seek strict and uniform enforcement of laws prohibiting alcohol and tobacco sales to underage and intoxicated individuals.
- ❒ Target trouble spots. Target high-risk drinking establishments for strict evaluations on how they obey laws. Identify locations where arrested drunk drivers purchased their last drink. Collect information from police arrests, counselor hearings, and DWI trainings.
- ❒ Set up DUI checkpoints. Work with local law enforcement to set up DUI checkpoints to deter and detect illegal activity.

Liability Activities

- ❒ Keep burden on the owner. Educate drinking establishments (owners and managers) on how to prevent injury for which they have legal liability. Explain potential business loss due to a license revocation.
- ❒ Promote community health. Educate drinking establishments (owners, managers, and servers) on alcohol-related public health issues affecting their customers and community.

License Activities

- ❒ Learn about local control. Help community prevention groups become involved in local control issues such as ordinances requiring responsible beverage server training. Help them become aware of licensing laws and processes, learn how to effect change, and become familiar with State laws and preemption laws to work together on prevention efforts geared to local enforcement.
- ❒ Collect and organize data. Initiate a data collection effort when communities perceive problems related to outlets. Collect data on police activities, citizen complaints, and State licensing complaints.
- ❒ Consider compatibility. Encourage local residents and businesses to interview potential outlet applicants to ensure compatibility with existing norms and values, such as those related to closing hours and late night entertainment. Ensure that the immediate neighborhood does not object to having the outlet move into their area.
- ❒ Know the law. Help communities become familiar with State and local laws regarding local control over the hours and days of operation to increase, whenever possible, the extent of power that localities can exercise in this area.
- ❒ Intervene early. Encourage states and jurisdictions to intervene early with problem establishments.
- ❒ Close loopholes. Help to prevent owners of problem establishments from transferring ownership to a friend or relative while continuing to operate it and prevent licenses from being transferred to a new owner. Encourage the State and jurisdiction to permanently revoke a license to a specific location and force potential new owners to apply for a license. Encourage careful screening of potential owners and managers of drinking establishments.

Responsible Beverage Service Activities

- ❒ Promote responsibility. Develop community norms/guidelines on principles and practices of responsible hospitality for employers and social hosts.

- ❒ Provide information and training. Institute professional development programs for management and service staff. Provide information and alcohol server training to individuals who organize and serve at special events such as sports and community events, street fairs, and private parties.
- ❒ Set and enforce regulations. Participate in regulation decision-making, such as when bars close in the community. Consistently enforce regulations governing the sales and serving of alcoholic beverages.
- ❒ Acknowledge positive behavior. Create positive incentives to recognize and reward businesses and events that practice responsible hospitality.
- ❒ Offer alternatives. Encourage drinking establishments to offer food and nonalcoholic drinks as an alternative to alcohol. Promote programs that encourage designated sober drivers, reduce intoxication and related problems and liabilities, and as a potential revenue source.
- ❒ Enhance programs. Make server intervention programs more effective by integrating them with management policies, combining them with community-based prevention programs that focus on alcohol problem reduction, and through strict enforcement of alcohol sales laws.
- ❒ Develop relationships. Work with hospitality-related organizations such as professional or trade associations to develop effective server training programs.
- ❒ Review training needs. Monitor the turnover of alcohol servers in the hospitality business – it is generally high. Offer frequent server training for new servers and periodic refresher courses for all servers.
- ❒ Monitor marketing. Encourage merchants to seek alternative marketing strategies and different markets for patrons. Avoid fierce competition that can lead to high-risk sales practices, such as discount drinks, events held to attract large crowds, and entertainment.

Zoning-Related Activities

- ❒ Document and test successes. Help to reduce disparity between undocumented and documented planning and zoning ordinances used to prevent, reduce, and respond to alcohol outlet problems by recording the preventive value of those experiences.
- ❒ Enhance zoning activities. Strengthen prevention efforts by expanding enforcement activities directed at outlets, creating a greater and more efficient use of existing ordinances, and developing stronger local ordinances to reduce alcohol outlet density.

Regulations at Special Events and Locations

- ❒ Plan early. Start discussions about alcohol control activities and alternatives to alcohol use early in the planning stages of community-sponsored festivals, street fairs, and other special events.
- ❒ Train servers. Ensure that all individuals responsible for dispensing alcoholic beverages at special events receive server training, understand the relevant laws and policies, and become informed about problem resolution policies.
- ❒ Disseminate rules. Publish and disseminate rules about alcohol consumption at the special event through signs, brochures, and printing of rules on tickets.
- ❒ Use physical aids. Encourage the use of hand stamps or identification bands issued at locations other than the purchase site.
- ❒ Provide safe alternatives. Limit sales and provide nondrinking areas to decrease alcohol-related incidents and reattract families who stop attending due to drunken rowdiness.

- ❒ Educate promoters. Provide information to promoters about all types of problems related to alcohol and special events, including problems that may occur before, during, after, and away from the event.
- ❒ Balance interests. Balance the needs and business concerns of those connected with alcohol sales, such as stadium and arena owners, sports teams, and catering companies, with community interests.

CHAPTER 5: MASS COMMUNICATION

What Is Mass Communication?

A definition of ***mass communication*** is "giving information to a large number of people." Messages can be communicated through print material, radio, television, the Internet, public events (such as large rallies), or participatory campaigns such as Red Ribbon Week. Each medium may include a variety of options for message types (public service announcements, advertising, counter-advertising, advocacy, etc.) and modes of dissemination (direct mail, point of purchase materials, etc.).

In most cases, the reason to use mass communication in prevention is to get prevention information disseminated. In other cases, the reason to use media messages is to reduce the volume of pro-ATOD messages or the effectiveness of those messages in stimulating substance abuse (including underage use of alcohol or tobacco).

Why Does Mass Communication Work?

At the simplest level, mass communication conveys information that people can use to understand issues and make choices. For example, by seeing or hearing information about a local prevention coalition, people can better understand actions taken by the coalition and can choose whether to actively support those actions.

Alcohol and tobacco sales techniques long ago moved past the level of overt information-giving and attempted to directly influence attitudes and behavior through images and the context of advertisements. More recently prevention messages have also been designed to change attitudes and behavior, through social marketing and media advocacy. The theoretical basis for social marketing stems from various conceptual models of health behavior and communications.

How Effective Is Mass Communication?

For dissemination of relatively simple messages, mass communication can be quite effective if done well. More complex information, such as the skills needed for effective parenting, generally require a more intensive dissemination route (such as parenting courses) for information or skills to be understood and mastered.

For changing attitudes and behavior, mass communication can be a helpful but limited approach. Media prevention messages compete with numerous pro-use messages (in media and elsewhere), particularly in regard to alcohol and tobacco. The relative impact of each message depends on:

- **Quantity.** How many times has each person in the target audience been exposed to a message?
- **Saliency.** How much attention does the message draw from those exposed to it?
- **Clarity.** How understandable is the message to the target audience?
- **Relevance.** Is the message perceived by recipients as being personally relevant: "News they can use?"

- **Credibility.** Are the message and the source (both the actual presenter and the sponsoring organization) perceived as believable?
- **Popularity.** Are recipients sympathetic to the message and/or the source? Messages which conflict with popular attitudes are less likely to affect attitude and behavior. Popularity may vary within different subgroups of the audience. Mass public events or participatory campaigns can help make messages more popular by eliciting public expression of support from participants.

What Else Does Research Tell Us About Mass Communication?

In regard to the effect of alcohol and tobacco advertising, research has demonstrated that:

- Very young children (ages 3-6 were studied) see, understand, and remember advertising.
- Perception of cigarette advertising is higher among young smokers than adults.
- Cigarette advertising encourages youth to smoke.
- Alcohol advertising increases alcohol consumption.
- Alcohol advertising increases highway fatalities.

In regard to preventive mass communications, research suggests that campaigns against youth ATOD use that target youth directly should primarily attempt to decrease perceived peer approval for use. These campaigns can include points about the real harms drugs can cause, but, perhaps contrary to adult intuition, images of likable peers who reject drug use will tend to produce a more positive effect than messages focusing on drug dangers.

How Can You Help Your Community To Implement Mass Communication Strategies?

Communication strategies help inform and influence communities by focusing public attention on important issues associated with alcohol, tobacco, and other drug prevention. Mass communication efforts can range from a single letter to the editor to a complex multi-channel, multi-strategy campaign. *How can you help your community to implement mass communication strategies?*

The ideas in this checklist focus on developing and implementing a mass communications campaign. Many of the ideas are derived from *Marketing Matters: Building an Effective Communications Program* (NCCAN, 1996), a collection of "lessons learned" by 20 grantees working to make communities safe and healthy. Consider available resources (time, money, people, etc.) in developing the best campaign and programs for a community's needs.

The checklist is organized by these topics:

- *General Recommendations: Mass Communication Planning Steps*
  - Getting Started
  - Audience Analysis
  - The Communication Plan
  - Message/Materials Development and Testing
  - Media Outreach Strategies
  - Implementation
  - Evaluation
- *Media Channels*
  - Print
  - Broadcast (Radio and TV)

- Electronic (Internet) Sites and E-Mail
- Mass Events
- Mass Participation Campaigns

General Recommendations: Mass Communication Planning Steps

Getting Started

- ❒ Analyze resources and needs. Assess the current abilities and resources (staffing, funding, etc.) of your organization.
- ❒ Facilitate planning. Structure an initial brainstorming meeting and provide a framework for deciding next steps. Have knowledge of the issue and provide insights. Identify potential solutions to the issue or know of resources available to find answers.
- ❒ Gain insight early. Use initial meeting(s) to help identify target audiences and communication channels that are most effective in addressing ATOD issues.
- ❒ Work with partners. Develop relationships with individuals and organizations to extend the reach, impact, and credibility of the campaign. Establish relationships with communications specialists and advertising or marketing agencies. Recruit from diverse backgrounds. Sustain contact with partners to gauge progress on activities, provide support, and make changes to their role as needed.

Audience Analysis

- ❒ Understand the audience. Assess the knowledge, attitudes, and behaviors of the target audience to narrow the focus of communications. Identify the primary factors shaping the behavior you wish to impact to define the focus of the communication campaign.
- ❒ Facilitate focus groups. Gather information from focus groups to design messages and materials that are appropriate to audience needs and characteristics (age, gender, language, and cultural backgrounds).
- ❒ Segment markets. Divide audiences into meaningful groups. Pinpoint popular and credible communication channels to reach target audiences.
- ❒ Target credible messengers. Identify credible and effective messengers for reaching audiences to increase the likelihood that messages will have impact.

The Communication Plan

- ❒ Build a plan. Design major components of a health promotion (mass communication) plan. Base the blueprint on the target audience analysis. Identify resources available to implement the campaign and potential partners who enhance its effectiveness.
- ❒ Establish goals and objectives. Set measurable communication goals and objectives that provide benchmarks for evaluation.
- ❒ Select strategies/channels. Use different media strategies (media literacy, media advocacy, social marketing, media relations, etc.) Identify the best communication channels for each objective. Consider reach, credibility, cost, exposure, and multiple media options.
- ❒ Identify messages, materials, and activities. Select messages, concepts, and materials. Define major activities such as strategy development meetings, press events, partnership activities, ongoing outreach to reporters, and marketing of public service announcements.
- ❒ Create evaluation parameters. Plan to track and evaluate the campaign's effectiveness.
- ❒ Set timelines. Identify due dates for each objective/activity in the plan to keep the campaign, you/your staff, and partners on track. Solicit input from partners in developing the timeline. Plan contingencies if timelines must be adjusted.

- ❒ Manage the campaign. Develop an outline of key people responsible for implementation. Work with these people to effectively and efficiently manage the campaign.
- ❒ Maintain the budget. Identify costs necessary to implementing the plan. Explore options to secure funding. When funds are limited, use free/inexpensive options such as news, feature, entertainment, or editorial coverage or public service announcements (PSAs).

Message/Materials Development and Testing

- ❒ Enlist expert help. Establish relationships with and obtain assistance from advertising and public relations firms and consultants.
- ❒ Develop evaluation criteria. Establish a criteria list to evaluate concepts and materials before approving drafts. (See OSAP Materials Guidelines, Appendix D) Communicate expectations with staff, partners, and vendors.
- ❒ Select/design messages and materials. Based on audience analysis, available resources, and timelines, choose the best option for materials development. Design messages and materials appropriate to audience characteristics including age, gender, language, and culture. Options include using pre-existing materials or creating new materials.
- ❒ Test message concepts. Narrow concepts and materials to be produced for the campaign based on audience characteristics. Use affordable techniques and tools for testing materials and messages including focus groups, literacy tests, and professional reviews.
- ❒ Revise materials. Modify plans, concepts, and materials based on test results. Carefully considers pros and cons of each revision.

Media Outreach Strategies

- ❒ Strategize. Use a variety of channels to reach your target audience(s) by identifying the most influential and accessible to them. Media channels include print, broadcast (radio and TV), electronic (Internet) sites and E-mail, mass events, and mass participation campaigns.
- ❒ Build relationships. Learn about local media options and how they can help promote your campaign. Meet with local contacts to discuss issues and needs. Obtain public support of media contacts as partners. Maintain solid relationships by being a professional partner.
- ❒ Be appealing. Present interesting and appealing issues and stories to media channels and target audiences. Gain the attention of the reader, listener, or viewer. Consider interest, local angles, timeliness, human interest/emotionsl, controversy, and celebrity/recognition.
- ❒ Organize information. Answer who, what, when, where, why, and how in preparing media concepts and materials.
- ❒ Unite efforts. Share communication channels and resources of partners. Coordinate events and activities with partners to increase visibility and impact.
- ❒ Focus on objectives. Consider the appropriateness of using a particular media channel in every situation. Select channels that will best achieve your objectives.

Implementation

- ❒ Finalize strategies. Take a final opportunity to ensure that media and message strategies are complete. Prepare final products.

- ❒ Launch the campaign. Develop and implement a launch plan outlining your communication campaign. Ensure that sufficient quantities of materials are available, distribution channels are secured, and resources are allocated to manage it and keep it on track.
- ❒ Evaluate. Assess the initial communication campaign's effectiveness in getting materials, services, etc. to the target audience(s). Track responses and reactions to campaign efforts.
- ❒ Maintain quality assurance. Manage your communication plan so that it is useful, timely, and continues to be effective. Monitor media coverage. Respond to unexpected problems.
- ❒ Follow-up. Respond to requests for additional information or services as they arise. Be prepared to follow-up with media channels.

Evaluation

- ❒ Implement evaluation measures. Determine evaluation methods and develop tools for one or more types of evaluation: formative, process, outcome, and impact. Implement measures at appropriate times during planning, implementation, and follow-up.
- ❒ Tap resources. Enlist the help of partners in evaluating your efforts.
- ❒ Document findings. Document evaluation results for future use by your organization and others in the field.
- ❒ Make improvements. Analyze evaluation results to make decisions regarding the campaign direction in a timely manner. Modify the campaign to make it more effective.

Media Channels

Print

- ❒ Assess options. Use print materials to provide information and increase awareness among audiences about a particular issue, especially when mass distribution is desirable. Consider an array of print communication options: newspapers, print PSAs, magazines, posters and flyers, direct mail, brochures and pamphlets, catalogs, outdoor advertising, and newsletters.
- ❒ Increase appeal. For print publications, add visual interest to issues by providing pre-made aids such as photographs or "camera-ready" charts or graphs with written material.
- ❒ Use press releases. To encourage coverage, inform the media about a story/issue via a press release. Releases should be short (two pages maximum), formatted correctly, (typed/ double-spaced on one side of letterhead), factual, and checked for accuracy.
- ❒ Write editorials. Increase public awareness of an issue through a letter to the editor. Write short letters on significant issues — those perceived as trivial are not likely to be covered, so be sure to communicate the impact of the issue on people's lives.

Broadcast (Radio and TV)

- ❒ Consider TV formats. Present issues/stories through a variety of formats including news, in-depth features, talk shows, and public affairs programming.
- ❒ Target listeners. Consider the target audiences' listening habits and format of radio stations in tailoring messages. Formats include country, jazz, contemporary, classical, news/talk, and rock. (Issues/stories are more often covered by stations with an all news/talk format.)

- ❒ Make direct contact. For television coverage, contact an assignment or features editor about issues or events. For radio coverage, contact the assignment editor or news director on upcoming events. Contact the producer or talk show hosts for public affairs programs.
- ❒ Secure PSA coverage. Work with local radio and TV stations in securing support of PSAs. (Remember that you are competing with numerous other PSAs.) In the early stage of developing TV or radio spots, schedule a meeting with the local station's public affairs director to discuss and get feedback on your message and to increase chances for airtime.
- ❒ Utilize the special capabilities available through local cable TV systems.

Electronic (Internet) Sites and E-Mail

- ❒ Access new technology. Use computer technology to reach a variety of audiences such as State officials, local agencies, selected media channels, and the general public.
- ❒ Network. Communicate via electronic mail, discussion groups or "chat rooms," and computer bulletin boards to access people locally, nationally, or internationally. Develop "global" networks to support issues and solicit ideas.

