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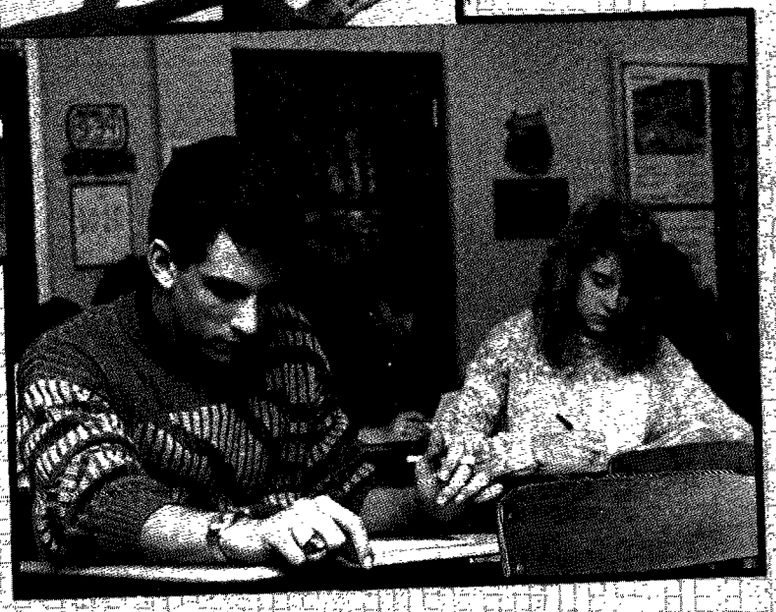
Prevention Plus II

Office for Substance Abuse Prevention

Tools for Creating and Sustaining Drug-Free Communities



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

1813.1 Prevention Plus II: Tools for Creating and Sustaining Drug-Free Communities

1813.1

OSAP

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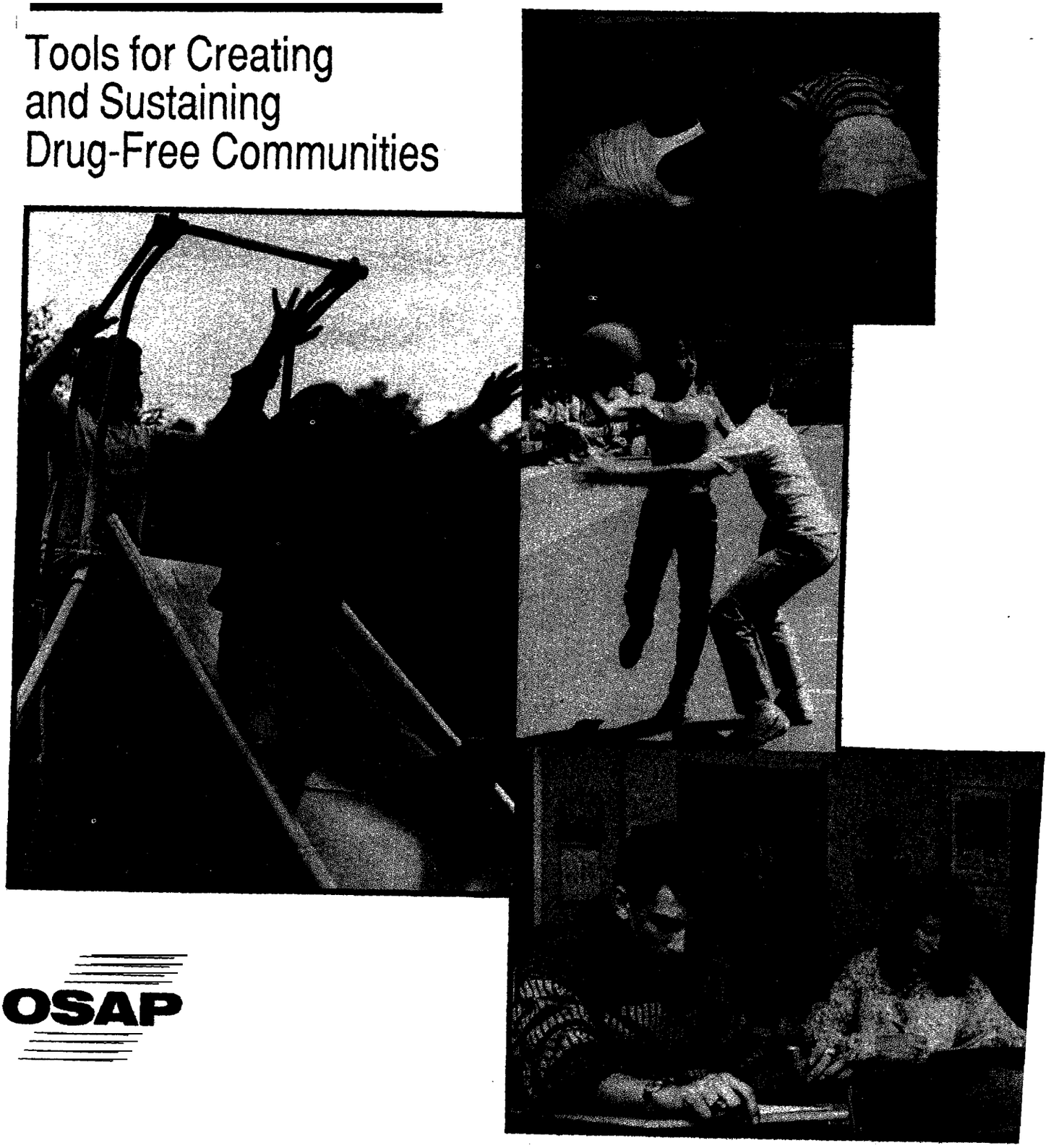
Tools for Creating and Sustaining Drug-Free Communities



OSAP

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Foreword

The primary goal of the Office for Substance Abuse Prevention (OSAP), a part of the Alcohol, Drug Abuse, and Mental Health Administration within the Public Health Service, is to prevent alcohol and other drug use among America's young people. In fact, OSAP was created by the Anti-Drug Abuse Act of 1986 as the cornerstone of the Federal strategy to reduce the demand for alcohol and other drugs. Youth have been targeted because almost all cigarette, alcohol, and illicit drug use is initiated before the age of 25; therefore, preventing the onset of ***use*** can lead to many lives free of the problems of alcohol and other drugs. In addition, the earlier a young person begins to consume alcohol or to use other drugs, the greater the likelihood that he or she will develop drug problems later. Alcohol, tobacco, and marijuana are the drugs that young people usually try first and are known as gateway drugs because they can lead to the use of other illegal drugs. For youth from higher risk environments, drug use may begin with a highly addictive form of cocaine known as crack cocaine, or with inhalants and PCP.

OSAP's message is clear: the use of any illegal drugs, the illegal use of alcohol, and the use of legal drugs in ways they were not intended should be prevented. The challenge is to gain acceptance and to have society speak with one voice through the media, family, religious institutions, worksites, youth programs, and schools. To meet this challange, a variety of prevention approaches that are sensitive to cultural and societal norms, values, and patterns are needed. Many of these approaches were described in the first volume of Prevention ***Plus.*** It has become clear, however, that to be effective, a message from one segment of a community must be reinforced by other segments within the community. Integrating prevention messages and activities throughout the community is a promising approach, an approach known as the "systems approach." This volume, ***Prevention Plus II*** seeks to help communities adopt a comprehensive systems approach to

prevention. As other approaches or strategies become apparent, OSAP will develop additional volumes.

The systems approach is based on the finding that prevention programs do not work in isolation. There must be a continuum of clear, concise, and unambiguous messages that occur regularly in all parts of a community-in its schools, workplaces, media, religious institutions, public and private sectors, legal and judicial systems, and families. Additionally, because the causes of alcohol and other drug use are multiple-depending on environment, age, and so forth-a variety of approaches are needed, all of which should be integrated across community institutions. The pieces must be brought together in the form of a comprehensive program that works with every part of the community, providing many strategies and addressing the needs of all populations.

This manual is designed to help program planners and others to develop an effective systems approach to fighting the war against alcohol and other drug use among youth in their communities. It explains how individual, interpersonal, and environmental situations and conditions contribute to alcohol and other drug use and provides strategies for combating each of these forces. Nine steps to planning and implementing an integrated program are also provided, with worksheets, planning charts, and other aids. Finally, model communities around the country that have been successful with these approaches are described.

The responsibility for the successful implementation and maintenance of a prevention program is a joint venture; only a total systems approach that interconnects specific approaches that address the audience, the effects of alcohol and other drugs, and the environment will be successful.

It is OSAP's hope that communities throughout the country will use and benefit from the information presented in this volume. The success of the model communities described in Chapter 4 should be inspiration for us all.

Elaine M. Johnson, Ph.D.
Director
Office for Substance Abuse Prevention

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Glossary of Key Terms

- Affective and Interpersonal Education-These prevention approaches seek to improve self-esteem, decision-making, communication, and clarification values on the basis of the belief that deficits in these traits and skills are related to alcohol and other drug use.

- Alternative Activities-This prevention strategy provides the opportunity for youth to participate in alternative activities, with the hope that the activities will serve some of the same functions as alcohol and other drug use would. The alternatives provide personal growth, excitement, challenge, and relief from boredom.

- Broad-based Programs-Broad-based community programs include the efforts of many segments of a community, increasing the commitment of time, money, and support.

- Community Norms-Community norms are the standards set by adults and youth that determine acceptable behavior in a community. For example, disallowing nudity on public beaches is the result of norms set by the community about appropriate behavior at the beach. Perceptions of community norms regarding alcohol and other drug use are believed to have a significant influence on behavior related to alcohol and other drug use.

- Cooperative Consultation-The purpose of cooperative consultation is to educate media personnel on the importance of creating entertainment programs that portray alcohol and other drug use in a realistic, nonglamorous, and responsible fashion. It involves the establishment of a nonaggressive but persuasive relationship with producers and writers so that they can adjust their styles to portray a more acceptable message in relation to alcohol and other drugs.

- Drug Trafficking-Drug trafficking refers to the buying and selling of illicit drugs, whether from supplier to dealer or from dealer to user.

- High-risk Youth-High-risk youth are particularly vulnerable to alcohol and other drug use. They generally fall into one or

more of the following categories: abused and/or neglected youth, homeless or runaway youth, physically or mentally handicapped youth, pregnant teenagers, school drop-outs, children of abusers of alcohol and other drugs, latchkey children, and economically disadvantaged youth. High-risk youth usually meet more than one of these criteria.

- Interactive Group **Process** Skills-This teaching technique is used to stimulate active participation of all students in the classroom activity, be it a discussion, brainstorming session, or the practice of new behaviors, Teachers of interactive group process skills must be properly trained in this teaching technique for it to be effective.

- Interpersonal Skills-Interpersonal skills include all capacities for relating to other people and for communicating effectively. For some youth, the lack of interpersonal skills appears to be related to or the result of the initiation of alcohol or other drug use.

- Intervention-The aim of intervention is to identify alcohol or other drug users and to assist them in modifying their behavior or, if necessary, to obtain early treatment. Intervention includes activities, programs, or practices that prevent a health problem from continuing once it has been detected.

- Latchkey Children-Children who do not have parental or other supervision after school are sometimes referred to as "latchkey children."

- **Peer Education or Peer Leadership---This** is the process of having same-age or slightly older students conduct programs. Often a combination of both education and leadership, the education component consists of peers providing factual information, and the leadership component consists of several elements, including modeling appropriate behavior, teaching social skills, and leading role rehearsals.

- Prevention-The objective of primary prevention is to protect the individual in order to avoid problems prior to signs or symptoms of problems. It also includes those activities, programs, and practices that operate on a fundamentally nonpersonal basis to alter the set of opportunities, risks, and expectations surrounding individuals. Secondary prevention identifies persons in the early stages of problem behaviors associated with alcohol and other drugs and attempts to avert the ensuing negative consequences by inducing them to cease their use through counseling or treatment. **It** is often referred to as early intervention.

Tertiary prevention strives to end compulsive use of alcohol or other drugs and/or to ameliorate their negative effects through treatment and rehabilitation. This is most often referred to as treatment but also includes rehabilitation and relapse prevention.

- Responsible Decision-making-Often confused with "responsible use," "responsible decision-making" is an important skill for all young people to develop. Teaching this skill is often included in health promotion programs for youth.

- Responsible Use-The presentation of factual drug information once was used to encourage underage youth to make a decision to use alcohol or other drugs "responsibly." Programs of this type were not effective and are not compatible with a philosophy that regards the use of alcohol or other drugs, in any quantity, as unacceptable behavior for youth.

- Scare Tactics-Many early educational efforts presented information concerning the most severe consequences that could result from alcohol and other drug use, along with a good dose of moralizing. Young people seldom accepted this information: therefore, it did little to affect their use of alcohol and other drugs. Realistic facts about risks and consequences, however, play an important role in prevention.

- Student Assistance Program-Modeled after the Employee Assistance Program found in industry, the Student Assistance Program focuses on behavior and performance at school and uses a referral process that includes screening for alcohol and other drug involvement. Student Assistance Programs also work with self-referred youth to address problems of alcohol and other drug use.

- Surrogate Parents-Surrogate parents, such as grandparents or other close relatives and adults, take on many of the responsibilities of raising children that have traditionally been the domain of natural parents.

- Systems Approach-A systems approach to prevention views the community and the environment as interconnected parts, each affecting the others and all needing to work together.

Style Sheet on Alcohol and Other Drug Terminology

When communicating about alcohol and other drugs, it is crucial for the terminology of professionals in the field to be both clear and consistent. The Office for Substance Abuse Prevention (OSAP) has developed the following list of terms to assist communicators of verbal and written information and program planners who are responsible for evaluating materials.

***Do Not* Use**	Use
Drunk driving	Alcohol-impaired driving (because a person does not have to be drunk to be impaired)
Liquor (to mean any alcoholic beverage)	Beer, wine, and/or distilled spirits
Substance abuse	Alcohol and other drug abuse
Substance use	Alcohol and other drug use
"Abuse" when the sentence refers to youth, teens, or children (anyone under 21)	Use (OSAP aims to prevent use-not abuse-of alcohol and other drugs by youth)
Hard or soft drugs	Drugs-since all illicit drugs are harmful
Recreational use of drugs	Use-since no drug use is recreational
Responsible use	Use-since there is risk associated with all use
Accidents when referring to alcohol/drug use and traffic crashes	Crashes

Drug abuse prevention or alcohol abuse prevention	Except when referring to adults. Use the phrase, "to prevent alcohol and other drug problems"
Mood-altering drugs	Mind-altering drugs
Workaholic	(Since it trivializes the alcohol dependence problem)

For more information about communicating messages about alcohol and other drugs more effectively, write the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852, or call (301) 468-2600.

Acronyms, Abbreviations, and Editorial Guidelines

Acronyms are used frequently today both in publications and in speaking. To help those involved in the prevention of alcohol and other drug problems, the following list of acronyms and their meanings was created. The list includes alcohol and other drug Federal agencies, organizations, and common phrases.

The Office for Substance Abuse Prevention is aware of the abundance and overuse of acronyms in the alcohol and other drug fields. To minimize the confusion and misunderstanding, acronyms should be used only when necessary. When one must use acronyms, the full title should be defined when used the first time.

AA	Alcoholics Anonymous
AAAA	American Association of Advertising Agencies
AACAP	American Academy of Child and Adolescent Psychiatry
AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
AAPA	American Academy of Physician Assistants
AAPSC	American Association of Psychiatric Services for Children
AASA	American Association of School Administrators
ABC	Alcoholic Beverage Control
ACDE	American Council on Drug Education
ACOA	Adult Children of Alcoholics
ACOG	American College of Obstetricians and Gynecologists

ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration
ADMS	Alcohol, Drug Abuse, and Mental Health Services
ADPA	Alcohol and Drug Problems Association of North America
ADTR	Alcohol and Drug Abuse Treatment and Rehabilitation
AHA	American Hospital Association
AHHAP	Association of Halfway House Alcoholism Programs of North America
AIDS	Acquired Immunodeficiency Syndrome
ALMACA	Association of Labor-Management Administrators and Consultants on Alcoholics, Inc.
AMA	American Medical Association
AMERSA	Association for Medical Education and Research in Substance Abuse
AMSAODD	American Medical Society on Alcoholism and Other Drug Dependencies
ANA	American Nurses Association
AOD	Alcohol and Other Drugs
APA	American Psychiatric Association
APA	American Psychological Association
APHA	American Public Health Association
ARBD	Alcohol-Related Birth Defects
ASAP	American Society for Adolescent Psychiatry
ASAP	Americans for Substance Abuse Prevention
ASIM	American Society of Internal Medicine
BAAD	Black Actors Against Drugs
BAC	Blood Alcohol Content

BATF	Bureau of Alcohol, Tobacco, and Firearms
BIA	Bureau of Indian Affairs
CA	Cocaine Anonymous
CAC	Certified Alcohol Counselor
CDC	Centers for Disease Control
CEAP	Certified Employee Assistance Professionals
CICAD	Inter-American Drug Abuse Control Commission
COA	Children of Alcoholics
COSSMHO	National Coalition of Hispanic Health and Human Services Organization
CRC/AODA	Certification Reciprocity Consortium/ Alcohol and Other Drug Abuse
CSPI	Center for Science in the Public Interest
DAWN	Drug Abuse Warning Network
DEA	Drug Enforcement Agency
DHHS	Department of Health and Human Services
DOC	Doctors Ought to Care
D U I	Driving Under the Influence
D W I	Driving While Intoxicated
EAP	Employee Assistance Program
FA	Families Anonymous
FARS	Fatal Accident Reporting System
FAS	Fetal Alcohol Syndrome
FDA	Food and Drug Administration
FFC	Futures for Children
FIA	Families in Action
HCFA'	Health Care Financing Administration
HIV	Human Immunodeficiency Virus
HUD	Department of Housing and Urban Development
IBCA	Institute for Black Chemical Abuse
ICAA	International Council on Alcoholism and Addiction

IV	Intravenous
LULAC	League of United Latin American Citizens
MADD	Mothers Against Drunk Driving
NA	Narcotics Anonymous
NAACOG	Nurses Association of American College of Obstetricians and Gynecologists
NAACP	National Association for the Advancement of Colored People
NAADC	National Association of Alcoholism and Drug Abuse Counselors
NAATP	National Association of Addictions Treatment Providers
NACoA	National Association for Children of Alcoholics
NADAP	National Association on Drug Abuse Problems
NALGAP	National Association of Lesbian and Gay Alcoholism Professionals
NANACoA	National Association for Native American Children of Alcoholics
NAPARE	National Association for Perinatal Addiction Research and Education
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NASN	National Association of School Nurses
NASW	National Association of Social Workers
NAPAFADA	National Asian Pacific American Families Against Drug Abuse
NATC	National Alcohol Tax Coalition
NAWAODD	National Association of Women in Alcoholism and Other Drug Dependencies
NBAC	National Black Alcoholism Council
NBNA	National Black Nurses Association
NCA	National Council on Alcoholism

NCAADCCB	National Commission on Accreditation of Alcoholism and Drug Abuse Counselor Credentialing Bodies
NCAAP	National Coalition for Adequate Alcoholism Programs
NCADI	National Clearinghouse for Alcohol and Drug Information
NCCA	National Clergy on Alcoholism
NCFR	National Council on Family Relations
NCPC	National Crime Prevention Council
NCYD	National Center for Youth Development
NECAD	National Episcopal Coalition on Alcohol and Drugs
NFP	National Federation of Parents
NHFADA	National Hispanic Family Against Drug Abuse
NHTSA	National Highway Traffic Safety Administration
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NMA	National Medical Association
NMHA	National Mental Health Association
NNRYS	National Network of Runaway and Youth Services
NNSA	National Nurses Society on Addictions
NO-ALCC	National Organization Against Liquor in Candy for Children
NPN	National Prevention Network
OSAP	Office for Substance Abuse Prevention
OTC	Over-the-Counter
OUI	Operating Under the Influence
PADA	Pharmacists Against Drug Abuse

PHS	Public Health Service
PRC	Prevention Research Center
PRIDE	National Parents' Resource Institute for Drug Education
PSA	Public Service Announcement
PTA	National Congress of Parents and Teachers
PTO	Parer&Teacher Organization
RADAR	Regional Alcohol and Drug Awareness Resource
RID	Remove Intoxicated Drivers
SADD	Students Against Drunk Driving
SALIS	Substance Abuse Librarians and Information Specialists
SPC	State Prevention Coordinators
TC	Treatment Center
VA	Veterans Administration
WIC	Women, Infants, and Children

CHAPTER 1

The Impact of Alcohol and Other Drug Use and the Importance of Prevention

The Importance and Payoffs of Prevention

Alcohol and other drug problems cost society in real dollars and in pain and suffering. These problems are often closely associated with such problems as automobile crashes, incest, child abuse, assault, vandalism, rape, and many other crimes. A personal understanding results when you experience or observe the negative consequences of alcohol and other drug abuse in people with whom we live, work, and play. The discussion that follows should clarify the impact that the use of alcohol and other drugs has on American youth and society.

Those experiencing alcohol and other drug problems and their families live with disruption in their lives. They often experience loss of income, accidents, injuries, illnesses, strained relationships, and involvement in crime. The use of alcohol and other drugs by-youth can have particularly serious consequences, as all too often it prevents young people from reaching their intellectual, social, and emotional potential-ingredients thought to be important for future personal and economic success. For example, when alcohol and other drugs are used young people do not acquire healthy skills for overcoming social awkwardness, or for tolerating anxiety and boredom. Alcohol and other drugs may also predispose young people to high-risk behaviors such as sexual behavior that may result in unwanted pregnancy or infection with sexually transmitted diseases. Alcohol and other drug use combined with driving too often result in related traffic fatalities. In fact, the 16- to 24-year-old age group is

the only age group in our society for whom life expectancy is not increasing because of alcohol-related traffic crashes.

Those who use alcohol and other drugs affect the lives of others. The most visible casualties are victims of alcohol- or other drug-related automobile crashes and victims of crimes committed to support an addict's alcohol or other drug habit. Less visible are the wives, husbands, sons, daughters, sisters, and brothers that are affected by the alcohol or other drug use of a family member. There are 28 million children of alcoholics in the United States alone, 7 million of whom are under the age of 18. The children of alcoholics endure a great deal of stress and abuse as a direct result of living with an alcoholic parent and may develop problems that persist throughout adulthood. Husbands and wives may also experience physical and psychological trauma. These families also disproportionately suffer other losses, including the loss from incarceration or death of the dependent or addicted family member.

Alcohol use is involved in up to 50 percent of spousal abuse cases (*NIAAA Fifth Special Report to Congress), 49* percent of all murders, 68 percent of manslaughter charges, between 20 and 35 percent of suicides, more than 62 percent of assaults, 52 percent of rapes, and 38 percent of child abuse fatalities (*NIAAA Sixth Special Report to Congress) (see* Figure 1.1). Figures such as these and others lead George Gallup, Jr., to say, "America does not have a crime problem. America does not have a problem of job absenteeism and low productivity. America does not have a teenage pregnancy problem. America does not have a problem of broken homes and marriages. America has an alcohol and drug problem."

Research has conclusively shown that the physical and psychological health of the young people of this country is best served by entirely preventing their use of alcohol and other drugs. The cost of not intervening to prevent alcohol and other drug use is great. The earlier a youth begins to drink alcohol and to use other drugs, the greater the likelihood of later alcohol and other drug problems. Alcohol and other drug use before age 15 greatly increases the risk of sustained problematic use in the future. In addition, the use of one psychoactive substance (e.g., tobacco, beer, wine, or marijuana> has, on the average, a predictable relationship to the eventual use of

other psychoactive drugs (such as cocaine, hallucinogens, barbituates, stimulants, or opiates). Although still possible, those individuals who do not use alcohol, tobacco, or illicit drugs (with the exception of abused prescription drugs) before age 25 are unlikely to start using them later (13th Annual High School Senior Survey, 1988).

Attitudes concerning alcohol and other drug use are formed early-usually during preadolescence and early adolescence. Consequently, the prevention of alcohol and other drug use must begin very early.

In October 1986, the Anti-Drug Abuse Act was passed, thereby creating the Office for Substance Abuse Prevention (OSAP). The establishment of this Federal office was based on the growing understanding of the importance of prevention and signals a new era for progress in combating alcohol- and other drug-related problems. OSAP,

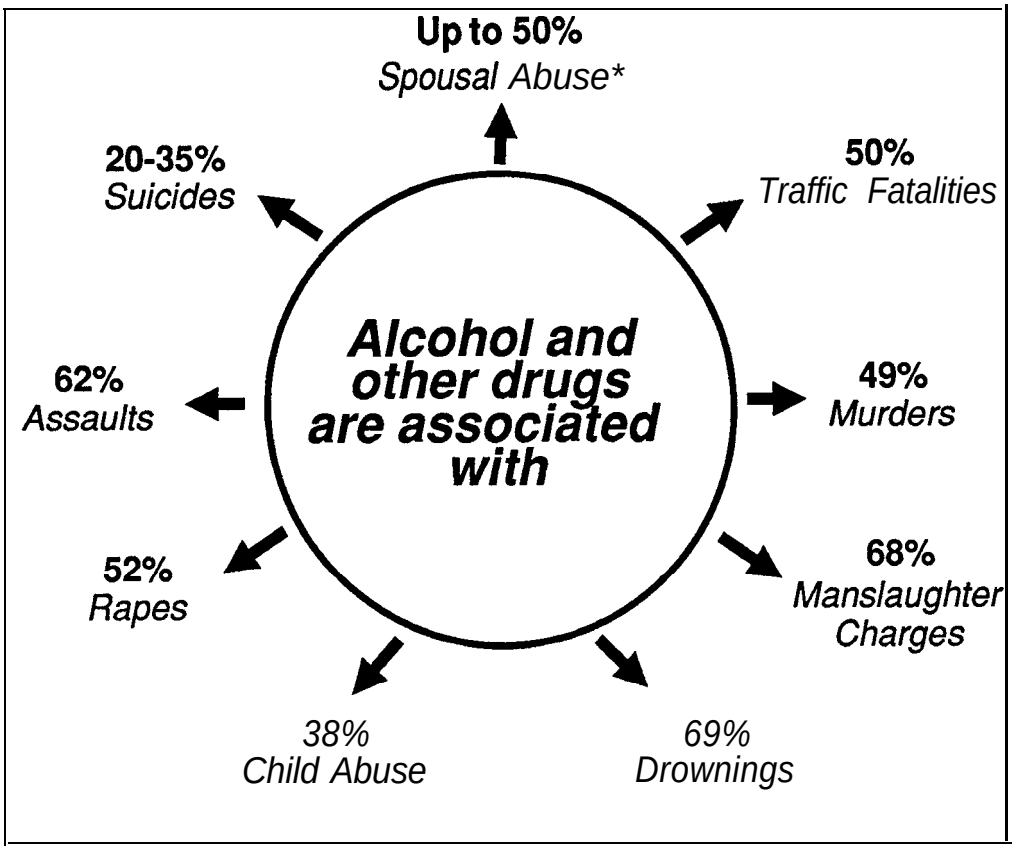

Figure 1.1 America Has a Big Problem with Alcohol and Other Drugs

** As reported in the NIAAA Special Report to Congress, 1983.*
All other percentages were reported in the NIAAA Sixth Special Report to Congress, 1987.

with support from the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism (also within the Alcohol, Drug Abuse, and Mental Health Administration), serves as a resource to States, communities, industry, and many other voluntary and professional organizations helping to diminish alcohol- and other drug-related problems.

The statistics that follow (in the box and in Table 1.1) portray the breadth of alcohol and other drug problems. Unfortunately, most people have been and repeatedly will be touched by alcohol and other drug problems at some time in their lives-either through use by a friend, relative, co-worker, or stranger or by their own use.

In 1988, there were 247 million people in America. Of these it is estimated[1] that:

- Over 28 million are children of alcoholics.

  = 1 out of 8

- Of the 28 million, 1 out of 4 is under age **18.**

Alcohol and other drug problems cost money:[2]

$117,000,000,000	= Alcohol-related Costs
60,000,000,000	= Other Drug-related Costs
$177,000,000,000	= Yearly Total*

In 1983, there were 234 million people in America. In that year, the total cost to society in dollars and cents-not in suffering and pain-for alcohol abuse and alcoholism was a staggering $117 billion and, for other drug abuse, $60 billion (see Table 1.1). This represents approximately $756 for each man, woman, and child in America, or $63 a month. In the long run, the whole society pays for the negative consequences of alcohol and other drug use. Employers experience losses in productivity, taxpayers pay the bills for programs and services, and consumers pay higher insurance premiums. $177 billion would buy 1.75 million houses costing $100,000 each. If we prevented alcohol and other drug problems, this money could be spent to improve the standard of living of all persons.

[1]National Association for Children of Alcoholics (NACoA).

[2]Research Triangle Institute, 1983 figures, rounded off.

Table 1.1 Estimated Costs to U.S. Society of Alcohol Abuse and Other Drag Abuse in 1983 (In millions)

Costs	Alcohol Abuse	Drug Abuse	Total
Core Costs			
Direct			
Treatment and Support	$14,685	$ 2,049	$16,734
Indirect			
Mortality	18,151	2,486	20,637
Reduced Productivity	65,582	33,346	98,928
Lost Employment	5,323	405	5,728
Related Costs			
Direct			
Motor Vehicle Crashes	2,667	*	2,667
Crime'	2,607	6,565	9,172
Social Welfare	49	3	52
Other	3,673	677	4,350
Indirect			
Victims of Crime	192	945	1,137
Crime Careers	0	10,846	10,846
Incarceration	2,979	2,425	5,404
Motor Vehicle Crashes	583	*	583
Total	$116,491	$59,747	$176,238

* No data available.

Source: "Economic Costs to Society of Alcohol and Drug Abuse, and Mental Illness," study for the Alcohol, Drug Abuse, and Mental Health Administration, conducted by the Research Triangle Institute, Chapel Hill, NC, 1984.

Some people think that drug abuse is something that happens only in poor neighborhoods, but

- One in 37 high school seniors uses marijuana daily, and 1 in 7 reported using marijuana daily at some time in his or her life (14th and 13th Annual Survey of High School Seniors, respectively, University of Michigan's Institute for Social Research, 1988 data; see Table 1.2 for more complete figures).

- One in 23 high school seniors drinks alcohol every day and nearly 2 in 5 become intoxicated at least once every 2 weeks (14th Annual Survey of High School Seniors, University of Michigan's Institute for Social Research, 1988 data; see Table 1.2).

- Thirty-four percent of sixth graders experience peer pressure to use marijuana. (Weekly ***Reader National Survey of Drugs and Drinking,*** spring 1987, Field Publication, Middletown, CT; see Figure 1.2).

- Fifty-one percent of sixth graders experience peer pressure to drink beer, wine, or liquor ***(Weekly Reader National Survey on Drugs and Drinking,*** spring 1987, Field Publications, Middletown, CT; see Figure 1.3).

- Whereas it can take many years for an adult to become alcoholic, it often takes only 6 to 18 months of heavy drinking for an adolescent to become alcoholic (American Psychiatric Association).

- Americans pay more than $33 million each year resulting from lost productivity because of drug abuse ("Economic Costs to Society of Alcohol and Drug Abuse, and Mental Illness," Research Triangle Institute, Chapel Hill, NC, 1984).

- Five hundred thirty-three hospital emergency rooms, primarily in 21 metropolitan areas, saw an increase across diverse population groups of 454 percent in mentions of cocaine use over a B-year period ending in June 1988 (Drug Abuse Warning Network; see Table **1.3).**

Some Americans think that drinking too much is funny or part of being a man (or woman), or sexy, or fun, but

- Alcohol-impaired driving is the leading cause of death for young people. In 1986, alcohol-related highway accidents killed nearly 9,000 15- to 24-year-olds, accounting for 38 percent of all alcohol-related highway deaths that year (National Highway Traffic Safety Administration, Fatal Accident Reporting System, 1986).

- One-third of all teenagers have problems related to their alcohol consumption (National Institute on Alcohol Abuse and Alcoholism, ***Alcohol Consumption and Related Problems.*** Alcohol and Health Monograph No. 1, DHHS Pub. No. (ADM) 82-1190, 1982).

- About one-fourth of all American homes have been affected by alcohol-related family problems (Gallup Poll, April 1987).

- Liver cirrhosis, often caused by drinking, is the ninth leading cause of death (National Institute on Alcohol Abuse and Alcoholism, ***Sixth Special Report to Congress on Alcohol and Health,*** 1987).

- Analysis of mortality data on direct or contributing causes of death linked specifically to alcohol showed that death caused by excessive blood alcohol resulted in an average estimated loss of 29.1 years of potential life and death from alcohol abuse resulted in an average estimated loss of 24.1 years of potential life (National Institute on Alcohol Abuse and Alcoholism, ***Sixth Special Report to Congress on Alcohol and Health,*** 1987).

Some problems are greater for specific groups of people either because of body differences or because the communities they live in contribute to the problems. For instance,

- Women become intoxicated more quickly than men do because they generally have more fat and less muscle in their bodies.

- Native Americans seem prone to genetic vulnerabilities that make them more sensitive than the general population to the effects of alcohol and that contribute to a greater susceptibility for developing alcoholism.

- People who eat poorly because they may not have access to healthy foods may have more physical problems

related to alcohol consumption, such as liver damage, than people who have nutritionally sound diets.

- People who smoke or who are exposed to asbestos or other cancer-causing substances are more likely to develop alcohol-related cancers.

Table 1.2 Highlights from the High School Senior Survey, the Class of 1988

	Ever Used (%)	Past Month (%)	Daii Use 0
Alcohol	92.0	63.9	4.2
Cigarettes	66.4	28.7	18.1
Marijuana	47.2	18.0	2.7
Stimulants	19.8	4.6	0.3
Inhalants	17.5	3.0	0.3
Cocaine	12.1	3.4	0.2
Tranquilizers	9.4	1.5	0.0
Hallucinogens	9.2	2.3	0.0
Sedatives	7.8	1.4	0.1
Crack	4.8	1.6	0.1
PCP	2.9	0.3	0.1
Heroin	1.1	0.2	0.0

Notes:

This table shows the percentage of high school seniors from the Class of 1988 who have used drugs. "Ever Used" refers to having used at least one time. "Past Month" means that the student used the drug at least once in the 30 days prior to the study. The High School Senior Survey report from which these numbers were taken is available from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852.

These numbers were gathered in an annual nationwide survey conducted for the National Institute on Drug Abuse by the University of Michigan Institute for Social Research. The 1988 survey involved more than 16,000 high school seniors from public and private schools.

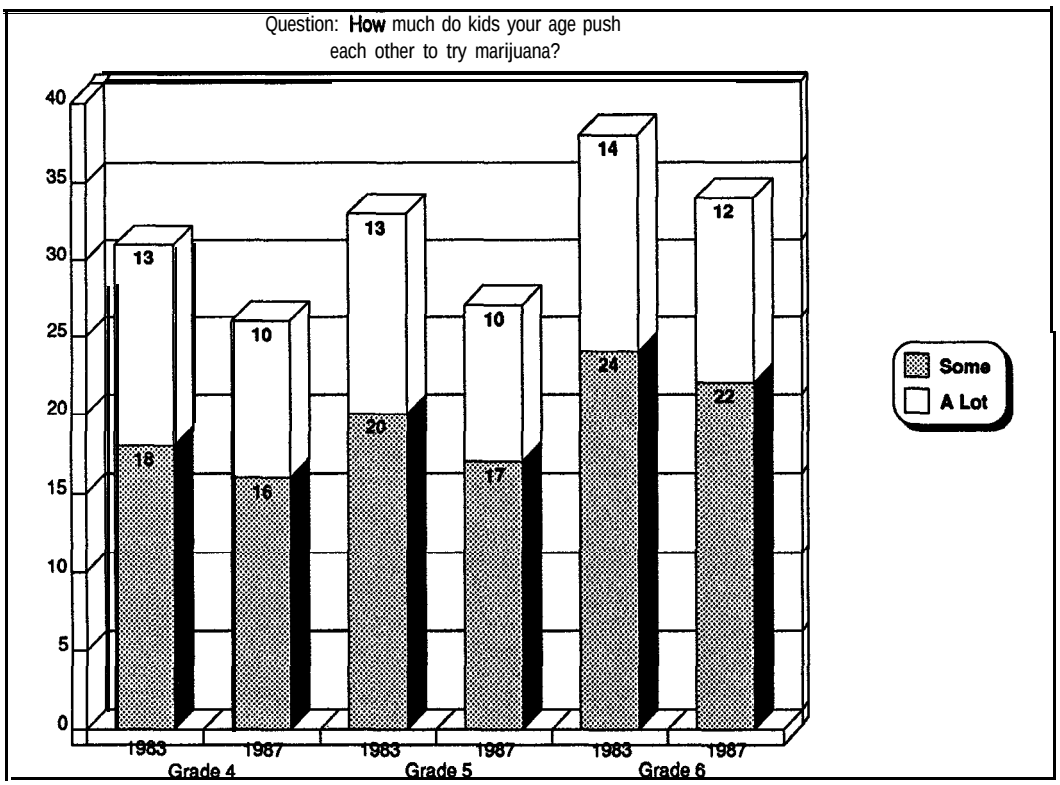

Figure 1.2 Perceived Peer Pressure to Try Marijuana, as Reported by Children, Grades 4-6, for years 1983 and 1987

Adapted from the Weekly Reader National Survey on Drugs and Drinking, ***Middletown, CT: Field Publications, spring 1987.***

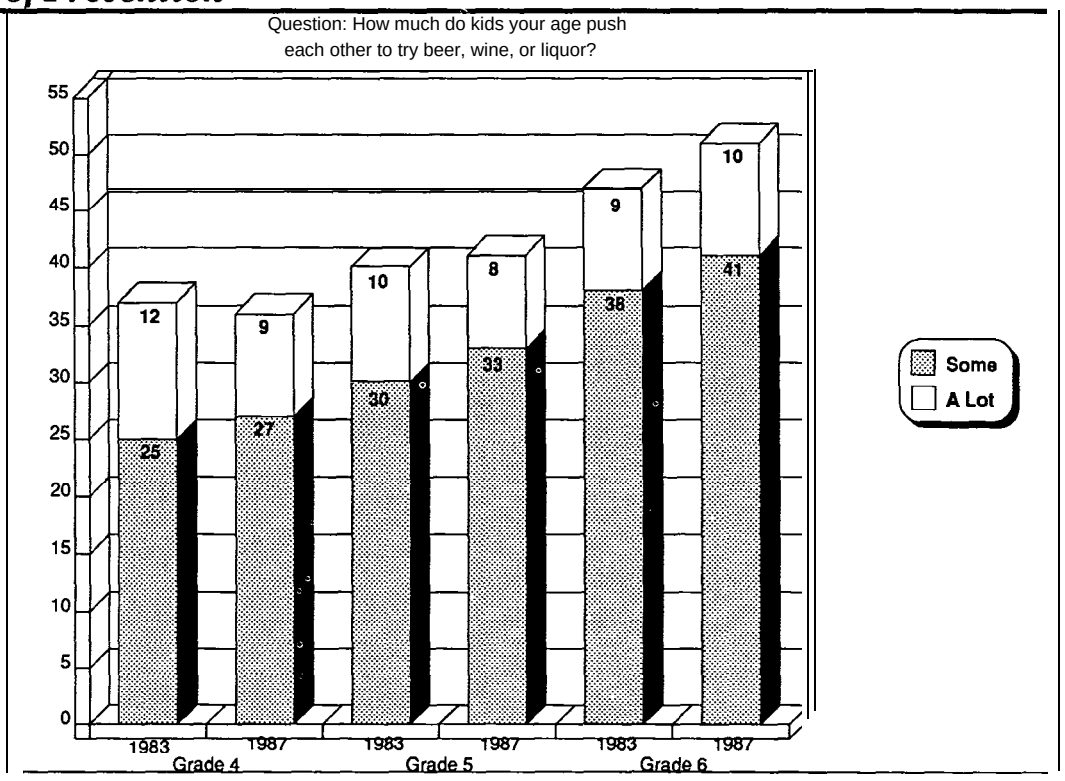

Figure 1.3 Perceived Peer Pressure to Try Alcohol, as Reported by Children, Grades 4-6, for years 1983 and 1987

In grades 4-6, there was a drop in the perceived peer pressure to try marijuana from 1983 to 1987. The largest drop-6 percentage points-took place in grades 4 and 5. The pressure to try beer, wine, and liquor, however, remained nearly the same in each grade and continues to show a steady increase through the grades, from 36 percent in grade 4 to 51 percent in grade 6.

Adapted from the Weekly Reader National Survey on Drugs and Drinking, ***Middletown, CT: Field Publications, spring 1987.***

Table 1.3 Total Number of Mentions of Cocaine Use in Emergency Rooms Over a &Year Period-June 1983 to June 1988

Year	*Dallas*	*Minneapolis*	*Phoenix*	*Philadelphia*
1983	*41*	*75*	*68*	*249*
1988	*1,999*	*471*	*1,063*	*4,171*
Percent Increase	+4,775%	+528%	+1,463%	+1,575%

The figures are those reported by 533 facilities, primarily located in metropolitan areas.

Why Young People Shouldn't Use Alcohol or Other Drugs

- Children learn from playing; they learn how to share, how to make friends, how to cooperate, and so forth.
- Before they enter adolescence, young people learn important skills such as how to solve problems, how to deal with mistakes, how to make decisions, how to cope with stress, and how to get along with others.
- Teenagers learn how to become independent, how to judge whether a risk is worth taking, how to deal with a new body image, and how to handle strong emotions.
- College-age youth prepare for the responsibilities of family and jobs.

The use of alcohol and other drugs makes learning difficult. It negatively affects concentration, attention, memory, thinking, and coordination. The use of alcohol and other drugs causes people to use poor judgment, which can result in unwanted pregnancies, automobile crashes, exposure to the Acquired Immunodeficiency Syndrome (AIDS) virus, heart attacks, suicide, and other major problems that last a lifetime.

Fortunately, many of the problems are not so devastating-but many result in not learning important skills, the loss of respect of friends and family, the loss of self-esteem, and even the loss of interest in normal activities such as dating, sports, and school work. You may know young people like these:

- The boy who brags about how many girlfriends he has but, in fact, has never felt comfortable around girls and can only ask one out if he has had a few joints.
- The tough girl who always takes the dares after she has had a couple of beers.
- The group of kids outside the movie theater, each with a cigarette in hand.
- The "normal" kid who always used to do well in school until he or she started using crack.
- The jock who is always proving his masculinity by downing a pitcher of beer.

- The young woman who is afraid that her friends won't like her unless she uses PCP with them.

Academic achievement, as measured by school grade average, declines as the regularity and intensity of alcohol and other drug use increase (Brennan et al., 1981). For many young people in America, an education is a ticket out of poverty. It may offer the opportunity that their parents never had, so it is heart-breaking to see a young person become involved with alcohol or other drugs.

Alcohol and other drug use can also interfere with the development of autonomy from parents, which is necessary for the development of self-identity and meaningful relationships.

Teenage alcohol and other drug use is usually heavy and fast, which causes serious problems, and addiction can occur much more quickly for teenagers than adults.

These activities also are illegal-getting caught can result in not only social humiliation but also a criminal record that can keep a young person from getting into college or getting a job.

Creating a Drug-free Community

This manual is a tool for organizing or expanding community efforts into a coordinated, complementary, and far-reaching system to prevent alcohol and other drug problems among youth. Alcohol and other drug use is a societal and community problem, not an isolated problem that originates with individuals. Therefore, this manual stresses the importance of involving more groups and institutions to solve the problem than are traditionally involved.

Presently, voluntary health care groups, the school, and the nuclear family carry most of the responsibility for preventing and intervening in alcohol and other drug problems. Although these institutions play an important role, they constitute only part of a larger matrix of societal influences. People in positions to assist in organizing or supporting a comprehensive prevention initiative exist throughout the community. They include members of community alcohol/drug, safety, and health task forces; prevention specialists; planners of State and local alcohol and other drug services; consultants and youth program coordinators; business and religious leaders; parents;

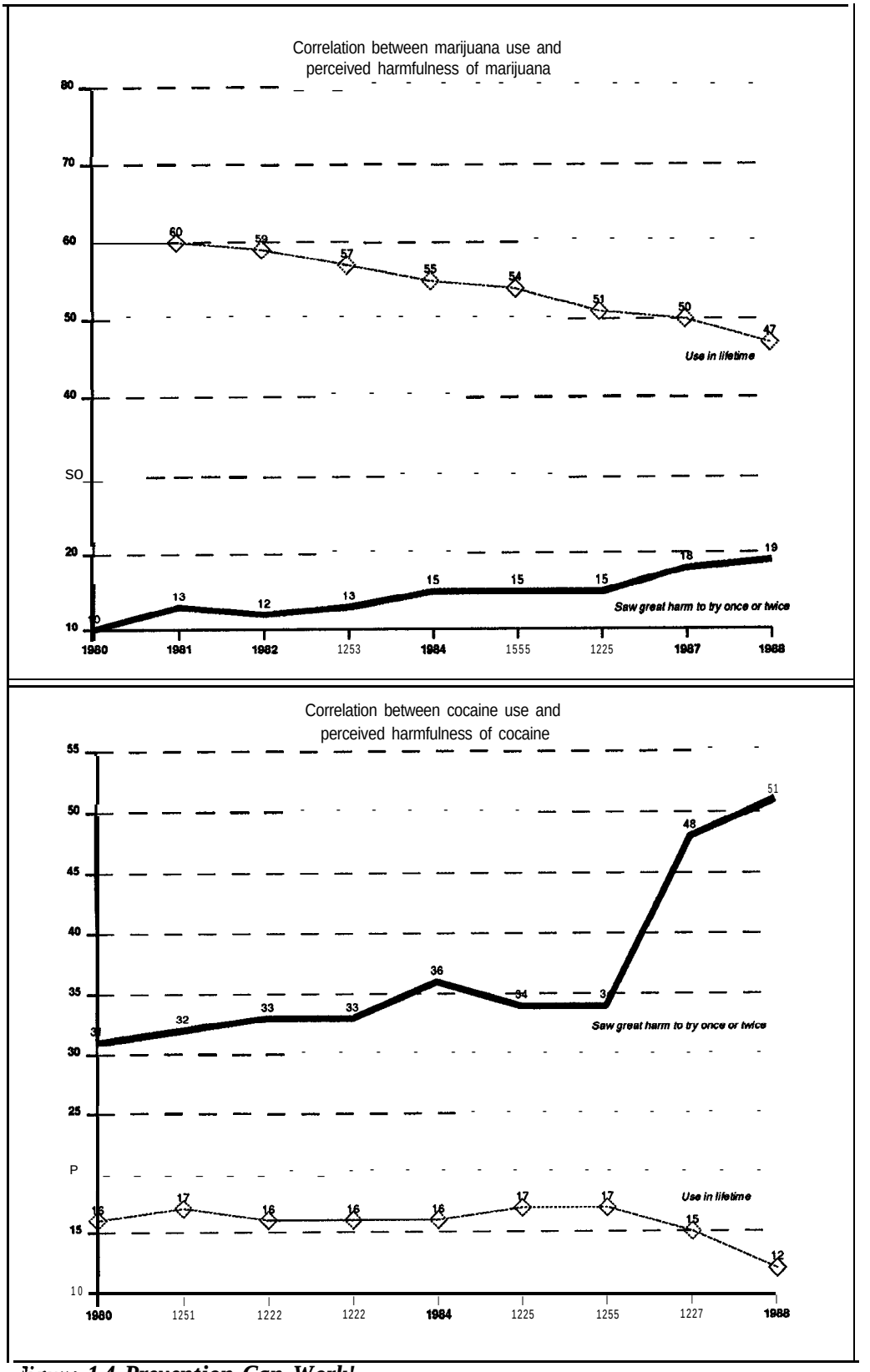

Figure 1.4 Prevention Can Work!
National Institute on Drug** Abuse **High School Senior Survey

educators; and other people who share personal and professional concerns about alcohol and other drug problems.

It is OSAP's hope that this manual will encourage community interest in and broaden its capacity for involvement in prevention activities. Chapter 2 provides an overview of the correlates and contributors to alcohol and other drug problems. It also describes numerous prevention strategies that can be combined to form a comprehensive community prevention initiative. Chapter 3 outlines the planning steps needed for organizing a community prevention program. The final chapter, Chapter 4, describes the prevention initiatives of sample communities that have successfully involved a broad spectrum of community groups and organizations in their efforts.

CHECKLIST

ALCOHOL AND OTHER DRUG PROBLEMS IN MY NEIGHBORHOOD INCLUDE

- ☐ Addiction
- ☐ Loss of productivity
- ☐ Juvenile delinquency
- ☐ Homelessness
- ☐ Traffic fatalities
- ☐ Teen pregnancy
- ☐ Fires
- ☐ Suicide
- ☐ Child abuse and neglect
- ☐ Incest
- ☐ Loitering
- ☐ Assaults
- ☐ Job absenteeism
- ☐ Low grades
- ☐ Poor nutrition and hygiene
- ☐ Domestic violence
- ☐ Poor birth outcomes
- ☐ Runaways
- ☐ Rape
- ☐ Dropouts
- ☐ AIDS
- ☐ Vandalism
- ☐ Homicide
- ☐ Drownings
- ☐ Illness and disease
- ☐ Isolation and loneliness
- ☐ Manslaughter
- ☐ Unsupervised youth
- ☐ Underachievers
- ☐ Unhealthy lifestyles

Others (List:) _____

_____

_____

_____

CHAPTER 2

A Systems Approach to Alcohol and Other Drug Use and Implications for Prevention

Introduction

Young people use alcohol and other drugs for many reasons. Among them are lack of parental supervision, breakdown of the traditional family structure, glamorization by the media, to have fun, to feel good, and peer pressure. Research into alcohol and other drug problems makes it clear that there are many additional reasons why young people use alcohol and other drugs. It is becoming equally clear that the strategies for preventing alcohol and other drug use by youth must be diverse and comprehensive if they are to be effective.

Too often, prevention activities focus on only a few of the factors that contribute to alcohol and other drug use by youth. For instance, a prevention initiative may teach young people skills for resisting peer pressure without also addressing broader environmental influences, such as the portrayal of alcohol in the media or the profit motives connected to the sale of other drugs. This type of prevention program generally does not produce lasting results. Another important shortcoming of many prevention efforts is that communication among different sectors of a community (e.g., the school, social services department, juvenile justice department, and businesses) is either poorly coordinated or essentially nonexistent. Certain parts of the community operate prevention strategies without taking into consideration the existence of other community efforts and interrelationships among the various programs.

A "systems approach," referred to in the title of this chapter, views the community and the environment as interconnected parts, each affected by the others and needing to work together. Because the individual parts have the potential either for support or to undermine each other's efforts, the goal of any community that is serious about prevention must be to make the parts work together. Cooperation and support will move communities closer to creating environments for youth that consistently discourage involvement with alcohol and other drugs. Although building a comprehensive program clearly takes time, if it is planned in stages, the systems approach to prevention need not be an overwhelming task.

Contributors to Alcohol and Other Drug Use

Effective prevention strategies begin with an understanding of the many reasons why young people start to use alcohol and other drugs. Historically, searches for explanations focused on the individual; researchers studied the personality traits, communication skills, family history, attitudes, and beliefs of individuals as factors related to alcohol and other drug use. Later, investigators observed that immediate environments are not all alike and that certain outside conditions might make a person more or less likely to use alcohol and other drugs. Researchers studied the family and the social and community experiences that shape an individual's environment. More recently, in the 1980's, investigators have taken a hard look at what are termed "distal"-or more global—environmental influences relating to the legal, economic, and cultural circumstances that affect lives in general as well as alcohol- and other drug-using behavior specifically. Without an understanding of the reasons why young people use alcohol and other drugs, prevention programs become a "hit or miss" activity. Understanding the underlying reasons leads to a targeted prevention approach.

Although it is not news that individuals are influenced by the world in which they live, many prevention programs continue to concentrate solely on changing the individual while ignoring environmental factors that may contribute to alcohol and other drug use. Research indicates that this limited approach seldom results in

long-term behavior change. As a result, prevention strategies are beginning to target elements of the environment known to be associated with alcohol and other drug use (see Figure 2.1). Few prevention initiatives can target every factor related to alcohol and other drug use simultaneously. Adopting a systems approach, however, does encourage the development of long-term prevention strategies that build over time to include many different projects.

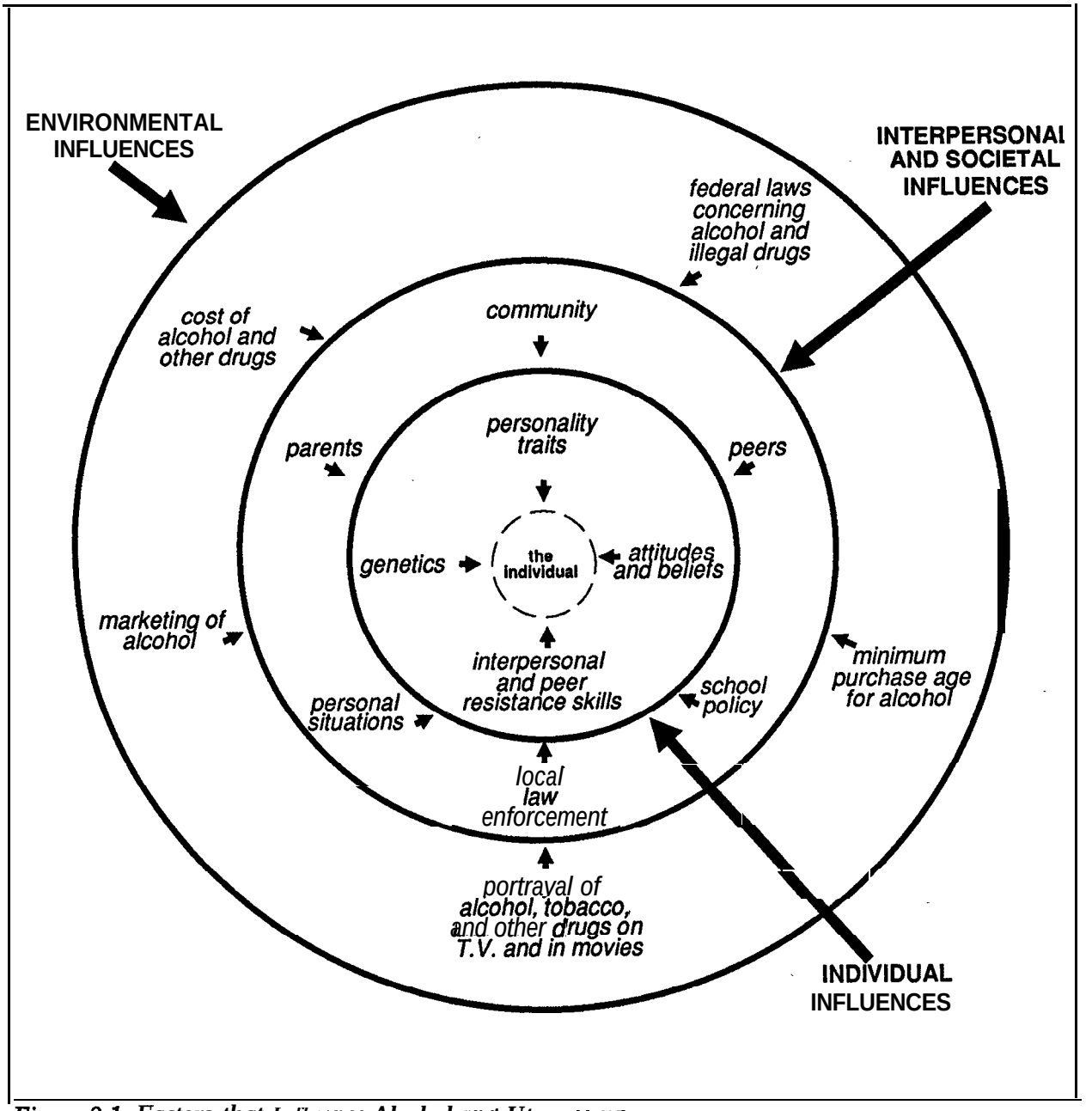

Figure 2.1 Factors that Influence Alcohol and Utner Drug use

Individual Characteristics and Situations

Personality traits

Personality is a complex concept that is not fully understood; nonetheless, a wide variety of personality factors have been linked to preadolescent alcohol and other drug use. Some personality traits stand out as the most predictive: they paint a portrait of a young person who is not bonded to mainstream societal values or structures such as schools, religious institutions, or the family. These traits include

- rebelliousness;
- high levels of sensation seeking;
- nonconformity to traditional values;
- high tolerance of deviance;
- resistance to traditional authority;
- strong need for independence;
- low self-esteem; and
- feeling a lack of control over one's life (Jessor and Jessor 1977; Kandel 1978).

Additionally, some researchers suggest that the personality traits of children who begin using alcohol and other drugs before adolescence may differ from the traits of those who begin use later. Young people who begin use of alcohol or other drugs before adolescence are more likely to engage in antisocial acts (such as being aggressive, or difficult to discipline) as compared to young people who begin use in later adolescence (Hawkins et al. 1985). There also appears to be a link between psychological distress or maladjustment (such as depression, short attention span, or severe aggressiveness or shyness) of preadolescent children and initiation of alcohol or other drug use. This link does not hold true when initiation occurs in later adolescence. (Gersick et al. 1981; Galizio and Maisto 1985). For example, a 12-year-old who refuses to follow classroom rules, has trouble keeping friends, is

hyperactive, or curses around adults may be heading toward involvement with alcohol or other drugs.

Despite the progress in research on individual personality traits, school prevention programs usually cannot focus on individuals but must instead target entire groups. This approach is in part because of the dangers of falsely labeling individuals as potential alcohol and other drug users when, in fact, they may never engage in alcohol and other drug use.

Alcohol and other drug use is not just a problem in the inner cities among ethnic youth, or exclusive to the school "heads" or "stoners" (or whatever term is used for students who dress in a way that indicates drug involvement). However, some of these youth may experience more severe consequences because of such stigmas or because poverty adds to the impact of alcohol and other drug problems. Increasing parental and teacher awareness of personality traits in children that might predict future alcohol and other drug use may be the most useful outcome of the research on personality correlates.

Knowledge, attitudes, and beliefs

Although research has confirmed what many people instinctively know to be true-that young people with attitudes and beliefs favorable to using alcohol and other drugs are more likely to use them than are young people with unfavorable or neutral attitudes-shaping long-lasting attitudes is not a simple matter. Strengthening negative attitudes toward alcohol or other drug use or shifting attitudes from a neutral to a negative position is easier than reversing positive attitudes once use has begun, toward alcohol and other drug use. This finding supports targeting children at an early age before beliefs have been strongly formed or use has become widespread. Unfortunately, all too often, education programs on alcohol and other drug use are introduced in the schools after a large percentage of the students have already begun to use alcohol or other drugs. For instance the highest percentage of increase in alcohol use among youth occurs between sixth and seventh grades (14th Annual Survey of High School Seniors, 1988 data).

Stimulating change involves education, yet even if educators reach youth at an early age, the resulting attitudes may not be permanent because of the many factors outside the efforts of the school-based prevention program.

Most prevention programs have documented gains in knowledge, and many have shifted attitudes away from alcohol or other drug use. At this point, however, it has been difficult to obtain research evidence of program effects on drug use behavior, and very little has been found to affect alcohol use behavior (Moskowitz 1987).

Nonetheless, because attitudes are important antecedents to behavior, attitude change remains a goal of many school-based prevention programs and media campaigns. Educational programs, while necessary to attain this goal, by themselves may not be sufficient to stimulate and maintain behavior change. Many of the newer programs have not been adequately evaluated, and their potential efficacy in reducing alcohol and other drug use has not been demonstrated yet. Until more research is conducted in this area, it will not be known exactly how knowledge, attitudes, and beliefs actually influence behavior.

Interpersonal and peer resistance skills

Interpersonal skills, for relating to other people and for communicating effectively, appear to be related to the initiation of alcohol or other drug use for some youth. Because the first use of alcohol and other drugs usually occurs in a social situation, the more confidence young people have about decisions not to use these substances and the better their skills in communicating this position, the more capable they will be of resisting peer pressure; in terms of using alcohol, some believe that this confidence and skill must be accompanied by inoculation to pro-drinking commercial messages. (Inoculation refers to the process of exposing a person to pro-drinking attitudes and beliefs that they are likely to encounter and explaining why these attitudes and beliefs should not be adopted, for example, that advertisers portray drinking as sexy or manly only to raise profits.)

Several alcohol and other drug prevention programs teach **peer resistance skills** as a means of preventing alcohol and other drug use. Preliminary evidence exists that such approaches, when included as part of a comprehensive program, can delay the first use of alcohol, tobacco, and other drugs. This is valuable because research indicates that the earlier a young person begins to consume alcohol or use other drugs, the greater the likelihood of that person later developing related problems.

Using drugs before age 15 greatly increases the risk of later sustained, problematic use. A discussion of these programs is presented later in this chapter.

Genetic differences

Although genetics probably is not related to a person's decision to begin alcohol or other drug use, research evidence reveals an increased inherited propensity to develop alcoholism. A genetic predisposition to become addicted to other drugs may be likely but has not been as fully researched as the genetic factor in alcohol addiction. Although the development of alcoholism seems to depend at least in part on the environment, individuals from families with a history of alcoholism or other drug addictions are now generally considered to be at higher risk than the general public for developing alcohol problems. In fact, male offspring of parents with histories of alcohol addiction are one and a half to two times more likely to develop alcoholism, even when they are separated at birth from their parents. Daughters of alcoholic mothers are up to three times more likely (Cloninger et al. 1986).

Children who are at high risk genetically for alcoholism too often experience compounded risk by growing up in homes where alcohol, use is problematic. The presence of an alcoholic parent who is actively drinking is a difficult situation for children and has been shown to lead to long-lasting dysfunction for many of them (Kumpfer 1987). As was noted earlier, psychological distress or maladjustment in preadolescent children has been associated with early alcohol and other drug use. Specialists in this area recognize the unique problems suffered by children from families with a history of addiction and are developing programs specifically to fill their needs. For instance, they deal with educating young people about the disease of alcoholism as well as how to take responsibility for their own behavior but not that of their parents, how to express feelings, and how to build friendships and positive relationships outside of the home. Special services for children of alcoholics are sometimes included in a Student Assistance Program (discussed later in this chapter) as well.

Personal high-risk situations

Some youth have special situations or circumstances that put them at high risk for using alcohol, tobacco, and other drugs. Young people at high risk generally meet one

or more of the following criteria: abused and/or neglected youth, homeless or runaway youth, physically or mentally handicapped youth, pregnant teenagers, school drop-outs, children of alcohol and other drug abusers, latchkey children (those who do not have parental or other supervision after school), and economically disadvantaged youth. High-risk youth usually have multiple risk factors.

Some of these situations may be related to other individual characteristics. For instance, a young person with a higher than average need for independence may drop out of school or run away from home. However, many of the high-risk situations are not attributable to individual characteristics. Instead, they are the result of poverty, racial discrimination, and unemployment, especially in ethnic minority communities. While the individual young person carries the burden that comes from these situations, the long-term solutions to these problems are not connected to a single individual but rather to large-scale community and institutional change. At the same time, young people identified to be at high risk need special attention to prevent them from using alcohol and other drugs.

Without intervention, high-risk youth tend to be among the heaviest users of alcohol and other drugs. Still, we know less about this population because commonly used information-gathering techniques fail to capture information about these young people. We do know, however, that high-risk youth benefit most from prevention services that address their special needs. Communities that are committed to preventing high-risk youth from using alcohol and other drugs need to familiarize themselves with the kinds of problems that exist for these youth and to develop special services to address their needs, be they afterschool programs for latchkey children, programs to prevent youth from dropping out of school, family counseling, and/or shelters for abused and neglected children.

Interpersonal and Social Influences

Clearly, conditions in young people's environments influence their decisions to use alcohol and other drugs. Some environmental conditions are of a personal nature: for instance, relationships create unique social environments for individuals. A child who lives with parents who drink heavily experiences a different home environment

from a child whose parents abstain or rarely drink. Other environmental factors, such as school policies, town ordinances, or community and cultural norms, generally affect people in close proximity to one another. For instance, the students at a particular high school may have a reputation for throwing graduation parties that feature heavy alcohol use. Each year, students from one class try to "outdo" the excesses of previous classes. Or, in many Black and Hispanic families, for instance, asking for help is a sign of weakness. Letting the community and the larger society know that there is a problem is equated with feelings of inferiority. Unfortunately, keeping these problems hidden results in an increase in the severity of the problem before help is sought, and consequences such as cirrhosis, cancer, or even criminal behavior may be extremely advanced and irreversible.

Each young person has a unique interpersonal or social environment comprising parents, siblings, peers, and other significant adults. Little dispute exists that people of any age can be greatly influenced by those significant to them; sometimes this includes relationships outside of the home when problems of child molestation, neglect, or abuse exist within the family. An individual's social environment is also influenced by the behavioral standards and expectations that are shared by the members of a given community, for example that marijuana use is relatively harmless. Community members, such as parents, teachers, school administrators, members of the law enforcement community, or those in other leadership roles, can shape the immediate social environment in which young people live by supporting and promoting norms, attitudes, and behaviors that decrease the likelihood that children and young people in that community will use alcohol or other drugs.

Parental influences

Parents still influence children and preteens most. This is true even though the structure of the family in the late 1980's has many forms: single-parent families, blended families made up of remarried parents and their children, surrogate parents such as grandparents, and others, as well as the traditional two-parent household. Positive and warm family relationships, involvement, and attachments appear to discourage the initiation of youth into drug use (Hawkins et al. 1985). There is also a relationship between inadequate family management, such

as ineffective discipline or poor parent-child communications and the occurrence of many types of delinquent behavior, including adolescent alcohol and other drug use.

Because children tend to model their behavior after that of their parents, parental alcohol or other drug use and attitudes about use send strong signals to children about the acceptability of their own alcohol and other drug use. Youth are more likely to use these substances when their parents have a tolerant attitude toward them or use these substances themselves (Kandell978).

Parents can have strong, positive influences over the lives of their own and other children. Many parents across the country join together successfully to protect their children from alcohol and other drug use by increasing awareness of the problem, seeking opportunities to make themselves heard, fighting to introduce laws and regulations that will protect their communities, and becoming more involved in the daily lives of their children. They also unite to support one another as parents faced with the sometimes difficult task of raising adolescent children. This chapter contains a discussion of approaches specific to parents.

Peer influences

Parents are wise to be concerned about the company that their children keep: association with alcohol- and other drug-using peers during adolescence is one of the strongest predictors of adolescent alcohol and other drug use. Peer influences are particularly powerful for initiation into.the use of cigarettes and marijuana. Some friendships and friendship groups may revolve around the use of cigarettes, marijuana, and other drugs. When this situation exists, nonusing peers do not fit in, and alcohol- and other drug-using peers are often intolerant or uninterested in pursuing nonusing friends.

It is not clear why adolescents choose alcohol- and other drug-using friends over others. One reason might be that adolescents need to belong, and often this group is the easiest one to join-all a young person has to do is smoke or drink or use other drugs. Studies show that these groups often are composed of lonely young people who need friends. Parents concerned about who their children hang out with need to probe about feelings of isolation, loneliness, or a need to belong and then take steps to help the child become part of another group. This may

involve steering a child toward after-school activities, especially ones away from his or her own school, where there is an opportunity to meet a new group of people, or coordinating transportation to activities of a club, such as Boy Scout Explorers, mountaineering clubs, crew activities, youth groups, and so forth. Parents can do a great deal to help their children, but this requires time, energy, and commitment.

Community influences

Together, adults and youth set standards for acceptable behavior in a community. These standards or norms exist in every community for nearly every behavior, including alcohol and other drug use. Perceptions of community norms are believed to have a significant influence on alcohol and other drug use.

Communities may be defined in many ways, such as townships, religious groups, neighborhoods, or schools, and differ in accepted alcohol and other drug use practices. Differences pertain to the type of drugs used, quantity used, location of use, or situation of use. Gender and age commonly dictate differences in alcohol and other drug use as well. For instance, some neighborhoods are inundated by drug traffic and use; it is the norm rather than the exception in these areas and most successful role models (those that are monetarily successful) are pimps or drug dealers. Among other groups, frequent and heavy alcohol consumption on a single occasion, especially among males, is traditionally more acceptable than it is among some other groups. On the other hand, people who belong to certain religious fellowships grow up in an environment in which the use of alcohol and other drugs is strongly frowned upon and actively discouraged.

Perceptions about the community norms surrounding the use or nonuse of alcohol and other drugs influence choices that are made about the use of alcohol and other drugs. This is especially true for adolescents, as this age is characterized by a need to fit in with one's peers. Researchers have repeatedly discovered that many young people overestimate the prevalence of alcohol and other drug use by their peers. These false assumptions contribute to the perception that "everyone is doing it, so it must not be so bad and so I should too." Therefore, correcting these overestimates can be a useful prevention message.

Studying community norms when planning a prevention program is important. Unfortunately, in the hurry to start to work many community-based efforts neglect initial homework. To be effective, prevention specialists need to know which drugs, including alcohol and tobacco products, are most widely used by youth and the contexts in which they are used. (Contexts are settings in which alcohol and other drug use occur.> Paying attention to these can have an important prevention impact, for example, if most alcohol-impaired driving fatalities are occurring late at night, a community might want to increase law enforcement efforts in certain areas or limit the hours of sale of alcoholic beverages. Strategies for obtaining this information appear in Chapter 3.

School policy

Establishing and enforcing school rules is related to alcohol and other drug use as well. Schools with a clear policy against cigarettes, alcohol, and other drugs, backed by consistent enforcement, reduce rates of cigarette smoking and alcohol and other drug use at school. Although policies cannot anticipate every situation, they make a statement about the intent and beliefs of the school and community. Schools with strong policies set a tone that supports the efforts of programs to prevent alcohol and other drug problems. Schools with a policy of offering assistance to students with alcohol or other drug use problems send a powerful message to young people that it is okay to ask for help. A discussion of how to use school policy as a prevention tool and the use of Student Assistance Programs appears later in this chapter.

Local law enforcement

Like school policy, community policies and local law enforcement can discourage alcohol and other drug use by youth in public places inside and outside the school setting. Laws that forbid loitering in public places or around the school after school hours, an area-wide curfew for youth, rules that prohibit "cruising" (driving up and down streets for the purpose of socializing), and strict enforcement of minimum drinking age laws are examples of community policies that discourage alcohol and other drug use by making use more difficult. (Of course, without effective enforcement and community support, laws will lose their capacity for deterrence.) As is the case with a strong school policy, community policies that take a

strong stance against the use of alcohol by underage people or illicit drugs by anyone set a tone that is supportive of other prevention efforts.

Global Environmental Influences

Characteristics of the immediate surroundings and personal circumstances only partly explain the use of alcohol and other drug use by young people. Other environmental factors contribute to alcohol and other drug use as well. Most important, national and State laws regulating the sale and distribution of alcohol and other drugs, the production and marketing of these substances, and the portrayal of drug and alcohol use on television and in the movies all appear to influence choices that young people make about alcohol and other drug use. Unfortunately, although many experts think that environmental prevention strategies are most useful and promising, these strategies are politically and economically controversial and not easily agreed on. Consider, for instance, that the alcoholic beverage industries maintain strong and well-funded lobbying groups in Washington, DC; the media enjoy the revenues from billions of dollars of tobacco and alcohol advertising; and many restaurants and bars rely on revenues from alcohol to remain profitable. Also, tax increases to strengthen enforcement of drug trafficking laws or to build new prisons (as well as tax increases on alcohol) may be unpopular with voters. Still, much progress has been and can continue to be made in creating a healthier environment for everyone.

Price of alcohol and other drugs

Investigators have found that simply raising the price of alcoholic beverages reduces overall consumption. Unfortunately, a policy to discourage alcohol problems through increased excise taxes on alcoholic beverages has seldom been used. Instead of rising with the rate of inflation, the Federal tax on distilled spirits remained unchanged between 1951 and 1985, and the tax on beer and wine has not increased at all since 1951 (Surgeon General's Report on Drunk Driving, 1989). Researchers have determined that if prices had risen with the rate of inflation, the number of youth who drink beer frequently would have been reduced by 32 percent, and the number of fairly frequent beer drinkers would have been reduced by 24 percent. In addition, if a policy to adjust the Federal beer tax with inflation since 1951 had been in place, the number of lives

lost in fatal crashes might have been reduced by 15 percent (Coate and Grossman 1987). Consider also that beer, the alcoholic beverage of choice of youth, is in some cases cheaper than soft drinks! Economic theory confirms that the price of goods affects their consumption.

Perhaps more important than the absolute prices of illicit drugs are their relative prices. For instance, the popularity of "crack," a smokeable form of cocaine, is due in part to its relative low cost ($5–$10 per "rock"), in comparison with the cost of a gram of cocaine prepared for snorting or sniffing ($60–$100). Cocaine addicts report using the drug PCP as a substitute when they are unable to afford cocaine. PCP is both popular and affordable in many locations. (See Appendix A for a discussion of drug effects.)

Minimum purchase age for alcohol

Increasing the minimum purchase age for alcohol to 21 has significantly reduced consumption as well as alcohol-related motor vehicle crashes among 18- to 20-year-olds. All 50 States have raised the minimum purchase age to 21.

The extent to which the minimum drinking age law is perceived to be enforced is critical to its success as a prevention strategy. Underage youth use several approaches to obtain alcohol, including using fake identification cards (IDs), arranging for older siblings or friends to purchase alcohol, or frequenting stores and bars known for not demanding proof of age. Preventing illegal sales to minors involves targeting local outlets (such as convenience stores and supermarket chains) and situations (such as alcohol sales at concerts and ball parks) where alcohol is regularly sold to underage persons. Making IDs more difficult to reproduce illegally may be another valuable strategy, if compliance can be enforced. A discussion of some of these strategies appears later in this chapter.

Federal and State Laws that prohibit production, sale, and use of illicit drugs

Historically, drug policy in the United States has focused on controlling the market through enforcement of laws against the production, sale, and possession of illicit drugs. These laws were designed to make drugs difficult to obtain, risky to use, and expensive. Although law enforcement has made some progress in reducing the

availability of drugs, there is serious doubt on whether tighter law enforcement can further reduce their availability.

Past increases in Federal enforcement efforts have produced disappointing results. Although Federal enforcement increased greatly in 1978, the percentage of high school seniors in 1982 reporting that they could easily obtain marijuana and cocaine (89 percent and 47 percent, respectively) did not decline in comparison to data from the mid-1970's. In fact, cocaine was reportedly readily available to 10 percent more students in 1982 than in 1975. In 1987, cocaine is even more available with 54 percent reporting that they could easily obtain this drug (14th Annual High School Senior Survey, 1988.)

Increased arrests and prison sentences for drug dealers and users would require enormous increases in financial resources and prison space. The large number of drug dealers and users in this country makes this option extremely expensive. Unfortunately, the risk of arrest and resulting prison time currently is very low. One study on the risk of arrest for selling marijuana found that only 4.3-11.2 percent of dealers are arrested annually (Polich et al. 1984). Another study indicated that a person arrested for felony marijuana sales had only a 1.2 percent chance of going to prison (Polich et al. 1984). If the probabilities for arrest are multiplied with the probability of serving a prison sentence, risk of inprisonment for a marijuana dealer would be 0.1 percent at most.

Because of the large number of people using and selling illegal drugs, increasing the risk for incarceration is an expensive prevention strategy. And because incarceration is not paired with alcohol or other drug treatment services, people incarcerated for illegal drug sales or use are likely to continue their involvement with drugs when they are released from prison.

Marketing of alcohol

Research has indicated that the typical teenager is exposed to approximately 1,000 advertisements for alcoholic beverages each year (Atkin et al. 1984; Wallack 1985) and that alcohol producers are very aggressive in their marketing. Manufacturers know that people establish brand loyalties early, and it is much less costly to maintain a customer's loyalty than it is to attract new customers. As alcohol sales have declined in recent years, attracting

new customers would seem to be increasingly important to producers. Much of the advertising for beer and wine coolers reflects a marketing approach directed at new and hence youthful consumers. Commercials for beer and wine coolers frequently feature music or personalities popular with young audiences.

Note, however, that the impact of alcohol and cigarette advertising on consumption of alcohol and tobacco remains controversial. In one study, teenagers who had been most heavily exposed to alcoholic beverage advertising in magazines and on television scored higher on each measure of an alcohol consumption survey than did other teenagers who had been less heavily exposed. However, this same study indicated that the most powerful correlate of beer drinking is peer influence, followed by exposure to advertisements for beer (Atkin et al. 1984, as reported in the *Sixth Special Report to the U.S. Congress on Alcohol and Health,* 1987). An additional nationwide survey of 1,200 respondents aged 12-22 found a moderately positive correlation between the amount of day-to-day exposure to advertisements for beer, wine, and distilled spirits and alcohol consumption in dangerous situations (Atkin et al. 1983, as reported in the *Sixth Special Report to the U.S. Congress on Alcohol and Health,* 1987). Another study that looked at the impact of advertising on teenagers found that advertising had meager effects on the level of consumption (Strickand 1983, as reported in the *Sixth Special Report to the U.S. Congress on Alcohol and Health,* 1987). In summary, the evidence suggests that advertising is a factor that increases consumption to a modest extent *(Surgeon General's Workshop on Drunk Driving: Background Papers,* 1989).

It is not known to what degree messages of alcohol and tobacco advertising influence consumption, but the billions of dollars spent annually by the alcohol and tobacco industries to promote their products indicates that they believe advertising to be an effective method of attracting consumers.

Marketing includes not only advertising in the traditional sense but also the image that a company portrays for its product through promotions and packaging. Through the sponsorship of activities, generally sporting or cultural events, a company has access to a targeted group of customers and delivers the message that the

particular brand is an appropriate choice for persons with their interests.

Wine coolers, a combination of wine, fruit juice, and carbonation, come in a variety of "fun" flavors, including strawberry, cherry, apple, peach, and passion fruit. By emphasizing the fruit flavor in wine coolers and using buzz words such as "light" and "natural," marketers have managed to promote wine coolers as being healthy. Young people accustomed to soda and fruit juice quickly learn to enjoy the taste of coolers. Some wine coolers are now even sold in 2-liter containers, as are soft drinks. Unfortunately, some parents seem to feel that coolers are harmless, fun drinks, although most coolers contain more alcohol than beer (6 percent versus 4 percent). Advertisements that portray young people frolicking on the beach with rock music in the background are used in some cooler commercials and would seem to be appealing to the youth market.

It is difficult to influence alcohol industry advertising. However, planners might find the suggestions listed later in this chapter helpful. It may be easier to influence the media that sell advertising space and time to refuse blatant advertisements. Community pressure has been useful for influencing local television stations as well as some national magazines.

Television programming and movie scripts

Television has become an important part of the environment from which young people learn many behaviors. Unfortunately, the lessons that children learn from television are not always healthy. Television characters drink alcoholic beverages more frequently than do people in real life situations (Wallack et al. 1987). It is estimated that a typical adolescent will be exposed to 3,000 drinking acts per year through television (Greenberg 1981, in Wallack 1985). In addition, many of the circumstances in which drinking occurs on television deliver messages that are inaccurate. All too often, drinking is portrayed as "consequence free"—for example, it is not uncommon for a television hero to "put a few away" and then rush off in his sports car, no questions asked and no harm done. Television characters also use alcoholic beverages to reduce tension in uncomfortable or unhappy situations. Thus, young people learn that alcohol can lessen pain or discomfort, despite the fact that in the long run it lessens

neither. Movies also present misleading information about alcohol and other drug use. Screenwriters are allowed greater latitude than television writers and are more likely to show characters who use illegal drugs in a casual and consequence-free manner.

Fortunately, scriptwriters are starting to be more responsive to public health concerns and are, on the whole, portraying the use of alcohol more realistically and responsibly. Community and professional groups have taken the time to understand more fully the needs of scriptwriters and have been able to work cooperatively to portray the consequences associated with the use of alcohol. This cooperative relationship must be furthur nurtured so that it continues.