Mass Events

- ❒ Find opportunities. Identify and plan alliances with events (sports, fairs, performances, festivals, conferences, etc.) that will be attended by members of your target audience.
- ❒ Select ideal messages/formats. Determine the best combination of print material, visual aids, speaking engagements, sociodrama, or other methods that work best for an event.
- ❒ Negotiate. Assess event procedures and determine how to best get messages out without interfering with flow of the event. Talk with event organizers and discuss ways that working with the campaign will be of benefit to the community.

Mass Participation Campaigns

- ❒ Link to pre-existing efforts. Disseminate important prevention messages through participation in *Red Ribbon Week*, *Great American Smokeout, Alcohol Awareness Month* activities, and other popular health awareness campaigns.
- ❒ Prepare supporting materials. Identify and create supporting materials (ribbons, buttons, key chains, T-shirts, etc.) that are needed to reinforce messages.
- ❒ Involve youth. Use youth to help publicize a campaign through a poster contest, essay contest, or other participation methods.
- ❒ Maximize coverage. Complete the groundwork needed to assure attention and coverage by local print and broadcast news reporters.

CHAPTER 6: PARENT PROGRAMS

What Are Parent Programs?

The term "parent programs" as applied to ATOD abuse prevention includes a variety of different ways parents may be helped in order to decrease the likelihood of youth substance use and abuse. Types of parent programs include parent education, family support, networking, advocacy, and parent involvement.

- **Parent education.** Short term courses that may cover family management, ATOD issues, or a combination of both.

- **Family support.** Programs and policies that help parents provide needed services to their families, such as child care and medical services.

- **Networking.** Groups of parents maintaining contact with each other and sharing information, resources (such as child care), and/or encouragement regarding parental responsibilities. Networks may be generic or ATOD focused.

- **Advocacy.** Actions that parents and/or others acting on behalf of parents take to encourage government, employer, or community policies that lessen the challenges facing parents. Policies may be generic (e.g., family leave policies of employers) or ATOD specific (e.g., making ATOD information available at work sites).

- **Parent involvement.** Programs facilitate parents' participation in their children's activities, particularly at school or in youth organizations.

Why Do Parent Programs Work?

ATOD-specific elements of parent programs strengthen the capacity of parents to handle ATOD issues. For example:

- Parent ATOD education gives parents knowledge to use in setting and enforcing ATOD related family policies.

- Parent networks organized to decrease youth ATOD use allow parents to reinforce each other by adopting shared anti-ATOD standards and sharing information about ATOD or about youth gatherings that may involve ATOD.

- Advocacy by parent networks or other anti-ATOD parent groups regarding ATOD policy can be one of the strongest influences on government policy.

Family management and resource components of parent programs have a less direct, but sometimes important role in preventing youth ATOD use. Because family management problems are a risk factor for youth substance abuse, parent programs that improve family management, particularly in families with young children, have potential to decrease youth substance abuse. Similarly, since lack of family resources and support is a risk factor for

youth substance abuse, programs that increase the level of support for families may decrease youth substance abuse in families that previously lacked such support.

Of course, the potential role of family management education and of increased levels of family support in fostering overall healthy youth development is stronger than the benefit of contributing to decreased youth substance abuse. However, for families in which management or resource issues are problematic, addressing these issues may be a necessary part of effective ATOD prevention efforts. To succeed in lowering youth ATOD use rates, family management programs must ultimately change the interaction between parent and child. For many families, the main avenue by which parent education programs decrease youth ATOD use is by increasing parental monitoring of their children's activities.

Parent involvement programs have many potential benefits. Programs can:

- Improve the parent/child bond
- Increase youths' and/or parents' connection with schools
- Improve the quality of school or youth organization activities
- Improve coordination between family policies and the policies of other adult authorities in youths' lives.

How Effective Are Parent Programs?

Parent programs have created or contributed to a number of positive changes in parents and youth. Programs that include a strong ATOD prevention component generally have the greatest chance of affecting youth ATOD practices. Family management parent programs that do not have an ATOD component may still have some ATOD prevention impact if they are used with parents in families with family management problems, or if they increase parental access to needed ATOD prevention or intervention resources.

As stated by parent educator, Kirby Alby,

> "It is unrealistic to expect any single intervention, like [parent training], to have a profound impact on the behavior and functioning of all parents. There are just too many other influencing factors that are operating ... The most powerful skill training program, for example, would not at all be effective with parents whose own substance abuse problems dictated that their needs always had to come first. The program ... would be a relative waste of time until other help was provided." (*Parent Training Today*, 1994, pp. 230-231.)

Parenting programs that combine ATOD elements and family management may have a greater potential for success than those that focus only on ATOD or only on family management. Family resource programs may aid ATOD prevention, but any notion of these programs being the key element of ATOD prevention is contraindicated by the extent to which youth from well resourced families account for a major, if not quite proportionate, segment of youth who experience ATOD problems.

Based on the capacity of parent involvement programs to increase school achievement and other developmental outcomes, such programs probably have the capacity to affect youth

ATOD use. However, the extent to which this can be achieved and the conditions necessary for doing so have not been established.

What Else Does Research Tell Us About Parent Programs?

Research suggests that there is a small population of youths, perhaps 5-10 percent at most, for whom their parent(s)' use of ATOD and/or parent(s)' pro-ATOD use attitudes are a main factor in the youths' decisions about use. The modalities for this effect may include a combination of role modeling, household accessibility of substances, support for youth ATOD use, erosion of family connectedness, and (in the case of parental alcoholism or drug addiction) a genetic susceptibility. For some of these youths (presumably those with strong protective factors), seeing their parent(s)' ATOD use is actually a strong influence NOT to use. For most, however, the effect is to promote use. The parents in these families need, at the minimum, intensive intervention about the importance of maintaining anti-ATOD norms for youth.

For the majority of youths, their parents' attitudes about ATOD, connectedness with the youth, and degree of skill in family management are significant to the extent that they affect parents' capacity to protect youth from the more powerful effect of perceived peer approval for ATOD use. In other words, parents typically don't promote youth ATOD use but miss opportunities to proactively prevent it. Prevention programs for these parents will be most effective if they help parents to define, communicate, and enforce strong norms against youth ATOD use.

As summarized by Hawkins, Catalano, and Miller (1992), parent programs for youth ATOD prevention should be adjusted to the developmental stage of the child and should "help parents develop skills to (a) set clear expectations for behavior, (b) monitor and supervise their children, (c) consistently reinforce prosocial behavior, (d) create opportunities for family involvement, and (e) promote the development of their children's academic, social, and refusal skills."

How Can You Help Your Community To Implement Parent Programs?

Parent programs are an important aspect of a comprehensive approach to alcohol and other drug prevention use among youth. Communities can support the effectiveness of parents and families by supporting no-use norms for youth, restricting pro-use influences on youth, and modeling healthy choices and lifestyles. Everyone in the community is responsible for reinforcing values, norms, and beliefs that foster the safe and healthy development of children and families. *How can you help your community to implement parent programs?*

Ideas are provided in the following checklist that can help you plan for, implement, or support parent programs. As you work with your community to determine the most appropriate program(s) for their needs, encourage the integration of alcohol and other drug specific elements to strengthen the capacity of parents to handle those issues.

The checklist is organized by these topics:

- *General Recommendations*

- Program Implementation
- Program Characteristics

- *Types of Parent Programs*
  - Parent Education and Training
  - Family Support
  - Networking
  - Advocacy
  - Parent Involvement

General Recommendations

Program Implementation

- ❒ Assess needs. Conduct a community needs assessment of parent program needs and special issues and the unmet needs of families. Clarify end results desired by the community. Determine target community segments/markets and their specific needs. Use interviews, forums, and/or surveys to gather data.
- ❒ Get community buy-in. Build an understanding of and support for parent programs in the community. Gain broader community commitment to the program(s).
- ❒ Deal with barriers. Consider obstacles to participation such as cost, transportation and lack of child care, time, and interest in parent training. Use representatives of diverse audiences in planning efforts to help problem solve effectively.
- ❒ Select programs. Select one or more program types to meet specific needs of target audiences. Consider factors such as children's ages, cultural needs, and whether the program will be prevention-focused or geared toward identified problems.
- ❒ Evaluate. Set-up a process and determine the best methods to evaluate parent programs. Set goals and benchmarks and measure outcomes. Identify areas needing improvement and make necessary changes. Identify unmet needs of participating parents and families.
- ❒ Collaborate. Contact program developers and providers who are already providing parent programs and work jointly or contract with them for implementation. Discuss enhancing existing efforts to address [some of] the results of the needs assessment.
- ❒ Publicize the effort. Work with the media and other outlets, including word-of-mouth, to publicize parent programs. Make advance announcements to generate interest.
- ❒ Manage program(s). Provide broad oversight and direction, as well as assist with logistics. Ensure that recruitment, enrollment, finding/preparing a location, staffing the program (paid or volunteer), coordinating equipment/material needs, and childcare are handled.
- ❒ Provide follow-up. Ensure success by continuing communication with people who have just completed programs. Assess additional needs and provide follow-up services such as consultation, more programs, and opportunities to join peer or support groups. Offer a forum in which residents are comfortable sharing ideas and concerns
- ❒ Report results. Keep records of the work accomplished and issue/publish reports on evaluation results. Share ideas of what works vs. what does not to educate others who are working on similar efforts.
- ❒ Discuss concerns. Provide forums for the community to share concerns about parent and family needs. Mediate disputes among individuals and organizations involved in a program.

Program Characteristics

- ❒ Maintain a prevention focus. Orient parent programs to keeping families healthy or on preventing any problem from becoming more serious.
- ❒ Emphasize support systems. Include informal and formal support systems in program efforts so that parents and families have ongoing networks to meet needs as they arise.
- ❒ Build on strengths. Acknowledge and build on parent and family strengths in programs, in addition to dealing with any identified problems.
- ❒ Use a community-based approach. Design programs within the context of community life so that parents and families can have closer contact with each other and community resources.
- ❒ Provide comprehensive services. Consider implementing a comprehensive array of services to accomplish program goals:
  - Parent information and/or training classes
  - Parent support groups
  - Parent-child groups
  - Child care
  - Drop-in time
  - Lending libraries
  - Newsletters
  - Advocacy
  - Information and referral
  - Crisis intervention and short-term counseling
  - Social and recreational activities
- ❒ Support parenting roles. Provide support to community-based programs focusing on parental roles that help prevent alcohol and drug use by children including parents as:
  - Role models
  - Educators or information resources
  - Family policymakers and rule setters
  - Simulators of and participants in enjoyable/healthy family activities
  - Consultants and educators on peer pressure
  - Monitors and supervisors
  - Collaborators/partners in prevention
  - Identifiers and confronters
  - Interveners/managers of intoxicated children
  - Managers of their own feelings

Types of Parent Programs

Parent Education and Training

- ❒ Raise public awareness. Advocate the need for effective parenting and parent training. Draw attention to how effective parenting can prevent social and health problems. Use informal (word-of-mouth) and formal (the media) methods to educate the public.
- ❒ Saturate communities. Involve every community institution in supporting, facilitating, and/or delivering parent training programs and information.
- ❒ Provide parenting education opportunities that:
  - Are regional, with community-based sites
  - Address specific parenting concerns in a given community.
  - Promote an environment that facilitates parent to parent communication.

- Provide a variety of resources to meet assessed needs
- Encourage the utilization and support of all elements of the community, including business, government, schools, churches, etc.
- Implement an ongoing evaluation process.

❒ Focus on children. Make programs available that focus on the intellectual and emotional development of children. Encourage parents to talk to children regarding issues/problems, including about alcohol and other drugs.

❒ Support the family unit. Provide education to parents so they can achieve positive growth to enrich the social, emotional, cultural, and ethnical elements of the family unit.

❒ Train trainers. Train and support more parenting instructors to bring a full array of parenting training to the community, making training available to every parent.

❒ Follow up. Organize parents into ongoing program efforts such as mutual support and/or parenting networks once they have completed a class or other program experience.

Family Support

❒ Encourage planned childbearing. Support family planning as part of preventive health services to reduce risks of child abuse and neglect, low birthweight, and infant mortality. Educate young people about parenthood.

❒ Promote prenatal care. Encourage women to pursue comprehensive prenatal care to increase their chance of delivering healthy, full-term, normal-weight babies. Support early and continuing risk assessment, health education and promotion, medical and social support services, and medical treatment for existing conditions.

❒ Improve parent/family benefits. Educate and support employers in implementing a range of policies such as improved parental leave, flexible work schedules, job sharing, child care information and referral assistance, and on-site or near-by childcare.

❒ Ensure quality child care. Advocate for quality child care standards that address child/provider ratios, group size, staff qualifications, health and safety, and linkage to parents and community services.

❒ Promote affordable child care options. Support government and businesses in affordable child care options. Endorse efforts to provide financial aid to poor and moderate income families so that they can choose quality care.

❒ Provide health care services for infants and children. Support comprehensive, preventive, and primary health care services that includes parental education and counseling. Consider special needs such as disabling or chronic conditions, transportation to health facilities, and translators to aid in communication.

❒ Protect children from injury and promote their health. Endorse safety and health efforts that encourage the use of child safety seats, fire alarms, window guards, and flame retardant sleepwear and to reduce the temperature of tap water in homes and child care settings.

❒ Sponsor mediation and peer counseling training for adults and young people as a way to alleviate stress and resolve disputes in families.

Networking

❒ Form parent peer groups. Encourage parents to join together and take a united stand against alcohol and other drugs. Support parent peer groups in providing education, support, community action, and supervision. Encourage parents to get to know their child's friends.

- ❒ Develop networks. Develop a comprehensive, community-based, family-centered network that links all child care programs and offers consumers a variety of child care settings.
- ❒ Hold parent forums. Create opportunities for parents to meet and discuss their problem and prevention-focused concerns and needs. Invite other community representatives so that they are made aware of current parent and family issues.
- ❒ Foster leadership. Solicit the help, interest, and concern of the leadership of the community. Communicate with and educate leaders and potential leaders (schools, youth, parents, media, judiciary, law enforcement, mental health, or community-at-large).
- ❒ Solicit interest. Get together and communicate with other parents to gain attention for your project. Begin with neighborhood parents, schools, churches, and social groups.
- ❒ Develop relationships with service providers. Familiarize yourself with community-based ATOD resources for prevention, education, and treatment. Become aware of programs for strengthening the family unit, parent and communication skills, and healthy alternatives for youth and family.
- ❒ Communicate via media channels. Use a variety of media channels such as local newspapers, parenting newsletters, school and religious institution bulletins, and local cable stations to communicate current issues and happenings that support parents and families.

Advocacy

- ❒ Promote responsibility. Focus attention on responsible behaviors. Work with community event organizers, local businesses (including alcohol establishments), and social groups to plan and conduct activities that do not include ATOD use.
- ❒ Move toward family-centered communities. Mobilize communities to support young children and families. Create safe environments for young children by endorsing ATOD, violence, and other prevention efforts for children, pregnant women, infants, and toddlers.
- ❒ Convey strong messages. Support the communication of firm and consistent standards for youth. Establish linkages between parents, schools, and other community sectors to create effective communication channels.
- ❒ Garner community involvement. Advocate for whole community involvement. For example, solicit businesses to provide after school and summer jobs and encourage park districts to make family-focused programs available all-year round.
- ❒ Support school-based efforts. Become involved in developing school ATOD policies and curricula. Participate in school-sponsored family activities and educational programs.

Parent Involvement

- ❒ Encourage responsible parenthood. Support parents in supervising their own children and encourage them to take an active role in the supervision of children in their neighborhood.
- ❒ Promote positive role modeling. Discourage parental ATOD use and emphasize the importance of being a positive role model. Encourage the community to adopt attitudes and policies that discourage ATOD among parents.
- ❒ Participate in youth activities. Urge youth to participate in meaningful activities and services. Make sure there are alcohol and other drug-free activities and sites available and accessible for young people including after-school activities, teen centers, and play space. Volunteer to be a coach, scout leader, or provide public transportation or refreshments.

CHAPTER 7: PREVENTIVE EDUCATION FOR ADOLESCENTS OR CHILDREN

What Is Preventive Education for Adolescents or Children?

One of the most popular forms of ATOD prevention is preventive education for adolescents or children. Youth in classrooms or other community settings are presented with lessons by a teacher, preventionist, trained police officer, or other authority. Often, trained teen volunteers may co-present a lesson. Lesson content may include ATOD information, life skills, or other components. ***(Note: Preventive education is just one way that schools play a prevention role. See the U.S. Dept. of Education's list of "Characteristics of a Safe, Disciplined, and Drug-Free School," in Appendix E of this Best Practices Handbook.)***

Why Does Preventive Education Work?

Different kinds of curricula are based on different premises. Some seek to remedy a lack of drug information. Some seek to develop decision-making and resistance skills. Some seek to help adolescents counter pro-drug social influence as the youth establish their attitudes about ATOD. Research indicates that only some of these premises are valid.

How Effective is Preventive Education for Adolescents or Children?

Preventionists have long been aware that preventive education alone is inferior to a more comprehensive approach that includes a focus on parents and community. Even so, preventive education as a sole approach has been one of the most heavily researched approaches to ATOD prevention. As a result of cumulative research, particularly in the 1980s and early 1990s, the evolving consensus of researchers in the field is that:

1. Given the appropriate content (concepts and skills), implementation support, and teaching approach, preventive education can have a significant positive effect in terms of delaying or preventing youth ATOD use.

2. Many currently used preventive education materials are not research-based, and are not necessarily effective.

What Else Does Research Tell Us About Preventive Education?

For adolescent ATOD education, two key research sources are Tobler (1997) and Hansen (1996). Following earlier (1986 and 1992) meta-analysis studies of drug prevention programs, researcher Nancy S. Tobler conducted a meta-analysis of 120 experimental or quasi-experimental school-based adolescent drug prevention programs (5th-12th grade) that evaluated success on self-reported drug use measures. Each program was classified as either ***interactive*** (included guided discussion among students) or ***non-interactive*** (included only a lecture and discussion with the class facilitator).

Tobler found a tremendous difference in effectiveness, with non-interactive programs having little impact but the interactive programs having a substantial impact. Surprisingly, this impact on drug use occurs even though the average program length was only 10 contact hours.

Content categories of the various programs also played a role in effectiveness. Programs that focused only on ***intrapersonal*** skills such as decision-making, goal setting, and values clarification were ineffective. Effective programs may have had some intrapersonal skills, but included a strong interpersonal skill component focused on dealing with peer influence. Even with this content, programs delivered in a non-interactive way were substantially less effective, and frequently ineffective.

Another attribute, ***program size,*** was unexpectedly found to play a significant role in effectiveness. "Small" interactive programs did much better than "large" interactive programs, even though the latter did better than small non-interactive programs. The Tobler article does not define "small" and "large", but a sub-analysis with "extremely large programs" may be used to infer a cutoff of about 1,000 students between the two categories.

Tobler's meta-analysis used self-reported drug use as the sole measure of effectiveness, but "mediating variables" including knowledge and attitudes were also measured. An interesting point about the pattern of results on these measures is that interactive and non-interactive programs were approximately equal in producing knowledge gain, but interactive programs were superior in changing attitudes and decreasing use.

William Hansen's summary of work in progress indicates that the three most powerful curricular elements in ATOD prevention are:

1. **Normative Beliefs.** Youth tend to greatly overestimate the percent of peers who use drugs. When given actual numbers, they apparently feel less deviant in their non-use.

2. **Life Style Compatibility.** In spite of hearing about the negative effects of drugs, many adolescents don't necessarily see any threat by drug use to their desired lifestyle. When these connections are explicitly made, it has an impact.

3. **Commitment.** Opportunities for adolescents to make a personal, public commitment to avoiding ATOD use can lead to lower use rates.

For preventive education for younger (elementary school) children, the National Structured Evaluation indicates that a "Psychosocial Skill" approach is best. The approach is congruent with a "youth development" model, emphasizing affective, social, and other skills. It includes **no didactic ATOD education**! Examples of beneficial life skills for prevention include resistance skills, assertiveness, social problem solving, and decision-making.

A project by the Drug Strategies organization in conjunction with Dr. Linda Dusenbury attempted to identify key elements of effective drug education curricula, based on review of the literature and input from fifteen leading drug prevention researchers (*Making the Grade: A Guide to School Drug Prevention Programs*, circa 1995). The resulting list included:

- helps students recognize pressures (such as peer attitudes, advertising, and stress) that influence them to use alcohol, tobacco, and other drugs;
- develops personal, social, and refusal skills to resist these pressures;
- teaches that ATOD use is not the norm among teenagers;
- provides developmentally appropriate material and activities, including information about the short-term effects and long-term consequences of ATOD use;

- uses interactive teaching techniques, such as role plays, discussion, brainstorming, and cooperative learning;
- covers necessary prevention elements in at least ten sessions a year (with a minimum of three to five booster sessions in two succeeding years);
- actively involves the family and community;
- includes teacher training and support;
- contains material that is easy for teachers to implement and culturally relevant for students.

The importance of evaluation was also stressed, and existing evaluation studies (on ten of the forty-seven programs reviewed by the project) were listed. The project included all grades k-12, but the programs (particularly the evaluated programs) tended to cluster around late elementary and early secondary levels (grades 5-9).

How Can You Help Your Community To Implement Preventive Education?

Preventive education is often a foundation for alcohol, tobacco, and other drug prevention efforts in schools and communities. Community, parent, and school representatives generally support the importance of exposing youth to prevention messages from an early age. *How can you help your community to implement preventive education?*

The following checklist contains preventive education ideas that can be used in both school and community-based efforts. Note that elements from William Hansen's current research (*Prevention Programs: What Are the Critical Factors that Spell Success*, 1996), the U.S. Department of Education's *Characteristics of a Safe, Disciplined, and Drug-Free School*, 1994, as well as points from numerous other documents are included. These ideas can help you plan for, implement, or support a school's or community's interest in preventive education.

The checklist is organized by these topics:

- *General Planning Recommendations*
- *Program Characteristics and Development*
- *Key Areas that Support Preventive Education*
  - Policy Implementation
  - Service Provider/Teacher Training and Support
  - Parent and Community Involvement
  - Youth Involvement
  - Evaluation

General Planning Recommendations

❒ Assess needs. Analyze or conduct a needs assessment or usage survey to determine the extent and nature of the ATOD problem. Coordinate with and identify end results desired by the school and community. Use interviews, forums, and/or surveys to gather data.

❒ Build partnerships. Convene a meeting for school and community representatives to build an understanding of and support for preventive education. Work together to explore

preventive education options to help prevent ATOD use. Gain broad community commitment for programs. Include parents of children from all age groups.

- ❒ Confront barriers. Discuss and deal with obstacles such as lack of interest, funding, and time to implement preventive education. Use teachers, administrators, parents, and community representatives in planning efforts to help problem solve.
- ❒ Review curricula and programs. Review various types of curricula and programs to meet varying needs. Consider factors such as childrens' ages and cultures.
- ❒ Create an action plan. Create a mission, goals, and objectives for the preventive education effort. Define roles and responsibilities to accomplish objectives. Set timelines.
- ❒ Evaluate. Set-up a process and determine the best methods to gauge the effectiveness of preventive education before, during, and after implementation. Set goals and benchmarks and measure outcomes. Identify areas for improvement and make changes.
- ❒ Allocate resources. Determine available and needed resources (people, budget, time, etc.) for implementation. Tap local, state, and national organizations for assistance.
- ❒ Use existing resources. Contact and work with program developers and service providers who provide preventive education. Find creative ways to enhance existing efforts. Work with schools to provide a full range of pre-school through grade 12 programming.
- ❒ Promote efforts. Work with school newsletters/newspaper, local cable stations and other media channels, including word-of-mouth, to publicize preventive education efforts.
- ❒ Manage programs. Provide broad oversight and direction in starting, implementing, and maintaining programs. Deliver leadership training to help the effort become self-sufficient.
- ❒ Follow up. Ensure success by continuing efforts for children who have completed programs. Assess ongoing needs and provide follow-up preventive education programs. Sponsor forums for school and community representatives to discuss issues.
- ❒ Report results. Keep records of accomplished work and report evaluation results. Share ideas about what works vs. what does not to educate others involved in similar efforts.

Program Characteristics and Development

- ❒ Educate school and community representatives. Encourage the use of research-based prevention methods that can help decrease ATOD use trends. Share current curricular research findings, such as those in the following list derived from Hansen, 1996, with school, parent, and community representatives:
  - Data-driven programs are now favored; programs must target and change variables that are strongly predictive of ATOD use.
  - Promising targets for programs include establishing traditional beliefs, building strong personal commitments, and developing prosocial bonds with school and other institutions such as church and boy/girl scouts. Others include resistance skills training, developing perceived disharmony between lifestyle and drug use, and developing general competence.
  - Prevention programs should address broader issues, given relationships between drug use and delinquency and drug use and premature sexual activity.
  - Many approaches that were popular in the past, including building self-esteem and teaching generic social skills and specific skills such as stress management may fulfill certain needs but are not likely to be effective in school-based prevention.
  - Programs that are primarily informational or affective have relatively small effect.

  - Programs that feature social influence approaches or life skills (resistance skills, assertiveness, social problem solving, and decision-making) approaches in addition to social influences approaches are relatively effective.
  - Resistance skills programs have potential for effectiveness, but only when students are initially motivated to learn skills.
  - Programs must operate by changing risk and protective factors.
  - Programs that target and change characteristics that statistically account for large drug use have potential to succeed.
  - Data suggests that a primary goal of prevention needs to be postponing and suppressing use.
- ❒ Establish a K-12 curriculum. Implement a comprehensive K-12 (even beginning in pre-school) prevention/health education curriculum. Integrate ATOD information and activities throughout all subjects, using teachable moments and current events to initiate discussion.
- ❒ Implement frequent, ongoing activities. Promote a comprehensive program with activities that are frequent, intensive, and of lasting duration. Avoid the implementation of isolated activities and events.
- ❒ Support ATOD programs that address:
  - Needs of all age groups, implementing age-appropriate ATOD education and activities
  - Information about all types of drugs, including prescription and over-the-counter drugs
  - Relationships of drugs to suicide, AIDS, pregnancy, violence, and other safety issues
  - The media's role in advertising alcohol and tobacco products
  - Social consequences of drug use
  - Respect for society's laws and values, including discussions of right and wrong
  - Healthy, safe, and responsible attitudes and behaviors
  - Strategies to enable students to resist influences that encourage drug use, such as peer pressure, advertising, etc.
  - Sensitivity to cultural differences in the school and community and local ATOD problems
  - Cooperative learning and consensus-building skills, as well as coping skills such as communication, decision-making, and conflict resolution
- ❒ Convey no-use messages. Support a firm no-use philosophy in preventive education. Communicate the message that ATOD use by youth is illegal and unacceptable.

Key Areas that Support Preventive Education

Policy Implementation

- ❒ Create and implement policy. Support preventive education efforts by establishing and enforcing fair no-use policies and address ATOD issues such as youth use, possession, sales, and concerns about personal use or a friend or family member's use. Address issues regarding faculty ATOD use or concerns of faculty members or parents about student use.
- ❒ Communicate policies. Inform all students, parents, and families of ATOD policies in a timely manner. Provide reminders and updates as appropriate.
- ❒ Offer assistance. Create policies that address actions to be taken by the school to intervene with/assist students (Student Assistance Program) or staff (Employee Assistance Program) who struggle with a personal or family ATOD problem.

- ❒ Be consistent. Adhere to policies once they are established. Support administrators in obtaining the backing of the school board to enforce the policies consistently, regardless of involvement by students, parents, or staff.
- ❒ Maintain records. Implement a reporting system to keep track of all ATOD policy violations. Train affected parties in procedures.

Service Provider/Teacher Training and Support

- ❒ Educate service providers/teachers. Encourage use of interactive programs (actively engaging youth in discussions, role plays, and games) versus non-interactive programs (relying heavily on lecture, film/videotape, and individual activities). Convey that interactiveness promotes behavior change because it leads to self-introspection, observable behaviors, and examination of other's attitudes, beliefs, and behaviors.
- ❒ Motivate service providers/teachers. Use training to motivate involvement. Promote teacher preparedness to engage in interactive methods.
- ❒ Create a training plan. Establish a comprehensive training plan that has the support of administrators, teachers, parents, support staff (e.g., bus drivers, security officers, etc.) and community resources/agencies. Conduct training at least twice a year. Include the following in an ongoing, mandatory training program:
  - ATOD policies and their implementation. Train the entire staff regarding its roles and responsibilities in implementing policies and programs.
  - Accurate and up-to-date information on ATOD use, abuse, and dependency, including information on topics on which there is a great deal of misunderstanding (drug-affected children, etc.)
  - Proper ways to respond to incidents of verbal and physical abuse and other violent acts
  - Identification of students using ATOD
  - Effects of ATOD use on individuals, family members, and others
  - Intervention and referral techniques for youth suspected of using drugs, threatening other students or staff, and engaging in criminal behavior
- ❒ Consider teachers' perspective. Support research-based premises for school-based teacher training:
  - Teachers respond to innovations in developmental stages
  - A multi-phase approach to staff development is needed to help teachers through each stage
  - Continuing training is important; pre-service training alone is insufficient although it is important in a comprehensive plan
  - Approaches to training should fit skill levels of teachers
  - Teacher training needs to be conducted in a manner that allows training and the implementation of the program to maintain high visibility, credibility, and value.
  - Require active participation by teachers in making decisions about program adoption.
  - Identify roles/responsibilities. Have clearly identified specialists in the community and/or school system responsible for ATOD preventive education programs and activities.

Parent and Community Involvement

- ❒ Involve parents. Engage parents in the development and implementation of ATOD preventive education and policies. Involve parents as decision-makers, teachers, learners, resources, supporters, and advocates.
- ❒ Offer training. Provide parents with information and training opportunities that address:
  - Effects of drug use, abuse, and dependency
  - Ways to identify drug problems and refer people for treatment.
  - Available resources to diagnose and treat people with drug problems
  - Laws and school policies on ATOD issues.
  - Importance of setting appropriate family rules, monitoring childrens' behavior, ensuring adequate child supervision, reinforcing positive behaviors, and imposing consequences.
  - Ways to improve family communication skills and conflict management
  - Networking with other parents.
- ❒ Develop teacher/parent relationships. Create opportunities for teachers (and service providers) and parents to work together to appreciate each other's ideas and methods.
- ❒ Collaborate with community groups/organizations. Develop partnerships with community groups/organizations (law enforcement, health, mental health, social services, etc.) to:
  - Identify youth in need of additional ATOD services.
  - Develop ATOD prevention and school safety programs, as well as the delivery of services such as student assistance programs, employee assistance programs for school staff, latch-key child care, continuing education programs for dropouts and pushouts, and programs for students at high-risk for ATOD use.

Youth Involvement

- ❒ Involve youth. Include all youth in opportunities to:
  - Assist in developing school and community tobacco, alcohol, drug, and safety policies
  - Recommend drug education and prevention programs and activities
  - Develop and operate drug-free social events
  - Implement drug prevention support programs, such as peer counseling and mentoring for younger students
  - Operate, under adult supervision, student courts and other programs designed to have youth recommend appropriate sanctions for other youth who have engaged in inappropriate behavior
- ❒ Empower leaders. Support leaders/potential leaders who give a strong no-use message through their lifestyle. Promote drug-free youth organizations and activities. Recognize youth for their efforts in preventing drug use and making communities and schools safe.
- ❒ Make programs/activities available. Increase youth involvement by making programs and activities such as the following accessible and available:
  - Tutoring, mentoring, and other academic activities
  - Counseling and support groups
  - Vocational programs
  - Community and school-based social activities
  - Alternative programs (alternative schools, etc.)
  - Community service programs
- ❒ Foster a positive environment. Create a community and school climate where students feel safe, motivated, and successful to foster ATOD avoidance and higher levels of achievement.

- ❒ Plan before, after, and non-school activities. Help the school to provide a safe haven for students before and after school for study, recreation, and other activities that provide a protected environment for students to learn and play.

Evaluation

- ❒ Evaluate ATOD usage. Encourage the community and school to document how programs are effective in reducing ATOD use. Base success judgments on whether programs reduce ATOD usage. Compare results to situations where the program has not been delivered.
- ❒ Focus on results. Educate communities and schools on program aspects that should be evaluated — drug use data, quality of program delivery, changes in modifiable risk and protective factors, and student perceptions of program quality — versus a focus on testimonials and subjective evaluations. Focus evaluation on end-points.
- ❒ Improve effectiveness. Incorporate information from evaluations into programming to guide program development and improvement. Use evaluation results to track the ultimate effectiveness and continuation of programs.
- ❒ Participate in research pools. Encourage communities and schools to actively participate in statewide assessments that collect data regarding program effectiveness and ATOD usage.

CHAPTER 8: PEER INFLUENCE PROGRAMS

What Are Peer Influence Programs?

For the purpose of youth ATOD prevention, peer influence programs are those with a primary goal of empowering drug-free youth to influence peers toward decreased ATOD use, or toward a set of positive behaviors that explicitly excludes ATOD use. These are primarily peer leadership programs, though instances of peer influence may be found in some peer teaching or peer helping programs. Peer leadership programs may include other approaches, such as preventive education, but for purposes of discussion, the terms "peer leadership" and "peer influence" will be used interchangeably in the remainder of this chapter.

The distinguishing characteristic of peer influence programs is their attempt to establish or strengthen a drug-free peer subculture among target groups of youth.

Why Do Peer Influence Programs Work?

Peer influence programs are based on the knowledge that peer norms are one of the strongest factors in youth ATOD use. Peer influence programs aim to counter negative peer norms by identifying or recruiting drug-free youth leaders and assisting them to actively serve as role models for same-aged or younger people.

How Effective Are Peer Influence Programs?

The effectiveness of peer influence programs in prevention can be evaluated either of two ways, depending on the intent of the program. One way is through direct impact on participant ATOD use. A second way is through assessing the degree to which participants go on to affect the ATOD use of others in their community.

1. Peer influence programs may have a direct positive effect on participants' ATOD use rate, but this is difficult to attain and perhaps even more difficult to maintain over time. It is difficult to attain because the nature of peer influence programs requires that most participants be non-users or, at most, "experimenters" with drug use; otherwise the prevailing norm may become **toward** drug use.