RISK-FACTOR CHECKLIST

- ☐ Rebelliousness
- ☐ Nonconformity to traditional values
- ☐ Resistance to authority
- ☐ Low self-efficacy
- ☐ Positive attitudes toward using
- ☐ Peer pressure
- ☐ History of family addiction
- ☐ Physical or mental handicaps
- ☐ Pregnancy during teens
- ☐ Homelessness
- ☐ Low socioeconomic status
- ☐ Racial or other discrimination
- ☐ Loneliness
- ☐ Availability/easy access to alcohol and other drugs
- ☐ Lack of or poor enforcement of school policy
- ☐ Alcohol and cigarette advertising
- ☐ High levels of sensation seeking
- ☐ High tolerance of deviance
- ☐ Strong need for independence
- ☐ Feeling of lack of control
- ☐ Poor communication skills
- ☐ Exposure to advertising
- ☐ Incest/abuse/neglect by parents
- ☐ Anxiety/stress/ depression
- ☐ Dropping out of school
- ☐ Lack of parental supervision
- ☐ Unemployment
- ☐ Affiliation with using peers
- ☐ Pro-use norms in the community
- ☐ Overestimation of peer pressure
- ☐ Lack of law enforcement
- ☐ Parental lack of concern about drug, alcohol, and other drug use

- ☐ Alcohol sales to minors
- ☐ Exposure to misleading information about alcohol use on television
- ☐ Poor role models

'Note: Any one of these risk-factors will not predict alcohol or other drug problems, but if there are many of them, the likelihood is that the environment may be ripe for such problems.

Strategies for Preventing Alcohol, Tobacco, and Other Drug Use by Youth

The previous section discussed many of the factors contributing to the high rate of alcohol and other drug use among youth. This section focuses on strategies that can be useful for preventing young people from becoming users of alcohol or other drugs and discusses the limitations of some of these strategies.

A wide variety of programs to prevent alcohol, tobacco, and other drug use by youth have been developed over the past two decades. The diverse program types, orientations, and methods have left people interested in prevention confused about which programs are worth their investment of time and money. The remainder of this chapter reviews some of the more promising strategies. Although the strategies are discussed individually, a community-based prevention effort should concentrate on coordinating many different strategies over time. Chapter 4 describes community programs that are successfully incorporating many of these strategies.

You will need to consider several things when coordinating prevention strategies. Most important, you will want to match the strategies that you choose to the problems and needs of your community. For instance, is open crack dealing on the street corners your main concern or are you more concerned about alcohol use by high school students? Is alcohol and other drug use on certain occasions-such as at proms or after high school sports events-especially widespread in your community? Are young women in your community giving birth to cocaine-addicted babies? The kinds of drugs used and the situations in which they are used must largely determine the direction of your prevention program.

Factor the age, sex, culture, and socioeconomic status of the youth you are targeting into your strategy choices as well. Research has determined that there is no single best approach for all groups. Providing a comprehensive prevention initiative, as opposed to a single prevention program, has the added advantage of meeting the needs of a wider audience and accommodating a greater number of the factors that are necessary for a prevention effort to be successful.

F'inally, you will also find that your efforts are most successful when they relate to and build on the strengths and interests of the people involved in your prevention initiative. Although strengths and interests alone should not create a program when the need for the program is not evident, when all else is equal these two factors will go a long way in sustaining your activities.

Strategies discussed in the remainder of this chapter are listed below. A comprehensive program will incorporate each type:

- strategies focused on the individual;
- strategies focused on the peer group;
- educational approaches targeting parents;
- prevention through school-based strategies;
- the Student Assistance Program;
- educational approaches for teachers;
- mass media approaches to prevention; and
- prevention through regulatory and legal action.

Strategies Focused on the Individual

Prevention strategies that direct or redirect the knowledge, attitudes, and behavior of young people are by far the most common type of strategy. These strategies concentrate on changing the individual not the social, political, or economic conditions that surround that person.

Prevention approaches of the 19'70's and early 1980's that fit this category were largely school based and include scare tactics, responsible use education, affective and interpersonal education, and alternative activities. Here is a summary of each approach.*

- Scare tactics-Many early educational efforts presented overblown information concerning the risks of drug use, with a good dose of moralizing. Young people did not accept this information as factual, and it did little to affect their use of alcohol and other drugs.

- Responsible use education-The presentation of factual drug information was used to encourage youth to make responsible decisions concerning their own drug use. Programs of this type were not effective and are not compatible with a philosophy that regards the use of alcohol or other drugs, in any quantity, as unacceptable behavior for youth.

- Affective and interpersonal education-These programs sought to improve self-esteem, decision-making, communication, and clarification of values, on the basis that deficits in these traits and skills are related to alcohol and other drug use.

- Alternative activities-The opportunity to participate in alternative activites that served some of the same functions as alcohol and other drug use is the goal of these programs. These activities provided personal growth, excitement, challenge, and relief from boredom.

Alcohol and other drug use continued to increase during this time, and many of these approaches were abandoned, either completely or partially. Currently, a reexamination of these approaches in light of new

*Material in this section was adapted from the ***Report to Congress and the White House on the Nature and Effectiveness of Federal, State, and Local Drug Prevention / Education Programs,*** published by the U.S. Department of Education in conjuction with the Department of Health and Human Services, October 1987. Material in this section was written by Michael Klitzner, Ph.D.

research that shows that some of these approaches, if modified, may be effective with some youth. None, however, include a return to teaching about "responsible use" by youth.

Current programs designed to influence the individual generally have fit one or more of the following seven categories and are based on research funded primarily by the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism.

- **Provide factual information-These** programs assume that individuals use alcohol or other drugs because they lack accurate information concerning harmful effects. While there is little research evidence that these programs, when used alone, have any impact on alcohol and other drug use behavior, providing factual information should not be discounted as one component of a comprehensive prevention program. Information from credible, respected sources that is not intended to scare students, when included as part of a larger prevention initiative, may be useful.

- **Reduce feelings that "it can't happen to me"—** These programs assume that young people know the risks of alcohol and other drug use but do not believe that these risks apply to them. Some programs have attempted to revise perceptions of invulnerability by focusing on short-term risks that are relevant to young people, such as the expense of an arrest for alcohol-impaired driving rather than on long-term dangers. Although the scare tactic programs of the 1960's have given fear arousal a bad name, there is evidence that fear arousal that is based on scientific or legal fact, appropriately directed to target audiences, can be effective.

- **Address beliefs about alcohol and other drug** use-These programs derive from research evidence that alcohol and other drug use is correlated with young people's beliefs about whether it is right or acceptable to use alcohol and other drugs. They attempt to shape beliefs in a direction unfavorable to use. These programs are relatively new

and represent a significant shift from the decision-oriented programs of the 1970's.

- **Help young people cope with emotions-These** programs are based on the theory that individuals use alcohol and other drugs to cope with emotional problems. Such programs may attempt to teach stress reduction and coping skills or may offer supportive counseling to individuals identified to be at high risk. Some schools develop programs that identify and refer students experiencing alcohol or other drug problems and/or mental health problems (i.e., Student Assistance Programs).

- **Meet the social or psychological needs of young people-These** programs are an outgrowth of the alternative program approach. They attempt to fill the social and psychological needs that young people have in a way that does not include the use of alcohol or other drugs. Offering peer "rap" groups or throwing an alcohol- and other drug-free party are two examples..

- **Improve poor life skills-These** programs try to improve the skills that are used by people to function as happy and capable individuals. Decision-making and communication skills are two types, among others, that are generally addressed by these programs. Assertiveness skills training and training to resist peer pressure fall into this category.

- **Address early antisocial behavior-These** programs are based on studies suggesting that early indications (third grade and younger) of aggressiveness, disruptiveness, impatience, shyness, impulsiveness, and acting-out behavior may be predictive of later behavioral problems, including alcohol and other drug use. Programs try to correct early behavior problems by providing specialized services for identified children or by structuring the school environment to reduce the frequency of antisocial behavior.

The criteria researchers have used to evaluate the effectiveness of these approaches include increases in

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knowledge about alcohol and other drugs, changes in attitudes about alcohol and other drugs, and changes in the use of these substances. The ultimate criterion is the third one: changes in the use of alcohol and other drugs. Unfortunately, isolating the effects of a program from effects of other events or conditions outside the program is difficult. As a result, it is especially hard to determine conclusively whether a program is useful and, if so, under what conditions it will work best.

Strategies Focused on the Peer Group

Current research indicates that peer influences play an important role in young people's decisions to use alcohol and other drugs. Accordingly, a number of strategies have been developed that attempt to counter the influence of both peer norms and peer pressure (Botvin et al. 1986; Hansen et al. 1988; Dielman et al. 1989).

Schools try to influence peer norms concerning alcohol and other drug use by encouraging clubs that support abstinence from these substances. In this way, students learn that not everyone is using alcohol and other drugs and that nonuse has benefits and is socially acceptable.

Providing opportunities for students to observe peer role models who do not use alcohol and other drugs, either in person or through the medium of videos and film, is another method for influencing norms. Because it is important that the model be perceived as attractive by the students, the model must be selected with great care. It is easy to ensure that live models will be considered attractive and competent by allowing students to nominate other students whom they consider leaders to serve as models for the program. However, when using films or videos, there is a danger that the models will appear dissimilar to the target audience. Films and videos must be carefully chosen with this in mind and must be kept current so the models' appearances do not become dated.

Peers can also be used to talk to students about the reasons that they choose not to use alcohol and other drugs and to participate in a program to prevent alcohol and other drug use. The process of having same-age or slightly older students conduct programs is commonly referred to as "peer education," or "peer leadership," and as "near peers." Often, programs are a combination of both: the peer education component consists of peers providing factual information, while the peer leadership

component consists of several elements, including modeling appropriate behavior, teaching social skills, and leading role rehearsals.

There are also many programs that teach social and peer pressure resistance skills. Presently, this type of peer program appears to be especially popular as a method for delaying the use of alcohol, tobacco, and other drugs, although it appears to be far more effective when there is a clear nonuse norm, for example, everyone accepts that cigarettes are harmful or most students think marijuana is dangerous. Still, many students do not believe that drinking, even heavily, is harmful. Unfortunately, this is because there remains a great deal of societal ambivalence about young people's use of alcohol. The "Just Say No" strategy teaches students, through rehearsal, different ways to get out of uncomfortable situations involving peer pressure. In addition to instructing students to say "no," the "Just Say No," or peer resistance strategies, teach students to give such responses as "I'm not interested," or "No, thanks, I would rather play basketball," to walk away, to change the subject, and to avoid situations in which alcohol and other drugs are likely to be used. Programs that directly teach youth behavioral skills such as assertiveness, communication, problem-solving, and decision-making have been widely used in prevention.

Unfortunately, within a given group it is not always possible to find youth who are respected by their peers and at the same time skilled in leadership abilities. This difficulty may be especially true of youth from high-risk, underprivileged groups. In one program, "Smart Moves," operated by the Boys Clubs of America in a public housing setting, youth that do not use alcohol and other drugs, who are respected by their peers, but who do not possess leadership skills, are identified by staff as "special assistants." This club feels that the presence of these youth in the group provides important, if somewhat less visible, role models for high-risk youth.

Educational Approaches Targeting Parents

Educational strategies that target parents are an important part of an effective prevention program. Parents are not born knowing everything necessary to protect their children from using alcohol and other drugs. However, if parents are well informed about alcohol and other

drugs and if they are taught methods to prevent their children from using these substances, they can provide a home environment that will discourage the use of alcohol, tobacco, and other drugs.

Parents can use the following strategies to help their children to stay drug and alcohol free:

- become informed about alcohol and other drugs;
- become aware of the situations in which alcohol and other drug use can occur;
- develop skills that build strong family bonds, including effective listening skills and skills for helping children feel good about themselves and for building values;
- become informed about prevention strategies to use at home, including role modeling, peer resistance techniques, involvement in healthy alternatives, and the establishment of clear family policy with consequences concerning alcohol and other drug use; and
- join with other parents to promote an alcohol- and drug-free environment in the school, neighborhood, and extended community.

There is no single correct way for parents to develop skills and knowledge. Reading books, pamphlets, and newsletters; attending seminars or meetings; joining parents groups; and speaking to social workers, clergy, or friends are some traditional methods used for broadening knowledge. Much of the material in this section was adapted from the series 10 *Steps to Help Your Child Say "No,"* published by the Office for Substance Abuse Prevention. To obtain a free copy of the complete text, contact the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852.

Strategy: Provide information to parents

1. Informing parents about alcohol, tobacco, and other drugs

Every parent should know certain basic facts about alcohol and the more popular drugs used by young people. (Popular drugs include marijuana, cocaine, crack, PCP, LSD, inhalants, and commonly abused prescription drugs such as amphetamines and barbituates.) Knowledge of the effects of drugs, their street or slang names, what they look like, and how they are consumed enables a parent to watch for signs of use and to answer questions that their children might ask. A general overview of these drugs is included in Appendix A.

A survey of fourth and sixth graders found that television and movies are major sources of their ideas about drinking. Yet many of the impressions about both alcohol and other drug use that children get from the media are wrong, as discussed earlier in this chapter. Parents, once made aware of the messages that their children receive from the media about alcohol and other drug use, can discuss these inaccuracies with their children, either during commercial breaks or while viewing a show together.

Finally, parents need to know what the warning signs of alcohol and other drug use are and what to do if they suspect that their children are using these substances. Appendix B lists some common warning signs. Parents who suspect that their children are using alcohol or other drugs need to learn how to assess the degree of involvement and how to best confront the problem.

2. *Alerting parents to the situations where alcohol, cigarette, and other drug use occurs*

Parents also need to become alerted to the environments (or settings) where alcohol and other drugs to which their children are or will likely be exposed are used. They need to know where children meet to use drugs (e.g., in their bedrooms,-homes when-parents are at work or out for the evening, and public parks), where alcoholic beverages can be obtained easily (including the family supply), and what sources for drug paraphernalia exist (e.g., rolling papers from the local convenience store).

To become better informed, parent groups can share what they know with one another or ask law enforcement representatives or alcohol and other drug counselors to

speak to them about the norms for teenage alcohol and other drug use in their community.

Strategy: Help parents develop skills for building strong family bonds

A close-knit family environment provides a supportive setting for avoiding alcohol and other drug use by youth. Parents can do much to foster strong family bonds. Three skills thought to be particularly important are listening effectively to the feelings and concerns expressed by children, helping children to feel good about themselves, and helping children to develop strong values.

1. Listening effectively

Children of all ages are more likely to talk to parents who know how to listen-about alcohol, other drugs, and other important issues. But there are certain kinds of parental responses that will stop children from sharing their feelings. Responses that have been shown especially to inhibit communication include being judgmental, self-righteous, or hypocritical; giving too much advice or pretending to have all the answers; criticizing or ridiculing; and treating children's problems lightly.

Effective listening communicates loving concern for children. Even the best parents need to concentrate on and practice the art of effective listening. Listening skills that can help parents reach their children include

- rephrasing a child's comments to indicate that the child has been understood;
- watching for face and body language that may contradict what a child is verbalizing-when words and body language say two different things, always watch the latter;
- giving nonverbal support and encouragement to express interest, by nodding, smiling, and so forth;
- using a caring tone of voice to answer a child; and
- using encouraging phrases to express interest and to keep the conversation going-phrases like "Oh, really? Tell me about it," and "Then what happened?" are helpful.

2. Helping children to feel good about themselves

People who have alcohol or other drug problems often have low self-esteem. Young people who feel positive about themselves are more likely to resist peer pressure to use alcohol or other drugs. Parents can help their children build self-esteem by

- giving lots of praise. and looking for achievement in even small tasks;
- praising effort, not just accomplishment;
- helping a child set realistic goals;
- avoiding comparisons of a child's effort with the efforts of others;
- criticizing the action, not the child, when correcting;
- not making a child feel under attack or bad when undesirable events outside the child's control occur;
- giving a child responsibilities that build self-confidence; and
- showing a child that he or she is loved.

3. Helping children to develop strong values

A strong value system can give children the courage to make decisions based on their own feelings rather than on peer pressure. By the time children are 9 years old, they are old enough to have ideas about which behaviors are right and which are wrong and to make decisions based on standards that matter to them.

Strategy: Teach and encourage parents to use prevention strategies at home

Many community members, including parents, often think that schools are responsible for prevention. It is important that parents understand that prevention is everyone's responsibility and be aware that there are several prevention strategies, (some covered here) that they can use at home.

1. Being a good model or example

Parents are models for their children, even when they are not trying to be. As a result, parents can use their strong influence to help their children avoid alcohol, 'tobacco, and other drug use. Parents need to be aware of their own alcohol and other drug use as well as the attitudes they express about that of others. This goes for alcohol, tobacco, and illegal drug use as well as prescription- and over-the-counter drugs, as people can develop unhealthy uses of these drugs, too.

The quantity of alcohol or other drugs used by parents is not the only alcohol- or other drug-related behavior about which a child learns. Children also notice the reasons why a parent drinks or uses other drugs (e.g., for relaxation, celebration, and so forth), when alcohol and other drug use takes place (e.g., after work or at parties), and whether any dangerous activity (e.g., driving a car) is performed after using alcohol or other drugs.

Parents can also be good role models by demonstrating the ability to say "no" and the ability to ask for help. Children need to be shown that it is a sign of courage and strength and not a weakness to ask for help. This will give the parent some peace of mind, in knowing that the child will more likely ask for help before a major problem develops.

2. Helping a child develop the shills to resist peer pressure

Parents can teach their children to resist peer pressure in several ways. Parents help their children by teaching them the value of individuality, that not everyone has to go along with the crowd, and that real friends do not base friendship on whether a. person is willing to try alcohol and other drugs. Parents can also teach their children how to refuse alcohol and other drugs by helping them to practice saying "no" and by explaining that it is important to assert oneself in certain situations. Parents might also look for programs for their children to join that support positive values.

3. Encouraging healthy and creative activities

There are two parts to this strategy. The first involves supporting a child's involvement in school activities, sports, hobbies, or music, without pressuring the child to always win or excel. The second part concerns the time

parents make for activities with their children. Surveys show that children appreciate the time parents spend with them even if doing chores is involved.

4. Establishing clear family policies

Children want more structure in their lives than is commonly believed. They behave more responsibly when parents set limits. Thus, it is helpful for parents to go over in advance how a child is expected to behave and what may happen as a result of certain actions. Young people need to be told that under no circumstances are they to use alcohol, tobacco, or other drugs. Parents can also help older adolescents by laying ground rules on off-limit places and by setting a curfew. Verbalized or written family policies can also give a child a way to say "no" to peer pressure, for example, "No, thanks, I don't want to get grounded."

Strategy: Form groups of parents to promote an. environment free of alcohol, tobacco, and other drugs

There is strength in numbers, and when parents join together they can reinforce the guidance they provide at home. For example, a network of parents can develop a "telephone tree" whereby information can be shared about any immediate concerns, such as upcoming social events that are likely to make alcohol available to their children. Parents need to learn about the existence of groups already started in their communities or how to start a parent group on their own. Because of the potential for parents to use their group's voice to influence school and local government policies, they must become informed about policy issues surrounding alcohol and other drug use.

Parents do make a difference in prevention, and the sacrifices made to ensure that a child does not get involved with alcohol and other drugs will have rewards. In cultures in which it is hard to admit that problems may exist, special efforts will need to be made to identify parents who will serve as leaders for prevention efforts. In many instances, outsiders will have to work with only one or two courageous community parents and then graciously turn the efforts over to them.

Further information for parents

A partial list of useful materials for parents is available at no cost by writing to the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852. Several organizations listed in Appendix C also provide information for parents.

Prevention Through School-based Strategies *

Without great expense, school-based program planners can implement a number of promising strategies, including

- broad-based community programs;
- parent involvement;
- curriculum concerning alcohol, tobacco, and other drugs; and
- policies regarding alcohol, tobacco, and other drug use.

Broad-based community programs

Schools that include the community in their prevention activites are likely to experience several benefits, among them increased community commitment of time, money, and support. The community and school, when working together, also send a unified message to young people that alcohol and other drug use is unacceptable.

One means of coordinating a broad-based program is to develop prevention advisory committees, composed of representatives of the school and community. These committees could include school administrators, teachers, students, parents, business leaders, law enforcement representatives, health and alcohol agency staff, and youth services personnel. Where possible, elementary schools and junior and senior high schools that serve the

*Material in this section adapted from "Report to Congress and tlie White House on the Nature and Effectiveness of Federal, State, and Local Drug Prevention/Education Programs," U.S. Department of Education in conjunction with U.S. Department of Health and Human Services, October 1987, pp. 2931.

same student population should consider sharing a single advisory committee or having overlapping membership to facilitate continuity. It is best for the group to set concrete objectives so that the program does not become overly diffuse.

Parent involvement

Although the difficulty of generating and sustaining parent interest and participation in education programs on alcohol and other drug use has been widely noted, parents are too valuable a resource to schools for them to be ignored.

At a minimum; presentations can be offered to parents on a number of topics, including the warning signs of a young person's involvement with alcohol and other drugs, community resources for dealing with alcohol and other drug problems, and the effects of parents' own behaviors on the behaviors of their children. A letter or brochure on all or any of the above topics can also be prepared and sent to the parents of every student in the school.

Schools should also consider working closely with concerned parent groups, or if such groups do not exist in the community, the schools should encourage their development, The Parent-Teacher Association, or other advisory groups can be tapped for interested parents.

In some communities, where a single parent works two jobs just to provide food and shelter, special efforts may be required to encourage parental involvement, such as serving dinner, providing transportation, and offering some social or recreational benefits after meetings.

Curriculum concerning alcohol, tobacco, and other drugs

Several types of curriculum are outlined in earlier sections entitled "Strategies Focused on the Individual" and "Strategies Focused on the Peer Group." Because of the wide range of curricula on the market, schools wanting to implement a program may find it difficult to choose among them. The Office for Substance Abuse Prevention (OSAP) and the Department of Education (DOEd) have begun a process to assess curricula and to make general recommendations for school districts.

However, even though curricula are the staples in many school-based prevention programs, too often the

expectations of curricula are inflated. Researchers now know that no curriculum is likely to be effective if implemented in a vacuum but should be part of a larger, comprehensive prevention effort. No evidence exists that any curriculum package, implemented alone, results in significant or long-lasting reductions in alcohol or other drug use.

Schools planning to adopt a curriculum might use the following criteria:

1. ***Material gives a clear no-use message.***

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

2. ***Material makes clear that illegal drug use is unhealthy and harmful for all persons.***

There are four kinds of illegal or unwise drug use:

- 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.

- Use of a drug for a purpose other than its prescribed use (e.g., tranquilizer for purposes other than prescribed).

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

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

Materials should communicate clearly that all of the above are illegal, 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.

- imply that there are no "good" or "bad" drugs, just "improper use, misuse, or abuse."

3. Material should make it clear that young people are responsible for their own decisions and should not provide opportunities for' them to make excuses for their behavior.

Although there are many factors in the environment that influence decisions regarding drug use, young people are still responsible for their own behavior. Prevention materials targeting youth should be positively focused. Children should be taught skills that will improve the quality of their lives rather than directing their energy to focus on their problems.

4. ***Material uses no illustrations or dramatizations that could teach people how to obtain, prepare, or ingest illegal 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 drugs are unacceptable. Prevention materials targeting youth should contain no illustrations of illegal drugs unless when making a nonuse point that cannot be made in any other way. Illegal drugs should not be used as graphic "fillers."

5. ***Material contains information that is scientifically accurate and up-to-date.***

Materials must be scientifically accurate, based on valid assumptions, supported by accurate citations, and appropriately used. Scientific information such as statistics, physiological effects of alcohol and other drugs, research information on addiction, and critical dosage levels of alcohol and other drugs should be checked for accuracy.

6. ***Material is appropriate for the developmental age, interests, and needs of the students.***

Developmental aspects as well as cultural systems must be addressed in an integrated fashion. Because children proceed developmentally at different rates, it is important to include activities and messages that address the needs found in different developmental stages.

7. The content should reflect an understanding of the target groups' cultural systems and assumptions.

Materials must not perpetuate myths or stereotypes. They should reflect the social, economic, and familial norms of the intended target audience and reflect the physical appearance of the audience. In screening materials, be alert to subtle racist or sexist biases (for example, if everything "good" is portrayed with white symbols and everything "bad" or "wrong" is portrayed with brown, black, or dark colors or if only males are arrested for alcohol-impaired driving). Norms and symbols important to the culture of the audience also must be reflected (e.g., group identity is more important to some cultures than individualism and spiritual symbols are to other cultures). Materials need to both reflect and respect cultural factors such as the importance of the extended family, key role of grandparents, and religion.

8. ***Materials targeting youth should not use recovering addicts or alcoholics as role models.***

Prevention education materials that use recovering addicts or alcoholics as role models do not conform to Office for Substance Abuse Prevention and Department of Education policy. Focus group testing has shown that children enrolled in prevention education programs (most of whom are not recovering users) may get a different message from what is intended from the testimony of recovering addicts. Rather than the intended "don't do as I did" message, children may hear the message that the speaker used drugs and survived very well or even became wealthy and famous. An exception may be 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.

In 1988 the Department of Education published a comprehensive guide entitled *Drug Prevention Curricula: A Guide to Selection and Implementation,* which offers educators important insights for choosing a curriculum. It is available, free of charge, from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852, (301) 468-2600.

Policies regarding alcohol, tobacco, and other drugs

A reexamination of exisiting policies on alcohol, tobacco, and other drug use or the development of new policies may be one of the school's strongest strategies for preventing the use of these substances at school. Policies that are enforced send a strong message to students that alcohol and other drug use is unacceptable. Schools that do not allow cigarette smoking or the use of chewing tobacco at school similarly discourage these behaviors. Enforcement policies must also be accompanied by policies that refer or provide services for youth who do use alcohol, tobacco, or other drugs or who are adversely affected by alcohol or other drug abuse in their families.

Administrators should be aware that no single set of standards is -appropriate for every school. Schools differ in size, tradition, and philosophies and are affected by varying State laws and local statutes.

The Department of Education has compiled guidelines for establishing school policies in a handbook titled ***What Works; Schools Without Drugs. An*** abbreviated version of the action plan for schools, discussed in this handbook, is presented below. To obtain a copy of the handbook, write to the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852.

Performing a written assessment of current school policy (or the lack of one) is an excellent way to -assess school goals concerning the prevention of alcohol and other drug use. The assessment also allows administrators to assess how faithfully the policy is followed and to identify gaps in the policy that need to be filled. One method for accomplishing this assessment is to compare the policy at your school with-the guidelines recommended in ***What Works, Schools Without Drugs.*** A second method is to use the ***Secondary School Drug and Alcohol Assessment Guide,*** developed by and available from Campus Alcohol Consultations, P.O. Box 65557, Washington, DC 20035 for $7.50. This guide helps secondary school administrators and interested persons to assess their school on 118 items. Answering "yes" to an item indicates that the school is effectively managing this portion of its effort to prevent alcohol and other drug use. Answering "no" indicates that this area is either not being addressed adequately or not being addressed at all. Having performed a

complete assessment, concerned individuals can quickly discover their school's strengths and weaknesses. Figure 2.1 includes a portion of the guide along with a listing of the remaining seven topics covered.

Strategy: Determine the extent and characteristics of alcohol and other drug use and establish a means of monitoring it

School personnel should be informed of the extent of alcohol and other drug use in the school. School boards, superintendents, and local public officials should support school administrators in their efforts to assess the extent of the alcohol and other drug problems and to combat them.

To guide and evaluate efforts to prevent alcohol and other drug use, schools need to perform the steps listed below:

- conduct confidential surveys of students* and school personnel and consult with local law enforcement officials or other knowledgeable people to identify the extent of the alcohol and other drug problem;
- consult all school personnel to identify areas where alcohol and other drugs are used and sold;
- meet with parents to help determine the nature and extent of alcohol and other drug use at school;
- maintain records on alcohol and other drug use and drug sales in the school over time, to use in evaluating and improving prevention efforts; and
- inform the community, in nontechnical language, of the results of the school's assessment of the alcohol and other drug problem.

*See Additional Reading section at the end of this chapter for information on commercially available student survey instruments.

THE SECONDARY SCHOOL DRUG AN-D ALCOHOL ASSESSMENT GUIDE

A. POLICY	Yes	No
1. Does a comprehensive drug policy, which includes statements on alcohol, exist in published form at your school?		
2. Does the rationale or a statement of philosophy appear in the policy itself?		
3. Does this statement of philosophy emphasize the importance of prevention?		
4. Does the policy address student drug use both on and off school grounds?		
5. Is the policy proactive, thereby providing assistance in anticipating or responding to drug-related issues?		
6. Does the policy address student or staff impairment due to the use of drugs (whether or not the use of drugs occurred on school grounds)?		
7. Are issues of confidentiality stemming from "priv elationships" addressed in the policy statement?		
8. Does the policy reflect a reasonable		

B. PROCEDURES	Yes	No
C. SCHOOL FUNCTIONS AND PARTIES	Yes	No
D. TRAINING FOR TEACHERS AND STAFF	Yes	No
E. EDUCATION FOR CLUB ADVISORS	Yes	No
F. EDUCATION FOR STUDENTS	Yes	No
G. EDUCATION FOR PARENTS	Yes	No
H. TREATMENT AND INTERVENTION	Yes	No
I. *RESEARCH*	Yes	No
J. COMMUNITY INVOLVEMENT AND LEADERSHIP	Yes	No

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Figure 2.1 The Secondary School Drug and Alcohol Assessment Guide

Strategy: Establish clear and specific rules regarding alcohol and other drug use

School policies should clearly establish that alcohol and- other drug use, possession, and/or sale on school grounds and/or at school functions will not be tolerated. These policies should apply to both students and school personnel and may include prevention, intervention, treatment, and disciplinary measures.

School policies should specify what constitutes an offense by clearly defining (1) the items that should not be brought to school, including alcohol, illegal drugs, and drug paraphenalia; (2) the area of the school's jurisdiction, such as the school property, its surroundings, and all school-related events; and (3) the types of violations, for example the possession, use, and/or sale of alcohol and/or other drugs.

The consequences for violating school policy should be clearly spelled out and should link punitive action with counseling and treatment where appropriate. Measures that schools have found effective in dealing with first-time offenders include

- a required meeting of parents and the student with school officials, concluding with a contract signed by the student and parents in which they acknowledge an alcohol or other drug problem and in which the student agrees not to use alcohol or other drugs and to participate in a counseling or rehabilitation program;
- suspension, assignment to an alternative school, in-school suspension, or after-school or Saturday detention with close supervision and demanding academic assignments;
- referral to an alcohol or other drug treatment expert or counselor; and
- notification of police.

Strategy: Enforce policies against alcohol and other drug use fairly and consistently and implement security measures to eliminate alcohol or other drugs on school premises and at school functions

Everyone must understand the policy and the procedures that will be followed when infractions occur. To ensure this understanding, make copies of the school policy available to all administrators, parents, teachers, and students and take other steps to publicize it.

Impose strict security measures to bar access to intruders and to prohibit drug trafficking by students. Enforcement policies should correspond to the severity of the school's alcohol and other drug problem. Examples-of enforcement policies include requiring the use of hall passes and mandatory identification badges for school staff and students, monitoring areas around the school, and permitting periodic searches of student lockers.

Strategy: Consider requiring uniforms or a dress code for students

Some schools are finding that the obsession by: youth for designer clothes may be associated with selling. drugs; that is, selling drugs is a way to get money to buy clothes to "fit in" with their peers. Some schools, therefore, are considering requiring uniforms or dress codes for all students to cut down on the need for large sums of money to purchase clothes.

Strategy: Reach out to the community for support and assistance in making the school's policy and program on alcohol and other drugs work

Develop collaborative arrangements in which school personnel, parents, school boards, the PTA, law enforcement officers, treatment organizations, and private groups can work together to provide necessary resources.

The Student Assistance Program

The Student Assistance Program is a promising approach for intervening in and preventing alcohol and other drug problems among school-age youth. Modeled after the Employee Assistance Programs found in industry, the Student Assistance Program focuses on behavior and performance at school and uses a referral process that includes screening for alcohol and other drug

involvement. Student Assistance Programs also work with self-referred youth to address such problems.

The Student Assistance Program is a partnership between community health agencies and the schools. Because school is the one place where all adolescents have unrestricted access and where most adolescents feel at least somewhat comfortable, it provides an ideal setting for instituting alcohol and other drug programs. But the growing alcohol and drug problem is not the sole responsibility of the school. The partnership places the responsibility for preventing alcohol and other drug use, so often delegated to the school alone, with several agencies.

The Student Assistance Program addresses important needs. First, it addresses alcohol and other drug use as a problem that affects a student's entire development and the program offers a strategy for eliminating alcohol and other drug use both during and after school hours. Second, it gives school staff a mechanism for helping youth with a wide range of problems that may contribute to alcohol and other drug use.

The Student Assistance Program also assists students who are suffering adverse effects from parental alcohol or other drug use. It is estimated that in the United States there are 7 million children of alcoholics under the age of 18 years in this country. These children are one and a half to three times more likely to become alcoholics than are children from families without a history of alcoholism. Studies have documented the positive results for the children of alcoholics who participate in groups that focus on the unique problems of growing up in a home with an alcoholic parent. Student Assistance Programs can offer opportunites for this kind of participation.

Student Assistance Program model

The emerging field of Student Assistance Programs is wrestling with the issue of identifying, referring, and assisting students with all problems or offering only alcohol- and other drug-specific services. Most Student Assistance Programs are a mix of these categories.

Although the components and people responsible vary widely, the following activities are found in virtually every school with a Student Assistance Program:

- early identification of student problems;
- referrals to designated "helpers";
- in-school services (e.g., support groups, and individual counseling);
- referral to outside agencies; and
- followup services.

Teachers and other school staff are advised and trained to identify students experiencing problems that interfere with their functioning at school: they are, however, not expected to specify the nature of the problem or to intervene personally. Students are referred to appropriate assessment and assistance resources. No matter what the mix of responsibilities and personnel of the Student Assistance Program, the endorsement of "top management"-school board, principals, community leaders-is critical to the success of the program. When this level of support is guaranteed, the way is clear for implementing an effective Student Assistance Program.

The number of Student Assistance Programs is growing. A list of contacts for obtaining additional information on Student Assistance Programs appears at the end of this chapter.

Educational Approaches for Teachers

To date, teachers have shouldered much of the responsibility for conducting programs to prevent alcohol, tobacco, and other drug use. Many have had to take on this responsibility without first becoming well informed about alcohol and other drugs and without adequate training in teaching techniques, especially those prescribed by the latest generation of prevention research. Specifically, to be effective prevention advocates, teachers need to:

- become well versed on the topic of alcohol and other drug use;
- develop skills for using the teaching techniques appropriate for the new generation of prevention programs; and

- become knowledgeable about the signs of alcohol and other drug use and other dysfunctional patterns of behavior among youth (such as those that might occur among the children of alcoholics) and develop referral skills.

Strategy: Provide training for teachers about alcohol and other drugs

Teachers of programs to prevent alcohol, tobacco, and other drug use must be well informed. Too often, students, even very young ones, have more first-hand knowledge about the subject matter than teachers do. For instance, during a prevention program with elementary school children in Washington, DC, police officers quickly found that third and fourth graders were able to identify PCP and the persons who sold it. If the teachers are discovered to be poorly informed or less well informed than the students the teachers will not be able to establish credibility as sources of information on the topic and may not be effective in persuading the students not to use alcohol and other drugs.

Unfortunately, many teachers, like other people, hold misconceptions about alcohol and other drugs. For instance, some people still incorrectly believe that most alcoholics are living on skid row, unable to hold a job, and easily recognizable. Someone with these beliefs would probably deny that a teenager could become alcoholic when in fact there are many teenagers who have become physically and psychologically dependent on alcohol. Another myth is that typical brands of beer and wine coolers do not contain as much alcohol as distilled spirits do. This misconception leads adults to underestimate the serious consequences that can just as easily result from beer and wine cooler use as from other alcohol use. Teachers, or other adults, who make light of or joke with teens about the use of beer, wine coolers, or other drugs undermine the health of these teenagers.

Teachers who do not live in the communities in which they teach need to develop an understanding of the environment for alcohol and other drug use in which their students live, in addition to learning basic information on alcohol and other drugs. Not all communities are alike with respect to alcohol and other drug use. Teachers can conduct relevant discussions only when they are informed about the ways that alcohol and other drugs are affecting

the lives of their students and, specifically, the reasons why students use them, for example, the need to belong, rebelliousness, risk taking, independence, relief of social awkwardness, or avoidance of pain. This need not be an obstacle, as teachers can easily become informed about their students' alcohol and other drug use?

Because there are over 7 million children of alcoholics (COAs) under the age of 18 in this country (approximately one in eight children), teachers should be made aware that many of their students fall into this high-risk group. Often the children of alcoholics become withdrawn when the topic of parental drinking is discussed in the classroom. If properly trained, teachers who suspect that a student is experiencing a problem with parental alcohol or other drug use can refer the child for assistance. Telling older students about available help, either at school or in the community can be especially useful. For more information about dealing with children of alcoholics, write to the National Association for Children of Alcoholics, 31706 Coast Highway, Suite 201, South Laguna, CA 92677-3044.

Strategy: Help teachers explore their own attitudes and beliefs about alcohol and other drug use

'People who plan to teach about alcohol and other drugs also need to clarify their own feelings about alcohol and other drug use: students ask many difficult questions for which teachers must be prepared. For example, students may question the fairness of a legal drinking age" that is set 3 years beyond the voting and draft age or about the illegality of marijuana when alcohol problems affect a far greater number of people. They may also ask probing questions about the teacher's own use-past or present-of alcohol, tobacco, or other drugs. Like parents, teachers need to present a positive role model. Teachers unprepared for these difficult questions can inadvertently damage their credibility or even have the opposite influence on students than they intended. Therefore, preparing teachers for teaching about alcohol and other drugs should include an examination of personal attitudes and how these attitudes will affect their work as prevention advocates (see Figure 2.2).

Figure 2.2

Tips for Teachers: Answering Difficult Questions

Teachers sometimes are asked questions that are difficult to answer. Here are some suggested approaches to answering common difficult questions.

Q: How come ***at 18 a person is old enough to fight, and maybe die, for his or her country, old enough to get married, sign contracts and engage in many other adult behaviors but not old enough to buy alcohol?****

A: Our society has a long tradition of conferring different rights, privileges, and responsibilities at different ages. Abiding by a combination of laws and parental regulations, a person might experience the following "rites (and rights) of passage":

- age 6—entering school
- age 12—obtaining a hunting license
- age M-obtaining a license to drive
- age 17—choosing a college
- age 18—voting, serving in the military
- age 25—serving in the U.S. House of Representatives
- age 30—serving in the U.S. Senate
- age 35—seeking the Presidency of the United States

There is really nothing inconsistent in saying that a person may be ready to accept and exercise responsibly a particular right or privilege at one age but may not be qualified for a different right or privilege until a later age. Neither is it unfair to say that the person in question may not be the best judge of whether he or she is ready for some new privilege. How many 18-year-olds, looking back, would seriously argue that 12-year-olds should be licensed to drive?

The problem, for most people, becomes most acute when society demands that an individual carry out some civic responsibility

*Responses to the first two questions appeared in ***Drinking Age 21: Facts, Myths and Fictions,*** published by the National Highway Traffic Safety Administration, January 1985, available from the National Technical Information Service, Springfield, VA 22161.

(such as military service at age 18) while denying that same individual a right (e.g.,. to drink). But is this really inconsistent? Isn't it logical to say that an 18-year-old may be sufficiently mature to carry out his or her service obligation, but may not yet be ready to handle drinking responsibly? After all, young people entering military service receive extensive training by experts and live in a well-regulated and disciplined environment. It is not at all comparable to purchasing and consuming a six pack of beer.

Q: ***If you forbid young people, ages*** IS-20 ***from purchasing alcohol, aren't you treating them like children?***

A: No, you are treating them as what they are: people evolving into adulthood, who can handle many of the responsibilities, rights, and privileges of adults, but not all of them.

As young people mature, rights and privileges are granted to them when they reach an age at which it is reasonable to expect that the typical person can handle them. Undoubtably, some 18-20 year olds have the ability to make educated choices about drinking. Similarly, there are some 18year-olds who would be able to handle driving safely. But too many of those age groups simply aren't ready to exercise those rights and privileges.

The evidence is clear and compelling: at age 18, 19, or 20, too many people can't handle the right to drink. By age 21, enough of them can handle it sufficiently well to justify bestowal of this privilege.

Q: ***Did you ever smoke?***

AI: No.

A2: Yes, and I quit when I realized what the health implications were. I also began to feel uncomfortable in social situations-as you get older you will find that nonsmokers are less and less tolerant of smokers. Needing to smoke made me feel that I was out of control, so I quit, once and for all. It wasn't easy though and I wish I had never started. Many people I know have not been able to quit successfully. Smoking is completely unnecessary for enjoying life.

A3: Yes, I still smoke and plan to seek help so that I can quit. (If you are stillsmoking and do not want to quit, you should not serve as a role model or teacher about alcohol and other drugs.)

Q: ***Do you drink?***

AI: No, and neither do about one-third of all adults.

Az: Yes, occasionally, but never to the point of intoxication, and never before I am going to drive or operate dangerous machinery.

Q: Do you ever get drunk?

AI: No.

AZ: No, but I used to and I'm sorry I did. At the time I thought it was cool. I was uneducated and I was lucky I didn't get into trouble.

A3: (If your answer would have to be "yes," you should not serve as a rolemodel or teacher about alcohol and other drugs.)

Q: ***When did you start drinking?***

A: Be honest. Most people will say something like, "I had my first beer when I was 16 with my dad. I didn't like the taste, but I thought he expected me to like it so I pretended I did. As I look back, I don't think drinking served any purpose." You can then lead into a discussion about the purposes that drinking might serve and alternatives for getting these needs met-to fit in or belong, to push aside social awkwardness, to rebel and assert independence or masculinity, and so forth.

Strategy: Train teachers in the teaching techniques appropriate for the latest generation of prevention programs

Teachers must be trained in teaching techniques that are being used in the prevention programs designed today. Some of these techniques are different from those with which they are familiar. For example, the more promising school-based prevention programs are using interactive group process skills to help students learn about alcohol and other drugs and methods for resisting peer pressure. Interactive teaching techniques are used to stimulate the active participation of all students in the classroom activity, be it a discussion, a brainstorming session, or the practice of new behaviors. Many teachers are uncomfortable using the interactive group process skills that are required in prevention programs and are more experienced with presenting material to a group, lecture style, with only a small amount of listener participation and interaction.

Many program developers now realize the importance of properly training teachers and have incorporated teacher training into program design. In fact, this feature can be one important criterion for a community to use when choosing a school-based prevention program.

Strategy: Train teachers to recognize the signs of alcohol and other drug abuse and other dysfunctional behavior and to develop referral skills

Classroom teachers may be the only adults, other than parents with whom a young person has contact on a daily basis. Teachers knowledgeable about the signs of alcohol and other drug use or the signs of dysfunction caused by use of alcohol or other drugs by family members serve as backups for parents who fail to recognize alcohol and other drug problems. Prevention programmers have sometimes found that teachers become aware of students who are already using alcohol and other drugs or who are children of alcoholics in the course of being trained to prevent alcohol and other drug use. A comprehensive prevention program will prepare teachers to recognize signs of alcohol and other drug use and familial alcoholism or other drug use. The program should also provide guidance for appropriate actions to take when a student exhibits these signs.

Mass Media Approaches to Prevention

The media provides important messages to shape and reinforce societal norms, including those associated with behavior resulting from alcohol and other drug use. Television is a particularly persuasive influence, although radio, newspapers, and magazines also contribute to attitude and value formation.

Using the media to reduce alcohol or other drug use has a long history and has become a science in and of itself. Media campaigns and "cooperative consulation" offer two ways to use the media effectively.

Media campaigns

Media campaigns typically include acombination of television and radio public service announcements (PSAs), advertisements, billboards, booklets, posters, specially planned events, and health education activities (or some combination of these components). When deciding which components to include, ask yourself these questions:

- Who is your target audience? You need to know who you are trying to reach since different

audiences will respond to different appeals, messages, and channels.

- Which persons are credible sources of information? Who does your audience identify with?

- What messages appeal to your target audience? People pay more attention to messages that tie into their needs and interests. For example, teenagers care a lot about their appearance, about being accepted by friends, and about being "cool." They are likely to listen to a message that says alcohol and other drugs interfere with attaining these things.

- Considering time and budget constraints, is it feasible for you to launch a media campaign? If it is feasible; which components can you afford to include?

To answer these questions you may need to do some research. Do you know where the youth you are trying to reach get information about alcohol and other drugs? Is it from television, parents, friends, or elsewhere? Do most youth in your community use the same sources of information? If not, are the youth at high risk in the community using different sources? The same kinds of questions need to be asked about spokespersons. To answer these you probably need to design a brief questionnaire and survey a representative sample of youth from your community.

To answer questions about costs and time constraints you will need to research the cost of purchasing air time, newspaper space, and so forth and find out which services you can obtain for free. Radio and television stations are required by law to donate a specific amount of public service time to respond to the concerns of the community they serve. Unfortunately, competition for this time is intense. The print media (newspapers and magazines) rarely offer free space although many cover issues related to alcohol and drug prevention activities.

-Mass media campaigns are most successful when the media messages are followed up with and linked to efforts on a local or personal level (Benard 1986). Parents or other role-models and neighborhood institutions such as a health clinic, fire department, pol-ice department, or school can be community spokespersons who reinforce

media messages and respond to special needs prompted by media messages. In turn, mass media can be used to supplement school-based or community-based prevention programming by reinforcing the information and skills being taught in the programs. By themselves, however, mass media programs usually are not effective (Flay 1986).

Research on the effects of media campaigns has determined that at best a media campaign generally does no more than increase awareness among the target population. Although the ultimate goal may be to reduce alcohol and other drug use by affecting behavior, it is unrealistic to expect to accomplish this change through the use of a campaign alone (Flay 1986). Yet increasing awareness about a problem is, of course, one of the first steps toward behavior change.

Necessary steps for behavior change:

Media campaigns impact at this important first step → Increase awareness of the problem

↓

Educate the public

↓

Change attitudes toward the behavior

↓

Change the behavior

Appendix H contains additional information about launching a media campaign.

Cooperative consultation

Prevention professionals have developed a strategy for working with Hollywood writers, editors, and producers that they call "cooperative consultation" (Breed et al. 1984). The purpose of cooperative consultation is to educate media personnel about the importance of creating programs that portray alcohol and other drug use in a realistic, nonglamorous, and responsible fashion. Researchers first analyze how often and under what circumstances alcohol is drunk or referred to on TV and relay

the findings to television professionals. More often than not, TV personnel are surprised by the study findings: most of the scenes involving alcohol were incidental to the story, and writers had not been conscious of the statements they were making.

It is not possible, or even desirable, for every community prevention planner to undertake a scientific study of the media or to descend on Hollywood to consult with scriptwriters. However, it is possible for planners to work with local media organizations, especially if the following are kept in mind:

- Before attempting any consultation, become familiar with how local media operate-you need to know who makes decisions, the requirements of the publication/program, and publication/program deadlines.

- Take time to develop relationships with media persons that are based on mutual respect; failure to nurture a relationship often results in misunderstandings. Remember, the media person has needs different from your own (such as a need for timely, interesting, simplified stories). Be prepared to be flexible.

The following local media strategies could form the basis of a community-based education effort. Those persons interested in learning more about media campaigns are referred to the additional reading page at the end of this chapter and to Appendix J, A Guide to Working with the Media.

Strategy: Ask radio stations to eliminate humorous and irresponsible comments made by radio disk jockeys about alcohol and other drugs, especially on stations that cater to young audiences

Alcohol and other drug use is often taken lightly or treated humorously on radio stations. Young people may interpret jokes to mean any number of things, including that alcohol and other drug use is normal and acceptable behavior for minors or that it is fun and exciting.

Communities should inform radio station managers about the underlying messages in disk jockeys' humor and should seek management support to end this kind of

reference. When a particular incident is offensive, protest letters and telephone calls to station managers are methods for getting heard. Most radio stations are actively involved in community affairs and are willing to support local prevention activities.

Strategy: Ask radio and television station managers to balance news reporting of celebrations that feature alcohol with those that do not

It is common to see local news coverage of a big sports triumph or of holiday celebrations such as New Year's Eve or St. Patrick's Day focusing on the use of alcohol. This kind of coverage reinforces the concept that drinking is a necessary part of celebrations. Communities can put pressure on producers of local news shows to balance the reporting of such celebrations so that they are not always shown as occasions when alcohol is used.

Strategy: Involve local sports stars and other celebrities in prevention

Many sports stars already participate in activities to prevent alcohol and other drug use. Communities need to continue to seek their supportby asking them to speak out publicly about the problem. Athletes who support alcohol- and drug-free lifestyles can be effective prevention advocates. Those who have not experienced alcohol problems or used other drugs are better role models than athletes who were formerly involved in alcohol and other drug use. Other celebrities, including hometown newscasters, disk jockeys, and actors or actresses can also be effective advocates of prevention efforts. (You must, however, be completely certain that the sports stars and celebrities you work with do not use illegal drugs or abuse alcohol-if they do and this information reaches the public, your program will be undermined. You will also want to make sure that the spokesperson you work with is well respected by your target audience and that, regardless of your knowledge of the person's drug-free lifestyle, he or she is not perceived by the audience to be a user of drugs.)

Strategy: Educate school administrators and editors of student newspapers about advertising and humor concerning alcohol and other drugs

In a 1984-85 national sampling of college and university newspapers, researchers found that national beer companies are using sophisticated marketing techniques

to promote their products (Breed et al. 1987). Promotional strategies include corporate sponsorship of campus activities and the introduction, through print advertisements, of the brewer's campus representative. According to an **Ad Age** author, promotions of this kind presumably reflect the manufacturer's attempt to strengthen its relationship with students and to portray an image of an altruistic organization, not an aggressive advertiser.

Local advertisements are also prominent in many college newspapers. The 1984–85 newspaper sample found that local taverns placed advertisements announcing promotions that encouraged heavy drinking. Here are four examples of such advertisments:

- "Drinks-3 for 1, all nite, every nite."
- "Tuesday-25 cent draft, 75 cent Kamikazes, 7 pm until...."
- "Friday 4 to 6:30 pm, $4.00 all you can drink."
- "Every Thursday, Ladies Nite. $1 cover, first 6 drinks free."

Community prevention representatives can work with school officials and student newspaper editors to set stricter standards for accepting alcohol advertising.

Strategy: Make radio commercials to persuade the public of your position

Unlike television, radio spots are relatively inexpensive to produce. Often, a portable tape recorder can be used to create the spot. Radio time is also relatively inexpensive and is within the purchasing grasp of many groups that do not want to rely solely on the use of public service announcements, whose number and spacing they cannot control. Using the listener analysis performed by the stations to sell air time also allows you to target your message to the audience you are most interested in reaching.

Creative commercials will capture the attention of the audience. For instance, try producing a spot that asks a question and ends with a headline (e.g., "We have heard on the news lately about the devastation caused by women who use cocaine during pregnancy. Well, did you

know that alcohol consumption during pregnancy is the third leading cause of birth defects in this country? Senator Slick does not support placing notices at liquor stores about the danger of alcohol consumption during pregnancy. Give the new generation a chance. Call Senator Slick's office at (201) 987-6543.")

A training tape entitled "Guerilla Media: A Citizen's Guide to Using Electronic Media for Social Change" is at the end of this chapter. It is an excellent guide for developing effective radio spots.

Strategy: Reinforce the mass media prevention messages that are being publicized in your community with coordinated activities

The goal of a strategy that reinforces mass media messages about alcohol and other drug use is to get the most from the message by bringing it "home." As an example, during the National Institute on Drug Abuse's "The Big Lie" campaign, parents could talk to their children about the dangers of cocaine, and schools could invite drug treatment counselors to speak at school assemblies or to host mock talk shows on the topic with drug experts as invited guests. When a message is received consistently from many sources it makes a stronger impact than when it is received from only one source.

There is an ongoing opportunity for every community to become involved in a major media and community education campaign, coordinated by OSAP and directed at 8- to 14-year-olds. In 1987, OSAP launched a communications program called "Be Smart! Don't Start!. .. Just Say No!" which is still reaping benefits today. The program includes

- booklets for parents and teachers;
- workbooks for children;
- public service announcements and a music video featuring the musical group the Jets; and
- campaign activities in all 50 States, Washington, DC, and the U.S. territories.

The success of the "Be Smart!" campaign has prompted OSAP to expand the effort into the "Be Smart!

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Stay Smart! Don't Start!" program aimed at children from the early elementary school grades through 14 years old. It includes:

- updated parents', teachers', and childrens' materials that include information on other drugs in addition to alcohol;
- a special outreach effort for low-literacy youth and families;
- materials adapted in a bilingual format to address the needs of the Hispanic community;
- a new public service announcement starring Dawnn Lewis, costar of the Cosby show spin-off "A Different World"; and
- a comic book featuring the crime dog, McGruff, for young children.

Prevention Through Regulatory and Legal Action

The important influence that laws and regulations have on the environment for alcohol and other drug use was discussed earlier in this chapter. Here strategies are outlined that can affect alcohol use and subsequent alcohol problems. Because alcohol differs from other drugs in legal status, these strategies cannot be generalized to prevent the use of illegal drugs, except to the extent that those who use alcohol, especially at early ages, are more likely also to use illegal drugs.

Communities can influence regulatory and legal action pertaining to alcohol use by young people. Essentially, communities achieve this by increasing public awareness of alcoholic beverage policies that might increase alcohol-related problems, explaining policies that compromise efforts to prevent alcohol use, and persuading public officials to create and enforce laws and rules that are sensitive to prevention issues.

Community advocacy groups concerned with these issues have been forming rapidly over the past decade. Some groups, such as Mothers Against Drunk Driving (MADD), have been concerned with a single issue, while others have dealt with a combination of issues. In either

case, it is important for the advocacy group to familiarize itself with the important agencies and individuals in the community that control policy issues. Public officials need assistance in understanding the issues; advocacy groups, by planning and timing their efforts, can play a significant role in educating officials and affecting change.

Community groups may want to pursue progressive regulatory and legal prevention strategies as part of their effort to prevent alcohol and other drug use by youth. Instead of focusing on changing individual behaviors, these strategies emphasize changing the environment in which alcohol consumption occurs.

Strategy: Increase sales tax on alcohol to raise prices

Research shows that increasing the price of alcoholic beverages will decrease consumption, particularly among young people (Surgeon General's Workshop on Drunk Driving Proceedings, 1989). Some communities are using the following strategy: community groups have petitioned the appropriate agency to increase the sales tax on alcohol. Groups wishing to apply this strategy will need to determine whether taxes are applied locally or at the State level. (This varies, because some States have a centralized taxation system while others return control of taxes to local entities, such as the counties or incorporated cities.) Groups will also need to determine which administrative agency is responsible for taxation. Generally, the agency responsible for taxation policy is one of the following: the Commission of Alcohol Beverage Control, the State Liquor Commission or Liquor Authority, the State Department of Revenue, the State Comptroller of the Treasury, or the State Department of Taxation. It may be useful to bring your issues to the attention of the Governor, who appoints members to some of these agencies. You must recognize, however, that if consumption goes down, so may the revenue generated for the State. This can be a strong motivation for not raising the price. You may need a strategy for dealing with this concern.

Strategy: Enforce the minimum drinking age of 21

Increasing the minimum drinking age from 18 to 21 has proved to significantly decrease alcohol consumption by 18- to 20-year-olds and to reduce the number of alcohol-related traffic crashes in which youth are involved. Community groups can take measures to see that the law is

strongly enforced. They can petition the police and governing body (typically the ABC) to enforce checking customer identification cards through surveillance operations and by applying stiff fines to businesses found selling alcoholic beverages to minors. Successfully petitioning the State to produce identification cards that are difficult to duplicate fraudulently would also enable fewer minors to obtain alcoholic beverages from merchants. Community groups should also encourage local establishments not to serve people who cannot prove their age.

Other strategies might include requiring stiff fines or community service from youth caught purchasing alcohol or drinking. In at least one State, any youth caught drinking in or out of a car is legally required to surrender his or her driver's license. In addition, adults other than merchants or parents that supply a minor with alcoholic beverages could be more actively prosecuted for contributing to the delinquency of a minor.

Strategy: Decrease the availability of alcohol by denying or revoking alcohol licenses to establishments that serve underage people; convenience stores, gas stations, and stadiums are three establishments that could be targeted

Convenience stores and gas stations are often operated by minors who are more willing than adult clerks to sell alcoholic beverages to other minors. Monitoring the sale of alcoholic beverages at stadiums for sports events or concerts is also a problem. Generally, multiple bars are set up at these events, and minors find it relatively easy to obtain alcoholic beverages.

Communities can petition the legislature to refuse alcohol licenses to establishments that are known to serve minors (so-called high-risk establishments). Applying pressure on policymakers to use surveillance operations and applying stiff fines to businesses that sell alcohol to minors are strategies that may be especially useful for discouraging the businesses mentioned in the strategy from selling alcoholic beverages to minors.

Strategy: Train salespeople and servers (bartenders, waiters, and waitresses) to identify underage persons

Training for salespeople and servers is now available to many communities. Community representatives can urge business owners to discuss with their employees the seriousness of laws concerning the sales of alcoholic beverages to minors. They might also urge businesses to create and enforce a policy specifying that employees who neglect to check the identification of customers appearing to be underage (or even under 30) will be fired.

Strategy: Enact stricter regulations for alcohol advertising and promotions

Young people and adults see a multitude of advertisements for beer, wine, liquor, and wine coolers. (Advertisements for liquor and cigarettes have been banned from television in the United States because of the health. risk associated with these products.) Television, radio, magazines, newspapers, and billboards feature famous former athletes, well-known entertainers, and other attractive people to deliver the message that consuming alcoholic beverages is associated with an athletic, rich, successful, and sexy lifestyle.

The Department of the Treasury's Bureau of Alcohol, Tobacco, and Firearms has a congressional mandate to control alcohol advertising on the national level. This mandate was enacted through the Federal Alcohol Administration Act of 1973 (FAA Act). It does not affect local advertising.

Some States have already adopted the FAA beverage industry codes for local and statewide advertising. Unfortunately, code sections that restrict advertising and promotions are often vague, difficult to monitor, and, as a result, difficult to enforce. Community representatives may therefore choose to develop and enforce restrictions that are much more detailed.

The community can petition lawmakers and policymakers to regulate alcohol advertising more strictly, but achieving change at this level is admittedly difficult. However, while working to change legislation, communities can also work to sensitize local advertisers, retailers, and producers to the health risks of alcohol use and can ask them to make appropriate changes voluntarily.

Another useful strategy that can be used by parents or in the schools is to teach children to analyze alcohol advertising. Some popular techniques used to advertise alcoholic beverages include the following: (1) the bandwagon ad-Its message is "Join the crowd, everyone is using this product so it must be good. In addition, you'll be popular if you buy it." (2) The testimonial ad-A famous person tells you to use the product. Since a celebrity uses it, it must be good. (3) The image ad-This kind of advertisement tries to create a certain kind of image about a product and about the person who uses it. (For instance, 'You'll have good taste if you use it.") Critical thinking can help children to understand that the purpose of the advertisement is to get the consumer to buy a product and that the messages frequently appeal to emotions rather than to good sense. The power of an advertisement may be diffised if children can learn about advertising and then compare what they have learned to the advertisements that they see.

Strategy: Eliminate sponsorship of sports and social. events by the alcohol industry, especially on campuses

On college campuses sponsorship of sporting and other events by alcohol companies is said by many communities to promote heavy drinking, often among underage students. This activity also is said to counteract health messages about the detrimental impact of alcohol consumption on athletic performance.

Communities can prevail on representatives from local universities and colleges to prohibit or to restrict the sponsorship of events by alcohol distributors and producers. Community representatives can also work with organizers of alcohol-sponsored events to encourage the dissemination of prevention-related messages at such events.

Many of the strategies mentioned here, and others, are reviewed in the proceedings from the Surgeon General's Workshop on Drunk Driving, available from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852, (301) 468-2600.

Summary

From this review of many of the trouble spots and strategies for preventing alcohol and other drug problems, it is clear that these problems are the shared responsibility of many different groups and entities. This chapter discussed prevention strategiesthat involve many of the people and institutions with whom most young people come into contact: parents, teachers, peers, the school, the media, and businesses. For a significant number of young people, other organizations, such as religious organizations, youth and athletic clubs, service organizations, and teen centers become important sources of learning about social relationships and responsibility. These settings can also be places for learning about alcohol and other drugs; many of the adults leading these programs are seeing that they are. Chapter 4 examines how several States and communities have organized efforts to include a variety of groups in their prevention efforts, including some not touched upon in this chapter.

Campus Alcohol Consultations of Washington, DC, has developed a "Community Drug and Alcohol Assessment Guide for Youth" as a tool for coordinating community-based efforts. This guide examines the activities of 14 sectors of the community: health services, social services, schools, religious institutions, parents, civic groups, businesses and industry, governmental agencies, courts, law enforcement agencies, media groups, other entertainment businesses, restaurants, and the community at large. You may want to develop your own list of questions and issues that need to be addressed by each sector, or you can send $14.50 to Campus Alcohol Consultations, P.O. Box 65557, Washington, DC 20035 for a copy of its guide.

Additional Reading and Resources

How Drug Use Develops

Galizio, M., and Maisto, S. *Determinants of Substance Abuse. New* York: Plenum Press, 1985.

Hawkins, J.D.; Lishner, D.; Catalano, R.F., Jr.; and Howard, M.O. Childhood predictors of adolescent substance abuse: Toward an empirically grounded theory, *J. of Children in Contemporary Society* 18(1-2), 1985.

Kandel, D.B. *Longitudinal Research on Drug Use: Empirical Findings and Methodological Issues. New* York: John Wiley and Sons, 1978.

Mills, C.J. and Noyes, H.L. Patterns and correlates of initial and subsequent drug use among adolescents, *J. of Consulting and Clinical Psychology* 52(2), *1984.*

National Institute on Drug Abuse. *Illicit Drug Use, Smoking and Drinking by America's High School Students, College Students and Young Adults, 1975-1987.* Washington, DC: Supt. of Docs., U.S. Govt. Print. Off. Available free from NCADI, P.O. Box 2345, Rockville, MD 20852.1988.

Weekly Reader Publications. *A Study of Children's Attitudes and Perceptions About Drugs and Alcohol.* Middletown, CN.: Xerox Educational Publications, 1983.

For Parents

American Association of School Administrators and the Quest National Center. *Positive Prevention: Successful Approaches to Preventing Youthful Drug and Alcohol Use.* Arlington, VA: American Association of School Administrators, 1985.

Fraser, M.W., and Hawkins, J.D. *Parent Training for Delinquency Prevention: A Review.* Seattle: Center for Law and Justice, University of Washington, 1982.

Office for Substance Abuse Prevention. *Parents. What You Can Do About Alcohol and Other Drug Abuse.* Available free from NCADI, P.O. Box 2345, Rockville, MD 20852, 1983.

Office for Substance Abuse Prevention. *Ten Steps to Help Your Child Say 'No."* Available free from NCADI, P.O. Box 2345, Rockville, MD 20852, 1986 (Revised 1988).

Office for Substance Abuse Prevention. *The Fact Is. . . You Can Prevent Alcohol and Other Drug Problems*

Among Elementary School Children. Available free from NCADI, P.O. Box 2345, Rockville, MD 20852, 1988.

Office for Substance Abuse Prevention. ***The Fact Is*** . . . You ***Can Prevent Alcohol and Other Drug Problems Among Secondary School Students.*** Available free from NCADI, P.O. Box 2345, Rockville, MD 20852, 1989.

Office for Substance Abuse Prevention. ***Prevention Networks-Multicultural Perspectives in Drug Abuse Prevention, Winter 1984-85.*** Available free from NCADI, P.O. Box 2345, Rockville, MD 20852, 1985.

Tobias, J.M. ***Kids and Drugs.*** Annandale, VA: Panda Press, 1986.

For Teachers and School Administrators

Ackerman, R.J. ***Children of Alcoholics: A Guidebook for Educators, Therapists, and Parents.*** Holmes Beach, FL: Learning Publications, Inc., 1978.

Finn, P., and O'Gorman, P. Teacher training in alcohol education: Goals, approaches and content. ***J. of Drug Education*** 12(3), 1982.

Hawley, R. A School ***Answers Back: Responding to Student Drug Use.*** Rockville, MD: American Council for Drug Education, 1984.

Morehouse, E.R., and Scola, C.M. ***Children of Alcoholics: Meeting the Needs of the Young COA in the School Setting.*** South Laguna, CA: The National Association for Children of Alcoholics, 1986.

Pyramid Project. ***School Drug Policy.*** Walnut Creek, CA: Pacific Institute for Research and Evaluation, 1986.

U.S. Department of Education. ***What Works, Schools Without Drugs.*** Available free from NCADI, P.O. Box 2345, Rockville, MD 20852, 1986.

U.S. Department of Education. ***Drug Prevention Curricula.*** Available free from NCADI, P.O. Box 2345, Rockville, MD 20852, 1988.

U.S. Department of Education and U.S. Department of Health and Human Services. ***Report to the White House and Congress on the Nature and Effectiveness of Federal, State, and Local Drug Prevention/Education Programs.*** Washington, DC: Supt. of Doc., U.S. Govt. Print. Off., 1987.

U.S. Department of Justice. For ***Coaches Only: How to Start a Drug Prevention Program.*** Washington, DC: Drug Enforcement Administration, 1984.

Student Assistance Programs

Publications

Anderson, G.L. ***When Chemicals Come to School: The Student Assistance Program Model.*** Available from DePaul Training Institute, 4143 South 13th Street, Milwaukee, WI 53221, 1987.

Griffin, T., and Svenden, R. ***Student Assistance Program: How It Works.*** Available from Hazelden Educational Materials, Pleasant Valley Road, Box 176, Center City, MN 55012-0176, 1980.

Morehouse, E. ***Preventing Alcohol Problems Through a Student Assistance Program: A Manual for Implementation Based on the Westchester County, New York, Model.*** Available from Student Assistance Services, 228 Fisher Avenue, White Plains, NY 10606, 1984.

Office for Substance Abuse Prevention. ***The Fact Is . . . You Can Start a Student Assistance Program.*** Available free from NCADI, P.O. Box 2345, Rockville, MD 20852, 1988.

Wisconsin Department of Health and Human Services. ***The Student Assistance Program: The Wisconsin Experience.*** Available from WDHHS, P.O. Box 7851, Madison, WI 53707, 1986.

Technical Assistance

The following organizations can help you locate resources and provide expertise on student assistance programs.

Student Assistance Services
228 Fisher Avenue
White Plains, NY 10606
(914) 997-7277

National Organization for Student
Assistance Program Professionals
250 Arapahoe Street, Suite 301
Boulder, CO 80302
(303) 449-8077

Commercially Available Student Surveys

American Drug and Alcohol Survey
2190 West Drake Road, Suite 144
Fort Collins, CO 80526
(303) 221-0602

I-Say: Information Survey About You
National Computer Systems
2510 North Dodge Street
Iowa City, IA 52245
(319) 354-9200

PRIDE Drug-Prevalence Questionnaire
50 Hurt Plaza, Suite 210
Atlanta, GA 30303
Attn: Janie Pitcock
(800) 241-7946

Media Resources

Flay, B.R. Mass media linkages with school-based programs for drug abuse prevention. ***Journal of School Health*** 56(9), 1986.

Funkhouser, J.E. Before the cameras turn. ***Alcohol Health and Research World*** Summer, 1987.

Hewitt, L.E., and Blane, H.T. Prevention through mass media communications. In: Miller, P.M., and Nirenberg, T.D., eds. ***Prevention of Alcohol Abuse. New*** York: Plenum Press, 1984, pp. 281-322.

Maloney, S.K., and Hersey, J.C. Getting messages on the air: Findings from the 1982 alcohol abuse prevention campaign. ***Health Education Quarterly*** 11(3), 1984.

U.S. Department of Health and Human Services, National Cancer Institute. ***Making Health Communication Programs Work: A Planners Guide.*** Bethesda, MD: Office of Cancer Communications, 1989.

Resources for Organizing Prevention Strategies that Target Public Policy

Publications

Alcohol Warning Signs: How to Get Legislation Passed in Your City. A practical guide for any group interested in the promotion of alcohol warning signs, 1985. Available from the Center for Science in the Public Interest (CSPI),

150116th St., NW, Washington, DC 20036 (202) 332-9110. $4.95.

The Booze Merchants. An enlightening look at the way the alcohol industry targets its products to special populations, 1983. Available from the Center for Science in the Public Interest (CSPI), 1501 16th St., NW, Washington, DC 20036 (202) 332-9110. $5.95.

The Impact of Alcohol Excise Tax Increases on Federal Revenues, Alcohol Consumption and Alcohol Problems. A report that discusses these relationships. 1985. Available from the Center for Science in the Public Interest (CSPI), 1501 16th St., NW, Washington, DC 20036 (202) 332-9110. $3.00.

Information packet on alcohol warning labels, including a fact sheet and history of the effort to pass a bill through Congress that would require alcohol manufacturers to put a health warning label on their products. Available from the National Council on Alcoholism, 1511 K St., NW, Suite 926, Washington, DC 20005 (202) 737-8122.

Marketing Booze to Blacks. A booklet that looks at the special marketing promotions targeted to Blacks, 1987. Available from the Center for Science in the Public Interest (CSPI), 150116th St., NW, Washington, DC 20036 (202) 332-9110. $4.95.

Myths, Men & Beer: An Analysis of Beer Commercials on Broadcast Television 1987. Study done by a team of university researchers who call for review of public policies related to television beer advertising, 1987. Available from your local AAA-affiliated motor clubs or by writing directly to the Automobile Association of America Foundation for Traffic Safety, 2990 Telestar Court, Suite 100, Falls Church, VA 22042 (202) 775-1456. Single copies free.

Surgeon General's Workshop on Drunk Driving: Proceedings. Solutions and recommendations in 11 interrelated areas pertaining to drunk driving. Action-oriented strategies for implementing the recommendations are also included, 1989. Available free from the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20852 (301) 468-2600. No charge.

Training Tape

Guerrilla Media: A Citizen's Guide to Using Electronic Media for Social Change. Techniques that any individual, group, or company without a lot of money, power, or skill can use to alter public policies in large or small ways. This 2-hour training tape features the pioneering work of the legendary New York media genius, Tony Schwartz, and has a three-part format for ease in viewing. Available from Varied Directions, 69 Elm Street, Camden, ME 04843, Attn: Curtis MacDonald (207) 236-8506. Cost: $299.00 purchase price or $75.00 for 10-day rental.

Community Training Manuals

Alcohol Policy for Worksites: Creating Policies To Prevent Problems

Outlines strategies that encourage and motivate employers to adopt corporate and employee alcohol policies that discourage, minimize, or reduce the risks associated with consumption of alcohol in the business or work setting.

Alcohol Use at Community Events: Creating Policies To Prevent Problems

Outlines community-action strategies to promote and plan alcohol-free eventsand activities in a community.

Changing Alcohol Policy at the State Level: How To Get Started

Outlines strategies that community groups can follow _to promote the passage of State legislation that controls the availability and use of alcohol on the local level.

Increasing Community Involvement in Alcohol Licensing: How To Work With the Alcoholic Beverage Control

Outlines community-actionstrategies to control the growth and location of alcohol outlets in a community by addressing the local zoning authorities and the state-level Alcoholic Beverage Commission.

Preventing Alcohol-Related Birth Defects: How To Educate Your Community

Outlines community-action strategies focusing on prevention of.alcohol-related birth defects (ARBD) and fetal alcohol syndrome (FAS) and on the passage of local legislation that requires liquor outlets to post warning signs to warn consumers about the link

between alcohol consumption during pregnancy and the risk of birth defects.

Preventing Youth Drinking: How to Get Started in Your Community

Outlines community action strategies -that local organizations can use to reduce the incidence of alcohol sales to underage youth.

Server Intervention: Encouraging Responsible Alcoholic Beverage Sales and Services

Outlines community-action strategies that encourage local bars, restaurants, and other alcohol providers to train servers (bartenders, waitresses, and hosts) in techniques that discourage intoxication and drinking and driving.

Working with the Media: How To Get Alcohol Problems on Your Community's Agenda

Outlines planning and organizational strategies that can help community groups establish effective working relationships with local media organizations and gain access to local media resources for community action and education purposes.

All manuals are available from:

Applied Communications ***or*** Technology
1010 Doyle St., Suite 17
Menlo Park, CA 94025
(415) 322-6466

County of San Diego
Alcohol Program
P.O. Box 85222
San Diego, CA 92158-5222
(619) 236-2004

Technical Assistance

The following organizations can help you locate resources and provide expertise on a variety of public policy prevention strategies.

Center for Science in the Public Interest (CSPI)
1501 16th St., NW
Washington, DC 20036
(202) 332-9110
Attn: Patricia Taylor, Director for Alcohol Policies

Council on Alcohol Policy
c/o The Trauma Foundation
San Francisco General Hospital
Building 1, Room 311
San Francisco, CA 94110
(415) 821-8209
Attn: Laurie Lieber, Director
or Karen Hughes, Associate Director

Marin Institute for the Prevention of Alcohol
and Other Drug Problems
1040 B Street, Suite 300
San Rafael, CA 94901
(415) 456-5692
Attn: James Mosher, Director

National Council on Alcoholism
1511 K St,, NW, Suite 320
Washington, DC 20005
(202) 737-8122
Attn: Christine Lubinski, Washington Representative

The following organizations are more specialized.

Responsible Hospitality Institute
P.O. Box 4080
Springfield, MA 01101
(413) 732-7780

This organization distributes information on server training programs, policy development, and social and commercial liability and responsibility, and can also refer callers to server training programs in their area.

Consumers Union
1535 Mission St.
San Francisco, CA 94103
(415) 431-6747
Attn: Jim Schultz

Consumers Union sponsors legislation to require warning labels on birth defects on alcohol containers and distributes material on how to run a campaign in other States.

Remove Intoxicated Drivers (R.I.D.)
P.O. Box 520
Schenectady, NY 12301
(518) 372-0034

(To receive return correspondence, please enclose a legal size, self-addressed stamped envelope with your information request.)

R.I.D. has 135 chapters in 33 States. The organization maintains a speakers bureau and distributes written materials on the topic of alcohol-impaired drivers. In addition, R.I.D. operates a victims hotline.

Project Techniques for Effective Alcohol Management (T.E.A.M.)
National Highway Traffic Safety Administration
Office of Alcohol and State Programs
400 7th St., SW
Washington, DC 20590
(202) 366-9588

Project T.E.A.M. helps sports/entertainment arenas and stadiums develop responsible alcohol policy and procedures that will dissuade persons from driving under the influence. Project T.E.A.M. also provides training for juvenile and family court judges on the topic of drinking and driving.

CHECKLIST

APPROACHES FOR PREVENTING ALCOHOL AND OTHER DRUG USE IN OUR COMMUNITY

INDIVIDUAL

- ☐ Provide factual information about alcohol and other drugs
- ☐ Address beliefs about alcohol and other drugs
- ☐ Meet social or psychological needs of young-;; people
- ☐ Address early antisocial behavior
- ☐ Reduce feelings that "It can't happen, to me"
- ☐ Help young people cope with emotions
- ☐ Improve poor life shills

PEER GROUP

- ☐ Support nonusing. groups and clubs
- ☐ Peer education programs and peer. leader; ship programs
- ☐ Provide opportunities to observe nonusing role models
- ☐ Teach peer-resistance strategies

PARENTAL **APPROACHES**

- ☐ Provide information on alcohol and other drugs
- ☐ Teach and encourage prevention strategies at home
- ☐ Help develop shills for building strong family bonds
- ☐ Form parent, support groups

SCHOOL-BASED STRATEGIES

- ☐ Involve parents or other caretakers
- ☐ Incorporate a comprehensive alcohol/drug curriculum
- ☐ Establish and enforce nonuse policies
- ☐ Establish policies for seeking help for students and faculty
- ☐ Monitor alcohol and other drug use; evaluate efforts
- ☐ Consider uniforms/ dress codes for students
- ☐ Involve the community
- ☐ Establish student and employee assistance programs

TEACHERS' PROGRAMS

- ☐ Provide training about alcohol and other drugs and about prevention
- ☐ Train teachers to recognize signs of trouble
- ☐ Help teachers explore their own attitudes and beliefs about alcohol and other drug use
- ☐ Develop referral skills

MASS MEDIA APPROACHES

- ☐ Ask radio stations to eliminate humor and irresponsible commentary about alcohol and other drugs
- ☐ Ask for equal coverage for celebrations that don't include alcohol
- ☐ Involve local sports stars and celebrities in prevention efforts
- ☐ Educate college and university newspaper editors about alcohol advertising
- ☐ Make TV, radio, and print commercials to raise awareness and reinforce prevention and intervention efforts
- ☐ Reinforce media prevention effort with long-term community programs
- ☐ Provide news or new angles for journalists and broadcasters

REGULATORY AND LEGAL ACTIONS

- ☐ Increase sales tax on alcohol to raise prices
- ☐ Support adherence to rules and laws and raise awareness of consequences of breaking laws
- ☐ Provide training for those who are responsi-. ble for enforcing laws
- ☐ Enforce minimum drinking age of 21
- ☐ Support equal and quick enforcement of laws
- ☐ Educate advocacy groups about how laws, ordinances, policies, etc., impact behavior (e.g., zoning laws regulating the number of alcohol distributors within zones)

This checklist represents only a sample of the strategies being used or tested in communities throughout the United States. To be truly successful, try to involve many additional segments of the community to establish, nurture, and sustain a long-term commitment to prevention.

Increased prevention efforts generally lead to an increased need for intervention and treatment services, and it is important not to stimulate a need that cannot be fulfilled. Prevention planning should be **mindful** of this situation.

CHAPTER 3

Prevention Planning Guide

Introduction

Some people who wish to become involved in community efforts to prevent alcohol and other drug problems look on planning as a complex process best suited for professionals. It is true that outside experts can be helpful, but even the most elaborate plans are based on the contributions of local people concerned about the problem of alcohol and other drugs. Many effective plans have been developed using only neighborhood volunteers. This chapter provides a step-by-step outline of the planning process that communities may use either to develop prevention programs or to help them work with outside experts.

Why Planning Is Important

In some communities, people concerned about alcohol and other drug abuse have tried to initiate prevention efforts without systematic plans. They want to spend their time doing something about the problem rather than discussing what they should be doing. Too often, however, communities learn that lack of planning results in well-intentioned efforts spread thinly over too many separata activities to make a meaningful difference. Planning a prevention initiative helps communities to concentrate on projects that will have the most impact on local alcohol and drug problems. Planning reduces the frustration and wasted effort that can occur when prevention efforts try to accomplish too much with too little.

There is another reason why planning may be important. To prevent alcohol and other drug problems costs

money, and groups may hope to receive financial support from government agencies, national organizations, and private donors. These funding sources prefer to assist prevention programs that demonstrate specific objectives and measurable accomplishments. Planning helps to provide the documentation that groups need to compete for support for their projects. For further information on funding sources and strategies you may wish to obtain a free copy of *Fundraising for Communities: What Works,* from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852.

Contents of a Community Plan To Prevent Alcohol, Tobacco, and Other Drug Use

Some people think of plans as lengthy formal documents filled with statistics, charts, and technical terms. At the community level, such elaborate plans usually are unnecessary. A plan for a prevention program can be a brief document written in plain language that defines what the program is designed to do, the resources required, and the measures that will be used to determine whether the program is achieving its objectives. The key to success is a systematic, realistic planning effort rather than a glossy formal planning document.

In general, communities interested in implementing ambitious programs to prevent alcohol and other drug problems are likely to become involved in a more elaborate planning process than those attempting more limited activities. It may be helpful for communities to begin a prevention program or activity with plans for 6 months or a year and to graduate to more comprehensive programs as they gain planning experience and prevention resources.

Whether planning is simple or elaborate, the process generally includes the following nine steps:

- needs assessment;
- development of goals;
- development of objectives;
- identification of resources;

- identification of funding sources;
- assignment of leadership tasks;
- implementation;
- evaluation; and
- program revision based on evaluation findings.

Often, a final planning document specifically refers to each of these nine components of the plan; sometimes the distinctions between goals and objectives (the difference between the two will be explained later) or between identifying funding sources and identifying other resources are not explicitly stated. In any case, it is helpful to review all nine steps to make certain that none have been forgotten during the planning process.

The Nine Planning Steps: An Overview

Figure 3.1 identifies the basic questions to be addressed in each of the nine steps of the planning process. These basic questions must be answered during the planning period to avoid future uncertainty. For example, assigning leadership answers the question, 'Who is responsible for each part of the prevention program?" Answering this question before the program actually begins avoids the problem of activities "falling through the cracks" when everyone involved in the program thinks someone else is responsible. Similarly, identifying funding sources responds to the issue, 'Where will the money come from?" The answer is crucial because nothing is more frustrating than a prevention program with great ideas and hopes but no money to carry them out.

Figure 3.1

Basic* Questions Addressed *During the Planning Process

Planning Step	Basic Prevention Planning Issue
Needs assessment	What alcohol and other drug problems does the community need to address?
Development of goals	What do prevention activists want to achieve during the next several years?
Development of objectives	What quantifiable results can be achieved in the near future?
Identification of resources	What resources does the program need to achieve the objectives?
Identification of funding sources	Where will the money come from?
Assignment of leadership tasks	Who is responsible for each part of the prevention program?
Implementation	What procedures will keep the program on track?
Evaluation	How can the community determine whether the objectives are met?
Program revision	What changes are needed to improve the program?

How do people involved in planning complete the nine steps of the process? Essentially, they tackle each step by performing two tasks: collecting information and making rational choices based on that information.

Consider, for example, the case of a group whose goal is to reduce alcohol- and other drug-impaired driving among teenagers in their multiethnic community. Early in the planning process, the group needs to collect information about the adolescents who are most likely to be

involved in impaired driving. They may learn from traffic court records that a high percentage of such teenagers in their community are Spanish speaking; the group may decide on a goal of distributing materials in both English and Spanish or, alternatively, it may decide to involve Hispanic community leaders and to support existing efforts within the Spanish-speaking community. Information collection may be conducted a second time if the group seeks to identify organizations offering informative print and audiovisual materials prepared accurately in Spanish as well as in English. The group would then select the materials to be distributed on the basis of this information.

The remainder of this chapter reviews each step of the planning process to describe the kinds of information and decisions involved and the sources of help available to community groups as they develop prevention plans.

The First Step: Performing a Needs Assessment

Needs assessment is the part of the planning process that answers the question, "What kinds of alcohol and other drug problems does the community need to address?" The answer to this question is not always obvious. Goals are not identical in every community, and. pursuing the wrong goal at the wrong time can-lead to wasted effort (see ease study). A needs-assessment provides the information for. prioritizing prevention goals according to the unique circumstances of each community.

A complete needs assessment will determine:

- what substances-are being used in the community, by whom and in which situations; and
- what other programs and services already exist to address alcohol and other drug problems.

All prevention programs require knowledge of the target community and the context in which alcohol and.other drug use occurs. Assessment is particularly important in communities of ethnic minorities when the people. working to prevent problems are not from these communities.- In culturally diverse communities the potential for

conveying irrelevant information is much greater. (A discussion of important considerations for prevention within ethnic communities appears later in this chapter.)

There are six approaches to conducting a needs assessment:

- community forums and hearings;
- case studies;
- social indicators;
- service provider surveys;
- key informant surveys; and
- target population surveys.

Figure 3.2 can help prevention workers decide which approaches are best for them to use. (You may find that some other group or organization has already collected some of the information that you are looking for and that it is willing to share that information.) You can compare the advantages and disadvantages of each approach and then examine how the approaches compare with each other in the areas of cost, time, labor, and so forth. Finally, you must rate your organization's requirements and resources and answer some questions about the approach that you have tentatively chosen.

Collecting and analyzing information from such diverse sources-especially surveys-may be the single most difficult planning task facing a community prevention effort. Designing and wording a useful questionnaire can be difficult; drawing a sample also requires special care. Begin by looking for existing survey instruments and adapting them to meet your specific needs. Faculty members of local- colleges and universities may provide assistance with the needs assessment and may even be willing to assign portions -of the needs assessment as a project for their students. Black colleges, for instance, have historically been concerned about alcohol and other drug problems and may be willing to help design culturally relevant tools for needs assessments. County or State public health departments may also be willing to

assist a community needs assessment effort, lending expertise as well as providing information.

The figures that accompany this text include suggestions for developing a questionnaire and some important considerations for selecting a sample. Figure 3.3 also describes how to design a questionnaire that is easy to administer. Figure 3.4 is a sample questionnaire that is used successfully in San Diego County, CA, to collect information from organizations that are concerned with alcohol and other drug problems and prevention. It incorporates many of the elements suggested here. This information is provided to help you start thinking about the issues involved in conducting a survey. Additional reading and sources of information helpful in developing a questionnaire and choosing a sample are listed at the end of this chapter.

WITH THE BEST OF INTENTIONS...

Mr. P., an adult advisor to a local youth group, had read accounts of the devastating impact of the drug PCP on school-aged youth in several major cities and-was determined that this menace would be-kept out of his small Midwestern town. His eloquence convinced other members of the community that a major effort should be mounted to prevent the use of the drug among the town's youth. The group established a PCP Prevention Council, raised money, and planned to hire an advertising agency and a printer in a nearby city to produce appropriate brochures to distribute to adolescents.

Mr. P. and the PCP Prevention Council were surprised to receive a lukewarm reception from the local medical community, the school system, and other youth organizations. At a meeting with the county commissioner of public health, the PCP Prevention Council learned that no cases of PCP intoxication or delirium had ever been reported in its town and that use of PCP was probably confined to the State's largest cities. "There is no question that PCP abuse is a serious public health problem in some communities," the doctor explained, "but we just aren't likely to see it here." Some members of the PCP Prevention Council left the meeting with the feeling that their efforts had been wasted.

COMMENT: A simple, unscientific needs assessment would have revealed that the PCP Prevention Council's efforts would have been more productive if its program had included the prevention of the use of other drugs, instead of or in addition to PCP.

Figure 3.2

Choosing the Approach

Type of Approach	Advantages	Disadvantages
1. Community Forums and Hearings This approach is designed around a series of public meetings and relies on information from both key informants and individuals within the general population.	Easy to arrange Inexpensive Educates attendees Describes needs to public for verification Allows citizen input	Attendees may not represent population in need Attendees' perceptions of need may be incorrect Can turn into a "gripe" session Can raise expectations of action and change too high
2. **Case Studies** Case studies provide descriptive data of persons who have used your services and those of other agencies in your field.	Data easily available at low cost Inexpensive to analyze data Increases communication among human service organizations Provides overview of services being provided in community	Must provide guarantee of anonymity Community needs may be falsely estimated by studying those who use services May take more time to collect information and reconcile differences among agencies
3. Social Indicators This approach is based on inferences, i.e., estimates of need drawn from descriptive data found in public records and reports (crime statistics, unemployment, disease, and so forth).	Vast existing data pools Low cost Design flexibility Foundation on which to build other needs assessments	Must verify with other evidence if need really exists Data is only in direct measure of need Personal or class bias of researchers can be introduced

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Choosing the Approach (continued)

Type of Approach	Advantages	Disadvantages
3. Social Indicators (cont.)		Few indicator series have been developed; therefore, specialized staff shills will be required to draw them up
4. Service Provider Survey Your research is directed at those who actually provide sevice to a population in your community (administrative program staff of other agencies).	Provides information on problems or service needs which may not be widely recognized Validates information on existing and potential community resources Good for developing overview of community or individual problems Assessment based on professional judgement Simple and inexpensive Complements other approaches Communication strengthened among human service organizations	Problems identified may reflect cultural or class biases of providers rather than real problems Data may reflect needs only of those already being served Needs identified may reflect vested interests of providers

Choosing the Approach (continued)

Type of Approach	Advantages	Disadvantages
5. **Key Informant Survey** This research activity provides information from those who are not participants in the service delivery system but represent and speak for various constituencies in the community (clergymen, elected officials, advisory group members, commissioners, and so forth).	Simple and inexpensive Input of many well-placed individuals Identifies problems that can become public issues and receive widespread exposure Indicates programs likely to be supported or opposed by community leaders Highlights issues of importance to vocal and active segment of community	Identification of problems may be from political or personal sensitivity May exclude some leaders who should have been included May exclude parts of community who have no access to a leader
6. Survey Based on a collection of data from a sample, or entire population of a community, this approach is designed to get information from respondents about their needs.	Most scientifically valid and reliable approach Most direct way to obtain information on needs of individuals Expands information found through other techniques Flexible costs and time depending on whether general or target population is surveyed	Most expensive approach Reluctance of chosen individuals to reply Requires extreme care in selecting a sample Requires specialized skills Can require greatest amount of time Choice of survey (person-to-person, mail, telephone) must be clear and applicable to your community

Figure 3.3

How to Design a Questionnaire That Is Easy to Administer and to Answer

X	#	Tips
____	1.	Include on Face Sheet: identification number, interviewer identity, interview address, name and phone (for making appointment), introduction, list for contact and outcome, respondent selection key.
____	2.	Print questions on one side of paper only.
____	3.	Make your introduction short, nonthreatening, and simple.
____	4.	Ask warm up questions first-least sensitive and most interesting to respondent (length of residence or respondent's ideas about community problems).
____	5.	Ask demographic questions last. Don't ask them if you don't need them.
____	6.	Make the questions flow naturally in logical sequence.
____	7.	Use transitions such as "Now, here's a different kind of question..." or "Turning to another subject...." They dispel boredom and allow you to change subjects easily.
____	8.	Use "Now, here are a few final questions," to indicate the end is in sight.
____	9.	Do not crowd the questionnaire page.
____	10.	Keep format consistent throughout questionnaire.
1 1	.	Ask only as many questions as you need. (20 questions will take no longer than 10 minutes to answer-a well-spaced lo-page questionnaire takes 30 minutes to answer.)
____	12.	Use white paper for the body of the questionnaire.

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How to Design a Questionnaire That Is Easy to Administer and to Answer (continued)

X	#	Tips
____	13.	Use colored pages to mark the beginning of different sections for the interviewer who might have to skip a whole section if the respondent is not eligible to answer.
____	14.	Use symbols to guide the interviewer through the questionnaire (... indicates a pause, * indicates answer leads to another question, arrows indicate direction, vertical lines separate or group items together).
____	15.	Write instructions for interviewer in capital letters; box them or put them in parentheses.
____	16.	Leave room in the left-hand margin for coded column and response numbers.
____	17.	Provide several lines to answer open-ended questions.
____	18.	Line up responses vertically. This makes it easier to keypunch and to respond.
____	19.	Use horizontal listing of responses when several questions have identical response categories.
2 0	.	Use small dots . . . . . to guide the eye across the page to answers.
2 1	.	End the questionnaire with "Thank You."

A Final Note: If you are asking personal questions, such as questions about the alcohol or other drug use patterns of students, **you will** receive honest answers only if the respondent feels certain that the survey is completely confidential. Someone unfamiliar to the young people must administer the questionnaire. Do not ask for names or identification numbers on the questionnaire. Instructions should also state that students should skip questions if they cannot answer for any reason.

Figure 3.4

Sample Questionnaire
San Diego County Alcohol Survey

Please answer the questions below by circling the number by the answer that best represents your opinion.

If your organization has adopted a formal position about alcohol, then the questionnaire should be completed with that position in mind. If not, please give your best estimate of where your organization would stand on these questions.

1. Has your organization adopted a formal written position on alcohol or alcohol problems? 0 No 1 Yes (c1)

   If so, please describe briefly or attach if available.

2. How important a community priority do you or your organization believe alcohol problems to be in San Diego County?

Very Important	*Somewhat Important*	*Not very Important*	*Not at all Important*	*Don't know*	
1	2	3	4	5	(c3)

3. Several alcohol-related issues are listed below. Do you agree or disagree that these issues are a major problem in your community? Please circle one number for each item.

This issue is a Major Problem in My Community	*Agree Strongly*	*Agree Somewhat*	*Neither Agree nor Disagree*	*Disagree Somewhat*	*Disagree Strongly*	
a. Sale of alcohol to minors	1	2	3	4	5	(c4)
b. Availability of beer/wine for purchase at gas stations	1	2	3	4	5	(c5)
c. Existence of happy hours at bars and restaurants	1	2	3	4	5	(c6)
d. Advertising of alcoholic beverages	1	2	3	4	5	(c7)
e. Family violence due to alcohol	1	2	3	4	5	(c8)
f. Crime due to alcohol	1	2	3	4	5	(c9)
g. Problems/ injuries at work due to alcohol	1	2	3	4	5	(c10)

248-444 0 - 89 - 6 : QL 3

Sample Questionnaire (continued)

This issue is a Major Problem in My Community	Agree Strongly	Agree Somewhat	Neither Agree nor Disagree	Disagree Somewhat	Disagree Strongly	
h. Drinking and driving	1	2	3	4	5	(c11)
i. Individual drinking problems	1	2	3	4	5	(c12)
j. Public drinking in parks, on beaches, in stadiums and other public places	1	2	3	4	5	(c13)
k. Number of alcohol outlets	1	2	3	4	5	(c14)

4. During 1986, did your organization conduct or participate in any programs that addressed alcohol problems? 0 No 1 Yes (c15)

If so, please describe these programs briefly:

5. We want to know about your organization's plans and activities concerning alcohol issues. Circle all reponses that apply.

	Have Done	Plan to do	Would Like To Do	Not Likely To Do	Not Relevant For Us	
a. Educate the community to designate a non-drinking driver at social gatherings	1	2	3	4	5	(c16)
b. Work with your local retail outlets to post health warning signs near alcohol displays	1	2	3	4	5	(c17)
c. Sponsor a program for members/clients showing ways to cope w/stress, other than the use of alcohol	1	2	3	4	5	(c18)
d. Establish guidelines for how and when alcohol is used within your organization	1	2	3	4	5	(c19)

Sample Questionnaire (continued)

	Have Done	Plan to do	Would Like To Do	Not Likely To Do	Not Relevant For Us	
e. Sponsor a program to prevent alcohol problems in high schools	1	2	3	4	5	(c20)
f. Organize training sessions for restaurant and bar personnel on responsible alcohol beverage service	1	2	3	4	5	(c21)
g. Sponsor an alcohol free event such as a New Year's Eve Party	1		3	4	5	(c22)
h. Work with your city council to pass an ordinance banning the sale of alcohol at gas station mini-marts	1		3	4	5	(c23)
i. Work with police and Alcoholic Beverage Control to enforce laws prohibiting sale of alcohol to minors	1		3	4	5	(c24)
j. Encourage local police to arrest more drinking drivers	1		3	4	5	(c25)
k. Speak out in the media about alcohol problems in San Diego	1		3	4	5	(c26)

Sample Questionnaire (continued)

	Have Done	Plan to do	Would Like To Do	Not Likely To Do	Not Relevant For Us	
1. Work with employers to establish a worksite alcohol policy	1	2	3	4	5	(c27)
m. Monitor statewide legislation on alcohol issues	1	2	3	4	5	(c28)

6. For any prevention effort you have conducted or anticipate conducting, which of the following alcohol problem prevention activities have you conducted or planned to conduct? Indicate all that apply.

Have not conducted and do not anticipate conducting alcohol problem prevention activities (SKIP TO QUESTION 9) (c33)

Publish an article in your newsletter about alcohol problems (c34)
0 No 1 Yes

Host a speaker at membership meeting (c35)
0 No 1 Yes

Speak to other groups about alcohol related issues (c36)
0 No 1 Yes

Distribute brochures to members/clients about alcohol problems (c37)
0 No 1 Yes

Plan joint activities with other organizations (c38)
0 No 1 Yes

7. With which other types of organizations have you shared information when you've worked on alcohol problem prevention activities?

Have not shared information with other organizations concerning prevention activities. (SKIP TO QUESTION 8)

Schools/education	0 No 1 Yes	(c42)
Local government	0 No 1 Yes	(c43)
Community/social/fraternal	0 No 1 Yes	(c44)
Church/synagogue	0 No 1 Yes	(c45)
Business/employers	0 No 1 Yes	(c46)

8. Overall, when you have conducted alcohol problem prevention activities, what kinds of resources did you contribute to these project?

Did you Contribute	How many/much?	
Staff?	_____	(c47)
Space?	_____	(c49)
Volunteers?	_____	(c50)
Supplies?	_____	(c50)
Funds?	_____	(c51)

Sample Questionnaire (continued)

9. If your organization were to choose to participate in an alcohol problem prevention effort, what kinds of assistance do you think you could most likely use? Indicate as may as apply.

   Materials to distribute to membership/clients (c52)
   0 No 1 Yes

   Individuals to speak at meetings (c53)
   0 No 1 Yes

   Monthly or quarterly newsletter to stay up-to-date on issues (c54)
   0 No 1 Yes

   Training in alcohol problem prevention strategies (c55)
   0 No 1 Yes

   A program to use with your members/clients to inform them about alcohol problems (c56)
   0 No 1 Yes

10. How interested would you or your organization be in working together with other San Diego organizations to accomplish goals of mutual interest in the prevention of alcohol problems in the county?

    1 Very 2 Somewhat 3 Not at all interested (c57)

11. If there was a meeting scheduled to discuss how your organization might contribute to the prevention of alcohol problems, would you send a representative?

    0 No 1 Yes (c58)

12. What impediments are there within your organization for working on alcohol problem prevention issues? Circle all that apply.

    1 Lack of staff time (c59)
    2 Low priority on organization's agenda
    3 Lack of staff interest
    4 Lack of financial resources
    5 Other, please specify _____

13. What supports are there within your organization for working on alcohol problem prevention issues? Circle all that apply.

    1 High priority on organization's agenda (c60)
    2 High staff interest
    3 Extensive volunteer/member network
    4 Available financial resources
    5 Other, please specify _____

14. How might your organization be able to contribute to a county-wide prevention effort (e.g., sponsor alcohol-free events, provide volunteers to staff a community event, contribute funds, etc.):

    (c61)

Sample Questionnaire (continued)

15. Tell us something abut your organization:

    a. If yours is a membership organization, how many members do you have?_____ (c62)

    b. If yours is a direct service organization, how many individuals do you serve annually? _____ (c63)

    c. What parts of San Diego County do you service? (c64)
    1 Entire County
    2 Central San Diego
    3 North City
    4 South Suburban
    5 East Suburban
    6 North County West
    7 North County East

    d. Are your members/clients predominantly (c65)
    1 General population (no primary ethnic or racial group)
    2 White 3 Black 4 Hispanic 5Asian

    e. How many people work in your organization? (c66)
    Full-time ___Part-time Volunteers

    f. What is your annual budget? _____ (c67)

16. Would you like to receive an Executive Summary of the results of this study? (c70)

17. Who in your organization would be the best contact person to receive future information about the alcohol prevention program?

    Name _____ (c71)

    Title _____ (c72)

    Organization _____ (c73)

    Address _____ (c74)

    _____

    Telephone _____ (c75)

Thank you very much! Please return this questionnaire in the envelope provided or mail to:

San Diego County
Division of Alcohol Program
3851 Rosecrans Street
San Diego, CA 92110

If you would be willing to share copies of alcohol problem prevention materials you've used, please include them with your response.

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SUGGESTIONS FOR DEVELOPING A QUESTIONNAIRE

Your questions and concerns should be clearly addressed in your questionnaire. The wording will be your own, but you might use the following questions to stimulate ideas about what to include in your questionnaire. If you plan to interview several categories of respondents (e.g., youth and adults), you will need to develop a distinct survey for each type of respondent. It is extremely helpful to pretest your questionnaire with several people you know before finalizing it and beginning the interviews.

Suggested Question Topics

- What are the problems affecting youth in this community?
- Are any of these problems related to alcohol or other drug use?
- Which drugs are used the most? The least?
- What are the characteristics of youthful alcohol and other drug users (age, habits, hangouts, or role models)?
- At what age do young people begin using tobacco, alcohol, and other drugs?
- In what contexts and settings are alcohol and other drugs used by youth? By adults?
- What behaviors do youth engage in while using alcohol or other drugs that might contribute to other serious problems (e.g., driving, swimming, sexual activity, or use of other drugs)?
- What community norms may exist that promote the use of alcohol and other drugs by youth?
- What norms and practices exist that help protect youth from using alcohol and other drugs?
- What are some of the consequences for the community of alcohol and other drug use (e.g., vandalism, thefts, or crashes and related fatalities)?
- Are there ethnic differences in patterns of alcohol and other drug use?

- What kinds of programs do youth want?
- What are some of the obstacles to implementing a successful prevention program?

SUGGESTIONS FOR SELECTING A SAMPLE

You will not have to interview everyone who fits the description of the population in which you are interested. You can carefully select a cross-section of the community and interview it. A cross-section is a group representing all the different attitudes, ideas, preferences, and behaviors in your community. For example, if you have 100 religious institutions, interview a group of 10 priests, ministers, or rabbis who represent the religious leaders in the community. The same should be done for business owners, parents, agency directors, teachers, and so forth. When you decide which youth to interview, do the same; for instance, interview four or five youth who play basketball; four or five who are leaders of religious youth groups; four or five who hang out on a certain corner; four or five who are leaders in the high school.

Researching Existing Programs

In addition to performing the portion of the needs assessment that answers questions about the scope of the alcohol and other drug problem, you will want to perform an inventory of-prevention programs and services already operating in your community. In doing so, you will avoid duplicating the work of others, discover possible opportunities for collaborating with other groups, and ensure that your. efforts complement what is already being done.

Because prevention is a relatively new issue, people who are involved in prevention of alcohol and other drug problems may not consider their efforts to be prevention. Therefore, you may have to probe to find out if these efforts accomplish the following:

- intervene in any special way with children who are experiencing problems in school, at home, with friends, or with the law;
- provide activities for youth who may otherwise be engaging in the use of alcohol or other drugs;

- **provide training programs for parents on such topics as better parenting, dealing with adolescents, coping with handicapped or disabled children, and so forth,**
- provide support services or groups for child abusers, alcoholics, gamblers, and so forth;
- provide educational films, or speakers, or small groups, on alcohol or other drugs for their members;
- offer training for professionals, paraprofessionals, or volunteers, associated with identifying and helping dysfunctional families; and
- offer job training programs for youth.

This is not a complete list of prevention activities; it is presented to help you think through a wide range of services that actually play a prevention role in your community.

You might begin by looking in the telephone book for local or State agencies that are established to handle alcohol and other drug problems. Schools are often a hub of prevention programs, and school officials should be contacted. As you speak with people about their activities, ask them about other programs that they have heard of and record this information on worksheets. Each time you learn more about that program or activity, you will want to update this sheet (see Worksheet A). The next list provides examples of places that you may want to contact as part of your exploration:

- alcohol/other drug agencies;
- community health agencies;
- hospitals;
- mental health agencies;
- law enforcement agencies;
- highway safety office;
- department of education;
- State prevention coordinators (listed in Appendices E and F);
- programs to prevent teenage pregnancy;

- juvenile probation office;
- civic groups;
- youth groups (e.g., Boys Clubs or Girl Scouts)
- peer programs;
- State chapters of national organizations such as groups for the children of alcoholics;
- religious organizations;
- child abuse offices;
- recreation associations or offices;
- parent groups; and
- sororities or fraternities.

WORKSHEET A

Data on Existing Programs and Services

Name of Organization or Group _____

Contact Person _____

Telephone Number ( ) _____

Address _____

Project Title _____

Project Description _____

Audience Targeted by Project _____

_____

Service is primarily _ Prevention _ Intervention _ Both

Education	Legislative Action
Referral	Networking
Alternative Activities	Funding
Training	Treatment
Peer Group	Informal Counseling
Skill Building (Adults and/or Youth)	Programs for Related Problems (e.g., suicide or delinquency)
Group Support	

Does program have a clear nonuse policy and message?
_ Yes ___ No

Notes _____

_____

_____

_____

Having collected information on the extent of alcohol and other drug use, its impact on the community, and existing programs and services, prevention planners must decide which problems need the most attention. No simple formula can replace the difficult process of deciding which prevention needs should be addressed first and which can be addressed at some future date. Fortunately, there are two general guidelines that may help.

First, it is important to remember that **prevention is directed at future alcohol and other drug use.** Most alcohol and other drug users begin their experiences with alcohol and other drugs long before they reach the age of 21. Second, young people rarely try heroin, cocaine, or hallucinogens before they use tobacco, alcohol, or marijuana. When prevention programs succeed in promoting abstinence from these so-called "gateway drugs" among adolescents and young adults, future underage use and adult abuse is reduced. However, if the streets of your community are being ravaged by drug-related murders among youth or by drunkenness by a large number of youth every weekend, intervention efforts may need to be a first priority.

The final result of a needs assessment should be a list of problems with alcohol and other drug use that require the community's attention. The items on this list should be as specific as possible. One community effort, for example, identified binge drinking associated with high school graduations and sports events as a serious problem in the affected communities; another seaside community saw alcohol and other drug use while boating and engaging in other water sports as problems that affected families in their area. In both cases, defining prevention needs in very specific terms helped community prevention efforts focus on specific problems that could be addressed with relatively modest means.

Special Considerations for Assessing the Needs of Culturally Diverse Communities

Members of ethnic and cultural minorities often cluster in communities that provide social support or maintain extended social networks. People from the same ethnic group typically share beliefs, values, and social and educational experiences. These shared experiences suggest that prevention strategies developed for these communities, whether the impetus comes from inside of

or outside of the community, will be most effective if members from the community are actively involved in all phases of program planning and implementation. People from within the community add credibility and visibility to the prevention effort because they generally have professional, social, and familial ties to it. These people are usually familiar with local language preferences, beliefs, and practices, including the beliefs and practices concerning alcohol and other drugs.

Although people from and those working with ethnic communities have identified some community characteristics such as typical ways of communicating within the group or typical community leaders, people involved in prevention should not assume that all Black, Hispanic, or any other groups are all alike. History, location, and a host of other factors produce striking differences between ethnically similar communities and even between members of the same community. For example, Native Americans belong to hundreds of tribes, representing many distinct cultural traditions dating far back into the history of this continent. Today, roughly half of the Native Americans remain on reservations, largely in rural areas-the other half live in cities, primarily in the West and Midwest. Asian and Pacific Island descendants come from at least ***32*** distinct ethnic and cultural groups, and the ethnic differences among them are complex. Similarly, the group of Americans known as "Hispanics" contains people of Mexican, Cuban, Central American, and Puerto Rican descent, each group with its own unique cultural heritage. Therefore, it is clear that making assumptions about a community can lead to costly mistakes in establishing credibility, in time, and in money. To avoid these mistakes, each community must first be assessed to determine its particular characteristics and needs.

Figure 3.5 lists examples of resource people from several ethnic communities who have traditionally been involved in community affairs and who may be valuable contributors in preventing alcohol and other drug problems, Figure 3.6 lists examples of mechanisms through which people from several ethnic communities obtain information. Many of the examples in each figure hold true for the majority population as well. The examples in the figures may be useful for stimulating ideas, but their information is not a substitute for evaluating the community about which you are concerned.

The Second Step: Developing Prevention Goals

With a completed needs assessment in hand, individuals planning a community prevention effort have the information necessary to develop reasonable prevention goals. The key is to establish goals that accurately reflect potential solutions to the problems found during the needs assessment (see the next case study).

Figure 3.5

Examples of Community Change Agents (CCAs)

Community CCAs	Native Americans	Asian/ Pacific Islander	Black	Hispanic
School teachers	X	X	X	X
Alcoholism counselors	X	X		
Religious leaders		X	X	X
Nurses	X		X	X
Club presidents	X	X	X	
Hometown clubs			X	
Mail carriers			X	
Unlicensed health professionals		X		
Business proprietors	X	X		
sports personalities	X	X	X	X
Media personalities	X	X	X	
Block captains			X	
Newspaper editors	X	X	X	X
WIC women		X	X	X
Community health clinics	X	X	X	X
Local chapter minority-oriented clubs and professional organizations	X	X	X	X
Local heart associations, cancer associations, and other health-related volunteer organizations	X	X	X	X
Businessmen's clubs	X	X	X	X

Reproduced from ***Strategies for Diffusing Health Information to Minority Populations: A Profile of a Community-Based Diffusion Model,*** U.S. Department of Health and Human Services, National Heart, Lung, and Blood Institute, September 1987.

Figure 3.6

Examples of Communication Channels

Channels	Native Americans	Asian/ Pacific Islander	Black	Hispanic
Family, general	X	X	X	X
Children	X	X	X	X
Hairdressers/ barbers			X	
Sheriff/police departments			X	
Church leaders	X	X	X	X
"Public" nurses	X	X	X	X
Social workers	X	X	X	X
Cinema owners/ operators				X
Store proprietors		X		X
Professional organizations	X	X	X	X
Senior centers	X	X	X	
Work crew leaders			X	X
"Ethnic" newspapers	X	X		X
Political leaders		X	X	X
Women's church groups	X	X	X	X
Television/radio	X	X	X	X
Mainstream health workers	X	X	X	X
Friends/peers	X	X	X	
Social/cultural clubs	X	X	X	X

Reproduced from *Strategies for Diffusing Health Information to Minority Populations: A Profile of a Community-Based Diffusion Model*, U.S. Department of Health and Human Services, National Heart, Lung, and Blood Institute, September 1987.

HITTING THE BULL'S EYE

It was common knowledge that underage freshmen and sophomores were responsible for many of the college town's alcohol-related problems. A needs assessment found that these groups made up a large proportion of those arrested for driving while intoxicated (DWI) and minor alcohol-related crimes. Several town leaders, however, were surprised to learn that the most pressing problem seemed to be student access to alcohol away from campus rather than on campus.

The draft of a goal statement that reflected the problem was phrased in very general terms: "Improve enforcement of the minimum drinking age off campus." The town police chief pointed out that he could not do anything to meet this goal outside of the town boundaries and that efforts to enforce the minimum drinking age in off-campus housing could raise complex legal issues.

A second attempt to formulate a goal statement focused on the issue of **access** to alcohol: "Improve enforcement of the minimum purchase age in local sales outlets." Several local businessmen objected, saying that the wording appeared to place the entire blame for the situation on them rather than on the students. Ultimately, a college student suggested the final wording of the goal statement, "Improve compliance with the minimum purchase age at local sales outlets." This statement implied that students shared the responsibility for meeting the goal by refraining from trying to break the law, and it had the potential to involve sales outlets outside the town limit.

COMMENT: A consensus on specific language that related directly to the problem produced the most useful, least inflammatory goal statement.

Perhaps the best way to develop prevention goals is to assign the task to a small number of individuals who are familiar with the needs assessment. The group can then analyze the needs assessment point-by-point, drafting a goal statement for each identified problem area, and drafting a brief justification for each goal on the basis of the information already collected. For example, a goal for an inner-city community might be to eliminate open drug dealing on the streets. In a suburban area, it might be to gain communitywide cooperation among alcohol outlets to enforce laws concerning the minimum purchase age. A draft of the goal statements may be submitted to other interested members of the community for review, comment, and possible revision. This is especially important when

attempting to plan for an entire neighborhood or a total community. The more people involved in the early stages of the planning, the greater the support available once the program begins. Thus, the final set of goals will represent community consensus based on the best available research.

The Third Step: Developing Objectives

People tend to use the terms "goals" and "objectives" as if they were the same. In planning, however, these words carry different meanings. A goal is an ultimate outcome of a long period of activity. It sets the general direction for the work performed. An objective is a specific accomplishment to be achieved during a given period of time.

Imagine, for example, a plan for a vacation trip. The goal of the trip might be defined as "to see the major sites in Washington, DC." The objectives might consist of places to visit on specific days: the White House and the Washington Monument on Monday and Arlington Cemetery and the Lincoln Memorial on Tuesday. When all of the activities are completed, the vacationers can be satisfied that they have met the goal of the trip. The objectives help attain the goal by translating a general purpose into a series of specific, manageable steps.

The same principle holds true when making plans for prevention activities. The basic question in developing objectives for preventing alcohol and other drug problems is, "What quantifiable results can be achieved in the near future?" In effect, the objectives associated with a given prevention goal are really the milestones that must be attained in reaching that goal.

Objectives are written in quantifiable terms so that there is no question about when and whether they have been achieved. For example, if a prevention program proposes to distribute materials to adolescents, it is useful to specify a set number of adolescents targeted to receive the literature. Without a target number, the objective might be perceived as fulfilled if two dozen adolescents received brochures or as unmet even though half of those in the community were reached.

Specifying a quantifiable target to reach in a given amount of time also helps planners to select objectives

that are realistic and attainable. When a community first attempts to prevent alcohol and other drug problem there is a tendency to be too optimistic about what can be accomplished in a short period of time. By using specific numbers, a list of objectives identifies exactly how much work has to be completed to meet the prevention goals (see the next case study). At the same time, dividing the work into manageable amounts will help planners identify the resources required and deadlines for obtaining them.

Setting objectives requires careful thought. The best approach is to begin with a prevention goal that has a high priority for the community. List all of the short-term results or conditions that must be attained to reach the goal. Next, select those results from the list that can be achieved during the first 6 months of the program's operation; during this process, it is better to underestimate rather than overestimate what can be accomplished. When this short list of results is completed, select the results that could not be achieved during the first 6 months but could be achieved during the first 12 months. This produces a list of 6-month and 12-month objectives; items on the list that cannot be achieved during the first year are classified as long-term objectives.

The next task is to review each 6-month and 12-month objective of the selected goal against the following checklist:

- Does the objective specify a single quantifiable result?
- Are there ways to determine that the quantifiable result is met?
- Does achievement of the objective contribute to meeting the goal?
- Can the objective reasonably be achieved within the time allowed?
- Is achievement of the objective likely given resources available for the prevention program?

If the answer to any of these questions is "no" or "maybe," the planners should modify the lists of 6-month and 12-month objectives until all of the objectives can pass the checklist.

The process is repeated for each of the prevention goals identified during the previous planning step. As a result, the development of objectives can be time consuming. Nevertheless, the final result is a thoroughly considered, reasonable timetable of planned accomplishments. The effort exerted in a creative, systematic process of developing objectives often will reap important benefits in terms of adequate resources, financing, and community support for the prevention program, as well as increased morale among prevention activists who know that they are approaching-or exceeding-the results targeted during planning.

CRAWL BEFORE YOU WALK

Use of inhalants-breathable chemicals that produce mind-altering vapors-is a major drug problem among teenagers in many communities but has received little attention from the media. The "Just Say No!" Council of a large working-class suburb, having learned that medical complications from inhalant use had been reported in surrounding towns, adopted a prevention goal of increasing awareness of the problem, its consequences, and its symptoms among the town's 8,000 teenage residents and their families. Because many high-risk teenagers who were high school dropouts could not be reached in the public schools, the Council decided to try a strategy that would involve the local mass media, distribution of brochures in neighborhood businesses, and a series of talks to parent groups by a concerned physician.

One member of the Council was the assistant vice president for marketing of a regional drugstore chain. He suggested to the Council that an objective of reaching all 8,000 teenagers and their families with all forms of public education within 6 months might be overly ambitious. "Even if we organize a talk to 100 parents twice a week, it will take more than 6 months to reach every household, and I think Dr. Murphy would burn out long before we finished." He also pointed out that negotiating with businesses might require several months.

Following his suggestions, the Council established lower numerical targets for the objectives of the first 6 months of the campaign: distribution of 5,000 brochures in 25 business establishments; 15 parent group talks; 2 articles in the daily newspaper; and a radio public service announcement. Three of the four objectives were met on schedule.

COMMENT: Associating objectives with specific numerical targets results in realistic expectations.

The Fourth Step: Identifying Resources

Many people think of resources strictly in terms of what can be seen and held: money, printed materials, videotapes, filmstrips, posters, and occasionally more general items such as reams of paper and boxes of thumbtacks.

The resources needed to meet the objectives for preventing alcohol and other drug use include both physical and less tangible resources. For instance, community-based prevention requires an investment of time and work by volunteers. It also may require expert knowledge of specialized topics or the cooperation of people and organizations to implement the plans of the prevention group. All of these can be described as resources that must be identified and secured to carry out a successful community prevention program. Many of these resources are called "in-kind" services. A business, for instance, may not be able to provide actual dollars, but it may be able to print a brochure if you give the business a place to put its logo. Alternatively, it may be able to lend you a public relations expert or an accountant for 1 day a month. In-kind donations can be as valuable as actual dollars.

In the planning process, the answer to the question, 'What resources does the program need to achieve the objectives?" must be based on the process of setting objectives. The objectives determine the resources necessary and not vice versa.

After accepting this basic point, resource planning for community prevention activities can proceed in a logical process of associating each objective with an estimate of the resources required to meet it. As illustrated in Figure 3.7, prevention planners frequently use a resource planning chart as a "shopping aid" to help ensure that they have identified all of the resources that they will need.

The examples in Figure 3.7 illustrate that detailed planning can highlight the hidden resource requirements of prevention activities. The efficient implementation of a speaking program, for example, requires a backup speaker to avoid disappointment if the primary speaker cannot attend a scheduled event. The backup speaker is a resource, at times a very important one. Similarly,

displaying posters requires community support-a resource that, in turn, may require a supply of letterhead stationery for formal requests to the owners of property where the posters will be located. A systematic effort to list all needed resources during the planning phase tends to prevent problems during implementation when a small but crucial item is overlooked.

The final part of this planning step is to decide from where the resources will come. Among the needed resources are often several that can be obtained through contributions from the community, such as volunteer labor and access to facilities for special events; however, others may be more difficult to obtain.

One approach to obtaining prevention resources is to join forces with other organizations in the health promotion and alcohol and other drug fields. You will identify many of these agencies when researching existing activities and programs during the needs assessment. These include State agencies, such as the Regional Alcohol and Drug Awareness Resource (RADAR) Networks, and local agencies, including the commission for public health and the public school system. Local chapters of private organizations, including the National Council on Alcoholism, Alcoholics Anonymous, Parents For Drug-Free Youth, the American Cancer Society, the March of Dimes, and the American Medical Society on Alcoholism and Other Drug Dependencies, may be helpful in suggesting community resources or placing community prevention activists in touch with sources of assistance. Prevention planners may be surprised by the extent to which pamphlets, fact sheets, speakers, posters, and audiovisual materials are available to communities at low cost from national groups concerned with alcohol and other drug problems.

Figure 3.7

Resource Planning Chart for Prevention Programs

Example 1:

Program Objectives	specific Expertise Required	Physical Labor Required	Community Support	Required Materials
Display 500 prevention posters through out the community	Writer for message Artist to design poster printer Coordinator to supervise project and obtain community support Distributors	Transportation of posters from printer to display locations	Permission to display posters at each location	Posters Access to telephones Thumbtacks or tape Letterhead stationery to use to request support

Example 2:

Program Objectives	Specific Expertise Required	Physical Labor Required	Community Support	Required Materials
40 speaking opportunities to parent groups with videotape	Speaker(s) (about 80 hours of work during 6 months) Backup person willing to speak on short notice project coordinator to arrange and help to publicize the program	Operation of video equipment and assistance to speakers(s)	Sponsorship of speaking engagements and help in publicizing	Videotape Access to equipment (e.g., VCR, televisions. etc.) Calendar Access to telephones Letterhead stationery

Your Own Needs:

Program Objectives	specific Expertise Required	physical Labor Required	Community Support	Required Materials

In addition to contacting State and local sources, community prevention groups may find it useful to send representatives to attend regional and national conventions and symposia. Such meetings are not only informative but they also provide excellent opportunities for exchanging ideas on resources and other aspects of planning with prevention activists from other communities. Advance notice of such meetings appears in a periodical of the National Clearinghouse for Alcohol and Drug Information (NCADI) entitled *Prevention Pipeline.* This publication may be obtained by writing to the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852. A $15 handling fee is charged but you may find a business that is willing to make a contribution for this item.

The Fifth Step: Identifying Funding Sources

Some resources cannot be obtained through voluntary contributions or networking; instead they must be purchased. This leads to the basic planning question of 'Where will the money come from?"

Obviously, the first piece of information needed to answer this question is how much money is needed. The identification of resources described earlier should eliminate all of the resources that will definitely be provided without the expenditure of funds. Planners should assume that everything else on the resource list must be paid for and should attempt to price every item realistically. This process will help fundraisers identify their target goals for funding and demonstrate to funding sources that the community prevention program has made a determined effort to limit unnecessary expenses.

The principal sources for funding of community prevention activities can be defined as follows:

- community fundraising;
- foundation grants; and
- government grants and contracts.

Community Fundraising

Community fundraising is perhaps the most familiar type of fundraising to local organizers. Local fundraising can take a variety of forms, from requests for donations from community businesses, organizations, clubs, and philanthropies to direct mail addressed to concerned citizens and the traditional method of door-to-door soliciting among neighbors. The key to success often is to specify exactly how the contributions will be used in providing prevention services to the community. Local donors usually prefer to give when they know how their money will be used and what needs the money will meet.

Community fundraising is initiated in a process called "webbing."* Webbing can be thought of as building a network of advocates for your organization-of discovering whom you know, whom *they* know, and what they can do for you. Though skills in project development and proposal writing are critical, developing a network of people to introduce you to funders—a "web" of contacts and advocates-can make the difference between success and failure.

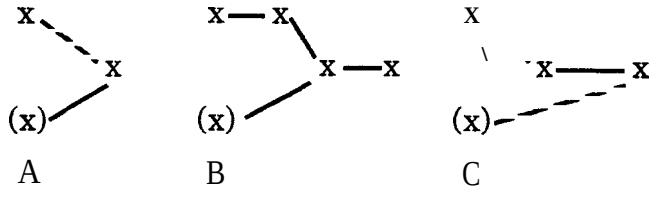
* Material on community fundraising and webbing was adapted from *The New Grants Planner,* available from Public Management Institute, 353 Brannan Street, San F'rancisco, CA, Conrad, 1980.

Worksheet A will help you create this "webbing" by determining people you know who can help you "get in the door" with funders and meet people who can help to promote your activities. Give the Webbing Form (Worksheet B) to everyone on your board, your key staff, your volunteers, community people you work with, and present funders-anyone who might know and introduce you to a funding executive. Ask them to fill it out and return it to you. You might also ask them to pass out copies to their friends or associates.

When you locate a funding contact using the Webbing Form, ask the person completing the form to set up an appointment for you with the funder, through the contact. If appropriate, ask the person making the appointment to come with you to the meeting. The contact's presence will add credibility to your presentation.

The ultimate goal of webbing is to make effective contact with a potential funding source--your targets, so to speak. The process of discovering your connections to these people and choosing which connections to pursue can be a tricky one. Even with thorough work, you may face one of three possibilities:

x = you, (x) = funder



WORKSHEET B

Webbing Form for _____

_____

Instructions: Please answer these questions as completely as you can. If you need more space, please use additional sheets. Return this form to _____ by _____ Your answers will, of course, remain confidential. They 'will be used to help us expand our funding base. Thank you for your help. Note: Please fill out a separate form for spouses of respondents.

1. Please list five people, organizations, and/or agencies you think can afford to make a gift to our organization.

   a> _____

   b) _____

   c) _____

   d) _____

   e) _____

2. Would you be willing to speak with any of these on our behalf?

   _____

3. Does your spouse know any of those people listed under Question #1? N/A Yes No.
   If so, which ones? _____

   _____

4. If applicable, what is the name and address of your business?

5. If applicable, are any of your customers or suppliers known givers to local philanthropy? ___ Yes ___ No.
   If so, which ones? _____

6. Have you ever helped this organization, or any other, get a gift of over $500? Yes No.
   Please describe: _____

   _____

7. What social, fraternal, athletic, or other clubs are you a member of? _____

   _____

8. What-is your educational background (college, date of graduation, degrees, etc.)? _____

   _____

WORKSHEET B (continued)

Webbing Form for _____ (continued)

9. What is your military history (branch of service, outfit, etc.)? _____

10. What church or synagogue do you belong to? _____

11. Please list any corporation and/or philanthropic memberships or directorships. _____

12. What is your home address? _____

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In Situation A, your network is small, but the introductory contact is weak. In Situation B, your network is strong, but involves many people and might become overextended. In Situation C, your network is of a little more manageable size perhaps, but the final, critical contact is weak. The key to success in each of these positions is to make those connections between people real-that is to develop good relationships with every contact on whom you will depend. Worksheet C helps you to identify types of officials to web in funding organizations and to delegate these tasks among your staff. Worksheet D gives 27 methods for developing and maintaining these relationships so that each person feels like a "critical link" in your network.

Webbing can result in nonmonetary support for your activities by helping you to establish a community advocate network-a network of the influential people and organizations that will act as your "friends in court." They will speak on your behalf, write letters of recommendation for you, and help you demonstrate community support for your project to potential funding sources.

Worksheet E covers three types of advocates (people from your organization, people from outside of your organization, and outside groups) and helps you plan whom to approach for support. Some of these people will be the same as those in your funding web, but many will be new. After you have identified possible advocates for your organization, the next step is to get them involved in what you do. Being an advocate can require a lot of extra time and work; no one will want to assume this role without some understanding of how your organization works. Worksheet F describes techniques for involving advocates in your organization. You should evaluate and choose the best advocates for your organization and assign them to your staff and board members.

WORKSHEET C

Contacts to Web

Funding Source	# Contacts To Web	Person(s) Responsible for Making Contact
Foundations	1. Officers	
	2. Directors, Trustees	
	3. staff	
Corporations	4. Contribution Committee Members	
	5. Contributions Officer	
	6. Executive Officer	
	7. Financial Officer	
	8. Local Plant Manager	
Federal Government	9. Elected Officials	
	10. Legislative Aides	
	11. Program Officers in Agencies	
	12. Regional Officers of Agencies	
	13. Other Key Agency Officials	

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WORKSHEET D

How To Develop Relationships with Funders A Checklist

X	#	Method
❑	1.	Go to conferences they attend.
❑	2.	Contribute to the specialized publications they read.
❑	3.	Send notes with information they would be interested in.
❑	4.	Call and ask for their advice on a program problem ("Do you know anyone who can help us?")
❑	5.	Go see them on an informal basis when you're "in the neighborhood."
Cl	6.	Send them a copy of any article you write, or publicity you get.
❑	7.	Ask what their travel schedule is and invite them to visit your organization.
Cl	8.	Ask them to speak to your organization.
❑	9.	Ask them to serve as project advisors.
❑	10.	Ask them to be advocates.
❑	11.	Ask them to refer you to other funders.
❑	12.	Call them for clarification of any new funding information you receive from them.
❑	13.	Ask them if you can be a reviewer of their proposals (Federal agencies only).
❑	14.	Volunteer to help community foundations raise money.
❑	15.	Join the groups they belong to.
❑	16.	Give parties or special dinners and invite them.
❑	17.	Speak at conferences and send them transcripts.
❑	18.	Ask them what the latest trends are in your field. ("Have you heard of anything new and unusual lately?")
❑	19.	Ask "Is there any project you'd like to see funded that you've never gotten a grant proposal for?"
❑	20.	Ask 'What were the most successful programs you've ever funded?"
❑	21.	Ask 'What are the main reasons why you reject most proposals?
❑	22.	Ask "How could we improve our grantseeking process?"
❑	23.	Ask if you could interview them for expert input on a proposal/project you're considering.
❑	24.	Ask if there's anything you or your organization could do to further any legislation they would like to see passed.
❑	25.	Send them copies of your needs assessments and opinion surveys and ask them to compare these with national norms.
❑	26.	Ask them to serve as board members of your organization.
❑	27.	Invite them to speak to a group of organizations that you have organized.

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WORKSHEET E

Advocate Network

Source	#	Type	Potential Candidates
Internal	1. Service Users		
	2. Previous Users (Clients, alumni, etc.)		
	3. Employers of Service Users		
	4. Donors		
	5. Board Members		
	6. Advisory Committee Members		
	7. Volunteers		
	8. Previous Staff		
External	9. Elected Officials		
	10. Professional Association Leaders		
	11. Religious Leaders		
	12. Social Leaders		
	13. Experts		
	14. Funding Source Staff and Trustees		
	15. Business People		
	16. Community Leaders Groups		
	17. Other Similar Institutions		
	18. Other Nonprofit Institutions		
	19. Planning Commission		
	20. Local Community Groups		
	21. Key Community Boards and Commissions (in your service area)		

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WOFXSHEET F

How To Get Community Advocates Involved in Your Organization

#	Technique	Person Responsible	Your Suggestions
1.	Ask them to join your board of directors.		
2.	Invite them to join special advisory boards.		
3.	Ask them to help you form consortia with other local agencies.		
4.	Ask them for advice on project-related issues.		
5.	Ask them to give you input on the needs in your community.		
6.	Ask them to speak with you at community group meetings.		
7.	Invite them to special events.		
8.	Ask them to donate to your organization.		
9.	Ask them to attend key local commission meetings in your field.		
10.	Ask them: "If they were you, where would they go for funding?"		
11.	Ask them to suggest other influential people in the community you could approach.		
12.	Ask them to participate in workshops given by your organization.		

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QL 3

Foundation Grants and Government Grants and Contracts

When you are unable to secure all the funds needed from within your own community, foundation grants and government grants and contracts can help. Many foundations share the concern over the epidemic of alcohol and other drug use in the United States and are interested in assisting reputable community prevention groups in meeting local needs. Competition for funding can be stiff. Smaller foundations rarely fund on the basis of unsolicited proposals received in the mail; personal contact and referrals are extremely important.. Even with larger foundations and corporations, most grants are made to organizations with which there has been prior contact, perhaps through a meeting or referral. Nonetheless, all funding organizations like to see an organized plan or proposal for upcoming activities and expenditures. (A list of sources for identifying information on grants and foundations is included at the end of this chapter.) As a preliminary step in the application process it is not uncommon for a foundation to ask for a brief letter (two to three pages) telling who you are, what your plan is, and how much funding you are requesting.

If foundations are interested in your letter proposal, they will then ask for a fully developed proposal. Requests for foundation grants generally are more loosely structured than requests for government funding. These requests should be based on the prevention planning process and should describe the following in specific terms:

- the nature of the problem to be addressed as indicated through the needs assessment;
- the solution proposed in terms of prevention goals and short-term objectives;
- documentation of the prevention group's ability to carry out the objectives;
- financial needs associated with- the request, including evidence that the prevention effort will not rely solely on the funder's support; and

- documentation that a systematic evaluation will be carried out to demonstrate that funding has made a difference in community prevention efforts.

Finally, when possible, requests for funding from charitable foundations and other private sector philanthropic organizations should be limited to support for specific resources, such as audiovisual materials or printing costs, that are too extensive to be financed exclusively from community fundraising. Foundations prefer to give support to organizations that have indicated that they also receive support from their community.

The process of preparing proposals (written requests) for Government funding depends on the funding agency. In general, when applying for Government support, many of the guidelines for requesting foundation money apply. However, Government support usually depends on successful response to a list of evaluation criteria provided by the funding agency. Community prevention activists should be alert to these criteria and to ensuring that their requests for funding meet the documentation requirements.

Although different Government programs may require different formats for the proposals, applicants for Government funding should be prepared to include the following standard sections in their proposals. (Once you have developed an effective proposal, you will find that you are able to recycle sections for future proposals, being careful to tailor the sections to the new prospective funding organization.)

1. ***Proposal Summary-The*** summary appears at the beginning of the proposal and provides the writer with an opportunity to interest the reader in what is to follow. Remember, when applications are screened, the summary may be the only part of the proposal read. It generally should be no more than half a page long and should include (in clear, concise language)

- identification of the applicant and a phrase or two about the applicant's history or background;
- the reason for the grant request-issue, problem, or need to be met;
- the objectives to be achieved through this funding;

- the kinds of activities to be conducted to accomplish these objectives; and

- the total cost of the project, funds committed, and amount asked for in this proposal.

2. Institutional Background and Qualifications--The discussion of your organization should be clear and to the point. You want to leave a favorable impression without overloading the reader with unnecessary details. Depending on your organization and its accomplishments, you may want to write about:

- when, how, and why the organization was started;

- its purpose, goals, and philosophy;

- prior and current activities;

- accomplishments and impact of activities;

- size and characteristics of your constituency or clientele;

- your funding sources and their positive comments on your work;

- the internal or external evaluations of your programs; and

- letters of support or endorsement.

3. Statement of the Problem-The statement of the problem is the most important part of your proposal. It tells the reader why you want to perform the activity for which you require funding. The needs assessment will supply much of the information required for this section. The statement of the problem should be:

- clearly related to the purposes and goals of your organization;

- supported by evidence drawn from your experience, from statistics provided by authoritative sources, or from the testimony of people and organizations known to be informed about the situation;

- something that you can realistically have an impact on over the course of a grant; and
- stated in terms of clients or constituents, rather than in terms of the needs or problems of your organization.

4. Program Objectives-Program objectives need to be stated in measurable terms. Statements about objectives should be quantifiable: use terms like "to increase" or "to reduce" instead of ones like "to create" or "to provide." This section should describe the objectives in numerical terms, define the population served, and state the time when the objectives will be met, if at all possible (e.g., to reduce the number of ninth grade students in Yolo County experimenting with cigarettes for the first time by 15 percent within ***12*** months).

5. ***Methods or Technical Approach-The*** next step is to spell out the methods by which you propose to achieve your objectives. This section requires clear and ample justification for your particular strategy. Ordinarily, this justification consists of a description of the applicant's past work or the evidence drawn from the work of others in the field. This section should present a reasonable scope of activities that can be accomplished within the time allotted for the program and the applicant's resources. A timeline of the program milestones is also helpful.

6. Evaluation-The steps involved in planning an evaluation of your activities are discussed later in this chapter. It is important to plan carefully the evaluation of your activities at the inception of the project and not as an afterthought; many evaluations depend on measuring certain characteristics before the program activities begin (e.g., number of people who have heard about the danger of alcohol consumption during pregnancy) so that changes over time may be assessed. Funding agencies expect you to have given thought to evaluating the proposed program by the time of proposal preparation. Do not fall into the trap of proposing an inconsequential effort or being overly brief; funding organizations may interpret this as an indication that you are not serious about evaluating your activities. Aside from their importance in securing funds, evaluation results will be useful to you in planning

ongoing activities and can provide satisfying feedback to the people supporting your program.

7. ***Future and Other Necessary Funding-When*** requesting funding for a new project, financial planning should go beyond the proposed grant period. Few funding sources want to adopt you as a long-term dependent, so it is important to show funders that you are already planning ahead. Funds might be secured, for example, by a successful fee-for-service program, from an agency that wants to "adopt" the program, from expanded fundraising efforts, or by membership in a fundraising campaign such as the one conducted by the United Way. Of course, the more specific you can be, the better your proposal.

8. ***The*** Budget-Funding sources require varying degrees of detail in an estimated budget. The Government generally requests a greater amount of detail than do foundations and corporations. Funding organizations usually provide budget forms and instructions for their completion. As with everything else, be as specific as possible when preparing your budget. Funding sources do not like to see every cost estimate rounded upward and expect you to research to the best of your ability the true costs to be incurred by the proposed activities. If, later you find that you have not adequately projected your costs, you can usually submit a "budget modification request." If you made a sincere effort to estimate costs at the outset, the funding agency will probably be receptive to any modifications and is also less likely to require a formal modification request.

A Final Note

Any discussion of funding is incomplete without mentioning the issue of what to do if adequate funds or other resources cannot be obtained. When this occurs, it may be necessary to restructure the community prevention activities or to find alternative approaches to achieving the same prevention goals. Remember, sometimes resources in place of cash will fill your requirements. For example, a printer could donate stationery or a grocer could supply food or other supplies for a student training event.

As a last resort, prevention objectives should be reexamined to determine if any are unfeasible at the present time: it is always better to change objectives or to delay their attainment than to waste effort trying to make the impossible happen.

Further suggestions on proposal writing appear in Figure 3.8. You can also obtain information on program planning and proposal writing by contacting the Grantsmanship Center, *1031* S. Grand Avenue, Los Angeles, CA *90015 (213) 749-4721.*

Figure 3.8

Suggestions for Better Government Proposal Writing

- Search multiple sources for bid opportunities, including but not limited to the State Registrar, newspapers, and the Commerce Business Daily (CBD). (The CBD is published daily and lists the products and services that the Federal Government wants to purchase as well as how to get specifications for each bid. A subscription is available from the Superintendent of Documents, Government Printing Office, Washington, DC 20402-9325. Also, many libraries subscribe to the CBD.)

- Order the application instructions from the funding agency.

- Seek assistance from your State government when applying for Federal funds and from your local government when applying for State funds.

- Seek advice on preparing your proposal from the designated contracting officer. Government Requests for Proposals (RFP) usually provide the name and telephone number of the contracting officer.

- Designate one person-not a committee-to be responsible for the process of coordinating your group's proposal. This person will ensure that the proposal sections fit together and that it is complete, photocopied, and delivered on time.

- Outline the proposal in detail before writing the document. An outline ensures that proposal contents are consistent with the evaluation criteria, as well as with your group's objectives.

- Read the RFP carefully and send any questions about its contents to the contracting officer as quickly as possible, in writing.

- Review the proposal to ensure that it responds exactly to the issuing agency's needs. A proposal is not an opportunity to convince the funding agency that it would be better to perform different projects and activities than are described in the RFP. That is, do not propose a project to prevent alcohol and other drug use in response to a request for innovative child care programs.

The Sixth Step: Assigning Leadership Tasks

When thinking of leadership, most people think of a single individual's authority over a group of followers. This form of leadership is, however, only one among many forms and is usually not appropriate for groups of organized volunteer citizens. Occasionally, a leader has enough magnetism to hold a volunteer group together, but even when this does occur, the group becomes so dependent on the leader that it may fall apart as soon as this person leaves the group.

How well a group can attract members will generally depend on the caliber of its leaders. One of the first considerations of those responsible for organizing a prevention initiative is locating leaders who can strengthen the interpersonal relations of all group members and maximize support for the group's objectives.

The essential ingredient for leadership is the possession of skills that help the group progress toward meeting its goals. Those capable of doing so and recognized by the group take on leadership roles for the group. One does not need to be a "born leader" to lead a group. In newly formed groups, one person or only a few people will fill leadership roles; however, every member of the group can be trained to fill a leadership role, and in a mature group, each person will probably function both as a leader and as a follower at one time or another.

Therefore, instead of looking for a leader, look for people who possess the skills needed by your group. Sometimes this will include someone who has excellent abilities in self-expression and persuasion-the kind of person who may seem like a natural leader. Other times your group will need people who know how to organize citizens or obtain cooperation from the business community. These people may be less visible and may have no leadership skills other than their expertise in what you want to do. Interpersonal skills can be developed; experience is not as easily obtained. A careful review of your group's needs will guide you to the most valuable leaders.

On some occasions, a local leader who possesses the skills you need may not be available. In this situation, it may be necessary to bring in an outside expert who can supply your group with the answers it needs. An outside

expert cannot, however, take the place of a local leader. Outside experts are not personally involved in the community, and those that become involved in the course of working on the project run the danger of preventing the development of local leadership. It is essential that the members of the group learn technical knowledge and leadership shills from the expert so that they can function without that person as soon as possible.

Training in effective group techniques is excellent preparation for learning group facilitation shills. Figures 3.9 - 3.11 list some functions identified by Donald Fessler in ***Facilitating Community Change: A Basic Guide*** as important to the long-term health of a volunteer group. The better the leader and group members are at performing these functions, the better off the group will be.

Figure 3.9

Task Roles for Group Leaders and Group Members

- Initiating activity: suggesting new ideas, new approaches, or new ways of organizing material or offering solutions.
- Seeking information: asking others to supply needed information or clarification of data on hand.
- Seeking opinions: getting others to evaluate ideas or procedures already suggested.
- Giving information: providing the group with facts or experience relevant to the question at hand.
- Giving opinions: expressing a belief about the value of ideas or procedures under consideration.
- Elaborating: building onto an idea already suggested so that it will better meet the needs of the group.
- Coordinating: relating various ideas so that they become a connected whole.
- Summarizing: restating briefly the important contributions made by the group so that none will be overlooked and bringing the group together in its thinking.
- Testing feasibility: applying the ideas to real-life situations to pretest their effects and to anticipate and avoid mistakes.
- Testing for consensus: asking for group opinions in a tentative manner to determine if the group is ready to make a decision.

Figure 3.10

Group Maintenance Roles for Group Leaders and Group Members

- **Encouraging:** being sincerely warm and friendly to others and encouraging them to participate by being positive about their contributions. This includes thoughtful consideration of both the merits and weaknesses of contributions made by the less outspoken members of the group.

- **Gatekeeping:** making it possible for individuals to be brought into the discussion by asking for their ideas or opinions and, in some cases, by restraining more vocal members so that others have a chance to talk.

- **Standard setting:** expressing standards or criteria for group operation that will help the group arrive at decisions objectively and amicably.

- **Expressing** group feelings: summarizing how the group seems to feel about an issue.

- **Diagnosing:** determining sources of difficulty and proposing the appropriate next steps.

- **Compromising:** achieving group agreement by providing compromises for opposing points of view, raising questions whose answers will eliminate misunderstanding, or offering to modify one's own position.

- **Harmonizing:** allaying negative feelings with humor or by shifting to **a** broader point of view.

- **Consensus testing:** sending up a trial balloon to test a possible group consensus.

- **Following: serving as an** interested listener while others are talking.

Figure 3.11

Nonfunctional Roles for Group Leaders and Group Members

- **Being aggressive:** deflating the status of others, disapproving of their contributions, or joking aggressively about them.
- **Blocking:** opposing unreasonably, or being stubbornly resistant.
- **Recognition seeking:** calling attention to oneself by boasting, name dropping, or mentioning personal achievements.
- **Self-confessing:** expressing personal feelings that have no bearing on the group or its task.*
- **Being a playboy/playgirl:** making a conscious display of noninvolvement in the group's activity by whispering, writing notes, engaging in horseplay, or reading something not relevant to the task at hand.
- **Dominating:** asserting authority or superiority over the group by giving directions, interrupting others, or flattering members.
- **Help seeking:** taking advantage of the group meeting to try to solve a personal problem or to gain sympathy.
- **Special interest pleading:** cloaking one's own prejudices by claiming to speak for "the housewife," "the small farmer," or "the general public."

Taken from D. Fessler, ***Facilitating Community Change:A Basic*** Guide, La Jolla, CA: University Associates, 1976.

* Many efforts to prevent alcohol and other drug problems begin as a group of people who band together because they are experiencing a similar problem, for example, their children's use of marijuana. Often these groups need some time to share their problems. Experience suggests that many of these people will become activists and begin to plan prevention and intervention programs and activities. However, if some of the members do not move on from talking about their own problems, they may require additional support. The group may wish to schedule a support group that meets at a separate time each week or each month to discuss personal concerns.

Finally, because of the important role of volunteers in prevention programs, community leaders need to be able to direct volunteers in a coordinated effort. Some people tend to treat volunteers as if they were employees who can be replaced when they perform below expectations. Other leaders may lean too much toward allowing volunteers to direct their own activities. Neither extreme is healthy for the success of a community prevention effort, Volunteers are irreplaceable resources who must be given an opportunity to perform as well as their circumstances permit. At the same time, volunteers need effective and decisive leadership to prevent the dissipation of effort. The ability to balance these characteristics is crucial to success. Techniques for improving your volunteer recruiting skills are outlined in Figure ***3.12.***

The Seventh Step: Implementation

The goals, objectives, and activities of the community prevention group have been determined. The necessary resources and funding have been acquired, and solid leadership is in place. The kick-off day for the prevention activities arrives and the program is launched, with everything operating in perfect order and not a single problem on the horizon.

This description rarely applies to the real world of community prevention programs. Even the most careful plans are subject to what administrators call Murphy's Law: everything that can go wrong, will go wrong. Therefore, planning must therefore include the development of procedures that ensure the success of prevention efforts when the unexpected happens. This is what is meant by "planning for implementation."

Figure 3.12

Recruiting Volunteers

Volunteers are critical to the success of many health education programs. Yet, most program managers end up doing the work themselves because "they can't find volunteers." While there is no quick and easy way to recruit volunteers, there are ways to improve your volunteer recruiting skills.

Know the Job

People are more likely to volunteer if they know the

- Specific volunteer duties
- Time commitment needed
- Location
- Project goals
- Training requirements
- Travel needs

If your project involves a number of different tasks, sketch out a brief job description for each task. Knowing what you want people to do will make it easier for you to locate volunteers and interest them in your project.

Fit the Volunteer to the Job

Let's face it, the world is full of different kinds of people with various skills, talents, interests, and experiences. Not everyone is willing to do anything, but most people will do something if(a) they feel confident they can do the job, and (b) they have some familiarity with the duties required. Draft a brief profile of the kind of volunteer you need for each task. If geographic location or availability at a specific time of day is important, note that too. Next, ask yourself where you might find someone who fits the qualifications. Then make a list of how and where you can contact potential recruits.

Use the Personal Approach

People like to be recognized and appreciated for their talents. A sign-up sheet says, in effect, "I'll take anybody." No one wants to be thought of as just anybody. Approach people on a one-to-one basis and show that you've taken interest in their specific talents. They will be more responsive to your request. Use the job descriptions and volunteer profiles to highlight volunteers' qualifications and to show how much you value them. Point out the benefits of volunteering to potential

recruits. While the spirit of service is an important motivating force for most volunteers, it helps to personalize each volunteer's reason for signing on. You will get turned down now and then. When this happens, be gracious and leave open the possibility to volunteer for future positions.

Interview Candidates

Finding a willing and able volunteer is a relief. However, for your own peace of mind and the success of your project, find out if this is really the person you want. Even if the volunteer fits your job description and profile, you want to be sure s/he doesn't have other characteristics that may jeopardize your effort or cause her/him to lose interest in the cause. Determine the volunteer's needs, expectations, and reasons for volunteering. For example, Chris may enjoy soliciting contributions but hates bookkeeping. If Chris is a real asset, you could then delegate the bookkeeping to another volunteer. The important thing is to know the strengths and weaknesses of the volunteer as they apply to this specific position. How formal or informal you make the interview will depend on the level of responsibility involved in the position.

Support the Volunteer

A good volunteer is hard to find. So treat your volunteers well and wisely. Provide them with whatever training, supplies, or instructions they will need to do the job right. Make yourself available to answer questions and resolve problems. Even if they don't call you, check on them periodically. Above all, recognize the service of volunteers. A personal "thank you" or a handwritten note goes a long way. Whenever possible, use a public gesture such as an award ceremony, a speech, or a press release to say thanks for a job well done. Also, asking a volunteer who has performed well to take on a position of greater responsibility is a good way to recognize service and to develop volunteer leadership.

Remember, a happy volunteer is your best recruiter.

Adapted by M. Pipp, from "Recruiting Volunteers." *AARP Highlights,* Bethesda, MD: University Research Corporation, 1987.

Supervision is probably the most important element of implementation. To a great extent, supervision means keeping the lines of communication open between leaders and others involved in prevention efforts. It requires continually checking the progress of prevention activities.

- Are the plans working as they were envisioned?
- Are data being collected accurately as planned?
- Do program objectives need to be adjusted? For example, is the target audience too large? Are the timetables realistic?
- Are plans sufficiently flexible? Do people involved in implementation believe there are opportunities for improving the effort?
- What is being learned from implementation that would suggest possible improvements in the activities? For example, is the videotape used for youth audiences eliciting giggles instead of interest? Is the key speaker unable to answer certain types of questions from the audience?
- Are there particular opportunities for current or future expansion? For example, do other groups want to participate in the prevention activities? Has a new potential funding source been identified?

A second important element of implementation is accountability. Although one obvious aspect of accountability is financial management—ensuring that funds are used for their designated purpose-other aspects of accountability can also be crucial. For example, one individual should be designated to be accountable for all relations with the press to ensure that a clear and unified image of the community prevention effort is provided through the mass media. Or, if this is to be considered part of the responsibility of each leader, then general procedures, agreed on messages, and so forth might be issued by the person who is accountable. For example, a style sheet might be used for the development of all materials that might be distributed through the media and other channels. A copy of the style sheet used by the

Office for Substance Abuse Prevention for all of their publications and articles appears at the front of this manual. When accountability is explicitly distributed among the group leaders, the group understands who must take responsibility for correcting problems that may emerge in implementation.

Finally, the group must devise at least informal mechanisms for troubleshooting specific problems that may arise during implementation. As illustrated in the next case study, the operation of even a modest community prevention program occasionally may involve legal, financial, regulatory, or administrative complications demanding expertise beyond that normally associated with prevention activities at the local level. Planning for implementation must include an effective method of locating and using the necessary expertise for troubleshooting, including a method for resolving crises and disputes.

The Eighth Step: Evaluation

There are several reasons for a community prevention program including an evaluation component. First, there is an innate curiosity among people involved in any community effort to learn how well their program is operating. For some efforts, such as community beautification projects, the results are physically obvious; in programs to prevent alcohol and other drug problems, however, a community cannot assess the success of a project without relying on some form of data collection.

Second, funding sources usually require an evaluation in order to determine whether their money has been invested wisely.

THE PREVENTION PROGRAM HOUSING CRISIS

The organizers of the community prevention program were delighted when a local business agreed to sublet office space for a low monthly fee at an excellent location in a neighborhood shop ping area. The arrangement seemed to work well for several months. There was no inkling that anything might be wrong with the situation until the owner of the building appeared with a court order requiring the program to vacate within 48 hours. The program's executive director then learned that the generous local businessperson had filed for bankruptcy and disappeared, leaving while several months behind in his payments to the building landlord.

The prevention program faced disruption of its activities as well as the loss of its highly visible location. The executive director, although knowledgeable about preventing alcohol and other drug abuse, was not sufficiently familiar with property law to protect the program's interest in this situation. Fortunately, the charter of the community prevention group included a provision that enabled the board of directors to create a special committee that would assume responsibility for any given area of implementation for a period of no more than 3 months. In this case, the board's "special committee" power was used to provide the group with legal expertise and public affairs influence that eventually enabled the program to stay in its location.

COMMENT Planning for troubleshooting in the charter of the prevention group averted a potentially disastrous crisis.

Third, and most important, an objective evaluation is the only certain method available to review the long-term effectiveness of specific prevention activities as a precursor to deciding whether the activities should be continued, expanded, modified, or eliminated in future prevention efforts.

The evaluation process begins before the prevention program is underway. Organizers of the program should determine what information they must collect, store, and analyze for evaluation purposes. If this selection does not occur in planning, the information may be unavailable when it is needed.

What kind of information does a community prevention group need to perform an evaluation? The answer depends on what specific evaluation questions the group wants to ask. Before the planning process is complete,

the planners must decide what they will need to know about their achievements in preventing alcohol and other drug use and abuse. The information provided next is intended as an introduction to basic evaluation questions. A detailed evaluation planning guide titled *Handbook for Evaluating Drug and Alcohol Prevention Programs* is available by writing the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852.

Process Evaluation: Did We Accomplish Our Objectives? Why or Why Not?

Every group wants to know if its program has achieved the planned objectives. This is answered in part by documenting or monitoring the group's activities.

Expressing your program objectives in specific, quantifiable terms will allow you to determine whether they have been met. On completing an evaluation period—6 or 12 months, for example-information should be available that will enable evaluators to say that "80 percent of the target of Objective A (e.g., delivery of an assembly program to 25 high schools) has been achieved" or that "the target for Objective C (e.g., distribution of 2,000 flyers at shopping malls) was exceeded by 130 percent."

Strategies for Implementing a Process Evaluation. Records kept by the prevention project should provide an explanation for the success or failure in meeting objectives. These explanations may be kept reasonably simple, for example, "30 posters were distributed instead of 60 because printing costs were higher than expected." Such explanations are important because they allow the program planners to learn from experience-in this case, to budget more money for printing. This type of effort is the core of what is known as an "implementation evaluation" or "process evaluation" because it emphasizes the process rather than the long-term results of a program.

Outcome Evaluation: Did Accomplishing Our Objectives Help Us To Achieve Our Goals?

Of course, meeting planned objectives is really only a means to the desired end of reducing alcohol and other drug problems in the community. Communities will want to know whether the prevention program is making progress toward its prevention goals, as well as meeting its target objectives for the performance of activities.

Measurement of this aspect of community prevention is known as "outcome evaluation" because it focuses on the effects of the program on the community. Typical questions answered by an outcome evaluation include the following:

- Is there evidence suggesting reduced incidence of alcohol or other drug use by youth in the community?
- Are people in the community more aware of the seriousness of alcohol and other drug problems?
- Are more community leaders and organizations becoming actively involved in preventing alcohol and other drug problems?
- Can any of these changes, if they have occurred, be traced directly to the effects of the community prevention program?

Strategies for Implementing an Outcome Evaluation. Some of the answers to these questions can be obtained by examining official records, such as hospital admissions and police reports, as indicated in Figure 3.13. In other cases, the community prevention program may have to plan a special effort to obtain the information. This effort may take several different forms:

- a survey to obtain information on changes in attitude and behavior among the target population;
- questionnaires completed by people who take part in the program's prevention activities, such as video presentations or prevention counseling; or
- interviews with individuals who are able to make an informed "guesstimate" about changes in the incidence of alcohol and other drug use in the community, including social workers or school administrators.

Effkiency Evaluation: Did We Use Our Resources Efficiently?

There is usually more than one way to do something. The rationale behind an efficiency evaluation is that you want to find the best way to achieve a result. A highly efficient effort is one that requires relatively few resources (funds, volunteer and staff hours, supplies, and so forth) to accomplish an important goal; a less efficient effort consumes more resources to produce the same result.

Figure 3.13

Examples of Sources of Data for Prevention Program Evaluation

Example 1:

Program Activity: Course for impaired drivers.

Process Evaluation: Documentation of number of clients served, e.g., four courses delivered to 25 students per course over 6-month period = 100 clients per half year.

Outcome Evaluation: Determination of whether or not the course changed the driving behavior, attitudes, or knowledge of class participants. Might use police records of number of repeat arrests from your class members over given period of time, or compare results of a pre- and post-course survey.

Efficiency Evaluation: Determination of whether there are ways to streamline operations. Records of staff hours used to advertise the course, register students, prepare materials, and deliver the course is one type of efficiency evaluation that could be performed.

Example 2:

Program Activity: Education campaign directed at youth on the health risks of marijuana use.

Process Evaluation: Analysis of internal program records on the number of materials distributed, and the number of PSAs aired.

Outcome Evaluation: Determination of whether awareness increased following campaign using, for example, a questionnaire given to target audience regarding awareness of the risks of marijuana use both before and after the campaign, using a control group for comparison. Could also use interviews with knowledgeable observers about perceived changes in awareness of the risks of marijuana use among the target population.

Efficiency Evaluation: Determination of resources used (monetary and staff time) for each type of public education activity conducted (e.g., placement of ads, distributing posters).

Strategies for Conducting an Efficiency Evaluation. Sometimes inefficiency cannot be avoided, but examining the relative efficiency of alternative approaches to a given end can often suggest ways to improve your program. Recordkeeping is extremely important: you will not know how efficient you are unless you can track the effort expended. The development and use of tracking forms to account for such things as the number of telephone calls placed or presentations made will be invaluable. Brainstorming in groups about alternative methods for achieving your goals is another useful way for assessing the efficiency of the approach you have chosen.

Evaluation Planning

Perhaps the best way to begin planning for evaluations is to list three or four questions that members of the prevention program would want answered in each of the three types of evaluations just described. A list of sample questions for each type is provided in Figure 3.14. Use Worksheet G to test your understanding of these categories. Your list will provide a draft set of 9-12 evaluation criteria for the community prevention program. Planners should discuss these draft criteria to ensure that there is a consensus that the evaluation items are appropriate and that the questions are clear and capable of being answered objectively and quantitatively. For most community projects, it will be reasonable to reduce a draft list of 9-12 criteria to 4-6 items, remembering that a large number of evaluation items requires a similarly large data collection effort.

The next step in planning for evaluation is to determine what specific information is needed to answer the final set of evaluation questions. Faculty members of local universities and quality control specialists from business or government can sometimes suggest appropriate information for each evaluation item. The appropriate mechanism for collecting information can be incorporated into the implementation of the prevention program.

The final step in planning for program evaluation is to ensure that resources are set aside to analyze the data collected and to apply the evaluation results to future planning. For example, when a community prevention program is initiated, it may be appropriate to schedule analysis of evaluation data at the end of the first 8 months, with a written report to the program leadership

to be formally scheduled 1 month later. This process will ensure that program leaders have the evaluation information they need early enough for planning the second year of the program.

The Ninth Step: Program Revision

Aside from generating data to justify activities to prospective funding sources, the reason for conducting an evaluation is to learn how to improve your program or activities. For example, a group may find from an outcome evaluation survey of students that the attitudes of students who participated in its program have not significantly shifted, despite the praise they received from faculty and students about the program. This finding should prompt the group to look at the program and to ask important questions, such as (1) "Are teachers implementing the program as it was designed?" or (2) "Is the theory behind our program sound?" (See Appendix G for a review of theories used in prevention programs.)

Figure 3.14

Types of Questions Asked in Process, Outcome, or Efficiency Evaluations

Process Evaluation Questions

- How many awareness sessions did parent groups provide to other parents last year?
- How many teachers did we train to implement alcohol and other drug prevention programs in their classes?
- How many other groups are we working with or collaborating with on our programs?

Outcome Evaluation Questions

- How effective is our traffic safety program in keeping young drivers from drinking alcoholic beverages and driving?
- Are fewer women drinking alcoholic beverages or using other drugs during pregnancy as a result of the health education material we have delivered to health care providers?
- Are local newspaper editors contributing more information about alcohol and other drugs in their papers as a result of our education program with them?

Efficiency Evaluation Questions

- Which program-peer- or adult-taught refusal skills training-results in the greater reduction of student intent to use alcohol or other drugs per dollar invested?
- Which strategy is most cost-efficient: pressuring the police department to increase surveillance of and penalties on stores selling alcohol to underage youth or training sales people to request identification of people appearing to be less than 30 years old?

WORKSHEET G

Mastering Evaluation Questions

Here is a test of your ability to identify process, outcome, and efficiency questions.

Place a P by a sentence if it is asking a process question.

Place an 0 by a sentence if it is asking an outcome question.

Place an E by a sentence if it is asking an efficiency question.

____1. Which recruitment approach yields, at the least cost, the most volunteers to work on the crisis lines?

____2. Does student participation in our peer counseling program reduce the reported use of marijuana and inhalants?

- 3 . How many parent classes did we provide in the last school year?

- 4 . Which was the most cost-effective recruitment strategy for parent participation in classes: food raffles or free child care?

____5. Do police patrols reduce the number of alcohol-related crashes among young people?

____6. Did radio advertising or community flyers do the best job of advertising our community drug-free day?

- 7 . How much influence did classroom visits by professional athletes have on students' attitudes about drug use?

Answers: E,O,P,E,O,E,O

Adapted from J.D. Hawkins and B. Nederhood, ***Handbook for Evaluating Drug and Alcohol Prevention Programs.*** DHHS Pub. No. (ADM)87-1512. Office for Substance Abuse Prevention, 1987. Available from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852.

A process evaluation to document teacher implementation could answer the first question. For instance, program staff could monitor classroom activities and record how closely teachers adhere to the program, based on objective criteria. After this kind of analysis, the group could determine whether teachers require additional training, resources, or incentives for participating in the program, or if they have other needs. Or the group may determine that the failure to attain the results that it had hoped for is attributable to something other than teacher implementation.

For groups and organizations involved in prevention, conserving resources is a common concern. An efficiency evaluation will pinpoint areas where program activities can be made more efficient, in dollars and in time. For example, 6 months of recordkeeping may reveal that certain services could be combined, prepackaged, contracted out, or brought in-house, thereby achieving greater efficiency.

Evaluating your activities provides the necessary information for program improvement and growth. Prevention practitioners report that charting new program directions, dictated by evaluation feedback, is one of the most important ingredients for keeping staff motivated and enthused and for keeping activities in high gear.

Additional Reading

Survey Research

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Business Issues

Dobrish, C.; Wolff, R.; and Zevnile, B. ***Hiring the Right Person for the Right Job. New*** York: Franklin Watts, 1984.

Grensing, L. ***A Small Business Guide to Employee Selection.*** Seattle: Self-Counsel Press, 1986.

Hancock, W.A. ***The Small Business Legal Advisor. New*** York: McGraw-Hill, 1982.

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J.K. Lasser Tax Institute. ***How to Run a Small Business. New*** York: McGraw-Hill, 1982.

Moscove, S.A. ***Accounting Fundamentals for Non-accountants.*** Reston, VA: Prentice-Hall, 1981.