   The effort (usually a great deal of it) needed to carry out such a program is therefore largely directed toward youth who may never be at great risk for ATOD problems, so that they can influence each other (and,in some cases, a few higher-risk youth) toward abstinence. Even if this is accomplished, participants are probably heavily exposed to other youth and/or adult influences when they are not involved in the program, and support for a drug-free lifestyle may be sparse outside the program.

2. A more consistently positive basis for peer influence programs is their role in supporting drug-free youths' leadership in the wider community. Limited formal research has been done on this, but anecdotal reports, observations, and demonstrated popularity of such programs indicate that drug-free youth find strength from them. Many youth go on to play key roles in their communities' ATOD prevention efforts.

What Else Does Research Tell Us About Peer Influence Programs?

Research consistently finds peer influence *toward* ATOD use to be one of the strongest correlates with use. This is partly due to the effect of peer variables (especially perceived peer beliefs about ATOD) on youth use, and partly due to the tendency of youth ATOD users to seek out other users as friends. Even though the correlation isn't entirely due to a cause/effect relation from peer influence to use, the strength and breadth of such a cause/effect route tends to outweigh most other contributing causes, except ATOD availability. The relative effect of peer approval is particularly strong in determining use of gateway drugs. This has ramifications for many of the prevention approaches, but most directly supports the notion of peer influence programs, if they can successfully counter the strong peer influences toward use.

How Can You Help Your Community To Implement Peer Influence Programs?

Peer influence programs support youth in maintaining behaviors that are alcohol, tobacco, and drug-free, as well as help them to influence others toward an alcohol, tobacco, and drug-free lifestyle. *How can you help your community to implement peer influence programs?*

The checklist in this chapter provides you with ideas that can support the planning and implementation of peer influence programs. Consult with your communities and schools on program benefits, types, and the specific program options that are available to them. Help communities in the process of determining the peer influence program best suited for their youths' needs.

The checklist is organized by these topics:

- *General Planning Recommendations*
- *Peer Influence Program Characteristics and Considerations*

General Planning Recommendations

- ❒ Assess community needs. Conduct a community needs assessment of peer influence program needs, special issues, and the unmet needs of youth. Clarify end results desired by the community. Use interviews, forums, and/or surveys to gather data. Assess the abilities and resources (staffing, funding, etc.) of the community to support programs.
- ❒ Understand the audience. Become knowledgeable about children/youth stages of cognitive, emotional, social, and moral development. Educate the community and schools about current youth needs at various stages, as well as program options and appropriateness.
- ❒ Sponsor a forum. Bring community representatives together to develop a sense of understanding and ownership in peer influence programs. Promote the importance of peer influence among youth. Gain insights early about target audiences and communication channels that are most effective in addressing ATOD and peer influence issues.

- ❒ Collaborate. Develop relationships with individuals and organizations from diverse backgrounds to extend the reach, impact, and credibility of peer influence efforts. Sustain contact with partners to gauge progress on activities and maintain support.
- ❒ Facilitate planning. Designate or establish an ongoing planning group. Sponsor an initial brainstorming meeting to provide a framework for deciding next steps. Define peer influence efforts by deciding whether to sponsor a school-based and/or community-based effort. Have knowledge of issues and provide insights. Identify potential solutions to issues or know of resources available to find answers.
- ❒ Select programs. Assist the community in meeting specific needs of the community and target audiences by consulting on program types and specific program options. Consider factors such as youths' ages/stages of development and cultural needs.
- ❒ Implement training. Conduct ongoing, age appropriate training to ensure an in-depth understanding of ATOD problems and solutions.
- ❒ Promote efforts. Reinforce the importance and value of peer influence programs by providing public relations for youth-based efforts. Work with school newsletters/newspaper, local cable stations, and other media channels, including word-of-mouth, to publicize efforts.
- ❒ Evaluate programs. Keep records of efforts and report evaluation results. Determine evaluation methods and develop tools for one or more types of evaluation: formative, process, outcome, and impact. Implement measures at appropriate times during planning, implementation, and follow-up. Share ideas about what works vs. what does not to educate others involved in similar efforts.
- ❒ Make program improvements. Analyze evaluation results to make decisions about the direction of a peer influence program in a timely manner. Modify the program to make it more effective.

Peer Influence Program Characteristics and Considerations

- ❒ Promote program benefits. Consult with communities about the benefits of various peer influence programs including that programs:
  - Are cost-effective because they supplement existing resources and efforts, as well as use the energy and enthusiasm of committed youth and adults.
  - Provide opportunities for young people to be involved in productive activities with other youth that are physically and emotionally safe and healthy.
  - Can be implemented in a variety of ways and different program approaches can address the needs of youth.
  - Help to fulfill youth needs at a time when they are experiencing stresses associated with growing into adulthood such as experiencing sexual maturity, developing individuality, forming commitments, stages of separation and autonomy, outgrowing types of egocentrism, and re-evaluating values.
  - Can help to foster cognitive, emotional, social, and moral development.
  - Can provide quality experiences between youth and adults, including opportunities to gain increased respect from adults and opportunities for adults to act as positive role models.
- ❒ Consult on program types. Consult with communities on types of peer influence programs and their characteristics. Help communities to understand that the types of programs described below support ATOD-free behaviors, interaction between peers and adults, and cognitive, emotional, social and moral development.

  - Peer counseling/helping programs provide an opportunity for youth to gain experience in a helping position that is generally focused on same age or younger peers. Programs such as Student Assistance Programs (SAPs) can include roles for youth, as well as roles for adults.
  - Peer leadership programs offer youth the opportunity to develop leadership skill in areas such as program planning and decision-making, as well as offer youth an opportunity to experience some responsibilities equaling that of adults.
  - Peer-to-peer or cross-age teaching programs provide youth with opportunities to use a variety of methods to impart ATOD prevention and other related information to peers and younger students in community or school-based settings. Presentations to younger children provide opportunities for youth to reinforce their own ATOD-free behaviors and act as role models to younger children

- ❒ Know specific program options. Become knowledgeable of and educate the community on specific peer influence programs they can implement on a local level. Share information on programs such as the Illinois Teenage Institute (ITI), Operation Snowflurry/Snowball/ Snowflake, the IDEA Youth Board, and Project Graduation.
- ❒ Involve youth early. Invite youth to participate in the membership of parent/community groups or task forces that are exploring peer influence program possibilities and options. Ensure that youth are actively involved in all stages of planning and implementation.
- ❒ Encourage adult involvement. Promote the importance of adults in peer influence programs. Motivate adults to volunteer for involvement in and attendance at events.
- ❒ Support youth-to-youth involvement. Provide opportunities for youth to take leadership roles in community and school-based ATOD prevention activities and peer influence programs. Encourage youth advocates to assist youth in supportive, behind-the-scenes roles.
- ❒ Secure funding. Calculate the costs necessary to implementing peer influence programs and explore options to obtain funding. Identify a sponsoring fiscal agent and obtain their commitment. Ensure that liability insurance coverage has been secured.
- ❒ Identify a contact person(s). Select a spokesperson for peer influence efforts who can clearly represent the best interests of the effort. Encourage youth to partner with adults or take on the leadership/contact role.
- ❒ Make opportunities for cross-age interactions. Plan constructive opportunities to facilitate the positive influence of older youth on younger children. Encourage cross-age interactions that are positive so that some of the important others in a child's life will be older children who can be constructive role models.
- ❒ Support ATOD-free events. Help communities and schools to implement ATOD events and programs for youth. Be a resource/volunteer in activities and educational programs.

CHAPTER 9: EDUCATIONAL ENHANCEMENT

What Is Educational Enhancement?

Educational enhancement consists of changes that schools or communities make to improve educational programs or policies for youth and their families. Criteria for improvement can include one or more of the following:

- Increasing academic achievement
- Increasing the educational and career aspirations of students
- Improving a school's "climate" (The safety of schools for students, including safety from threats to emotional health)
- Increasing a school's capacity to engage students and parents in ongoing partnership
- Broadening the mission of a school to address the full range of competencies needed by youth, rather than a limited set of cognitive skills.

Examples of educational enhancement include tutoring programs, systematic support for transitioning students, service learning, career exploration, cooperative learning, parent involvement initiatives, and student advisory programs.

Why Does Educational Enhancement Work?

The basis for supporting educational enhancement as a component of ATOD prevention comes from risk and protective factor research. Risk factors for ATOD problems include these school-related issues:

- Poor academic achievement
- Alienation of youth and/or parents from schools
- Hazardous school environments

To the extent that educational enhancement can decrease one of these factors, it may decrease ATOD problems. In terms of protective factors, the school has the potential to foster resilience by exercising clear behavioral standards, by giving opportunities for students to play meaningful positive roles, and by publicly acknowledging the positive contributions of each student to the community (in school and beyond).

How Effective Is Educational Enhancement?

In regard to ATOD prevention, educational enhancement is probably most effective when applied in response to situations where significant risk factors (low achievement rates, widespread alienation from school, or high rates of physical or emotional damage to students) exist. Of course, educational enrichment can be beneficial in many other ways aside from ATOD prevention.

What Else Does Research Tell Us About Educational Enhancement?

Educational enhancements that can reduce ATOD risk factors include:

- Increased use of developmentally appropriate instructional practices such as cooperative learning
- Increased opportunities for student involvement
- Greater school-faculty-community integration
- Improvements in school discipline procedures
- Improved facilitation of school transitions

How Can You Help Your Community To Implement Educational Enhancement?

Many people, including many educators, think of schools primarily in terms of cognitive instruction. Prevention groups and prevention professionals can make a unique contribution to educational enhancement by working with schools on initiatives that improve school policies and programs apart from the core curriculum. Goals of these initiatives can include improvement in students' affective development, quality of life, pro-social behavior, and academic achievement. Preventionists who have been or still are a professional educator or school board member are particularly well prepared to lead educational enhancement initiatives.

General Planning Recommendations

- ❒ Establish key partnerships. Very early in the planning of an initiative establish partnerships with persons and groups needed as part of the planning or implementation. Examples of partners within a school are building and district level administrators, PTA/PTO leaders, and teacher union representatives. External partners may include related agencies, town governments, businesses, or community organizations ranging from chambers of commerce to ministerial alliances.
- ❒ Know your topic. Become familiar with the latest research and practice models for the type of educational enhancement you are proposing. Explore formal research results and examples of applications of these results, including national program centers and local or regional program examples, if available.
- ❒ Assemble support material. Collect and/or create communication material that explains the key points about the initiative you are proposing. If possible include audio/visual material as well as print.
- ❒ Be flexible. The initial concept for an educational enhancement initiative may need to be modified to fit the realities identified by educators, community partners, or pilot efforts.

Examples of Issues for Particular Enhancement Initiatives

1. Easing Educational Transitions

- ❒ Focus on key transitions, such as change of building, progression from elementary to secondary level teaching designs, or students arriving in a new school district.
- ❒ Consider students' developmental characteristics. Keep in mind the developmental characteristics of the students who are in transition. For example, 10-14 year olds may

need the kind of structure provided by a "middle school" model rather than less developmentally based educational formats.

- ❒ Consider family backgrounds. Students from different cultural backgrounds may have perceptions and needs that should be addressed as a part of the transition process. This is most crucial in the case of newly arrived immigrants or children of families temporarily living in this country.
- ❒ Include parents. Be sure that transition programs include early and frequent communication with parents.

2. Career Exploration

- ❒ Explore whole domains. Expose students to the multiple jobs within a career category to increase chances of each student feeling interested in one or more jobs within that domain. For example, rather than looking at physicians as a distinct occupation, explore a variety of health care jobs ranging from emergency medical technicians to hospital support staff.
- ❒ Create "hands-on" opportunities. Integrate classroom learning about jobs with on-site visits or job shadowing experiences.
- ❒ Establish connections between job skills and school subjects. Have guests or site-visit discussions include mention of the ways that reading, writing, arithmetic, or other subjects are vital for job performance.
- ❒ Emphasize necessary organizational and social skills. Have guests discuss the importance of teamwork and being organized on the job.
- ❒ Highlight drug-free workplace issues. When applicable, ask guests to mention employers' policies about being drug-free, and the dangers that could ensure if workers were under the influence of alcohol or other drugs.

3. Parent Involvement

The Midwest Regional Center for Drug Free Schools and Communities (1993) listed the following characteristics of effective parent involvement:

- ❒ Comprehensive. Parent involvement is a process, not an event. It should not exist as a separate program, but serve as one element of a comprehensive prevention program.
- ❒ Values Parents. Parents often are "one down" when communicating with school or community personnel, and in order to alleviate this, schools need to truly value parents.
- ❒ Knows Parents. It is imperative for any parental involvement effort to know about the parents from whom involvement is sought. This includes knowing demographic characteristics, day-to-day stresses, and what parents need by way of information, skills, and support.
- ❒ Benefits Parents. Any effort to include parents must clearly benefit parents. Examples include relevant information, discipline skills, or emotional support. [Also, parents' contributions of time and expertise to the school should be publicly recognized.]
- ❒ Responds to Parents. There are always potential obstacles to parents getting involved. Parent involvement efforts must anticipate possible obstacles and be responsive to the needs of parents.
- ❒ Collaborates With Community Resources. No school or community program planning for parent involvement should reinvent the wheel. An inventory should be taken of available

parent programs offered across the community. Staff should make referrals and work jointly on offerings.

CHAPTER 10: MENTORING

What Is Mentoring?

Mentoring can best be described by the classic example of the Big Brother/Big Sister Program. In the Big Brother/Big Sister Program, an adult volunteer mentor commits to developing a supportive relationship with a youth who is between 6 and 16 years old. Although older youth can mentor younger ones, mentoring programs most typically rely on adult mentors.

Informal mentoring may happen as part of any youth/adult interaction, but mentoring programs seek to purposefully structure mentor/mentee relationships to maximize success. Mentoring may be a component of treatment or intervention, but mentoring for prevention involves youth who have not experienced significant ATOD problems.

Why Does Mentoring Work?

Mentoring is strongly rooted in resiliency theory and research. The goal is to "bond" each youth (via a caring, enjoyable relationship) to a positive role model who gives the youth encouragement and support for healthy activities and development.

Key studies of eight Big Brother/Big Sister programs by an organization called "Public/Private Ventures" in the early 1990's differentiated successful "developmental" mentor/mentee relationships from less effective "prescriptive" relationships. In the less effective "prescriptive" relationships, adults sought to guide or direct youth, apparently leading to alienation in those youth rather than the success of the developmental, supportive relationships.

How Effective Is Mentoring?

The studies mentioned above found very substantial effects toward decreased likelihood of mentored youth initiating alcohol or other drug use, in comparison to a control group.

What Else Does Research Tell Us About Mentoring?

Bonnie Benard (1996) summarizes characteristics of effective mentoring relationships as follows:

- Relationships have sufficient intensity and duration (regular weekly contacts, three-four hours per meeting, longer than one year in duration, etc.)
- Sustained relationships are those in which the mentor sees him/herself as a friend: not as a teacher or preacher. Success is based on the mentor's belief that he or she is there to meet the developmental needs of youth—to provide supports and opportunities the youth does not otherwise have.
- Mentors center their involvement and expectations on developing a reliable, trusting relationship and expand the scope of their efforts as the relationship strengthens.
- Mentors place top priority on having the relationship enjoyable and fun to both partners, listen non-judgmentally, look for the youth's interests and strengths, and incorporate the youth into the decision-making process around their activities.

- From a resiliency perspective, mentors provide the three protective factors of a caring relationship that conveys positive expectations and respect, and that provides ongoing opportunities for participation and contribution, and see risks existing in the environment, not in the youth.
- Relationships are fundamentally based on the belief that the development of a caring, trusting, respectful reciprocal relationship is a key to reducing risks, enhancing protection, and promoting positive youth development in any system.

How Can You Help Your Community To Implement Mentoring Programs?

Mentoring programs have gained recognition for success as non-problem-focused interventions that produce positive results. Benefits of mentoring programs for youth and the community include that they can:

- Deter the initiation of/reduce drug and alcohol use.
- Have overall positive effects on academic performance and behavior and attitudes.
- Improve peer and family relationships.

How can you help your community to implement mentoring programs?

Included in this checklist are ideas that you can use to support the planning and implementation of mentoring programs. Consult with your communities on effective program characteristics, benefits, types, and specific program options that can best meet their needs.

The checklist is organized by these topics:

- *General Planning Recommendations*
- *Elements of a Successful Mentoring Program*
- *Program Benefits and Development*

General Planning Recommendations

❒ Assess community needs. Conduct a community needs assessment of youth needs that may be met through mentoring programs. Clarify end results desired by the community. Use interviews, forums, and/or surveys to gather data. Assess the abilities and resources (staffing, funding, etc.) of the community to support programs.

❒ Understand the audience. Become knowledgeable about children/youth stages of cognitive, emotional, social, and moral development. Educate the community and schools about current youth needs at various stages, as well as program options and appropriateness.

❒ Sponsor a forum. Bring community representatives together to develop a sense of understanding and ownership in mentoring programs. Gain insights early about target audiences and communication channels that are most effective in addressing ATOD and youth issues.