Publications available from the U.S. Small Business Administration, P.O. Box 15434, Fort Worth, TX 76119:

Budgeting in a Small Business Firm, $50

Recordkeeping in a Small Business, $.50

Should You Lease or Buy Equipment, $.50

Selecting the Legal Structure for Your Business, $.50

Checklist for Developing a Training Program, $.50

Employees: How to Find and Pay Them, $1.00

Managing Employee Benefits, $1.00

Sources of Information on Grants and Foundations

Note: These materials are available at larger libraries or directly from the publisher.

Conrad, D. ***The New Grants Planner.*** San Francisco: Public Management Institute, 1980.

A tool for searching out grant support from foundations, corporations, and Government agencies. Topics include networking, development of ideas, researching, budget strategies, contacting funders, preproposal review, proposal writing, and developing continued grant support.

Flanagan, J. ***The Grass Roots Fundraising Book: How To Raise Money in Your Community.*** Chicago: Swallow Press, 1977.

Practical guidance for raising money at the local level. The major emphasis is on planning fundraising events that are both fun and profitable.

Foundation Center. ***Foundation Center Sourcebook. New*** York: Foundation Center, 1975.

Detailed information on the larger grant-making foundations that operate on a regional or national basis in the United States. Located in the reference section of larger libraries.

The Foundation Center has a nationwide network of foundation reference collections for free public use. To find the nearest location, call 800/424-9836, Monday through Friday, 10:00 a.m. to 5:00 p.m. (Eastern Standard Time).

Foundation Center. ***Corporate Foundation Profiles. New*** York: Foundation Center, 1985.

Detailed information on 234 of the largest company-sponsored foundations in the United States. Located in the reference section of larger libraries.

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List of funding interests of major foundations by subject, geographic area, and type. Located in the reference section of larger libraries.

Kurzig, C. ***Foundation Fundamentals: A Guide for Grantseekers. New*** York: Foundation Center, 1980.

Discussion of the basics of foundations and procedures for securing funds.

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Examination of various funding options, with obstacles to obtaining funds and how to overcome them.

Public Management Institute. ***Corporate 500. The Directory of Corporate Philanthropy.*** San Francisco: the Institute, 1979.

Detailed analyses of corporate philanthropy in the United States. Located in the reference section of larger libraries.

PLANNING CHECKLIST— HAVE WE...

- ☐ Performed a Needs Assessment?
- ☐ Developed Prevention Goals?
- ☐ Developed Objectives?
- ☐ Identified Resources?
- ☐ Identified Funding Sources?
- ☐ Assigned Leadership Tasks?
- ☐ Developed Procedures for Carrying Out Tasks?
- ☐ Supervision
- ☐ Accountability
- ☐ Developed an Evaluation Component?
- ☐ Process Evaluation
- ☐ Outcome Evaluation
- ☐ Efficiency Evaluation
- ☐ Revised the Program as Necessary?

CHAPTER 4

Case Studies of Community Prevention Efforts

Introduction

Just as people are unique, with distinct personalities, talents, and circumstances in which they live, every community is unique, with different assets and problems. Thus, a program used successfully in one may be irrelevant to the needs of another, or several programs might work equally well. Nonetheless, comparison provides a reference point from which to work. Communities interested in prevention can model and adapt their efforts after other successful efforts. This chapter highlights the prevention activities and programs that are successfully meeting the needs of several American communities.

The first part of the chapter outlines the ongoing activities of six well-established prevention initiatives. Each includes strategies for combating a wide range of factors that influence young people to use alcohol and other drugs. The six programs all met criteria set by a review committee stipulating that the programs would:

- Target multiple sectors of the community (e.g., schools, parents, civic organizations, businesses), as dictated by a systems approach to prevention;
- Incorporate multiple activities;
- Address the needs of multiple target populations;
- Maintain community involvement and foster community "ownership" of the program components; and

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- Have the capacity to provide the information we needed to accurately describe program activities and the willingness to be contacted by other people interested in the group's work.

The information presented about the six programs was supplied by the offices that administer them and is assumed to be accurate.

Doubtless, there are many more programs than the six described here that meet the criteria for inclusion-the success of other programs is no less exciting or worthy of recognition than these.

The second part of the chapter describes 40 programs selected as exemplary prevention programs through a nomination and review process sponsored by the National Association of State Alcohol and Drug Abuse Directors, the National Prevention Network, and the Office for Substance Abuse Prevention. These and similar programs are or can be used together with other programs in a community to form a comprehensive prevention strategy. Although it was not possible to show how every program fits into the total picture in its, community, or even State, it is easy to imagine, after reviewing the six examples that precede them, how the exemplary programs might complement other programs to form a more complete prevention initiative. In fact, one of the 40 exemplary programs, the "Illinois Prevention Resource Center," is described as part of "Prevention Programming in Illinois," one of six prevention initiatives fully described in this chapter.

Compare your community activities to those described. If you are just now organizing a prevention initiative or thinking about doing so, the examples can stimulate ideas about the types of activities you could begin and about how these activities would fit into a comprehensive initiative in the future. If you are already providing prevention services and are ready to expand or improve upon your efforts, the examples can also suggest some possible directions. You might ask yourself, do some of the activities described resemble the ones we are involved in? Would our program or programs fit the criteria by which the exemplary programs were chosen? Is there a coordinated system of prevention activities where we live?

Six Comprehensive Programs

Kansas Alcohol and Drug Prevention System

Kansas is striving for a coordinated, integrated, and comprehensive school- and community-based prevention and intervention system. Kansas Governor Mike Hayden has promoted a renewed effort by appointing a special assistant on drug abuse and a coordinator of drug abuse programs within his office. The Governor's theme for his coordinated program is "Toward a Drug-Free Kansas." For the first time, the Kansas Department of Education has created within the agency the full-time position of Specialist, Substance Abuse Educator.

In July 1987, five new regional prevention centers were opened. Administered through the Kansas Department of Social and Rehabilitation Services, these centers provide high-quality, consistent services through application of six basic prevention strategies: information, life skills training, alternatives, social policy development, community and constituency development, and early intervention. These centers will be able to ensure regional coordination, consistent quality of programming, and statewide evaluation administered through a separate grant. The scope of services uses strategies such as "Just Say No," Project STAR, Kansas School Team Training, and others. Both Project STAR and School Team Training are statewide in scope and have a sound evaluation base. An intervention position is also funded in each center for an expert to establish intervention systems within the region.

A statewide coordinating body has been developed to ensure continued coordination among the numerous resources and agencies within the State.

The recurring theme in Kansas is that "local people solve local problems." By providing a structural framework for local citizens and agencies and by providing consultation, technical assistance training, and resources, the local schools and communities can address problems of alcohol and other drug use at the local level. By training people who influence children and youth, Kansas can move toward the goal of reducing the use and abuse of alcohol and other drugs.

For more information, contact

The Kansas State Department of Social
and Rehabilitation Services
Alcohol and Drug Abuse Services
300 S.W. Oakley, Topeka, KS 66606
or call 913/296-3925.

In early 1986, the Kansas Department of Social and Rehabilitation Services, Office of Alcohol and Drug Abuse Services (ADAS), assisted by a nationally recognized prevention consultant, examined the Kansas prevention system, reviewed prevention services in other States, and studied the most recent prevention research. The result was a regional prevention service system for the State.

In that year, Kansas had a population of over 2.4 million people living in 105 counties. The Department of Social and Rehabilitation Services analyzed demographic data and divided the State into 17 prevention service regions. Organizations that had experience providing services concerning alcohol and other drug abuse or other social services within the regions were invited to submit applications for funding and designations as the prevention service providers for their regions.

Program philosophy and direction

The regional plan in Kansas functions under the philosophy of networking and collaboration to conserve limited resources, to build on existing community strengths, and to achieve the highest quality in programming. The goal of a collaborative effort is cohesion and the blending of services. The regional plan also facilitates community empowerment because successful applicants will train participants within the target population to provide most direct services.

Regional prevention centers

The prevention centers provide long-term, ongoing primary prevention services to children and youth and to those who affect them. Seventy-five percent of services must be delivered to those who have an impact on youth (no more than 25 percent are delivered directly to children and youth.) The program uses a community and school system approach and focuses on six major objectives: alcohol and other drug information, life skills

development, alternative activities, social policy, and community and constituency development and early intervention. The rationale and activities associated with each objective, as described by ADAS, appear in Figure 4.1.

To meet the objectives set forth by ADAS, the regional prevention centers are mandated to

- maintain an aggressive board of directors and/or Volunteer Advisory Committee;
- assess the current level of services in the region in relation to the five core objectives;
- coordinate and network with other groups (i.e., other alcohol and other drug projects, medical facilities, schools, youth programs, county and city governments, local alcohol and other drug advisory committees, parent groups, grassroots groups, or civic groups) to promote prevention;
- develop a regional resources directory of available referral sources;
- develop objectives that will reflect any special needs and strengths of cultural and ethnic populations;
- develop marketing plans to meet goals and to reach the target population; and
- perform process, outcome, and efficiency evaluations.

(Chapter 3 contains information on many of these activities.)

ADAS assists the centers by

- providing statewide coverage of the regional prevention system through newsletters, press releases, and so forth
- providing marketing materials, including a brochure about the new regional system, and a consistent design to be used on letterhead and business cards;

- distributing print materials from the 1987 National Institute on Alcohol Abuse and Alcoholism Youth Campaign;
- making materials from the ADAS Resource Clearinghouse available; and
- offering technical assistance on marketing.

In support of the school and community system approach, ADAS developed several tools. The first is a guide that reviews both prevention and intervention programs available to Kansas communities. The guide highlights different strategies, including school-based curriculum programs, parent programs, student activities, teacher preparation and intervention strategies, and student and employee assistance programs. Figure 4.2 is an example of the checklist used to summarize the features of the programs and activities mentioned in the guide.

ADAS has also prepared ***Kansas Communities, What You Can Do About Alcohol and Other Drug Abuse,*** a guide for community members concerned about preventing alcohol and other drug use or abuse. (The guide is reproduced in part at the end of this section.) This guide assists communities in defining their community and its concerns. It also outlines school, workplace, community, and parent and family prevention strategies available to Kansas communities.

Figure 4.1

Alcohol and Drug Abuse Services Rationale and Designated Activities for Outlined Objectives

Rationale: Accurate, honest, and timely information is needed on alcohol and other drugs and their effects on the family; legal aspects; and physiological, pharmacological, and psychological effects in humans. History and research prove that information alone will not prevent use but is a necessary element in a comprehensive program.

Activities: 1. Provide factual alcohol and other drug information in a sequential format over an extended period of time.

2. Compile and distribute printed materials and maintain a library of curriculum information (resource center).

Objective: *Life Skills Development*

Rationale: People who do not abuse alcohol or other drugs have a number of characteristics that strengthen their ability to cope with life. Learning these skills is a critical part of human development. People possessing good intrapersonal and interpersonal skills such as refusal, communication, conflict resolution, and negotiation skills along with stress management skills are less likely to abuse alcohol and other drugs.

Activities: 1. Promote School Team Training through coordinated efforts with the Kansas school team coordinator.

2. Promote Project Star (a school-based prevention program) by recruiting schools for training.

3. Encourage the development of parent groups for training in a life skills development model.

4. Promote the development and maintenance of "Just Say No" clubs through coordinated efforts with the Kansas "Just Say No" coordinator.

5. Promote student leadership training.

Objective: *Alternative Activities*

Rationale: Activities providing challenging, positive experiences are needed to help young people to develop the necessary skills to become socially mature individuals with self-discipline, confidence, personal awareness, self-reliance, and independence.

Alcohol and Drug Abuse Services Rationale and Designated Activities for Outlined Objectives (continued)

Activities: 1. Promote Project Graduation efforts within the service region.

2. Train adult and student leaders to provide alternative activities within existing community youth organizations.

Objective: Social ***Policy***

Rationale: Sometimes written, but most often unwritten, community customs or practices are related to alcohol and other drug use. To affect the behavior and attitudes of young people, it is important that they receive clear, consistent messages concerning alcohol and other drugs.

Activities: 1. Promote implementation or review of school policies related to staff and student alcohol and other drug issues.

2. Promote examination of community social policy development by reviewing cultural norms with parents and community leaders.

3. Promote involvement with the legislative network functioning within Kansas.

4. Develop a cooperative relationship with local law enforcement agencies and the court system.

Objective: ***Community Development***

Rationale: A total community effort is required for communities to make any significant impact on their alcohol and other drug problems.. The regional prevention centers will be working toward involving all segments of the community, encouraging more people to become active in addressing alcohol- and other drug-related issues.

Activities: 1. Develop a network of volunteers to work with the program.

2. Assist in developing local program funding.

3. Develop an advisory committee using key community and regional representatives if the current board of directors is not structured to fulfill this requirement.

Alcohol and Drug Abuse Services Rationale and Designated Activities for Outlined Objectives (continued)

Objective:	*Intervention*
Rationale:	Intervention can be a simple process if it occurs early enough. The goal is to confront the young person's behavior, get past the denial, and get the right kind of help.
Activities:	1. Provide intervention training. (Each center has an intervention specialist for this purpose.) 2. Assist in the developing Student Assistance Programs.

Figure 4.2

Checklist Used in Kansas for Categorizing and Describing Programs

Program Title		Intervention Programs	Employee Assistance Programs	Student Assistance Programs
Program Intensity	Single Presentations			
	Multiple Sessions			
	Intensive Retreat			
	Extensive Curriculum			
	Integrated into Curiculum			
	Separate Unts			
Message Orientation	DWI Risk			
	AID Information			
	Alternatives			
	Health Promotion			
	Diagnostic & Referral			
Evaluation Material	Non Available			
	Being Developed			
	Minimal			
	Multiple Evaluation			
Target Age	Faculty/Staff			
	K – 2 grade			
	3 - 4			
	5 – 6			
	7 – 9			
	10 – 12			
	University			
	No Age Distinction			
Program Focus	Individual			
	Peer			
	School			
	Family/Parents			
	Community			
	Policy/Social			
	Norms			
Training Needed	School Policy Required			
	Required			
	Recommended			
	No			

Exhibit4.1

KANSAS COMMUNITIES...WHAT YOU CAN DO ABOUT ALCOHOL AND OTHER DRUG ABUSE

DEFINING YOUR COMMUNITY

We all live and participate in Communities. A community may be large or small and can be as simple as a few people who think of themselves as "us" and who share some common interests, concerns, or activities. A community may be a political unit (State, county, township, voting district, or political party); a place where you share common public services (schools, parks, shopping centers, utilities); a residential area (town, neighborhoods, subdivision or block); or an institution (church, synagogue, neighborhood center, club, workplace, college).

DEMOGRAPHIC. Who lives in the community? What are the ages, ethnic backgrounds, religious preferences? Are there many single parent families? Single people? Young people? Old people?

SOCIAL,. Where do people get to know each other and interact socially? What are the accepted social activities in your community? How do newcomers meet people? What groups are active?

ECONOMIC. What are the industries or sources of income in the area? Where do people spend their money? What opportunities are there for people? Is there a high level of unemployment?

LEADERSHIP. Who are the community leaders (formal and informal)? Which are the influential groups? Who are the people who know what's going on in the community? Who are the people who are skilled, popular, or listened to by others?

HEALTH AND WELL-BEING. What are the major health resources? Are there plenty of things to do for all age groups and interests? Are people active? What are the health concerns of the community?

VALUES. Are there any "community" beliefs that seem to dominate or affect decisionmaking? How unified or divergent are people's values? What is the "community spirit" and how is it expressed?

COMMUNICATIONS. How is information spread? What are the mass media outlets? What are the common informal means of spreading information? How accurate is communication?

By briefly putting together all the information you have gathered from these and other questions you may ask, you will begin to get a pretty good picture of your community. You may find that you know a great deal and that you are involved with many aspects of community life. You probably interact with and influence many people-by what you say, who you talk with, how you vote, where you spend your time and money, and what you want to see changed or remain the same.

This material appeared in a brochure prepared and distributed by the Alcohol and Drug Abuse Services, Kansas Department of Social and Rehabilitation Services.

DEFINING YOUR CONCERNS

Once you have described the community you live in you will want to focus on the concerns you have and the potential changes you wish to make. The following questions will serve as guidelines to help you determine that direction:

- What is it, exactly, that concerns us? Why does it concern us? What makes our concern a concern?
- What factors contribute to our concern? (Potential areas include values, behaviors, attitudes, laws, the economy, social pressures, and what various agencies do or don't do.)
- How do these factors relate to each other?
- What other information do we need to better understand the nature of our concern, and where do we get that information?
- What are the attitudes or thoughts we want to see changed? Who thinks that way, and why?
- What are the behaviors we want to change? (Be sure to include the behavior of those who may be a cause for concern and those who interact with them-families, friends, employers, teachers, service agencies, government, etc., as a way to avoid blaming and isolating people.)
- Are we concerned about lack of information, misinformation, or a lack of skills or services? Or is our concern a symptom of broader underlying issues such as group conflicts, double standards, differing perceptions, or a true difference of opinion?

  (NOTE: Although it is relatively easy to provide better information for people, that alone will not necessarily change someone's thinking or behavior. If your concern is one involving attitudes or values, then to succeed, you will have to go beyond providing information and strive to create an atmosphere which considers different attitudes and perceptions while supporting and encouraging those that are desirable for the community and its people.)
- Who are the people involved with this concern and in what way? (The answer to this question will help determine the many different people you will want to involve and communicate with, all of whom can assist in some way to resolve your concern.)
- What will we do to resolve our concern?

STRATEGIES

This publication outlines prevention strategies in four critical social systems: communities, parents and families, schools, and the workplace. Specific projects which have been implemented in Kansas, as well as a number of other ideas for prevention are presented for each system. These are not the only areas where prevention efforts may occur nor are the strategies listed inclusive of everything that can be done. It is hoped that the ideas and materials described will help communities make decisions and take appropriate action in their prevention efforts.

COMMUNITY STRATEGIES

Developing community projects requires considerable cooperation among parents, schools, law enforcement agencies, government, private sector, media, young people, and others.

Channel One: This program provides a seven-step process for assessing community needs and involving youth in constructive community service projects. An important element in the program is the role of private sector leadership. While encouraging community service Channel One models offer an opportunity for youth to develop new skills and meaningful alternatives to alcohol and other drug use.

Community Coalitions: A coalition of concerned community people can provide a crucial forum for the sharing of ideas and perceptions about issues related to alcohol and other drugs in the community. Local task forces, service clubs and others may develop programs for specific populations (i.e., youth, elderly), sponsor non-alcoholic beverage (NAB) contests or parties, and identify funding sources for programs.

Community-based Services: Community agencies may offer a range of services that include the development of positive skills for living as well as early intervention and treatment. Often these services focus on a number of closely associated problem areas such as alcohol and other drug abuse, truancy, poor school performance, depression, and violence.

Social Policies, Laws, and Regulations: Communities need to develop policies and norms that provide consistent messages about alcohol and other drugs, and should include awareness of appropriate behavior and role modeling by adults as well as youth. Many communities are looking at the effect of changing laws and regulations with regard to alcohol and other drug use among youth.

Health Promotion: Many people have a high regard for their bodies and can be interested in programs which promote healthy lifestyles that are incompatible with alcohol and other drug use. Highlighting health promotion techniques is an increasingly popular form of community action.

Media: The media can contribute positively to attitudes, perceptions, and knowledge about alcohol and other drugs. Local newspapers and radio and television stations can be encouraged to deglamorize alcohol and other drug use as well as to provide current and accurate information. Establishing good relationships with the media can influence editorial policies and media coverage.

Networking: Effective local networks can be a means for making the most of available resources. With many public and private community groups becoming involved in alcohol and other drug abuse prevention, it is critical for people to *work together* in order to develop consistent and comprehensive solutions.

PARENT AND FAMILY STRATEGIES

Parents and families are often the hardest hit by alcohol and other drug problems in the community. Yet parents and families can also be the most dedicated activists. Here are some ways to organize and take action:

Developing Capable People: A major effort in Kansas is the development of trainers available in local communities to facilitate a family skills program "Developing Capable People" (DCP). Additional trainings are being planned. DCP provides ideas regarding how parents can help their children develop self-discipline, self-esteem, listening skills, the ability to deal with peer pressure, and a variety of other issues related to alcohol and other drug abuse.

Elder **Ed:** This program is designed to train service providers and inform the elderly about the proper use of medications. Elder Ed provides practice in effectively communicating with physicians and pharmacists, recommendations for responsible medication use, and methods for keeping track of medications.

Family Life Skills Development: These programs emphasize such important aspects of family health as positive role modeling, problem-solving, and discipline. These strategies enable parents and children to learn personal and interpersonal skills which allow them to communicate more effectively. These skills can play an important role in the primary prevention of, and early intervention into, alcohol and other drug problems.

Parent Groups: These groups are formed by parents for parents. Through these groups, parents help one another become informed about alcohol and other drug issues and cope with the alcohol and other drug problems in their homes and neighborhoods. Parent groups can develop guidelines for acceptable behavior (e.g., curfews), sponsor social events for teenagers, organize community awareness projects, and help other parents supervise young people's activities to ensure that they are free of alcohol and other drug use. These groups can work with Federal, State, and local governments, law enforcement agencies, schools, and businesses to influence social policies regarding alcohol and other drug use. Examples include working for legislation and local ordinances that will safeguard children's health and well-being.

Parent Alcohol and Other Drug Education Programs: Through these programs parents learn about the pharmacology of alcohol and other drugs and the impact that use can have on one's health. Parents have the opportunity to assess and share their beliefs and opinions about alcohol and other drug use with others, as well as understanding the importance of their behavior as role models. Then, prepared with this knowledge, parents may become influential partners with community prevention agencies by offering education courses and information in their schools and other community settings.

SCHOOL STRATEGIES

Schools can provide an important setting for prevention. Working together, parents, school administrators, students, teachers, other citizens, and professionals can have a positive impact on the future of young people and the community. Here are a few ideas for action:

School Team Training to Prevent Alcohol and Other Drug Abuse: Training is available for administrators, teachers, support staff, parents and/or other interested community people in the area of developing programs in their schools. School Teams learn to implement action plans in their respective schools, which will have the most favorable impact on improving school climate and addressing alcohol and other drug-related issues.

School Policies: Clear policies regarding use and possession of alcohol and other drugs both on and off school property are critical to all members of the school community.

Positive Peer Programs: These programs help develop students as role models, facilitators, helpers, and leaders for their peers. Programs such as these can provide assistance to young people who are having problems, who are in the midst of normal adolescent stresses and want to confide in someone, or who want to participate in school and community service activities. Young people may become the primary source of their own prevention initiatives and problem solutions.

Peer Resistance Programs: Peer resistance or "Saying No" programs have been developed to offer young people a way to resist the peer pressure to use cigarettes, marijuana, and alcohol. These programs generally help students learn that substance use is not as common as they perceive it to be, that "everybody" is not doing it, and that there are clear ways to say "no" when these substances are offered.

Comprehensive Health Education Programs and Other School Curricula: Many curricula and materials attempt to increase students' knowledge about their own health. Some relate to the effects of specific drugs but they may also be focused on the enhancement of healthy, constructive lifestyles. Often, these programs emphasize communication skills, self-understanding, improved decisionmaking, and the strengthening of one's self-concept.

Student Assistance Programs: These programs can serve primary prevention purposes when set up for students who may be at high risk for developing alcohol, other drug, and other

problems, and can serve as an intervention tool with those who have already developed problems.

WORKPLACE STRATEGIES

Alcohol and other drug abuse pose a major problem to the workplace in terms of worker health and productivity, which, in turn, result in increased costs to the organization.

Employee Assistance Programs **(EAPs):** Many employers, both public and private, have formed programs that help troubled employees, including those who experience alcohol and other drug problems. Most programs ensure confidentiality and encourage employees to take advantage of the program's resources. Employees may be referred to other programs and community agencies who can most adequately assist with their problem resolution.

Alcohol and Other Drug Policies: One important aspect of drug abuse prevention in the workplace is for employers and unions to have appropriate, clear, and fair policies relating to alcohol and other drug use that are consistently enforced. Once the policies are in place, decisions about appropriate prevention and treatment programs can be made.

Wellness Promotion: Companies have developed programs to inform employees about general health issues and to provide opportunities (often at the workplace) to improve their fitness, nutrition, and other health-related behavior. Stress-awareness and -reduction workshops are one example of the many convenient and inexpensive efforts which can take place.

Family Programs: Alcohol and other drug problems which affect a worker may also derive from pressures outside the workplace. Where problems result from non-workplace issues, programs can be set up to assist the employee and his or her family. Many companies have implemented policies such as the use of flexible work schedules and maternity leave to help families.

Alcohol and Other Drug Information and Education Programs: Accurate information about the negative health effects of alcohol and other drug use can be useful to employees in the workplace. Educational programs can provide positive reinforcement for non-use, and employees might also be allowed to participate in health screenings as a way to assess their own needs.

Social Responsibilities: Workers reflect the company image and it is in the organization's interest to be positively portrayed. If you have employees who drive frequently in the course of their work, training programs about safety belts and drinking and driving could be helpful. More directly a corporation can be responsible for its employees' behavior at such functions as holiday parties and company picnics.

The Regional Drug Initiative, Multnomah County, Oregon

The Regional Drug Initiative (RDI), formed in December 1986, is a task force of policymakers from government, education, law enforcement, corrections, citizen groups, treatment providers, and private business in Multnomah County, OR. The RDI is pioneering a coordinated effort to combat the problems of drug use on all fronts to free the community of illegal drugs.* The overall strategy of RDI is to reduce the supply and availability of illegal drugs by supporting enforcement efforts and to reduce the demand for illegal drugs by fostering changes in social attitudes and increasing opportunities for recovery.

For more information, contact
The Regional Drug Initiative
Multnomah County Courthouse
1021 S.W. 4th Avenue, Room 600
Portland, OR 97204
or call 503/796-3439.

The planning process for the Regional Drug Initiative

In May and June 1987, eight study committees were convened by the RDI. They were charged with the task of analyzing issues and recommending solutions to the problems relating to drug use. These study groups involved over 100 volunteer experts who were guided in their work by the RDI Steering Committee. The specific areas of study were

- drug offenders and drug abuse;
- low-income populations and drug abuse;
- drugs in the workplace;
- barriers to treatment and to treatment planning for minorities and special needs populations;

*RDI concentrates on reducing problems associated with illegal drug use. Many of the processes and strategies used by RDI can be applied to the prevention and reduction of alcohol-related problems as well.

- dual-diagnosis clients;
- youth and drug use;
- women and drug abuse; and
- families and drug abuse.

The recommendations of these study groups focused on developing coordinated efforts to address unmet needs and to change community attitudes. These recommendations were compiled and reviewed by the RDI task force, and three community forums were held to receive public testimony on the study groups' recommendations. Over 150 individuals participated in the public discussions.

Comments from neighborhood residents and other concerned individuals dramatically illustrated the pain, anger, and frustration that drugs have wrought in this community. The public testimony during these hearings stressed the need for early intervention and law enforcement at the neighborhood level. Support was expressed for study group recommendations regarding increased services to low-income individuals, minority-sensitive programs, and intervention to prevent fetal drug syndrome.

To ensure that all sectors of the community were heard from, interviews were also conducted with criminal justice, treatment, and community leaders. Early intervention and street-level interdiction continued to receive support in these conversations.

After guiding the study groups through their efforts, the RDI Steering Committee evaluated all the data and recommendations. The plan presented to the RDI for approval consolidates the priorities of the entire community into an action agenda.

The RDI action agenda

The action agenda (Figure 4.3) outlines six broad social goals, specific program objectives, activities required to accomplish these objectives, first-year priorities, and proposed implementation steps. Evaluative criteria are provided with which to measure the effectiveness of the activities. An overview of the RDI goal statements and action agenda are also presented.

The RDI action agenda is intended to be a dynamic document. The community will revise this document as needs change. The RDI plans to continue in its efforts to bring appropriate jurisdictions, agencies, organizations, and individuals together to implement the objectives under this plan.

Figure 4.3

RDI ACTION AGENDA

Goal 1.	Foster and change social attitudes regarding drug use
Sample Action:	Direct a public information campaign targeted at youth
God 2.	Make communities safe from illegal drug use and crime
Sample Action:	Eliminate neighborhood drug houses
Goal 3.	Support healthier lives for our citizens and families
Sample Action:	Prevent fetal drug syndrome; provide detoxification services for drug addicts
Goal 4.	Promote a more productive workforce
Sample Action:	Adopt drug abuse policies in all workplaces
Goal 5.	Provide an attractive climate for economic development
Sample Action:	Encourage business to use vacant commercial space in target areas
Goal *6.*	Increase coordination among government, businesses, schools, service providers, and citizens
Sample Action:	Develop coordinating bodies to focus on services for youth, mentally ill drug users, and minorities

Goal 1. Foster and Change Social Attitudes Regarding Drug Use

Need: Drug use for recreation is currently accepted in some social groups. This problem exists throughout our community regardless of age or social status. Frequently, individuals who are concerned about this behavior are reluctant or uncomfortable about confronting their peers' behavior. For some, the social pressure of these settings leads them to participate in drug use. For some with alcohol or other drug use problems, the fear of stigma makes them reluctant to seek treatment.

Objectives: The Regional Drug Initiative (RDI) will change social attitudes regarding drug use by:

- Supporting the concepts that prevention is preferable to and cheaper than treatment but that recovery is possible;
- Assuring our citizens that something can be done about the problem of drug abuse;
- Warning people about the dangers of drug use;
- Increasing individual awareness of the extent of the problem;
- Educating people to understand that drug use is not acceptable recreation;
- Promoting recognition that illegal drug use is not a victimless crime;
- Encouraging individuals in the community to feel free to speak out against drug use by their peers; and
- Motivating people to recognize that receiving treatment is acceptable to and encouraged by the general community.

Activities: The RDI will support adoption of programs by educators, employers, public agencies, the media, public officials, community groups, and religious organizations to accomplish these objectives by using the following methods:

- Public affairs programs;
- Forums and workshops;
- Articles;
- Public service announcements;
- Peer education and social skill-building efforts; and
- Adoption of resolutions and public policies.

Evaluation: Program activities will be evaluated through the development of a survey instrument to measure social attitudes and perceptions in the community. This survey will provide baseline information. Repeated surveying will measure changes in attitudes. Additional evaluations will focus on individual program effectiveness and the number of programs developed.

Priorities for Year 1: The RDI will develop a public information campaign and support existing public information campaigns to change social attitudes. The RDI will focus efforts on education and the prevention of drug use among youth and populations with special needs.

Implementation Steps for Year 1 Priorities:

1. Organize an interorganizational public relations team to determine goals, strategies, and budget. Make sure that youth are involved.
2. Identify priority target populations for public information efforts.
3. Inventory existing efforts to ensure coordination.
4. Seek sponsorship and assistance from local communication professionals.
5. Seek financial support from local, private, and public sector resources.
6. Implement a public information campaign.

Goal 2. Make Communities Safe From Illegal Drug Use and Crime

Need: Illegal drug use is directly linked to criminal activity. Preliminary results of a recent study of Multnomah County inmates found 73.4 percent of offenders to be under the influence of illegal drugs at the time of arrest.

Drug sales in neighborhoods often result in increased crimes such as burglary and prostitution. The problems of drug-related crime are not isolated in any single neighborhood.

Objectives: The RDI will increase neighborhood safety by involving the community in:

- Working toward the reduction of burglary, theft, robbery, prostitution, and other drug-related crime rates;
- Involving citizens directly in efforts to reduce fear in their communities; and
- Encouraging the entire community to be involved in combatting drug-related crime.

Activities: The RDI will encourage criminal justice, treatment, and neighborhood organizations to develop coordinated efforts to arrest, prosecute, and supervise drug involved offenders.

RDI will also advocate for the dedication of new and existing resources to:

- Promote crime prevention activities;
- Assess and target drug-involved offenders, both juvenile and adult, with sanctions and treatment;
- Promote neighborhood cohesion; and
- Target street enforcement of buyers and dealers.

Evaluation: Program success will be measured by the number of new and enhanced program efforts undertaken, reduced crime statistics, and survey information regarding changing attitudes toward community safety.

Priorities for Year I: Develop programs to arrest, prosecute, sanction, treat, and rehabilitate drug offenders. Focus significantly on drug-involved offenders who are street and drug house dealers and commit a variety of crimes to support drug habits.

Implementation Recommendations for Year 1 Priorities:

1. Support criminal justice leaders in the development of new and in the continuation of existing interdiction and sanction strategies. Coordinate planning effort with neighborhood leaders and treatment agencies.
2. Develop additional treatment and supervision resources to facilitate community-based rehabilitation efforts.
3. Identify program costs and resources available.
4. Develop criteria for target populations and communities.
5. Seek local, State, and Federal funds for coordinated efforts.
6. Implement.

Goal 3. Support Healthier Lives for Our Citizens and Families

Need: Only two beds are available for detoxification of low-income drug addicts in Multnomah County. Most treatment programs for low-income individuals have waiting lists. Specialized programs are needed to address the needs of low-income women and other populations that remain underserved.

In addition, the problem of drug use must be recognized as a family problem. Babies born with fetal drug syndrome, children of substance abusers, and parents and siblings of abusers need support and treatment if the cycle of drug use is to be broken.

Objectives: The RDI will help to provide all citizens access to a continuum of services from detoxification to rehabilitation by:

- Assessing and providing treatment for drug involved target populations;
- Increasing public detoxification and treatment for low-income and homeless populations;
- Reducing fetal drug and fetal alcohol syndrome births;
- Helping families recognize and intervene in drug use problems of family members;

- Ensuring that the entire family has access to treatment as well as the identified abuser;
- Providing drug-involved women with opportunities to maintain bonds with their children as they eliminate their bond to drugs;
- Developing systems to ensure that entitlement programs reduce rather than inadvertently enable drug use; and
- Providing programs to improve and enhance parenting skills.

Activities: The RDI will work with State and local agencies as well as with private sector providers and insurance carriers to advocate for the development of:

- Prevention and intervention programs for fetal drug and fetal alcohol syndrome births;
- Increased outreach efforts to ensure use of prenatal care by drug-abusing pregnant women;
- Third-party resources for treatment of families of drug abusers;
- Increased detoxification and treatment resources for low-income individuals;
- Child care for people in treatment; and
- Parent training programs.

Additionally, the RDI will advocate for a review of spending policies-and procedures of entitlement dollars for alcohol- and drug-abusing families.

Evaluation: Success indicators for the listed objectives will include reductions in the number of fetal alcohol and fetal drug syndrome births, and increases in the numbers of families and individuals in treatment, increases in the number of high-risk women receiving prenatal care, and increases in the use of parenting programs and child care resources. Appropriate changes in third-party funding policies will also be recognized as success indicators.

Priorities for Year *1*: Develop increased outreach, detoxification, and rehabilitation services for low-income individuals, women, minorities, and other populations with special needs and develop a comprehensive prevention and intervention program on fetal drug and fetal alcohol syndrome.

Implementation Recommendations for Year 1 Priorities:

1. Convene planning teams to develop program proposals for specified target populations.
2. Inventory existing resource providers with which to coordinate.
3. Seek increased funding from local, State, and Federal governments and private foundations.
4. Implement.

Goal *4.* Promote a More Productive Workforce

Need: Alcohol and other drug abuse is the most significant contributor to employee absenteeism and lost productivity. Seventy-five percent of drug abusers are employed. Substance-abusing employees are more likely to have accidents on the job and cause safety hazards for coworkers. Employee theft is often linked to drug abuse. Frequently, employers are unsure of how to address or prevent employee alcohol and other drug abuse problems. Most employers, particularly small business employers, do not have drug abuse policies for their workplaces.

Objectives: The RDI will ensure the development of a more productive workforce by:

- Promoting the development of policies on workplace drug abuse;
- Supporting efforts to ensure that workers and families have access to treatment;
- Advocating the development of better-quality insurance programs for workers and families, with emphasis on the programs of small business;
- Encouraging workers to be free from the influence of alcohol and other drugs;

- Educating employers that it can be cost-effective to bring drug-abusing employees into recovery; and
- Educating workers that being drug free will increase safety and productivity in the workplace.

Activities: The RDI will work with employers and labor to:

- Develop model workplace drug policies;
- Provide training and technical assistance to businesses (especially small businesses) regarding drugs and workplace issues;
- Assess existing insurance programs and promote insurance policies that provide treatment;
- Support employee wellness programs;
- Promote employee assistance efforts; and
- Hold seminars for employers and employees regarding drug use concerns.

Evaluation: Indicators of success will include reductions in the use of sick time, on-the-job accidents, and employee theft and increases in the development of workplace drug policies and treatment programs for employees. Employers will be asked to participate in a baseline and followup survey to gain measurable data.

Priorities ***for Year 1:*** Develop model policies on workplace drug abuse and provide training and technical assistance to management and labor regarding the establishment of such policies.

Implementation Recommendations for Year 1 Priorities:

1. Review model policies on workplace drug abuse and sponsor training efforts.
2. Seek public and private resources to provide training workshops and materials.
3. Implement.

Goal 5. Provide an Attractive Climate for Economic Development

Need: The linkage between poverty, drug use, and street crime has made some neighborhoods less attractive than others to business developers. Unemployment often leads to the despair that motivates drug use. Residents of low-income neighborhoods need opportunities for success in meaningful mainstream employment if they are to choose to remain drug free. Business developers need community and governmental support if they are to supplant illegal drug economics with mainstream private sector investment.

Objectives: The RDI will work with neighborhoods, criminal justice agencies, and educators to enhance economic development in targeted areas by:

- Developing a larger and more skilled workforce;
- Undermining the profitability of the existing drug economy;
- Cooperating with schools to maintain excellence and drug-free environments;
- Improving the regulatory environment and availability of capital to support business development in targeted areas; and
- Reducing crime rates in targeted areas.

Activities: The RDI will work with State and local government agencies, employers, community-based organizations, and educators to ensure that:

- Training and employment programs are linked to recovery and treatment services for target populations;
- Policies are developed to provide tax incentives and low-interest loans for economic development in targeted areas;
- Incentives are provided to promote crime prevention through environmental design for business;

- Technical and financial assistance is available to property owners and developers to clean up areas contaminated due to illegal drug production; and

- Programs are developed to restore abandoned properties to productive economic use.

Evaluation: Indicators of success will include increases in the development of new businesses in targeted areas, in employment among targeted populations, and in the number of individuals from targeted populations who have completed employment training and entered the workforce. Indicators will also include reductions in crime statistics in targeted areas and improved attitudes about local educational and employment opportunities.

Priorities for Year 1: Develop incentive programs to enhance economic development in targeted areas.

Implementation Recommendations for Year 1 Priorities:

1. Convene a committee of economic development specialists, business leaders, and government policymakers to discuss strategies.
2. Select areas to be targeted for incentive efforts.
3. Draft a proposal for discussion and implementation.
4. Implement.

Goal 6. Increase Coordination Among Government, Businesses, Schools, Service Providers, and Citizens

Need: Traditionally, our community has approached the problems of drug abuse and illegal drug use from a variety of arenas. Treatment professionals, criminal justice officials, and private citizens have all made sincere efforts to address these problems, but they often are unaware or distrustful of each other. Consequently, drug-involved client populations and those affected by them receive less effective help.

Objectives: The RDI will work with government, businesses, schools, service providers, and citizens to increase coordination by:

- Establishing policies that foster coordinated approaches to combat drug use;

- Expanding the scope of organizations to involve other agencies and organizations in planning;
- Developing interdependent and cooperative service systems to meet the needs of mentally ill drug users, youth, and other populations with special needs;
- Advocating program and budget changes to promote coordination priorities;
- Encouraging organizations to understand services and parameters of other organizations with which they can coordinate;
- Training staff in various organizations routinely to consider coordination when problem solving; and
- Providing minority-sensitive training to criminal justice and treatment personnel.

Activities: The RDI will work with agencies, government, businesses, and community organizations to:

- Allocate personnel and financial resources to develop coordinated efforts;
- Develop interorganizational agreements to coordinate efforts;
- Ensure that drug-related service contracts have language requiring coordination;
- Involve citizens and community-based organizations in planning efforts of treatment programs, criminal justice systems, and other agencies involved in drug abuse;
- Develop an information and referral catalog regarding alcohol and drug resources for purposes of coordination;
- Review laws, statutes, and procedures to overcome obstacles to coordination relating to confidentiality while still protecting the rights of clients; and

- Develop training materials and workshops regarding minority issues for criminal justice and treatment personnel.

Evaluation: Indicators of success will include the number of policies adopted to foster coordination, the publication of an information and referral catalog, and increased satisfaction of individuals and organizations regarding the level of coordination and knowledge of other organizations.

Priorities for Year 1: Develop coordinated systems for mentally ill drug users, youth, and minority populations.

Implementation Recommendations for Year 1 Priorities:

1. Develop interorganizational agreements regarding coordination.
2. Develop an interagency coordinating council.
3. Develop concept papers for coordinated projects serving targeted populations.
4. Identify and advocate for needed resources.
5. Implement.

The Alcohol Program, San Diego County, California

Webster's New Collegiate Dictionary describes "plan" as "an orderly arrangement of parts of an overall design or objective." The objective for the San Diego County Alcohol Program is "alcohol-safe" communities. However, although the process for achieving that objective may be planned, it is not orderly. Frankly, those of us involved in the San Diego Alcohol Program believe that San Diego is making progress toward its objective principally because the planning strategy depends on spontaneity and responsiveness to community issues as they arise.

That is not to say that there is no method to the madness. The governing principles of the planning process are that it be alcohol focused and information based and that it incorporate public health principles, with an emphasis on environmental interventions. The achievement of alcohol-safe communities will not be the result of a "campaign" or "program" with a beginning and an end.

For information, contact
The County of San Diego
Department of Health Services Alcohol Program
P.O. Box 85222, San Diego, CA 92138-5222
or call 619/692-5717.

The San Diego County Alcohol Program, developed and coordinated by the County of San Diego, Department of Health Services, concentrates its efforts on changing the drinking environment rather than on educating or rehabilitating individuals. This orientation, coupled with a responsiveness to community-identified concerns, makes the San Diego program stand out as progressive and innovative.

The program operates in San Diego County, the home of over 2 million people and a county in which 12 percent of the workforce is employed by the U.S. military. Although San Diego is experiencing population growth at the rate of 2-3 percent per year, alcohol outlets have grown one and a half times faster than the population since 1975.

Program philosophy and direction

One primary interest of the San Diego County prevention effort is in reducing alcohol-related problems through environmental change strategies, that is, prevention efforts targeted at direct alteration of the drinking

environment. These environmental strategies may focus on decreasing alcohol availability by passing new ordinances related to where and how alcohol may be consumed, by increasing enforcement of existing laws, or by server intervention. Or, for example, environmental change strategies may focus on decreasing demand for alcohol, e.g., by educating the community about fetal alcohol syndrome and alcohol-related birth defects that may result from consumption of alcohol by pregnant women.

A key correlate to the program's emphasis on environmental change strategies is its emphasis on achieving change by responding to the community and its concerns, rather than mandating and orchestrating change directly. Thus, the program provides stimulus, information, and technical assistance to community organizations, businesses, and individuals who seek to reduce alcohol problems, but it does not implement change strategies.

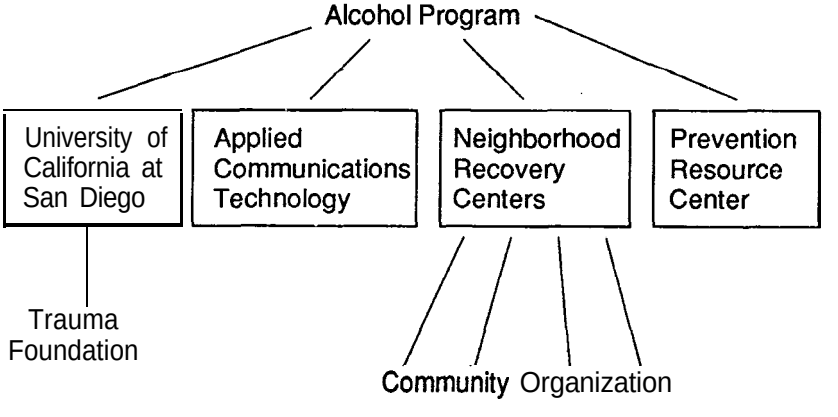
How the Alcohol Program Achieves Its Goals

To achieve its goals, the program typically works through contractual arrangements with external organizations that provide prevention activities on behalf of the program. These external contractors include nine neighborhood recovery centers (NRCs), the University of Califorma at San Diego (UCSD), the Prevention Research Center (PRC), the Trauma Foundation, and Applied Communications Technology (ACT).

Figure 4.4 depicts the organizational structure of the program's current prevention effort.

Figure 4.4

Organizational Structure of San Diego Prevention Effort County of San Diego



The alcohol program contracts with nine NRCs to provide direct service to the communities they serve. This direct service takes two general forms. First, the NRCs provide recovery and education services to those dealing with personal or family alcohol problems. Second, the NRCs work to inform community members of the importance of preventing alcohol problems and to motivate them to help reduce the incidence of alcohol problems in their areas. This second area of activity is relatively new to most of the NRCs, having been formally written into their contracts only 2 years ago. NRCs sometimes lead community projects as well. For instance, one NRC developed a training program to educate the clergy about community-level interventions and is working with the clergy to restrict the number of alcohol outlets in a given region. Another NRC formed a task force on alcohol-related birth defects (see the box). Thus, the NRCs provide the alcohol program's first point of contact within the community. Most of San Diego is within reach of one of the NRCs that usually serves a specific geographic area. An NRC may exist as a specific program within a social service agency providing other services, or it may operate as a free-standing NRC.

The alcohol program calls on three contractors to provide technical assistance in support of its prevention effort. These contractors include UCSD, which publishes ***Prevention File*** (a quarterly magazine about the prevention of alcohol problems) for distribution to the community and interested groups. UCSD in turn has a subcontract with the Trauma Foundation at San Francisco General Hospital to develop slide shows on specific environmental change strategies. The scripted slide shows include "Alcohol Prevention from a Public Health Perspective," "Alcohol Advertising and Women," "Promotion and Price-How the Alcohol Industry Targets Youth," and "Alcohol Availability in a Public Health Perspective." UCSD also holds annual prevention forums to inform community members about and interest them in alcohol-related probloms.

Another source of technical assistance to the alcohol program is PRC, located in Berkeley, California. PRC is developing a study of drinking behaviors and other alcohol practices in the county. It also provides a unique training program to local decisionmakers through the use

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of an interactive computer game. This game makes use of data collected in San Diego County and allows decisionmakers to understand the complex community system of alcohol problems and to find relevant prevention strategies for their communities. The computer game brings community leaders (i.e., health care providers, police, and school personnel) together and provides an opportunity for them to view the problems associated with alcohol consumption from many different perspectives. With the use of a computer, they can estimate the cost and effectiveness of different prevention strategies. In addition, PRC is compiling data on driving under the influence from several sources within the county to help to define better the nature and extent of the drinking and driving problem.

ACT also provides technical assistance to the alcohol program. ACT was hired to study San Diego County and to design a comprehensive prevention program based on its findings. ACT first wanted to learn how community and media organizations in San Diego perceived alcohol problems. Gathering survey information, it learned that alcohol is a community concern in San Diego and that the organizations surveyed were not well informed about the role of environmental change strategies. ACT then conducted a survey of 2,000 community and religious organizations, religious institutions, businesses, and government officials about their perceptions of alcohol problems in the county and about their interest in working to reduce these problems. (A copy of one of several versions of the survey forms used appears in Chapter 3 as Figure 3.4.) The information gathered from these surveys contributed to the development of several tools to inform community groups about environmental change strategies. These tools include the following materials:

1. ***The Alcohol Hazard Appraisal (AHA)***—This appraisal is a questionnaire designed to provide individuals and organizations with feedback about their own knowledge, attitude, and behavior with respect to alcohol problems (Exhibit 4.2.) The AHA is intended for use by NRCs with community groups and is useful when an NRC makes an initial presentation to such a group. Because it takes only 10 minutes to complete, the AHA can be used as the icebreaker at a meeting, preparing the audience for a presentation by the NRC representative on environmental strategies to prevent

alcohol problems. If the group decides that it wishes to take action to prevent or to reduce alcohol problems in its community, the NRC can help the group to select and achieve its goals by using one of the eight community training manuals developed by ACT (described next).

2. ***Community Training Manuals-These*** materials are resource manuals that provide guidelines for community groups to implement environmental change strategies. The eight manuals address a wide range of environmental change strategies and include a "Coordinators Manual" and "Participant Materials" suitable for reproduction and distribution to individuals participating in the activities. Exhibit 4.3 gives the title and a brief description of the contents of each guide.
3. ***Community Program Handbooks-More*** concise versions of some of the information in the training manuals are to be developed. These handbooks will be used to promote interest and knowledge in a particular environmental change strategy for those people. not yet ready to commit themselves to a more intensive action plan.

ONE NEIGHBORHOOD RECOVERY CENTER'S SUCCESSFUL EFFORT

In keeping with its dedication to pursuing environmental prevention measures, the Claremont NRC responded enthusiastically to a call from the National Council on Alcoholism (NCA), San Diego Chapter. NCA invited the NRC to participate on a task force for the prevention of alcohol-related birth defects. The task force initiated a drive to require alcohol outlets to display a sign warning of the dangers associated with consuming alcohol during pregnancy. The task force obtained a copy of a pamphlet, "Alcohol Warning Signs: How to Get Legislation Passed in Your City," from the Center for Science in the Public Interest and used the pamphlet for guidance. (It is available for $4.95 from the Center for Science in the Public Interest, 150116th Street, NW, Washington, DC, 20036.)

Other groups interested in the problem of alcohol-related birth defects were invited to join the task force. Among those who joined were the March of Dimes, California Women's Commission on Alcoholism, the Association for Retarded Children, the Junior League of San Diego, The Women's Action Committee on Alcohol, the Childbirth Education Association of San Diego, and other interested NRCs. This unified group was able to persuade San Diego County and 12 of the 18 other cities in the county to adopt ordinances requiring the posting of educational signs on alcohol-related birth defects education signs in retail outlets. The County Alcohol Program participated to

ensure that the language of the signs accurately conveyed the information. Eighty-six percent of the 4,500 alcohol outlets in the county are now covered by the ordinances.

Other activities grew out of this initial effort. The NRC worked with the Restaurant Association to obtain its support for displaying warning signs in eating establishments. The NRC participated in a kick-off celebration of Fetal Alcohol Syndrome Week and, with the underwriting of a local hospital, sold "Alcohol-Free Baby" T-shirts for pregnant women. Balloons with the words "Alcohol-Free Baby" on them were available for children as well.

The Claremont NRC continues to be involved in programs to prevent alcohol-related birth defects. They provide volunteers to speak at March of Dimes functions and are consulting with counties throughout the State of California interested in forming similar task forces in their own areas.

Exhibit 4.2

Alcohol Hazard Appraisal

This community alcohol problem survey will start you thinking about the problems alcohol can cause in your community and what can be done about them. Please fill it out following the instructions in italics. The survey has three parts: The first part asks you to rate how "alcohol safe" your home and your community are. The second part measures your overall knowledge of alcohol problems. The third part helps you assess the likelihood that you or organizations to which you belong will become active in helping to prevent alcohol problems.

A scoring guide is included in the center sheet. This section will help you interpret your scores, and keep a record of how well you did. Take the sheet home as a reminder of ways that you can get involved.

How Do your Family and Community Rate?

Your family

Answer by Circling YES or NO

A. If you serve alcohol in your home, do you always offer non-alcoholic beverages as well as alcoholic drinks? (If you don't serve alcohol, circle 'Yes.")	YES NO
B. When you and your friends go out, do you always pick one person who will drive and not drink if alcohol is to be consumed by anyone in the group? (If you and your friends do not drink, circle "Yes.")	YES NO
C. Would you insist on driving home a friend who had too much to drink, even if he/she said he/she was OK?	YES NO
D. If you serve alcohol, do you usually stop offering alcohol to friends an hour or more before they are due to drive home? (If you do not serve alcohol, circle 'Yes.")	YES NO
E. Do you make it a policy never to have minors drink in your home (except on religious or ceremonial occasions)?	YES NO
F. Do you know the number of places within walking distance of your home that sell alcoholic beverages? (Include liquor stores, convenience stores, grocery stores and restaurants.)	YES NO

How do your Family and Community Rate?

Your community

Answer by Circling YES, NO, or DK (for Don't Know)

G. Do convenience stores, liquor stores and gas station mini marts in your neighborhood:

Check the identification of people under 25 purchasing alcohol?	YES NO DK
Sell beer only in six packs (not in singles)?	YES NO DK
If they sell singles, do they prohibit their sale from displays at the cash register?	YES NO DK

H. Do bars and restaurants in your neighborhood:

Refuse service to intoxicated patrons?	YES NO DK
Make sure intoxicated patrons get rides home?	YES NO DK
Promotenon-alcoholic drinks during happy hour?	YES NO DK

I. Is there a policy on alcohol use at your place of work?	YES NO DK
Does it require non-alcoholic drinks to be served at social events?	YES NO DK
Does it refuse to pay expenses for alcohol at business lunches?	YES NO DK
Is there a "safe rides" policy after social events where alcohol is served?	YES NO DK
J. Are there any health messages about alcohol use on local radio and television stations?	YES NO DK
K Is there a community-wide policy to prevent alcohol-related problems at sporting events, rock concerts, and other large gatherings in your community?	YES NO DK

What Do You Know About Alcohol Problems?

Nationwide

Circle one answer.

1. How many alcohol-related problems are caused by alcoholics?	a) more than half b) about half c) less than half
2. Three years after Maine passed stricter driving under the influence (DUI) laws, DUI crashes	a) decreased b) increased c) stayed the same

3. The number of alcohol outlets grows just about as fast as the population.	a) true b) false
4. Alcohol-related birth defects are the third leading cause of mental retardation in the United States.	a> true b) false
5. Of all fatal single-car crashes involving alcohol, how many drivers were under 25?	a) 75% b) 44% c) 32%
6. What proportion of Americans has two or more drinks a day?	a) 75% b) 50% c) 11%
7. It is against the law for the alcohol industry to make campaign contributions to California legislators.	a) true b) false
8. Employers who serve alcohol are legally liable for the drinking and driving crashes of their employees.	a) true b) false

San Diego

9. In a special police operation in San Diego, how many liquor and convenience stores sold alcohol to a minor?	a) 5% b) 24% c) 45%
10. The social and medical cost of alcohol use is much greater than the alcohol taxes received by San Diego County.	a) true b) false
11. The number of alcohol outlets in San Diego has grown one and a half times faster than the population.	a) true b) false
12. The City of San Diego has a general ban on drinking in public places.	a) true b) false
13. Half of the San Diegans arrested for drinking and driving had their last drink at a bar or restaurant.	a) true b) false

Action Steps

How likely are you and members of your organization to complete these activities? Write any number between 0 and 100 that reflects just how likely you are to do the task. Use the following scale:

0	10	20	30	40	50	60	70	80	90	100
Not at all likely					Moderately likely					Extremely likely

Things You Might Do

Individual Actions

1. Talk with friends and family members about the dangers of drinking in high-risk situations.
2. Drive home a friend who has had too much to drink.
3. Get together a group to lobby for an alcohol policy where you work.
4. Attend a city council meeting on alcohol policy.
5. Start (or join) a group in your neighborhood to plan ways to make your community alcohol safe.

Things Your Organization Might Do

Organizational Actions

6. Write letters to support legislation on alcohol policy.
7. Organize a fund raiser for an alcohol program.
8. Join a coalition of organizations on alcohol policy.
9. Organize in-service training at your worksite on alcohol-related problems.
10. Work with the media to develop and show health messages about alcohol.
11. Work with community organizations to implement an "alcohol safe" policy for large community events.
12. Set up a program to monitor the granting of new alcohol licenses.

Scoring Guide

How Did You Rate?

There were 18 opportunities to score "yes" in this section, with 6 questions about your personal life and 12 about your community. Count up the number of YES's, NO's; and DON'T KNOW's you circled, and write each in the spaces below.

TOTAL MARKED "YES":_____

Remember, the more "YES's" you circled, the more "alcohol safe" your community and family are.

TOTAL MARKED "NO":_____

A "NO" answer means you may have found the source of a possible alcohol problem in your family and/or community. Ask the leader of today's presentation about what you and your organization can do to reduce these risk factors.

TOTAL MARKED "DON'T KNOW":_____

This number gives you an indication of how much homework you still have to do in order to assess how "alcohol safe" your community is. Write "DK" items in the spaces below, then spend some time looking around your neighborhood, observing and asking questions.

Rate How Much You Know About Alcohol Problems

Go through the questions on the last page of your survey sheet, and check off the ones you got right:

1. c) Alcoholics cause fewer than half of all alcohol-related problems. Most alcohol problems are caused by drinkers whose high risk drinking is the exception, not the rule.

2. c) While enforcement is an important part of the picture, recent studies in Maine and Massachusetts show that they have limited effect in reducing DUI.

3. b) False. The number of outlets in the United States has been growing faster than the population.

4. a) True. Alcohol-related birth defects are the third leading cause of mental retardation, and are totally preventable.

5. b) 44% of all drivers in single-car crashes involving alcohol were under 25-far more than any other age group.

6. c) Only 11% of Americans consume two or more drinks a day, which is considered heavier drinking. Over one third (35%) don't drink at all. The remaining 54% drink less than two drinks a day.

7. b) False. There's no law against the alcohol industry making campaign contributions to California legislators (and they do).

8. a) True. Employers may be held liable for damages as a result of drinking at work-related social events.

9. ***c) 45%*** of liquor and convenience stores in San Diego sold alcohol to a minor.

10. a) True. The cost of alcohol use in this country far outstrips the income we receive from alcohol taxes.

11. a) True. In San Diego, the number of outlets has grown one and a half times faster than the population between 1975 and 1985.

12. b) False. The City of San Diego is one of the few major cities that does not have a general ban on drinking in public.

13. a) True. Half of all San Diegans who were arrested for drinking and driving had their last drink at a bar or restaurant.

NUMBER OF CORRECT ANSWERS:_____

Interpreting Your Knowledge Score

If your ***TOTAL SCORE IS 5 OR LESS, -you*** can learn a lot from the presentation.

If your ***TOTAL SCORE IS 6–10,*** your knowledge about alcohol problems is about average. The presentation will fill in some of the gaps.

If your ***TOTAL SCORE IS 1 I OR ABOVE,*** congratulations! You correctly identified most of the facts and fictions about alcohol use.

Rate Your Action Steps

By rating your likelihood of getting involved in these **issues, you have identified a starting** point for you and your organization to prevent alcohol problems. To score this section, count the number of projects that you rated as ***75*** or over and write them here.

LIKELIHOOD OF INDIVIDUAL ACTION:_____

LIKELIHOOD OF ORGANIZATIONAL ACTION:

To help translate that "likelihood" into action, write out some of your "high likelihood" projects here:

Now that you have a list of projects that you would feel confident working on, you have several options. For example, you can:

- Discuss the projects that are most interesting to you as a group.
- Ask the representative from the Neighborhood Recovery Center about getting involved in a project.
- Start your own project using the Community Training Guides available at the Neighborhood Recovery Center.

Exhibit 4.3

Community Training Manual Titles

Preventing Youth Drinking: How to Get Started in Your Community

Outlines community action strategies that local organizations can use to reduce the incidence of alcohol sales to underage youth.

Preventing Alcohol-Related Birth Defects: How to Educate Your Community

Outlines community action strategies focusing on prevention of alcohol-related birth defects and fetal alcohol syndrome and on the passage of local legislation that requires liquor outlets to post signs that warn consumers about the link between alcohol consumption during pregnancy and the risk of birth defects.

Server Intervention: Encouraging Responsible Alcoholic Beverage Sales and Services

Outlines community action strategies that encourage local bars, restaurants, and other alcohol providers to train servers (bartenders, waitresses, and hosts) in techniques that discourage intoxication and drinking and driving.

Alcohol Policy for Worksites: Creating Policies to Prevent Problems

Outlines strategies that encourage and motivate employers to adopt corporate and employee alcohol policies that discourage, minimize, or reduce the risks associated with the consumption of alcohol in the business or work setting.

Increasing Community Involvement in Alcohol Licensing: How to Work with the Alcoholic Beverage Control

Outlines community action strategies to control the growth and location of alcohol outlets in a community by addressing the local zoning authorities and the State-level Alcoholic Beverage Commission.

Alcohol Use at Community Events: Creating Policies to Prevent Problems

Outlines community action strategies to promote and plan alcohol-free events and activities in a community.

Changing Alcohol Policy at the State Level: How to Get Started

Outlines strategies that community groups can follow to promote the passage of State legislation that controls the availability and use of alcohol at the local level.

Working with the Media: How to Get Alcohol Problems on Your Community's Agenda

Outlines planning and organizational strategies that can help community groups establish effective working relationships with local media organizations and gain access to local media resources for community action and education purposes.

Each community action guide contains an overview of the problem addressed and an action plan for a community group to follow. The action plan includes interactive steps for identifying the problem, setting goals and objectives, collecting community-level data, identifying intervention strategies, selecting an appropriate strategy, implementing the plan, and evaluating the effort. Included as appendices to each guide are case reports from other groups that have implemented similar programs, examples of applicable policy statements or guidelines, and other supplemental material.

To obtain the, guides, contact:

Applied Communications Technology
1010 Doyle Street, Suite 17
Menlo Park, CA 94025
415/322-6466

or

County of San Diego Alcohol Program
P.O. Box 85222
San Diego, CA 92X38-5222
619/692-5717.

Within You, Inc., Berkeley, California (Formerly Oakland Parents in Action)

The challenge to organize effective programs to prevent drug abuse in ethnic communities is especially urgent. Within You, Inc., believes that there is no substitute for local citizen involvement in drug abuse prevention. Citizens need to insist that drug use is unacceptable in their neighborhoods to help young people to resist the pressures to use drugs and to help them become productive and healthy members of the community.

When young people learn to say "no" to alcohol and other drug abuse, they need the kind of guidance and assistance that will enable them to say "yes" to life and to positive values. Young people need to know that the adults in their community care about them and want them to be successful human beings. By working with both the public and the private sectors, community groups can see that young people do not fall prey to a life of alcohol and/or other drug use and that they receive the kinds of education, skills, and manners needed to function productively throughout their lives. To meet this goal, however, a group cannot rest on its laurels; instead, it must look forward to new challenges and be flexible enough to adapt to change.

For information, contact:

Within You, Inc.
3101-A Sacramento Street,
Berkeley, CA 94702
or call 415/848-0845.

Oakland, California, is a port city directly east of San Francisco. Of its 347,000 residents, 49 percent are Black, and most live in the inner city. Open drug dealing on the streets of Oakland is a widely recognized problem.

Groups began to form to implement strategies to deal with the local drug problem. As is so often the case, one person, or several key people, make a big difference in such efforts. In Oakland's case, Joan Brann was that person. Mrs. Brann has experience as a community activist concerned about issues such as health care and Black pride, and she is an Oakland parent who has seen many lives lost to drugs.

As she worked, Mrs. Brann recognized the need for greatly increased parent involvement, especially in low-income and minority communities, and she knew that families needed all the help that they could get to support their children in resisting drug use.

With the help of a nonprofit agency, Mrs. Brann prepared a grant proposal that was successful in securing funds from a community foundation, the San Francisco Foundation. She became the project's part-time director, and another activist and Oakland resident, Linda Wiltz, was hired to be the project's community organizer.

The Oakland project set out with eight major objectives to accomplish in a North Oakland neighborhood of **50,000** people. The objectives were to:

- involve parents in parent peer support groups;
- get parents and school officials involved in producing a sound, fair, and enforceable set of school policies designed to prevent students from using alcohol and other drugs in and around schools;
- develop and circulate a project newsletter providing information about the project and its goals and accomplishments;
- develop a network of parent peer support groups and conduct at least two community meetings to enlist the support of officials of local schools, government agencies, law enforcement agencies, religious institutions, the media, and civic organizations in preventing drug use among youth;
- develop a handbook to mobilize parent groups specifically for low-income and ethnic communities;
- establish youth groups that promote and endorse alcohol- and other drug-free activities;
- develop a parent education program to train parents about the effects of drugs, the youth drug culture, and prevention and intervention strategies; and

- take action to stop the sale of illicit drugs on the streets of North Oakland.

The group that formed called itself Oakland Parents in Action (OPA). OPA decided to try a variety of strategies for involving parents, educators, community leaders, and others who could be helpful. Its first step was to establish a committee to oversee the development of OPA projects and to help in reaching out to others. To accomplish this task, it talked to parents, grandparents, school principals, teachers, members of the clergy, school board members, city council members, county supervisors, editors of local newspapers, and anyone else who would listen.

A core group of 24 people formed to actively support one another, whether this meant helping a parent find a job, creating safe places for their children to play, or providing food and clothing.

In an effort to accelerate the involvement of business and political establishments in OPA's work, members of OPA and their children invited then-First Lady Nancy Reagan to spend part of a day at a North Oakland elementary school and to meet with OPA committee members. The First Lady's visit was her first such appearance at an inner-city event to prevent drug use. News of the visit galvanized the city's business and political leaders. The story made the front page of most of the area newspapers and helped to create important linkages with people who were in positions to move the project forward.

Within a year of receiving its first grant from the San Francisco Foundation, OPA made significant progress toward its original goals. (The OPA story is told in a booklet published by the National Institute on Drug Abuse. It is titled "A Guide to Mobilizing Ethnic Minority Communities for Drug Abuse Prevention" and is available free through the National Clearinghouse for Alcohol and Drug -Information by writing to P.O. Box 2345, Rockville, MD 20852.) Some of its activities and projects are listed here.

- ***'World of Work."*** A program 'for children in grades 4-8, "World of Work" links young children with adult mentors in the community who regularly invite them to share part of their workday. The purpose of this program, which is sponsored by the O&land Rotary Club, is to provide young people

with appropriate adult role models who will encourage them to aim high and to reach their goals.

- ***Publication of a newsletter.*** Mailed to an increasing number of people in the community during the course of the year (after one year, the mailing list contained 2,000 names), the newsletter is an important means of getting out the word about the project's activities and events.

- ***Continued development of parent and community networks.*** The OPA committee expanded during the first year to include 46 people. Additional schools, the police department, the local media, sports figures, representatives of the business community, the Oakland Rotary Club, and many other people and organizations began to participate on a regular basis. In turn, the project staff became increasingly active in community organizations that shared their concern about youth and drug use. For example, OPA was invited to participate on the City's School Attendance Review Board (SARB), the formal body for adjudicating school-related cases of juvenile delinquency. This participation helped to connect the project with young people in need of assistance and support. Through OPA's participation in SARB, students became involved in the "World of Work," and their parents found help in solving family problems.

- ***Drug education in-schools.*** As word of OPA's activities spread in Oakland, the project staff received invitations to make presentations in several Oakland schools about drugs and their effects.

- School ***policy development.*** Recognizing the importance of a strong "no drug" school policy, especially for the elementary grades, a school drug policy committee was established that recommended policies for adoption by schools.

- ***Public commitments to reject drugs.*** "Just Say No" clubs are positive youth groups that adopt saying "no" to drugs as a major goal. Approximately 1,000 children in Oakland schools had joined "Just Say No" clubs by the spring of 1985, and more than

1,000 children participated in a major "Walk Against Drugs." The "Just Say No" clubs were an expression of the use of peer pressure to refuse drugs. Similar clubs soon began to form in communities across the country, and the students who founded the original clubs were invited to a reception at the White House at which then-First Lady Nancy Reagan officially recognized them for their achievements.

- ***Community advertising. The*** project staff convinced a local outdoor advertising company to donate unused billboard space to publicize the "Just Say No" concept. With graphics that were donated, 10 billboards were developed and prominently featured throughout the city, showing "Just Say No" club members and encouraging others to say "no" to drugs.

- ***Relationship to law enforcement.*** OPA was one of several leading community organizations that the Oakland Police Department credited for the noticeable reductions in drug-related crimes and increased drug arrests in 1985. Although Oakland still had a long way to go, according to the police department's official reports and records of arrests, the drug problem was beginning to be controlled.

The organizing steps used by OPA are described in Exhibit ***4.4.***

The power of the "Just Say No" movement is impressive. The First Lady's recognition of the first club, established in Oakland in 1985, and of the movement in general has stimulated the growth of 15,000 "Just Say No" clubs nationwide in less than 3 years. The rationale for the clubs is based on research indicating that young people who learn techniques to resist peer pressure to use alcohol and other drugs before actually being confronted to do so are less likely to submit to peer pressure when confronted.

In 1986, the *Just Say No" Foundation was established to support local "Just Say No" clubs and to promote the movement on a national level. The Foundation is a project of the Pacific Institute for Research and Evaluation, a nonprofit organization, and is a resource available

to all "Just, Say No" clubs and to communitiesthat wish to start clubs: The Foundation staff provides free consultation by telephone and produces a steady stream of written materials, most of which are available without charge. The "Just Say No" club book, over 200 pages long, contains complete information on starting a club and many activityideas and worksheets. It is available --for $10 by writing to the "Just Say No" Foundation, 1777 North California Boulevard, Suite 200, Walnut Creek, CA 94596. The "3 Steps to Say No" (Figure 4.5) used by the clubs and a sample activity (Worksheet H) from the club book are included in this section. For further information about the Foundation or "Just Say No" clubs, call 800/258-2766 outside California or 415/939-6666 within California.

Many members of the original staff from OPA have recently formed a new entity called Within You, Inc. This new-component was organized to extend the work with "Just Say No" participants. Within You, Inc., promotes concepts for young children that encourage positive lifestyles and values. The group plans to sponsor events that fosterthe kind of positive growth in young people that enables them to feel good about themselves and to make positive contributions to their communities.

Chapter reprinted from ***A Guide to Mobilizing Ethnic Communities for Drug Abuse Prevention,*** DHHS Publication No. (ADM) 86-1465, 1986.

IV. Basic Organizing Steps

This section describes ten basic organizing steps that worked for OPA, and are now being used to help similar communities across the country in the fight against drug abuse.

I. *Select the Community*

The success of a community mobilization effort will depend to a great extent on the type of community it is. Both in Oakland and other parts of the country, OPA's organizers sought communities that had:

- A significant percentage of low-income, primarily ethnic residents (Black, Hispanic, Asian, or American Indian);
- Parent activists who would be available to support the program;
- The potential for cooperation from local schools, police departments, the business community, and other community leaders and decisionmakers; and
- The potential for private support from such funding sources as businesses and foundations.

Perhaps most important, however, is the effort to increase awareness in the community about the extent and seriousness of the drug problem. In Oakland, for example, concern was centered on the significant rise in drug-related crimes throughout the community just prior to the formation of OPA. Community councils and churches held meetings to discuss the problem, and it was given a great deal of attention in the media. The community was prepared for an organization that offered constructive and positive solutions, especially solutions that included parents and their children.

2. *Identify Grassroots Leaders*

The OPA approach is based on the active involvement of grassroots leaders, parents, and children. These are the people who care most about doing something to stop

drug abuse in their communities. Although outsiders, politicians, and drug abuse professionals can be helpful, outside programs and experts come and go in low-income communities, leaving little accomplished and creating skepticism among community residents about the possibility of change.

OPA's community organizing process is more than just a way of dealing with the drug problem. It is a means of restoring faith in low-income, ethnic minority communities, creating new linkages and networks among community residents, and reconnecting the community with itself. In short, it is a way of building a sense of community by rallying diverse elements to address a common concern.

To accomplish this, strong, effective, and where possible, charismatic parent leaders are essential. They must be community people who have a reputation for getting things done, and they must be able to work effectively with many different kinds of individuals and groups. They should have:

- A good knowledge of the community;
- An awareness of the community's history, especially past efforts at helping youth and families or at dealing with the drug problem;
- Acquaintances with diverse people in the community; and
- A willingness to work long and demanding days—and to go to evening meetings occasionally as well.

Effective parent leaders should not be too closely aligned with specific groups or organizations, even if those groups or organizations are known for their good works. This could hinder the organizers' ability to reach out to the entire community. The program's organizers should be credible, reliable people who can lead a new organization and convey the sense of a fresh start in dealing with a difficult problem. One resource that has helped OPA significantly has been the work of experienced labor organizers. Their sensitivity to the dynamics of organizing has been invaluable in "making it happen."

3. Identify Grassroots Resources and Support

A variety of agencies and organizations in ethnic minority communities can be enlisted to support a drug abuse prevention effort. These include:

- Minority-owned media;
- Sororities and fraternities;
- Minority-owned businesses or minority business associations;
- Churches and religious organizations;
- Youth-serving agencies such as Boys Clubs and Girls Clubs; and
- Coalitions serving youth.

These and many other grassroots community resources can provide various forms of support for a new group as it starts up. In addition to concerned parents, they are the ones that have the greatest stake in the success of minority youth and the well-being of the community generally. As much as possible, leaders and activists in these organizations should be recruited to join the new organization's founding committee, where they can play an important role in developing linkages and support. Their formal involvement should reduce possible opposition to the parent group.

4. *Work With the Established Community System*

A major premise of the OPA process is that grassroots individuals and groups should enlist the cooperation and support of "establishment" (usually predominantly white) businesses and organizations as a key resource. Although these businesses and organizations may not be well informed about problems and issues in ethnic minority communities, the experience of OPA and other groups is that, when approached effectively, they can be strong allies. Many different kinds of individuals and organizations in this category might be approached, including:

- Politicians and council members;
- Leaders of major businesses and labor unions;

- Leaders in service organizations such as Lions, Rotary, or Soroptimists; and
- Editors and reporters from the major news media.

In some cases, working with these groups will mean enlisting the support of ethnic minorities who have succeeded in middle-class terms (i.e., in mainstream businesses and organizations), and who wish to help those who are less fortunate. This is particularly true in cities like Oakland and Atlanta, where ethnic minorities are an important part of the established system. In other cases it will mean working closely with whites who are in positions of power and decisiomnaking who are concerned about the well-being of the community.

OPA's general guideline in soliciting support from the power structure is: Do not exclude sincere people who want to get involved and who have skills, connections, energy and ideas that may be helpful.

5. ***Identify Funding Sources***

An effective community mobilization effort in low-income, ethnic communities requires money. This is perhaps the most important distinction between drug abuse prevention efforts in low-income communities when compared with those in middle-class communities.

The white, middle-class parent movement has been sustained almost entirely by parent volunteers. These are people who have the time and commitment to get very involved in solving a complex community problem by attending meetings, making telephone calls day after day, and often paying for a variety of miscellaneous expenses out of their own pockets.

It would be misleading to say that these middle-class parent volunteers "have it easy.* On the contrary, many of them are either single parents or in two-parent families in which both adults have full-time jobs. A more accurate statement would be that they have it ***easier*** than people in low-income, ethnic minority communities, and are able to find the extra time and energy needed for the fight against drug abuse.

The same kind of spontaneous action cannot be expected from low-income, minority parents and community residents. For one thing, volunteerism and community

action are not as strong in the country's less privileged communities. People are more inclined to offer help to each other in the form of extended families than by getting involved in broader community issues. Unlike middle-class parents, low-income parents are often intimidated by the school system because they themselves often had a poor school experience. They are not likely to march into the principal's office and demand that something be done about the drug problem.

Another consideration is that the problems of low-income communities-basic survival and hard-core crime, for example—often seem so overwhelming that community residents are reluctant to launch an effort that may seem to have little hope of success.

For all these reasons it is not realistic to expect that parents and other community residents will readily come together in a sustained effort to deal with the drug problem. Experienced organizers should be available to help make this happen. They may only be needed part-time. The job may be one that a concerned parent activist can do as an extension of his or her regular employment—for example, in a youth-serving organization or community agency.

Because paid staff will be needed, however, it will be important to identify potential funding sources such as foundations and large businesses in advance. The volunteer services of a community-involved educator, labor organizer, businessman, etc., may be useful in helping to develop and present a proposal to a foundation or business. If such financial resources are not available, it will be necessary to find a parent activist who will be authorized to start up a grassroots network as part of his or her job.

OPA was able to get under way because of a grant from a major foundation. Smaller grants from businesses and other foundations followed. These and similar funding mechanisms are key resources in sustaining a grassroots network's activities. Other sources can be developed-for example, sales of T-shirts with "Just Say No" and similar slogans printed on them, and fundraising parties and events. It is important to recognize that you have something valuable to sell-a drug free community—and that the development of a plan and a core group

ready to do the hard work to implement, that plan, will be attractive to many.

6. ***Target a Specific Neighborhood***

Wanting to deter drug dealing in an entire city is a noble goal, and it may be achievable over the long term. Great triumphs begin, however, with small successes.

It is especially important to start small because an overly ambitious effort is likely to fail-and then never to recover from its initial failure. A successful drug abuse -prevention effort will usually begin by working just in one specific neighborhood, preferably one where there has been unusual concern about the problem of drugs and youth.

The program's organizers should become well informed about the dynamics of the neighborhood and get answers to the following kinds of questions:

- What is the extent of the community's drug problem? How serious is the problem? How do you know?
- What is the size of the youth.population? The minority population?
- What is the incidence of poverty in the community? Of single-parent families?
- What efforts have been made to identify community problems and needs in addition to drug abuse?
- How many schools are there in the community, and how cooperative are school officialslikely to be in a community drug abuse prevention effort?
- Who are the other community leaders who should be involved in your effort?
- What are the best ways of reaching and recruiting young people for positive prevention activities?

In communities where there has been a high incidence of drug-related crime, or young people themselves have been involved in drugs and crime, community concern about the problem is likely to be high. This is the best

kind of situation in which to begin a grassroots community mobilization effort. People in such communities recognize that the drug problem is a serious threat. Parents and grandparents who might not otherwise get involved in community action efforts can become important allies, and parents of younger children who are not yet involved with drugs are often eager to help.

7. ***Be Prepared With a Plan***

An important element in OPA's success from the beginning has been a well thought out plan with specific, measurable goals and objectives. This plan was first developed in the context of OPA's proposal to the San Francisco Foundation, and it has been followed consistently from the beginning, with few modifications.

Whatever an organizing group's goals and objectives, a plan should be carefully developed, reviewed by a variety of people who can offer constructive criticism, and then made available throughout the community. A simple summary, perhaps in the form of a brochure or flyer, can be used to announce the group's goals and objectives. Also important to include are specific program ideas for involving young people and their families-for example, "Just Say No" clubs, programs like "World of Work" to help young people in setting and achieving career goals, and parent education programs.

8. ***Develop Meaningful Projects***

Many grassroots efforts to deal with the drug problem have started with a burst of energy and then fizzled out because their leaders lacked ideas for strong, worthwhile projects to sustain the energy and enthusiasm of the participants. Merely sitting around and talking about the drug problem is not an effective way to fight it. Instead, it is important to have relevant, meaningful projects that involve parents and children. Examples include:

- "Just Say No" clubs;
- Bowling leagues or other recreational opportunities for youth;
- Programs like 'World of Work" that will help young people develop an orientation to jobs and careers;

- Drug education programs for schools or churches;
- Neighborhood watch programs;
- Rallies or walks against drugs;
- Fundraising events; and
- Summer youth programs.

None of these project will be easy to implement. Wherever possible, it is important to work with other groups and use existing resources to develop projects. A few worthwhile projects like those listed above will be more important, however, than many meetings that lead to nothing. (See chapter VI for specific ideas about how to establish and operate a variety of activities.)

9. Document the Group's Efforts and Accomplishments

Both for potential financial supporters and for new members and constituents, keeping a lively, visible record of the group's accomplishments can be an important key to success. This need not be an elaborate written document or formal evaluation. Valuable, persuasive records to keep might include:

- Photographs of significant events;
- News clippings;
- Important letters from community leaders;
- Copies of proposals and awards of funds; and
- Records of interviews with participating parents and children.

An interesting, vital record of the project will become its "living history."

10. Get an Appropriate Office

In the sixties and seventies, grassroots groups often settled in any space available to them. Oakland Parents in Action began its operations in the home of its founder, and meetings were held in the backyard. As soon as space could be located, however, the organization moved

to an attractive office in a building convenient to mass transportation, which made OPA more accessible to parents and children. The storefront approach should be avoided, if possible. Organizers should seek the best office they can find within the community to be served (office buildings often have vacant space that owners might be willing to donate). With an appropriate and attractive place to meet and work, the participants will feel proud of their organization. Their efforts and their organization are not second-rate and they should not be seen by themselves or others as less important. At the same time, they must never lose their identity with the community and they should be particularly wary of going uptown either geographically or spiritually.

All of these steps have been critical to the success of OPA and the early phases of similar replications across the country. Inevitably there will be some variation among projects from one community to another. Whatever the community's differences, however, the OPA organizing process offers a solid foundation for success.

Figure 4.5

The "Just Say No" Clubs' "3 Steps to Say No"

Step 1: Figure out if what your friend wants to do is OK.

Sometimes this is easy, sometimes it takes a little detective work. If you're not sure, ask your friend questions like, "Is it safe?", "Is it good for me?", "Is it legal?", "Could it get us in trouble?" Ask yourself questions like, "Would my parents allow me to do that?", "Would I feel right about doing it, or does the thought make me feel bad inside?"

Step 2: If it's wrong, say No.

As soon as your friend, or you, gives an answer that lets you know that what he or she suggested is wrong, stop asking questions. Say, "No, thanks." Be nice about it-don't be mean or put your friend down-but let him or her know that you're serious. Then explain your reason for saying No.

Step 3. Suggest other things to do instead.

After you've said No, suggest other activities that are. fun, safe, legal and healthy. Sound enthusiastic. Be positive. Let your friend know that you'd like to be with him or her, but not if it means doing something that's wrong.

If the other person keeps trying to convince you to do something you know you shouldn't, ***walk away.*** Real friends respect their friends' decisions, Sometimes it's hard to say No, but you'll feel better about yourself knowing you've done what's right.

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WORKSHEET G

JUST SAY NO CLUB BOOK ACTIVITY

DRUGS ON TV

Researcher's Name _____

Researcher Assignment _____

Day Time a.m. p.m. Network _____

Program(s) to be watched

Commercials

Total number of commercials _____

Number of commercials for wine _____

Number of commercials for beer _____

Number of commercials for snuff, chewing tobacco _____

Programs

Number of times you saw someone smoking _____

Number of times you saw someone using chewing tobacco or snuff _____

Number of times you saw someone drinking alcohol _____

Number of times you saw someone using illegal drugs _____

Which drugs? _____

Sports Shows

Type of sport _____

Length of game _____

Total number of commercials _____

Number of commercials for beer _____

Number of beer commercials using former athletes _____

Number of commercials for wine _____

Number of commercials for chewing tobacco or snuff _____

Number of times you saw one of the players using chewing tobacco or snuff _____

Number of billboards you saw at the stadium, rink, etc., for alcohol or tobacco products _____

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Illinois Department of Alcoholism and Substance Abuse

The Illinois Department of Alcoholism and Substance Abuse believes that schools and communities play vital roles in promoting health and well-being for our youth. The much needed component missing in linking these two vital components has been a system that provides the opportunity for schools and the community to work hand-in-hand on comprehensive prevention programs.

Because prevention is in everyone's best interest, the Illinois model involves several arms of State government in developing its programs. This example of cooperation among government offices provides a model for the type of cooperation that will be needed at other levels of the prevention initiative.

Through the integration of prevention programs and the spirit and determination of their members, society can build the powerful alliances necessary for positive cultural change.

For information contact

The In-Touch Coordinator of the Department of
Alcoholism and Substance Abuse
100 West Randolph Street, Suite 5-600
Chicago, IL 60601
or call 312/917-3840.

Illinois is a large State with urban and rural populations totaling more than 11.4 million and with agricultural as well as highly industrialized areas. Professionals at the State level recognized that to be successful, a prevention strategy needed to be responsive to diverse community needs and constraints.

Program philosophy

The Illinois prevention model is based on the knowledge that community members who have participated in developing and implementing local programs are more likely to regard them as "their" programs rather than "the State's" programs. The Illinois model makes efficient use of centralized resources to support community-level activities, but communities assume responsibility for their own programs, including funding. In doing so, the communities are less likely to be overly dependent on

State resources, an important factor in determining long-term success.

Consistent strategies guide prevention programming in Illinois

The *five* basic strategies that guide prevention programming in Illinois are to:

- provide information on the physiological, pharmacological, psychological, and legal consequences of drug abuse;
- enhance social competencies to strengthen family stability, help individuals set goals for themselves, identify and deal constructively with their emotions; and build self-control, self-confidence, social skills, and healthy peer relationships;
- promote constructive means for people to use to respond to feelings of boredom, frustration, pain, powerlessness, and lack of hope for change;
- influence social policies and norms to ensure that the written and the unwritten messages that young people receive are consistent and that the messages reinforce the fact that people do not need chemicals to lead satisfying lives; and
- train community leaders in prevention skills so that they can strengthen prevention efforts in their *own* community.

The Illinois framework for prevention-program descriptions

The In-Touch Program (Illinois Network to Organize the Understanding of Community Health). There are many prevention initiatives working concurrently in Illinois. In-Touch is the broadest of them, developed and administered by the Department of Alcoholism and Substance Abuse (DASA), and in partnership with the Lieutenant Governor's Office and the Illinois State Board of Education. In-Touch is a management system designed to facilitate networking throughout the State. The cooperation of the agencies involved is an example of the type of cooperation and mutual support needed at the community level to ensure success.

In-Touch's goal is to give all school children in Illinois, in the kindergarten through grade 12, the necessary information and skills to avoid alcohol and other drug use. Although schools play a critical role in implementing the In-Touch program, they are not expected to assume full responsibility for preventing alcohol and other drug problems in their communities. Parents, business people, government leaders,.and other concerned citizens are also important prevention advocates.

As part of In-Touch, DASA created 18 prevention service areas, each staffed by a prevention area coordinator. Cutting across the prevention service areas are 60 regional prevention groups. This system for delivery of prevention services incorporates the State's five prevention strategies while seeing that the unique needs of each community are addressed. For example, in an affluent, suburban neighborhood in Illinois, a program targeted at parents might involve employers to reach parents in their workplaces. In low-income, inner-city neighborhoods, day care centers may be a better channel for reaching parents. Grandmothers may be targeted by the inner-city programs as well because of the high rates of single-parent households and the important role that grandmothers play in the lives of their grandchildren.

Participation by the Lieutenant Governor's office

In addition to articulating the requirements of the In-Touch Program to the State legislature and securing legislative support for In-Touch, the Lieutenant Governor's Office participates in three other prevention activities: Sports Teams Organized for Prevention (S.T.O.P.), Community Congress, and the Growing Free Conference.

Sports Teams Organized for Prevention. S.T.O.P. is a nonprofit corporation founded by the Lieutenant Governor's Office and the Chicago Bears. The program enhances awareness of issues surrounding alcohol and other drug use and promotes community prevention programs. Ten professional teams-six Chicago and four St. Louis teams-visit community groups and school groups to speak about the dangers of alcohol and other drug use. An outstanding feature of this program is the requirement that any group receiving assistance must be willing to follow the visit with ongoing long-term prevention activities and must state how the athlete's visit will enhance these activities. This requirement not only ensures

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that athletes' time will be spent working with groups serious about committing resources to prevention but also sends the message to community groups that prevention is a complex process. An adaptation of the S.T.O.P. Program has been developed for the elementary school level. The Elementary Mascot Program has the same guidelines and criteria as the S.T.O.P. Program except that a team mascot rather than an athlete visits the elementary school.

Community Congress. Community Congress is a program that includes many people from the community in prevention planning. In groups, community members (i.e., students, school administrators, teachers, Parent-Teacher Association representatives, religious leaders, local government officials, and medical personnel) are trained in prevention and participate in an assessment of community prevention resources. The assessment is an important first step in planning programs.

Growing Free Conference. Growing Free is an annual conference cosponsored by the Lieutenant Governor's Office that trains influential community people in alcohol and other drug problems and prevention.

Participation by the Department of Alcoholism and Substance Abuse

DASA is mandated by the State legislature to plan, develop, monitor, allocate funds, and evaluate prevention and treatment programs for alcohol and other drug abuse throughout the State. It concentrates on providing a cohesive system of programs rather than operating a variety of programs itself. As was discussed earlier, DASA has responsibility for administering and coordinating the In-Touch Program. It also funds the Prevention Resource Center.

The Prevention Resource Center. The Prevention Resource Center, in operation since 1980, provides on-site consultation, technical assistance, training workshops, and support services and operates a variety of information services. The staff assists groups with teacher training, community organization, proposal planning, networking, curriculum development, and evaluation.

The information service of the Prevention Resource Center includes a lending library of prevention-related materials-such as books, periodicals, curriculum, and

films-computerized literature searches, a reference service, a newsletter, and other related services. (This project was selected to be one of the 20 exemplary programs in 1987; a detailed summary of the project appears later in this chapter.)

Participation by the Illinois State Board of Education

The Illinois State Board of Education promotes the incorporation of prevention concepts and curricula into all levels of education. It encourages every school district to develop a strong policy statement concerningits position on the use, sale, or possession of illegal drugs on school grounds, the sanctions imposed for violation of policy, and the assistance offered to students having alcohol- or other drug-related problems. The Board requires schools to incorporate prevention concepts into academic programs as well, although the decision regarding the particular curriculum is left to the local district. In addition, the Board encourages local schools to involve students and the larger community in all phases of development and implementation of prevention programs.

Project *Graduation.* The Illinois Board of Education played an important role in developing the In-Touch concept and continues to be instrumental in promoting In-Touch to schools throughout the State. The board also promotes the Project Graduation Program. Project Graduation began in Maine and has become a popular alternative nationwide to postgraduation parties that frequently involve alcohol and other drugs. Project Graduation organizes chemical-free graduation night parties and celebrations well in advance.

Participation by the Illinois Alcoholism and Drug Dependence Association

The Illinois Alcoholism and Drug Dependence Association (IADDA) is a statewide association of individuals and service providers concerned about alcoholism and other drug dependence. IADDA maintains contact with a wide variety of prevention programs throughout the State and serves as an advocate for their needs at the State level. IADDA also developed two successful programs, the Illinois Teenage Institute on Substance Abuse and Operation Snowball.

The Teenage Institute. The Teenage Institute provides intensive week-long training to high school students from throughout the State on alcohol and other drug abuse, family communications, alcoholism and families, building self-esteem, and developing a healthy lifestyle. Program participants bring the information and leadership skills they have learned back to their own communities. Alumni of this program continue to meet in followup sessions to share what they have done in their own communities and to receive continued support and assistance from one another.

Operation Snowball. This program is an outgrowth of the Teenage Institute. It provides many of the same experiences to youth as the Teenage Institute does, but in a community-based program occurring over a long weekend. Operation Snowball has provided many students with the opportunity to participate in prevention efforts, and can be tailored to the specific needs of a community.

Participation by the Illinois Drug Education Alliance

The Illinois Drug Education Alliance (IDEA) is the statewide umbrella organization for parent groups interested in preventing alcohol and other drug abuse among their children. IDEA forms a system for relaying information about pending prevention legislation and for supporting parent groups around the State.

Started by concerned parents, IDEA is fully supported by donations and membership dues and is composed strictly of volunteers. IDEA maintains a speakers bureau to advise groups on prevention, holds an annual statewide conference, publishes a bimonthly newsletter, and works with local school systems to promote "Just Say No" clubs.

Prineiples of effective prevention programs

Figure 4.6 outlines 12 attributes identified by the National Prevention Network as the ingredients that contribute to effective prevention programs. The State office in Illinois adopted these attributes as their guiding principles.

Figure 4.6

Prevention Programs That Work

Twelve Important Attributes of Effective Prevention Programs Used in Illinois*

1. ***Program Planning Process:*** The program is based on a sound planning process. The planning process is conducted and/or affirmed by a group which is representative of the multiple systems in the community, such as family, church/synagogue, school, business, law enforcement, judicial system, media, service organizations and health delivery systems, including alcohol and other drug agencies involved in referral, treatment and aftercare.
2. Goals ***and Objectives:*** The program has developed a written document which establishes specific measurable goals and objectives that focus on alcohol and other drug prevention. The goals and objectives should be based on a community needs assessment and reflect specific action plans appropriate to the target groups.
3. ***Multiple Activities:*** The prevention program involves the use of multiple activities to accomplish its goals and objectives. These may include information, education, skills development for youth and adults; training of impactors, alternatives, environmental policy and public policy segments. The public policy components may include the development of specific written school policies and/or local, State and national public policies on availability, marketing, and other relevant alcohol beverage control issues.
4. ***Multiple Targets/Populations***: The prevention program includes all elements of the community and/or population served, including all ages, such as the elderly, high-risk groups, and culturally specific groups. The impact and interrelatedness of each group upon the other must be recognized and emphasized in program development, i.e., youth usage is strongly influenced by community norms and adult role models.
5. ***Strong Evaluation Base:*** The program has a mechanism for data collection on an ongoing basis and a method of cost analysis that can be used to calculate cost effectiveness. In addition, the outcomes of the evaluation need to include a focus on behavior change and be tied back to the planning process so that appropriate programmatic changes can be made.

*This list was developed by the National Prevention Network. (See Appendix E for more information on the Network.)

Figure 4.6 (continued):

Prevention Programs That Work

6. ***Sensitive to Needs of All:*** The program takes into account the unique special needs of the community/population. The community will not adopt, without study and adaptation, the package deals of another community, but will seek to redesign and tailor prevention programs to reach the specific needs of its own individuals and cultural groups, including different ethnic and gender-specific efforts.

7. ***Part of Overall Health Promotion and Health Care System:*** The prevention program is an integral, essential component of the health care system. It works with the other agencies who provide intervention, referral treatment and aftercare components of the continuum. It also seeks to work with other prevention agencies (e.g., Health Maintenance Organizations, American Cancer Society) in order to build a supportive community environment for the development of healthy lifestyles and healthy lifestyle choices.

8. ***Community Involvement and Ownership:*** The prevention program reflects the basic, essential, philosophical understanding that prevention is a shared responsibility between national, State, and local levels and that specific programs are best done at community levels. "Grassroots" ownership and responsibility are the key elements in the planning, implementation, and evaluation of the program. The prevention program should enable the community to not only examine its problems, but also take ownership and responsibility for its solutions.

9. ***Long Term: The*** prevention program recognizes that there is no such thing as a quick fix or bottled formula or a magic curriculum that will solve the problem. The prevention program seeks to promote. a long-term commitment that is flexible and adaptable and responds to a changing environment. The prevention program seeks to build upon its successes and continually enhance its efforts toward its goal. The long-term process integrates prevention activities into existing organizations and institutions such as families, schools, and communities. The long-term nature of the program ensures that interventions begin early and continue through the life cycle.

10. ***Multiple System /Levels:*** The prevention program utilizes multiple social systems and levels within the community in a collaborative effort. Each system's involvement is necessary but not sufficient for the success of the program. In order to impact a full range of target populations, all the social systems that are involved must be

included. (For example, a program targeted to Hispanic youth must involve family, church, school, community recreation, and the law enforcement system.)

11. ***Marketing/Promotion:*** The prevention program needs to include a marketing approach that showcases the positive effects that prevention has within the community and the effects it has on the various individuals and systems within the community. Policymakers are key targets for the marketing strategy. (For example, in marketing to youth prevention programs, the involvement of policy makers in the marketing strategy may ensure the continuation of the prevention program.) Mechanisms by which programs can achieve self-sufficiency should be built into the design.

12. ***Replicability:*** The prevention program has documented its philosophy, theory, methods and procedures in sufficient detail and clarity to permit other organizations to assess its utility and applicability in their setting and to permit orderly development of a similar or related program in a new and (somewhat) different setting.

The Center for Human Development, Lafayette, California

Over the years, the Center for Human Development (CHD) has pioneered, disseminated, and evaluated many primary prevention programs with the major goal of preventing substance abuse, mental illness, and juvenile problems. The key strategy for the prevention of these problems has been a positive developmental approach enabling communities, community organizations, schools, human service agencies, and individuals to develop their own unique programs for the diverse needs of their respective populations.

The Center believes that prevention is a proactive process designed to promote health and to reduce the need for remedial treatment of physical, social, and emotional problems. Several basic principles guide the development and implementation of all programs at the Center. These guiding principles are that:

- prevention programs must meet people in the context of the settings in which they live and work;

- the responsibility of all programs is to facilitate the conditions or processes that empower persons and systems to assert their own unique strengths;

- people have the power within themselves to bring about change and to create improved life situations (and it is the program's role to assist them in discovering this power);

- individuals, institutions, and communities must not become dependent on professionals or program models that perpetuate powerlessness;

- as professionals, we must form partnerships with identified helpers in the community to work with community members rather than "doing to them" or "for them"; and

- the role of programs and professionals is to transfer knowledge, skills, and resources to communities so that social change may be realized.

It is through the above principles that CHD continues to develop and implement prevention programs that will have a positive impact on the problems faced by individuals, families, institutions, and communities.

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The Center for Human Development (CHD), located in Lafayette, CA, is a nonprofit corporation that provides a wide range of alcohol, other drug, and mental health services to residents of Contra Costa County. Contra Costa County has people of many different ethnic backgrounds and widely varying economic circumstances. The key strategy for the prevention of problems has been to enable school districts, community organizations, and human service agencies to develop their own programs for the diverse needs of their populations. This strategy was facilitated by a change in the CHD staffing pattern; prior to 1978 CHD maintained a director and six to eight full-time professionals who worked on-site with groups. This system tended to make clients dependent on CHD

and reluctant to continue programs once the CHD professional staff withdrew. As a result, CHD altered its staffing pattern and delivery of services to that of a broker of resources providing technical assistance. In this way, CHD helps others to help themselves.

CHD offers technical assistance to school districts, parent and community groups, and human service agencies. A list of the general services provided.by CHD follows, as well as descriptions of many of the prevention programs established by CHD.

General services

CHD provides the following services to school districts:

- assessment of school climate and needs;
- providing management tools for maintaining classroom discipline;
- development of curriculum-alcohol and other drug information, self-concept, communication, and decisionmaking skills;
- in-service training for staff--classroom management, counseling strategies, staff development, and teaching techniques; and
- development of student programs--leadership training and recreational alternatives.

CHD provides the following services to parent and community groups:

- family and parenting courses;
- community conferences;
- university extension courses; and
- classes and workshops.

CHD also provides the following services to human service agencies:

- assistance with program planning, evaluation, and organizational development; and

- assistance to facilitate involvement with State and Federal services and resources.

Program descriptions

The Tribes Program. Tribes is a teaching (training) process with activities designed to build self-esteem, responsible behavior, and academic achievement-three factors thought to be inversely related to drug use. Because the Tribes process teaches students to work effectively together in small groups and to share their personal concerns, students learn to feel good about themselves and to develop trust and respect for others. In addition, the Tribes approach facilitates classroom management and thereby allows teachers to devote more time to creative teaching and less time to managing behavior problems.

Tribes is used in many parts of the United States. To implement the Tribes program effectively, a 30-hour in-service training is recommended.

Parent Educator Program. The Parent Educator Program trains parents to present a health and drug prevention curriculum in elementary school classrooms. The 21-hour training teaches parent volunteers to choose and implement a process-oriented health curriculum that promotes self-esteem and positive peer interactions.

Parent educators are a valuable asset to a school. They are extremely helpful in stretching overextended staff resources, and their presence in the classroom indicates to children that parents care about the issues for their own children and for all children.

For a Parent Educator Program to work effectively, the CHD outlines the following prerequisites:

- The program uses a team approach: the school and community must recruit enough parent volunteers to cover at least two target grade levels.

- Teachers and administrators must be willing to have parents teach 6-16 sessions, depending on grade level and curriculum selected.

- Schools must purchase curriculum.

- The school and community must select two parents to serve as liaisons between volunteers and the

school and to meet regularly with other schools' representatives.

- All parents must attend the entire training program.

Youth Educator Program. The Youth Educator Program targets youth at a critical developmental stage—early adolescence. (Research indicates that most use of tobacco, alcohol, and marijuana begins prior to the tenth grade, whereas less than 5 percent of the seventh grade students are regular users of tobacco and marijuana, and 10 percent are regular users of alcohol.) High school students are selected by a review committee and trained by adult community members to work in teams that deliver a seven-session alcohol and other drug prevention curriculum in junior high classrooms. The curriculum used is designed to strengthen the abilities of seventh and eighth graders to resist peer pressure to use alcohol and other drugs.

The Youth Educator Program is based on research and experience that show that young adolescents are particularly susceptible to peer influences and are likely to imitate peer behavior; high school students as "near peers" can be most effective in delivering a prevention program to junior high school students.

To establish an effective program, CHD works with a local area coordinator, identified by the high school and trained by CHD. The coordinator works with school administrators in planning program activities and implementing the program at the junior high schools. In addition, the coordinator recruits, trains, and directs the Youth Educator group.

Youth Services Technical Assistance Project. Youth Services Technical Assistance Project is a community-based needs assessment project organized to coordinate the alcohol and other drug-related concerns of school staff, students, parents, and key members of the community. The groups identify needs and set priorities for prevention, intervention, treatment, and recovery. CHD staff is available to provide technical assistance to the groups and to help them to select appropriate strategies to meet their goals.

As part of this project, CHD sponsored "A Forum on Strategies and Public Policy in California." This forum was held to link key decisionmakers at the local and State levels, to promote the adoption of state-of-the-art, multilevel approaches to addressing alcohol-related problems among youth, and to articulate local and State-level policy issues. The forum also developed recommendations sent to the California Department of Alcohol and Drug Programs on youth alcohol services, strategies, and policy issues.

NEAT Family Project (NEAT means New Experiences in Affection and Trust). The NEAT Family Project is a peer support group for teenagers, 12- to 18-year olds, with alcohol and other drug problems. A trained youth facilitator, often someone who has overcome an alcohol or other drug problem, leads the group while supervised by a clinical social worker. Groups explore ways of handling the pressures of everyday living without resorting to alcohol or other drugs. Together they learn "survival skills" such as fending off peer pressure, resolving conflicts, and communicating more effectively. They learn to have a good time without being high.

The NEAT Family Project is a structured group process through which members develop trust in and concern for each other. Members come to feel better about themselves and more confident in their ability to succeed at school, in relationships, and in life in general.

Several activities have been developed by the NEAT Family Project. Members operate their own businesses, with support from the community. They also take part in community service projects that help others while providing personally rewarding experience for participants. NEAT Family groups hold recreation and social events every weekend to give members something to do and to provide opportunities for socializing without the pressure to consume alcohol or use other drugs. The Parent Connection is another part of Neat Family Project, designed to inform parents about alcohol and other drug use and to provide a supportive setting for parents to share their concerns. Parent Connection meetings are held twice a month.

New *Bridges. New* Bridges is a l-week intensive summer camp with ongoing followup activities; it brings together teenagers from diverse ethnic, cultural, religious,

and socioeconomic backgrounds to discover ways to overcome social divisions that exist within society. New Bridges helps youth to deal creatively with such issues as racism, sexism, changing sex roles, and family situations so that they build confidence in themselves and develop higher self-esteem.

For *Kids' Sake.* For Kids' Sake is a community service campaign created by KPIX, Channel 5, with the assistance of CHD. For Kid's Sake provides programs, community events, and news series aimed at making young people and their parents more aware of their individual needs and responsibilities, with the main focus on alcohol and other drug abuse. CHD trained media professionals in alcohol and other drug abuse prevention and in effective parenting skills for new parents and for those with older children. KPIX staff used the training they received to develop prevention strategies, messages, and materials.

Pregnant Teens/ Teen Parent Program. One community supported by CHD began a program for pregnant teenagers and teenage parents after realizing the link between teenage pregnancy, alcohol and other drug use, and mental health. Members of this community felt that to be truly effective, the program would need to address an entire system of problems, instead of focusing only on teenage pregnancy or alcohol and other drug use.

The Pregnant Teens/Teen Parent Program has made effective use of a valuable resource-senior citizens. It also involves the parents of the teenage parents. The following components make up the core of the program:

- Teen Mother Support Group (mothers, 17 years old and under&-teenage mothers support each other while facing the new challenges of motherhood.

- Case Management Services-case managers are adult advocates for individual clients, *17* years old and younger, and arrange formal agreements among education, health care, and social service providers to link these services.

- Teen Father Support Group (fathers, 19 and under)----teen fathers support each other in meeting the new challenges of fatherhood.

- Volunteer Group (young parents and their parents)—participants organize social events.
- Young Parents Support Group (18- to 28-year-olds)—young parents provide support for each other as well as for teenage parents.
- Grandparent Support Group (parents of teenage mothers and young mothers)-participants provide support for teenage and young parents.
- Senior Citizens Group (participants 55 and older& senior citizens become mentors to teenage parents and pregnant teenagers and establish a network system for teenagers to obtain information to help them through their pregnancies.

The Pregnant Teens/Teen Parent Program is a project developed by the community and supported by CHD. It is coordinated by two professionals working almost full time. The professionals working on the project were recruited partly because they live and work in the community, so the problems they are working to correct are familiar. This closeness between provider and recipient enables the program to be particularly responsive to community needs.

A special portion of the program is the Tots and Toddlers Clothes and Things, a store started by young mothers to provide baby clothes and toys to mothers at discount rates. The store was started with very little money-$200 raised through a dance and the sale of cupcakes, popcorn, and dinners. Donations of baby items—new and used-poured in, and two sewing machines were donated to help repair donated clothes. For the young mothers, all of whom receive government assistance, starting and operating a business was a lesson in self-reliance.

Twenty
1989 Exemplary
Prevention Programs

"Helping Communities to Help Themselves"

PROJECT SUMMARIES

Sponsored by
National Association of State
Alcohol and Drug Abuse Directors

The National Prevention Network

Office for Substance Abuse Prevention
Alcohol, Drug Abuse, and
Mental Health Administration

March 1989

Twenty Exemplary Programs for Preventing Alcohol and Other Drug Abuse

In the fall of 1988, a national nomination process was used to identify 90 particularly effective alcohol and other drug abuse prevention programs. Early in 1989, a Project Advisory Committee, composed of representatives of national organizations and State Alcohol and Drug Agency representatives reviewed and rated all the submissions and selected ***20*** exemplary programs. Ten other programs were given honorable mention by the Committee.

This summary provides an overview of each of the selected programs. It also explains how States and national organizations nominated programs; how the Project Advisory Committee went about making the selections; and provides a look at the criteria for making the selections. The 20 selected programs are arranged in alphabetical order by State.

The project was supported by the Office for Substance Abuse Prevention (OSAP), the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and its subsidiary, the National Prevention Network (NPN).

Program Description

Tuba City, Arizona, FAS Prevention Program

This prevention program for Native American women sees FAS as a "family and community systems birth defect" that calls for intervention with the individual woman, her family and her community.

Chemical Addiction Course, U. of Arkansas

Using a non-traditional approach to prevention, this program trains and educates key impactors-pharmacy students who will act as unique professional and personal resources in their communities.

"Teens Are Concerned" of Arkansas

This program was started by a group of tenacious teens who wanted to take action on alcohol and other drug problems among their peers in spite of adult denial that the problems existed.

"Dare to be You" of Colorado

A primary prevention for youth, DARE to be You "clones" itself by helping six communities each year initiate services for their own residents.

Winyan Was'aka, Denver, Colorado

Recognizing that the woman is the heart of the American Indian community, this program promotes spiritual, emotional, and physical support for Native American women in the Denver, Colorado, area.

COPE of Brevard County, Florida

Using a variety of strategies to provide prevention services to the residents of Brevard County, Florida, this program shows clearly that a well-informed, dedicated parent organization can grow into an effective, comprehensive prevention agency that combines professional and volunteer strengths.

RICCA Prevention Services, Illinois

This multi-faceted program carries a potent prevention message to Western Illinois, and shows a refreshing willingness to share its failures, along with its successes, to contribute to the state of the art in prevention programming.

4-H CARES of Kansas

This program for members of 4-H Clubs in the State of Kansas emphasizes the ideas that all human life is valuable and that respect for self and others is a foundation for all human interaction.

The COPES Prevention Program-, Kentucky

With deep roots in both school- and community-based programs, COPES provides prevention services to all residents of Louisville and Jefferson County, Kentucky.

Peer Leader Program-CLIME of Maine

Working with teens in three public housing projects in Portland, Maine, this community-based program helps traditionally "hard-to-reach" youth become pro-active community leaders.

Roxbury, Massachusetts, Substance Abuse Prevention Program

This program for high-risk minority youth in Roxbury, Massachusetts, addresses factors that foster alcohol and other drug abuse and focuses on improving attitudes and knowledge about preventative health care.

BABES Curricula, Detroit, Michigan

Recognizing that there are no simple solutions to alcohol and other drug abuse, BABES links all of the systems within a community to create an environment that permits citizens to lead healthy, drug-free lives.

FAS Prevention Program, Lincoln, Nebraska

This nationally recognized. program provides comprehensive FAS prevention services to women of childbearing age in a 34-county area of Nebraska.

PROJECT CONNECT, New York

This prevention and intervention service for gay men and lesbian women in New York City makes effective use of established community linkages and networks.

Women's Alcohol and Drug Education Project, New York

This innovative project, the only one of its kind in the country, is assembling a model that will reach underserved women and their children across the country.

Citizens Against Substance Abuse (CASA), Cincinnati, Ohio

Starting as a task force organized by Cincinnati's Mayor, this coalition motivates and empowers communities to develop and implement prevention initiatives in their neighborhoods and support networks.

Licking County, Ohio, Alcoholism Prevention Program

Over its 13-year history, this program has evolved from an "information only" model to a multiple-mode delivery system based on the assumption that most human beings are capable of significant change.

Austin, Texas, "Adventure Alternatives" Program

Working with high-risk youth, this program blends experiential education that uses the environment as a teaching tool, with a client-centered counseling program.

Appleton, Wisconsin, School District Prevention Program

The Appleton Area School District meets student alcohol and other drug problems head-on by integrating prevention information and assistance into the daily life of every student.

Ozaukee County, Wisconsin, Prevention Consortium

The residents of Ozaukee County, Wisconsin, receive comprehensive prevention services from this catalytic consortium of parents, youth, business leaders and service providers that represent all segments of the community.

CRITERIA & PROCEDURES

Background material on the process used to select programs for recognition.

PROJECT ADVISORY COMMUNITY MEMBERS

TUBA CITY FAS PREVENTION PROGRAM

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CLIENTELE:

Pregnant women and their families in the Tuba City Service Unit of the U.S. Public Health Service Indian Hospital. The target population resides in the western half of the largest Indian reservation in the country, the Navajo. With an estimated population of 21,740, the Tuba City Service Unit is the scene of widespread poverty. The 1980 census found an average per capita income of $2,400. On the Navajo Reservation, studies have found that 5.9 out of 1,000 women of child-bearing age in the target group give birth to babies with Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE). The total target population of the Tuba City Service Unit consists of 25 to 30 highest risk women, their families, and their local community.

MAJOR SERVICES:

Participants in this program are referred by the Indian Health Service, the Navajo Tribe, local service providers, and criminal justice officials. Program services are based on a survey of the FAS-related attitudes and educational needs of the community. They are classified as follows:

- Individual services to high-risk pregnant women and mothers of FAS children. This includes case management, assessment, education counseling, referral and support services.
- Intervention, education, and counseling for participants' families. This service is coordinated with the Navajo Division of Social Work Child Protective Service.
- Training of service providers from such organizations and agencies as:
  - the Indian Health Service
  - the Navajo Tribe Office of Mental Health and Substance Abuse

— WIC

— Head Start

— Foster Grandparents

— representatives of community health and social service agencies, and school personnel.

- Community services, including presentations to community groups, case findings, and development and support of a community board that will continue FAS prevention activities.

The Program was initiated after local medical staff asked the Service Unit for a protocol on the management of intoxicated pregnant women. Needs assessment revealed that there were no FAS prevention activities available to the target population. Screening for alcohol use by pregnant women was not being done and no community education on FAS was in place. With technical assistance from experts at the Universities of Washington, New Mexico, and the Northern Arizona University, the project was initiated in 1988. Funded by the Indian Health Service, the program now operates as a part of the Community Health Services Department of the Indian Hospital's Tuba City Service Unit. Two Native American staff members who are fluent in Navajo and are "Natural Helpers" perform secondary, primary, and tertiary prevention activities.

With a primary goal of reducing the rate of FAS in the target population by 25 percent, the program has already provided a substantial base of services.

- 181 professional staff, including 34 from the Hospital, have been trained in FAS.
- 10 women have been referred to residential treatment.
- Of 11 women entering the program before their 3rd trimester of pregnancy, 7 (66 percent) have stopped drinking.
- November of 1988 was "FAS Awareness Month" throughout the Tuba City Service Unit.
- A screening mechanism was put into place using a Ten-Question Drinking History developed by Boston City Hospital. It is now used in the prenatal clinic. A protocol for assessment and follow-up of pregnant women who are using alcohol is in place.

This program is especially replicable in Native American communities. It was used as a model program at the 1988 Indian Health Service FAS Symposium in Tuscon, Arizona. The program's accomplishments were also presented to a national Conference on Native American Wellness and Sexuality in Phoenix, Arizona. The program would welcome studies on its replicability in other areas.

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CLIENTELE:

Students enrolled in the College of Pharmacy at the University of Arkansas for Medical Sciences. The population of pharmacy students includes about 50 to 100 students per year. In general they are reflective of the ethnic, cultural, and socioeconomic subgroups in the State. The class is primarily female and includes minorities, particularly Blacks.

MAJOR SERVICES:

This program is not, on the surface, a traditional prevention program. It is a course listed in the University catalogue as "Chemical Addiction (Pcol 5473)." It is a component of the required curriculum for graduation with a Bachelor of Science in Pharmacy.

The course is taught each year to seniors in the College of Pharmacy. Presented for three hours each week, the curriculum has two underlying foundations. The first is the knowledge that the "office" of a typical pharmacist is within the community. Indeed, the pharmacist is involved as much in the lifestyle and social interactions of the patient as in the medical aspects. Thus, the pharmacist is in an ideal position to **identify early signs of addictive disease.**

The second foundation is a recent Gallup poll finding that the public's esteem of the pharmacist as a professional is either first or second only to the clergy. With this trust and confidence, the pharmacist can significantly impact the progress of alcohol and other drug abuse in the patient.

The goals of the course are:

- To increase students' understanding and recognition of their own personal vulnerability to addictive disease.

- To educate students regarding the patterns of abuse of psychoactive drugs in our society as well as the onset, progression, diagnosis, treatment, prevention, and impact of addictive disease.
- To familiarize students with possible roles for pharmacists in this area and to prepare them to fulfill those roles.

In keeping with these goals, subject matter is approached from the sociological/ psychological viewpoint. As a part of the course, students are required to model the potential prevention roles of the pharmacist through preparation and delivery of two drug education presentations to school-aged youth. Thus, this population receives a significant secondary service of this project.

The development of this course was funded by the Arkansas Office on Alcohol and Drug Abuse Prevention, which also endowed a named professorship on alcohol and other drug abuse within the College of Pharmacy. Interest earned from this endowment, along with general college revenues, maintains and continues the course.

During calendar year 1986, the course was presented to two classes totalling 110 students. These students gave drug education presentations to 6,891 school-aged youngsters throughout the State of Arkansas.

Program evaluation has, to date, consisted mostly of pre- and post-course attitude surveys. A control group is used to control for intervening variables. Following the completion of the course, students have an increased knowledge of addictive disease and its impact on the family, a decrease in moralism toward addicted individuals, and increased optimism about the treatment and recovery process.

The program anticipates that every College of Pharmacy will replicate this course and include it in its required curriculum. For this reason, a description of the course was published in the leading journal covering educational issues in pharmacy. To date, several colleges have contacted the program for further developmental details.

TEENS ARE CONCERNED

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CLIENTELE:

Youth, aged 4 to 21, in Greene County, Arkansas. This rural community has a population of 30,274, 99 percent of whom are white. Most of the target group is enrolled in one of the county's six school districts.

MAJOR SERVICES:

Teens Are Concerned (TAC) is a comprehensive educational program designed to enhance and foster positive development of young people's feelings and skills. Its major services, all tailored to specific age groups, are:

- A one-day orientation training program for all new TAC members. The course covers alcohol and other drug abuse information, alternatives to use, verbal and non-verbal communication skills, problem-solving, authority, rules, self-esteem and peer pressure.
- Program presentations across the State by TAC members to youth groups and schools. These include puppet shows, skits and lecturettes.
- A billboard located on the major road in Paragould, Arkansas, for the past two years. The billboard reads, "Get High on Dreams, Not Drugs."
- Alcohol and other drug-free alternative activities such as an annual New Year's Eve party, trips, shopping sprees, dinners and Adventure River outings.
- Media campaigns on issues such as impaired driving and the dangers of alcohol and other drug use.
- Sponsorship of conferences, children's health fairs, and law enforcement programs.

TAC's history is one of tenacity and genuine concern. The program was started because a group of high school students lobbied the Greene County Volunteer Resource Council for help in dealing with alcohol and other drug problems among their peers. At a February 1984 meeting of the Council, called to discuss starting a prevention program, four people—two teachers and two students-attended. The teachers stated that there was no need for a program because there was no alcohol and other drug abuse problem in the schools, and the idea was dropped.

However, one of the teens disagreed strongly enough to take action. She organized a group of about 30 students who attended the next meeting of the Council with a strong message that. alcohol and other drugs were problems for the county's youth. As a result, the Council applied for and received a small grant from the Arkansas Office of Alcohol and Drug Abuse Prevention (AODAP).

Now associated with the Crowley's Ridge Development Council's Early Intervention Program, TAC has an Advisory Board of 20 adults and youth, representing business leaders, clergy, parents, school personnel and law enforcement officials. In 1986, the program received $1,500 from AODAP. The rest of its operating budget (about $4,000) was obtained through fund-raising activities and contributions.

Local media have been very supportive of TAC. One TV station has provided four PSAs and featured the program many times on its news broadcasts. Local papers often run news releases on TAC activities. And, the "Get High on Dreams" billboard is donated by a local industry. During the course of a year, the program provided direct services to 2,840 youth and community members. About 50,000 people were reached indirectly through two local TV stations, five newspapers, five radio stations, the billboard and 40 business marquees.

The program's widely distributed brochure fully describes its philosophy, theory, methods and procedures. TAC is also highlighted in a documentary tape, "Out of the Fast Lane," that is distributed to all educational cooperatives in the State by the Arkansas Education TV Network. To date, one school has established a TAC-type group that is in its first year of operation.

DARE TO BE YOU

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CLIENTELE:

This program is implemented in six communities in the State of Colorado each year. After conducting a local needs assessment, a sponsoring agency applies for the program through a competitive mini-proposal. Thus, the target population varies greatly from year to year. Communities served have been rural, suburban, and urban with populations ranging from primarily Caucasian to primarily Hispanic, Black, or Native American.

MAJOR SERVICES:

The DARE to be You project identifies, trains, and provides technical support for teams of volunteers from selected community organizations. This enables existing community resources to provide workshops to children, teens, peer helpers, parents and other adult caregivers. The goals of the program are:

- To enhance the development of healthy, functional adolescents and thereby prevent behavior problems.
- To create and reinforce a network of agencies in each target community with the mission of preventing problem behaviors in youth and to enable local groups to provide training in life skills and prevention.
- To provide continuing technical assistance and training to existing DARE to be You volunteers.

Available resources include:

- A training manual for community teams to use with 8- to 12-year-old youth, teens and community adults to provide activities and workshops.
- A guidance curriculum for middle school children.
- A Process for Health Care Providers.
- Cultural adaptations designed by cultural focal groups.

- A DARE to be You Peer Counciling Curriculum.

A new DARE to be You K-12 Substance Abuse School Curriculum is currently being tested.

The program was developed in 1979 as a collaborative effort between the Extension Service of Colorado State University and the State Health Department with funds from the Centers for Disease Control. The program's materials are designed to increase self-esteem, self-responsibility, decisionmaking, communication, and peer resistance skills. They also focus heavily on creating family support systems and positive community role models.

Participants have applied-the program's strategies and activities in everything from one-on-one counseling to high school assemblies; from training for summer youth employment workers to church youth groups; from juvenile diversion referral training for families to school guidance curriculum and leadership training classes. Summer support program coaches, out-of-school youth groups, after school care programs and many other agencies have adapted the program to reach their clients.

The program has also been used with high-risk populations such as Native American youth in summer employment programs, alternative school students, and youth referred by juvenile diversion programs.

In a 1986 followup, 85 percent of volunteers surveyed reported using the program with community youth or adult groups, many even after five years. In addition, the program has been implemented by several school districts using community volunteer teams and teen leaders. DARE to be You volunteers reach over 20,000 undupli-cated youth and adults each year. These persons receive an average of eight contact hours of programming.

The program's funding sources have included State and Federal agencies, fees for service, and Tribal grants.

A stringent evaluation study conducted during the first two years of the program documented that the program resulted in a 15 percent reduced onset of alcohol and tobacco use among 8- to 12-year-old participants. Statistically significant increases in decisionmaking, communication, and control skills were also documented.

Each year, a different component of the program is tested in the area of impact evaluation. Evaluation of the level of program use is conducted annually.

DARE to be You was designed to be replicated in diverse communities. The structure encourages local needs assessment and provides a flexible program that can be applied to meet a wide variety of community needs through many points of access. DARE to be You programs have been implemented through other sponsoring agencies in Oklahoma, Alabama, Virginia, New York, North Dakota, Indiana and New Mexico.

The program was recommended as a model prevention program in the National Initiative for Building Human Capital by the National Extension Service in 1988, the Colorado Action for Healthy People study group, the Colorado Adolescent Project in 1986, and the Centers for Disease Control in 1982.

WINYAN WAS'AKA

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CLIENTELE:

High-risk American Indian women over 18 years of age and their children. An education/support group for men is also provided. The largest concentration (20,000) of American Indian people in the State of Colorado is in the Denver Metropolitan area. Approximately 45 percent of these residents are members of the Sioux Tribes, 15 percent are Navajo, and 40 percent are from 55 other Tribes. Economically, these citizens are at the lower end of the spectrum, with low levels of education and employment. The target population also experiences high rates of homicide, accidental death, and child abuse. Their rates of alcohol and other drug abuse are very high. In fact, one in four deaths of American Indian women is caused by alcohol cirrhosis.

MAJOR SERVICES:

The cornerstone of Winyan Was'aka's services is community ownership. Its philosophy is to foster cooperation through involvement between and among women, build participant self-respect through contribution of talent and resources, and empower American Indian women individually and collectively to solve the problems they encounter in an urban environment. The services provided are:

- A 12-week education and support group for high-risk American Indian women over the age of 18.
- A 12-week education prevention program for high-risk children, aged 4 to 8, to develop coping skills and strengthen positive self-concept.
- Community forums in the Indian community that provide alcohol and other drug information and showcase exemplary American Indian programs.
- Twice-monthly support groups for "graduates" of the 12-hour weekly curriculum.
- Drug-free activities, both social and spiritual, that encompass traditional and contemporary events.

Winyan Was'aka, which means "strong women" in the Sioux language, was created in the spring of 1986 to address the stresses facing American Indian women in an urban environment. Initiated by Denver Indian Health and Family Services, Inc., the program focuses on the heart of the American Indian community and family—its women. By strengthening her positive attributes and skills, a woman is empowered to live a healthier life and influence her children, family, community and Tribe to do the same.

Winyan Was'aka is funded by the Alcohol and Drug Abuse Division of the Colorado Department of Health. Highly cost effective, the program reached 95 women and 30 children in 833 encounters during its first year-all on a $20,000 budget. Presentations and forums reached 500 other persons.

During its relatively short existence, Winyan Was'aka has achieved a high level of visibility and credibility. Program staff have been asked to provide technical assistance and training to other American Indian Tribes and invited to make presentations on the program to regional and State conferences and workshops. In addition, during 1986/87:

- Eleven women received 18 hours of facilitator training in drug and alcohol abuse prevention.
- Four 12-week groups of approximately 11 women each successfully completed the program.
- Approximately 25 women received other drug and alcohol counseling or were referred to other treatment services.
- Child care services were provided to 30 children whose mothers participated in the project.
- Approximately 150 family members received indirect services through community forums and alternative drug-free activities.
- Five thousand program brochures were distributed.

In addition, Ikce Wisasa, a men's educational and support group, was initiated in November of 1988.

The evaluation of the program examines a number of specific change factors: assertiveness, acceptance of one's self and others, motivation to pursue live goals, co-dependent relationships, and coping ability during major life transitions and less stressful times. Self reports from participants indicate that participants experience improvement in each of these areas. Pre- and post-administration of the Tennessee Self-Concept Scale also indicates increased self-esteem among all participants.

Winyan Was'aka **has, in effect, replicated itself through the initiation of the men's support group. The use of this primary prevention model with cultural specific values and customs enhances community ownership and the effectiveness of the program.**

COPE OF BREVARD, INC.

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CLIENTELE:

The population of 386,650 residents of Brevard County, Florida. A rapidly growing community, Brevard has a school-age population of 86,557 (23 percent). The overall population is 8.7 percent Black and 2 percent Hispanic. There are 13,416 children in Brevard below the poverty level, a significant number in a State with stringent eligibility requirements for public benefits.

MAJOR SERVICES:

Because COPE is a relatively small agency, its Board of Directors has set a limit of one new initiative per year as a way of maintaining high quality services. The partnership and financial support of community groups are important factors in new programs. In spite of this pattern of restrained growth, the program offers a wide range of services. These include:

- Information and awareness services, including an extensive resource library of print and video material, a speakers' bureau, a major annual drug prevention awareness campaign, and a quarterly newsletter distributed to COPE members and key decisionmakers in all county systems.
- Education and training programs, including alcohol and drug-free graduation parties, Just Say No clubs at schools, community centers and churches, parent peer groups and youth support groups.
- Direct prevention services, including information and referral, initial screening, an early intervention program for high-risk youth, and education and drug-free clubs for teens and their parents in high-risk neighborhoods.
- Advocacy for alcohol and other drug abuse prevention and community responsibility, an especially successful aspect of COPE's activities, including a 50-hour Community Intervention Team training course and regular networking with other groups and organizations concerned with alcohol and other drug abuse.

COPE began in 1979 as one of the nation's first local parent groups. Initially an all-volunteer organization, COPE established an initial goal to build a mandate for a K-12 drug education curriculum in the public schools. In pursuit of this goal, COPE initiated meetings with school administrators and followed up these efforts with a strong advocacy campaign aimed at the School Board in 1983. More recently, COPE advocated successfully for a student assistance program. Subsequent to this, COPE members actively participated in the selection of the curriculum, "Here's Looking at You, Two," still regarded as a national model for prevention education.

COPE's first professional staff member was hired in 1984. Celebrating its 10th anniversary this year, the program has achieved stability through a broad base of private and public funding and six full-time professional staff. Funding sources are varied and include the United Way, the Gannett Foundation, Brevard County, the State of Florida, and the U.S. Department of Education.

COPE is the only agency in Brevard exclusively committed to prevention. Its services and resources are available to the entire community free of charge. Examples of the program's accomplishments include:

- Distribution of about 20,000 pieces of prevention literature a year.
- Presentations to 7,500 to 10,000 individuals a year in about 200 public awareness programs.
- A mailing list of 800 individuals who receive COPE's quarterly newsletter.
- Drug- and alcohol-free graduation parties in 11 high schools (including all 10 public high schools), 25 Just Say No Clubs, 8 parent peer groups and a new initiative that has established a youth peer leadership group of 65 teens.
- Early intervention services to over 300 high-risk 4th and 5th graders in 15 schools.

During 1986, COPE provided direct services to 32,721 individuals. The program estimates that 100,000 members of the general population of Brevard were affected by its prevention activities.

Most elements of COPE's program exist in other agencies. The program's major success has been its ability as a small organization to work closely with many community systems. COPE's success shows clearly that a well-informed and committed parent organization can grow into an effective comprehensive prevention agency that combines professional and volunteer strengths.

RICCA PREVENTION SERVICES

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CLIENTELE:

The general population of a six-county area of Western Illinois, plus specific target groups of children, adolescents, parents, the elderly, ethnic minorities, and the developmentally delayed. The total population of this region is about 350,000. Ethnic minorities (Black, Hispanic, American Indian, and Asian American citizens) comprise about 4.3 percent of the region's residents. A mixture of urban, suburban, and rural communities, this part of Illinois has fallen on hard economic times in recent years.

MAJOR SERVICES:

RICCA Prevention Services, a department of the Rock Island County Council on Alcoholism, operates under a broad community development model that uses five prevention strategies (information, life-skills, training of impactors, alternatives, and social policy change). The major services of the program are:

- School-based activities, including:
  - prevention in-service training for classroom teachers
  - training and support in establishing student assistance programs
  - development and evaluation of pilot prevention curricula for classroom application
  - drug and alcohol education presentations to augment existing materials and curricula
  - organization of active positive peer support groups
  - comprehensive AIDS prevention programming for students, teachers, parents, administrators, and school boards.
- Community-based activities, including:

— a series of four prevention training sessions offered to community groups to build independent prevention capability

— parent network'organizations that enhance development and support of community-based prevention programs

— youth organized activities to provide alternatives and develop prevention skills among youth.

- Public education and information activities, including:

— development and dissemination of PSAs that both increase awareness of alcohol and other drug dangers and support drug-free alternatives and activities

— education of local and regional politicians to increase their knowledge and commitment to continued reduction of alcohol and other drug abuse.

RICCA has provided prevention services to the target region for about 12 years, gradually increasing the numbers of strategies and the size of its target audience. In the late seventies, the program began to work with youth; other groups served by RICCA since then include children of alcoholics, public housing residents, and teachers of rural business and special education classes. RICCA's prevention department has a full-time staff of five professionals.

The program's primary funding source is the Illinois Department of Alcoholism and Substance Abuse. Substantial financial support is also provided by United Way and the local mental health board.

The breadth of RICCA's activities has resulted in significant contact with the full range of regional residents. In 1986, the program:

- Provided direct classroom presentations to 41,728 students.
- Reached 5,211 parents through training, networking, and presentations.
- Trained 1,315 classroom teachers in curricula, alcohol and other drug abuse, prevention, and supportive classrooms.
- Trained 1,341 youth in leadership, prevention of alcohol and other drug abuse, and team-building.
- Reached 721 elderly people with presentations on topics such as prescription drugs, alcoholism and mentoring of young people.
- Made alcohol and other drug presentations to 5,296 business persons and employers.
- Made alcohol and other drug abuse presentations to 87 church groups, 15 law enforcement groups, and 37 groups of medical professionals.
- Disseminated about 6,000 pieces of prevention literature and coordinated three major media campaigns that reached about 200,000 people.

RICCA uses both outcome and impact evaluation to improve the program's effectiveness and responsiveness to community needs. For example, data that indicated

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minimal long-term behavior change as a result of traditional prevention services have resulted in the development of dosage intensive, skill-focused materials for classroom and community groups. The impact of these activities is now being evaluated.

The program places a high priority on the testing, documentation, and publication of the results of its activities and programs. As the program itself states, 'Whether programming fails miserably or provides glowing results is not essentially the . . . issue. . ..The key issue is to provide evidence about what can work and what cannot and why it can or cannot." This refreshing attitude results in a valuable contribution to the state of the art of prevention efforts nationwide.

4-H CARES OF KANSAS

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CLIENTELE:

Youth, aged 7-9 years. Older youth are actively involved as tutors, and parents also participate. This pilot project involves 1,250 young people and 400 adult leaders and parents. About 87 percent of 4-H members in Kansas are white; 8 percent are Black, and 3 percent are Hispanic. Only one quarter of these youth live on farms; about one third live in cities of over 50,000 residents.

MAJOR SERVICES:

4-H CARES is a comprehensive health and wellness curriculum that takes the best of several drug and alcohol education programs, adds some new twists, creates some new activities, and is adapted to a youth club meeting setting. It provides a complete program, from get-acquainted activities through recreation. The core activities of the program are:

- Ten one-hour lessons taught by volunteer adults and teen leaders to elementary aged children in local youth groups.
- Experiential, interactive learning activities focused on building self-esteem, communication skills, decisionmaking, peer pressure, and influences to use drugs.
- Recreational activities that reinforce success, cooperative learning, and creative problem solving.
- Audio and visual aids that complement the curriculum and emphasize feeling OK about who you are and resisting other drug and alcohol use.
- Individual journals kept by young participants to help them reflect on the importance to them of each lesson and the insights they have gained.

In the winter and spring of 1984 and 1985, the agency surveyed 4-H and other teens in Kansas City on such topics as attitudes about self, drug use, and knowledge about alcohol and other drug dependency. The results indicated that 4-H

youth were relatively uninformed on a number of levels when compared to their Kansas City counterparts. The agency realized that it had a real opportunity to provide a prevention education program to 4-H youth who were evidently not receiving such services from other organizations. Thus, from 1987 to 1988, an interdisciplinary team designed ***4-H*** CARES, using the best of the material available in existing curricula and their understanding of the specific needs and concerns of elementary aged 4-H youth.

4-H CARES is funded by the Kansas 4-H Foundation through non-restricted donations and a special grant. The work of the design team of 4-H State and county **staff is** also contributed.

More than 85 adult and youth leaders from 47 4-H clubs across the State of Kansas were trained in two-day intensive workshops that took participants through each of the 10 lesson plans. This established the theoretical basis for 4-H CARES. In September of 1988, clubs began using the 4-H CARES material on a pilot basis.

The program emphasizes teaching young people that all human life is valuable and that respect and care for self and others is a foundation for all human interaction. It was designed on the belief that young people must be assisted to develop skills for living. Rather than teach youth to "just say no," 4-H CARES aims to teach them how to say no, how to affirm their beliefs and values, and why this should be done.

As a pilot project, 4-H CARES plans a variety of evaluation activities. These include pre/post-tests designed to measure self-esteem, self concept, decisionmaking skills, and perceived levels of alcohol and other drug use by self and peers.

The program is being used by other youth groups. It can be replicated by any group of young people of elementary age who meet in regular intervals for at least 10 hours. The time frame in which the program can be conducted is very flexible.

THE COPES PREVENTION PROGRAM

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CLIENTELE:

All residents of Louisville and Jefferson County, Kentucky, This population of 685,000 is about 83 percent white and 16 percent Black. The program notes that "mint juleps, bourbon whiskey, beer and tobacco products play a very important role in the overall culture . . . of Louisville and Jefferson County." AA, Al-Anon, and Al-Ateen are also growing components of these communities.

MAJOR SERVICES:

The Council on Prevention and Education: Substances (COPES), which is managed by a community board, is very involved in service, education, religion, criminal justice, and media networks in its community. Its major services include, but are not limited to:

- Teacher training on the use of K-12 prevention curricula.
- Ongoing curriculum refinement.
- Consultation to such school-based programs as student assistance and peer leader training programs.
- Core trainings that promote prevention programming in the community.
- Agency training in prevention program development and implementation.
- University courses on prevention for pre-service teachers.
- Consultation to numerous service organizations.
- Development and coordination of media campaigns.
- Planning and execution of the Teen Leadership Conference.
- Prevention training for the U.S. Army at Fort Knox.

COPES began as a tentative program of an independent school board concerned with inhalant abuse among its students. Initially an informational activity for students, the program quickly recognized the need to broaden its scope to the community and to provide more than simple educational approaches. Thus COPES evolved naturally to include the widening circle of influences at work in the community.

COPES was incorporated in 1981 and was able to obtain significant financial support from both Jefferson County and the City of Louisville. The program has also developed a private contribution base and received a number of Federal grants. One clear measure of COPES professionalism and expertise is the willingness of local business and industry to contract with the program for prevention consultation services.

During 1987, COPES provided direct services to 6,187 individuals. Examples of service delivery activity are:

- 285 school teachers received over 12 hours of in-service training.
- Over 170 parents received 16 hours of training in working with their children.
- Over 120 students were trained as peer leaders in more than 6 schools.
- Over 245 professionals completed a 15-hour prevention training seminar.
- 650 people received alcohol and other drug information and screening; 102 were referred for alcohol and other drug abuse assessment.
- Alcohol and other drug abuse consultation with major college sports teams including consultation and training to athletes, coaches, trainers, and administrators.

The program estimates that approximately 540,000 people were reached through mass media messages and other indirect services.

COPES employs a variety of evaluation instruments and activities. Sophisticated pre- and post-tests have been developed for some programs. All of COPES activities are subjected to process and outcome evaluation and subjective participant feedback. School-based programs are assessed for their impact. For example, the number of students referred for services as children of alcoholic parents has been measured and has increased in those schools where COPES' teacher training and classroom curricula have been used.

All of COPES' programs can be replicated. Several of them are locally adapted replications of nationally recognized programs. Procedural manuals have been written for staff training and development. The program's growth and activities have been fully documented throughout its existence.

PEER LEADER PROGRAM

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CLIENTELE:

The teenaged residents of three large Public Family Housing Projects in the City of Portland, Maine. These neighborhoods are essentially locked in extreme poverty. Cultural experience stems from severe environmental deprivation, and from the crippling problems of alcoholism, and sexual and physical abuse. The major sources of income are Aid to Families with Dependent Children, Supplemental Security Income, and unemployment compensation. Children under 20 are found in 320 of these families.

MAJOR SERVICES:

The Peer Leadership Program involves teens who are often classified at "hard to reach" or "difficult" by traditional service systems in a pro-active outreach and prevention program. Its core activities are:

- A two- and one-half day training retreat that focuses on prevention of alcohol and other drug abuse and teen pregnancy, development of helping skills, and referral information.
- Weekly meetings that continue to build leadership skills through workshops and event planning.
- Other drug- and alcohol-free activities such as dances, beach trips, and movies.
- Exchange of ideas and expertise between Peer Leaders and adult community leaders.
- A media campaign that promotes community awareness of the program.

In 1985, a United Way needs assessment identified alcohol and other drug abuse as among the five most serious problems on a list of 40 issues facing the Portland

community. This finding was supported by a subsequent independent survey by the program's sponsor, the Community Leadership Institute of Maine (CLIME). The program was initiated in the fall of 1987 as a joint effort of the local housing authority, the Portland business community, local family tenant associations, service providers, the municipality of Portland and CLIME. It is based on the nationally recognized Natural Helpers Program and on social science research on the importance of natural helping networks in high-risk neighborhoods.

The program's funding base includes monies from the State of Maine, the city of Portland, United Way, several foundations, and private donations.

Teens are dominant in the program's decisionmaking process. Peer Leaders designed survey instruments and the retreat workshop and participated in data collection. They also evaluate the program and refine it to tailor activities to the issues facing their turbulent neighborhoods. During 1987, the program:

- Trained 20 Peer Leaders, selected because their names surfaced repeatedly in community surveys as someone other teens would turn to for help.
- Sponsored an other drug- and alcohol-free dance for 75 teens.
- Assisted 200 to 300 hundred teens with information and referral on such problems as alcohol and other drug abuse, teen pregnancy, suicide, and family and peer conflicts.

During 1988, 13 Peer Leaders attended an International Youth Leadership Conference in Washington, D.C. Staff and Peer Leaders raised $8,000 to finance the trip. As recently as February of 1989, the program was recognized by the U.S. Department of Housing and Urban Development.

The program's evaluation techniques include pre- and post-testing, changes in school performance and attendance, weekly feedback from Peer Leaders and community members, and questionnaires administered to policymakers. Some outcomes indicated by evaluation findings to date are:

- Arousal of interest among teens and adults in the community.
- Increased adult involvement in the program.
- Increased input by the community in the delivery of services.
- Improvement of Peer Leader skills in leadership, interpersonal relationships, and cooperation.
- Successful intervention by Peer Leaders in the lives of teens who were abusing alcohol and other drugs, suicidal, or experiencing family problems.
- Improved school performance and increased community service among Peer Leaders.

The Peer Leader Program can be adapted to the needs of other communities without threatening the integrity of the model. Successful duplication depends on establishing community trust, developing networks and linkages and, most importantly, the inclusion of teens in program planning, implementation, and evaluation.

ROXBURY SUBSTANCE ABUSE PREVENTION PROGRAM

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STATE PREVENTION COORDINATOR:
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CLIENTELE:

High-risk youth (aged 10 to 21) in the Roxbury/North Dorchester area of Boston, Massachusetts. This is a predominantly low-income minority community with a disproportionate level of major health problems. These include infant mortality, teen pregnancy, alcohol and other drug abuse, AIDS, homocides and suicides. Eighty percent of the targeted youth will probably not complete high school. Thus, they are facing multiple-risk factors for use. of alcohol and other drugs.

MAJOR SERVICES:

Operated by the Mental Social Health Unit of the Roxbury Comprehensive Community Health Center, the Roxbury Substance Abuse Prevention Program (SAPP) offers an integrated, collaborative approach to prevention, intervention, and evaluation services for the target population. The Mental Social Health Unit is able to provide immediate treatment services to youth and families in need of them. The major services of SAPP are:

- Educational services, including:
  - 8- to 10-session educational groups for parents and key community members
  - 12 educational classes for elementary, middle, and high school students, using age-appropriate material
  - dissemination of educational materials such as age-appropriate brochures, posters, and pamphlets
  - tenant orientation and ongoing educational forums for families living in subsidized housing developments

- Training services for professionals (teachers, counselors, social workers, clergy, housing managers) parents and teen peer prevention specialists on:
  - identification of troubled youth and those at risk for alcohol and other drug abuse, early sexual activity, or family problems
  - knowledge of referral resources available to such youth
  - crisis management and intervention with troubled youth
  - for peer prevention specialists, additional training in alcohol and other drug abuse, communication skills, leadership skills, and SAPP resources.
- Intervention services provided by counselors who offer screening assessments of youth and families, individual counseling and-support groups for children of alcohol and other drug abusers.

In providing these services, the SAPP has established effective collaborative relationships with local schools, youth service organizations, churches, and social service and public housing agencies.

The SAPP was developed to address gaps in available prevention and intervention services within the Roxbury community and in the collaboration of agencies dealing with high-risk youth. Funded by a grant from the U.S. Office for Substance Abuse Prevention, the program has been in operation for about two years. During that time, the SAPP has designed curricula to train youth, parents, and key community leaders in prevention skills. The people who have completed this training now work with SAPP staff in schools, religious and community settings, providing prevention information and education.

As of the end of 1988, the program had provided direct services (public education forums, training, health fairs, clinical intervention) to 612 individuals. The SAPP's indirect services (media campaigns and material dissemination) had reached an additional 5,500 members of the Roxbury community.

The program's evaluation activities result in both process and outcome data. Process notes on educational sessions, staff discussions, and network linkages are maintained by all staff. Outcome is measured through questionnaires administered to recipients of education and training services. The goal of these activities is to elicit both qualitative and quantitative information that will demonstrate the value of the program. The Final Evaluation Report on the SAPP will be available in August of 1989.

BABES CURRICULA, DETROIT, MICHIGAN

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Beginning Alcohol and Addictions
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CLIENTELE:

Pre-school through 12th grade students nationwide. The program is designed to capture the attention, imagination, and creativity of the total community—individuals, families, social and religious organizations, schools, business and government-in an effort to combat alcohol and other drug abuse.

MAJOR SERVICES:

The BABESWORLD views alcohol and other drug abuse prevention as a part of broader generic health promotion and disease prevention efforts. It is designed to foster the development of communities where all residents, especially children, feel safe, loved and protected from alcohol and other drug abuse. It also facilitates public/private collaboration in sharing responsibility and providing resources. This is done through a variety of curricula tailored for the various segments of the BABES community. These include:

- BABES in the School, a broad-based curriculum designed to teach general life and cognitive skills. Comprised of seven individual sessions, the curriculum is enlivened by seven puppet characters with personalities that represent various prevention concepts. Modules have been tailored for age groups 1-1/2 to 3, 3 to 8, 9 to 13, and 14 to 18.
- BABES and the Family provides prevention techniques to parents with emphasis on development of positive parenting skills. It uses the basic BABES characters and their parents.
- BABES for Clinicians is especially for use by therapists. One module is available for family work and another is for very young children from alcohol and other drug abusing families in group therapy.

- Building a BABES Community is a 6-module package designed to teach an interested community how to organize itself to combat alcohol and other drug abuse. The modules target government officials, business and church leaders, social service agencies and the media. A Community Action Plan has also been developed to assist prevention efforts.

Starting as the Beginning Alcohol and Addictions Basic Education Studies course in 1979, this primary prevention program is now reaching more than 1 million children in 40 States and 4 foreign countries each year. The program provides training and technical assistance to communities interested in creating a BABESWORLD of their own.

Funded by material sales and training fees, BABESWORLD works through local groups known as BABES Godparents—local organizations designed to coordinate and enhance existing alcohol and other drug abuse prevention efforts by using the BABES curricula within their communities. There are currently eight Godparent organizations nationwide representing diverse, multi-ethnic populations.

All participants in BABES curricula are given pre- and post-tests. Training participants also complete evaluation forms. BABESWORLD reviews these documents to maintain quality and to modify and improve the program.

BABESWORLD has also been subjected to a range of program evaluation studies. These have resulted in such findings as clearly observed behavior change in elementary students and mastery of the BABES subject matter by 8- and 9-year-olds.

The entire BABESWORLD program is based on its replicability. BABESWORLD has developed several methods of ensuring that the program can be used throughout the United States. These include:

- Development of grade and culture specific materials.
- Training of BABES presenters.
- Constant program evaluation.
- Monitoring and enhancement of the BABES Godparents organizations.

The program has recently received funding from the U.S. Office for Substance Abuse Prevention to market the Building a BABES Community program.

FAS PREVENTION PROGRAM

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CLIENTELE:

Women of child-bearing age in a IS-county area in Southeast Nebraska and another two-county area that includes Omaha. Services are also targeted to lay persons, health care professionals and specific groups of high-risk women. The service area contains two major urban areas (Omaha and Lincoln), and also comprises a number of rural communities.

MAJOR SERVICES:

The Fetal Alcohol Syndrome/Effects (FAS/FAE) Prevention Program is operated by the Lincoln Council on Alcoholism and Drugs, Inc. Its ultimate aim is to decrease the number of new FAS/FAE cases and to create awareness that consumption of alcohol during pregnancy can have negative effects on the unborn baby. To this end, the program provides primary, secondary, and tertiary prevention services.

- Primary prevention services are:
  - teacher training on use of a FAS prevention curriculum
  - public information through mass media campaigns, PSAs, and distribution of written material to agencies and organizations that serve women
  - community workshops for health and human service professionals, including special sessions for physicians
  - provision of updated information to nursing schools for use in curricula.
- Secondary prevention services are:
  - professional education and consultation
  - use of a screening questionnaire to evaluate women's alcohol and other drug use

— assistance in intervention and referral.

- Tertiary prevention services are:
  - — referral, assistance and information for families and individuals with affected children and to alcohol and other drug abusing women
  - — a volunteer network to support mothers of affected children
  - — educational support groups provided to treatment centers and outpatient programs.

Each prevention level is applied to the various stages of the maternal-child health care continuum-preconception, prenatal, intrapartum, and postnatal.

The FAS/FAE Prevention Program was initiated as a pilot project in 1984 by the Lincoln Council. Since then, it has expanded into the Omaha area and has also been replicated in the ll-county Nebraska panhandle. These expanded efforts have built on experience and emphasized those activities that have proven to be the most effective.

The program is assisted by a FAS Advisory Board that includes representatives from agencies focused on mental retardation, maternal and child health, chemical dependency, and developmental disabilities. Other human service organizations, the University of Nebraska, area hospitals, and voluntary groups are also represented. Volunteer services are provided by women with affected children and other concerned citizens. Program funds come from a Federal maternal and Child Health Block Grant through the Nebraska Department of Health.

During fiscal year '87-88, the program:

- Provided direct services (consultation and referral) to 142 clients.
- Provided educational and training services to 6,261 individuals.
- Reached over 320,000 people through media campaigns and public displays.
- Distributed about 45,500 pieces of literature.

The program uses both process and impact evaluation techniques. Impact evaluation includes pre- and post-testing of training participants. Data are also collected from WIC clinics on the results of the health questionnaire completed by all prenatal clients. Data on the number of FAS/FAE cases are not available due to lack of both expertise in diagnosis and a comprehensive reporting system.

Pre- and post-test scores show consistent improvement. Program evaluations by participants have also been very positive, totalling an average of 9.05 out of 10 possible points. The health questionnaire reveals that 7.7 percent of the 981 respondents showed risk or symptoms of alcohol abuse or dependence.

The project has been replicated in two other parts of the State. It was cited as a model program in the fall, 1985, edition of *Alcohol, Health and Research World.* In the summer of 1986, it received an award from the Department of Health and Human Services as one of Nebraska's Outstanding Health Promotion Programs. It also received the Prevention and Educational Commendation Award from the National Council on Alcoholism.

PROJECT CONNECT

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CLIENTELE:

Lesbian women and gay men in the Greater New York City area. This culturally diverse population is at high risk of alcohol abuse. It is estimated that about 1 million gay persons reside in the metropolitan area. While demographic statistics are not available, affiliated organizations include Hispanic, Italian, Black and handicapped groups as well as a wide range of professionals.

MAJOR SERVICES:

The services of Project Connect fall into two categories:

- Direct prevention and early intervention services
  - telephone referral and information available from 9:00 a.m. to 11:00 p.m. on weekdays
  - individual assessment and referral
  - short-term motivational help services
  - lo-week psychoeducational support groups for people trying to get or stay sober or clean, HIV-positive people, people in a relationship with an addicted person, people in relapse or just coming out of relapse, and people in recovery for a while who want to work toward personal and spiritual growth.
- Community education
  - development and dissemination of educational materials to community groups
  - presentations to gay and lesbian organizations
  - appearances on gay cable TV to address alcohol use and abuse issues
  - production of a prevention video

— a special educational symposium on a variety of women's health issues.

The gay community has long been aware of the need for gay-sensitive and gay-affirmative alcohol and other drug abuse prevention and treatment services. In response to this need, and to increased public demand, the Lesbian and Gay Community Services Center in New York City planned and initiated Project Connect with a grant from the New York State Division of Alcoholism and Alcohol Abuse. Started in January of 1988, the program operates from the Center, which is the major resource for gay and lesbian social, recreational, educational, cultural and health activities and services in the Greater New York City area.

Since its inception, the program has expanded its funding base to include private donations, in-kind contributions and volunteer provision of professional services valued at $18,000 per year.

Project Connect, although relatively young, has documented significant contact with its target population. From February through October of 1988, the program provided:

- Individual direct services to 590 people.
- Psychoeducational group services to 100 people.
- Telephone information and referral services to 1,800 people.
- Twenty-two community education events.
- Thirty-seven professional education presentations.

The program has established linkages with a wide variety of professional and community resources, including community health services, private group therapy practices, and public and private providers of alcoholism and drug addiction services. Special effort has been made to reach out to Black and Hispanic gay people living in the outer boroughs of the City.

Project Connect collects demographic and service data on each person served, maintains confidential records on clients, and obtains participant feedback on program services. While the program is too new for a meaningful analysis of outcome data, process data indicate that the program's services have enabled many gay men and lesbian women to address alcohol and other drug problems in a proactive way. Volunteers welcome the opportunity to contribute to their community and to receive training and experience with the gay population. Referral sources report that the majority of Project Connect referrals have effectively engaged in treatment.

Project Connect has already received and responded to requests for assistance in developing similar programs in other communities. The Project Connect model could be readily replicated in communities with a gay-identified organization that is able to forge links with a range of gay-affirmative community resources.

WOMEN'S ALCOHOL AND DRUG EDUCATION PROJECT

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CLIENTELE:

Underserved Black, Hispanic, and low-income women and their children. Designed for eventual national replication, the model program is being tested in women's centers in New York City; Buffalo, New York; Ann Arbor, Michigan; El Paso, Texas; and Fort Wayne, Indiana. These centers are community- or campus-based multi-service organizations. The majority of women served are displaced homemakers, welfare recipients, or single parent heads of households with an average income under the poverty level. Many are teenagers. They are often battered, sexually abused, and unemployed or underemployed.

MAJOR SERVICES:

It is estimated that there are about 4,500 women's centers and other women's service organizations in the United States. The program taps into this largely ignored network as a vehicle through which alcohol and other drug education services may be provided in service settings without the barriers often encountered by female clients in traditional programs. Thus, its major services are actually a series of model program activities currently being completed in pilot and field test sites.

- Training of staff in women's centers to provide them with the information, awareness, sensitivity, and strategies to implement the model program.
- Hiring and training of an alcohol and other drug educator who will coordinate all education, prevention, intervention, and referral activities of the center. This professional's tasks will include:
  - ongoing staff training and development
  - establishing an alcohol and other drug component in the center's information and referral services
  - training and support of intake workers in identifying women with alcohol and other drug problems

infusion of alcohol and other drug information into the center's ongoing support groups

initiation of at least one new support group on the relationship between alcohol and other drug problems and the center's focus (e.g., job readiness, parenting, etc.)

provision of 12-topic alcohol and other drug education classes to center clients

provision of information on alcohol and other drugs through center outreach activities

establishment of an alcohol and other drug Community Liaison Committee

referral of a specified number of women to treatment or counseling services

establishing AA, NA, or Al-Anon groups at the center as required

advocacy for the development of recovery or co-dependent women's support groups as needed or requested.

The ultimate product of the program will be a *Guide* that explains how to establish such a program in women's centers and other women's organizations, The *Guide* will be published in 1990 by Scarecrow Press under the Alliance imprint and marketed to women's centers, colleges, libraries, and other organizations nationwide.

In 1987, the Women's Action Alliance established the program because of the lack of programs and services specifically designed to reach women with alcohol and other drug information. The concept was developed during a series of meetings between Alliance staff and professionals from the prevention and treatment fields. Program design was also based on the results of a questionnaire distributed at the 1986 Founding Convention of the National Association of Women's Centers. Responses indicated a need for alcohol and other drug programs in the centers, The Alliance also assembled a prestigious National Advisory Board to assist in the development of the program and the *Guide*.

About 60 percent of the project is funded by the New York State Division of Alcoholism and Alcohol Abuse. The remaining funds are contributed by foundations and corporations.

During 1987, the program provided direct services to 3,200 individuals in its three pilot test sites: Medgar Evers college, the Hispanic Women's Center, and Everywoman Opportunity Center. An additional 13,500 people received educational, referral, and training services.

Using an extensive set of evaluation instruments, the program monitors both staff attitudes, knowledge and perceptions, and the outcome of project activities in the individual centers. Evaluation instruments include pre- and post-tests, and an interview that gathers baseline data about the centers before the program is initiated

and post-program closing interviews. Centers use monthly tally sheets on target population use of program services.

The replication of the program is the driving force behind this project. At each stage of this effort, the staff has taken care to assess changes and measure their applicability to women's centers and other community-based service organizations. The *Guide* will be available in English. Some accompanying materials will be available in Spanish.

CITIZENS AGAINST SUBSTANCE ABUSE (CASA)

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CLIENTELE:

Residents of Hamilton County, Ohio. The total population is about 852,100, 8.8 percent of whom are of Black heritage. People under 18 comprise 26 percent of County residents and 27 percent are over 50. About 20 percent of County households have incomes below $10,000 and the unemployment rate in the area is 5.7 percent.

MAJOR SERVICES:

Citizens Against Substance Abuse (CASA) is a coalition of parents, teens, government officials, and service providers. Recognizing that the potential for impact is heightened if more than one approach is used and more than one system is involved, the program practices a multi-dimensional approach to alcohol and other drug abuse prevention. Filtering national and State initiatives to the local level, the program emphasizes involvement by community groups within which the programming is to occur. These groups include churches, schools, community councils, parents, professionals, and policymakers.

CASA's major services can be summarized as follows:

- Measuring the prevalence of alcohol and other drug use and abuse among 7th to 12th grade students in Hamilton County schools.
- Promoting primary prevention activities in the Greater Cincinnati area through such activities as:
  - organizing parent groups
  - facilitating the formation and support of TEEN CASA groups, Just Say No Clubs, and school-based peer counseling programs
  - providing drug-free activities for youth aged 13 to 19

— conducting workshops for parents, teachers, police officers, and media specialists.

- Building networks among treatment centers, schools, social service organizations, and other community resources through such vehicles as a local resource directory and a CASA newsletter.
- Increasing public awareness of alcohol and other drug abuse and effective prevention strategies through PSAs, speakers, and a local drug awareness week.
- Examining local needs related to alcohol and other drug abuse that CASA may choose to address, including employee assistance programs, treatment services for the medically indigent, school-based K-12 prevention education, court-based intervention programs, treatment alternatives, and teen court.

In 1986, Cincinnati Mayor Charles Luken established a special initiative task force on alcohol and other drug abuse. Since that time, the task force has evolved into an incorporated non-profit voluntary organization housed in City Hall. This process resulted primarily from the overwhelming response of over 200 concerned citizens and from the involvement of the Mayor, City Hall, and a prominent community leader. Since September of 1986, CASA's volunteer roster has grown from 200 to 1,600.

The program is funded by an annual fundraiser, donations for specific projects and grants from local corporations, foundations, and private citizens. Staff costs and space are contributed by City Hall.

During 1987, CASA volunteers donated more than 15,000 hours to the program. A total of 7,412 persons participated in direct presentations. General awareness activities reached more than 160,500 persons living the Greater Cincinnati area. CASA also sponsored skill-building workshops and drug-free activities for youth, conducted a county-wide survey of 40,000 school students, and increased the number of Just Say No Clubs from 10 to 160. This is a small sample of CASA's activities on behalf of its community.

CASA uses process and outcome evaluation strategies. While process data are collected through program reporting sheets, outcome evaluation is in the planning stage. Program outcome will be measured using the county-wide school survey of 7th through 12th graders as a baseline. This survey will be readministered every 2 years to track shifts in attitudes, knowledge, and alcohol and other drug use.

The program is currently being piloted in Dayton, Ohio, and Paducah, Kentucky. CASA staff provide technical assistance to both pilot groups. It is expected that the CASA structure and function can be replicated in other areas.

LICKING COUNTY ALCOHOLISM PREVENTION PROGRAM

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CLIENTELE:

High-risk youth, youth in general, senior citizens, minorities and the handicapped. Of the 129,000 people living in Licking County, 30.53 percent are under 18 years of age and 19.93 percent are over 55 years old. Fewer than 2 percent of these citizens are Black. This is a rural community with a predominantly blue-collar population.

MAJOR SERVICES:

The services of the Licking County Alcoholism Prevention Program (LAPP) are designed to disseminate broad-based multiple prevention strategies throughout the community. These services include:

- A comprehensive school-based program that includes
  - Teens in Action, a county-wide organization of high school students who support a drug-free lifestyle
  - insight groups at schools with large numbers of high-risk youth
  - support groups for children of alcohol- and drug-abusing parents
  - K-12 prevention presentation in all county classrooms.
- An annual Alcohol Awareness Week that provides activities for all ages, including a corporate-sponsored 5-mile run fundraiser, a non-alcoholic bar tended by county, dignitaries, and a family night banquet honoring local volunteers, professionals, and winners of a 5th and 6th grade poster contest.
- An annual peer leadership training conference for students from all of the County's high schools. Participants are expected to use the information they learn on such topics as drug use, family, and sexuality, to exert positive influences on their peers at school.

A similar conference is conducted for 5th and 6th graders from all county elementary schools.

- A culturally specific program, called Teens Teaming Together, for minority youth.
- Awareness programs for women and senior citizens and their service providers, and an information and referral service that helps link participants to positive alternatives to alcohol and prescription drugs.

LAPP was founded in 1968 by several concerned citizens working in cooperation with the Community Mental Health Board and the United Way. Initially an information and referral service, the program began with the "information only" approach to prevention that was so popular in 1960s. Since then, it has evolved into a comprehensive, multiple strategy prevention system.

Multiple funding is a part of LAPPS's deliberate strategy to promote the continuity of its services. Its primary funding sources are the Central Ohio Regional Council on Alcoholism, Ohio's Division of Alcohol Abuse and Alcoholism Recovery, the Community Mental Health Board of Licking and Knox Counties, the United Way, and private donations. In 1987, the program was awarded an OSAP grant that allowed the agency to focus services on high-risk youth.

During 1986, LAPP provided prevention presentations to 17,000 residents of Licking County. Forty high school students and 45 5th and 6th graders completed peer leadership conferences. And, almost 2,000 people participated in Alcohol Awareness Week. This level of community support is the major reason that LAPP has met or exceeded all of its prevention objectives for the past six years. Pre- and post-tests and participant feedback indicate positive attitude change, growth in knowledge and achievement of the objectives of all key program events. Data and observations from the juvenile court, the Regional Council on Alcoholism, and the medical examiner all suggest that alcohol and other drug problems among youth have been reduced in the target community. Many educators, service providers, and criminal justice officials believe that the LAPP has played a significant role in this positive trend.