❒ Collaborate. Develop relationships with individuals and organizations from diverse backgrounds to extend the reach, impact, and credibility of mentoring programs. Sustain contact with partners to gauge progress on activities and maintain support.

- ❒ Facilitate planning. Designate or establish an ongoing planning group. Sponsor an initial brainstorming meeting to provide a framework for deciding next steps. Define mentoring program efforts by deciding whether to support existing programs or establish new ones. Have knowledge of issues and provide insights. Identify potential solutions to issues or know of resources available to find answers.
- ❒ Involve youth early. Invite youth to participate in the membership of parent/community groups or task forces that are exploring mentoring program possibilities and options. Ensure that youth are actively involved in all stages of planning and implementation.
- ❒ Identify a contact person(s). Select a spokesperson for mentoring efforts who can clearly represent the best interests of the effort. Encourage youth to partner with adults or take on the leadership/contact role.
- ❒ Secure funding. Calculate the costs necessary to implement mentoring programs and explore options to obtain funding. Identify a sponsoring fiscal agent and obtain their commitment. Ensure that liability insurance coverage has been secured.
- ❒ Select programs. Assist the community in meeting specific needs of the community and target audiences by consulting on program types and specific program options. Consider factors such as youths' ages/stages of development and cultural needs.
- ❒ Publicize efforts. Reinforce the importance and value of mentoring programs through public relations channels. Work with school newsletters/newspaper, local cable stations, and other media channels, including word-of-mouth, to publicize efforts.
- ❒ Evaluate programs. Keep records of efforts and report evaluation results. Determine evaluation methods and develop tools for one or more types of evaluation: formative, process, outcome, and impact. Implement measures at appropriate times during planning, implementation, and follow-up. Share ideas about what works vs. what does not to educate others involved in similar efforts.
- ❒ Make program improvements. Analyze evaluation results to determine the direction of a mentoring program in a timely manner. Modify programs to improve effectiveness.
- ❒ Advocate for volunteerism. Support efforts to increase volunteer pools. Make communities aware of the importance of mentoring programs and the roles individuals can play to support these programs.

Elements of a Successful Mentoring Program

The following list includes elements of an effective mentoring program. In your community-based prevention role, assist those involved in the implementation of mentoring programs by promoting these elements.

- ❒ Encourage quality relationships. Support efforts to build on research-based findings associated with successful mentoring relationships.
- ❒ Screen mentors. Use thorough volunteer screening methods that filter out adults who are unlikely to make a lasting commitments or might pose a safety risk to the youth.
- ❒ Train mentors. Conduct mentor training that promotes caring relationships, conveying a deep belief in a youth's innate resilience. Train on communication and limit-setting skills, tips on relationship-building, and recommendations on the best way to interact with a young person.
- ❒ Make careful matches. Ensure a good match between the youth and mentor expectations and program goals. Conduct interviews with mentors that explain the type and depth of a mentoring relationship and commitment expectations. Consider youth

preferences, their family, and the volunteer, as well as use a professional case manager to analyze which volunteer would work best with which youth.

- ❒ Establish structure and a process. Build a program structure and process supervised by case managers/youth workers. Ensure that case managers supervise each match through quality contact with the parent/guardian, volunteer, and youth in an ongoing/consistent manner and provides help as needed. Use staff to provide "back-up" stability and continuity in a mentoring relationship, especially so that youth are not left alone if their mentor leaves.
- ❒ Create a communication process. Ensure that a communication and feedback loop is established for youth and adults to discuss needs, progress, and problems.
- ❒ Support social activities/ATOD-free events. Support the relationship and activities of youth and adults by providing community-based activities and events that are ATOD-free. Be a resource/volunteer in activities and educational programs.
- ❒ Meet mentor needs. Respond to a mentor's needs, as well as the youth's needs to support the mentoring relationship.
- ❒ Involve families. Communicate clear expectations about family involvement in the mentoring program. Build in opportunities for the families of the youth and adult to become involved in activities.

Program Benefits and Development

- ❒ Convey program benefits. Communicate the benefits of mentoring programs within communities, including that programs:
  - Can deter the initiation of/reduce drug and alcohol use and have overall positive effects on academic performance, behavior and attitudes, and improved peer and family relationships.
  - Are cost-effective because they supplement existing resources and efforts, as well as use the energy and enthusiasm of committed youth and adults.
  - Provide opportunities for young people to be involved in productive activities with adults that are physically and emotionally safe and healthy.
  - Can be implemented in a variety of ways and different program approaches can address youth needs.
  - Can help to foster the cognitive, emotional, social, and moral development of youth.
  - Help to fulfill youth needs at a time when they are experiencing stresses associated with growing into adulthood such as experiencing sexual maturity, developing individuality, forming commitments, stages of separation and autonomy, outgrowing types of egocentrism, and re-evaluating values.
  - Can provide quality experiences between youth and adults, including opportunities to gain increased respect and support from adults and opportunities for adults to act as positive role models.
- ❒ Consult on program types. Confer with communities on mentoring program options and characteristics and help match needs to an appropriate program type. Help communities to understand that programs types described by the Search Institute, 1995 (see following list) support ATOD-free behaviors and result in other benefits to youth, adults, and communities.
  - ***Traditional programs*** consist of one adult in a friendship oriented role model relationship with one child (one-to-one relationship) of which the Big Brother/Sister

program is an example. Traditional programs generally require a one or more year commitment, meeting a minimum of about three hours per week.

- ***Long-term, focused activities*** focus on a particular goal or outcome, over and above friendship or role modeling. Long-term activities are sometimes remedial in nature, such as tutoring programs, but often are designed to build on existing skills and abilities to encourage or promote academic progress or career exploration and skills.
- ***Short-term, focused activities*** focus on a particular area such as school or career and do not require mentors to make a commitment of more than about six months. An example of a short-term activity is a summer-long, work internship program.
- ***Team mentoring*** consists of one or more adult volunteer working with a youth and may include a family or two (or more) working together. Meetings are generally held once per week for two to four hours and the commitment is usually one year or longer.
- ***Group mentoring*** consists of one adult volunteer building a relationship with a small group of young people such as girl or boy scouts.

❒ Create a mentoring system. Build mentoring into social institutions; families, schools, communities, social programs, youth organizations, etc. Support environments that create many opportunities for young people to interact with an array of caring adults. Create a whole system of support, that includes more than one adult mentoring-type relationship.

❒ Unite mentoring with societal issues. Infuse mentoring programs into prevention, educational, and welfare reform efforts at the local, state, and national levels. Support the creation of jobs and supply job training for youth to help ensure their success and contribution to society.

❒ Improve parent/family benefits. Support family-centered social policies that promote improved parental leave, fair wages, family healthcare benefits, flexible work schedules, job sharing, and quality childcare options.

❒ Increase youth-focused activities. Support communities in creating opportunities for youth to be directly involved with more adults through activities such as community service, work apprenticeships, and involvement in local government.

CHAPTER 11: SUPERVISED YOUTH PROGRAMS

What Are Supervised Youth Programs?

Supervised youth programs are often referred to as "Alternative Activities." Supervised youth programs cover a wide variety of programs, all of which include the provision of drug-free youth activities supervised by adults. Examples include:

- Safe haven programs
- Church youth groups
- Youth athletics
- Post-prom events
- Youth service projects

Often these programs also have components of peer leadership, tutoring, mentoring, or other approaches.

Why Do Supervised Youth Programs Work?

At a most basic level, preventive impact from supervised youth activity programs comes from simple displacement; time spent in a safe, drug-free environment is that much time away from opportunities for ATOD use. This is particularly relevant to "latchkey" youth, who would otherwise be at heightened risk for ATOD use. Alternative activities generally fill only a portion of a youths' non-school time, so opportunity for drug use is decreased but not eliminated.

As with other types of youth program approaches, more powerful preventive effects occur if participants become "bonded" in identity with the program, such that the norm of avoiding ATOD use is carried to unsupervised settings. Bonding is facilitated by providing opportunities for social, academic, and personal enrichment and success. Programs that involve youth as partners and appeal to youth as individuals and/or as members of their cultural group (through emphasis on the positive heritage of that group) are more likely to develop bonding. High quality youth programs can play a particularly important role with youth who have not been exposed to positive peer settings and opportunities.

How Effective Are Supervised Youth Programs?

Explicitly drug-free programs that are ongoing (i.e., not just one-time or rare events) and that succeed in developing a bond with youth, as described above, have the potential to decrease ATOD use. Programs that include tutoring, mentoring, or youth involvement components also have the potential for impact via those approaches. Other youth activity programs have not been proven effective in ATOD prevention, though they may have other beneficial effects.

What Else Does Research Tell Us About Supervised Youth Programs?

As is reported in *SAMHSA News*, Spring, 1997 (pp. 18-19), research suggests that "alternative activities" should:

- Be attractive to participants. Researchers have noted enhanced program effectiveness when youth have been involved in the development of the alternatives programming. Alternatives based on culturally specific designs are often attractive to racial and ethnic minority youth.
- Be intensive. Participants should be involved with the program several days a week and, if possible, attend occasional "booster sessions" once the intensive program is completed.
- Incorporate skills building into program design.
- Be used to reach high-risk youth who are frequently disengaged from social institutions. Programs that provide adult supervision offer the opportunity to develop positive relations with mentoring adults.
- Support the establishment of community norms against youth ATOD use.
- Be implemented in combination with prevention strategies with a proven record of effectiveness, such as environmental approaches that focus on promoting laws and ordinances that reduce the availability of ATOD and otherwise discourage youth use.

How Can You Help Your Community To Implement Supervised Youth Programs?

Supervised youth programs or "alternative activities" have been used as a basic prevention strategy for many years. They are similar in focus to peer influence and mentoring programs — emphasis is placed on influencing youth toward a positive lifestyle that discourages alcohol, tobacco, and other drug use. Like mentoring programs, the success of alternative activities are greatly dependent on adult participation and the quality of relationships between youth and adults. *How can you help your community to implement supervised youth programs?*

The following checklist contains ideas that can be used to support the planning and implementation of supervised youth programs. Ideas from "The Alternatives Approach: Is It Any Good?," Prevention Pipeline, May/June 1996, as well as points from other resources are included in this chapter. Consult with communities on effective program characteristics, benefits, and various program options that can best meet their needs.

The checklist is organized by these topics:

- *General Planning Recommendations*
- *Characteristics of a Successful Supervised Youth Program*
- *Program Benefits and Development Considerations*

General Planning Recommendations

❒ Assess community needs. Conduct a community needs assessment of youth needs that may be met through supervised youth programs. Clarify end results desired by the community. Use interviews, forums, and/or surveys to gather data. Assess the abilities and resources (staffing, funding, etc.) of the community to support programs.

❒ Understand the audience. Become knowledgeable about children/youth stages of cognitive, emotional, social, and moral development. Educate the community and schools about current youth needs at various stages, as well as program options and appropriateness.

- ❒ Sponsor a forum. Bring community representatives together to develop a sense of understanding and ownership in supervised youth programs. Gain insights early about target audiences and communication channels that are most effective in addressing ATOD and youth issues.
- ❒ Collaborate. Develop relationships with individuals and organizations from diverse backgrounds to extend the reach, impact, and credibility of supervised youth programs. Sustain contact with partners to gauge progress on activities and maintain support.
- ❒ Facilitate planning. Designate or establish an ongoing planning group. Sponsor an initial brainstorming meeting to decide next steps. Decide whether to support existing supervised youth programs or establish new ones. Have knowledge of issues and provide insights. Identify potential solutions to issues or know of resources available to find answers.
- ❒ Identify a contact person(s). Select a spokesperson for supervised youth efforts who can clearly represent the best interests of the effort. Encourage youth to partner with adults or take on the leadership/contact role.
- ❒ Secure funding. Calculate the costs necessary to implement supervised youth programs and explore options to obtain funding. Identify a sponsoring fiscal agent and obtain their commitment. Ensure that liability insurance coverage has been secured.
- ❒ Select programs. Assist the community in meeting specific needs of the community and target audiences by consulting on program types and specific program options. Consider factors such as youths' ages/stages of development and cultural needs.
- ❒ Publicize efforts. Reinforce the importance and value of supervised youth programs through public relations channels. Work with school newsletters/newspaper, local cable stations, and other media channels, including word-of-mouth, to publicize efforts.
- ❒ Evaluate programs. Keep records of efforts and report evaluation results. Determine evaluation methods and develop tools for one or more types of evaluation: formative, process, outcome, and impact. Implement measures at appropriate times during planning, implementation, and follow-up. Share ideas about what works vs. what does not to educate others involved in similar efforts.
- ❒ Make program improvements. Analyze evaluation results to determine the direction of a supervised youth program in a timely manner. Modify programs to improve effectiveness.
- ❒ Advocate for volunteerism. Support efforts to increase volunteer pools. Make communities aware of the importance of supervised youth programs and the roles individuals can play to support these programs.

Characteristics of a Successful Supervised Youth Program

The following list includes characteristics of an effective supervised youth program. In your community-based prevention role, consult with community representatives involved in the implementation of supervised youth programs by promoting these characteristics.

- ❒ Encourage quality relationships. Support efforts to build on research-based findings associated with successful youth and adult relationships. See "Elements of a Successful Mentoring Program" in the *Mentoring Programs* chapter, summarized from Benard, 1996.
- ❒ Respond to youth differences. Recognize, value, and respond to the diverse backgrounds, experiences, and needs of youth.
- ❒ Promote skills, knowledge, and attitudes. Develop and implement programs that develop and reinforce skills, knowledge, and attitudes that support youth in refraining from ATOD use.

- ❒ Occupy free time. Create and implement programs that fill the free time of youth that might otherwise be idle or unstructured. Provide safe and attractive places to youth so that they can relax and be with their friends.
- ❒ Focus on meaningful involvement. Provide youth with opportunities for meaningful involvement in community service and other prosocial activities.
- ❒ Encourage peer interaction. Provide youth with opportunities to interact with prosocial peers.
- ❒ Build relationships between youths/adults. Create opportunities for the development of positive relationships between youths and adults. Provide adult supervision for events and activities.
- ❒ Consult on types of programs and events. Confer with communities on supervised youth program and event options. Help communities understand the importance of implementing various types of programs and events that support ATOD-free behaviors and result in other benefits to youth, adults, and communities (Prevention Pipeline, May/June 1996). Numerous options include:
  - Events programming such as sober prom and graduation events
  - Athletic and other recreational alternatives
  - Programs promoting health and well-being (nutrition, sexuality, AIDS, etc.)
  - Programs building personal and social competence such as life and relationship-skills training, counseling for individuals and groups, etc.
  - Programs building intellectual competence such as English as a second language and tutoring
  - Adventure-oriented alternatives such as a wilderness challenge course
  - Programs or events based on ethnic history and cultural traditions
  - Programs or events consisting of entrepreneurial ventures
  - Programs or events aimed at high-risk youth (such as children of substance abusers and youth in institutional settings)
  - Programs or events promoting leadership and citizenship such as community service and leadership skills development
  - Programs or events consisting of creative or artistic activities
  - Work readiness programs such as internships, career awareness, summer job placement, etc.
  - Community drop-in centers
  - Programs attempting to promote attachment to social institutions (ex. School, family, church), academic achievement, educational aspirations, social competency, and/or attitudes unfavorable to ATOD use
- ❒ Make programs intensive. Involve participants with the program several days a week and, if possible/appropriate, encourage participants to attend “booster sessions” once the intensive program is completed.
- ❒ Target all youth. Use alternative activities to reach low-risk youth, as well as high-risk youth who are frequently disengaged from social institutions. Use drop-in centers as an effective way of reaching dropouts.

Program Benefits and Development

- ❒ Convey program benefits. Communicate the benefits of supervised youth programs within communities, including that programs:

- Can support the deterrence of ATOD use and have overall positive effects on academic performance, behavior and attitudes, and improved peer and family relationships.
- Can be inexpensive to implement if they supplement existing resources and efforts, as well as use the energy and enthusiasm of committed youth and adults.
- Provide opportunities for young people to be involved in productive activities with adults that are physically and emotionally safe and healthy.
- Can be implemented in a variety of ways and different program approaches can address youth needs.
- Can help to foster the cognitive, emotional, social, and moral development of youth.
- Help to fulfill youth needs at a time when they are experiencing stresses associated with growing into adulthood such as experiencing sexual maturity, developing individuality, forming commitments, stages of separation and autonomy, outgrowing types of egocentrism, and re-evaluating values.
- Can provide quality experiences between youth and adults, including opportunities to gain increased respect and support from adults and opportunities for adults to act as positive role models.

❒ Establish clear program objectives. Make sound planning decisions and create clear objectives for programs and events. Focus objectives on preventing or reducing levels of ATOD use among participants. (Note that there is little or no research to support that youth engage in ATOD use due to low self-esteem or anxiety.)

❒ Establish structure and a process. If possible, build a program structure and process supervised by paid staff. Use staff to provide "back-up" stability and continuity in a supervised youth program.

❒ Create a support system. Build supervised youth programs into social institutions; families, schools, communities, social programs, youth organizations, etc. Support environments that create many opportunities for young people to interact with an array of caring adults. Create a support system that includes more than one adult supervised relationship.

❒ Increase youth-focused activities. Support communities in creating opportunities for youth to be directly involved with more adults through activities such as community service, work apprenticeships, and involvement in local government.

❒ Make alternatives attractive to participants. Invite youth to participate in the membership of parent/community groups or task forces that are exploring supervised youth program possibilities and options. Ensure that youth are actively involved in all stages of planning and implementation. (Researchers have noted enhanced program effectiveness when youth have been involved in the development of alternatives programming.)

❒ Support community norms. Use alternative programs and events as an effective means of establishing community norms against ATOD use. Use events such as Red Ribbon Week and First Night to draw public and media attention to ATOD issues and mobilize support for other more intensive and targeted prevention efforts.

❒ Link programs to other efforts. Implement alternatives in combination with prevention strategies that have a proven record of effectiveness such as environmental approaches focusing on the promotion of laws and ordinances to reduce ATOD availability and discourage use.

❒ Screen adult volunteers. Use thorough volunteer screening methods that filter out adults who are unlikely to make a lasting commitments or might pose a safety risk to the youth.

- ❒ Train youth leaders. Conduct training that promotes caring relationships and conveys a deep belief in a youth's innate resilience. Train on communication and limit-setting skills, tips for relationship-building, and recommendations for the best way to interact with youth.
- ❒ Create a communication process. Ensure that a communication and feedback loop is established for youth and adults to discuss needs, progress, and problems.
- ❒ Involve families. Communicate clear expectations about family involvement in the supervised youth program. Build in opportunities for the families of the youth and adult to become involved in activities.

EPILOGUE

This *Best Practices Handbook* text has progressed from the broad principles of Chapter 1 to the research findings of Chapter 2 and applications of these to professional practice in Chapters 3-11. A further step needed for the practice of prevention is mastery of the practical details of prevention work: how to act as a consultant, how to give a public presentation, how to write effective communications, how to manage a prevention office, etc. Although these details are also a part of "best practices," coverage of them is beyond the scope of this publication. Many printed resources and training opportunities exist for persons seeking development of these skills. More information about such learning aids is available from Prevention First, Inc. in Illinois (800-252-8951 or 217-793-7353) and similar prevention resource centers in other states.

A catalog of "best practices" covers an extensive array of considerations, but still has limits of how far it can guide or assist. Blending all these individual ideas into a practical synthesis in any given situation is more of an art than a science. As in any field, talent, training, experience, support from colleagues, and leadership from supervisors are required to bring best practices to life.

APPENDIX A:
DESCRIPTION OF COMMUNITY RISK FACTORS

1. Availability of ATOD

- **Description:** How easily accessible drugs are in the community.

- **Examples of Supporting Data:**
  a. For Alcohol and Tobacco
     - Number of retail outlets relative to population
     - Underage use data
     - Availability reports from youth
     - Underage sales citations
  b. For Other Drugs
     - Use data
     - Availability reports
     - Rate of arrests for sales and possession
     - Volume confiscated

- **High/Low References:** Supporting data for your community can be compared to similar communities or to state or national averages.

2. Stresses Associated with Transitions and Mobility

- **Description:** A combination of the community's mobility rate (people moving in or out of town) and how well the community is structured to buffer normal transitions, such as students entering a school new to them.

- **Examples of Supporting Data:**
  - Student mobility rate
  - Length of stay at residence
  - Population % change
  - Residential real estate transfer rate
  - SAP referral for transition years to other grades.
  - Community mental health reports

- **High/Low References:**
  a. Mobility: Rural areas tend to rate this factor low. Typically mobile populations include migrants, employees of companies with frequent transfers, and college students.
  b. Transitions: A high rating may reflect either (or both) a greater than usual number of transitions or signs of unmanaged stress associated with transitions. A school in which students enter a new building every year or two would be an example of greater than usual number of transitions. A 7th and 8th grade Junior High with a high rate of academic, discipline, or personal problems among 7th graders would exemplify signs of unmanaged stress.

3. Unsafe Neighborhoods and Community Disorganization

- **Description:** An absence of cohesiveness in neighborhoods and whole communities.

- **Examples of Supporting Data:**
  - % of Vacant Housing Units
  - Neighborhoods Crime Rates
  - Neighborhoods activities/organizations
  - Degree of community-wide collaborations to promote community health
  - Rate of youth or family involvement in positive community activities

- **High/Low References:** In communities that need work on this factor, residents feel little attachment to their neighborhood or community, and so citizen action is at a minimum. Crimes like vandalism are prevalent, because police have no organized support from the community.

  In communities that are strong on this factor, neighbors and neighborhoods work together on common problems. Manifestations of this can include neighborhood crime watch groups, youth advocacy groups, a wide range of youth and family activities available and supported by the community, or private/public collaborations to improve community health and general quality of life. This is a difficult factor for rural areas because of the lack of neighborhoods, but whole rural communities vary in degree of cohesiveness and organized action.

4. Parental Drug Use and Pro-ATOD Family Norms

- **Description:** Quoting Drs. Hawkins & Catalano, "In families where parents use illegal drugs, are heavy users of alcohol, or are tolerant of children's use, children are more likely to become drug abusers in adolescence. The risk is further increased if parents involve children in their own drug - or alcohol-using behavior — for example, asking the child to light the parent's cigarette or get the parent a beer from the refrigerator." This becomes a community risk factor if there is a high rate of such parental behavior in a community.

- **Examples of Supporting Data:**
  - Parental survey data
  - Youth survey data relative to parental attitudes
  - Trends reported by treatment agencies
  - % of mothers smoking during pregnancy
  - % of mothers drinking during pregnancy
  - Reported substance affected infant cases

- **High/Low References:** In a 1993 statewide survey, Illinois 7^{th}-12^{th} grade youths were asked how their parents would feel about the youth's use of alcohol and marijuana. For alcohol, about 75% said "Not O.K.", 8% said "O.K.", 3% said their parents "Don't Care", and 13% said they "Don't Know" what their parents would think. For marijuana 90% said "Not O.K.", 2% said "O.K.", 2% said their parents "Don't Care", and 5% said they "Don't Know" what their parents would think.

5. Early Initiation of ATOD Use

- **Description:** The younger a person is when initiating the use of a substance, the greater the risk of ATOD problems when older.

- **Examples of Supporting Data:**
  - Youth survey data on age of first use
  - Reports from youth
  - Youth treatment referral data
  - Rates for underage arrests for purchases and sales

- **High/Low References:** One approach would be to compare data to state and national averages. For example, the 1993 Illinois DASA Youth Survey found that about 18% of surveyed 7th graders report using alcohol in the past month. A community that reached that level with younger persons or that had a higher rate by 7th grade probably has a problem with early initiation of alcohol use.

  A second approach is to refer to a minimum legal ages for use. By this approach, any large percentage of alcohol use before age 21 would cause a high need rating on this factor. This approach differs in that it is not based on the research that indicates high risk of later problems for young initiation of use. In fact, an age 19 initiation of alcohol use currently would predict lower risk of later ATOD problems. Rather this approach is based on findings (used to set the age 21 minimum) that underage use increases risk of imminent injury.

6. Latch-Key Status and Unsupervised Time Among Youth

- **Description:** The extent to which community youth lack adult supervision proportionate to their age. In protective factor literature, clear, consistently enforced, healthy standards for youth decrease the risk of ATOD use.

- **Examples of Supporting Data:**
  - Surveys of parents or youth on this issue.
  - Proportion of single parent and dual income families among student population
  - Reports from youth
  - Reports from police officials

- **High/Low References:** The quantity and quality of adult supervision needed by youth changes as they grow. Generally children need nearly constant supervision through early elementary years, though it may alternate between close and distant supervision. Grade 10-12 youth generally need considerable independence but with ongoing accountability for behavior. Grades 4-9 are particularly salient years for this factor because the youth have often developed enough independence to handle standard daily situations but lack the skills to handle more challenging peer interactions that may relate to ATOD use. Communities in which many nine to fifteen year olds experience substantial blocks of unsupervised time may rate high need for attention to this factor.

7. Lack of Family Resources or Supports

- **Description:** The ability of parents in a community to maintain healthy family environments depends on the interaction among their well-being (economic, physical, and psychological), the life challenges they face and the existence of family support resources available to them. Even excellent parenting skills can be insufficient to cope with overwhelming challenges to family health and well-being. Family support services such as child care, health care, adult education, and vocational preparation may be needed to preserve family well-being. Populations that are economically disadvantages may have particular difficulty gaining access to such services.

- **Examples of Supporting Data:**
  - Census data on family income
  - Eligibility rates for services such as free lunch, unemployment, WIC, or public aid
  - Percentage of community members participating in family support programs relative to the number eligible.
  - Reports from social service agencies (DCFS, domestic violence shelters, etc.,)
  - Reports from schools

- **High/Low References:** The most direct measures for this factor are high prevalence of family management problems in a community, as reported through agencies or schools that serve a community. This may occur in communities of any socio-economic level. Communities in which substantial numbers of people experience poverty or are slightly above the poverty level are likely to experience higher risk for ATOD abuse unless the community has sufficient family support resources to counter the adverse conditions that challenge families. Other possible indicators are a substantial decrease in jobs available, or lack of some key support service relative to need. For example, a neighborhood in which most families are "underemployed" may not show high incidence of poverty but may greatly need one or more specific family support services, such as affordable child care for working parents. For populations that are economically disadvantaged, this factor should usually not be narrowed to addressing only issues of parenting skills.

8. Family Management Problems & Stressful Home Environments

- **Description:** The ability of parents in a community to provide developmentally appropriate, caring, and safe home environments for their children and for themselves. Communities with high levels of populations that have not themselves lived in caring homes and/or populations that are experiencing high levels of stress may have particular vulnerabilities with respect to this risk factor.

- **Examples of Supporting Data:**
  - Alleged child abuse/neglect cases per population level
  - Arrests for offense against children and families
  - Family reunifications
  - Divorces per population
  - % of births to teen mothers
  - Reports from social service agencies (DCFS, domestic violence shelters, etc.)

- **High/Low References:** The most direct measures for this factor are high prevalence of family management problems in a community, as reported through agencies or schools that serve a community. This may occur in communities of any socio-economic level.

9. Pro-ATOD Media Messages

- **Description:** Positive portrayals of ATOD in mass media (broadcast, print, outdoor, etc.). Pertains especially to advertising or other messages formulated by the alcohol or tobacco industries, but may also pertain to news or entertainment content.

- **Examples of Supporting Data:**
  - Counts of particular kinds of ads
  - Focus group reactions to specific ads or public service announcements
  - Advertising expenditures of particular (alcohol or tobacco) companies
  - Evaluation of ad campaigns using established standards
  - Public opinion poles on ATOD issues relevant to recent media messages

- **High/Low References:** This factor refers to both the quantity and nature of pro-ATOD messages. Messages that are particularly destructive (such as those associating drinking with sexual victimization) may be significant irrespective of quantity. To judge quantity, the number and salience of pro-ATOD messages in the community can be compared to the number and salience of ATOD health warnings. Salience refers to the number of persons or person exposures reached by that message. For example, alcohol advertisements on prime time television would not be effectively balanced by alcohol health warnings broadcast after midnight.

10. Community Laws and Norms Favorable Toward ATOD (including Peer Culture Norms)

- **Description:** The degree to which youth, community groups, and institutions enable ATOD abuse or discourage healthy behaviors in regard to ATOD.

- **Examples of Supporting DATA:**
  - Arrest rates for AOD violations (such as DUI and underage possession)
  - Police reports on ATOD enforcement actions (such as underage purchase "stings")
  - Surveys of parents or youth on extent of unenforced violations (such as drinking parties for youth).
  - Surveys of youth, parents, or other adults on their attitudes toward ATOD use.
  - Institutional policies regarding ATOD (e.g. police arrest policies, physician referral policies).

- **High/Low References:** Arrest rates and frequency of enforcement actions can be compared to similar communities, or to past rates in that community, or to parent/youth reports of unenforced violations. Adult attitudes and institutional policies can be compared to known standards of what would be needed to maintain a

consistent anti-ATOD abuse message. The communities at least risk on this factor have gone beyond enforcing relevant state and national laws to adopt preventive local ordinances, such as restrictions on cigarette machines. In communities that need attention to youth peer group norms there may be strong peer pressure toward ATOD use, whether real or perceived. Prosocial values may be over-shadowed by such issues as excessive materialism, racism, sexism, or excessive individual competitiveness.

11. Lack of Educational Readiness and School Success

- **Description:** High rates of truancy, failing grades, and dropping-out among a student population. High rates of school difficulty among young students entering school.

- **Examples of Supporting Data:**
  - Average daily truancy percentage
  - Rates of failing grades
  - Rates of student retention
  - Reports from preschool and primary teachers

- **High/Low References:** School rates can be compared to state averages, to schools in similar communities, or to previous data for a school. Comparison may need to include correction for methodological variations from school to school. For example, some schools may calculate graduation rates from numbers of students entering and number completing school, while others may factor in move in/move out rates.

  Schools with high rates of truancy, failure, and/or dropping out show a high need for attention to this risk factor. Whether the attention should focus on school improvement, ancillary programs for disadvantaged student populations, or some other kind of preventive action requires study of the specific nature of the school and community.

  High rates of difficulty with school among young students (especially kindergarten and first grade) may indicate a widespread lack of school readiness.

12. Lack of Child/Family Attachment to Schools

- **Description:** A lack of coordination between families and schools, or a school environment that is unsafe for youth. Lack of coordination can include lack of parental involvement in children's education and widespread feelings of alienation or mistrust between educators and parents.
-
- **Examples of Supporting Data:**
  - Reports from youth
  - Reports from parents
  - Reports from school staff
  - School disciplinary statistics

- **High/Low References:** In healthy schools, youth have the skills necessary for participation, opportunities for participation, and recognition for participation. They feel bonded to positive role models and have clear, consistently enforced standards of behavior. Parents show an interest in their children's education and reinforce teachers' positive academic expectations for students.

In communities that need attention to school environment there may be high rates of student problems, sometimes at particular ages. Students and/or parents my feel alienated toward the school, and teachers may have little contact with parents.

13. Developmentally & Physically Hazardous School Environments

- **Description:** Schools can be unsafe due to drugs, gang activities, and/or violence. They can also be unsafe due to policies or practices that threaten emotional health or that enable drug use.

- **Examples of Supporting Data:**
  - Average enrollment size per grade
  - School violence rates
  - Reports form school staff (and SAP's)
  - Pupil-teacher ratios

- **High/Low References:** In healthy schools, youth feel safe and bonded to positive role models and have clear, consistently enforced standards of behavior. In communities that need attention to school environments there may be high rates of student problems, sometimes at particular ages. Student and/or parents may feel alienated toward the school, and teachers may have little contact with parents. Of particular relevance to ATOD, school ATOD policies or procedures may not adequately promote safe and drug free lifestyles.

14. Anti-Social Youth Behavior

- **Description:** This factor includes criminal delinquency and non-criminal instances of poorly resolved conflict among youth or by youth toward adults. Examples of poorly resolved conflict include school discipline problems or aggression by youth in any setting. Such anti-social behavior may be a precursor to substance abuse, or may be the first noticeable signs of behavior associated with substance abuse. Some drugs, such as alcohol, are prone to lead to violence under the influence. High rates of juvenile crime and violence in a community call for appropriate preventive action (in addition to law enforcement). Gang crimes may be of particular concern because of the potential for criminal gangs (i.e., gangs that promote criminal behavior) to recruit youth into a criminal lifestyle.

- **Example of Supporting Data:**
  - Juvenile crime rates
  - Police reports
  - Newspaper reports

- School violence rates

- **High/Low References:** Rates can be compare with state and national averages, similar communities, or previous data for a community.

APPENDIX B:
DESCRIPTION OF PROTECTIVE FACTORS

Unlike the risk factors listed in the previous appendix, some of these may apply more at an individual level rather than community-wide.

1. Parental Involvement

High rates of parental involvement support greater academic success. Positive parent attitudes toward education, high expectations for children's achievement, and support for positive school standards all can be helpful. Programs that involve parents in the classroom can also be helpful, as can parental participation in school policy setting and supportive activities.

2. ATOD Knowledge and Anti-ATOD Attitudes

Attitudes toward drugs exert significant on one's own use and on social norms in one's family and peer group. Certain kinds of ATOD knowledge are necessary (though not sufficient) to maintain anti-ATOD) abuse attitudes. Youth need to have the basic facts about drugs are and why they are dangerous. The knowledge should be age-appropriate, with COA information starting in elementary school, gateway drug information starting mid to late elementary grades, and other drug information starting in middle school years. The more this information is lacking, the greater may be the need to address this factor. Note that specific information about how to obtain or use drugs is not appropriate for youth, and may indicate the likelihood of use.

Parents need enough drug information to be able to comfortably communicate with youth about drug dangers. Parents have a particular need to know family ATOD abuse prevention information, signs of youth drug use, and actions to take if use is suspected. Drug displays may be helpful to parents (but should not generally be presented to youth).

Other adults in the community need ATOD knowledge relative to their role in setting or carrying out of policies that impact youth or that bear upon adult ATOD issues. So, for example, employers especially need ATOD information relevant to maintaining a safe and productive work environment, and secondarily need ATOD information relevant to their company's role as a community resource.