LAPP's theoretical and methodological components could be used as a framework for a community-wide program in other areas. However, LAPP recognizes that its success lies in its responsiveness to community needs. Therefore, the program should be adjusted to reflect a local needs assessment before it is replicated.

ADVENTURE ALTERNATIVES

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CLIENTELE:

Youth aged 9 to 17 who are at risk for alcohol and other drug abuse. The overall population of the service area is over 500,000. Approximately 22 percent of program clients are Black, 51 percent are Anglo, and 27 percent are Hispanic. The male/female ratio is about 3 to 2. Target youth are wary of traditional counseling and are often unable to pay for services. They suffer from low self-esteem, and are prone to associate with alcohol and other drug abusers, or come from alcohol and other drug abusing families.

MAJOR SERVICES:

Operated by the Austin Wilderness Counseling Service, the Adventure Alternatives Program is made up of three components:

- Professional counseling in individual, group, and family settings. Specific services include:
  - admission screenings and social histories that result in the development of individual service plans
  - maintenance of accurate and complete client records
  - follow-up to support group members.
- Alternative activities that combine counseling with carefully structured outdoor activities. There are three formats for this service:
  - 6- to lo-week adventure based counseling groups that meet after school and on weekends during the school year
  - a 7- to 14-day therapeutic camping program that incorporates wilderness backpacking, campcraft, astronomy, nature study, map and compass reading, and outdoor cooking with staff led group discussions around evening campfires and use of the group living experience to teach relationship skills

  - alternative activities for professional counseling clients, scheduled at regular intervals on weekends.

- Education services for specific target populations, including
  - parents who receive training in parenting skills, decisionmaking and problem-solving and talking about alcohol and other drugs with their children
  - high-risk youth who receive information on alcohol and other drugs in the context of exercises designed to teach refusal skills, identification and expression of feelings, and alternatives to alcohol and other drug use.

The program originated in 1975 as an alternative to residential treatment for high-risk adolescents. During its first few years of operation, the program found that it was serving a high proportion of children from alcohol and other drug abusing families, especially those with histories of physical and/or sexual abuse. Thus, by 1981, the program's focus began shifting toward prevention and early intervention work with children of substance abusers. Current funding sources include the Texas Commission on Alcohol and Drug Abuse, United Way, the City of Austin, client fees and contributions.

Program staff work closely with community organizations and former clients to assess service effectiveness and plan for emerging needs. They are also extensively involved in coordinating services with other organizations at community, State, and national levels.

During 1986, the program provided professional counseling services to 54 individuals. Eighty-six youth participated in alternative activities and 60 individuals participated in educational activities. Over 200,000 members of the community were reached by the program's media coverage or newsletter.

The program uses an evaluation strategy that includes administration of instruments, collection and analysis of data, and summary and reporting of findings. These activities are largely the responsibility of graduate student interns. Evaluation studies to date indicate that 80 percent to 90 percent of clients show an increase in knowledge about alcohol and other drugs and their effects and about the dynamics of alcohol and other drug abusing families. Thirty-two percent of clients were occasionally involved with alcohol and other drug use before participation in the program; only 7 percent were so involved at termination.

The program has developed an extensive policy and procedures manual and specific curricula for the three adventure program components. Program staff consult with organizations interested in implementing similar programs. The program has been recognized by the National Institute on Mental Health as being of "national model" caliber, and as a model for the delivery of prevention services to children of alcoholics by the Governor and State Legislature of Texas.

APPLETON SCHOOL, DISTRICT PREVENTION PROGRAM

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CLIENTELE:

All students in grades K-12 in the Appleton, Wisconsin, School District. The total target population is 11,933—2,583 high school, 2,607 junior high school, and 6,743 elementary school students. The population of the school district is 6 percent ethnic minority, with Asian/Pacific Islanders comprising the majority of this group. Students from low-income homes represent 7.9 percent of the total enrollment, and. the proportion of low-income students in individual schools ranges from 34 percent to 2 percent.

MAJOR SERVICES:

The Alcohol and Other Drug Abuse Prevention Program believes that the mission of a school is to educate for life and that alcohol and other drug issues can block attainment of that mission. To deal with this roadblock, the major services of the program are:

- A Student Assistance Program (SAP) that provides:
  - training of staff, parents, community and policymakers in alcohol and other drug abuse intervention
  - 12-week Concerned Person Support Groups for elementary and secondary students affected by someone else's alcohol and other drug abuse
  - identification and referral to appropriate agencies of students with problems
  - B-week Informational Groups for secondary students who want additional education

- — 12-week Insight Groups for secondary students who want to examine their alcohol and drug use
- — an ongoing Aftercare Support Group for secondary students who have received treatment or made a commitment to abstinence.

- A drug education program that includes:
  - — staff training by district-certified trainers
  - — 6 to 21 lessons a year for all students, using the "Here's Looking At You, 2000" curriculum
  - — parent drug education presentations, and a 4-week parent outreach group
  - — community drug education presentations, and community awareness activities.
- Extra-curricular groups, including:
  - — "Just Say No" clubs in elementary schools
  - — a Peer Facilitator program in secondary schools that disseminates information and provides drug-free activities and outreach to elementary schools.
- Networks, including participation in county, State and national organizations, and groups thatfocus on the prevention of alcohol and other drug abuse.

The commitment of the Appleton Area School District to the prevention of alcohol and other drug abuse is not new. The SAP was implemented in 1980 at the secondary level. Concerned counselors and teachers began to insert prevention material into classroom instruction. With the development of a Peer Facilitator Program and the expansion of the **SAP,** the program became institutionalized. In 1987, the State of Wisconsin awarded the program a grant for revitalization training and expansion. Prevention activities are now in place in all 20 schools in the district and throughout the community. The program receives funding from local, State, and Federal sources.

During the past year, the program has provided direct service to all students in the district's public schools. In addition to classroom instruction and ongoing awareness and alternative activities, the program provided specialized services to 1,105 students through the SAP, and direct services to about 1,000 parents and community members through individual conferences, awareness presentations, and volunteer activity. All of the district's 800 teaching staff are involved in the program; 150 of them contribute about 4,300 hours of volunteer time during a one-year period.

Because the program has made an ethical decision not to establish research control groups, it relies on qualitative over quantitative data for evaluation. Data are collected on changes in student knowledge and attitudes. Data on alcohol and other drug use are also collected for a future longitudinal study. Ethnographic data are

collected through written evaluations, interviews, and observations. Outcomes and impacts indicated to date include:

- Increased student, parent, staff and community awareness of the program and knowledge about alcohol and other drugs.
- Decreased student use of alcohol and other drugs during school, school activities, and on school grounds.
- Increased numbers of students completing treatment.
- Increased student acceptance of their recovering and abstaining peers.
- Increased positive parent involvement in resolving dysfunctional behaviors.

The district has a history of leadership in prevention programming and serves as an example to many other districts seeking to implement prevention programs. It has responded to frequent requests for information and the program has been presented at numerous State and national conferences. Feedback suggests that other districts have successfully replicated many aspects of the program.

OZAUKEE COUNTY PREVENTION CONSORTIUM

AGENCY:
Ozaukee Council, Inc.
125 N. Franklin Street
Port Washington, WI 53074

CONTACT NAME:
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Executive Director

PHONE:
(414) 3751110

STATE DIRECTOR:
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WI Division of Alcohol & Drug Abuse
1 West Wilson Street
PO Box 7851
Madison, WI 53707
(608) 266-3442

STATE PREVENTION COORDINATOR:
Mr. Lou Oppor
(608) 266-9485

CLIENTELE:

All residents of Ozaukee County, Wisconsin. Twenty-five percent of the population of about 69,200 is under age 15, and 8 percent are 65 or older. Minorities-Hispanic, Black, and Asian Americans-make up slightly more than 2 percent of Ozaukee County residents. About 3.5 percent of the population lives below the poverty line and 5.3 percent are unemployed. The county is comprised of a unique cross-section of urban, suburban, and rural communities. Special populations that are high priorities for the Consortium are youth, women, the elderly, educators, parents and clergy.

MAJOR SERVICES:

The Consortium coordinates a range of school- and community-based prevention initiatives in the following categories:

- Alcohol and other drug abuse prevention and education services
  - the Peer Education Program, a network of trained high school students who serve as peer leaders and referral resources and also facilitate programs for elementary and middle school students
  - development and presentation of comprehensive K-12 prevention programs, as well as teacher training and curricular consultation
  - the Middle School Awareness Plus Program, designed to extend primary and secondary prevention resources through small support groups, parent education, referral and follow-up
- Positive Parent Involvement, a county-wide network designed to educate, motivate, and mobilize parents to identify prevention strategies
- Secondary prevention and early intervention services

— the Systematic Alcohol/Drug Intervention Linkage, assessment, support and education groups for youth aged *13* to 18 who are identified as having alcohol or drug related problems and their parents

— information and referral services and support groups for women, public inebriates, and others identified by law enforcement officials, and employees.

The Consortium has also formed Suicide Prevention Committees in each of the area's five school districts. A county-wide sexual abuse task force and a truancy task force report to the Consortium.

The concept of the Consortium was developed by the Ozaukee Council in 1981. Membership includes representatives from each of the county's school districts, parents from these areas and representatives from law enforcement, juvenile justice, social services, mental health and alcohol/drug treatment organizations. Clergy and medical professionals are also represented.

For eight years now, the Consortium has served as a decisionmaking body responsible for strategic program planning, and development based on current community needs assessment. Ongoing data collection and program development continue to be an integral part of program activities.

The Consortium's funding base is varied and includes United Way, State grants and private donations.

During 1986, the Consortium:

- Directly touched over 7,500 people with its public information and education programs.
- Reached all Ozaukee County 5th and 8th graders and other groups through its Peer Resource Education Program.
- Provided parent education programs and alternative activities to about 1,500 individuals.
- Provided information, intervention, and referral services to about 1,800 individuals.

The Peer Resource Education Program was one of eight programs selected nationwide in 1982 by the U.S. Department of Health and Human Services as a model prevention program.

The Consortium's evaluation activities are comprehensive. Data are collected through such sources as interviews, questionnaires, institutional and school records, government statistics, police files and self-reports. The evaluation process currently indicates such outcomes as:

- Increased community awareness and understanding regarding the use and abuse of alcohol and other drugs.
- Increased cooperation between agencies, schools, parents, and service providers.

- Creation of a no-blame climate and expansion of belief that no one thing is the answer.
- Decreased recidivism for alcohol- and drug-related contacts by underage youth.

The Consortium's prevention model has been used effectively by neighboring Wisconsin communities. The program has developed a program description that is comprehensive and attuned to the need for adaptability. Some of the programmatic qualities that result in this high level of replicability are:

- Identification of required social and human services systems as participants.
- Grassroots ownership and responsibility.
- A high degree of cost-effectiveness.

CRITERIA & PROCEDURES

CRITERIA

The Project Advisory Committee used criteria developed during an earlier project. The criteria consisted of a short descriptive paragraph on each of 12 important attributes of effective prevention efforts. Programs seeking consideration as an exemplary program were asked to discuss each of these attributes in their nomination document indicating the way in which the various attributes were implemented or reflected in their programming. Because of the wide diversity of program types and the varying importance of the attributes for those various types, no specific numerical weights were given to the attributes.

Prevention Programs That Work

Twelve Important Attributes of Effective Prevention Programs:

A. ***Program Planning Process:*** The program is based on a sound planning process. The planning process is conducted and/or affirmed by a group that is representative of the multiple systems in the community, such as family, church, school, business, law enforcement, judicial system, media, service organizations and health delivery systems, including alcohol/drug agencies involved in referral, treatment, and aftercare.

B. Goals, ***and Objectives:*** The program has developed a written document that establishes specific, measurable goals and objectives that focus on alcohol and other drug prevention. The goals and objectives should be based on a community needs assessment and reflect specific action plans appropriate to the target groups.

C. ***Multiple Activities:*** The prevention program involves the use of multiple activities to accomplish its goals and objectives. These may include information, education skills development for youth and adults; training of impactors, alternatives, environmental policy, and public policy segments.' The public policy components may include the development of specific written school policies and/or local, State and national public policies on availability, marketing and other relevant alcohol beverage control issues.

   The activities/strategies are implemented in sufficient quantity (no one-shot deals) to have a positive effect on the targets. The program concept may have replicability for other communities.

D. ***Multiple Targets /Population:*** The prevention program includes all elements of the community and/or population served, including all ages, such as the elderly, high-risk groups, and culturally specific groups. The impact and interrelatedness of each group upon the other must be recognized and emphasized in program development, i.e., youth usage is strongly influenced by community norms and adult role models.

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E. *Strong Evaluation Base:* The program has a mechanism for data collection on an ongoing basis and a method of cost analysis that can be used to calculate cost effectiveness. In addition, the outcomes of the evaluation need to include a focus on behavior change and be tied back to the planning process so that appropriate programmatic changes can be made.

F. *Sensitive to Needs of All:* The program takes into account the unique special needs of the community/population. The community will not adopt, without study and adaptation, the package deals of another community, but will seek to redesign and tailor prevention programs to reach the specific needs of its own individuals and cultural groups, including different ethnic and gender-specific efforts.

G. *Part of Overall Health Promotion and Health Care System:* The prevention program is an integral, essential component of the health care system. It works with the other agencies that provide intervention, referral treatment and aftercare components of the continuum. It also seeks to work with other prevention agencies (e.g., HMOs, American Cancer Society) in order to build a supportive community environment for the development of healthy lifestyles and healthy lifestyle choices.

H. *Community Involvement and Ownership:* The prevention program reflects the basic, essential, philosophical understanding that prevention is a shared responsibility among national, State, and local levels and that specific programs are best done at community levels. "Grassroots" ownership and responsibility are the key elements in the planning, implementation, and evaluation of the program. The prevention program should enable the community to not only examine its problems, but also take ownership and responsibility for its solution.

I. *Long-Term:* The prevention program recognizes that there is no such thing as a quick fix, or bottled formula, or a magic curriculum that will solve the problem. The prevention program seeks to promote a long-term commitment that is flexible and adaptable and responds to a changing environment. The prevention program seeks to build upon its successes and continually enhances its efforts toward its goal. The long-term process integrates prevention activities into existing organizations and institutions such as families, schools, and communities. The long-term nature of the program ensures that interventions begin early and continue through the life cycle.

J. *Multiple Systems /Levels:* The prevention program utilizes multiple social systems and levels within the community in a collaborative effort. Each system's involvement is necessary but not sufficient for the success of the program. In order to impact a full range of target populations, all the social systems that are involved must be included. (For example, a program targeted to Hispanic youth must involve family, church, school, community youth recreation, and the law enforcement system.)

K. ***Marketing/Promotion:*** The prevention program needs to include a marketing approach that showcases the positive effects that prevention has within the community and the effects it has on the various individuals and systems within the community. Policymakers are key targets for the marketing strategy. (For example, in marketing youth prevention programs, the involvement of policymakers in the marketing strategy may ensure the continuation of that prevention program.) Mechanisms by which programs can achieve self-sufficiency should be built into the design.

L. ***Replicability:*** The prevention program has documented its philosophy, theory, methods, and procedures in sufficient detail and clarity to permit other organizations to assess its utility and applicability in their setting and to permit orderly development of a similar or related program in a new and (somewhat) different setting.

Separate Category for Targeted Programs

Prevention Programs that are targeted to specific populations and needs would be at a disadvantage if they were held to Criteria C, D, and J above which call for "multiple activities," "multiple targets," and "multiple social systems/levels" respectively. Such programs requested consideration in a separate category by writing "targeted program" under the program name on the rating sheet. Reviewers considered only the remaining nine criteria when rating entries in the "Targeted Program" category.

RATING PROCEDURE

State Agency personnel and national organizations submitting nominations were asked to complete a State & National Organization Program Rating Scale on each nominee. Thus, for each nomination reaching NASADAD/NPN, there was a self-rating by the nominee which indicated where data supporting each of the ratings was to be found in the nomination, plus a State or National Organization rating form for that program. For each attribute a specific numerical score was indicated.

Nominations were submitted to NASADAD/NPN, Suite 520, Hall of the States, 444 North Capitol Street, NW, Washington, DC 20001.

Upon receipt, the original of the nomination with the nominator's rating sheet attached, was filed in the NASADAD/NPN central file. Three additional copies were assigned to rating teams composed of Project Advisory committee members and promptly shipped to them. The rating team members carefully reviewed and rated the program descriptions. Their signed rating sheets were attached to the submission and returned to the NASADAD/NPN office.

NPN staff prepared a composite rating for each program which consisted of an average of the three team members' ratings, and a rating given by NASADAD/NPN central office readers.

The Project Advisory Committee met in February 1989 to study all the nominations. They selected a representative set of 20 programs that reflect an appropriate mix of geographic and cultural variables and a cross-section of program types and sponsoring organizations.

PROJECT ADVISORY COMMITTEE MEMBERS

Valerie Ackiss is Associate Project Director of "Project LEAD: High Expectations!" at the LINKS, 1200 Massachusetts Avenue, Washington, DC 20005.

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Susan **Galbraith** is a Washington Representative to the National Office of the National Council on Alcoholism, (Suite 320), 1511 K Street, NW, Washington, DC 20005.

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Basil Henderson is Director of-Public Policy for the Children of Alcoholics Foundation (31st Floor), 200 Park Avenue, New York, NY 10066.

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William Pimentel is Director, Rhode Island Division of Substance Abuse, PO Box 20363, Cranston, RI 02920.

Ketty Rey is Assistant Director of the NYC Department of MI-I, MR and Alcoholism Services, (Room 1203), 93 Worth Street, New York, NY 10013.

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Twenty
1987 Exemplary
Prevention Programs

"Helping Communities to Help Themselves"

PROJECT SUMMARIES

Sponsored by
National Association of State
Alcohol and Drug Abuse Directors
a n d
National Prevention Network

Under Contract with the.

Office for Substance Abuse Prevention,
Alcohol, Drug Abuse, and
Mental Health Administration

October 1987

Twenty Exemplary Programs for Preventing Alcohol and Other Drug Abuse

In the Spring of 1987 a national nomination and selection process was used to identify 50 particularly effective alcohol and other drug abuse prevention programs. A Project Advisory Committee, composed of representatives of national organizations and State Alcohol and Drug Agency representatives, reviewed submissions in July from throughout the United States and selected 20 exemplary programs.

This summary provides an overview of each of the selected programs. It also explains how States and national organizations nominated programs; how the Project Advisory Committee went about making the selections; and provides a look at the criteria for making the selections. The 20 selected programs are arranged in alphabetical order by State.

The project was supported by the Office for Substance Abuse Prevention (OSAP), the National Association of State Alcohol and Drug Abuse Directors (NASADAD), and its subsidiary, the National Prevention Network (NPN).

Program Descriptions

City of Tempe, Arizona "Say No" Program

This city, its schools, and the schools of surrounding districts have been effective in mobilizing the entire community.

Contra Costa County, California New Connections Program

A mature program, now 15 years old, started as an alternatives program and matured into a community umbrella group now more focused on intervention strategies.

Tuolumne County, California Project Opportunity

Focused on women in transition (divorce, employment, etc.), this is a growth-oriented group development experience.

Grand Junction, Colorado "Youth Who Care"

A large western town uses youth teams as the principal carriers of prevention messages throughout the community.

Illinois Prevention Resource Center

A state-funded central source of community organizing, technical assistance, information dissemination, and media campaign development.

Alcohol/Drug Program, Archdiocese of Louisville, Kentucky

This parochial school system in Mid-America is making very effective use of the CASPAR curriculum as part of an effort to reach dysfunctional families.

Kentucky TWYKAA/TWYSAA Program

A statewide program based on a lifestyle risk-reduction model; this brings parents and youth together to talk about alcohol.

Michigan Model for Comprehensive School Health Education

Michigan has developed and is implementing a statewide comprehensive health and substance abuse curriculum with strong teacher training and evaluation components.

Oakland County, Michigan Senior Citizen Project

This large urban midwestern county (about 1 million population) has a strong, comprehensive program targeted to its elderly citizens.

Minnesota Parent Communication Network

This statewide affiliate of a national parents organization places emphasis on publishing, alternatives, communication, and education.

Toms River, New Jersey "ASAP" Program

This program in a fast-growing suburban area got its major growth impetus from the 1983 Teen Drinking & Driving Conference in Chevy Chase, Maryland.

New ***York Citizens Attiance to Prevent Drug Abuse***

This statewide "association of associations" is a coalition of parent groups and community prevention organizations that performs advisory, promotional, and technical assistance functions.

Queens County, New York Early Intervention Alcohol Program

A city program teaching 5th and 6th graders about COA issues, getting self-referrals (and parent approvals) for in-school groups.

New ***York Statewide Alcohol Campaign***

A high visibility media campaign designed to replace "controlled drinking" messages with messages designed to reduce public acceptance of intoxication.

New ***York City FAS Warning Poster***

First the Big Apple, and now many cities, have passed ordinances requiring point-of-sale posters warning of the risks of drinking during pregnancy.

Texans' War on Drugs

This federally funded, state-administered, movement-oriented organization is mobilizing youth, parents, teachers, and community leaders to fight drugs in every city and town in the State.

Hampton, Virginia "HIPP" Program

The school system of this city of 125,000 serves as the hub of a community-wide alcohol and other drug abuse prevention effort.

Lynchburg, Virginia "SODA" Program

This school and community-based peer counseling program has been operating for ***16*** years. A number of teachers in the system came up through the program years ago.

Madison, Wisconsin "PICADA" Program

A city-wide umbrella group that provides a broad mix of direct service delivery and community organizing/ consultative services.

New ***Holstein, Wisconsin Student Assistance Program***

A rural school district developed and implemented a model Student Assistance Program.

CRITERIA & PROCEDURES

Background material on the process used to select programs for recognition.

PROJECTADVISORY COMMITTEE MEMBERS

"SAY NO" TO DRUGS AND ALCOHOL

AGENCY:
City of Tempe, Arizona

ADDRESS:
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CITY, STATE, ZIP:
Tempe, Arizona 85281

CONTACT NAME:
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PHONE NUMBER:
(602) 731-8278

PROGRAM TYPE:
School

GOVERNOR:
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CONGRESSPERSON:
John J. Rhodes III
Phone Contact: (202) 225-2635

STATE AGENCY DIRECTOR:
Gwen Smith
Phone Number (602) 255-1152

STATE PREVENTION COORDINATOR:
Kristine Bell
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PROJECT ADVISORY COMMITTEE MEMBER:
Michael Cunningham
Phone Number: (916) 323-2087

CLIENTELE:

Students in grades 4 through 8. During academic year 1986–87, 18,264 students and 780 teachers from 31 schools were exposed to the program (a secondary aim of the program is to encourage adults, as well as youth, to say no to substance abuse); 4,500 parents participated in parents' nights. The population includes Caucasians, American Indians, Blacks, Asians/Asians, and Hispanics. About half the students are non-Caucasian. Many of the materials developed were bilingual.

MAJOR SERVICES:

- A five-day "Say No" curriculum with prevention information incorporated into other curriculum areas (i.e., reading lessons used prevention information for subject matter). "Say No" week was conducted at each school community.
- A six-week, twelve-hour, in-service training program for teachers focusing on prevention, early intervention, and the physical, psychological, and social effects of other drugs and alcohol use.
- "Say No" petitions printed as full-page ads in the local newspaper, along with other media coverage.
- Monthly four-hour prevention classes for parents and teachers. Technical assistance provided to neighboring school districts on how to establish and

operate similar programs. Local business adapted the materials for their adult employees.

- A Youth Diversion Program for all first offenders and their parents cited for alcohol use.

During the school year 1984-85, Tempe, Arizona's Youth and Family Services Division recognized that the city faced a strong potential for growing drug abuse problems among its youth. The population was growing rapidly, and, while the population of Tempe itself was not in serious financial trouble, the neighboring town of Guadalupe was suffering severe unemployment (four times the rate of Tempe). Realizing that nearly 23 percent of the total population of the City of Tempe was under the age of 18, planners decided to help students say no to drugs before they had ever said yes. The City of Tempe sponsored a Youth Town Hall; teens themselves hatched the idea for the program at this meeting. The Youth and Family Services Division agreed to sponsor the program, which meant that policy decisions reflected the thinking of the seven-member city council. However, all program activities were coordinated with and closely supervised by the school boards in the two participating districts, and school principals assumed responsibility for collecting evaluation data.

Financial support, came from a wealth of in-kind contributions from local businesses and service organizations, city funds, a grant from the East Valley Behavioral Health Center, and funds from two school districts and civic groups.

The program has grown, diversified, and touched virtually every person in the two communities. Aggressive marketing has included imaginative incentive programs for which students could not be eligible unless they wore their free "Say No" Buttons. Over 200 media kits were distributed to every print and broadcast outlet in the valley, and local network affiliates landed their helicopters on school grounds. The capstone of the marketing program was the award of a free trip to San Diego's Sea World for a family of four from each of the six junior high schools; all expenses were donated by the participating hotels, airlines, and Sea World itself.

Although it is too soon to quantitatively evaluate the program by such hard measures as reduction in DWI for youth or in referrals or enrollments in other drug and alcohol treatment programs, early effects have been deemed extremely positive as exemplified by:

- An increase in the number of requests for prevention presentations and in the amount of community support;
- The fact that students entering high school took a strong anti-drug stand during freshmen orientation sessions;
- Substantial indications of comprehensive and retention of prevention information during in-school instruction and of attitude change (evidenced by the fact that increasing numbers of students have asked for help on substance abuse issues).

The program, originally begun in four schools, has been replicated within the local area. A statewide conference, originally slated to accommodate 100 participants, was so popular that the number of participants was doubled; even so, nearly two hundred other applicants had to be turned away. Program staff are frequently, and increasingly, asked to provide technical assistance to other districts in the area. All the materials are written in such a way that they can be readily integrated into the curriculum of any school.

NEW CONNECTIONS ON-SITE SCHOOL PROGRAM

AGENCY:
New Connections

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CITY, STATE, ZIP:
Concord, California 94520

CONTACT NAME:
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Executive Director

PHONE NUMBER:
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PROGRAM TYPE:
School

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Phone Contact: (916) 4452841

CONGRESSPERSON:
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Phone Contact: (202) 225-2095

STATE AGENCY DIRECTOR:
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Phone Number: (916) 445-0843

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PROJECT ADVISORY COMMITTEE MEMBER:
Michael Cunningham
Phone Number: (916) 323-2087

CLIENTELE:

In the City of Concord and West Contra Costa County, 29 percent of the 287,371 people are under the age of 18. New Connections targets these youth and their families for their substance abuse prevention education programs and projects. About 40 percent of the population is Black, Hispanic, American Indian or Asian/Filipino/ Pacific Islander. The percentage of families with incomes below the poverty levels ranges between 2.61 percent and 24.95 percent in the communities served by the program. On-site school programs are located in seven intermediate and senior highs in Northwest County and Concord. Although prevention activities are intended to reach broad populations, special efforts are made to attract at-risk youth to the counseling program.

MAJOR SERVICES:

Networking activities in schools-counselling (intervention) and prevention.

- Counselling for at-risk youth and prevention education classes. Training and consultation for adults who work with youth. During fiscal year 1985-86, 335 students were counselled in the schools and another 223 were seen at the community office; 2,173 students participated in drug education classes, 534 adults participated in training, consultations, or parent groups.

- A telephone hotline during normal business hours.
- Joint counselling and prevention services: with the YMCA, a weekend "ropes course" for teens; with the Youth Service Bureau, an effort directed to pregnancy and substance abuse counselling and community training; New Connections also makes meeting space available for a teen AA group and a single parent recovery group from Narcotics Anonymous, and works closely with local police.
- A Teen Drama Group puts on skits on substance abuse, family problems, and peer pressure.

After nine years of offering recreational programs as an antidote to various youth problems, community members saw a need for a more aggressive, coherent, organized, goal-directed substance abuse prevention program. At that time, the agency focus changed to working with the schools in Northwest County. After seeing the success of this program, the City of Concord provided the funding for its expansion to their city. Funding (a total of $200,329 in cash for fiscal year 1986-87) mixes resources from the City of Concord, the Contra Costa County Drug Program Division, the United Way of the Bay Area, the John Swett Unified School District, and client and program donations; in-kind contributions include office space, printing, and time of graduate student interns. The board of directors and professional advisory board represents a cross-section of social science disciplines, service-delivery agencies, and the private sector.

All activities are designed to enhance self-image, problem-solving skills, and to improve family relationships. The aim, broadly stated, is to increase students' knowledge about substance abuse while giving them the emotional wherewithal to refuse to abuse chemicals or to give up their abuse patterns. These ends are accomplished through school-based prevention projects, community education, in-service training for adults who work with youth, counselling in schools and at their community office. Presentations and services are evaluated by the recipients, and results have been overwhelmingly positive. No long-term impact evaluation has been undertaken due to funding limitations, but limited follow-up evaluations have shown positive results (i.e., decreases in disciplinary referrals in school, improved grades, etc.).

New Connections started its school programs in Northwest Contra Costa County and then successfully replicated them in the City of Concord. As the program has received publicity, New Connections has received requests to develop their program in additional schools. The teen drama group has been the subject of a documentary filmed for local cable broadcast, and the program was identified as a local community resource in the national TV special, "Chemical People II."

PROJECT OPPORTUNITY, SONORA, CALIFORNIA

AGENCY:
Mental Health Services for Tuolunme County and the Mother Lode Women's Center, Inc.

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Sonora, CA 95370

CONTACT NAME:
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PHONE NUMBER: .
(209) 532-4746

PROGRAM TYPE:
Targeted

GOVERNOR:
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CLIENTELE:

Women, primarily ages 19-39, who are at greatest risk for drug and/or alcohol abuse as a result of having experienceda major life transition (or several such transitions) based on the Holmes/Rahe scale for judging levels of personal stress because of death of a spouse, divorce or separation, domestic violence, and other such problems (relocation, unemployment, departure of child from home, etc.). A minimum of 120 at-risk women receive support each year. Their participation is proportionate. to the ethnic breakdown of the community of approximately 42,300, residents: 93 percent Caucasian, 1.1 percent Black, 1.8 percent Native American, 5.2 percent Hispanic, and 2.1 percent Asian/Pacific Islander.

MAJOR SERVICES:

All services provided are in the general areas of improving coping mechanisms for women in major transitions so that other drugs and alcohol will not be used to reduce stress and re-establish emotional equilibrium. Three complete, seven-month programs begin each year; each accommodates 40 women and operates in three phases:

- Phase I: a twelve-week support education group focusing on such topics as stress management, working through "blocks," and sex-role stereotyping.

- Phase II: a series of three 12-hour classes whose content is determined by the clients' needs and action plans. Topics include transforming body image, couples communication, women's sexuality, and coping with depression.
- Phase III: a "closure" period that involves self-assessment and evaluation, goal setting, and getting information. about resources and referrals.

An important aspect of this program is a three-year research study that will include both quantitative and qualitative data on the impact of the program. Objective measures, such as the Tennessee Self-Concept Scale and a chemical use survey, are being used. A control group, derived from applicants who could not be accepted because the program was full, has been established and will be measured using the same instruments at the same intervals; pre- and post-treatment scores will be available for the experimental group and these will be compared internally and with the control group receiving no treatment. The study has been underway for only one year.

Tuolumne County is a rural area about 150 miles east of San Francisco. It is dotted by small, unincorporated towns; seventy-six percent of the land is publicly owned (national parks and forests), and low-income residents comprise 85 percent of the population. The local tax base is small, employment is seasonal, and wages very low. This economic picture, coupled with rural isolation, creates particular hardships for women who have even more difficulty than men in finding employment (and, not incidentally, a sense of community>: most of the jobs available are "men's work"-mining, construction, lumbering. It was with this background in mind that the California Department of Alcohol and Drug Programs targeted some ($50,000 annually) of its special population drug prevention program funds to the increasingly at-risk population of underserved rural women. The aim is to locate and serve women at particular risk of dysfunctional coping responses, the risk being defined by the Holmes/Rahe stress factors noted above.

In 1986,140 women participated in the three-phase program; 70 children were cared for in the child care program that is part of the operation; 500 were reached at a two-day health fair; 80 attended various public presentation, and 1,500 received brochures. There is always a waiting list for the services, which are showing success as measured by the objective scales and by more informal program evaluations: on a scale of O-4 (where 4 is excellent), program and content always received either a 3 or 4 from participants; in 1986, 62 percent of the participants improved by 10 percent or more on the self-concept scale; 70 percent of all entrants completed the program, reflecting the accomplishment of the objectives they set for themselves in their action plans.

The program content and approach are derived from a careful blend of local need and theoretical models that suggest the types of interventions needed to discourage maladaptive behavior and build positive responses to stress. A number of other caregiving and educational institutions participate in Project Opportunity's planning and review processes, including the local hospital and college. An in-depth, concise handbook catalogs techniques, exercises, homework assignments for Phase I and Phase III groups; Phase II classes can be managed by consultants

(i.e., counselors, social workers) who are available in virtually every community. Thus, the design can be easily replicated in other communities, and has been exported to a group in Denver working with urban Native American Women.

The addition of a substantial and controlled research study will prove a valuable contribution to the state of knowledge about helping women manage stress and avoid falling into depression and dysfunctional patterns.

YOUTH WHO CARE, INC.

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Youth Who Care, Inc.

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CLIENTELE:

Primarily middle school and high school students, college students and parents, and community groups, including the police and businesses, to educate them about substance abuse.

MAJOR SERVICES:

Youth Who Care (YWC) organizes a wide-range of activities, most of them centered in the schools, and the majority of them intended to provide positive experiences that promote a "high-on-life," substance-free existence. They combine the local passion for outdoor, recreational undertakings with important educational messages.

- School-based activities including YWC clubs in seven schools, YWC 3-D (Don't Drink and Drive) teams, and a speaker's bureau. Under the auspices of these various groups, outreach, recreational and competitive activities, public awareness, and media campaigns are organized. These included:
  - Biking and skateboarding exhibitions tied to prevention messages;
  - Run Against Drugs, a 200-mile relay race to the State Capitol in Denver, where runners present the governor with a proclamation supporting drug-free youth (six weeks of intense training precede the race);

— Preparation of a music video and various print and broadcast public service spots (produced and performed by the youth).

- Fundraising activities to allow youth to be involved in the community and to provide maximum exposure for the program. A popular event is the Christmas tuck-in service: for a small fee, teens dress as Santa's elves and visit children, passing out candy canes, reading bedtime stories, and tucking children in bed.
- Public awareness activities including a "Just Say No" parade and community service projects that involve teens as volunteers in hospitals, museums, and public events.
- Workshops and seminars for adults to help them help children say no and teach them about specific drugs.

Grand Junction is located in Mesa County, about 250 miles west of Denver on the western slope of the Rockies. Unemployment in Mesa County is running at about 10 percent because of the bust in the oil industry; the county has the highest divorce rate in the State, and indicators of economic hard times are seen everywhere (real estate foreclosures, etc.). With this backdrop, Parents Who Care felt it was important to head off serious substance abuse problems before they started, and to create an environment that clearly opposed substance abuse. These parents saw the need to involve youth and thus Youth Who Care was created. Although the board of directors of YWC sets policy, the youth themselves are very actively involved in planning and implementing all aspects of the program, working closely with representatives from all aspects of the community: health care, law enforcement, media, alcoholic beverage industry, etc. (who are members of the board). The project operates on about $57,000 annually, with the two main sources of funds coming from the state department of health, alcohol and drug abuse division ($14,000) and the VISTA volunteer project ($15,000; volunteers work as part of the project team); foundations and corporations account for another $8,000 of the budget, and Mt. Garfield Plumbing and Heating allocates $6,000 for office space and utilities. Importantly, fundraising activities by the youth themselves add another $8,000 to the project's purse.

In 1984, Nancy Reagan visited Grand Junction to learn why the project had been so successful. The project has been replicated in other Colorado communities (with technical assistance from the YWC staff) and around the Nation, often using a booklet developed by the YWC staff, the booklet is distributed by the Parents Resource Institute for Drug Education in Atlanta, Georgia.

In 1986, the project directly served some 10,000 people and indirectly reached another 40,000—well over half the population of the county. Media relations are excellent, and because of the diversity and wide appeal of the programs, community support is very strong. In spite of the economic difficulties in the area, this program provides important outlets for both recreational and educational activities that involve youth in time-consuming, goal-directed, enjoyable enterprises. Not incidentally, the youth recognize the importance of both earning their keep (through

fundraising activities) and giving something back to the community (through volunteering when additional hands are needed). A well-organized community effort such as this one that has the enthusiastic support of many individuals and organizations, obviously has great potential for creating an atmosphere of caring, sharing, and mutual responsibility-an atmosphere that clearly counters the self-absorbed, alienated attitudes that often foster substance abuse.

Staff find it difficult to evaluate the program; results of the above-mentioned 1986 substance abuse survey had not been tallied at the time this information was submitted. However, if retention of students in the various activities is any indicator, the project can be deemed successful, since many of the participants (from both high-risk and low-risk groups) are repeaters.

PREVENTION RESOURCE CENTER

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"Prevention Resource Center"

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PROJECT ADVISORY COMMITTEE MEMBER:
Linda Chott
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CLIENTELE:

The clients for PRC's services are as diverse as the population of the State itself and include teachers from the public schools around the State. Demographics are always considered when PRC offers its services in any given community or geographic area.

MAJOR SERVICES:

As the major and central prevention resource, PRC combines both information and training services:

- Four hundred days of technical assistance, special retreats for prevention area coordinators (from the State's In Touch Program), and an annual two-day workshop on "Developing Prevention Programs for Children of Addicted Parents." Staff from the library conduct five seminars on using various library services. A statewide prevention conference is held annually and seven weeks of teacher training are sponsored to help teachers develop prevention action plans they can use in their schools.
- A clearinghouse providing free materials to Illinois residents, and a lending library offering over 6,000 publications (including audio-visual materials).
- Two quarterly newsletters, and other materials, as needed.

- IPASS, a prevention program grounded in social policy strategy to change attitudes and behavior in a community, currently operated by PRC in a Chicago neighborhood; one aim of this program is to reduce the infant mortality rate by discouraging women under 20 from using tobacco, alcohol, or drugs during pregnancy.

When it began in 1980 as a small operation under the auspices of the Department of Mental Health and Developmental Disabilities, PRC had a staff of three and a budget of $100,000. The center now enjoys a funding level of $1,000,000 exclusively through the Illinois Department of Alcoholism and Substance Abuse. PRC's task has evolved through (1) selling the concept of prevention, (2) providing prevention services to those best positioned to implement them (i.e., school systems and parent groups), and (3) training other trainers to provide these technical assistance services to the various target groups.

In all of its work, PRC emphasizes the importance of community-wide planning and of basing prevention efforts on sound research (to which end PRC employs a research specialist). The aim of all PRC work is to ensure that organizations and individuals in the State have access to timely information, training, technical assistance, and resource materials that will be helpful in launching or strengthening local prevention efforts. Networking is clearly central to the success of PRC's work, and some State Agencies have contracts with PRC for specialized services. PRC staff aim to provide models for cooperation and joint planning.

In 1986, PRC provided 525 days of technical assistance, trained 125 professional school personnel in a week-long training program, and hosted over 300 participants in a statewide prevention conference. Staff also met with special interest groups, including librarians and teachers. The demand for PRC's services has grown each year, but planning, done in concert with technical advisors representative of the types of organizations throughout the State who might use PRC's services, is always organized to ensure that particular groups are targeted for attention as the State's needs and problems change. Final approval of the annual plan lies with the Department of Alcoholism and Substance Abuse, but the project director (an employee of AH Training and Development Systems, Inc., the nonprofit organization contracted to operate PRC) is responsible for day-to-day operations.

No systematic evaluation has been completed on PRC's impact, but training and library services are carefully monitored and feedback is regularly sought from clients about the quality and content of the services. The fact that the demand for services grows each year might indicate that PRC is serving an important function for diverse groups that are in a position to foster and aid prevention efforts for various target populations. PRC's activities can be duplicated in any locale willing and able to spend the money to organize a central resource that can educate and coordinate multiple client populations.

ALCOHOL/DRUG PROGRAM, ARCHDIOCESE OF LOUISVILLE

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Archdiocese of Louisville

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CLIENTELE:

Seventy-nine elementary and eleven high schools in this Archdiocese serve 25,582 students, 649 of whom are Black and 1,182 of whom are not Catholic. These students and their parents are the focus of this program, but teacher/staff training is an integral part of the operation. (Thus far, 625 elementary teachers and 114 high school teachers have been trained.) Importantly, a number of these educators have discovered, in the course of their training, that they themselves are adult children of alcoholics. Thus educators have become an unanticipated additional target population. In fact, many educators have found their participation to be personally therapeutic, and have accessed additional services on their own. This program is designed for communities and areas where there exists heavy alcohol consumption and a large group of children of alcoholics.

MAJOR SERVICES:

The CASPAR alcohol education curriculum: 739 teachers have received a 16-hour training course in CASPAR's use by staff of Copes Inc. (certified CASPAR trainers). These trained CASPAR teachers have, in turn, delivered it to 76.3 percent of the elementary students (another 12.1 percent of these students have been exposed to other alcohol education programs) and to some 60 percent of the high school

students (another 21 percent are in other programs). The use of this curriculum has been augmented by:

- Peer education that uses outstanding high school juniors and seniors to assist in the instruction of ninth and tenth graders;
- Revisions in the school disciplinary codes so that self-referral and intervention (not expulsion) are the major modes of handling substance abuse problems (with appropriate family intervention being encouraged);
- An adaptation of Ellen Morehouse's Student Assistance Counseling Program that provides special ***outside*** training and supervision for high school counselors so that they can better serve their high-risk students and conduct COA groups, insight groups, after-care support groups as well as mandatory meetings with incoming students to discuss alcohol and drug issues; and
- Parent involvement in varying degrees on a regular basis.

From an early concern that other drugs and alcohol might be as problematic in Catholic schools as in the general population, has grown a deepening awareness of the extent to which children in this Archdiocese (as children in the general population) are affected by alcohol misuse themselves or within their families. Drinking and smoking (tobacco) are integral parts of social rituals. Distilled liquor and cigarettes are the second and third leading industries in Jefferson County. Mint juleps, bourbon whiskey, and beer are important symbols. Attitudes toward alcohol abuse are frequently permissive, and sometimes even indulgent.

Confronting the problem in the Catholic schools posed a particularly delicate policy question. Since the schools are dependent on the good will and tuition of the community: "Would bringing the problem into focus alienate parents?" A decision was made to confront the problem head-on and risk the consequences.

What happened were results, not consequences. Local Alcohol and Drug Abuse professionals assisted in helping to develop the skills, training, and financial resources necessary for a comprehensive approach. Parent approval is essential when any curriculum or policy change is made. So in the formative years of the program nearly 3,000 parents attended a series of four nightly sessions on the nature of alcohol and other drug dependency and its effects on the family. One important early outcome of this parental support for curriculum changes was that school communities voted to prohibit the sale of alcoholic beverages at events that involve grade school children. A second critical policy change is that students who are found to be using chemicals (including alcohol) are treated rather than being punished (expelled), and their parents are involved in this process whenever possible. The community at large has come to see the Catholic schools as being good for children, so good, in fact, that some students from other schools who have been in treatment are being referred to them for a recovery-supportive-environment.

Since each school is financially autonomous, data have not been compiled to track the specific costs of program implementation in each facility. Some central costs

have been managed through grants: some directly to the Catholic school system, others developed and managed by local community professional service providers:

- An excess of $50,000 a year from city and county government to COPES (The Council On Prevention and Education: Substances Inc.) enabled COPES for over 5 years to provide quality teacher training for a number of groups, including the Catholic school teachers;
- $22,800 average (Federal money) was made available in each of the last three years for the student assistance counselor program by the Kentucky Substance Abuse Division and its local mental health center (Jefferson Alcohol and Drug Abuse Center-Seven County Services);
- $2,900 a Kentucky Department of Education set-aside allocation, has defrayed some travel, workshop, materials, etc., costs over the past several years;
- $3,000 grant from the St. Jude Foundation purchased A-V supplements.

Because the needs of the youth are so great and the COPES CASPAR training so valuable, schools have spent over $40,000 hiring substitutes to free about 410 teachers for the two-day training during the school time, and while about 330 teachers donated two days of vacation or outside of school time.

Evaluation of the program is still in the data-collection stage. The need for systematic, standardized evaluation is clearly felt. Where the community and the schools themselves are receptive to the program, the level of involvement and enthusiasm has been very high. But program staff point out that, even though the CASPAR materials are highly regarded, replicating the program is difficult when either the resources or the commitment to the program are in short supply. For example, more than 20 elementary schools are currently desirous of establishing the special educational/support groups for children from alcoholic/other drug dependent families—yet resources to meet all of these needs are not available.

TALKING WITH YOUR KIDS ABOUT ALCOHOL/TALKING WITH YOUR STUDENTS ABOUT ALCOHOL

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CLIENTELE:

"Talking With Kids" is targeted for parents; "Talking With Students" is targeted for school officials, particularly teachers. The latter program, which has been used in 41 public and 11 private schools, is more specifically aimed at teachers who work with grades 5, 6, 7, 8, 9, and 10. The programs are designed for statewide use, and so reach the broad population of Kentucky, half of which lives in urban areas, one-quarter of which lives in Appalachian areas of the State. Some 15 percent of all families live below the poverty level; 10 percent of the population receives public assistance. Ninety-two percent of the population is white; 7 percent Black; Oriental, Native American, and Mexican-American groups comprise just over 1 percent of the total. This program is endorsed by the National Council on Alcoholism.

MAJOR SERVICES:

PRI's services fall into three categories:

- Training for parents; a structured, four-session training program that presents genetic, sociological, biological, and health-related facts about alcoholism and seeks to debunk commonly-held myths about its causes,

manifestations, and cures so that parents can then thoughtfully discuss drinking with their children.

- Training for teachers is similar in content and focus to the parents' materials, but trains teachers in various didactic and experiential techniques to involve students in the training program. Whenever a "Talking to Students..." course is scheduled for presentation, PRI staff make the parent training available in the community because they believe that parents have both the right and the responsibility to communicate about alcohol and because the support of the parents is a vital adjunct to the school curriculum.
- The development of a laboratory community project that has provided in-depth training in prevention theory, consultation theory, principles of community organization and marketing strategies for a core group of both teachers and parents who, in turn, become prevention specialists for their communities and able to implement the PRI programs. These people reflect a cross-section of community responsibilities; clergy, mental health workers, volunteers from civic organizations, and the like.

The risk-reduction model used by the programs PRI has developed is based on certain principles and beliefs about what information, mind-set, and self-image must converge to reduce an individual's probability of becoming an alcoholic or impaired by or because of (in a traffic accident) alcohol use or abuse. At the heart of the programs are five principles: (1) Everyone has some level of risk for alcoholism; (2) Some people have an increased level of risk for alcoholism; (3) Biological factors establish only the level of risk; (4) Specific behaviors (quantity and frequency of alcohol use) can be identified that increase or decrease a person's risk of triggering alcoholism or other alcohol-related problems; and (5) Psychological and social factors can influence the choices people make about the quantity and frequency of alcohol use, but cannot directly cause the problems.

Accepting these principles, the programs then seek to establish five conditions that must underpin any risk-reduction campaign. These are that:

- People believe that alcoholism could happen to them and that frequency and quantity choices increase or decrease the likelihood that it will;
- People know exactly what to do to reduce THEIR risk of triggering an alcohol problem;
- People believe that others believe that making low-risk drinking choices is a good idea;
- People see themselves as making low-risk choices because they value their health and happiness and because they're worth it;
- People know how to make low-risk choices at all times and under all circumstances.

Given these principles of risk reduction and the conditions that must be present to achieve it, the project materials are designed, in essence, to affect drinking choices and to establish life-long habits related to drinking by helping people establish

these conditions and perceptions. The instructor's manual is a tightly sequenced text that includes a structured training format, glossary, question and answer section, and a lo-page bibliography citing research on which the program is based. It includes 44 overhead transparencies intended to help trainers manage the material in a consistent fashion and emphasize key points. Parents receive a 12-page booklet at the end of each session. School students receive materials varying in length depending on their grade level.

The only funding for PRI's efforts is through the registration fees charged for the workshops and materials, although for several years some of these costs have been defrayed for participants by scholarships provided by the Kentucky Division of Substance Abuse. Controlled evaluations of the programs have been sufficiently positive that they have been proposed by the National Council on Alcoholism as subjects for a demonstration project and controlled, longitudinal evaluation of outcome and impact. The programs have been replicated by several organizations, including a parents' group in Colorado Springs; through the New York State Council on Alcoholism; the Arlington County (Ohio) Community Team; and under the auspices of the South Carolina Commission on Alcohol and Drug Abuse.

MICHIGAN MODEL FOR COMPREHENSIVE SCHOOL HEALTH EDUCATION

LEAD AGENCY:
Michigan Department of Education
(6 other State Agencies sponsoring)

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PROJECT ADVISORY COMMITTEE MEMBER
Alvera Stern
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CLIENTELE:

The primary target for services are 1.36 million school children in grades kindergarten through eight. Roughly 81 percent of these children are Caucasian, 17 percent Black, 2 percent Hispanic, and the rest belong to other minority populations. Some 252,869 children between the ages of 5 and 17 were living below the poverty level in 1980. Teachers are a secondary target audience of whom there are 34,646 for K-8. The program also involves parents.

MAJOR SERVICES:

- Training: Training of teachers occurs annually for new personnel and is provided by Michigan Model Coordinators/Trainers at 26 regional sites (intermediate school districts/local school districts). This plan provides statewide coverage. Schoolteachers are trained by local and regional program coordinators and involve approximately 30 hours of training per teacher that is specific to their grade level. Training covers basic health information, practice in techniques and procedures, and assistance in materials preparation.
- Materials distribution: A comprehensive school health education Materials Center is part of the project contract. The Center handles over 260 items.

- Classroom implementation: Some 40 lessons are presented by the teachers; they cover ten topics in health (these meet the ten topic areas defined by the Education Commission of the States and the Michigan Department of Education's Goals and Performance Objectives for Health Education). Teaching students about the specific health risks of using alcohol and other drugs and giving them skills to resist pressures to use are included.
- Parent participation: Parents receive materials describing what is being taught to their children in the health education classes and providing suggestions for activities and materials that can be used at home to reinforce instruction. Parents are also invited to the schools to review materials and assist in classroom activities.
- Coordination and revision: Members of the Interdepartmental State Steering Committee meet bi-weekly to direct and organize the program. Curriculum materials are updated annually after review and approval from the steering committee.

In 1982, the Governor of Michigan's Health Curriculum Task Force reviewed the health education practices in the State's schools and recommended ways that a curriculum could be devised that would respond to immediate and long-term health needs. In 1983, the State Board of Education, accepting the findings of the task force, endorsed the concept of comprehensive health education. Later that same year, the State Office of Substance Abuse Services launched a five-year prevention plan in which the development of a comprehensive school health education component figured largely. Thus, the stage was set and the necessary networks of players were committed to the plan on both comprehensive health education and information designed to prevent and/or arrest substance abuse. Currently, the program is an inter-agency effort sponsored by seven State agencies:

- Michigan Department of Public Health;
- Michigan Department of Education;
- Michigan Department of Mental Health;
- Michigan Department of Social Services;
- The Office of Substance Abuse Services;
- The Office of Highway Safety Planning; and
- The Office of Health and Medical Affairs.

Curriculum development and marketing, the acquisition of funding, training of trainers, and establishment of evaluation designs then proceeded; the standardized (and thus highly replicable) curriculum was first implemented during the 1984-85 school year in 14 regional sites that served 34 school districts. The program has since expanded to include a total of 155 local school districts and reaches 175,000 elementary (K-6) students. Substance abuse is seen as part of a larger pattern that also leads to school failure, teen pregnancy, delinquency, and other maladaptive behaviors. It is considered to be the result of other underlying social and

psychological causes, and prevention, in this framework, is viewed as requiring "psychological innoculation," which includes learning to resist peer pressure, developing a strong self-concept, acquiring a diversity of coping mechanisms, etc. The curriculum focuses on the short- and long-term health effects of certain behaviors and attempts to foster attitudes that result in healthy living habits in all areas (i.e., nutrition). The curriculum uses basic principles of reinforcement theory to give students opportunities to develop and strengthen these habits. In many regards, the curriculum is patterned after the nationally validated "Growing Healthy" program developed by the national Centers for Disease Control in Atlanta. Classroom teachers who implement the curriculum are required to have up to 30 hours of training in its presentation and have constant access to regional and state-level curriculum experts. Because the curriculum is institutionalized in the schools, it is an enduring part of each student's education, not a one-shot, short-term event. An informal outcome evaluation found that 95 percent of the parents surveyed reported that their children had improved in at least one area of health behavior (i.e., brushing teeth more often, eating healthier snacks, being aware of the problems related to substance abuse, etc.). Other, formal evaluation procedures are underway but the results are not yet available. One such evaluation uses a School Health Education Evaluation instrument developed and validated by Abt Associates with funding from CDC.

During fiscal year 1986-87, the State appropriated $2,245 million for the operation of the program. $1.8 million was administered by the education department for use by the comprehensive health program sites; the remaining $357,000 was administered by the public health department for evaluation, operation of the materials center, and demonstration projects. A 20 percent local match is required from each participating site.

In fiscal year 1987/88 use of $3.5 million in federal Drug-Free Schools and Community Grants funding will support expansion to over 295 local school districts. Statewide, approximately 6,000 teachers will be trained and over 350,000 students will participate in the program.

248-444 O - 89 - 12 : QL 3

SENIOR CITIZEN SUBSTANCE ABUSE PREVENTION PROJECT

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Targeted

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PROJECT ADVISORY COMMITTEE MEMBER:
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CLIENTELE:

All county residents over 65 years, which comprises 8.9 percent of the total population (in 1980) of 1,011,793. In 1980, 6.7 percent of residents over 60 had incomes below the poverty level. Caucasians account for 96.6 percent of all residents over 65; Blacks for 2.6 percent; other minorities in the area include a small community of Eskimo/Aleuts.

MAJOR SERVICES:

Primarily, the services take advantage of many media to inform senior citizens about safe drug-taking practices. To this end, the project has created print and broadcast public service campaigns, has recruited pharmacists as speakers and counselors to discuss the details of responsible drug use, has developed dramatic pieces to deliver the message, and has coordinated its efforts with seven substance abuse coordinating agencies regionally. Specifically, 17,561 people have participated in such programs as:

- Using Medicines Wisely
- Health and Aging
- MIXO: Does Medicine Mix?

- A dump contest encouraging participants to throw out outdated medications
- Talk to Your Doctor.

Training has also been provided for various groups and individuals who work with senior citizens to help them understand, recognize, and deal with the problems of medicine and alcohol misuse. Since 1979,537 providers have benefited from this training.

A 1978 Michigan survey, stimulated by national findings that over 90 percent of adults of 65 and over suffer adverse effects due to improper use of prescription and over-the-counter (OTC) drugs, produced the following findings:

- 71 percent take prescription medicines daily, on average, 3 prescriptions per person;
- 32 percent of these have prescriptions from more than one physician, but 77 percent of them never discuss with one doctor the drugs prescribed by the other(s);
- 50 percent use OTC drugs at least weekly;
- more than 50 percent never discuss potential food/drug or drug/drug interactions with physicians or seek information from pharmacists;
- 30 percent save old drugs (one DUMP contest turned up a prescription from 1946 and OTC medication circa 1935);
- 30 percent stop taking prescriptions early;
- 14 percent change the dosage without consulting the physician;
- 7 percent of the seniors surveyed had alcohol-related problems.

Given these rather alarming figures, the Health Division's Substance Abuse Office began planning public education and provider training strategies that would dramatically alter the potential for iatrogenic problems. Although the limited budget for the program-$16,827 in fiscal year 1986-87 (exclusive of the director's salary)-does not allow for the collection of impact data, process and outcome evaluations show substantial changes in the participant's knowledge, attitudes, and intentions to be more careful when using medications.

The budget for the program is small, and within the means of most communities. The materials and diversity of the effort mean that it can be replicated in whole or in part and are available to any organization that wants to duplicate them. The theoretical base for the program is well documented and grounded in solid social and learning theory.

PARENTS' COMMUNICATION NETWORK OF MINNESOTA

AGENCY:
Parents' Communication Network of Minnesota
National Federation of Parents for Drug-Free Youth

ADDRESS:
P.O. Box 24392

CITY, STATE, ZIP:
Apple Valley, Minnesota 55 124

CONTACT NAME:
Sue Blaszczak, Program Coordinator

PHONE NUMBER:
(612) 432-2886

PROGRAM TYPE:
Community

GOVERNOR:
Rudy Perpich
Phone Contact: (612) 296-3391

CONGRESSPERSON:
Bill Frenzel
Phone Contact: (202) 225-2871

STATE AGENCY DIRECTOR:
Cynthia Turnure
Phone Number: (612) 296-4610

STATE PREVENTION COORDINATOR:
Sharon Johnson
Phone Number: (612) 296-8574

PROJECT ADVISORY COMMITTEE MEMBER:
Linda Chott
Phone Number: (312) 917-6846

CLIENTELE:

Parents with teenage children, now extended to reach parents whose children are still in elementary school. Estimates are that some 10,000 families throughout the State are involved in PCN's activities.

MAJOR SERVICES:

PCN is a grassroots effort to promote parent groups as the core group for a total community prevention plan. An attempt is made to train each parent group to look at awareness and attitudes regarding AOD health and AOD abuse prevention issues in their community, to assess current curriculum, programs, and activities, to assess local, State, and national resources, and then use those resources to provide the programs and activities which they feel they need in their community. In each community, parents usually work in four major areas:

- Publishing directories of members, newsletters, guidelines for hosting parties; etc.
- Sponsor or co-sponsor alternate AOD-free activities;
- Encourage communication among parents, and between parents and children; and

- Educate themselves on basic parenting skills, and educate themselves, their children, and the community about AOD health and AOD abuse prevention.

PCN believes that parents are the missing link in AOD abuse prevention efforts, and groups are forming throughout the State. Until January 1987, the groups operated solely on donated funds; a small grant (with expenditures of $6,000 in the first three months of its operation) has helped to defray expenses to a small degree. PCN is held together by a State steering committee that provides the information and resources to help new groups of parents become organized and take advantage of other's successes.. Although impact evaluations are beyond the scope of PCN's budget, the fact that the organization continues to grow provides substantial evidence that it is deemed effective by participants. In the first quarter of 1987:

- 61 school districts requested information;
- 9 new chapters were formed;
- 462 new volunteers signed up, and
- 1,140 hours of service were clocked in new groups alone.

The model is simple: parents should be involved in their children's lives in positive, supportive ways, not merely as authority-figures who tell them what NOT to do. The local chapters take full advantage of other resources and community groups and rely heavily on the Minnesota Prevention Resource Center's media and consultant services. Moreover, local chapters work closely with the schools and other community education services to provide parent education programs.

A.S.A.P.-ALCOHOL SUBSTANCE ABUSE PROGRAM

AGENCY:
A.S.A.P.-Alcohol Substance Abuse Program
Toms River Regional School District

ADDRESS:
High School South Annex
Hyers Street

CITY, STATE, ZIP:
Toms River, New Jersey 08753

CONTACT NAME:
Carolyn Hadge, Program Coordinator

PHONE NUMBER:
(201) 244-7370
(201) 341-9200, ext. 405

PROGRAM TYPE:
Targeted

GOVERNOR:
Thomas H. Kean
Phone Contact: (609) 292-6000

CONGRESSPERSON:
James J. Howard
Phone Contact: (202) 2254671

STATE AGENCY DIRECTOR:
Riley Regan (Alcohol)
Phone Number: (609) 2928947

STATE AGENCY DIRECTOR:
Richard Russo (Drugs)
Phone Number: (609) 2925760

STATE PREVENTION COORDINATOR:
Dorothea Harmsen (Alcohol)
Phone Number: (609) 292-0729

STATE PREVENTION COORDINATOR:
Charles Currie (Drugs)
Phone Number: (609) 292-4346

PROJECT ADVISORY COMMITTEE MEMBER:
Ketty Rey
Phone Number: (518) 473-0887

CLIENTELE:

16,460 students (K-12) in 16 buildings (10 of which are elementary schools). Roughly 96 percent of the population is Caucasian. Although the median family income for the district is $25,000, several factors converge to put these students at risk for substance abuse: a highly mobile and rapidly growing population; a large number of latch-key children (either in single-parent families or families where both parents work); and a summer resort atmosphere (Toms River is a coastal town with a seasonal influx of beach-seekers) that encourages substance abuse. Based on a random survey of 770 high school students, program staff estimate conservatively that 10 percent of the students are in serious trouble with substances. In addition to the direct and indirect services aimed at students, the program also

targets parents (132 were seen in one-to-one or small group sessions in 1985–86) and school personnel at all levels of school operations, including bus drivers.

MAJOR SERVICES:

- Primary prevention to help youth avoid starting to use other drugs or alcohol;
  - older teens are trained to present factual information, refusal skills, coping mechanisms, self-image enhancement to students in grades 5-7.
  - recreational activities are scheduled throughout the year.
  - a suicide awareness program has been developed to help staff and students recognize and deal with suicidal thoughts or attempts on the part of other students.
- Secondary prevention to intervene with students who are abusing substances:
  - each of the intermediate and high schools has ASAP counselors who provide direct services to youth using drugs and to those who come from families where alcoholism is a problem.
  - the Crossroads program deals with students who come to school under the influence or in possession of alcohol or other drugs; parents are asked to meet with ASAP staff; urine testing is conducted with parental approval; students breaking substance policy rules are suspended for five days.
  - an athletic program, using some bonding principles common to Outward Bound and similar programs (i.e., wilderness adventures), encourages drug-free athletes to help team members who are in trouble; some participants from this program also are involved in primary prevention activities, working with younger children to provide role modeling and foster cohesive group action (through "new games").
- Tertiary prevention for recovering students who are dependent or who have received in- or out-patient care for substance abuse is provided in the form of three group sessions each week at the A.S.A.P. office.-

In 1980, the Toms River School Board contracted with the National Council on Alcoholism of Ocean County to provide services one day each week for seventh and eighth grade students and their teachers. Three years later the program, under the auspices of the superintendent of schools and with assistance from some high school students, had grown to encompass primary prevention efforts for grades 5-7. "Teens Educating on Alcohol Misuse" (TEAM) was then expanded to become the planning body for the entire Toms River area. A full-time director was hired in 1983; the staff now numbers seven full-time employees, two student interns, and a part-time secretary. By the 1985–86 school year, the program was operating on a budget of $109,400 generated from a number of sources, including the local advisory committee on alcoholism, the local beer wholesalers association, and the U.S. Department of Education's Northeast Training Institute.

In addition to having reached at least 12,000 students directly (in counseling or small group discussions) or indirectly (through curriculum materials, workshops, speaking engagements) during the 1985-86 school year ASAP has provided a minimum of six hours in-service training for all school district employees. ASAP has developed a half-dozen publications, including a handbook for coaches and a suicide brochure. The program was featured in the winter 1985 issue of the New Jersey Educational Association (*Review*) and has received media attention.

The wheels are in motion for data collection to produce useful impact information. Process and outcome evaluations are a consistent part of every activity and have been consistently used to make the program more responsive to needs expressed by both teachers and students. The program has been chosen as a model by four State Agencies, including the division of Criminal Justice because it can be operated on a low budget, and with diverse targets, by calling on students themselves to take a large share of responsibility.

THE CITIZENS ALLIANCE TO PREVENT DRUG ABUSE (CAPDA)

AGENCY:
The Citizens Alliance to Prevent Drug Abuse

ADDRESS:
PO Box 8200

CITY, STATE, ZIP:
Albany, New York 12203

CONTACT NAME:
Dr. Ernest Cannava
Superintendent
Hyde Park Central School District
Administrative Offices
Haviland Road, Hyde Park, NY 12538

PHONE NUMBER:
(914) 229-7984

PROGRAM TYPE:
Statewide

GOVERNOR:
Mario Cuomo
Phone Contact: (518) 474-8390

CONGRESSPERSON:
Samuel S. Stratton
Phone Contact: (202) 225-5076

STATE AGENCY DIRECTOR:
John Gustafson
Phone Number: (518) 457-7629

STATE PREVENTION COORDINATOR:
Niel Hook
Phone Number: (518) 457-7096

PROJECT ADVISORY COMMITTEE MEMBER:
Ketty Rey
Phone Number: (518) 473-0887

CLIENTELE:

All citizens of the State of New York, especially the 14,558,500 over the age of 12, but special attention is given to programming for underserved and high-risk groups, especially youth, women, urban dwellers (especially minority urban dwellers), and people more than 60 years old.

MAJOR SERVICES:

CAPDA's services fall into two broad categories, and their realization depends in large measure on the needs of the population in particular locales. CAPDA sees its responsibilities as involving (1) the creation of public awareness of the magnitude of the drug problem and resources available and necessary for its amelioration and prevention and (2) the development of the resource materials that volunteers can use to create this awareness and respond to it.

In the former case, CAPDA has used traditional communications media as well as a toll-free information line, bumper stickers, and close working alliances with public broadcasting to get its message out. In the latter case, CAPDA has produced three major books in collaboration with the Division of Substance Abuse Services:

- ***Handbook for Parents***
- ***Community Organization Guide***
- ***Substance Abuse Prevention Resources for Volunteers***

Since 1979, the total population of New York State has grown by only one percent a year. The substance abusing population, however, rose by 22 percent between 1979 and 1983, and past trends suggest it will grow by another 16 percent by 1988. Some 40 percent of the population over the age of 12 report having used substances nonmedically at some time in their lives; almost 29 percent of these users are between the ages of 12 and 17 (although this group comprises only slightly more than 11 percent of the total population of the State). With these and other alarming figures and trends in mind, and on the heels of the devastating heroin epidemic of the 1970s, it became apparent that some coordinated and yet localized prevention campaign was critical to halting the spread of substance abuse. Thus CAPDA was mandated to create a vast and diverse network of volunteers in a position to help through contributions of time, money, information, space, and access to high-risk and/or underserved populations (i.e., women and the elderly). The central premise of CAPDA philosophy is that creating a drug-free environment is everybody's responsibility.

The most recent financial information shows that CAPDA incurred $81,200 in central office operating expenses. These were covered by a New York State Division of Substance Abuse grant totalling $50,000 (with $6,000 of in-kind services), a $10,000 allocation from Narcotic Drug Research, Inc., and by $15,000 of combined cash and in-kind donations from corporations. In spite of this rather small central budget, CAPDA estimates it reached nearly 100,000 people through direct services and local community action group undertakings in 1986 alone, excluding the 10,000 callers who used the toll-free number. Two hundred and seventy-five groups have been established through CAPDA's efforts; local groups have conducted more than 2,800 prevention activities involving nearly 631,000 participants over a six-year period. Moreover, CAPDA volunteers are instrumental in keeping local and State legislators and policymakers informed of trends in substance use and abuse.

CAPDA relies on input from local sources and on local creation and endorsements of activities they select (and, not incidentally, on locals operating the drug programs in their area). A youth advisory council is an important part of CAPDA's operations, and broad community representation is sought. With this as a model, the program can be exported to any area where people are willing to take responsibility for the welfare of their citizens.

EARLY INTERVENTION ALCOHOL PROGRAM

AGENCY:
Project 25, Community School District 25
Alcohol and Drug Prevention/Intervention Program

ADDRESS:
34-65 192nd Street

CITY, STATE, ZIP:
Flushing, New York 11358

CONTACT NAME:
Mrs. Alice M. Riddell, Director

PHONE NUMBER:
(718) 359-0823

PROGRAM TYPE:
School

GOVERNOR:
Mario Cuomo
Phone Contact: (518) 474-8390

CONGRESSPERSON:
James H. Scheuer
Gary Ackerman
Mario Giaggi
Phone Contact: (202) 225-5471

STATE AGENCY DIRECTOR:
Robert V. Shear
Phone Number: (518) 474-5101

STATE PREVENTION COORDINATOR:
Ketty Rey
Phone Number: (518) 473-0087

PROJECT ADVISORY COMMITTEE MEMBER:
Ketty Rey
Phone Number: (518) 473-0087

CLIENTELE:

Primarily, fifth and sixth graders who are from families where alcohol abuse is a problem; however, all fifth and sixth graders in four selected schools (the schools change each year) receive the classroom program. The 25th school district serves a total of 20,000 students, 49 percent of whom are native born Caucasians; the rest of the student body reflects a broad ethnic mix: families from over 110 foreign countries and Black Americans. The economic status in the district ranges from welfare recipients and public housing residents to high income families living in single. family houses and duplexes.

MAJOR SERVICES:

Four classroom lessons on alcohol. All fifth and sixth grade teachers are involved in conferences that explain the purpose of the lessons. Teachers also participate in follow-up conferences. Students are individually screened, and, where appropriate and desirable, they may take advantage of additional services targeted specifically for children of alcoholics and intended to address some of the adjustment and emotional problems that result. These special services involve weekly self-awareness support groups and additional individual and/or family counseling.

Program staff also speak to PTAs, other community groups, other school personnel, and make referrals when necessary.

Children from families where alcoholism is a problem are themselves at high risk for problems with alcohol and other drugs, for adjustment difficulties, for school problems, and for a range of psychological and emotional consequences that result from feeling guilty, helpless, different, embarrassed, frightened, and inhibited. Recognizing the need that these children have for early intervention, and that family denial would weigh heavily against the children's receiving help outside the school, the prevention program staff organized services to deal specifically with these children at a very early age-during the fifth and sixth grades. Given the statistics on adult alcoholism, they expected to find 40-50 children of alcoholics in their fifth and sixth grade groups; they found 150. The cost of operating the program, since a prevention program was already funded by the district, would be negligible-involving merely the expansion of personnel services to children identified as needing more than the four-lesson curriculum.

In 1986,817 children received the classroom lessons, 90 received counseling, 456 teachers and administrators were involved in some aspect of the program, and 5,000 community members (including parents) participated in some form of organized meeting or conference. Some evaluation conclusions seem particularly important for others wishing to replicate this program (which has not been done, but the potential is certainly there because the program is thoroughly documented):

- Parents in denial do not remove their children from the program;
- Children are always amazed that so many of them are living with or affected by a family member with an alcohol problem;
- Male children cannot accept the fact that their mothers are alcoholics;
- Children of alcoholics have tremendous anger toward the non-alcoholic parent for not doing something about the problem;
- On pre-, post-exposure/counseling measures, all students' self-image improved; 95 percent of them developed trust with the group and the facilitator; and all students accepted and internalized that they were not at fault nor could they change the alcoholic.

It was also found that children of alcoholics were disproportionately represented in special education classes, yet no attention to alcohol was evident during screening, testing, or in the delivery of services.

HIGH-RISK LOW-RISK DRINKING CAMPAIGN

AGENCY:
New York State Division of Alcoholism and Alcohol Abuse

ADDRESS:
194 Washington Avenue

CITY, STATE, ZIP:
Albany, New York 12210

CONTACT NAME:
Betsy Comstock, Assistant Director

PHONE NUMBER:
(518) 473-3231

PROGRAM TYPE:
Statewide

GOVERNOR:
Mario Cuomo
Phone Contact: (518) 4748390

CONGRESSPERSON:
Samuel S. Stratton
Phone Contact: (202) 2255076

STATE AGENCY DIRECTOR:
Robert V. Shear
Phone Number: (518) 474-5417

STATE PREVENTION COORDINATOR:
Ketty Rey
Phone Number: (518) 473-0887

PROJECT ADVISORY COMMITTEE MEMBER:
Ketty Rey
Phone Number: (518) 473-0887

CLIENTELE:

In theory, all 17.7 million residents of New York State are recipients of "High-Low" services; in practice, certain target groups have been identified as being particularly at risk for alcohol abuse or problems arising from its injudicious use:

- Those who use alcohol in high-risk situations-boating, driving, using machinery, or in common tasks that could be dangerous if one were drinking (cooking, doing home repairs, babysitting);
- Those whose use of alcohol could increase the risk of their developing alcoholism, alcohol-related physical problems, or alcohol dependence unless frequency and quantity are reduced; and
- Those who belong to such high-risk groups as children of alcoholic parents.

Moreover, some campaign activities are targeted to those considered to be among low-risk groups so that they can identify signs of becoming at high-risk themselves.

MAJOR SERVICES:

This public information campaign coordinates message communication with local sources of information, referral, and assistance. Multi-media messages were developed by the Division in conjunction with advisory committees from the two agencies

(New York State Council on Alcoholism and the community action project). Local alcoholism councils have distributed print information to their constituencies and local schools, churches, and at other events. Broadcast messages are carried on 36 cable stations, on weekly radio programs, and on local independent and network-affiliated TV stations. An 800 number was inaugurated in 1985 to provide referral and information services (1-800-ALCALLS).

Nearly 14 percent of the population of New York State report drinking five or more drinks on at least one occasion each month. Nearly one million New Yorkers drink at least two drinks daily. Literally millions of people are now growing up in or grew up in alcoholic families. All of these people are at high risk for developing a range of problems with alcohol and for causing problems for other people (and themselves) if they drive, boat, work in kitchens, etc., after drinking too much. Public information campaigns on the risks of alcohol use needed to be expanded beyond the traditional caveats about drinking and driving, and people needed to understand clearly the health problems that could ensue from regularly drinking in excess of two drinks daily.

The solution, a joint creation of the division and NYSCA, was felt to lie in a massive public information campaign that would be targeted to these groups and that would take maximum advantage of communications resources and local energies and organizations. Thus, conferences, health fairs, and even the New York State Fair (which annually attracts 100,000 visitors) have become outlets for print materials developed as part of the campaign. Mechanicals of the print materials are lent to organizations that wish to reprint them (as did the State National Guard). Broadcast materials have been made available to businesses and organizations so that they can be used in-house, not just over the airwaves.

By most indicators, the campaign has been a success. A May 1987 survey of 2,000 people disclosed that nearly three-quarters of them had seen or heard at least one message. Calls to the ALCALLS toll-free line nearly doubled when public service announcements (PSAs) were being aired. When the messages were aired during *purchased* media time (PSAs aired for free rarely, if ever, find their way into prime time), calls increased to 2,189 a month (contract with the PSA average of 465 each month). Beyond these preliminary figures, little impact data are yet available, although a thorough study is underway to determine the relationship of exposure to messages, attitudes, and knowledge about alcohol. It would appear that the expenditure of $648,000 to mount the purchased-time campaign paid off, but this is a very large sum of money for most States. However, materials developed by the campaign will be made available at cost to any public or private agency wishing to use them. Costs of implementing the PSA portion of the campaign were small ($44,000, which covered production and duplication of the campaign materials and printing, as well as administrative costs); the estimate is that this aspect costs about five cents for each person exposed to the message. It is estimated that nearly 13 million people were exposed to at least one media campaign message.

NEWYORKCITYWARNING POSTER ON DRINKING DURING PREGNANCY

AGENCY:
Alcoholism Council of Greater New York

ADDRESS:
133 East 62nd Street

CITY, STATE, ZIP:
New York, New York 10021

CONTACT NAME:
Mrs. Kevin Bellows, Executive Director

PHONE NUMBER:
(212) 9357075

PROGRAM TYPE:
Targeted

GOVERNOR:
Mario Cuomo
Phone Contact: (518) 4748390

CONGRESSPERSON:
Bill Green
Phone Contact: (202) 2252436

STATE AGENCY DIRECTOR:
Robert V. Shear
Phone Number: (518) 474-5417

STATE PREVENTION COORDINATOR:
Ketty Rey
Phone Number: (518) 473-0887

PROJECT ADVISORY COMMITTEE MEMBER:
Ketty Rey
Phone Number: (518) 473-0887

CLIENTELE:

Specifically, the warning poster is meant to advise women of childbearing age of the risks to the fetus because of the mother's drinking. Secondarily, of course, the campaign is meant to spread the word to everyone.

MAJOR SERVICES:

The service provided by this undertaking is in two areas: first, the passage of the law mandating the FAS poster at all liquor-serving establishments, and second, its implementation. The only product is the warning poster that says: "Warning: Drinking alcoholic beverages during pregnancy can cause birth defects." Eight thousand establishments in the City of New York are required to display this poster prominently. When the poster becomes worn, the council provides a replacement copy.

Fetal Alcohol Syndrome is the third most common cause of mental retardation—and the only one that is' preventable. It also accounts for various other birth defects. Drinking during pregnancy adversely affects one out of every 100 live births, even among women who are moderate (two drinks daily) drinkers. Yet

many physicians fail to discuss this risk with their pregnant clients, or fail to point out just how devastating even small amounts of alcohol might be.

With this in mind, the Alcoholism Council of Greater New York set out to win legislation that in some measure would be the alcohol counterpart of the Surgeon General's warnings on cigarette packages. After 15 months of campaigning, and with a broad base of support, the council persuaded the city council to require such warning notices at every establishment where alcohol was sold. By a vote of 28 to 4, the law passed; not only is such a warning required, but there is a $100 fine to establishments that fail to display it.

No real costs were incurred by the Council. However, two Gallup polls have been completed to determine whether the posters have made any impact on the population; the New York City Department of Health paid $18,000 to conduct the polls as well as to print the posters.

The Gallup evaluations were conducted on a pre- post-test model. A survey was concluded in March of 1984 just before the posters were placed and then one year later. Overall, New Yorkers' awareness of the dangers to the fetus from drinking rose from 56 percent to 68 percent; men showed a 14 percent gain; women, an 8 percent increase. In another survey that compared responses from women of childbearing age in New York City against those of women upstate (where the posters aren't required), almost twice as many women in the city as upstate recognized pregnant women as a group at risk for "illness or other problems as a result of their use of alcohol."

Twenty-seven other communities around the country are currently exploring some version of the warning project, and similar laws have been passed-ten incorporated areas and two States.

TEXANS' WAR ON DRUGS (DRUG ABUSE RESEARCH AND EDUCATION, INC.)

AGENCY:
Texans' War on Drugs
DARE Foundation, Inc.

ADDRESS:
11044 Research Boulevard,
Bldg. 0, Suite 200

CITY, STATE, ZIP:
Austin, Texas 78759

CONTACT NAME:
Jo White, Administrative Assistant
John McKay, Executive Director

PHONE NUMBER:
(512) 343-6950

PROGRAM TYPE:
Statewide

GOVERNOR:
Bill Clements, Jr.
Phone Contact: (512) 463-2000

CONGRESSPERSON:
J. J. Pickle
Phone Contact: (202) 225-4865

STATE AGENCY DIRECTOR:
Bob Dickson
Phone Number: (512) 463-5510

STATE PREVENTION COORDINATOR:
Jim Bradley
Phone Number: (512) 463-5510

PROJECT ADVISORY COMMITTEE MEMBER:
Richard Hayton
Phone Number: (314) 751-4942

CLIENTELE:

The War on Drugs reaches out to every Texan with information, services, and activities that will dissuade them from abusing AODs. Youth are singled out for particular attention. Because community involvement is central to the success of the program, emphasis is given to recruiting representatives of all aspects of community life to volunteer their time and energy, and to taking a "zero tolerance" stance with regard to illegal drug use.

Texas has a large (16 million), mobile (6.5 million of them changed residences between 1975 and 1980), ethnically diverse (Hispanics comprise 21 percent of the population, Blacks account for 12 percent and the State ranks ninth in the Nation in its number of American Indian residents) population. Some 420,000 Texas families live in poverty, and the March 1987 unemployment rate reached 8.7 percent, reflecting a general downturn in the economy spurred by limited tax dollars and declining oil revenues.

MAJOR SERVICES:

The War on Drugs is intended to alert communities to the existence of abuse problems, their medical, social, emotional, and financial consequences, and to set in

motion whatever activities, coalitions, curricula and/or services seem appropriate to preventing or ameliorating these problems. Essentially, this is a community organization effort on a grand scale. The process begins under the aegis of paid War on Drugs staff and trained volunteers; these field coordinators visit leaders in each community in their assigned region to discuss the problem and mobilize the community to do something about it. War on Drugs staff and volunteers then offer their services as resource people.