Specific other populations need specific other ATOD information. For example, women of child bearing age, especially those who know they are pregnant, need information on Fetal Alcohol Syndrome, and Fetal Drug Effects.

3. Coordination and Integration of Health, Social Service, and Educational Systems

Increasingly, "Best Practice" in health, education, and social service involves collaborative systems of agencies and schools using the strengths of each entity to fashion an overall system that best serves youth and families in the community.

Communities that have actualized this vision are better able to prevent ATOD abuse and other problems.

4. **Culturally Enriching, Positive Social Activities**

Most potent in promoting health are activities which strengthen ties to positive influences: family, healthy peers, and cultural groups. Youth who become bonded to healthy groups (i.e., groups that do not promote violence, ATOD use, or other destructive practices) experience less risk of ATOD abuse or other problems.

5. **Life, Social, and Academic Skill**

Youth who can communicate well, socialize well, achieve well, and cope well with developmental issues are protected in a number of ways from ATOD abuse. Sometimes the pubic wrongly takes this to mean that students with good grades are not a risk. Instead, it means that all youth need as much of a well-rounded preparation as possible for the range of life challenges they will face.

6. **Positive Adult and Peer Role Models**

Well-liked celebrities may have some influence on youth, but the most potent role models are those that are present on a real and ongoing basis in the lives of youth. Relatives (especially parent and siblings), friends, teachers, and "mentors" (as in "Big Brothers/Sisters" type of mentor programs) can play a key role in youth development.

7. **Opportunities to Participate/Contribute**

The basic human desire to play an important role in the family and beyond can provide a powerful protective factor when matched with opportunities for youth to make meaningful contributions to family life or meeting community (including school) needs. This is a basis for self-worth, which some would differentiate from a more shallow sense of self-esteem ungrounded in meaningful participation in life.

8. Rewards and Recognition

As youth (or adults) participate in family, school, and community, the recognition they receive for their interests, efforts, and achievements can strengthen both their sense of self-worth and their bond with the family, school, or other organization that rewards them.

9. **Caring and Support**

This protective factor emphasizes the point that recognizing achievement is only one aspect of bonding. Youth must also be the recipients of caring and support, especially within their families. Research has shown that infants need care not only to survive but to become capable of caring for others. Older youth may not reflect this truism so dramatically, but still experience an analogous need. On a community-wide level, efforts

that strengthen parents' and other care givers' capacity to offer caring and support are addressing a basic component of healthy development.

APPENDIX C:
NATIONAL STRUCTURED EVALUATION RESULTS

This study attempted to answer the question, What types of prevention initiatives, among those currently in use, produce measurable positive impact on ATOD outcomes? The study gathered all reported cases of U.S. prevention programs with measured outcomes relevant to AOD (tobacco prevention research was examined separately and discussed in an appendix). Rather than pre-determine a classification system to categorize the programs, the study started with a list (of twenty-seven activities) that covered the range of all activities included in the programs, and then used cluster analysis to group the programs into different approaches. Seven approaches emerged, and were labeled:

1. Positive Decisionmaking
2. Safety/Health Skills
3. Psychosocial Skills
4. Counseling Intensive
5. Case Management
6. Multidirectional
7. Environmental Change.

The results of each program in each approach were examined in regard to three kinds of relevant outcomes: reduction or delay of AOD problem behavior, change in AOD related knowledge and/or attitudes, and effects on risk and protective factors that might reduce future AOD abuse. The results for each approach as a whole were calculated and reported along with a number of characteristics of the programs evaluated in that approach, such as; the percent targeted to each of four age ranges (under 10 years, 6-18 years, 10-18 years, and adults); percent led by a peer facilitator, educator, or other adult facilitator; and percent that exposed participants to programs for more than twenty-five weeks.

The value to prevention practitioners of this kind of study is that it covers an extremely broad range of possible prevention initiatives, and has considerable validity by virtue of the large number of programs included and the rigorous criteria used when selecting and combining results from these initiatives. The two weaknesses of this kind of study are: (1.) The study's capacity to recognize and take into consideration differences among various programs within each approach category is limited. So, for example, an approach may have great potential for effect but may only actualize that potential when implemented in certain ways. The National Structured Evaluation ("NSE") attempts to recognize some issues such as variations in program duration, but must be considered along with other kinds of research and evaluations (particularly mega-analyses) to identify characteristics that influence outcomes. (2.) The study is based on current (1988 - 1992) prevention practice and the current drug problem environment, but doesn't tell us what other approaches may be developed, nor whether changes in demographics, drug technology, or other future trends may alter the success ratios of different approaches.

In spite of these limitations, the NSE provides valuable information for best practice, and may help point the way toward new or more effectively delivered approaches. The NSE report is (or will soon be) available to the public. The following is a presentation of some of the NSE results, interpreted from the perspective of the Illinois prevention system funded by DASA.

Two of the seven identified approaches, Counseling Intensive and Case Management, are essentially early intervention approaches and so fall outside the realm of most DASA-funded prevention programs. Early intervention programs tend to serve identified clients with existing AOD related problems. These populations require a greater intensity of service per client than the general populations served by primary prevention programs. Given that level of service, the Case Management approach showed substantial success in risk factor reduction, particularly in regard to pregnant women and women with young children. The Counseling Intensive approach seemed generally ineffective except in regard to reducing risk among "high risk" adolescents. It is likely that many of the clients served with the "Counseling Intensive" approach needed an even more intensive intervention, i.e., substance abuse treatment.

The "Multidirectional" category of programs were ones that "appeared to operate under the principle that more is better. In effect, when an activity is believed to contribute to prevention of AOD abuse, organizers of the Multidirectional approach believed that every individual should be exposed every activity" (NSE, p. 68). The NSE goes on to differentiate this from targeted comprehensive services. Evaluation results indicate that the Multidirectional approach is remarkably ineffective. The study notes that, "In the examples studied, the Multidirectional approach received low ratings for effectiveness among all populations and all types of outcomes." This approach tended to be simple in concept but complex in structure, due to the multiple activities involved. The study recommends that prevention efforts should instead be sophisticated in concept and simple in administrative structure. Unlike many of the other approaches, programs that use a "Multidirectional" approach may lead people to erroneously conclude that prevention can't be effective.

One of the seven approaches attempted to operate through environmental change rather than directly impacting individuals. Programs in this "Environmental Change" included some combination of community mobilization, training impactors, and policy change. These programs were found to be effective for reducing or delaying AOD abuse (mainly alcohol abuse), but even more effective at "changing AOD knowledge and attitudes among the general population and affecting long-term risk and protective factors throughout the community" (NSE, p.89). The NSE text notes that, "The NSE findings do not specify what types of Environmental Change activities are most effective; in fact, this may vary depending on existing community policies and problems. The specific contribution to prevention of formation of community coalitions and other linkages is another critical issue not addressed by the NSE findings. To date, most evaluations of creating community infrastructure in support of prevention have focused on the process rather than the outcome of such efforts. The ... studies that have examined outcomes suggest that community involvement in the prevention infrastructure is less important than a community wide reach of prevention activities" (NSE, p. 89).

The three remaining approaches all were targeted toward groups, rather than community environment, and all included instruction in "personal skills," such as communication, assertiveness, decision-making, problem solving, and stress management. The three approaches were differentiated by what they included along with personal skill development.

The most common of the three approaches was "Positive Decisionmaking." This included didactic AOD (alcohol and other drug) education as well as some combination of personal skills. It was most typically carried out in schools with children or adolescents, but in some cases was applied to adults (19%) and/or used in non-school settings (22%). The NSE's

assessment of this approach was that, "More than for other approaches, the ratings of the Positive Decisionmaking approach appeared to vary depending on the implementation or the content of its curriculum. In the examples studied, careful implementation of the limited activity-mix among adolescents or adults, using content based on a clear understanding of the etiology of AOD problems, achieved impressive outcomes in reduction or delay of AOD problem behavior. Such results, however, were atypical. Whether because of problems in implementation or in curriculum content, many examples of the Positive Decisionmaking approach succeeded only in changing knowledge and attitudes. Impact on risk and protective factors, in particular, was frequently very limited" (NSE, p. 23). The NSE noted that the Positive Decisionmaking approach was particularly **in**effective with young children, i.e., children under age 12. On the other hand, "the highest mean effectiveness ratings for affecting AOD problem behaviors were obtained when the approach was applied to adult populations" (NSE, p.92).

The "Safety/Health Skills" approach represented a small (15 cases) group of projects that added safety education to AOD instruction and personal skills development. Many also included health education and/or "task-oriented skills" such as seat belt use and safe driving. School classrooms were the usual settings for this approach, and the youth involved tended to be "already hostile to AOD use" and already evidencing some of the target skills. As a result, the NSE report is cautious about recommending this approach beyond populations "who already are motivated to give priority to health and safety concerns" (NSE, p.33). Even with that population, the Safety/Health Skills approach was typically no more effective that the other two similar group influence approaches (Positive Decsionmaking and Psychosocial Skills). The report noted that this approach is "probably widely used among adult work site programs," but that the NSE "identified too few examples with rigorous evaluations to reach reliable conclusions related to its effectiveness" (NSE, P.92).

The final approach, "Psychosocial Skills," combined "personal skill development" with training in "task-oriented skills" such as academic skills, parenting, or employment preparation. Most notably, these programs were characterized by the **absence** of specific AOD education. As would be expected, these programs had little impact on AOD knowledge and attitudes. For affecting AOD behavior, it **was** effective, especially with children under 12 years old. It was less effective in this regard when presented to adolescents (12 to 18 years old), but had significant positive impacts on risk and protective factors with those older youth. The NSE report notes that, "Although individual examples of other approaches received higher [effectiveness] ratings, the activity mix of the Psychosocial Skills approach appeared to be one that was successfully implemented by many different types of agencies using a wide variety of settings, formats, and facilitators" (NSE, p.44).

Two other findings of the NSE should be noted. One is support for the importance of cultural sensitivity in prevention efforts. "Among all rigorously evaluated individual interventions, those efforts that demonstrated concern for cultural issues in the client population were more likely to have effective outcomes than those that did not" (NSE, p.95). The other point is the apparent **lack** of effectiveness of drug-free activities, at least in the studied programs. The approach most associated with such activities was "Multidirectional," in which 80 of the 81 programs featured such activities. The lack of effectiveness of the Multidirectional approach has already been noted. Drug-free activities were also included in about half of the "Psychosocial Skills" programs. However, when the NSE compared these to the other Psychosocial Skills programs, "Among rigorously evaluated examples of the Psychosocial

Skills approach, the NSE found that the inclusion of access to drug-free alternative activities did not affect the outcome of the prevention effort. In fact, highly rated examples of this approach were less likely than lower rated examples to offer access to drug-free activities or wilderness challenge experiences" (NSE, p. 44).

APPENDIX D:
MATERIALS GUIDELINES - OSAP, 1991

SCIENTIFIC GUIDELINES

The material is scientifically significant, based on valid assumptions, supported by accurate citations, and appropriately used. if the developers are working from hypotheses, theories, or models but not from statistically significant and conclusive research which has been replicated, this should be noted under comments; for example, this appears to be based on a promising prevention hypothesis, which is in the testing phase. This would not be rated unacceptable unless the National Institute on Drug Abuse (NIDA) or the National Institute on Alcohol Abuse and Alcoholism (NIAAA) believe that harm could result from further testing; for example, an applied theory has resulted in increased drug use or application may result in misperception or other harm.

The scientific methods and approaches used are adequate, appropriate, and clearly described. These **include** the methods of basic biomedical research, behavioral research, and applied research. Clinical studies use and describe sound modalities.

Findings reported are accurate, current, applicable to the subject matter, and appropriately interpreted. The findings follow from the methods and approach used. For instance, facts should not be exaggerated nor purposely understated.

POLICY GUIDELINES

1. **Material makes clear that illegal and unwise drug use (including alcohol for those under 21) is unhealthy and harmful for all persons.** There are five kinds of illegal or unwise drug use:

    a. Use of any legally prohibited drug. For example, heroin, cocaine, PCP, and “designer drugs” are all legally prohibited drugs--it is unlawful to produce, distribute or purchase these drugs under any circumstances.

    b. Use of a drug for a purpose other than its prescribed use (e.g., tranquilizer or diet pill for purposes other than prescribed).

    c. Use of any product or substance that can produce a drug-like effect (e.g., using glues, gasoline, or aerosols as inhalants).

    d. Use of any legal drug, including alcohol or tobacco, by individuals legally underage for its use.

    e. Illegal or unwise use of a legal drug; for example, public intoxication or operation of a car after drinking or other drug-taking.

Materials should communicate clearly that all the above are either illegal and/or potentially harmful. Look for “red flag” phrases incorrectly implying that there is a “safe” use of illegal drugs. For example, materials that use the term “mood-altering” as a euphemism for “mind-altering” drugs or imply that there are no “good” or “bad” drugs, just “improper use, misuse, or abuse.”

2. **Material gives a clear message that at risk is associated with using any form or amount of alcohol or other drugs.**

   It is misleading to state or imply that there are any risk-free or fully safe levels of use of alcohol or other drugs. Even small amounts of alcohol and other drugs can increase risk of injury or to health.

   If the message is that some people use alcohol to relax or to celebrate, it also should say that alcohol is a drug and, as with any drug, there are risks associated with use. No materials should give or imply mixed messages: for example, it's safe to drink as much as you want as long as you don't drive; using drugs “recreationally” or “experimentally” is safe but don't get hooked; beer drinkers can't become alcoholic; or marijuana is a “soft” drug and heroin is a “hard” drug, implying that one is safe and the other is dangerous.

   Materials recommending a designated driver should be rated unacceptable. They encourage heavy alcohol use by implying that it is okay to drink to intoxication as long as you don't drive.

   Materials that carry messages, either implicitly or explicitly, that drinking alcoholic beverages is universal or the norm for virtually all occasions are unacceptable. For instance, a publication that states you should not drink to the point of intoxication and drive, but encourages “moderate” use on other occasions as a norm, should be considered primarily promotional and rated as unacceptable.

3. **Material gives a clear message of no alcohol use for persons under 21 years of age, pregnant women, recovering alcoholics and drug addicts, and persons taking prescription or nonprescription drugs.**

   Persons Under 21 Years of Age

   Clearly young people must go through a decision-making process regarding alcohol use. Learning how to make wise decisions is an important skill. However, the material should make it clear that a non-use decision is best and give support for this decision.

   Be sure that materials targeting underage college students convey the alcohol “no use” message. If materials addressing this audience are not age specific, assume that most undergraduate college students are under the legal drinking age of 21.

   All youth materials should adhere to a strict abstinence message. Any material that talks about drinking and driving should be aimed at adults, not at underage youth. Materials recommending designated drivers should be rated unacceptable as they are giving a mixed “no use” message to youth — they imply that it’s okay to drink as long as you don't drive.

Pregnant Women

Material for pregnant women should give a clear abstinence message. The U.S. Surgeon General says that "the safest choice is not to drink at all during pregnancy or if you are planning pregnancy." Abstinence during pregnancy removes the risk of producing a child with alcohol-related birth detects. Material that merely warns about the dangers of drinking during pregnancy without stating an abstinence message should be rated as unacceptable. For example, this is unacceptable: "you owe it to yourself and your unborn child to be informed about drinking during pregnancy and to avoid excessive or abusive drinking."

Materials stating that "research is inconclusive" or "not enough is known to make judgment" or "some believe this...while others believe that" are waffling. In fact, since not enough is known about how much alcohol is acceptable, for whom, and during which stages of pregnancy, the safest choice is not to drink during pregnancy. This message should be clearly stated.

Recovering Alcoholics

Abstinence from alcohol is regarded as a major goal of treatment for alcoholics in the United States. Those in treatment are urged to abstain from drinking and also are counseled to avoid psychoactive drugs. Clinical and scientific evidence seems to support the view that once physical dependence has occurred, the alcoholic no longer has the option of returning to social drinking. Materials indicating that controlled drinking or an occasional social drink is all right for recovering alcoholics, should be rated as unacceptable. Many treatment professionals also support the hypothesis that recovering addicts also should not use alcohol--but additional testing is required before assessing materials based on this concept.

Individuals Using Prescription or Nonprescription Medications

Materials should state that persons taking medications should not drink alcohol. An alcohol and drug combination may alter a drug's effectiveness. The physical reactions are unpredictable and sometimes fatal. Also, many medications
contain alcohol.

4. **Material states clearly that pregnant women must not use any drugs (prescription or nonprescription) without first consulting their physicians.**

Although scientists do not know, and may never know, about the exact effects of all drugs on unborn babies, animal research and the unfortunate thalidomide tragedy have provided important clues about the possibility of prenatal damage. Materials should clearly state that pregnant women should consult their physician before buying any new drug, refilling a prescription, or taking medication on hand for common ailments, such as headaches and colds.

Common over-the-counter drugs that should be avoided by pregnant women without first consulting their physicians are antacids, aspirin, laxatives, nose drops, nasal sprays, and vitamins. Likewise, commonly prescribed drugs that can be dangerous to a fetus are

antibiotics, antihistamines, antimigraines, antinauseants, diuretics, hormones, such as in oral contraceptives, vaccinations, tranquilizers, and sedatives. Materials must state clearly that these and other drugs should only be used by pregnant women on the advice of their physicians or other medical practitioners.