Alcohol and other drug abuse cost Texas $12.4 billion in 1986. In 1985, 442,000 people were arrested for alcohol-specific offenses. More than 300 Texans die annually from drug overdoses, and premature deaths due to alcohol abuse cost the State $1.4 billion each year. Alcohol and other drug abuse exact heavy emotional costs as well, and their elimination became a major focus for legislative concern in the late 1970s. The Texans' War on Drugs (TWOD) was established to fight major battles and minor skirmishes, and to do it with a largely volunteer army that knew each hamlet and city well, and was positioned to make an impact.

TWOD is funded nearly equally by the Governor's Office of Criminal Justice and the Texas Commission on Alcohol and Drug Abuse, the Single State Agency for Texas. In 1986, the program was funded at nearly $800,000, about $4 for each of the 182,698 people served directly (or about a tenth of a penny apiece for the 59,033,516 who were served indirectly). Funding is used to pay staff salaries and travel expenses for the director and administrative staff, six regional field coordinators, three statewide coordinators (for youth, minority, and law enforcement), for publication and circulation of a quarterly newsletter, for education materials, and for general operating expenses.

Regional coordinators are responsible for identifying and informing community leaders about substance abuse problems, but the social work principle of community organization (that each community is unique, knows its own needs, and can be responsible for and find its own solutions) is the *modus* operandi-networking and developing local coalitions and solutions are the objectives of each region. However, the regional staff, who are required to remain up-to-date on both problems and solutions, provide technical assistance to help local groups find the resources they need to implement their own solutions.

Although no substantial impact evaluation has yet been done, school-based surveys show that Texas compares favorably to other States. Data are being gathered now that will provide the baseline for other longitudinal studies..

The War on Drugs model has been replicated in other States, and specific information and technical assistance are available. Perhaps the single most important determinant of success is the strong commitment of the State legislature and the business community, coupled with the involvement of qualified professional staff who know how to effect social change.

HAMPTON INTERVENTION AND PREVENTION PROJECT (HIPP)

AGENCY:
Alternatives, Inc.

ADDRESS:
1520 Aberdeen Road, #102

CITY, STATE, ZIP:
Hampton, Virginia 23666

CONTACT NAME:
Cindy Carlson, Director of Prevention

PHONE NUMBER:
(804) 838-2330

PROGRAM TYPE:
School

GOVERNOR:
Gerald L. Baliles
Phone Contact: (804) 786-2211

CONGRESSPERSON:
Herbert H. Bateman
Phone Contact: (202) 2254261

STATE AGENCY DIRECTOR:
Wayne Thacker
Phone Number: (804) 786-3906

STATE PREVENTION COORDINATOR:
Hope Seward
Phone Number: (804) 786-3906

PROJECT ADVISORY COMMITTEE MEMBER:
William J. McCord
Phone Number: (803) 734-9520

CLIENTELE:

The Hampton Intervention and Prevention Project (HIPP) is targeted for all students in the Hampton City Schools:

- 10,708 students K-6
- 3,003 middle school students
- 6,647 high school students

Of a total population of 124,900, 54 percent of the residents of this area are Caucasian. The median household income is $21,788; 26 percent of the population is either an employee of the military or a military dependent.

MAJOR SERVICES:

HIPP offers specific services as follows:

- Elementary prevention for grades K-5 involving a "Keeping Healthy Kids Healthy" prevention curriculum, various activities designed to promote positive self images and peer pressure for substance-free lives, and "Just Say No" clubs in all the schools that have attracted over 2,000 members from grades 4-6.

- Secondary prevention for middle and high school students incorporating a wide range of activities and organizations, including a "Natural Helpers" group (students are trained for 30 hours to provide peer support and prevention projects for other students), and a "Friends Who Care" organization that promotes drug-free after-school events.
- Parent and community projects designed to impart information and enlist parents' cooperation (using the "Safe Homes" model, among other things) in sponsoring and chaperoning substance-free events.
- Consultation and education, provided by the HIPP staff, to school personnel and social services agencies and to communities in general.
- A student assistance program operated by HIPP counseling staff who work in the middle and high schools with students who are having problems or who have been suspended from school for substance offenses.
- Volunteer services give graduate students and other volunteers the opportunity to learn substance abuse prevention and treatment techniques and applying these in clinically supervised practice where particular attention is given to children of alcoholics.

It is the policy of the Hampton City Schools to suspend students for ten days for their first offense, or the charge of distribution of drugs carries with it the recommendation of expulsion from school. In the early 1980s, school personnel realized that these two policies required a more comprehensive approach if their effects were to be long-lasting. It was then that Alternatives, Inc., was approached to design both a treatment program (now. mandatory for expelled or suspended students) and a prevention program that would not only discourage students from using substances but encourage them to participate in experiences that seem to be valuable in promoting an AOD-free existence,

Phase I of the program was fully implemented in 1983; it was evaluated two years later. One important finding: substance abuse suspensions and expulsions decreased by 32 percent from the 1984-85 school year to the 1985-86 school year. For the latter period, the following figures give an indication of the extent to which the community is involved with and supportive of HIPP:

- 4,874 elementary school children participated in the curriculum; 525 of their parents had direct contact with the program, and 377 teachers were trained to use the materials;
- 7,500 adults attended presentations on prevention; 78 community members volunteered to be on various steering committees and task forces, as did 285 parents;
- 914 students and 399 parents availed themselves of student assistance program services;
- nearly 40,000 people were reached indirectly, including nearly 10,000 students who signed substance-free scrolls.

Costs for the program in fiscal year 1986 totalled $358,247, of which $175,000 came from the City of Hampton, $25,000 from the school system, and the rest from the Department of Criminal Justice Services, the United Way of the Virginia Peninsula, and a Federal Prevention Block Grant. In addition, in-kind services have been substantial: the Rotarians, for example, made it possible for the school system to implement the Operation Aware curriculum throughout the schools; the Department of Parks and Recreation facilitated alternative activities; the Peninsula Hospital provided consultation and printing services; and the mayor's office sponsored various events. The Hampton Police Department, while involved in control efforts, is also strongly involved in the prevention programs.

The HIPP program has been selected by the State of Virginia as a model for a statewide initiative from the Attorney General's office, and it can be duplicated (with varying combinations of services and programs) in any community where joint ownership of the drug problem and shared responsibility for its prevention can be created. The HIPP staff are developing a "how-to" manual describing school and community partnership that will be available at the end of the 1987–88 school year. All HIPP undertakings were themselves based on other proven models from around the country.

STUDENTS ORGANIZED FOR DEVELOPING ATTITUDES (SODA)

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CLIENTELE:

Currently SODA services 12 high schools and 17 elementary schools in a geographic area that comprises one city and three counties. It is designed for sixth and seventh graders and eleventh and twelfth graders (SODA partners, who are selected on the basis of high achievement and the ability to relate well with younger children). Caucasians in the area total 142,921; Blacks, 32,652. Of this total of 175,573, 6,914 people earn over $35,000 per year, and 17,137 earn less than $10,000; the rest fall in between.

MAJOR SERVICES:

The SODA program involves sixth and seventh graders in ten 40-minute sessions designed to promote self-awareness, foster cooperation, impart problem-solving skills, and enhance self-concept. The sessions are led by high school juniors and seniors who have been trained for a total of 30 hours over two weekends in how to use the materials. Each SODA partner works with four or five younger children over the entire 10-week period. The SODA coordinator from Central Virginia Community Services and classroom teachers monitor the sessions, and SODA partners have regularly-scheduled meetings and debriefings with their own faculty supervisors. Other members of the community-the police, Al-Anon, etc.,-participate in

the training for the partners and are available for consultation throughout the school year.

On the belief that teenagers can serve as important role models and "teachers" for younger children, the SODA program was organized around the concepts used by "Dope-Stop," the prevention education arm of the Community Organization of Drug Abuse Control (CODAC) that is in use in and around Phoenix, Arizona (and that has been widely endorsed in that State and nationally). One important message that the program seeks to broadcast to elementary school students is that one can be "straight" (i.e., drug-free and involved in community activities, as are their high school "partners") and still be well liked and respected. Two other educational aims are paramount: one is to increase the younger students' knowledge of drugs (and, not incidentally, the knowledge of the older partners) and the other is to foster the attitudes that discourage drug use.

Based on a target group of 1,630 direct participants, the program cost $9 per student in 1986-87, but only $0.65 of this per-student cost is borne by the schools (for purchase of the SODA manuals and activity sheet packages at $4.00 and $3.00 each, respectively). Other funding in 1986-87 came from Central Virginia Community Services (about $9,000), from donations by civic organizations ($2,200), and from private industry donations ($4,000).

Evaluation of the program is aimed at getting reactions from four groups: parents of the elementary students; parents of the high school partners; SODA partners themselves; and elementary school teachers. In addition, each elementary school participant writes a sentence-completion activity about his or her experiences. Students report looking forward to the sessions, and their parents report that their children's knowledge of drugs and their hazards has increased and their general attitudes have improved. Teachers were most favorable to the program and to the maturity of the partners. The program has been in operation long enough that some of the early sixth grade participants have now graduated from college; several of them have returned to teach in the school system, noting that the SODA program was the single most influential factor in this decision. A substantial impact evaluation is not planned, but assessments and adjustments in the program are an important part of day-to-day operations.

The program has quadrupled in size since its beginnings, and staff **believe** it can be easily replicated in any community that is committed to preventing drug abuse and willing to take the time to organize the program and train the partners.

THE PREVENTION AND INTERVENTION CENTER FOR ALCOHOL AND OTHER DRUG ABUSE (PICADA)

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CLIENTELE:

PICADA seeks to reach all of Dane County's 323,545 residents with prevention information and intervention services when these are needed. Madison, the County's largest city and central campus for the University of Wisconsin, accounts for about 175,000 of the county's total population. Roughly 80 percent of all county residents are over the age of 13; about 8 percent of them are over 65. Caucasians account for 96 percent of the county's residents, Blacks and Asians for nearly 3 percent; the rest are American Indians and other ethnic groups. According to 1980 census figures, 25 percent of the population over 16 earned less than $10,000 annually; on average, the income was just slightly over $18,000 per year.

MAJOR SERVICES:

PICADA categorizes its major service areas as follows:

- Information and referral: PICADA makes available several publications and maintains a library on alcohol and other drug abuse information. It responds to direct requests for information (2,951 in 1986) and maintains close ties with all media in the area.

- Education and training: PICADA works with health-care providers, parent groups, and with school faculty and staff both to impart information to them and to equip them to impart this information themselves. Among other areas receiving attention, PICADA has focused on fetal alcohol syndrome, peer education and refusal programs, the sponsorship of health fairs, and the development of K-12 curricula.
- Family information and interviewing: PICADA staff work with at least one parent and his or her teenage child to prevent costly treatment or incarceration of that child for alcohol or other drug abuse. Some 100 people were seen in this program in 1986.
- Community prevention: PICADA staff provide technical assistance to local communities to create prevention programs, train community volunteers through workshops, and sponsor other activities, including helping local groups develop leadership and locate financial support for prevention programming.
- Worksite programs: PICADA staff provide the services necessary to set up employee assistance programs and wellness programs at the workplace. In 1986, some 4,000 workers benefited from these efforts.

PICADA has a large staff-17 employees-and a large budget $466,800 annually, some of which comes from fees for services, the rest from county funding, private donations, and the United Way. Its broad range of services reaches into every part of the community: schools, business and industry, community and youth groups, professional organizations, and various parts of the local government. Yet one of the organization's major efforts is to impart self-sufficiency in prevention programming to any organization that asks for its services and to ensure that prevention services are provided in a coordinated manner throughout the county. To this end, PICADA maintains cooperative agreements with all related community service organizations and staffs a number of task forces and committees.

PICADA operates on the principle that a drug-free existence is but one manifestation of a general commitment to wellness, and that physical wellness must also involve the positive sense of self necessary to take care of one's body. This is especially true in PICADA's work with school-aged clients (e.g., "Teens Teach Teens," a cross-age peer education program). Results of a survey (by the Dane County Youth Commission) first conducted in 1980 and again in 1985 indicate a slight decrease in some aspects of youth alcohol and other drug abuse. Other ongoing evaluations by PICADA itself show positive responses from participants (although youth seem to show more positive results than their parents think warranted!).

PICADA provides an interesting example of the various ways in which one organization with a central mission can become an important resource for diverse populations that can affect the achievement of that mission. The county executive has proclaimed October as Alcohol and Drug Awareness month, and during that month, PICADA not only sponsors but assists other organizations in implementing a great

range of prevention activities. The program can be replicated in communities that are willing to organize around a central theme and allow one organization to become the "expert" in promulgating information and skills and generating new ideas.

*After November 15, 2000 Fordem Avenue, Madison, WI 53704, (604) 246-7606.

NEW HOLSTEIN STUDENT ASSISTANCE PROGRAM (SAP)

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CLIENTELE:

Approximately 6 percent of the K-12 school population has been involved in this program since its inception. Students are selected on the basis of being affected by their own or another's alcohol or other drug use, but youth not having such problems also receive positive benefits from the program. The school system serves about 1,600 students in this very rural community of 5,000 people, 99.2 percent of whom are Caucasian. About 7 percent of the households report farm income, and about 4.8 percent of all families were below poverty income in 1980.

MAJOR SERVICES:

The school-based program operates on a cycle of identification through support of students who are themselves abusing substances. or concerned about another's abuse:

- Identification of youth with problems,
- Assessment of the nature and extent of the problem,
- Motivation of the student to get help,
- Referral to appropriate in-school or outside agency services, and
- Provision of support for the changes the youth wants to make.

Each of these points in the process may be handled in very different ways, depending on the situation (for example, some youth are identified by teachers or community members; assessment may be as informal as observation of the student or as complex as using a battery of evaluative and diagnostic instruments; referral, help, and support may be in the form of counseling, registration in a formal in- or outpatient treatment program, or involvement of the student in ongoing support groups).

Over the five school years that SAP has been in operation, 491 students have been referred to the program and 474 of them have been involved in groups. Impetus for the program grew out of the recognition that students were having their own problems with substances but were also being affected when others in their lives had problems-in fact, the program staff often found that the behaviors and coping styles were the same in each case. Since the program was begun, the school district has noted a decrease in disciplinary referrals, an increase in attendance, and a significant increase in grade point average (up by 49 percent for students in the SAP program).

The program is operated by a core team of school personnel (faculty and administration) who have been trained by the Wisconsin Office of Alcohol and Other Drug Abuse (it is noteworthy, however, that the SAP planning committee has members from the police department, parents' groups, and other professional organizations). Each school has an administrative coordinator who is responsible for that school's program and who works with the overall program coordinator and the pupil personnel services contact person to ensure the smooth and successful operation of the program. These people network with other community organizations to secure treatment and referral services, information, and program ideas. Teachers are carefully trained to identify the early warning signs of substance abuse problems so that students will find their way into the treatment loop at a very early stage of the problem. To the extent possible, families are involved in all stages of the process.

Once identified, students may take advantage of a range of services, but they all have the option of becoming involved in a school-based support group.- This has been shown to be essential for youth who have been in formal treatment programs as the best hedge against recidivism.

This program has served as a model for many other similar efforts throughout Wisconsin, and staff have acted as technical resources for organizations in a dozen States. A manual has been developed to help other school districts replicate the process. The model works because people see the need for it, believe in it, and see positive results. While it may only be coincidental, it bears noting that this is one of the few school districts in the area that has had no suicides or suicide attempts among the student body.

CRITERIA & PROCEDURES

CRITERIA

The Project Advisory Committee developed a short descriptive paragraph on each of **12** important attributes of effective prevention efforts. Staff from programs seeking consideration as an exemplary program were asked to discuss each of these attributes in their nomination document indicating the way in which the various attributes were implemented or reflected in their programming. Because of the wide diversity of program types and the varying importance of the attributes for those various types, no specific numerical weights were given to the attributes.

Prevention Programs That Work

Twelve Important Attributes of Effective Prevention Programs:

A. ***Program Planning Process:*** The program is based on a sound planning process. The planning process is conducted and/or affirmed by a group that is representative of the multiple systems in the community, such as family, church, school, business, law enforcement, judicial system, media, service organizations and health delivery systems, including alcohol/drug agencies involved in referral, treatment and aftercare.

B. Goals and ***Objectives:*** The program has developed a written document that establishes specific measurable goals and objectives that focus on alcohol and other drug prevention. The goals and objectives should be based on a community needs assessment and reflect specific action plans appropriate to the target groups.

C. ***Multiple Activities:*** The prevention program involves the use of multiple activities to accomplish its goals and objectives. These may include information, education skills development for youth and adults; training of impactors, alternatives, environmental policy and public policy segments. The public policy components may include the development of specific written school policies and/or local, State and national public policies on availability, marketing and other relevant alcohol beverage control issues.

   The activities/strategies are implemented in sufficient quantity (no one-shot deals) to have a positive effect on the targets. The program concept may have replicability for other communities.

D. ***Multiple Targets/Population:*** The prevention program includes all elements of the community and/or population served, including all ages, such as the elderly, high-risk groups, and culturally specific groups. The impact and interrelatedness of each group upon the other must be recognized and emphasized in program development, i.e., youth usage is strongly influenced by community norms and adult role models.

E. ***Strong Evaluation Base:*** The program has a mechanism for data collection on an ongoing basis and a method of cost analysis that can be used to calculate cost effectiveness. In addition, the outcomes of the evaluation need to include a focus on behavior change and be tied back to the planning process so that appropriate programmatic changes can be made.

F. ***Sensitive to Needs of All:*** The program takes into account the special needs of the community/population. The community will not adopt, without study and adaptation, the package deals of another community, but will seek to redesign and tailor prevention programs to reach the specific needs of its own individuals and cultural groups, including different ethnic and gender-specific efforts.

G. ***Part of Overall Health Promotion and Health Care System:*** The prevention program is an integral, essential component of the health care system. It works with the other agencies that provide intervention, referral treatment, and aftercare components of the continuum. It also seeks to work with other prevention agencies (e.g., HMOs, American Cancer Society) in order to build a supportive community environment for the development of healthy lifestyles and healthy lifestyle choices.

H. ***Community Involvement and Ownership:*** The prevention program reflects the basic, essential, philosophical understanding that prevention is a shared responsibility between national, State, and local levels and that specific programs are best done at community levels. "Grassroots" ownership and responsibility are the key elements in the planning, implementation, and evaluation of the program. The prevention program should enable the community to not only examine its problems, but also take ownership and responsibility for its solution.

I. ***Long-Term:*** The prevention program recognizes that there is no such thing as a quick fix or bottled formula or a magic curriculum that will solve the problem. The prevention program seeks to promote a long-term commitment that is flexible and adaptable and responds to a changing environment. The prevention program seeks to build upon its successes and continually enhances its efforts toward its goal. The long-term process integrates prevention activities into existing organizations and institutions such as families, schools, and communities. The long-term nature of the program ensures that interventions begin early and continue through the life cycle.

J. ***Multiple Systems /Levels:*** The prevention program utilizes multiple social systems and levels within the community in a collaborative effort. Each system's involvement is necessary but not sufficient for the success of the program. In order to impact a full range of target populations, all the social systems that are involved must be included. (For example, a program targeted to Hispanic youth must involve family, church, school, community youth recreation, and the law enforcement system.)

K. ***Marketing/ Promotion:*** The prevention program needs to include a marketing approach that showcases the positive effects that prevention has within the community and the effects it has on the various individuals and systems within the community. Policymakers.are key targets for the marketing strategy. (For example, in marketing youth prevention programs, the involvement of policymakers in the marketing strategy may ensure the continuation of that prevention program.) Mechanisms by which programs can achieve self-sufficiency should be built into the design.

L. *Replicability*: The prevention program has documented its philosophy, theory, methods, and procedures in sufficient detail and clarity to permit other organizations to assess its utility and applicability in their setting and to permit orderly development of a similar or related program in a new and (somewhat) different setting.

Separate Category for Targeted Programs

Prevention programs that are targeted to specific populations and needs would be at a disadvantage if they were held to Criteria C, D, and J above which call for "multiple activities," "multiple targets," and "multiple social systems/levels" respectively. Such programs requested consideration in a separate category by writing "targeted program" under the program name on the rating sheet. Reviewers considered only the remaining nine criteria when rating entries in the "Targeted Program" category.

RATING PROCEDURE

State Agency personnel and national organizations submitting nominations were asked to complete a "State & National Organization Program Rating Scale" on each nominee. Thus, for each nomination reaching NASADADMPN, there was a self-rating by the nominee that indicated where date supporting each of the ratings was to be found in the nomination, plus a State or National Organization rating form for that program. For each attribute a specific numerical score was-indicated.

Nominations were submitted to NASADAD/NPN, Suite 520, Hall of the States, 444 North Capitol Street, NW, Washington, DC 20001.

Upon receipt, the original of the nomination with the nominator's rating sheet attached was filed in the NASADAD/NPN central file. Two additional copies were assigned to rating teams composed of Project Advisory Committee members and promptly shipped to them. The rating team members carefully reviewed and rated the program descriptions. Their signed rating sheets were attached to the submission and returned to the NASADAD/NPN office.

NPN **staff** prepared a combined ratings sheet for each program that indicated the submittor's rating, the team members' ratings, and a rating given by NASADAD/ NPN central office readers.

The Project Advisory Committee met in July, 1987, to study all the nominations. They selected a representative set of 20 programs that reflect an appropriate mix of

geographic and cultural variables and a cross-section of program types and sponsoring organizations.

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Appendix A

Drugs: What Are Their Physical and Psychological Effects?

Alcohol

Alcohol, a natural substance formed by the fermentation that occurs when sugar reacts with yeast, is the major active ingredient in wine, beer, and distilled spirits. Although there are many kinds of alcohol, the kind found in alcoholic beverages is ethyl alcohol. Whether one drinks a 12-ounce can of beer, a shot of distilled spirits, or a 5-ounce glass of wine, the amount of pure alcohol per drink is about the same—one-half ounce. Ethyl alcohol can produce feelings of well-being, sedation, intoxication, or unconsciousness, depending on the amount and the manner in which it is consumed.

Alcohol is a "psychoactive" or mind-altering drug, as are heroin and tranquilizers. It can alter moods, cause changes in the body, and become habit forming. Alcohol is called a "downer" because it depresses the central nervous system. That's why drinking too much causes slowed reactions, slurred speech, and sometimes even unconsciousness (passing out). Alcohol works first on the part of the brain that controls inhibitions. As people lose their inhibitions, they may talk more, get rowdy, and do foolish things. After several drinks they may feel "high," but their nervous systems actually are slowing down.

A person does not have to be an alcoholic to have problems with alcohol. Every year, for example, many young people lose their lives in alcohol-related automobile accidents, drownings, and suicides. Serious health problems can and do occur before drinkers reach the stage of addiction or chronic use.

In some studies more than 25 percent of hospital admissions were alcohol-related. Some of the serious diseases associated with chronic alcohol use include alcoholism and cancer of the liver, stomach, colon, larynx, esophagus, and breast. Alcohol abuse also can lead to such serious physical problems as:

- Damage to the brain, pancreas, and kidneys
- High blood pressure, heart attacks, and strokes
- Alcoholic hepatitis and cirrhosis of the liver
- Stomach and duodenal ulcers, colitis, and irritable colon
- Impotence and infertility
- Birth defects and Fetal Alcohol Syndrome, which causes retardation, low birth weight, small head size, and limb abnormalities
- Premature aging
- A host of other disorders, such as diminished immunity to disease, sleep disturbances, muscle cramps, and edema.

Marijuana

Contrary to many young people's beliefs, marijuana is a harmful drug, especially since the potency of the marijuana now available has increased more than 275 percent over the last decade. For those who smoke marijuana now, the dangers are much more serious than they were in the 1960s.

Preliminary studies have shown chronic lung disease in some marijuana users. There are more known cancer-causing agents in marijuana smoke than in cigarette smoke. In fact, because marijuana smokers try to hold the smoke in their lungs as long as possible, one marijuana cigarette can be as damaging to the lungs as four tobacco cigarettes.

Mew studies using animals also show that marijuana interferes with the body's immune response to various infections and diseases. This finding may have special implications for those infected with the Acquired Immune Deficiency Syndrome (AIDS) virus, Human Immunodeficiency Virus (HIV). Although not everyone infected with the virus gets the disease, those who use immune-weakening drugs such as marijuana may increase their risk for developing full-blown AIDS.

Even small doses of marijuana can impair memory function, distort perception, hamper judgment, and diminish motor skills. Chronic marijuana use can cause brain damage and changes in the brain similar to those that occur during aging. Health effects also include accelerated heartbeat and, in some persons, increased blood pressure. These changes pose particular health risks for anyone, but particularly for people with abnormal heart and circulatory conditions, such as high blood pressure and hardening of the arteries.

Marijuana can also have a serious effect on reproduction. Some studies have shown that women who smoke marijuana during pregnancy may give birth to babies with defects similar to those seen in infants born with Fetal Alcohol Syndrome-for example, low body weight and small heads.

More importantly, there is increasing concern about how marijuana use by children and adolescents affects both their short- and long-term development. Mood changes occur with the first use. Observers in clinical settings have noted increased apathy, loss of ambition, loss of effectiveness, diminished ability to carry out long-term plans, difficulty in concentrating, and a decline in school or work performance. 'Many teenagers who end up in drug treatment programs started using marijuana at an early age.

Driving under the influence of marijuana is especially dangerous. Marijuana impairs driving skills for at least 4 to 6 hours after smoking a single cigarette. When marijuana is used in combination with alcohol, driving skills become even more impaired.

Cocaine

Cocaine is one of the most powerfully addictive of the drugs of abuse-and it is a drug that can kill. No individual can predict whether he or she will become addicted or whether the next dose of cocaine will prove fatal. Cocaine can be snorted through the nose, smoked, or injected. Injecting cocaine--or injecting any drug-carries the added risk of contracting AIDS if the user shares a needle with a person already infected with HIV, the AIDS virus.

Cocaine is a very strong stimulant to the central nervous system, including the brain. This drug produces an accelerated heart rate while at the same time constricting the blood vessels, which are trying to handle the additional flow of blood. Pupils dilate and temperature and blood pressure rise. These physical changes may be accompanied by seizures, cardiac arrest, respiratory arrest, or stroke.

Nasal problems, including congestion and a runny nose occur with the use of cocaine, and with prolonged use the mucous membrane of the nose may disintegrate. Heavy cocaine use can sufficiently damage the nasal septum to cause it to collapse.

Research has shown that cocaine acts directly on what have been called the "pleasure centers" in the brain. These "pleasure centers" are brain structures that, when stimulated, produce an intense desire to experience the pleasure effects again and again. This causes changes in brain activity and, by allowing a brain chemical called **dopamine** to remain active longer than normal, triggers an intense craving for more of the drug.

Users often report feelings of restlessness, irritability, and anxiety, and cocaine can trigger paranoia. Users also report being depressed when they are not using the drug and often resume use to alleviate further depression. In addition, cocaine users frequently find that they need more and more cocaine more often to generate the same level of stimulation. Therefore, any use can lead to addiction.

"Freebase" is a form of cocaine that is smoked. "Freebase" is produced by a chemical process whereby "street cocaine" (cocaine hydrochloride) is converted to a pure base by removing the hydrochloride salt and some of

the "cutting" agents. The end product is not water soluble, and so the **only** way to get it into the system is to smoke it.

"Freebasing" is extremely dangerous. The cocaine reaches the brain within seconds, resulting in a sudden and intense high. However, the euphoria quickly disappears, leaving the user with an enormous craving to freebase again and again. The user usually increases the dose and the -frequency to satisfy this craving, resulting in addiction and physical debilitation.

"Crack" is the street name given to one form of freebase cocaine that comes in the form of small lumps or "rock" shavings. The term "crack" refers to the crackling sound made when the mixture is smoked (heated). Crack has become a major problem in many American cities because it is cheap-selling for between $5 and $10 for one or two doses-and easily transportable-sold in small vials, folding paper, or tinfoil.

PCP

PCP is a hallucinogenic drug; that is, a drug that alters sensation, mood, and consciousness and that may distort hearing, touch, smell, or taste as well as visual sensation. It is legitimately used as an anesthetic for animals. When used by humans, PCP induces a profound departure from reality, which leaves the user capable of bizarre behavior and severe disorientation. These PCP-induced effects may lead to serious injuries or death to the user while under the influence of the drug.

PCP produces feelings of mental depression in some individuals. When PCP is used regularly, memory, perception functions, concentration, and judgment are often disturbed. Used chronically, PCP may lead to permanent changes in cognitive ability (thinking), memory, and fine motor functions. Mothers using PCP during pregnancy often deliver babies who have visual, auditory, and motor disturbances. These babies may also have sudden outbursts of agitation and other rapid changes in awareness similar to the responses in adults intoxicated with PCP.

Heroin

Heroin is an illegal opiate drug. Its addictive properties are manifested by the need for persistent, repeated use of the drug (craving) and by the fact that attempts to stop using the drug lead to significant and painful physical withdrawal symptoms. Use of heroin causes physical and psychological problems such as shallow breathing, nausea, panic, insomnia, and a need for increasingly higher doses of the drug to get the same effect.

Heroin exerts its primary addictive effect by activating many regions of the brain; the brain regions affected are responsible for producing both the pleasurable sensation of "reward" and physical dependence. Together, these actions account for the user's loss of control and the drug's habit-forming action.

Heroin is a drug that is primarily taken by injection (a shot) with a needle in the vein. This form of use is called intravenous injection (commonly known as IV injection). This means of drug entry can have grave consequences. Uncertain dosage levels (due to differences in purity), the use of unsterile equipment, contamination of heroin with cutting agents, or the use of heroin in combination with such other drugs as alcohol or cocaine can cause serious health problems such as serum hepatitis, skin abscesses, inflammation of the veins, and cardiac disease (subacute bacterial endocarditis). Of great importance, however, the user never knows whether the next dose will be unusually potent, leading to overdose, coma, and possible death. Of all illegal drugs, heroin is responsible for the greatest number of deaths.

Needle sharing by IV drug users is fast becoming the leading cause of new AIDS cases. It is conservatively estimated that one in six persons with AIDS probably acquired the virus through needle sharing. The AIDS virus is carried in contaminated blood left in the needle, syringe, or other drug-related implements and is injected into the new victim when he or she uses this equipment to inject heroin or other drugs. There is no cure for AIDS and no proven vaccine to prevent it.

Heroin use during pregnancy is associated with stillbirths and miscarriages. Babies born addicted to heroin must undergo withdrawal after birth and these babies show a number of developmental problems.

The signs and symptoms of heroin use include euphoria, drowsiness, respiratory depression (which can progress until breathing stops), constricted pupils, and nausea. Withdrawal symptoms include watery eyes, ***runny*** nose, yawning, loss of appetite, tremors, panic, chills, sweating, nausea, muscle cramps, and insomnia. Elevations in blood pressure, pulse, respiratory rate, and temperature occur as withdrawal progresses.

Symptoms of a heroin overdose include shallow breathing, pinpoint pupils, clammy skin, convulsions, and coma.

"Designer Drugs"

By modifying the chemistry structure of certain drugs, underground chemists have been able to create what are called "designer drugs"-a label that incorrectly glamorizes them. They are, in fact, analogs of illegal substances. Frequently, these drugs can be much more potent than the original substances, and they can therefore produce much more toxic effects. Health officials are increasingly concerned about "ecstacy," a drug in the amphetamine family that, according to some users, produces an initial state of disorientation followed by a rush and then a mellow, sociable feeling. We now know, however, that it also kills certain kinds of brain cells. These "designer drugs" are extremely dangerous.

Source: U.S. Department of Health and Human Services, ***What You Can Do About Drug Use in America,*** DHHS Pub. No. (ADM) 88-1572, 1988.

APPENDIX B

Signs of Alcohol and Drug Use

Changes in patterns of behavior, appearance, and attitudes may signal use of alcohol or other drugs. Not all youth who use alcohol also use other drugs and not all youth who use other drugs use alcohol, but use of more than one type of substance is not uncommon. The items in the first category listed below are direct evidence of drug use; the items in the second of alcohol use. Items in other categories are signs that may indicate use of either alcohol or other drugs, although some of the signs listed may relate to other serious problems.

Signs of Drug Use

- Possession of drug-related paraphernalia such as pipes, rolling papers, small decongestant bottles and small butane torches.
- Possession of drugs or evidence of drugs, peculiar plants, or butts, seeds or leaves in ashtray or clothing pockets.
- Odor of drugs, smell of incense or other "cover-up scents."
- Identification with the drug culture.
  - Drug-related magazines, slogans on clothing.
  - Conversation and jokes that are preoccupied with drugs.
  - Hostility in discussing drugs.

- Flashy, expensive clothing and jewelry not purchased by parent.
- Possession of large amounts of money and expensive items.

Signs of Alcohol Use

- Drunkenness, including slurred speech or difficulty walking.
- Possession of a fake identification card.
- Odor of alcohol.

Signs of Alcohol or Other Drug Use

- Physical Deterioration
  - Memory lapses, short attention span, difficulty in concentration.
  - Poor physical coordination, slurred or incoherent speech.
  - Unhealthy appearance, indifference to hygiene and grooming.
  - Bloodshot eyes, dilated pupils.
- Dramatic Changes in School Performance
  - Distinct downward turns in student's grades—not just from C's to F's, but from A's to B's and C's. Assignments not completed.
  - Increased absenteeism or tardiness.
- Changes in Behavior
  - Withdrawal from the family.
  - Changes in friends, evasiveness in talking about new ones.
  - Increasing and inappropriate anger, hostility, irritability, secretiveness.
  - Reduced motivation, energy, self-discipline, self-esteem.

— Diminished interest in extracurricular activities and hobbies.

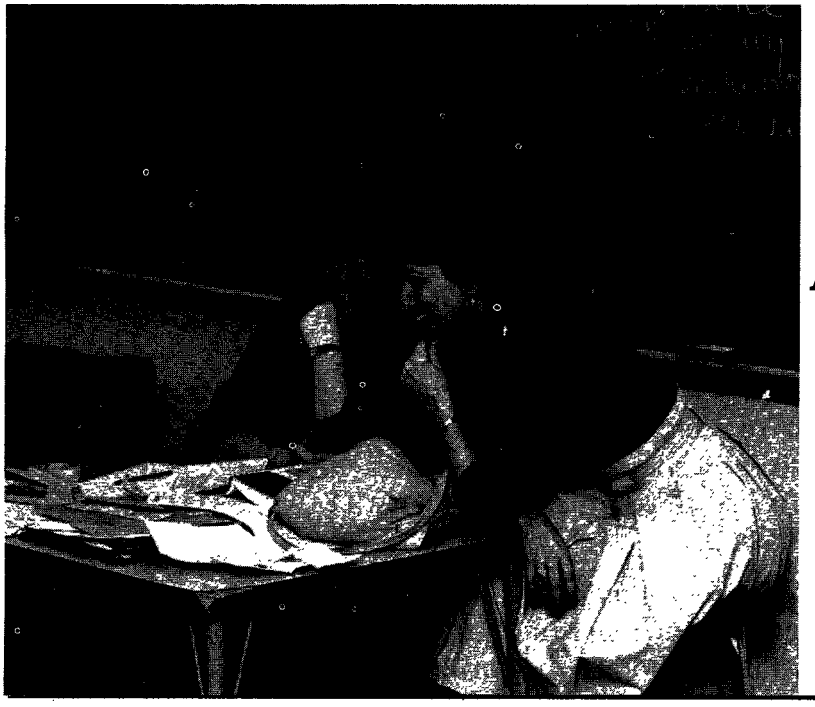
— Chronic dishonesty (lying, stealing, cheating). Trouble with the police.

— Use of eyedrops.

— Sleeping more than usual and at unusual hours.

— Car accidents, fender-benders.

Adapted from ***What Works, Schools Without Drugs.*** U.S. Department of Education, 1986.



APPENDIX C

Message and Material Review Process

Introduction

One of the most dramatic results of the President's declared "War on Drugs" that resulted from the passage of the 1986 Anti-Drug Abuse Act and the 1988 Omnibus Anti-Drug Act has been the proliferation of prevention materials-printed and audiovisual products generated by the American public in response to the Nation's needs. Unfortunately, even the best intentions do not always result in the best prevention products, and prevention material consumers are faced with the overwhelming task of sorting out which materials contain the appropriate and accurate information for effectively reaching their respective audiences. The Federal Government has acted to assist the American public.

The Office for Substance Abuse Prevention (OSAP), in the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), has implemented a review program to help prevention workers screen for appropriateness, accuracy, credibility, appeal, and so forth. The cornerstone of the OSAP program is the Communications Message and Material Review Process, a detailed manual designed to assess a product's conformance to public health policies and principles, scientific accuracy, and appropriateness of communication strategies.

This manual is available for either the development or review of prevention products for use by Federal, State, and local prevention workers. The manual contains a product description form and a guide for completing the form and the ADAMHA/OSAP scientific, 'policy, and

communications review form with definitive guidelines for completing the review. These guidelines are first and foremost based on the principle of "do no harm." They have evolved over a period of time and have been tested with more than 2,000 products. If you have any corn-ments or suggestions regarding the use of this manual, please send them to National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20852.

These forms were not designed to assess prevention programs, training programs, or comprehensive curricula, although the underlying principles may be applicable for those developing or reviewing these programs. They were designed to review videotapes, books, pamphlets, and so forth, whether used individually or as a communications package. The Office for Substance Abuse Prevention, in cooperation with the Department of Education, is cur-rently in the process of developing guidelines for the re-view of curricula. A curricula review should be completed by September 1990.

An acceptable rating on any product does not imply Government endorsement or approval of the message(s) or material(s). Current and relevant materials receiving an acceptable rating, however, will be listed on resource lists. Not being listed on a resource list does not in **any** way reflect that materials are unacceptable. To be **in-**cluded in the review process, an author or producer must make a copy of the material available, free of charge, for storage and retrieval at the National Clearinghouse for Alcohol and Drug Information.

Accession No. _____
Date _____
Reviewer _____
A UA

PRODUCT DESCRIPTION
Office for Substance Abuse Prevention
Alcohol, Drug Abuse, and Mental Health Administration

Title of Product: _____
Producer/Author: _____
Organization: _____
Address:. _____
_____
Other Sponsors/Endorsers: _____

Publication Date: _____
Revision Date: _____
Contact: _____
Phone: _____
Grant/Contract: _____

Format:
_ Article
_ Book
_ Booklet
_ Brochure
_ Catalog
_ Classroom Material
_ Comic Book
_ Communications Package
_ Fact Sheet
_ Magazine
_ Newsletter
_ Other (describe) _____
_ Workbook
_ Poster
_ Print Ad
_ 3/4" Video
_ VHS Video
_ 16mm Film
_ Radio PSA
_ script
_ Slides
_ Audio Tape
_ Skit Script
_ Software

Length:
_ pages
_ sessions
_ minutes

Context(s): (check all that apply)
_ Stands Alone
_ Part of a Program/Packet (describe)
_____
_ Has Training Component (please enclose)

Topic(s): (check no more than 3)
_ Alcohol
_ Drugs (specify) _____
_ Alcohol/Drugs
_ Prevention
_ Intervention/Treatment

Mode(s) of Delivery: (check no more than 2)
_ Self-Instructional
_ Instructor-led
_ Mass Media

Target Audience(s): (check no more than 3)
_ A/D Prevention Professionals
_ A/D Treatment Professionals
_ African America&Blacks
_ Asian and Pacific Islanders
_ Caucasians
_ College Students
_ Community Service Groups
_ Disabled
_ Educators (specify grade[s])
_ Elderly
_ Elementary Youth (5-12)
_ Employees
_ Employers
_ General Public
_ Health Care Providers (specify specialty)
_____
_ High-Risk Families
_ High-Risk Youth
_ Hispanics/Latinos (specify)
_ Jr. High Youth (13-15)
_ Media Representatives
_ Native Americans (specify)
_ Other (describe) _____
_ Parents (specify age of child)
_ Patients
_ Policymakers/Administrators
_ Preschool (age 4 and under)
_ Recreation/Sports Personnel
_ Scientists and Researchers
_ Sr. High Youth (16-18)
_ Women
_ Young Adults (19-25 years)

Setting: (check no more than 2)
_ Community Organizations
_ Government
_ Health Care
_ Home
_ Legal/Judicial
_ Military
_ Recreation/Sports
_ Religious
_ Rural
_ School
_ Suburban
_ Urban
_ Worksite
_ Other (describe) _____

Language(s): (check all that apply)
_ English
_ Spanish (specify) _____
_ Bilingual (specify) _____
_ Other (indicate) _____

Readability: (see attached examples)
_ Low Literacy (grade level 4)
_ Easy (5-8)
_ Average (9-10)
_ Fairly Difficult (11-13)
_ Difficult (14-18)
_ N/A

Pretested/Evaluated:
_ Yes
_ No
_ Unknown
(If yes, describe and include copy of report if possible.) _____
_____

Current Scope: (check only 1)
_ National: _____
_ Regional: _____
_ State: _____
_ Local: _____

Availability:
_ Unknown
_ Restrictions on Use (Explain under Comments)
_ Copyrighted (Owned by: _____
_ Public Domain
_ Available Free
_ Negatives Available on Loan
_ Payment Required
Price $ _____
_ Available Through Free A-V Loan Program
_ Source (if different from above) _____
_____
_____

Description: (Please describe the product in two-three sentences.)
_____
_____
_____

Comments: (Use separate page for further information as described under Comments in Product Description Guidelines.)

Product Description Form Guidelines

1. Accession Number

Actual assignment of an accession number for materials data base items will be done in the data analysis or acquisitions unit of the Clearinghouse. The five-character numbers will be assigned in sequence. However, the reviewer filling out the Product Description form should identify the review source as being NCADI or some other entity (e.g., OSAP staff, grantee). If reviewed at NCADI, the reviewer should write "vf" on the accession number line. Other reviewers should leave it blank. These two-character notations will be the accession number prefixes used on the automated materials data base.

2. Screener and Date

Fill in the date of the review and your first initial and last name.

3. Evaluation

Circle "A" (Acceptable) or "UA" (Unacceptable) after you have completed filling out both the Product Description form and the OSAP/ADAMHA Review form. It will be the last step of the review. An **"Unacceptable" rating in either the Scientific Review or the Policy and Principles Review will cause a product's overall rating to be "Unacceptable."**

4. Title

Print the title with its subtitle(s) exactly as it appears on the piece except (1) where a period or dash is used to separate subtitles, substitute a colon, (2) omit articles (a, an, the) as the first word of an English-language or Spanish-language title, and (3) correct misspellings.

Be careful to record all subtitles. These can be identified by (1) reading the cover and title page from left to right and top to bottom, (2) looking for variations in typesize or print boldness, and (3) for books, reading the spine.

5. Publication Date

Print the month and year, if available, using the standard three-letter abbreviation for the month (the first three letters). If no publication date is provided, try to derive the publication year from the information provided. To indicate that a publication year is derived, place the year between brackets. If no date is available and a date cannot be derived, write "N.D." to indicate no date is available.

6. Author/Producer

Identify a specific author/producer for the item being processed. The entry should always be a person's name. Provide the first and middle initial(s) and the last name. Do not include. author titles, degrees, and so forth. If no author's name is provided, leave the space blank.

7. Organization Name, Address, and Telephone Number(s)

List the organizational affiliation of the author/producer, with a complete address and phone number; include area codes, zip codes. If more than one phone number is provided, such as a toll-free number, include all numbers.

8. Contact

If given, name the person to contact for ordering materials (first and middle initial(s) and last name).

9. Sponsor/Endorser

List the sponsor/endorser of the product if it is clearly identified for a product.

10. Contract/Grant

If the product was produced under grant or contract, provide the sponsoring agency's name (public or private) as well as specific grant or contract numbers.

11. Format

Check the single most appropriate category in the Format section of the sheet. However, if a film is available in a number of formats, such as 3/4" video or 16mm, check all appropriate categories. The following categories are defined for clarification.

Article:	Journal articles or reports that would not normally be included in the bibliographic data base, such as an article that does not appear in a peer-reviewed journal. If possible, show the full citation in the organization section.
Book:	Formally bound publication, usually of standard size.
Booklet:	Usually odd-shaped pages (under 60 pages) informally bound (i.e., saddle stitched, stapled, GBC).
Brochure:	Single sheet *folded* to create more than one page (panel) of information.
Classroom Material:	Material designed to be used by both teacher and students in implementing alcohol/other drug education (e.g., puppets, posters, games, coloring books accompanied by a teacher guide).
Communications Package:	Check this category when reviewing a set of materials distributed as a "package." In addition to reviewing the package as a whole, be sure that each piece of material is reviewed independently and given its own accession number.
Fact Sheet:	Usually a xeroxed or printed 8 1/2" x 11" sheet with basic factual information often bulleted; may be more than one page, but is not folded.
Magazine:	This category includes periodicals. NOTE: only one issue of a "magazine" will be entered into the materials data base, and this issue will be used to represent the magazine as a whole. Therefore, the magazine's description should not be based on a single issue or article, but rather the magazine itself.
Newsletter:	Only one issue of an organization's newsletter will be entered-general topics covered by the newsletter as a whole should be described, not just the articles in any one issue.

Workbook:	Printed material that is designed for interactive learning where the audience, following directions, writes in responses.

12. Length

Fill in the total number of pages for printed materials (a double-sided page is counted as two pages), the number of minutes for films and videos, and the number of sessions to be used, if applicable (e.g., 10 sessions).

13. Context

If the material is a piece of a program or if it is distributed as one piece of a package, check "part of program/packet" and fill in the name of the program or a brief description. If the material was designed to stand alone and is not a piece of a program/packet, check "stands alone." If there is a training component that comes with the material, check the appropriate space.

14. **Topics**

To aid in identifying topics please use the following definitions:

Drug: (specify)	If the product has a single drug topic, fill in the name of the appropriate drug category (use the attached list of 15 drug categories).
Prevention:	Provides information or strategies about alcohol and other drugs with the purpose of preventing alcohol and other drug problems before they start.
Intervention/ Treatment:	Provides information about alcohol and other drugs with the purpose of intervening in existing alcohol and other drug problems.

Note: Reviewers should include topics covered, such as AIDS, alcohol-related birth defects, drugged driving, etc., in the Description section.

15. Mode of Delivery.

- Self-instructional: can be used without a teacher or leader.

- Instructor-led: requires a teacher or leader.
- Mass media: delivered through TV, radio, or the press.

16. **Target Audience(s)**

Identify the audience that the product is INTENDED to reach, e.g., teachers (who will use it with students). If the targeted audience is not clearly identified, consider the language style, use of terminology, length, appropriateness of examples, and format to determine the target audience. Remember that the target audience is not necessarily the same group that is being described in the product, and the reviewer may need to call the product source to determine the intended audience.

17. Setting

Materials may be targeted to particular settings as well as particular audiences. Settings should convey images and symbols appropriate to the particular classification.

- Community Organization: for use by a wide range of groups such as Boys Clubs, ***4-H,*** Elks, PTA, etc.
- Government: Federal, State, and local alcohol/drug, education, health, law enforcement, etc., agencies.
- Health Care: images include hospitals, emergency vehicles, clinics, offices, visiting caretakers, etc.
- Home: materials actually used in the home, e.g., an interactive workbook to be completed by parent and child.
- Legal/Judicial: may include prisons, probation offices, courtrooms, paralegal offices, etc.
- Military: the armed services.
- Recreation/Sports: images include gymnasiums, fields, courts, playgrounds, streets, etc.
- Religious: images include mosques, synagogues, and churches or religious-oriented storefronts, camps, etc.

- Rural: characterized by the country, farmland, agriculture, and open spaces. Images include farms, low density, crafts, blue-collar labor.
- School: from preschool to college. Images include classrooms, school buildings, teachers, students, etc.
- Suburban: residential areas adjacent to cities. Images include schools, large grassy playgrounds, shopping malls, open space parks, middle-class family orientation.
- Urban: characteristic of a city in general; multi-ethnic, dramatic range from wealth to poverty. Images include high density, heavy traffic, public transportation, public playgrounds and parks, city street scenes.
- Worksite: inside buildings or at other sites such as mines, construction areas, etc.

18. Language

Identify all languages that the product is available in. If a product is bilingual, check bilingual and fill in the names of the two languages. If in Spanish, specify the actual audience: Mexican American, Puerto Rican American, Cuban American, etc.

19. Readability

To determine the readability level, apply the following SMOG Test readability formula: Count *30* sentences in the following manner: 10 consecutive sentences near the beginning, in the middle, and near the end of the text. Next, count the number of words with *3* or more syllables (polysyllabic) in your choice of 30 sentences. Then locate the total number on the SMOG Conversion Table in the left-hand column and find the corresponding grade level in the right-hand column.

Some Tips for Applying the SMOG Test

- A sentence is defined as a string of words punctuated with a period(.), an exclamation point (!), or a question mark(?).
- Hyphenated words are considered as one word.

- Numbers that are written out should also be considered, and if in numeric form in the text, they should be pronounced to determine if they are polysyllabic, e.g., pol-y-syl-la-bit.
- Proper nouns, if polysyllabic, should be counted.
- Abbreviations should be read as unabbreviated to determine if they are polysyllabic.

SMOG Conversion Table

Total Polysyllabic Word Counts	Appropriate Grade Level (+ 1.5 Grades)	
o-2	4	Low Literacy
3-6	5	
7-12	6	Easy
13-20	7	
21-30	8	
31-42	9	Average
43-56	10	
57-72	11	
73-90	12	Fairly Difficult
91-110	13	
111-132	14	
133-156	15	
157-182	16	Difficult
183-210	17	
211-240	18	

20. Pretested/Evaluated

Check "unknown" unless it states somewhere on the product that it was evaluated. (It is expected that within the next 2 years, all materials to be listed on resource lists produced by NCADI will have been at **least minimally pretested/evaluated with the target audiences.)**

21. Current Scope

Indicate the intended distribution pattern for the product. If it was prepared by a State organization, check State.

22. Availability

Leave blank if there is no indication of availability (i.e., ordering information). If there is no address for the product's organization or phone number, check "Unknown." If the source for the product is different from the producing organization, fill in the name of the source. NOTE: when developing resource lists using this material, you may need to call the organization and get availability and ordering information. It is wise to do this with all materials over 6 months old to be sure available information is current. Include date of last revision whenever possible.

23. Description

Write a two to three sentence description of the content of the product. Be sure to write in complete sentences and include the topics covered. The written description should be meaningful and concise and not repeat the descriptive information provided above. It should focus on the content of the product and include information about the populations described by the product (as opposed to the target populations), details about the subjects (e.g., alcohol- or drug-impaired drivers), and the product's intent; If appropriate, it can include information about the graphics (pictures, graphs, colors) and style (humorous, easy to read). The description ***should not*** be promotional in nature, for example, this "award-winning" film.

24. Comments (to be filled out by screener/reviewer)

The comments section is meant to contain information related to ordering the material being reviewed, its availability at NCADI, and any other specifics not covered above. It should include the following:

- Additional product information that is useful for ordering materials such as copyright and edition numbers.
- Publication numbers and/or inventory numbers. For example, most government publications distributed by NCADI have ADAMHA (ADM) control numbers and internal inventory numbers-both such numbers would be entered in the comments section. Include the Superintendent of Documents

ordering information and cost whenever appropriate.

- Information that will help with ordering products that are part of a series or a program/packet.
- Detailed information about the appropriate audiences; for example, materials are best suited for physicians and not other health care providers, or materials are best suited for Native Americans living in urban areas and not those living in tribal areas.

Drug Classification Attachment

1. ALCOHOL
2. ANABOLIC STEROIDS
3. CNS DEPRESSANTS (other than alcohol)
4. COCAINE/CRACK
5. DESIGNER DRUGS
6. HALLUCINOGENS
7. INHALANTS
8. MARIJUANA AND CANNABINOIDS
9. NICOTINE
10. OPIOIDS (Opiates, Narcotics, Narcotic Analgesics)
11. OVER-THE-COUNTER (OTC) MEDICINES
12. PHENCYCLIDINE (PCP)
13. PRESCRIPTION DRUGS
14. STIMULANTS (other than cocaine)
15. OTHER DRUGS

Name: _____
Date: _____
Reviewer: Scientific _____
Reviewer: Policy _____
Reviewer: Communications _____

OSAP/ADAMHA REVIEW

I. SCIENTIFIC REVIEW (see attached Guidelines)

1. Material is scientifically significant, based on valid assumptions, supported by accurate citations, and appropriately used. — Yes ____ No ____ N/A
2. Scientific methods and approaches are adequate, appropriate, and clearly described. — Yes ____ No ____ N/A ____
3. Findings reported are accurate, current, and applicable to the subject matter. — Yes ____ No ____
4. Recommendations: — acceptable ____ unacceptable ____
5. Comments on above:

II. POLICY REVIEW (see attached Guidelines)

1. Material makes clear that illegal drug (including alcohol for those under 21) use is unhealthy and harmful for all persons. — Yes ____ No ____ N/A ____
2. Material gives a clear message that risk is associated with using any form or amount of alcohol or other drugs. — Yes ____ No ____ N/A ____
3. Material gives a clear message of no alcohol use for — Yes ____ No ____ N/A ____
   - persons under 21 years of age
   - pregnant women
   - recovering alcoholics and addicts
   - persons taking prescription or non-prescription drugs
4. Material states clearly that pregnant women must not use any drugs (prescription or nonprescription) without consulting their physicians. — Yes ____ No ____ N/A ____
5. Prevention material does not contain illustrations or dramatizations that could teach people ways to prepare, obtain, or ingest illegal drugs. — Yes ____ No ____ N/A ____

   Intervention material does not contain illustrations or dramatizations that may stimulate recovering addicts or alcoholics to use drugs. — Yes ____ No ____ N/A ____
6. Material does not glamorize or glorify the use of alcohol and other drugs. — Yes ____ No ____ N'A ____
7. Material does not "blame the victim." — Yes ____ No ____ N/A ____

a. Material targeting youth does not use recovering addicts or alcoholics as role models. — Yes ____ No ____ N/A ____

9. Material supports abstinence as a viable choice. — Yes ____ No ____ N/A ____
10. Material is culturally and ethnically sensitive. — Yes ____ No ____ N/A ____
11. Recommendation: — acceptable ____ unacceptable ____
12. Comments on above:

NOTE: If either of the above is rated unacceptable, the product's overall rating will be unacceptable.

III. COMMUNICATIONS REVIEW (see attached Guidelines)

1.	Material is appropriate at cognitive and developmental levels.	Yes ____	No ____		
2.	Institutional source is credible.	Yes ____	No ____		
3.	Individual source is credible.	Yes ____	No ____		
4.	Language is appropriate.	Yes ____	No ____	N/A ____	
5.	Tone is appropriate.	Yes ____	No ____	N/A ____	
6.	Length is appropriate.	Yes ____	No ____	N/A ____	
7.	Format/graphics quality is acceptable.	Yes ____	No ____	N/A ____	
8.	Messages				
	– are appealing	High ____	Med ____	Low ____	N/A ____
	– are believable	High ____	Med ____	Low ____	N/A ____
	– create awareness	High ____	Med ____	Low ____	N/A ____
	– persuade	High ____	Med ____	Low ____	N/A ____
	– call for action	High ____	Med ____	Low ____	N/A ____
	– have been pretested	High ____	Med ____	Low ____	N/A ____
9.	Material needs to be combined with other messages or materials to be effective.	Yes ____	No ____	N/A ____	
10.	Readability level is appropriate.	Yes ____	No ____	N/A ____	
11.	Comments on above:				

NOTE: Even though the product receives a Communications Review, it will not be rated as acceptable or unacceptable at this time. It is expected, however, that this rating will be implemented as part of the overall assessment by January 1, 1991. Developers are encouraged to use these guidelines as. they plan and produce products.

Scientific Review Guidelines

1. 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.
2. 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.
3. 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
4. Recommendation: rate as acceptable or unacceptable. If rated unacceptable, an overall rating of unacceptable should be recorded on the Product Description Form.
5. Comments: complete per instructions above. Highlight positive aspects and problems.

OSAP Policy Review 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:

   - 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.
   - Use of a drug for a purpose other than its prescribed use (e.g., tranquilizer or diet pill for purposes other than prescribed).
   - Use of any product or substance that can produce a drug-like effect (e.g., using glues, gasoline, or aerosols as inhalants).
   - Use of any legal drug, including alcohol or tobacco, by individuals legally underage for its use.
   - -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 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 decisionmaking process regarding alcohol use. Learning how to make wise decisions is an important skill. However, the material should make it clear that a nonuse 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 defects. 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 a 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 alright 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

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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 or 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 physician 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 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 "fillers."

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 such 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 individual's 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 just 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 other 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 or 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. ***Materials 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 must be culturally and ethnically sensitive. Materials must not be biased and must 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 must 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 such cultural factors as the importance of the extended family, key role of grandparents, and religion.

11. ***Recommendation: rate as acceptable or unacceptable.***

If rated unacceptable, an overall rating of unacceptable should be recorded on the Product Description Form.

12. ***Comments: highlight positive aspects and problems.***

Communications Review Guidelines

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

   Look carefully at the material to determine if it is best suited for the target audience identified on the Product Description Form.

   - 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 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 or an. attitude of personal invulnerability-" it can't 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 as 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 grey; 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 offer 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 must

- 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. ***Needs To Be Combined With Other Messages and /or Materials To Be Effective***

Some materials, such as videos, are more effective if accompanied by a facilitator's or user's guide. Materials that have been submitted as a series of products have already been combined with other products, so indicate N/A.

10. ***Readability Level***

The readability level should reflect the skills of the target audience. Use the SMOG Readability Formula to determine reading level:

The SMOG Readability Formula (short version)

- Count off 10 consecutive sentences near the beginning, in the middle, and at the end of the text.
- From this sample of 30 sentences, circle all polysyllabic words (3 or more syllables).
- Count the number of words in the 30 sentences, and look up appropriate grade level in the following table.

SMOG Conversion Table

Total Polysyllabic Word Counts	Appropriate Grade Level (+ 1.5 Grades)	
o-2	4	Low Literacy
3-6	5	
7-12	6	Easy
13-20	7	
21-30	8	
31-42	9	Average
43-56	10	
57-72	11	
73-90	12	Fairly Difficult
91-110	13	
111-132	14	
133-156	15	
157-182	16	Difficult
183-210	17	
211-240	18	

Some Tips for Applying the SMOG Test

- A sentence is defined as a string of words punctuated with a period(.), an exclamation point (!), or a question mark(?).
- Hyphenated words are considered as one word.
- Numbers that are written out also should be considered, and if in numeric form in the text, they should be pronounced to determine if they are polysyllabic.
- Proper nouns, if polysyllabic, should be counted.

- Abbreviations should be read as unabbreviated to determine if they are polysyllabic.

11. ***Comments: highlight positive areas and problems.***

Note: The Communications Review will not be used for rating products as acceptable or unacceptable until January 1, 1991. However, it is important to complete the Review so that feedback may be provided.

Feedback on Message and Material Review Process

Since OSAP expects the Message and Material Review Process to continually evolve, we encourage you to provide us with your comments and suggestions. Please send them directly to:

Division of Communications Programs
Office for Substance Abuse Prevention
5600 Fishers Lane
Rockwall II Building, Room 9C03
Rockville, MD 20857

Appendix D

Organizations and Programs

ACTION, 806 Connecticut Avenue, NW, Washington, DC 20525, (202) 634-9759. Through its Drug Alliance, the Federal Domestic Volunteer Agency inspires and promotes community-based, volunteer drug use prevention projects for the Nation's at-risk youth and the elderly.

ALCOHOL AND DRUG PROBLEMS ASSOCIATION OF NORTH AMERICA, 444 N. Capitol Street, NW, Suite 181, Washington, DC 20001, (202) 737-4340. The association is a policy advocate for those measures that offer a positive impact on alcohol and other drug problems and provides a forum and opportunity for professionals to improve the quality of prevention and treatment services. The association also provides training and professional development programs for professionals, and timely, useful information via newsletters and bulletins.

ALCOHOLICS ANONYMOUS (AA), P.O. Box 459, Grand Central Station, New York, NY 10163, (212) 686-1100. With more than a million members in 114 countries, AA is the largest self-help group for recovering alcoholics. Alcoholics of all ages are welcome. Local groups are listed in all telephone directories.

AL-ANON FAMILY GROUPS; P.O. Box 862, Midtown Station, New York, NY 10018, (212) 302-7240. Al-Anon Family Groups, which includes Al-Anon for adults and Al-ateen for youth, are self-help groups for family members and friends of persons with alcohol-related problems. Local groups are listed in all telephone directories.

AMERICAN COUNCIL FOR DRUG EDUCATION, 204 Monroe Street, Rockville, MD 20850, (301) 294-0600. Resource for information on drug use. Develops media

campaigns, reviews scientific findings, and publishes books and a newsletter. Offers films and curriculum materials for teens.

AMERICAN SOCIETY OF ADDICTION MEDICINE, 12 West 21st St., New York, NY 10010, (212) 8486050. An organization of physicians that disseminates information and encourages the attainment of professional skills in the area of diagnosis and treatment of alcohol and other drug dependencies. This organization also sponsors continuing education programs for physicians and offers certification for expertise in alcohol and other drug dependency issues. (Formerly American Medical Society on Alcoholism and Other Drug Dependencies)

BOY SCOUTS OF AMERICA, Drug Abuse Task Force S200, 1325 Walnut Hill Lane, Irving, TX 750383096, (214) 580-2000. Launched a major anti-drug program to inform people of the dangers of drug use, including a booklet for youth, a teacher's guide, PSAs, and a video.

CHEMICAL PEOPLE PROJECT, WQED-TV, 4802 Fifth Avenue, Pittsburgh, PA 15213, (412) 391-0900. National coalition spawned by the telecast "The Chemical People" and its sequel, "Generation at Risk." The project supplies information in the form of tapes, literature, and seminars. School version of ***Our Troubled Teens,*** a booklet funded by Metropolitan Life Foundation, is available free to educators, along with a free loan of VHS cassette of PBS documentary, "Generation at Risk." Address all inquiries to The Public Television Outreach Alliance, c/o WQED.

DAVID M. WINFIELD FOUNDATION, Turn It Around Campaign, 2050 Center Avenue, Ft. Lee, NJ 07024, (201) 461-5535. The Foundation's fight against drug use is designed to move from individual awareness of drug use to community-wide awareness and action.

DRUG ENFORCEMENT ADMINISTRATION, U.S. Department of Justice, 1405 I Street, NW, Washington, DC 20537, (202) 786-4096. Provides information on Federal Narcotics and Dangerous Drug Laws and disseminates DEA public information, including sports drug awareness programs for schools.

ENTERTAINMENT INDUSTRIES COUNCIL, INC., Reston Avenue, Reston, VA 22090, (703) 481-1414. Organized to bring the power, influence, and talent of people in

the entertainment industries to bear on the problems of alcohol and other drug use, particularly among the Nation's youth. Produces audio and audiovisual materials designed to help reduce alcohol and other drug use, promote seat belt use awareness, and describe drug use as it relates to the problem of AIDS. Publishes quarterly newsletter, maintains celebrity speakers' bureau, and sells "Stop The Madness," an anti-drug use rock video (1/2" for $20 and 3/4" for $25).

FAMILIES-IN ACTION, 2296 Henderson Mill Road, Suite 204, Atlanta, GA 30045, (404) 934-6364. Maintains a drug information center with more than 100,000 documents. Publishes a quarterly newsletter that abstracts professional articles and answers questions about drug abuse.

HAZELDEN FOUNDATION, Pleasant Valley Road, Box 176, Center City, MN 55012-0176, (800) 3289000. Distributes educational materials and self-help literature for individuals in 12-step recovery programs and the professionals who work in the field. Materials include books, pamphlets, audio cassettes, and films for members of Alcoholics Anonymous, Al-Anon, Narcotics Anonymous, Families Anonymous, and other recovery programs.

INSTITUTE ON BLACK CHEMICAL ABUSE (IBCA), 2614 Nicollet Ave., Minneapolis, MN, 55408, (612) 871-7878. Provides training and technical assistance to programs that want to serve Black clients and others of color more effectively. Training includes a look at how "culture" affects both addiction and recovery. A resource center that has reprints from scholarly journals concerning Black AOD abuse is also available to the public through IBCA.

INTERNATIONAL COMMITTEE ON ALCOHOL, DRUGS, AND TRAFFIC SAFETY, NATIONAL SAFETY COUNCIL, 444 North Michigan Ave., Chicago, IL 60611-3991, (312) 527-4800. The National Safety Council is a non-governmental, not-for-profit public service organization devoted to prevention of accidental death and injury and preventable illness. The Council sponsors National Drunk and Drugged Driving Awareness Week each year and offers a server intervention education program for public establishments that serve alcohol,

JUST SAY NO FOUNDATION, 1777 N. California Boulevard, Suite 200, Walnut Creek, CA 94596,

(800) 258-2766. In California call ***(415) 939-6666.*** Valuable resource for information and a national link for all the "Just Say No" Clubs, which are made up of children, 7-14 years old, who are committed to not using drugs. Offers technical assistance to local clubs and distributes an adult leader's guide and children's handbook (with educational, recreational, and service activities), poster/study guides, information, T-shirts, and buttons at a nominal cost.

JUVENILE JUSTICE CLEARINGHOUSE, Box 6000, Rockville, MD 20850, (301) 251-5307, (800) 638-8736. The Juvenile Justice Clearinghouse, a part of the National Criminal Justice Reference Service, is a service of the National Institute of Justice. The Clearinghouse is an information service for criminal justice practitioners, researchers, and the general public. It provides reference services, screens and collects publications and audiovisual materials for its collections and disseminates written materials. Primary emphasis is on prevention.

MOTHERS AGAINST DRUNK DRIVING (MADD), 669 Airport Freeway, Hurst, TX 76053, (817) 268-6233. An organization focusing on youth education to combat drinking and driving.

NATIONAL ASSOCIATION FOR CHILDREN OF ALCOHOLICS, 31582 Coast Highway, Suite B, South Laguna, CA 92677, (714) 499-3889. A national, nonprofit membership organization for children of alcoholics and those in a position to help them. Maintains a clearinghouse of resources.

NARCOTICS ANONYMOUS (NA), World Service Office, P.O. Box 9999, Van Nuys, CA 91409, (818) 780-3951. Narcotics Anonymous is a self-help program based on the 12 steps of Alcoholics Anonymous. NA members are people for whom drugs had become a major problem. It is a program of complete abstinence from all mind-altering drugs. If a local group is not listed in your telephone directory, the World Service Office (above) can provide information.

NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS (NASADAD), 444 N. Capitol Street, NW, Suite 520, Washington, DC 20001, (202) 783-6868. NASADAD is a non-profit organization that coordinates and facilitates education and information regarding alcohol and other drug abuse and alcohol

and other drug abuse programs among States and the Federal Government.

NATIONAL CLEARINGHOUSE FOR ALCOHOL AND *DRUG* INFORMATION (NCADI), P.O. Box 2345, Rockville, MD 20852, (301) 4682600. The new Federal clearinghouse for information and services on alcohol and other drugs. NCADI is the largest, most comprehensive resource on alcohol and other drug information in the world. Prepares pamphlets, booklets, posters, fact sheets, directories, resource lists, and other useful products. Answers inquiries, offers new prevention ideas, coordinates Regional Alcohol and Drug Awareness Resource (RADAR) Network among State and national organizations' clearinghouses, reviews and compiles lists of audiovisual materials, and maintains negative loan program. Most of NCADI's materials are free to the public.

NATIONAL COUNCIL ON ALCOHOLISM, INC. (NCA), 12 W. 21st Street, New York, NY 10010, (212) 206-6770. The NCA is a national voluntary health agency that provides information about alcoholism and alcohol-related problems through more than 300 local affiliates. Some of the NCA's affiliates provide counseling for alcoholics and their families. In 1986, the NCA launched an educational campaign to prevent children from drinking by promoting the theme "Say No. And Say Yes to Your Life," targeted to young people ages 9 through 14. The campaign uses television, radio, and print media.

NATIONAL CRIME PREVENTION COUNCIL, SUBSTANCE ABUSE PREVENTION PROGRAMS, 733 15th Street, NW, Room 540, Washington, DC 20005, (202) 393-7141. Resource for curricula, brochures, and other consumer literature for young persons in junior high school grades. Newsletter *Catalyst* highlights new prevention materials as they are developed.

NATIONAL EDUCATION ASSOCIATION (NEA), 1201 16th Street, NW, Washington, DC 20036, (202) 833-4006. Contact: James H. Williams. In cooperation with the National Association of School Nurses, the NEA issued guidelines for school-based programs to create a drug-free school environment through prevention and intervention programs.

NATIONAL PTA DRUG AND ALCOHOL ABUSE PREVENTION PROJECT, 700 North Rush Street, Chicago, IL 60611, (312) 787-0977. Offers kits, brochures,

posters, and other publications on alcohol and other drug awareness for parents, teachers, and PTA organizations.

OFFICE FOR SUBSTANCE ABUSE PREVENTION (OSAP), 5600 Fishers Lane, Rockwall II Building, Rockville, MD 20852, (301) 443-0373. OSAP is a Federal office established to address alcohol and other drug problems, and develop strategies for preventing them. OSAP has a commitment to supporting programs that address the needs of high-risk youth. Activities include the development of prevention messages and materials, coordination of media campaigns, funding and administering a grant program, and operating the National Clearinghouse for Alcohol and Drug Information.

PARENTS' RESOURCE INSTITUTE FOR DRUG EDUCATION (PRIDE), 100 Edgewood Avenue, Suite 1216, Atlanta, GA 30303, (404) 310-9000. HOTLINE: (800) 241-9746. National resource and information center. Offers assistance to parent groups, and provides a drug-use survey service. Publishes newsletters, handbooks, and brochures. Sells books, films, and videos. Also publishes a catalog of videos, pamphlets, and books that are available free or for a nominal fee.

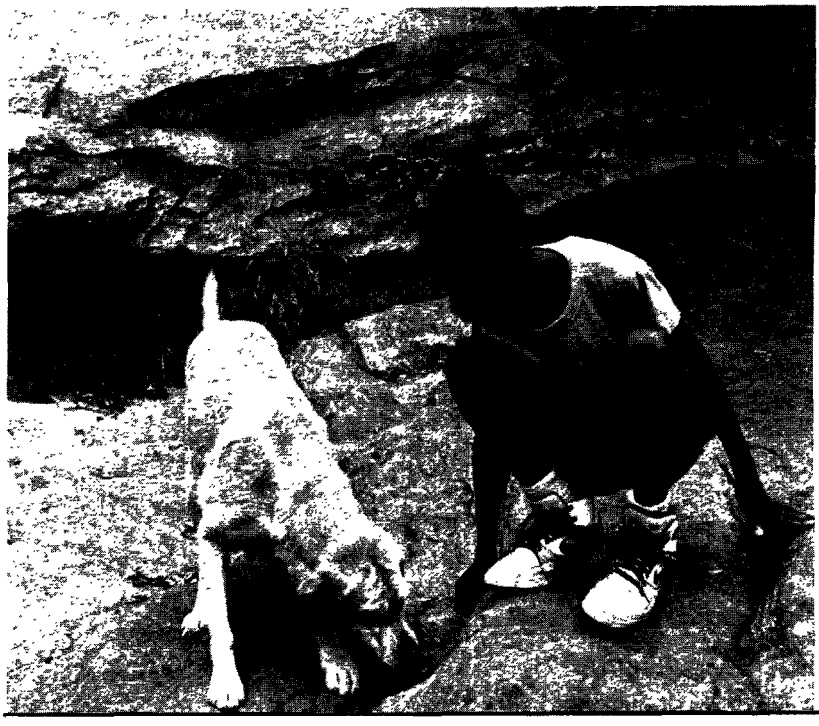
SMART MOVES, Boys Clubs of America, 771 First Avenue, New York, NY 10017, (212) 3515900. National prevention program focused on alcohol and other drug use, and teenage pregnancy, using skills mastery and resistance training techniques. Involves youth in planning and program delivery, including small group leadership.

U.S. DEPARTMENT OF EDUCATION, ALCOHOL AND DRUG ABUSE EDUCATION PROGRAM, 400 Maryland Avenue, SW, Room 4145, MS 6411, Washington, DC 20202, (202) 732-3030. Assistance in developing the capability of local schools to prevent and reduce alcohol and other drug use is provided in three major ways. (1) Grant programs for State and local government, institutions of higher education, materials development; (2) Federal activities such as drug-free schools recognition program, network of drug-free colleges, drug use curricula guide, workshops, and The Challenge, a program to encourage and sustain a national network of drug-free schools; and (3) Regional centers providing training and expertise to achieve drug-free schools, located in New York (516/589-7022), Atlanta (404/651-2548), Chicago

(312/324-9500), Oklahoma (405/325-1711), and Oregon (503/275-9500).

WORLD YOUTH AGAINST DRUGS (WYAD), 100 Edgewood Avenue, Suite 1216, Atlanta, GA 30303, (800) 241-9746. Founded in 1986, WYAD has membership in 35 countries and an international pen-pal program involving thousands of drug-free young people. An organization run by young people for young people who share the goal of drug-free youth. Quarterly newsletter and notice of local, national, and international meetings.

YOUTH TO YOUTH, *700* Bryden Road, Columbus, OH 43215, (614) 224-4506. Founded in 1981, this organization stresses youth training youth to do prevention programs in their own schools. Annual 5-day intensive prevention training program prepares junior and senior high school students to conduct local programs. Youth to Youth groups are active in over 25 States, with regional conferences, international youth exchanges, and a national speakers bureau of high school students. Free quarterly newsletter.



Appendix E

National Prevention Network Directory

The National Prevention Network (NPN) is a collaborative effort of State representatives and members of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) of the U.S. Public Health Service. Through a system of committees, NPN members promote prevention standards, encourage the development of prevention constituencies within each State, and exchange information on current prevention research, techniques, and policies. ADAMHA, the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) provide technical assistance through the dissemination of research findings to NPN members.

Listed in this directory are the representatives designated by each State and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) Prevention Committee co-chairs. Because names, addresses, and telephone numbers are subject to change, periodic updates to this listing will be made available. For more information, contact the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852, or call (301) 468-2600.

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"A" = Representative for alcohol abuse prevention

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COMMITTEE MEMBERSHIP CODES

EX - Executive Comm.	MB - Membership Comm.	NP - NASADAD Prev. Comm.
PI - Public Information	PP - Policy and Planning	RD - Resource Devel.
RE - Research and Eval.	RR - RADAR Network Comm.	SP - Special Projects

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This directory has been prepared by the National Clearinghouse for Alcohol and Drug Information (NCADI). NCADI is a service of the Office for Substance Abuse Prevention (OSAP), of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), Public Health Service (PHS), U.S. Department of Health and Human Services (DHHS). This publication is not copyrighted and duplication of contents is encouraged.

Appendix F

State and Territorial Alcoholism and Drug Abuse Program Directors

This directory of State and Territorial Alcoholism and Drug Abuse Program Directors is intended as a communication aid. Because names, addresses, and telephone numbers may change, periodic updates are made. For further information contact:

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Appendix G

The RADAR Network

A new communication resource was established in 1988 to provide communities with information, publications, and services for combating alcohol and other drug problems. Known as the Regional Alcohol and Drug Awareness Resource (RADAR) Network, this network features an office in each State that has access to the Office for Substance Abuse Prevention (OSAP). This network allows the public and professional groups to obtain information and services previously available only through the Federal Government from their State RADAR offices.

RADAR centers answer information requests, house a resource center, and facilitate networking among groups involved in prevention of alcohol and other drug problems. They also keep OSAP up-to-date by providing information about prevention activities, and local trends in alcohol and other drug use.

The following pages contain the list of full RADAR members as of June 1989. A current list is maintained by the National Clearinghouse for Alcohol and Drug Information (NCADI). If the contact in your State is no longer current, contact Outreach Services at NCADI at (301) 4682600, or write to: P.O. Box 2345, Rockville, MD 20852, for updated information.

The Regional Alcohol and Drug Awareness Resource (RADAR) Network consists of State clearinghouses, specialized information centers of national organizations, and the Department of Education Regional Training Centers. Each RADAR Network member can offer the public a variety of information services. Check with the representative in your area to find out what services are available.

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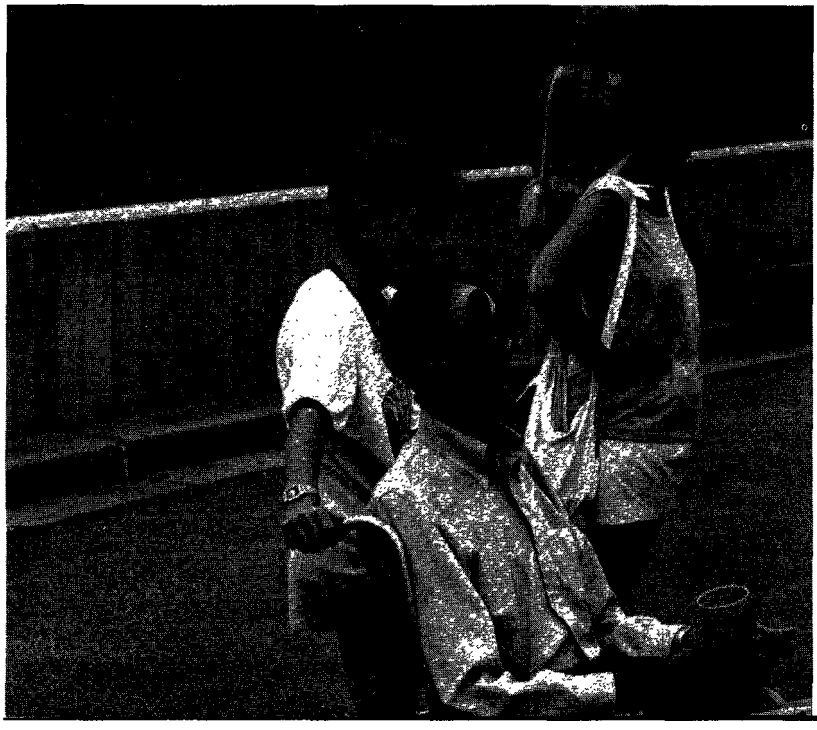


Appendix H

Theories and Models Supporting Current Prevention Approaches

Models are derived from a body of research and allow us to generalize from one set of circumstances to the next. The models and theories presented here derive from a base of knowledge that, although usually associated with one or several researchers, has been expanded upon by numerous other researchers and practitioners. Those models and theories should prove useful for both developing prevention programs and assessing prevention approaches and products currently in the marketplace.

Learning Models

Bandura-Social Learning Theory and Modeling

Albert Bandura's "Social Learning Theory" builds on the work of B.F. Skinner, who originally described the process of learning as a response to rewards and punishments. According to Bandura's theory, learning is acquired and shaped by the positive and negative reinforcements resulting from one's own behavior, as well as by observation of other people's behavior and its consequences for them. Bandura also notes that the ability to anticipate both the consequences of one's behavior and the attitudes of other persons toward such behavior develops as an individual matures. This ability allows persons to self-regulate or internalize rewards and punishments and to serve as agents of their own behavioral change.

Bandura recognized the potential for using "modeling" as a way of directing and changing behavior. We observe the behavior of others in person, on television, and by

means of other communications media. The more attractive and competent a model is, the more likely others are to adopt that model's behavior. "Near peers," who are slightly older than the target audience and who resemble the target audience, often are used in educational programs to transmit messages by depicting behavior and attitudes that young people would like to imitate.

McGuire—Cognitive Inoculation, Behavioral Commitment, and Cognitive Dissonance

William McGuire has outlined procedures for developing and maintaining attitudes, values, and beliefs that favor non-use of unhealthy substances. These procedures are called "pretreatments" because they are applied before a behavior is adopted or experimented with and are not designed for youth already using alcohol and other drugs.

"Cognitive inoculation" is one of these pretreatments. Cognitive inoculation prescribes that lessons concerning attitudes and beliefs about alcohol and other drugs be accompanied by a discussion of the conflicting attitudes and beliefs that a student might encounter in the future. This teaching method prepares students for, and thereby protects them from, pressure to adopt beliefs and attitudes that may be unhealthy.

Another pretreatment approach requires that a "behavioral commitment" be made on the part of the individual. Commitments can take the form of a private decision, a public announcement of one's beliefs, active participation on the basis of the belief, and commitment based on being told that someone else is committed to the belief (external commitment). McGuire was surprised to find that external commitment was stronger than a private commitment in most cases-convincing evidence for the power of peer, parental, community, media, and societal support for non-use behavior among youth.