5. **Material does not glamorize or glorify the use of alcohol and other drugs.**

   Materials should not portray alcohol and other drug use as a positive experience. For youth, the first temptation to use alcohol and other drugs often comes as pressure to be "one of the gang." Depicting alcohol and other drug use as a way to have a good time, a way to "fit in" be sexy, or attain social and financial status may lure potential users. Rate as unacceptable materials that depict alcohol and other drug use in a positive or attractive light.

6. **Prevention material does not contain illustrations or dramatizations that could teach people ways to prepare, obtain, or ingest illegal drugs, and whenever feasible materials for youth contain no illustrations of drugs. Intervention material does not contain illustrations or dramatizations that may stimulate recovering addicts or alcoholics to use drugs.**

   Prevention materials that illustrate drug paraphernalia and methods of Illegal drug use In such a way that they may inadvertently instruct an individual about how to use or obtain illegal other drugs are unacceptable. Prevention materials targeting youth should contain no illustrations of illegal drugs unless when making a non-use point that cannot be made in any other way. Illegal drugs should not be used as graphic "filler."

   Intervention materials depicting action scenes of consumption or Ingestion of alcohol and other drugs may negatively influence the audience they are intended to help. For example, scenes of people injecting drugs, sniffing cocaine, or drinking alcohol may stimulate the behavior. A powerful craving for cocaine has been found to be very common for all cocaine addicts and can be easily stimulated by the sight of this drug and by objects, people, paraphernalia, places, and emotions associated in the addict's mind with cocaine. Therefore, explicit Illustrations or dramatizations of drugs or drug use should not be used in materials targeted to recovering persons. All materials containing such illustrations or dramatizations should be rated unacceptable. Caution is actually wise In depicting any illegal drug use for any population, since it Is unclear as to who may be most likely to use alcohol or other drugs after seeing which depictions.

7. **Material does not "blame the victim."**

   Addiction is an illness. therefore, material should focus on preventing and treating the disease and not on berating the individual. Materials that focus on an Individuals shortcomings as a reason-for usage or addiction are "blaming the victim" and should be rated as unacceptable. This is not to imply that a person should not take responsibility for his or her alcohol and other drug problems, which may be related to addiction. dependence, and even lust very unwise use. The material, however, should also include

encouraging the person to take responsibility for seeking help, if alcohol and other drug problems continue and/or dependence is suspected. The material should include resources for seeking help.

Materials using insulting terms about the victims of drug or alcohol abuse do not conform to OSAP policy and should be rated unacceptable. for example, information that refers to those who consume alcohol and illegal drugs as “drunks,” ”skid row bums,” “pot heads,” or “dope fiends” should be rejected.

8. **Material targeting youth does not use recovering addicts, or alcoholics as role models.**

Prevention education materials targeting youth that use recovering addicts or alcoholics as role models do not conform to OSAP policy. While the power of the confession may be useful in an intervention program counseling high-risk students or adults who are recovering users, it often has the opposite effect on children.

Focus group testing has shown children and adolescents enrolled in prevention education programs (most of whom are not recovering users) may get a different message than what is intended from the testimony of recovering addicts and ,alcoholics. Rather than the intended “don’t do as I did” message, children may hear the message that the speaker used alcohol and other drugs and survived very well or even became wealthy and famous. An exception may be made for role models who clearly show they have been negatively affected by the use of alcohol and other drugs, such as someone now visibly handicapped or injured as a result of alcohol and other drug use.

Materials targeting adults that use these individuals as role models may be acceptable, provided they meet all of the other criteria.

9. **Material supports abstinence as a viable choice.**

Materials need to give a clear message that abstinence is a feasible choice for everyone. For example, they should not imply that the only solution for a headache is an over-the-counter analgesic or that the only way to celebrate a special event is with an alcoholic toast. Materials focusing on reducing or limiting the amount of alcohol or other drugs taken are unacceptable if they don’t also present the message that abstinence is another viable choice. This in no way implies that valid medical attention, including appropriate drugs, should be withheld from anyone for any reason.

10. **Cultural and ethnic sensitivity**

Examples should be culturally and ethnically sensitive. Materials should not be biased and should not perpetuate myth or stereotype. They should reflect the social, economic, and familial norms of the intended audience and reflect the physical appearance of the audience. Extreme care should be taken in detecting subtle racist or sexist biases. For example, everything “good” is portrayed with white symbols and everything “bad” or “wrong” is portrayed with brown, black, or dark colors; or only males being arrested for alcohol-impaired driving. Norms and symbols important to the culture of the audience also should be reflected; e.g., groups are more important than individuals among some

audiences; spiritual symbols are very important among some populations. Materials also need to both reflect and respect which cultural factors as the importance of the extended family, key role of grandparents, and religion.

COMMUNICATIONS GUIDELINES

1. **Material is Appropriate for Target Audience at Cognitive and Developmental Levels**

   Cognitive

   The reading level should not be higher than that of the audience so the material can be clearly understood. Thinking capabilities should be addressed; for example, is the audience capable of concrete or abstract thinking? Is the audience able to distinguish subtleties or must the consequences be very clear?

   Developmental

   The material must address the social, emotional, physical, and intellectual skills of the audience. For instance, since children of alcoholics may have underdeveloped social and emotional skills, recommended strategies may need to be implemented at a slower pace; high risk youth with attention deficits must be given special consideration; peer resistance strategies may require positive social skill development prior to implementation of “saying no” techniques; etc.

2. **Institutional Source**

   The institutional source should be credible for the target audience. Although some organizations create high-production quality materials there may be a real or perceived conflict of interest. The same message delivered by the alcohol beverage industry may be less credible for some audiences than if delivered by NIAAA. Likewise, tobacco lobby groups may lack credibility with a public health audience.

3. **Individual Source**

   The individuals delivering the messages can be very important; for example, doctors listen to other doctors, preteens listen to teenagers, and many Americans trust the Surgeon General on health issues. Keep in mind your target audience. Recovering addicts and alcoholics are not good sources for children/youth because they often misinterpret the messages of these individuals.

4. **Language**

   Language should be appropriate and grammatically correct. if Spanish is used, it should be grammatically correct and appropriate to the particular Hispanic/Latino target audience.

5. **Tone**

   The tone should not be condescending, judgmental, or preachy. Some fear-arousing tone may be acceptable. If fear-arousing tone is excessive it may lead to denial or to the formation of an attitude of personal invulnerability— "it cant happen to me."

6. **Length**

   The length of the product should allow sufficient time for a conclusion to be drawn. It should be short enough to prevent boredom without sacrificing the message.

7. **Format**

   Production quality is an important consideration. The material should be as professional in appearance at possible, attractive, and well written. The format (type, size, and layout) should be appropriate to the audience (a large typeface is preferable for materials that will be read by either young children or people with a low-literacy level; text should not be dense; headings and photo captions should be used for imparting essential information). Color is very important. People pay more attention to materials that have color rather than just black and white. However, black and white can be enhanced and be highly appealing by using screens to achieve various shades of gray; by boxing in copy; by using photos, graphs, bullets to highlight text, and so forth. Use of high-cost techniques is not necessary to reflect high production quality. Audiovisual materials should otter clear and understandable sound and visual quality. If the material is intended for TV or radio use, commercial broadcast standards should be applied.

8. **Messages should:**

   - **Be appealing.** Appearance should be current and stylish. Products currently popular with youth need to match existing trends.

   - **Be believable.** The reader/viewer should be able to relate to the message--age, gender, socioculture, ethnic group.

   - **Create awareness.** Messages should make the reader aware of the need for change, need for further information, seriousness of alcohol and other drug problems.

   - **Persuade.** Message must not preach, but rather find positive appeals that engage the target audience.

   - **Call for action.** Some stated behavior should be called for so the message is not merely an intellectual exercise. Examples include seeking treatment, calling a referral number, confronting a drug-using spouse or friend, forming a parent group.

   - **Be pretested.** Messages can be easily misinterpreted, and therefore, should be carefully pretested with gatekeepers (e.g., Cub Scout leaders) and with the intended audiences (e.g.,

Cub Scouts). For instance, Cub Scout leaders may believe that drug-free means without drugs, but the Cub Scouts themselves may think that drug-free means free drugs. Children think concretely and literally, whereas most adults think abstractly.

9. **Stand-Alone versus Combined With Other Messages and/or Materials**

   Some materials, such as videos, are more effective if accompanied by a facilitator's or user's guide.

10. **Readability Level**

    The readability level should reflect the skills of the target audience.

APPENDIX E:
CHARACTERISTICS OF A SAFE, DISCIPLINED, AND DRUG-FREE SCHOOL

U.S. DEPT. OF EDUCATION, 1994

In addition to giving the six characteristics listed below as criteria for rating schools, the USDE listed policies or practices that would disqualify schools from eligibility for recognition under this program. These objectionable items are:

- Using a curriculum that teaches "responsible use" or emphasizes open-ended decision-making about the use of tobacco, alcohol, and other drugs.
- Use by staff of resource materials, including audiovisual and library materials, that promote "responsible use" or send a "mixed message."
- Permitting student activities that promote "responsible use" or send a "mixed" message.
- Allowing students to possess, smoke, or use tobacco products in school, on school grounds, or at school-sponsored activities.
- Holding up recovering alcoholics and other drug users as role models for non-using students.
- Permitting adults to use or sell alcoholic beverages at any school-sponsored activity.

The definitions of "responsible use" and "mixed messages" given by USDE were:

- **Responsible use:** A belief that illicit drugs are harmful only under certain circumstances.
- **Mixed message:** A message that encourages students not to use illicit drugs, but nonetheless details a course of action for the student to follow if he or she uses illicit drugs, e.g., "Don't drink; but if you do, don't drive!"

The following six characteristics and sub-points were listed by USDE as criteria for rating how effective and comprehensive a school's drug-free programs were:

1. **RECOGNIZING, ASSESSING, AND MONITORING THE PROBLEM**

- The school has determined:

  — the extent and nature of its tobacco, alcohol, and other drug problems and
  — the extent and nature of its discipline and violence problem.

- The school has coordinated with outside community groups to accurately assess the nature and extent of its problem.

- The school makes its assessment and progress reports available to the public.

- The school has documented evidence that it is making progress in reducing tobacco, alcohol, and other drug use, and incidents of violent and disruptive behavior.

2. **SETTING, IMPLEMENTING, AND ENFORCING POLICY**

- The school has established and implemented a policy that clearly states that the unlawful possession, use, distribution, or sale of all drugs, including alcohol and tobacco, is wrong and harmful and will not be tolerated. Policies apply to students, school staff, and others attending school functions. Responses to policy violations by students and staff reflect a range of appropriate consequences and rehabilitative measures; and every violation, regardless of how minor, receives a response.

- The school maintains records on all infractions of school policy, including disruption in class, verbal/physical abuse of staff and other students, and absenteeism.

- The school has clear policies regarding the reporting of behavior problems and infractions of law. The school has evidence to show that it is adhering to its policies.

- The school has a range of sanctions for those who violate school policies and uses a variety of those sanctions.

- The school maintains records that show that policies related to discipline and drugs are equitably enforced.

- All students, parents, and faculty has been informed of the school policies.

3. **DEVELOPING AND IMPLEMENTING THE DRUG EDUCATION AND PREVENTION PROGRAM**

- The school's drug education and prevention program is based upon an assessment of the problem (See characteristic 1).

- The school has a drug education curriculum for all students.

- The school provides educational programs for students who have been suspended/expelled from the regular classroom.

- The curriculum makes it very clear that there is no room for students to make choices about whether or not it is all right to use tobacco, alcohol, or other drugs. Their use by students is illegal and unacceptable.

- The school has developed a comprehensive set of drug education and prevention programs to assist all of its students. The program includes, but is not limited to, such activities as:

  — Tutoring, mentoring, and other academic activities;
  — Counseling and support groups;
  — Vocational programs;
  — Social activities;

- Alternative programs, e.g., alternative school; and

- Community service programs.

- The program includes/address the following:

  — Information about all types of drugs, including medicines;
  — Relationship of drugs to suicide, AIDS, drug-affected babies, pregnancy, violence and other safety issues;
  — Media role in advertising alcohol and tobacco products;
  — Social consequences of drug use;
  — Respect for the laws and values of society, including discussions of right and wrong;
  — Healthy, safe, and responsible attitudes and behaviors;
  — Strategies to enable students to resist influence that encourage drug use, such as peer pressure, advertising, etc.
  — Ways to increase self-esteem and self-control ;
  — Sensitivity to cultural differences in the school and community and to local drug problems; and
  — Cooperative learning and consensus-building skills.

- The school provides opportunities for student participation in drug-free activities. These include, but are not limited to:

  — Assisting in the development of the school's tobacco, alcohol, drug, and safety policies;
  — Recommending the types of drug education and prevention programs and activities in which the school engage;
  — Operating drug education drug-free social events;
  — Implementing drug prevention support programs, such as peer counseling and mentoring for younger students;
  — Operating, under teacher supervision, student courts and other similar programs designed to have students recommend appropriate sanctions for fellow students found to have engaged in inappropriate behavior.

- Students are recognized for their efforts in preventing drug use and making the school environment safe, disciplined, and conducive to learning.

- The school has documented evidence that its programs are effective in reducing tobacco, alcohol, and other drug use and in making the school a safe, disciplined environment.

4. **EDUCATING AND TRAINING STAFF**

- The entire staff has been trained regarding its roles and responsibilities in implementing the policies.

- The school has an on-going mandatory training program for all administrators, teachers, and support staff. This program includes/addresses the following:

- School's tobacco, alcohol, and drug policies and their implementation;
- Accurate and up-to-date information on drug use, abuse, and dependency, including information on topics on which there is a great deal of misunderstanding, e.g., drug-affected children;
- Proper ways to respond to incidents of verbal and physical abuse and other acts of violence;
- Identification of students using drugs, including tobacco and alcohol;
- Effects of tobacco, alcohol, and other drug use on individuals, family members and others; and
- Intervention and referral techniques for students suspected of using drugs, threatening other students or staff, and engaging in criminal behavior.

- Training is conducted at least twice a year.

- Training is conducted in cooperation with community resources/agencies.

5. **PROMOTING PARENT INVOLVEMENT AND PROVIDING PARENT EDUCATION AND TRAINING**

- Parents are actively involved in the development and implementation of the school's tobacco, alcohol, drug, and school safety policies.

- Parents are involved as decision-makers, teachers, learners, resources, supporters, and advocates.

- Parents are provided information and training opportunities that address the following:

  - Effects of drug use, abuse, and dependency;
  - Ways to identify drug problems and refer people for treatment;
  - Available resources to diagnose and treat people with drug problems;
  - Laws and school policies on tobacco, alcohol, other drugs, and safety issues;
  - Importance of establishing appropriate family rules, monitoring behavior of children, ensuring adequate supervision of children, reinforcing positive behavior and imposing appropriate consequences;
  - Ways to improve family communication skills and conflict management; and
  - Networking with other parents.

6. **INTERACTING AND NETWORKING WITH COMMUNITY GROUPS AND AGENCIES**

- The school has developed an active partnership with community groups and organizations, including agencies involved in law enforcement, health, mental health, and social services. Where appropriate, the school has included in this partnership such organizations as probation agencies and parole offices.

- The school provides a "safe haven" to which students may come before and after school hours for study, recreation, and other activities which provides a tranquil and protected environment for students to learn and play in safety.

- The school coordinates and collaborates with community groups and or organizations for the following:

  - Identification of student populations that are in need of additional drug prevention services, and
  - Development of tobacco, alcohol, and other drug prevention and school safety programs, as well as the delivery of the following kinds of services:

    - Student assistance programs;
    - Employee assistance programs for school staff;
    - Latch-key child care;
    - Medical care, including treatment for alcohol and other drug use and mental
    - health care;
    - Nutritional information and counseling;
    - Social welfare services;
    - Probation services;
    - Continuing education programs for dropouts and pushouts; and
    - Programs for students at high risk for drug use.

APPENDIX F:
WEB SITES

The growing availability of information through the internet will in the future stimulate efforts to carefully review web sites that may be identified as sources of valid information pertinent to ATOD best practice. For this first edition of the *Best Practices in ATOD Prevention Handbook* the following four listings are offered of examples of such sites:

http;//www.cyfernet.org/

This site is managed by the US Department of Agriculture and provides a searchable database of programs designed for "at-risk" children, youth and families. Specific types of programs (e.g. "after-school program") may be searched to access program descriptions, evaluation results and contact information.

http://www.ssc.wisc.edu/irp/

Created by the Institute for Poverty at the University of Wisconsin-Madision, this website contains articles published in their newsletter called *Focus*. Articles cover topics about applied research and programs that target children in early childhood and school age years as well as issues affecting families in poverty.

http://www.carnegie.org

This website contains downloadable publications funded by the Carnegie Corporation. These publications cover topics from early childhood education/development through adolescent health and development.

http://aspe.os.dhhs.gov/PIC/intro.htm

Managed by the US Department of Health and Human Services, this website contains abstracts on in-process, completed, and on-going health and human services evaluations; short-term evaluative research; and policy-oriented projects conducted by HHS as well as by other federal departments and agencies, and the private sector.

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