In addition, McGuire found that, in general, people want their attitudes and beliefs to be compatible with their behavior. If they are not, there is "cognitive dissonance" that a person will want to eliminate. For instance, if an adolescent strongly values his or her athletic ability, to successfully attach the belief that smoking marijuana diminishes this ability would create dissonance. Resolution of dissonance would require the individual either to abstain from smoking marijuana or to place a lower value

on athletic ability. Connecting new beliefs about alcohol and other drugs to existing cognitions, if used as a pre-treatment or prevention measure, requires a clear understanding of the cognitions students hold important.

Evans-Social Inoculation Theory

Richard Evans' "Social Inoculation Theory" extends McGuire's theory to address the many social influences, beliefs, and attitudes that create pressure on a young person to use alcohol and other drugs. Such pressures might include, "If everyone is doing it, it can't be bad," or joining a group that, by its use behavior, exerts pressure on the young group member. Students are instructed about social pressures to use alcohol and other drugs and are assisted with the development of skills to resist the pressures. Many programs based on the Social Inoculation Theory use modeling, as suggested by Bandura, to teach peer resistance skills. Others encourage public commitments from students as an added incentive to resist negative peer pressure and as positive social reinforcement for the group as a whole.

Behavioral Development Models

Bry, McKeon, and Pandina-Multiple Risk Factor Theory

Bry, McKeon, and Pandina suggested that drug-related problems are a function of the number of other problems experienced by teenagers. They developed a multiple risk factor model that tested the effects of six diverse, etiological variables on drug use. The independent variables were: grades, affiliation with religion, age of first use of alcohol, psychological distress, self esteem, and perception of parental love. Results showed that the number of risk factors was strongly correlated with drug use. The authors concluded that "...the number of factors an individual must cope with is more important than what the factors are."

The multiple risk model was recently extended and tested by Newcomb, Maddahian and Bentler. Four risk factors (deviance, sensation seeking, perceived peer drug use, and perceived adult drug use) were tested in addition to those used in the Bry study. It was found that the ***number of risk factors*** was linearly associated with the use,

frequent use, and heavy use of a substance. The effects were observed with a variety of drugs, including cigarettes, alcohol, cannabis, and other drugs but the amount of explained variation in drug use was low, ranging from 1 percent of subsequent cigarette use, to 4 percent of later alcohol use and 7 percent of subsequent "hard" drug use.

Erickson-Developmental Model

Eric Erickson argues that psychological development occurs in identifiable stages throughout the life cycle. In order for one to develop a healthy personality, the psychosocial "crises" associated with each stage of development must be successfully resolved. In the first year of life, for example, a child must develop a sense of trust rather than mistrust. Similarly, autonomy (versus doubt) must be developed in early childhood (2-3 years), initiative in play (4-5 years), and industry during the elementary school years. Erickson argues that the major crisis to be dealt with in adolescence is that associated with establishing identity and avoiding identity diffusion.

Adolescence is a period of transition. Erickson calls it a period of role confusion out of which should emerge identity. The individual who has previously accepted his or her role as a child now attempts to adopt some aspects of the role of an adult. Certain adult behaviors, such as becoming sexually active, smoking, and drinking alcohol are considered deviant because they are essentially adult behaviors exhibited at an earlier stage of the life cycle.

A second aspect of role confusion involves the adolescent's developing self-image. The adolescent's body is changing rapidly. The rapid physical change causes a young person to feel clumsy and ill-at-ease. These physical and social changes often result in a poor self-image among adolescents and excessive concern about acceptance by others, especially peers.

The identity crisis also is marked by changing relationships with parents. As adolescents break away from the previously close personal guidance of their parents or guardians, they seek support elsewhere, usually with a peer group. In this developmental context, adolescent smoking and use of alcohol and other drugs may appear to the young person as a way of expressing a growing sense of independence.

Fishbein and Ajzen-Behavioral Intention Theory

Martin Fishbein and Icek Ajzen have developed a system of quantifying attitudes because, like others, they believe that attitudes are logical determinants of behavior. Their theory states that, when measured properly, attitudes and subjective norms held by an individual can be used as predictors of behavioral intent and of behaviors. Attitudes are the beliefs a person holds about the outcome of a behavior along with the value he or she places on that outcome. Subjective norms are the individual's assumptions about the views of significant others regarding the behavior, along with the individual's motivation to comply with these views.

In order for attitudes and subjective norms to be good predictors of behavior, their measurement must be in terms of specific behavioral situations, e.g., a person drinks (action) beer (target) in a car (context) on the weekend (time). Attitudes and subjective norms must be assessed keeping the action, target, context, and time in clear focus. The use of this measuring technique ensures that the content of messages used to change attitudes is relevant to the target group and that adequate attention is given to the strength of social influences on behavior. This theory provides a good framework for understanding the important role that perceived social norms play in directing behaviors. For example, adolescents generally perceive a prevalence of alcohol and other drug use among their peers that far exceeds actual consumption. Students who overestimate the use of alcohol and other drugs may view use as "normal" and may be more accepting of such use.

Hawkins-Social Development Model

David Hawkins and his colleagues have developed a "Social Development Model" that seeks to address key risk factors for alcohol and other drug use at developmentally appropriate points. Hawkins advocates providing a young person with opportunities for active involvement, skills for successful participation, and a consistent system of rewards and punishments. According to the Social Development Model, this practice will lead to the development of bonds of attachment, commitment, and belief between young persons and the social units (families, school classrooms, or groups of friends) in which they are participating. The model also suggests that when a social

unit's expectations or norms for behavior are clear, young people will be less likely to violate these expectations, particularly if they feel socially bonded to the unit.

According to the Social Development Model, prevention programs should seek to increase opportunities for active involvement in family, school, and positive peer groups; ensure the development of skills needed to perform successfully in childhood and adolescence; and ensure that children's social environments provide clear expectations and consistent reinforcement for behavior.

Jessor and Jessor-Problem Behavior Theory

Jessor and Jessor originally hypothesized that marijuana use, experimentation with alcohol, problem drinking, sexual activity, and general deviant behavior could be explained by variations in the individual personality system, perceived environmental structures, socialization patterns, and demographic statuses. Subsequent empirical research has lent considerable support to the Jessors' argument. In general, a low value or expectation for academic achievement, a high tolerance of deviance, and a high value on personal independence have been associated with teenage drug use. Perception of parental and peer modeling of drug use, and the adolescent's perception that peers or parents approve or tolerate drug use are likewise associated with the use of drugs.

Part of the strength of this model is its specification of adolescent perception of parental or peer values and behavior as the antecedent variable for problem behavior. Since humans have the ability to perceive and interpret environmental experiences in original ways, knowledge of the subject's interpretive framework makes prediction more accurate. Less sophisticated models tend to specify environmental factors associated with drug use without attempting to understand the subjective values attached to them by adolescents.

Several researchers have studied the relationship among problem behaviors and investigated the existence and nature of their common antecedents. Poor performance in school, association with delinquent or drug using peers, lack of conventional bonding, sexual activity, and general deviance are the factors most commonly found related to problem behaviors that include drug use.

Jessor and Perry-Health Behavior Theory

The formulation of Richard Jessor and Cheryl Perry's "Health Behavior Theory" follows in the tradition of Karl Lewin's Field Theory, which emphasizes the unique developmental history each person brings to a situation and, at the same time, the similarities among people due to common circumstances.

Like Lewin, Jessor and Perry take great care to specify the variables and relationships between variables that influence behavior-specifically, health behavior-in order to address multiple behaviors. Health is comprised of four domains: physical, psychological, social, and personal. Because a single behavior can affect several of these health domains, their relationship must be examined fully in terms of prevention strategies.

Jessor and Perry recommend two strategies for prevention: (1) weakening or eliminating behaviors that compromise health; and (2) strengthening or introducing behaviors that enhance health. These complementary strategies are the products of a prevention focus directed toward achieving a balance in an individual's entire behavioral functioning. Because a covariation exists among a number of health-compromising behaviors-i.e., adolescents engaged in one of several risky behaviors are more likely to be involved in others-preventing or eliminating any health-compromising behavior may have an effect on other behaviors. The promotion of health-enhancing behaviors includes such activities as understanding that alcohol and other drug use may be serving as a way to gain independence from parents; with this understanding, new and healthier behaviors that serve the same purpose may be introduced.

Kandel-Stages of Drug Involvement

Denise Kandel and her colleagues describe drug use as a process involving clear-cut stages and largely determined by a matrix of social relationships. Different influences are involved at different stages, with situational and interpersonal factors most important for initiation into drug use behavior and psychological factors most important for increased involvement or participation in that behavior.

Three specific stages of drug use described by the researchers are: (1) use of liquor, (2) use of marijuana, and (3) use of other illicit drugs. Distinct predictors mark

initiation into each stage of use. The most important predictor of liquor use is the involvement of a youth in minor delinquent activities. Young persons with beliefs and values favorable to marijuana use, who also are associated with friends who use marijuana, are more likely to enter the second stage of drug use. Parental factors, feelings of depression, and contact with drug-using peers are the primary predictors of illicit drug use.

Kaplan, Martin, and Robbins-Misuse as a Deviant Response

Kaplan, Martin, and Robbins' model is an explanation of deviant behavior that, inasmuch as drug use in adolescence is an example of deviance, provides one explanation for such use. The researchers note that deviant responses are motivated by the earlier development on the part of the adolescent of self-rejecting attitudes. These attitudes result from unhappy or unsatisfying normative participation in a variety of interpersonal or social interactions.

According to the researchers, repeated self-devaluing experiences in membership groups will take away personal motivation to conform with normative patterns of behavior. When normative patterns of behavior are no longer motivationally acceptable responses, deviant patterns represent alternative responses by which an individual can act effectively to boost self-esteem.

Drug use is more visible if use is prevalent among peers at school or in the neighborhood. An individual's perception of the likelihood of self-enhancing consequences resulting from a particular pattern of drug use also reflects such variables as: perceived attitudes toward the pattern of drug use held by positive and negative reference groups; the visibility of more or less prevalent adverse consequences of use; the perceived compatibility of the consequences and concomitants of the drug use pattern with behavior appropriate to valued social roles that are not themselves the basis for one's rejection; and the ability to justify use without overwhelming feelings of guilt.

Zuckerman—Sensation-Seeking as an Explanation for Drug Use

Marvin Zuckerman's research has explored the relationship between an individual's need for sensory stimulation and a host of behaviors, among them the use of alcohol

and other drugs. He observes that all individuals look for varied, novel, and complex experiences; but have different optimal levels of arousal.

Stimulation serves different functions. Zuckerman found the primary functions to be: (1) offering thrills or adventure; (2) providing new experiences; *(3)* facilitating disinhibition; and *(4)* reducing boredom. Using alcohol or other drugs, eating, smoking cigarettes, and engaging in sexual activity are all sources of sensory stimulation arousal. Individuals who have strong sensation-seeking tendencies will be more likely to engage in these activities and to a greater extent.

The most important demographic correlates with sensation seeking are age and sex. Thrill/adventure-seeking and disinhibition-seeking begin to sharply decline in one's early 20's and experience-seeking declines after age 30. Males generally score higher on all sensation-seeking scales except for experience-seeking. Zuckerman has found that persons who experiment with a variety of drugs tend to be-high on the sensation-seeking scale. Alcohol use alone, however, tends to be associated with a 'narrower kind of sensation-seeking, that of the disinhibition type.

Communications Models

Bettinghaus-Health Promotion and the Knowledge-Attitude-Behavior Continuum

Erwin Bettinghaus expands the original knowledge-attitude-behavior continuum by including research from Fishbein, McGuire, and others to suggest ways to improve health campaigns aimed at avoiding, maintaining, increasing, changing, or adopting new behavior. Evaluations of such campaigns have found that they are effective in gaining the attention and arousing the interest of a target audience. .Bettinghaus suggests that the knowledge-attitude-behavior model can be improved by using measures of behavioral intention (Fishbein) rather than generalized attitudes. In addition, Bettinghaus advocates addressing ***countermeasures*** (anti-smoking efforts that compete with pro-smoking print media messages); ***difficulty*** (losing 50 pounds is more difficult than reducing salt intake by 10 percent); ***addictive***

properties (of tobacco, alcohol, and other drugs); and ***socialpressures*** (from peers). Finally, Bettinghaus proposes the use of McGuire's information processing model, which argues that moving between the elements of the knowledge-attitude-behavior continuum demands processing time on the part of individuals, as well as attention to a set of elements within a communication matrix. The matrix includes, at least, addressing attention, comprehension, yielding, retention, and action-while, at the same time, paying attention to the five elements of the communications process (source, message, channel, receiver, and destination).

Maccoby and Solomon-Communication-Behavior Change Model

Nathan Maccoby and Douglas Solomon have studied mechanisms used by mass media campaigns to change behavior and have defined steps required to move a target population from initial awareness of interest in a problem to the adoption and maintenance of advocated attitudes or behavior. The first step involves attracting attention and focusing it on specified issues and problems, a process referred to by mass media researchers as "agenda setting" that, for major national campaigns, has been accomplished by broadcast media. Once a subject is on the public agenda and is perceived as an important issue, a campaign must explain the issue in a way that is personally relevant to individuals in the target audience; this step is referred to as "informing." The population also must be given positive incentives to change behavior, together with support and encouragement to maintain new behavior ("motivation"). Once members of the population fully understand their personal relationship to the problem, they must be taught how to modify risk-related behaviors ("training"). Finally, if newly acquired habits are to be maintained, that maintenance must be accomplished by self-control ("self-maintenance"). Self-cuing at appropriate times and places is critical to the maintenance process.

Variables that exert an influence on each of these processes include the receiver's age, sex, socioeconomic status, current health beliefs, and previous education. Prevention strategies must be designed to take into account the full range of potential influences operating at the personal as well as the community and economic levels.

McGuire-Persuasion-Communications Model

William McGuire also has worked extensively on theory underlying communication campaigns. He describes the components necessary to construct a communication capable of changing attitudes and behavior, along with successive responses persons must make if they are to "yield" to the communication.

A communication is comprised of five variables: *source*—the characteristic of the individual from whom the message is perceived to be coming (which strongly influences the communication's credibility and acceptability to the audience); message-the context, how it is presented, organized, what is and is not included, its length, speed of delivery, and other characteristics; ***channel-the*** medium through which the message is delivered (i.e., print, radio, or television); receivers-the target population; and destination-the type of behavior at which the communication is aimed.

According to McGuire, the effectiveness of a communication campaign depends on its ability to lead an audience through a successive **12-step** process:

1. Being exposed to the communication
2. Attending to the communication
3. Liking or becoming interested in the communication
4. Comprehending or understanding the message
5. Learning how to incorporate the target behavior in one's life
6. Accepting or yielding to the change
7. Remembering the content of the message and remembering that one has agreed to it
8. Being able to retrieve the information from memory
9. Making decisions based on the retrieval of the information
10. Behaving in accord with the decision
11. Experiencing reinforcement for the behavior
12. Engaging in postbehavioral activities, such as reorganizing one's related beliefs.

Rogers-Diffusion of Innovations

Prevention often entails the introduction of new health-related ideas to members of a social system. The process by which new ideas or products are spread is called "diffusion." Everett Rogers has studied the diffusion process and observed processes that both facilitate and impede diffusion.

It is not critical that an idea or product be original in order for it to be considered innovative. Rather, it is the perceived or subjective newness of an idea to an individual that determines his or her reaction to it. New ideas can be introduced from within the social system or from outside. When introduced from outside, new ideas spread by selective contact change or through directed, planned change. Either way, the rate of adoption of a new idea is influenced by several factors, including (1) the degree to which the innovation is perceived as better than the idea it supersedes, i.e., its relative advantage; (2) the degree to which an innovation is perceived to be consistent with the existing values, past experiences, and needs of the receiver, and its compatibility; (3) the degree to which an innovation is perceived as difficult to understand and use, or its complexity; (4) the ability to test the innovation before fully adopting it-its trial ability; and (5) the degree to which the results of the innovation are visible to others.

Rogers notes that, if the stage of introducing a new idea is at the awareness or information level, mass media channels are the most rapid and efficient mechanism. If, however, the stage is at the attitude, the behavior change, or the "adoption point," then an interpersonal, face-to-face interchange is much more effective. The most successful diffusion occurs when mass media are used to build awareness and reinforce newly adopted attitudes and behavior in conjunction with face-to-face interchanges for trying, adopting, and maintaining new attitudes and behaviors.

Source: Funkhouser, J.E., and Amatetti, S.K. "Part Two: Alcohol and Drug Abuse Prevention: From Knowledge to Action." Task Force on Alcohol and Drug Abuse Hearing, January 28, 1987, Lexington, KY.

Appendix I

THE FACT IS . . . You Can Effectively Launch Media Campaigns

Working with the media can be fun, creative, and a chance to carry out a project of real value to your community. School, community, parents, and religious groups—all have been the successful sponsors for a local media project.

You too can launch an effective campaign. New technology puts media development into the hands of everyone—you can videotape a teenagers' rapping contest or a parents' discussion group, create professional-looking flyers on desk-top publishers, record your own radio spots with electronic backup sound, plasticize children's posters for permanent display. Many exciting and worthwhile projects are possible. Here are some guidelines for how to turn your ideas and concerns into effective media messages.

How Can I Be Sure to Reach the Target Audience?

- Decide exactly whom you want to reach-select your target by such factors as age, sex, ethnic group, financial status, values, interests. This is called "segmenting" the audience. You need to know your target since different audiences will respond to different appeals, messages, and channels (what TV or radio shows do they watch?; which newspapers do they read?).

- Choose a person your audience can identify with to deliver the message who will be perceived as credible and knowledgeable.

- Design a message that appeals to your target audience and will hold their interest. People pay more

attention to messages that tie into their needs or values. For example, teenagers care a lot about their appearance, about belonging and being accepted by friends, about being "cool" and in control. They are likely to listen to messages that say alcohol and other drugs interfere with getting these things.

- Pre-test your message with the target audience before going into production. Ask people from the target group what they think of the message. Do they like it? Do they understand it? Would they act on it? Might an alternative message be more effective? Message testing services are available if you need help.

What Would Be an Effective Alcohol/Drug Message?

- Plan to create messages that can influence the knowledge and attitudes of your target audience. It is not realistic to expect a media campaign—even a highly effective one-to change people's behavior. Messages can, however, reinforce behavior change initiatives and can help people maintain healthy lifestyles.

- Develop messages that can get your audience to think about and discuss the issues. Even better is to generate some action; the media can effectively convey clear, concrete suggestions for action, such as showing alternative behavior or ways of resisting pressure to use drugs.

- Base your message on scientific fact, being cautious to provoke only a low level of discomfort (as opposed to a high level of fear that cannot be dealt with and will thus be rejected or ignored).

- Tie your messages to satisfying human wishes in the present, not in some distant future. People want desired gratifications and social acceptance in the "here and now" (e.g., control over one's life and health, improved self image, support from others, sense of belonging). Not wanting "bad breath now" will gain more notice from most audiences than a

"there and then" message, such as "cirrhosis in 20 years."

- Consider creating a campaign to help your community establish social norms that promote and sustain healthy, safe behaviors. Society's norms can change, as is shown by the shift in American attitudes about smoking over the past 15 years.

What Does a Media Campaign Need to Be Successful?

- Be attuned to the key components: adequate reach, frequency, and duration. One-shot messages are not enough. The audience needs to be reached, over time, with consistent repeated messages. Commercial advertisers believe that advertisements require an average of three exposures before consumers become aware of the product and achieve the "intend to purchase" stage. Even greater exposure is surely required to influence alcohol/drug and other behaviors, since these involve personal values and habits.

- Provide for interpersonal communications about the messages. Give the audience an opportunity to discuss-as opposed to just viewing-the campaign messages. Such personal involvement increases the likelihood that the campaign will be perceived as important and relevant, with an improved chance to influence people's attitudes and behavior.

- Demonstrate to the audience the desired actions or behavioral skills. The messages and skill-building efforts should be consistent and reinforce each other. Media plus community intervention usually produce greater effects on more people than media alone.

Plan a successful campaign that will:

1. Build awareness, knowledge, and understanding;

2. Create or build motivation based on feelings and attitudes; and

3. Facilitate appropriate behavior by providing clear and specific steps to take and, where possible, demonstrate these...the "Call To Action."

How Can I Provide Follow-up in the Community?

- Supplement your media campaign with written materials and with programs carried out wherever you can gain support-through the schools, community organizations, face-to-face interventions, or employee assistance programs. For campaigns involving drinking/driving, alcohol sales to minors, and regulatory matters, you will want to involve law enforcement and/or other environmental and regulatory agencies.

- Supplement your public service announcement (PSA) campaigns with messages delivered through other media channels. Examples are setting up guest appearances on talk shows, press kits, news conferences, general news stories, and posters where target audience members convene.

- Broaden your vision when planning your campaign so it reflects the issues your community cares about and will work on. You may want to focus on a public policy, regulatory, or enforcement issue, such as alcohol being served at teenage parties and public events, minor penalties for drunk-driving deaths, enforcing local laws on drugs, or enforcing the ban on tobacco sales to underage youth. Media and publicity campaigns can be effectively used to build public awareness about changes in laws, compliance, and knowledge of the consequences from alcohol/drug behavior.

Who Are the "Movers and Shakers" to Involve in My Campaign?

- Enlist the help of experienced media people-TV and radio station managers, disc jockeys, local newspaper and magazine editors, and the writers of newsletters for key local organizations. These gatekeepers should be the first to be convinced of the worth of a media campaign. You may be surprised also at the extent of help available through

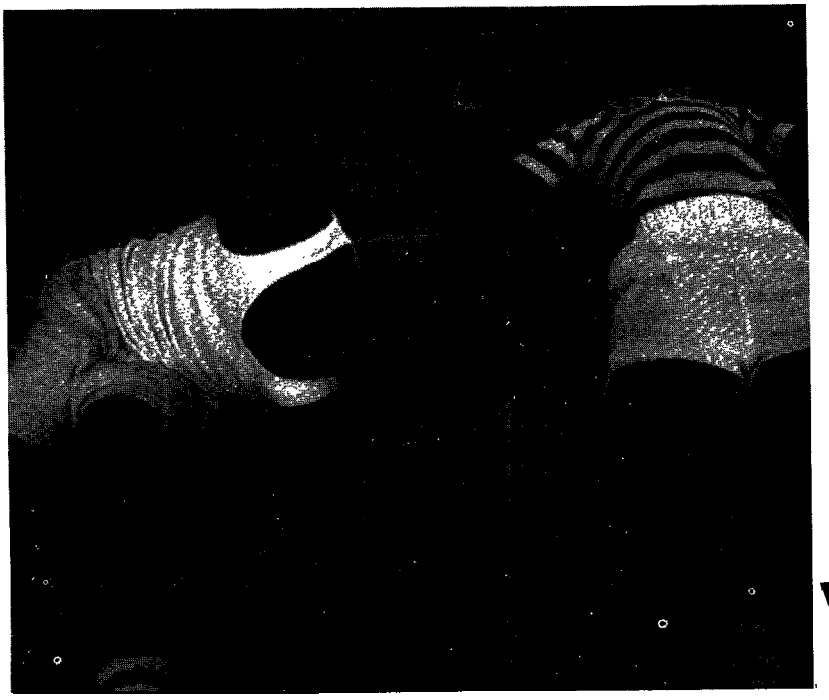
local schools and colleges for creating a 30-second PSA, taping a role-play scenario, or some similar activity.

- Enlist the support and cooperation from your community opinion leaders-people in a position to help politically or through their programs. These gatekeepers can include legislators, parent and teacher groups, activist groups, drug prevention and treatment organizations, law enforcement associations, and others. Their support will be absolutely essential for your campaign's success.

- Involve these gatekeepers in a significant way throughout your campaign. Through them, you will be able to extend the reach, the frequency, the duration, and the targeting of the campaign messages. Use these leaders, experienced in the ways of your community, to help "segment" your audience and plan how best to reach your target groups-whether by TV, radio, the local "rag," displays on buses, or maybe a sign on the town's water tower.

Remember-drugs and alcohol are everybody's problem. Many people in your community care and want to help. Your media campaign can be fun, can be effective, and can involve many groups and people.

Prepared by the Office for Substance Abuse Prevention, 5600 Fishers Lane, Rockwall II Building, Room 9C03, Rockville, MD 20857. For further information, contact the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20852.



Appendix J

A Guide to Working with the Media

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Introduction

One function of a RADAR Network Center is to increase public awareness of the issues related to alcohol and other drug use in your community. You will want to inform your community about the resources and services of your RADAR Network Center, how alcohol and other drug problems are affecting the communities in your State, and how citizens can help in creating a drug-free community.

Newspapers, radio stations, and television stations are important allies in getting your message out in a timely fashion to the largest audience possible. This guide presents a number of suggestions for establishing a good working relationship with the media in your community and working with them effectively.

As you read it, you will note that it often refers to "business" or "industry." That's because the guide was originally developed for another audience by the U.S. Department of Health and Human Services, Office of Health Maintenance Organizations, under Contract PL 282-79-0102-JBW. It covers such topics as talking with reporters, how to become a "source," appearing on. television, conducting a news conference, and scheduling speakers. The principles and information contained in the guide are useful for anyone who needs to work with the media and are easily adapted to any organization.

Working with the Media

Importance of Communicating with the Media

Everyone has an image. You may choose to control it or allow others to control it. Silence on your part means that only the other half of the story will be told.

"No Comment" and the closed door are obsolete in today's business environment. The public gets its news through the eyes and ears of television, radio, and newspaper reporters.

Without sources, therefore, the media speculate, and you have no control over the speculation.

The irony is that both you and the reporter have the same goal: accurate, timely communication of information. Misunderstandings occur because of a lack of understanding

of how the media works and what a reporter needs. Unfortunately, faults charged to the media are often a reflection of an industry or person who made the job tougher or did little to help the reporter "get the facts."

The news media are individuals who have a job or assignment to do. Of course, they have individual biases, as we all do, but the vast majority are reasonable and receptive.

However, the good reporter remains the one who questions. You will find working with the news media much easier if you understand that to ask the tough question is part of their job.

Newsmen seldom have the time to research a subject as much as you or they would like to. Instead, they depend on you to work with them in getting the whole picture.

The complexity of many issues requires significant preparation so that you can fill the reporter's knowledge void. To most people, business is dull. Many reporters are indifferent to business and, what's more, ALL reporters are skeptical by training if not by nature.

Your part of the equation is to supply useful, accurate, and meaningful data without losing sight of your point of view. The success of your approach depends largely upon your ability to understand the relationship and to know your role.

Simply knowing what the reporter needs and how his day is structured gives you an advantage. Because your competition, other businessmen, and government agencies know how the media works today, you are at a disadvantage if you don't. Government spokesmen, for instance, have staffs who know deadlines and when to schedule news conferences. By one estimate, the executive branch of the Federal Government spent in excess of $300 million on news-oriented operations last year.

Moreover, misconceptions about the media's role can lead to wrong assumptions about your role, such as:

1. The media are out to get me;
2. I have no control over an interview on television; and
3. Everything I say will be aired.

This does not have to be the case if you keep in mind the following basic points:

- ***Know where the reporter is coming from.*** Reporters may have no more personal interest in your issue than the fact that they were assigned to cover it for one day.

- Be ***polite.*** Get on a first-name basis and establish a personal relationship with the reporter. Keep in touch if possible.

- ***Be informative and accurate.*** Always strive to be truthful. Avoid statements that can not be supported with facts. Above all, never be afraid to say, "I don't know." If you make an error, correct it. Few reporters will expect you to be an "expert." It is far more impressive-and worthwhile to a reporter-to admit that you do not know something, and get back to him later with the information, rather than attempting an obvious bluff.

- ***Be consistent.*** If you use a statistic once, do not contradict it later. Do not be forced to make comments you will regret.

- ***Utilize every opportunity to make a positive point.*** For example, if asked to downgrade the opposition, do not question its motives. Instead, question the effectiveness of the program as compared to your proposal, or suggest that the facts are not as presented. Also, look for opportunities to change the direction of an interview which may be focusing on some of your weaker arguments. Instead of waiting for the reporter to ask you about your best points, as you finish a question go right into another subject by using such phrases as, "But what really excites me about this issue..." or, "But the points of the issue which interest most people with whom I have talked are..." etc. Avoid being involved in "off-the-record" discussion. All statements made in interviews should be quotable; do not say anything to a reporter that you might regret seeing in print.

- Use ***examples, either visual or verbal, to illustrate your message.*** Slides, graphs, and photographs speak a thousand words.

- ***Keep to your message.*** Remember that editors may cut your response to any question, particularly in electronic media interviews. Therefore, your immediate response should be a definitive and positive answer to each question, using secondary points or qualifications for the remainder of your answer. First respond with an emphatically positive statement; then address any problems in a positive manner.

- Be lively. Think in headlines. Use anecdotes and personalities to demonstrate a point. Don't be afraid of conflict. Newsrooms look for conflict; that's their definition of news.

- Be ***responsive.*** Print and broadcast deadlines must be met. Not meeting their deadlines means not being included in a story and missing an opportunity.

- When a reporter calls:

  — ***Be careful when reporters lead with, "I*** have heard..." They may have unreliable information or a rumor they are trying to confirm. Don't reveal a confidence to a reporter just because you think he already knows.

  — ***Don't speak for others.*** Often the response to a question can properly come only from someone else. Refer the reporter to that person.

  — ***Don't give the reporter the run-around.*** If it seems reasonable to give more information than you can supply, tell the reporter you will have someone else call back. Then make sure that person calls back.

  — ***When a major story breaks,*** and you anticipate a deluge of media inquiries, try to make note in advance of salient points you want to get across to the media.

  — ***Deny firmly.*** Reporters are suspicious of hedged denials.

- Correct errors. Effort must be made to correct misinformation. While it is unwise to quibble over minor or typographical errors, significant errors of fact should be called to the attention of editors or reporters in a helpful way by a courteous telephone call, meeting, or letter.

- Follow up. Consider ways to provide follow-up to any interview or news story. Keep in mind points on which the interviewer was either particularly interested or misinformed. Send detailed information on those points to the reporter after the interview. Monitor all other stories and shows on your issue. Send information when appropriate. If the program covered only the opponent's position, contact the interviewer or producer and simply suggest that there is another side of the story which the public deserves to hear. Try to arrange an interview or appearance, or at least a meeting, to discuss your position. Letters-to-the-editor sections of publications are one of the most widely read sections. When writing, limit the content to facts instead of opinions, and keep it short (300-350 words).

- Use news to create news. Try to relate your story to news of the day. Be alert to seasonal or related events that present opportunities to tell your side of the story.

Getting Their Attention: How the Media Works

Communicating with the media first starts with getting their attention. To this end, knowing how their operation works-what they need and how they need it-is essential. You need to know what they are looking for and structure your information to fit their needs.

Once you become a "source" to the news media, half your job is done. You are then called for information in your area. This can be accomplished if the media feel you will provide information and other assistance as they need it.

What They Are Looking For

One thing all media have in common is the requirement of accessibility of spokespersons.

The retiring chairman of DuPont, Irving Shapiro, recognized that business needed a spokesman and served not only business but his company by being accessible and ready with comments and figures. He and his staff were prepared with information in the form the media needed it.

Starting from this basic assumption, think how your message can be structured to fit the media's formats.

Print: Print needs are primarily for information. Types of stories dictate type of information, or story angle:

- hard news stories
- feature articles
- editorial opinions (more often in newspapers than on TV or radio)
- background, or "outlook" articles
- industry round-ups/trends
- industry opinions/reactions to fast-breaking news stories
- local angles to national stories
- profiles/spokesmen interviews
- "how-to" consumer stories
- photography/graphic/illustrative pieces

Broadcast: In addition to information, broadcast needs "talking heads." It needs a spokesman, a voice, a face.

Television:

- Newscast-News reporters are looking for the action/conflict in the story. Evening news is drama—visual and moving. TV news looks also for the local angle to the national story of the day.

Primarily, TV wants it in 30-second segments. There is usually not time to "background" the reporter.

- The interview/talk show-The "host," who frequently is not the person who produces the show or schedules the guests, has an "image" or personality as either a nice guy or controversial one. There will usually be a representative from the opposition (this meets FCC requirements for "equal time">; sometimes you are even asked to suggest a representative from the other side. Subject matter for these shows is local, or the local angle to the national story, unless you are on a national show, such as "The MacNeil Lehrer Report." Topics need to be broad enough to fill 15 minutes.

- The Panel Discussion-When an issue is of interest to the entire community, a panel discussion is appropriate. It usually follows the interview format, with a moderator rather than a host, a forum that can last up to an hour; the issue must be very broad.

- Editorial endorsement-TV stations seldom take editorial positions on issues. When they do, it is almost always on local issues. There are two forms: commentary and editorial. The commentary is attributed only to the spokesman, and not expressed as the opinion of the station management. The editorial is the official position of station management. These positions are taken after meetings with those concerned to get background information and ask questions of the chief spokesmen. TV looks for conflict in this area also.

Radio: What is true for TV is true for radio, only more so. Radio has smaller staffs and varies more as to format. Generally, radio reporters are looking for stories to fill:

- The newscast, mostly "headline" with short statements by those involved. Sometimes newscasts include "feeds" or taped statements called "actualities."

- Call-in shows in which guests who are authorities on subjects answer listeners' questions
- Continual news breaks and updates on stories
- Features, particularly with the "all news" or "all talk" formats
- Editorial statements or commentaries (see TV)

How the Media Works

Daily Newspapers: It is essential to understand that advertising is separate from editorials. This separation of news from the business of running a paper is complete and carefully guarded. Never make the mistake of assuming that because you are a big advertiser, the reporter or editor considers your issue special.

A newspaper is organized around subject lines, "beats" with content and amount of news dependent upon news cycles, days of the week, and deadlines. For example, the amount of news'a paper needs depends on the "news hole" that is available, which goes back to how much advertising will be run. Advertising supports the amount of news space available. Thursday papers, with grocery and weekend shopping ads, are the largest. Next are Wednesday papers, with Monday the smallest; Friday is in-between in size. Sunday papers, although they have the most pages, actually have the smallest "news" availability because most of the Sunday paper is printed by Thursday. The skeleton staff fills in news on Saturday mostly with wire copy. If you want to be in Sunday papers, have your information, or talk with the reporter, by Wednesday.

Another determining factor in the news coverage is the AM deadlines (late afternoon) and PM deadlines (early morning). Timing of your release or news conference selects which paper will get first crack at your story. Editorial meetings for AM papers are generally held around 2:00 p.m., so stories are usually under way or complete by then. PM papers are working on second-day stories to AM's lead stories.

Because all newspaper are departmentalized, reporters may cover specific areas, and your information must be directed to a certain reporter or area. Newspapers are also

changing format to meet the TV generation, with special sections geared to target advertising and subject matter directed to target audiences, as in the "Home Sections."

Some of the editions are tabloid inserts and even have a separate staff from the news or feature sections. One positive result of these news sections is a concentration on certain areas, such as business, from the local point of view. For instance, the ***Washington Post*** Business Section that comes out each Monday provides greater coverage of Washington area business issues than before.

Another newspaper development that came about in response to TV influence is a greater use of graphics, photography, and other illustrations. The TV generation likes pictures.

Newspapers rarely initiate issues, but they do take sides. They will more often than television take editorial positions on national, as well as local, issues, and are more willing to meet in editorial and background sessions to discuss them. In addition to editorial writers and cartoonists, such meetings will also usually involve reporters covering the area being discussed, as well as the publisher in some cases. If the paper takes a stand that you do not agree with, even after such a meeting, there is still a forum for your views in the "op ed" section and 'letters to the editor." Newspapers prefer that these pieces be written or attributed to a local citizen rather than a national figure. There are exceptions to this rule, of course, depending' on the issue.

News and editorial sections of the paper are separate, News reporters cover the news on a spot news, feature, or background basis, and work under deadline pressures requiring immediate response to their queries. New technology in the form of computerized typesetting and even page makeup has changed their deadline and editing structure, but the result seems to have given them less rather than more time.

Weekly or Semi-weekly Suburban Newspapers: These publications usually function as a service to their communities rather than as conduits of information. With few urgent deadlines, they are looking for the feature more than the news story, ***always*** with the local angle. The national story is not really interesting to them without a local angle; breaking news is often old before the paper is printed. One suburban editor, explaining what he could

cover in a national story, said his headline would read, "DeKalb resident declares World War III."

Trade and Business Publications: These range from newsletters, to tabloid weekly newspapers, to monthly magazines. They concentrate on service material, specialized information, and problem-solving for the readership. It is said that even the media looks to the trade press to learn about developments in a particular field, and Congress reads the trade press (see ***WHAT INSIDE WASHINGTON READS*** in recommended reading section).

Wires: Al?, UPI, Reuters, and Dow-Jones send news around the country as a service to newspapers, and to TV and radio stations. AP is owned by the member newspapers. UP1 is privately owned, and is directed to radio stations as well as newspapers (sometimes not carried by the newspaper). Dow-Jones is a financial wire which just recently entered the broadcast market with packaged economic material; Reuters entered the financial wire field in competition with Dow-Jones in 1968 and also has strong international 24-hour news service and an information retrieval service. The subject matter and distribution are directed at local, State, regional, and national areas and wires. Reporters with special "beats" are based in bureaus where the news usually develops, such as financial in New York, political in Washington, etc. Most State or large city bureaus will have a listing of the events to cover that day, called a "Day Book" or "Date Book." This alerts the media to newsworthy events in addition to the daily "budget" or listing of stories that newspapers or stations can count on being covered by the wire during the next day or cycle.

Wires also have photo services, now sent by laser. They also offer a private photo service that will shoot photos and send them from one side of the country to another over their wires, although not as part of their news service per se.

Television:

- ***Newscasts: TV,*** like radio, is a headline service. Remember "short and capsulated," and you know TV. The nightly news occupies only 22 minutes, containing fewer words than one page of the daily newspaper. The news director and producer determine what is to be covered, in conference with the

assignment editor. The assignment editor is the primary contact for news; the producer, the primary contact for feature shows. There is a weekend staff, as well as an after-7:OO staff, with the weekend and evening shift making assignments and news decisions for their segments.

News reporters have a maximum of three hours to spend on the average story, most of the time far less, including the filming of the story. This produces only a couple of minutes on air, and boils down to around *30* seconds for a spokesman to tell his story.

TV crews now have sophisticated "Mini-cam" equipment that has changed the way news is filmed and shown. The equipment is expensive, and the crews like to film "live" while a news show is going on.

Whether taped or live, interviews can be conducted in the TV studio, in your office, before or after a speech, and even in the parking lot outside the station.

News interviews or segments are short and to the point. Frequently, you will be asked to remain on camera while other angles are shot for later insertion in the interview, showing your reporter listening, nodding, etc. This is called "cutaway" or "reverse shots."

- *Talk/Panel Shows:* Opportunities for a more in-depth coverage of your issues are available on shows with panel or talk formats. Even these are usually no longer than 15 minutes, and frequently include a representative from the opposition. Sometimes segments are excerpted from these shows for use on the news segments. The setting is less glamorous and smaller than it appears on the screen, and the talk is frequently interrupted by commercial breaks. Most often, these shows are taped weekdays and shown on weekends or mornings. Most shows with audiences are live, and some accept call-in questions from viewers. The person you contacted to make the arrangements for the show, usually the producer, initially receives the information you send, and forwards on to the show host what he thinks is necessary for the

interview. The personality and preparation of the host/ interviewer varies widely, as does the extent to which you can directly promote your cause or position.

- ***Editorial Boards:*** Commentaries and editorial positions are taken based on station policy, usually after a meeting of a spokesman and the news director, PSA manager, station manager, and program director. While much like newspaper editorial briefings, they tend to be shorter and are less likely to result in an immediate editorial endorsement. Most issues on which a station will take a stand are local. Transcripts of the broadcast statement are available upon request.

- ***PSA Spots:*** Announcements of a public affairs or public interest nature can be aired over a slide identifying the television station call letters. You may also supply a slide with the logo or name of your group, and the public service announcement to be read. PSA directors have the responsibility for selecting what is aired. Stations prefer local issues for such announcements, and can use 16mm film supplied from you if the public-interest and noncommercial nature of the announcement is clear. Nationally produced films can be localized with a tag identifying the local angle or person involved.

- ***Documentaries:*** Less frequent is the in-depth coverage given an issue through a documentary. Formats range all the way from the light approach of "PM Magazine" to the more serious look of "20/20." Days of filming and months of preparation are involved.

- ***Cable:*** Cable television's growth in the past five years has created a second system of locally, regionally, and nationally produced programs. National programming includes The Modern Satellite Network carried on more than 400 cable systems, and the Cable News Network with 24-hour news and feature programming now carried on more than 480 stations. "Superstations" like WTBS from Atlanta and specific audience programming

syndications are also national in scope. While most local cable systems do not produce their own programming, there are a few with local access availability, and probably more will appear in the future.

Radio:

- ***Newscasts:*** Most large cities now have a radio station with an either all-news or all-talk format. These stations feature in-depth coverage of issues and present many interview opportunities. Otherwise, radio news is limited to 5-minute headlines, with feeds from network newscasts (Mutual, NBC, ***ABC,*** CBS) and wire services. Many news directors will accept interviews conducted by telephone, or taped and sent to the station over telephone lines. These are called "actualities" and provide the most control over what goes over the air.

  The news department of any station is busiest around the half and hour times and during drive time in the morning and evening. Do not bother them during these times unless you have no alternative. Noon and 6:00 p.m. are particularly busy times.

  In smaller stations, news departments are not staffed after six in the evening, and only answer news lines calls coming over the news telephone extension. If you need to reach them after hours, you need that number.

  News gets old fast on the radio. The day following an event is too late for radio news. This is especially true for actualities.

- ***Editorial Comment: Radio*** stations are even less likely to take an editorial position than television stations, but the process is the same.

- ***Public Service Programs and PSA Announcements:*** Recent deregulation of the radio industry has removed the public service requirement for stations to get a license. The accessibility of radio stations to public service announcements and programs is expected to be minimal in the future.

This will cut down on interview programs unless there is a consumer angle or "personality" angle.

- *Interviews:* Following deregulation, the radio interview segment, outside of the all-talk, all-news stations, is expected to decrease. Consumer and/or "how to" information will be needed to obtain air time or get the interest of today's radio reporter or manager if the subject lacks fastbreaking news interest.

Tips for the Newspaper Spokespersons

Working with Newspapers

A prime public relations goal for an industry or a company must be to win editorial support and news treatment for its policies and goals. Be on the offensive as much as possible in media relations, in particular in newspaper relations.

Catching up with misinformation is tough once it appears in print, and it's nigh on to impossible to change an editorial position once it's taken.

How to take the offensive: Get acquainted with newspaper reporters and editors. Talk with them when you don't want anything. Get to know them and let them know you will respond to requests for information. When they call you, you've become a "source." When you have established yourself as a source, a lot of your work is done-a direct result of establishing mutual trust.

This mutual trust helps you prevent stories that ignore your side of the issue, simply because reporters did not know: (1) that your company existed, (2) that your company or industry had a position on an issue, (3) that your company or industry would be affected by the issue.

Industry statements have the greatest impact on the first day of a major story. A day's lag dilutes much of the impact of the industry's statement. You want to tag on to stories in which you have a role or interest, right from the beginning.

One of the most effective techniques of this preventive medicine is to meet with reporters and editors for an editorial backgrounder. Most of the techniques of

communication in this situation also apply to feature or news interviews, so here is an in-depth look at the Editorial Backgrounder.

The Editorial Backgrounder

Editorial sessions can involve reporters covering your area and members of the editorial staff that decide on what position the newspaper will take. They are usually scheduled through the main editor or editor of the editorial page. Mornings are best, around 10:00 a.m., and you should not impose on deadline responsibilities of the editors by taking more than 30-60 minutes of their time.

Send briefing kits in advance to the editors that include background on who you are, who your association or group is, and what your reason is for meeting with them. This information should be sent ahead because many issues are so multifaceted that it is difficult to cover them in a manageable time period. Moreover, you lose effectiveness if you talk too long and do not answer the specific questions that the reporter or writer has.

It is best initially to only introduce the subject to set the stage, and then let the questions direct the discussion. You are there to answer their concerns. KEEP ***YOUR*** PRESENTATION TO A MINIMUM (20 minutes the maximum).

Depending on the knowledge of the reporters or writers, the areas to be affected can just be listed or discussed. At this point, ask what the editors want to know.

Low-Key Approach: Be conversational. Approach your subject on the non-technical, simple level. Be direct. Present yourself as an individual or interested professional genuinely concerned about the future of your company and the industry. One of the first questions they ask is usually, "How will this affect you?" Give them an honest assumption of how you see the issue. Keep it as simple as you can. Don't try to tell how a watch is put together when what the reporter really needs is just the time.

First of all, state why you are there. Don't be wary of stating a selfish interest. That is expected, or you wouldn't be taking the time to talk with them. Then, go beyond that and add that you are here because you also believe that the public interest is involved and here's why...

Your purpose can be served best by establishing a dialogue, rather than a "preaching" session. Listen to them. Try to elicit the tough questions while you are there to answer them.

Some Definite No-No's:

- ***Don't point with the fingers and speak in a loud voice:*** this seems too overbearing.

- ***Don't interrupt others while speaking*** or take part in a side conversation, even if to answer a question.

- ***Don't dominate the entire presentation. Be*** aware that others should talk and their questions should be aired.

- ***Don't say, "I'm glad you asked me that..."*** That's the last thing they want to hear. It leaves the impression that you have a canned presentation and they just asked that very question you were waiting for. Instead, say something to the effect that, "That's a tough one...? or, "Well, see if this will answer that..."

- ***Don't answer too quickly. This*** again leaves the impression that it is a canned presentation. After a question, first give yourself time to think and see if your initial impression of the question is ***really*** what they are asking. If you answer too quickly, you may not even address their particular question. But also, just counting a beat before answering avoids the "canned" impression.

- ***Don't smile and shake your head at the discussion.*** This leaves the impression that either the presentation is going too weak (the tough questions aren't being asked) or the interviewers are limited intellectually. Avoid emotional reactions.

- ***Don't say, "'You've got to understand that..."*** Sounds overbearing.

- ***Don't tape editorial meetings.***
- ***Don't be late for meetings.***

Opposition Media: Occasionally you will be meeting with journalists who have opposed your position editorially. It is important that you avoid reacting emotionally to journalists whom you perceive as the opposition. Rather, you need to work doubly hard to try to persuade them to see the many facets, the complications and the shades of grey in this issue. It is unrealistic to think you can win them to your point of view, if the paper has already taken a firm opposition stand. It is enough to win their respect for your willingness to discuss the issue cogently and unemotionally. You may, in this manner, be able to neutralize these writers.

On some occasions, editorial background sessions are not possible, or you may want immediate coverage. In that case, these same techniques can be used in talking to one reporter on an interview basis.

One other point: Publications usually only use black and white glossy photographs, and 5" x 7" photos are preferred. Never send a matte-finished or color photograph unless by request. Sometimes, during an interview, and even some editorial sessions, the St&photographer may appear to photograph you while you are talking. Ignore him and continue your discussion.

Tips for TV Spokesmen

Preparing for a TV Appearance

Homework: The key to a successful TV appearance is confidence. Anticipate as many questions as possible and be prepared to make sure you have your say. There is a technique called "bridging," which trained spokesmen frequently employ. If you get a negative question thrown at you, answer it fast, if it's answerable at all, and move on to something positive that makes a point you want to make. To think on your feet this way requires some methodical work in advance. One way might be to write out the things in your industry that make you uncomfortable, and make another list of good things, and then think of

ways to bridge from one to another. At any rate, here are some suggestions to help you prepare:

- Set objectives you want to accomplish. Prepare "mini-speeches" you can bridge into when the opportunity is right. But don't rehearse your remarks until they are so pat they sound canned.

- If you will use visuals, check with the producer and director inadvance on size and appropriate color or tonal contrast.

- Analyze the potential audience. Consider type of station, time of day, nature of the community, possible audience attitudes toward the subject. Plan your comments to appeal to this audience.

- Analyze your data. Don't speak in generalities. Determine ahead of time specific examples you can use to illustrate major points. If you have the statistics, have them available, If you can make them meaningful to the average person.

- If possible, determine in advance how much ground the subject area will cover and which topics will be presented. Is the interviewer interested in a representative opinion from the "industry" or your company's specific policies? Are your personal views of chief interest?

- Again, if possible, learn the interview's angle, and whether the direction is to be open or closed. Will the interviewer seek factual information on a specific topic (closed) or pursue a general line of questioning (open) and depend on you to develop ideas and direction?

Comments on Makeup and Attire:

- Suits: Avoid suits with stripes, checks or patterns. (Medium tone grey, blue, brown, or mixed colors are preferable.) If you wear a black or dark blue suit, avoid light-colored accessories. Don't wear anything you wouldn't wear at the office-no matter what cut the anchormen are wearing. If you feel silly, you'll look silly.

- Shirts: Grey or light blue shirts give the best effect. Off-white or pastel colors may also be worn, but avoid pure white shirts.

- Neckties: Muted colors are suggested. Avoid checks or very small patterns. Bow ties have a tendency to bob with every word you say. Unless it really makes you ill at ease, wear a straight tie.

- Handkerchiefs: Avoid pure white breast pocket handkerchiefs. Muted colors. or off-white are recommended. If you must use a pocket handkerchief, make sure its fresh and unwrinkled.

- Accessories: Avoid large flashy tie clasps, jewelry cufflinks, and the like. They will flare and distort the picture.

- Makeup: The best makeup is a deep tan. And if you have a heavy beard, be sure to shave just prior to leaving for your interview. Otherwise, don't worry about makeup. If there's a problem that requires cosmetic correction, the studio will take care of it.

- Glasses: Lens that turn dark in the light will darken under strong TV lights. This gives the spokesman a sinister look that should be avoided.

- Look neat-every gravy stain is magnified on TV and hurts your image.

Things to Know About TV Production Procedures

You'll be more at ease if you know what to expect. The actual production of broadcast interviews is pretty standard.

Office Filming-If a news crew is coming out to your office to film an interview for later broadcast, allow time for equipment set-up. This will take a minimum of 10 minutes. Have a building electrician handy to help find power outlets and fuse boxes. There's no need for you to be around as all this happens; as a matter of fact, it's a good idea for you to leave the room.

Often the reporter will be interested in talking to you privately to narrow the area of questioning down, generally in the interests of saving time and film. This

can usually be done while the crew sets the camera up. Take the reporter into another room but remember not to say anything to him that you wouldn't want repeated on the air. And even though the reporter outlines the interview for you, don't be surprised if he brings something else up in the course of actual questioning.

When everything is ready, proceed as if you were the guest. Let them tell you where to sit. Let the technicians hang the mike on you if they are using lavalieres. Try to forget it's there until everything is done and then let a technician take it off you.

The interviewer may ask for a "voice level" at the very beginning of the interview. This means they want to preset the volume on your microphone. Simply talk in a natural voice until you're told to stop. Do not simply mumble three or four words and then ask, "Is that enough?"

At the end of a filmed interview in your office, the reporter may want to film "cut aways." These are short segments of film that can later be inserted between your responses. This allows the station to rearrange the whole interview to fit any time slot. So the reporter will probably ask the questions all over again, this time with the camera trained on him or her. Stick around just long enough to satisfy yourself that substantially the same questions are being asked. Then feel free to excuse yourself. They would probably rather pack up their equipment in peace anyway.

Television news crews have very portable equipment, including lights. They will light your office, or other location quickly and easily, with a few portable lights. Normally two lights are used. One is placed so that it shines on your face, while a back light is placed behind you to take out your shadow. Since TV lights are very bright, you should ask that they be turned on a few minutes before the interview begins so your eyes can get used to them. You may have trouble seeing at first. It's a bit like coming out of a dark theater into bright sunlight, but after a few minutes your eyes will get used to the light. If the light is shining directly on your face and it still bothers you, ask the technician to change the angle of the light a bit.

Studio TV-Discuss the program with one of the production assistants well in advance of the actual broadcast or

taping. Pin down the topics to be discussed, names and background of any other guests appearing with you, identity of program host, total time allowed for your segment, and the exact time you are to be at the studio.

During this advance discussion, if you have visuals that would illustrate the points you wish to make, ask if they can be used. Arrangements to show them must be made ahead of time, particularly if you want to offer something to viewers; the producer may want to superimpose your address on the screen.

When you go to the station, you will be placed in a waiting area. Networks usually also take you to makeup; local stations generally do not. A few minutes before your segment is to be aired, you will be taken into the studio and seated in a spectator's area. Generally you will not meet the program host until you are taken onto the set. There is usually only a minute or two before the program will be back on the air. Sit where you are told. A technician will place a microphone around your neck. Get comfortable. If you brought notes or visuals, place them where they are unobtrusive but easily reached. Keep your eyes on the show host. THINK FRIENDLY.

At the end of your segment, stay put and stay quiet until you're told you can talk and get up. You may still be on camera and your microphone may still be "live" even though the questioning has ended. On the other hand, once you're dismissed, clear out-they'll need to get the next program guests onto the set.

How ***To Present Your Best Image on Television-The ideal, of course, is to be yourself-to appear as natural as possible. Unfortunately, on television that's not quite as easy as it sounds: the activity on the business side of a camera lens has been known to make fullfledged monsignors look shifty-eyed. But projecting a pleasant image on television is not impossible.***

First of all, remember your posture. It sounds obvious, but sit up straight. Studio chairs for some reason range from those requiring a delicate balance to stay on, to those that wrap themselves around you when you lower yourself in. Sometimes, they swivel. You shouldn't. It will make you look uneasy if you sit there swaying back and forth when asked why you're the world's worst employer.

In stand-up interviews, stand up straight. Resist what will be a strong inclination to bend over into the microphone. By all means, don't reach for the mike. It's the reporter's job to make sure he's got your voice on tape. In almost all cases he'll succeed.

During an interview filmed in your office, look directly at the reporter: ignore anything else happening in the room. The cameraman may leave the main camera and start shooting with a hand model. The reporter may never take his eyes off his stop watch and notes. Someone may even crawl in at knee level to adjust your mike cord. Ignore it all. Just keep looking where the reporter's eyes would be if he were looking at you.

When on camera, try not to fold your arms in front of you and try not to look down at the floor. These are defensive actions. Fold your hands in your lap or clasp your wrist with one hand. This prevents shaking. Remember, body language has a lot to do with the impression you convey to the audience. Look at the reporter, not at the camera. If you look at the camera, it seems as though you are trying to propagandize. Reinforce your remarks with gestures, facial expressions, and the pacing of your response.

If your interview is being filmed at a studio or is on live TV, resist the temptation to look at the monitor. The exception is when you are showing a visual. When you are sure the camera is focusing on it, check the monitor to see if the viewer can see or read the important portion; if it isn't clear, describe what the visual shows.

If it's a press briefing being filmed and you're being interviewed by several reporters at once, pick the questions you want to answer and ignore the others. Your selection should have nothing to do with the volume the question comes in. Keep your eyes on the person who asked it. The other reporters will read this signal and keep their questions till you look away from the first person. Don't be surprised if you are asked the same question several times by different broadcast reporters-they may have missed your earlier response to an important question since their cameras seldom churn away during the whole news conference. When you want to end the interview, thank the reporters and leave. Don't start answering more questions.

Never smoke or chew gum during the interview.

Smile only at humor. A toothy grin after each question doesn't look friendly, just phoney. Especially try not to laugh at a genuinely serious question.

Most important, never blow your cool. Stay calm. Nothing can make you look as bad as losing your temper, no matter how much provocation there is. Getting angry at an interviewer (or another guest on the show) destroys your dignity and will make every viewer lose respect for you. Once that happens, everything you have accomplished earlier in the interview goes down the drain.

Before You Go On the Air

- If you're jittery, relax your throat muscles by yawning or stretching.
- Review your material. Don't be afraid to walk around the studio and talk to yourself, reviewing the points you're going to make.
- Practice speech consultant Dorothy Sarnoff's three positives: you're glad to be here, you're interested in the audience, you have authority ("I know that I know").

Intewie w Tips

1. If you know you are likely to be interviewed on TV, watch TV news interviews for a week or two. You can get a good idea of how questions are structured and how to prepare yourself.
2. If you are called for an interview, bear in mind that the total air play of your story, if you're top news, will be no more than 1.5 minutes. That means you get 30 seconds to tell your story; that's your maximum time. So think your topic through before you go on the air -or before your filmed interview starts; you must decide in advance how much of the story you can tell in 30 seconds. Don't plan to go in depth; the more you talk, the more chance there is for taking things out of context, editing, and misquoting. But do have in mind one or two major points that you want to get across in the finished story.

3. If you are to be quizzed on a negative aspect of a topic, remember: by dealing well with the negative, you will be establishing your credibility with the station for the future. Giving yourself a future with the station means that you may get a chance later to tell the positive side of your story. For example, when vinyl chloride problems were in the news, Goodyear was open, helpful and available; they established credibility with the station and will be a likely source for that station in the future.
4. Welcome the interviewer and the questions. Take the attitude that he or she represents the public and that the public is entitled to know.
5. Refer to the interviewer by name, early and often.
6. Remember that the TV reporter is not aware of how scared the interviewee may be; reporters do so many interviews and are so expert in the interview situation they forget about your being scared. An *experienced* reporter will try to put you at ease by smiling and small talk. Such a person is not "licking his chops" over you; it's a sincere effort to put you at ease.
7. During the "set up" time (time when cameras and lights are being set around you) get your point across to the reporter. Indicate the focus you want to establish. The reporter will be grateful because a line of questioning may not have been prepared and he or she may not know much about you or your topic.
8. Remember that TV works under terrific time problems. Don't be alarmed if a reporter comes at you with a to-the-point question; that's his or her job.
9. The reporter wants your points of view, not the whole story. His or her job is to ask the tough question. BE PREPARED.
10. Make sure your points are relevant to the reporter's question. Don't try to snow him or her.
11. Be realistic in your answers. Look at each question from the public's point of view.
12. Be positive in your answers.
13. Place your most important points at the beginning of each response where they will be clear and isolated. In filmed interviews, this is especially important. Responses like "I have twelve points to make. One...

Two... Three... etc." drive film editors crazy and invite poor editing. The editor may choose an insignificant part of your response simply because it's easier to edit. Reporters are delighted to have "the most important thing" flagged for their benefit.

14. Short answers are better than long ones. A few sentences give the interviewer less opportunity to misunderstand you. And on television, where time is measured in dollars, this is especially important.

15. If a reporter tries to interrupt you before you have finished your response, pause, let him finish, and then continue your answer. Don't let yourself be drawn into the ridiculous position of having to talk louder just to be heard. If the reporter persists in interrupting, don't get into an argument but do insist on the right to give a complete answer.

16. On the other hand, if the reporter interrupts you, there may be a reason. Don't run off with the interview: allow for plenty of give and take between yourself and the reporter. Don't start every answer back at the Flood; be immediately'responsive, giving only enough background information to clarify the issue.

17. If a reporter asks several questions at once or poses several false premises in asking a question, don't let this get by. You might reply, 'Well, you've really raised several questions there. Let me respond to your main point first, etc." Unload the loaded preface ("Given the bad image your industry has...").

18. Interviewers want colorful language, not bureaucratic gobbledygook. The more informal, the better. If an answer must be technical to be accurate (and there are a few of these) also provide an appropriate analogy. Give illustrative anecdotes where possible but keep them brief.

19. If you absolutely must use jargon in an interview, make sure you define and explain it. Do not use industry terms that dehumanize your topic, such as "well-baby care" for "pediatric care."

20. Don't repeat a reporter's terminology unless you want to. He will often use colorful language to encourage you to do the same. His question probably won't appear in the final story, but your answer will.

21. Don't let a reporter put words in your mouth. Occasionally, an interviewer will rephrase your response to a question and test it on you. It's good policy to answer all questions that start, "Do you mean to say..." with a clear, concise statement of what you do mean to say. Don't let what may sometimes sound preposterous throw you off. For example, after explaining that the company promoted employees on the basis of ability, one executive was asked, "Do you mean to say that your Black workers are less qualified than your white workers?" If you are asked a negatively stated question, turn it around, block it and answer with a positively formulated statement.
22. Don't feel obliged to accept the reporter's facts or figures. Start your response with something like, "I'm not familiar with your figures, but I'd like to respond to the main thrust of your question," if the statistics are new to you. If you know the correct figures and the reporter is wrong, straighten it out. If the reporter is right and you know it, don't feign ignorance.
23. If a reporter wants information you can't release because of clear company policy, don't evade. State matter-of-factly and without resentment that you can't release it; if you are able to do so subsequently, you will. If the reporter presses, repeat yourself in a calm, polite manner. If you can explain why the information is withheld without getting into the specifics you want to avoid, do so.
24. If a reporter asks a question "off the record," remember that anything you say can be used-and most likely will be. Say nothing off the record or outside the actual interview that you wouldn't want published with direct attribution to you.
25. Never respond to a question with, "No comment." Explain graciously why you cannot answer that question.
26. Avoid phrases like, "That isn't my area of responsibility." If you don't know the answer to a question, say so. But always offer to find out or to put the interviewer in touch with someone who does know.

27. Never assign blame for any situation unless there is clear company policy on the matter. If a reporter wants to know why something has gone wrong, give the reporter background information on the complexities of the situation as much as possible.

28. Never answer a question that you don't understand. Ask the reporter to restate it. And, if you don't know an answer, say so. Don't bluff.

29. Remember that the reporter will take what you reveal in each of your answers and use it to formulate the next question. So don't reveal more than you want to. Answer questions simply.

30. It should be obvious: Never-absolutely never-lie to a reporter. You don't have to expound; just be sure what you say is absolutely true.

31. Be yourself. 'You are appearing not as an actor or actress, but rather as an interesting person in your own right," advises the National Association of Broadcasters. Talk in ordinary conversational tones.

32. Be natural. Look relaxed but don't slouch, throw your arms over the chair back, or cross and uncross your legs. Act as you would before any small audience, or imagine a good friend is in place of the television camera.

33. Use eye language. Look directly into the eyes of the person talking to you. If there is a live audience, talk to various individuals in it. Resist the temptation to look at yourself in the studio monitor. And don't stare blankly into space when others are speaking. Look directly at them.

34. Distractions to avoid: rapid hand movements (difficult for the camera to follow), repeatedly clearing your throat, foot tapping, rolling your eyes upward when answering a question.

35. If **you** feel that a TV news story contains factual errors, it is okay to call the reporter and point out the mistakes. Most professional reporters acknowledge that they are human and do make mistakes, and they will appreciate hearing from you. Confine your criticism to factual errors, never to a newsman's judgment. Make your point once, and then forget it. Don't beat a dead horse. Just as newspapers have

more ink and paper than you do, television stations have more air time than you. Crying "foul" over and over only exposes you to more of the same treatment.

36. Watch those repetitive words: "oh-oh" or "ah" or "like" or "you know."

37. Never assume you are off camera if you are still on the set while someone else is being interviewed. You may still be in range.

38. Above all, be on time, as directed. You may be required to be at the studio long before air time, while earlier guests are being interviewed, or just minutes before your own spot. You won't know which until after you are there, so don't take any chances.

Tips for Radio Communication

Radio interviews generally follow the rules for TV interviews, with the exception of the call-in show, which is found more frequently in radio than TV. Below are some tips for handling this format:

- Call-in shows on radio frequently tend to attract consumers unsympathetic to industry problems.

- If you participate in a radio call-in show, it's best to respond calmly and frankly.

- During radio"talk shows" take back-up materials or notes with you (including an outline of the most important points you may want to make). Feel free to refer to your notes, but be careful not to rustle the papers during the interview, since the noise will be picked up by the microphone.

- When appearing on radio call-in shows, pay careful attention to what the basis of a caller's question really is.

- A caller may be confused as to how to phrase what it is he or she wants to know. Likewise, the real question may be buried in rhetoric. Keeping in mind the interest level of the rest of the listening audience, you may want to summarize or re-phrase the question before answering. Use phrases like,

"It seems to me the real question you are asking is... and the answer is..."

- Remember that listeners to talk shows may "tune in" in the middle or near the end of a program. Therefore, always answer each question completely, as if there has been no reference to an issue previously (even if there has been).

- On talk shows, repeat your best arguments as often as possible. When scheduled to appear on a talk show, determine ahead of time if anyone else has been invited to appear with you. If an opponent has been invited, follow the instructions listed in the Debate Tips section of the kit. In particular, establish the ground rules ahead of time (try to arrange a format similar to those recommended for debates); stress your desire to ensure that both sides have an opportunity to answer each question (particularly on call-in shows); take notes during radio shows on what the opponent says, and tailor your answers accordingly.

- Do not become frustrated if a talk show host seems unfair or biased. Many hosts build audiences around their own personality, which sometimes is highly aggressive. You will have to work with the tone established by the host, since you are the guest. However, when there are obvious misstatements or biases, do not be afraid to disagree with a host strongly and point out any statement that is not factual, or to provide a strong factual response to a stated opinion.

Telephone Interviews

Because of the small crew that usually staffs the news operation of local stations, interviewsare frequently conducted by telephone rather than by personal coverage of a speech or event. It is best to arrange for you to call the station. This permits you to be ready mentally and physically, but there are occasions when you will be called and will need to respond quickly.

As in other cases, just keep your central point in mind, and speak in a normal, conversational tone of voice.

If you anticipate a time crunch, record your, statement ahead of time and have it sent by telephone (this is called a "radio feed" or "actuality") to a newsroom. In this case, be sure to have the direct news line number, especially if you will be "feeding" when the switchboard is closed. Keep such statements to a maximum of 30 seconds and send either by early morning (6 - 7:30 a.m.) or the evening before, but certainly before 11:30 a.m. If you are referring to an event the day before, stations usually will not accept the feed after the noon news.

News Conferences

There is no set format for a news conference. But there are some basic ground rules that should be considered.

You should ***neuer*** call a special conference unless the news ***cannot*** be handled through a standard release. If you build a reputation as an indiscriminate news conference caller, you'll probably irrevocably damage personal relations with editors and correspondents. Remember— media outlets are constantly working against time, and in the news business, in particular, time is money.

You should call a conference when important news is expected to break and when all or most media are able to participate in the nature of the news (but not the story itself), the time of the conference, your address, the conference room name and telephone number. You should also notify by telephone the major news outlets and special correspondents in your area.

Be very careful about "leaks." It's highly risky to tip off a reporter in advance. If he breaks your confidence, your reputation is damaged. Avoid all advance news leaks and treat all news sources equally. Caution staff people in your agency against premature discussion of a news conference subject.

Be prompt. Remember again, time is critical to newsmen. If you call a conference at 1O:OO a.m. you should be prepared to start at 10:OO. Keeping a room full of reporters waiting for one TV station to show up can cause a lot of dissension and resentment.

If an announcement is to be made by one person, he or she should be fully briefed and be prepared to answer any questions. It should be understood in advance that the

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person will be fully available for questions or for personal interviews following the conferences, in fact for the next 24 hours.

There are many details to remember in scheduling a news conference. Keep a checklist and doublecheck every step of the way.

Steps to Schedule

- Schedule 3-4 weeks in advance, if possible.
- Reserve room (10:00 a.m. best time).
- Send media advisory material one week before (2-3 weeks before for a major news conference). Call to check receipt. If a weekend event, check to see who staffs the assignment desk, city desk on Saturday or Sunday.
- Get phone number for weekend access to news room.
- List with the UP1 and AP Day (Date) books (City Wires) 2-3 days in advance.
- Send mailgram to local bureaus; 2 days prior call all media.
- Make arrangements with spokesman morning before to reach him anytime in the following 24 hours.
- Have media kits ready for reporters.* Mail or messenger out kits to reporters not attending.

* Information in media kit:
- bio on all participating
- schedule for conference and who will speak when
- backgrounders
- general release
- photo or graphic
- reproduction of visuals used during conference
- back-up for any study or research used
- avoid slick booklets unless annual reports are necessary

For Television and Radio

- Be sure that speakers are reminded to stay with mikes:
- Best for TV to have each person come to podium.
- Podium should carry identification of group.
- Check background — should be plain or solid wallcovering for backdrop behind speaker.
- Be sure there is adequate sound amplification for all speaking as well as those asking questions.
- Have name plates (readable from media area) for those on panel.
- Provide equipment for multi-plugging into the amplifications system (a "multi-box") and check to be sure power and fuses are adequate.

Establishing Credibility

When speaking before any group, you must begin by allowing the audience to recognize you as an authority who has something valuable to say.

To start, present yourself as an individual, rather than as a "spokesman." While you may be representing an organization or company, it should not be forgotten by you or by your audience that you are an individual with values, ethics, and concerns like anyone else. Hence, it is important to use the word "I" rather than "we," and to talk on as personal a basis as possible, constantly injecting your own concerns and feelings. Likewise, if you are genuinely concerned about environmental issues, or belong to an environmental organization, begin any discussion on related subjects by saying, "As an environmentalist, I believe..." Also, try to relate personal experiences.

Base your talk on facts rather than rhetoric. As often as possible, support each statement with the technical data necessary to illustrate your point. The audience can quickly become lost in long rhetorical statements, so avoid them. Also, avoid wordy language. The audience

will not be impressed with your use of long words, and may, in fact, have a negative reaction to all of your presentation.

Use acceptable data. To many people, data developed by the industry is not acceptable because of bias. It is therefore very useful to utilize data developed by State Governments, universities, and independent foundations to support your case. Rather than quoting your figures on your particular issue, quote government figures, which may be low but are presumably less biased in the eyes of the public. Whenever possible, quote "unexpected sources."

Always answer the question asked, not the motive you think is behind the question. Many spokesmen, especially when speaking on a controversial issue, have a tendency to read things into questions. If there is a low-lying motive behind the question, address it as an addendum, without making it part of your specific answer. Using the phrase, "That also brings to mind..." can help to dispel whatever the innuendo was, and separate it from the main question, which helps keep you off the defensive.

Be concise. When a question is asked, the basic answer should be given, in blanket form, within 30 seconds. After that, a more detailed discussion on the question may well be appropriate. However, if you go into a lengthy discussion on the question raised and do not reach the conclusion until three or four minutes have lapsed, you will have lost a great portion of the audience.

Speak plainly; remember that many in the audience have no opinion whatsoever on the subject being discussed. Do not be afraid to speak simply, without being condescending. It will quickly become apparent what level of understanding exists in the group, and you can adjust accordingly.

Do not be afraid to project yourself as an expert. You have a certain amount of knowledge that enables you to speak about your subject with some authority. Make that clear. Refer constantly to your profession and your background.

Use the "challenge" technique to involve the audience actively in thinking about the subject. When participating in a debate, even with a skeptical audience, challenge them to ask themselves key questions about the issue at

hand. This can be an effective and direct method of exposing weaknesses in the other side's point of view.

Preparing a Good Speech

A well-constructed, dynamic speech can be instrumental in raising the level of your effectiveness. As you prepare a speech, be mindful of the following.

First, consider your audience. Determine the areas of your subject that will, and will not, interest them. A Rotary Club is probably more interested in the economic aspects of the problem, while a college group may be more concerned with the environmental aspects. Therefore, consider the unique interests of each group and modify your presentation accordingly.

Jot down the major points you want to make, once again giving the group's interest top priority. However, do not exclude any aspects of your overall theme. Simply prioritize the points you want to make to suit your audience.

Outline the support data and facts that you want to use to back up statements in your speech. Outline in detail the points which you want to emphasize, being sure to include all the necessary technical data.

Use concise, direct statements. Do not waste time with drawn-out discussions of single points. Also; use simple language and do not become involved in long, intellectual arguments. Most audiences resent this approach.

Read the speech aloud several times, practicing timing and delivery. Make sure it is not too long for the situation in which you will be speaking, and make sure your delivery is clear and concise.

Practice the speech before a friend, asking him or her to comment on the style and content. Perhaps you should also record the speech and listen to it yourself. In doing so, there are a number of things you should note.

- Are you speaking forcefully and with authority?
- Is your speech too long?
- Are you speaking slowly and enunciating everything?

- Are you speaking from your diaphragm and not your throat?
- Is your speech tailored to the formality of your audience? In other words, is it formal for a business organization and more casual for a college audience?
- Is your speech organized in a logical fashion?
- Are your points presented so that someone totally unfamiliar with the subject will understand?
- Are you practicing eye contact with your audience and not looking at your text?

Next, rewrite the speech based on your own criticisms and those received from your friends, again keeping in mind that you want to be concise and direct with as much factual data and as little rhetoric as possible.

Reread the speech several times until you are thoroughly familiar with the content. Then place your outline of the speech on 3 x 5 cards. Generally, if you are thoroughly familiar with the speech, you can deliver it more effectively from cards than from a prepared text.

Scheduling Speakers

There are a great number of public forums available which can be utilized by an organization interested in addressing issues of public concern. These forums range from high school and college lecture committees (usually sponsored by the student government) to civic and service organizations such as Lions, Rotary, Sertoma, League of Women Voters, Sierra Clubs, Jaycees, Kiwanis, Exchange, and Optimists. A list of civic and service organizations usually can be obtained from the local Chamber of Commerce or the Welcome Wagon. These groups are particularly influential, since they count among their members active opinion leaders within the coxnmunity.

It is important to remember that one of the principles of influencing public opinion is to make as many different impressions on an individual as possible. Impressions received through personal contact are far more positive and

longer lasting than those gained from radio, television, or the print media. Primary impressions received via personal contact can be constantly reinforced through the use of print and electronic media.

Scheduling civic events can be an ongoing process with the goal of addressing all groups in a given area within a given period of time, such as a.year, or it can be telescoped into a "blitz" when civic organization presentations, radio and television programs, and newspaper interviews are conducted in a relatively short period of time, such as a week or 10 days. While the former method is more comprehensive, the latter tends to focus and concentrate your message--and is particularly effective when there is a need to mobilize public opinion rapidly.

Sources

Before a series of events can be scheduled, it is necessary to assemble a list of sources for your city or State. The two basic sources are: (1) a list of civic and service organizations-available from the local Chamber of Commerce or Welcome Wagon, and (2) a media list of radio, television, and newspapers-available from the telephone company or the State press association.

One often overlooked resource is your own co-workers. A procedure should be developed to determine if any of your co-workers are members of civic organizations or have contacts within the media. These people can be asked to make a personal contact to schedule an appearance.

Source lists must be updated to reflect changes in personnel and programming. In order to update lists, call the organization and request the following information:

For Civic Organizations

- President's name, address, and telephone number
- Program Chairman's name, address, and telephone number
- Meeting day, date, place, and time
- Number of club members

For Electronic Media-Radio and Television

- News Director or Assignment Editor-name
- Talk show or public affairs programming format, broadcast day, time, duration, producer, and host
- Station studio address and telephone number
- Reporter assigned to business, health, etc.
- Regular newscast deadline time
- Network affiliation, if any

For Print Media-Daily, Weekly, and Semi-Weekly Newspapers

- News Editor's name (or assignment—usually City Editor)
- Editorial Page or Managing Editor's name
- Environmental reporter's name
- Energy reporter's name
- Health reporter's name
- Women's issues reporter
- Business reporter's name
- Address, telephone number
- Circulation
- News deadline time for evening, morning, and Sunday editions

Speakers' Bureau Committee

The most efficient method of organization for a Speakers' Bureau Committee is to combine the actual speakers with the schedulers. The Chairman should have the time and authority to manage the group. Although not absolutely

necessary, the Chairman should already be active in community affairs and have experience in dealing with the media.

The Committee should be divided into a speakers' section and a support section. The support section need be only a few people whose responsibilities are to maintain source lists and speaker availability calendars and, of course, to schedule available speakers on an ongoing basis. The Committee should meet frequently so that speakers can feed back to schedulers information on which forums have been most receptive. The support section should also endeavor to make available to schools and organizations films and other material provided by allied industries and trade associations. The Speakers' Bureau Committee should, in short, be the resource to which people turn for information on the issue.

Advance Letters

The first step in organizing an ongoing speakers' tour is to send all civic, service, and professional organizations a letter soliciting speaking engagements. Groups such as the Kiwanis, Rotary, Jaycees, League. of Women Voters, and AAUW are particularly receptive to this approach. The letter should clearly state when you are available, your subject matter, your position on the issue, and a contact name and telephone number. Approximately 10 days after mailing the solicitation letters, follow-up telephone calls should be made to the addressee to schedule engagements.

Letters to radio and television public service directors, talk show hosts, and producers should be mailed concurrently with the civic organization letters. These letters should follow the same format as the letters to civic organizations. Similar letters should be mailed to editorial boards, business and health editors, etc., at this time. Follow-ups and scheduling should revolve around civic events, as these are in and of themselves newsworthy and can generate coverage.

As each appearance is confirmed, place it on a master schedule. A letter of confirmation should be sent containing the date, time, and place of the event, including a copy of a biography of the speaker(s).

Coverage of Events

Choose the largest audience or most prestigious organization before which you are appearing and invite news media reporters to cover your presentation. Arrangements should be made to allow the media to join in the meal, or advise them of the time when the presentation is scheduled to begin. A short press release directed to individuals, i.e., health reporter, should be mailed or hand delivered no later than three days before an event. Reminder follow-up calls should be made 24 hours in advance, if possible. Remember, the press will not cover every presentation, so choose only a few major events a year.

Press Releases

A news release should be mailed to selected local media, both print and electronic, about 10 days before a scheduled event. The timing of this release is important, as it should arrive in time for weekly newspapers to run it before you arrive. The release should not exceed two double-spaced pages, and should include several quotations and the name of a contact with a telephone number for further information. The release should be mailed or hand delivered, if possible, to the attention of the news director at the radio and television stations, and the appropriate reporter or news assignment editor at newspapers. An ideal first release is an announcement of the formation of the speakers' committee.

Events

Contact persons for each event, such as a program chairman, must be called 48 to 24 hours in advance to reconfirm your appearance. This is an ideal time to ask for driving directions.

Always allow 25 percent more driving or travel time between events than you think you will need. Depending on the ability of the advance personnel, this cushion will be expanded or eliminated. A rule of thumb is to allow one hour and a half for a civic event, a half-hour more than the "air time" for television and radio, and one hour for a newspaper briefing.

Upon arrival at an event, the advance man should introduce the speaker to the President, Program Chairman, or Editor, and provide that contact person with an extra

copy of the speaker's biography. (The biography should be written in such a manner that it can be read as an introduction.) For civic events, request from the program contact permission to pass out any material or place signs, etc. Always offer to pay for your meal if one is served at a civic organization function.

Editorial Briefings/Public Affairs Programming

Editorial editors and public affairs and talk show producers are usually much more flexible in their availability for scheduling. Schedule taping sessions and editorial briefings in the morning and early afternoon respectively. Many public affairs and talk shows are either late in the afternoon or early morning, or are presented live on the weekends.

Under the Federal Communications Commission's Fairness Doctrine, electronic media, i.e., radio and television, are required to present both sides of an issue in an equitable manner. Whenever the opposition receives air time, or the subject is featured, you have the right, as a responsible spokesperson, to present an opposing viewpoint.

It is easy to take advantage of this free time. First, write the news or public service director of all electronic media informing them of your availability to respond to the mandatory deposit issue on an ongoing basis. Continual monitoring of television public affairs programming and radio talk shows will then allow you to contact the station and request equal time. Television and radio stations welcome responsible views.

Follow-Up

It is vital to maintain good relations with the groups and stations on which you have appeared. Return engagements are much easier to schedule if a good working relationship is established. Always send a thank you note from the speaker and be sure to mention the continued availability of your group.

For electronic media appearances, always request a copy (audio or videotape) of the events. These tapes prove to be an invaluable resource in critiquing your speakers. Review of these tapes can help speakers to be utilized to their best advantage, whether it be on radio or television.

The print media will usually send a tear sheet or copy of articles written as a result of an editorial briefing or the coverage of a civic event. However, it is good policy to retain a clipping service in order to secure all printed material on the issue. Clippings should be filed by newspaper categories-thereby giving the speaker a good idea of the paper's stand on the issue. Newspapers often provide space for opposition editorials; a clipping service will provide a record of editorials to which you may respond.

Appendix K

NCADI Resource Lists

Resource lists are available, free of charge, through the National Clearinghouse for Alcohol and Drug Information (NCADI). These lists contain descriptions of many kinds of materials, such as pamphlets, brochures, books, journal articles, and videotapes, on a wide range of topics. The lists are updated frequently, and new lists are continually added. For instance, in 1989, new lists will be prepared on materials for several different ethnic groups, and on materials of particular relevance to urban and rural audiences and for members of religious institutions or programs. If you do not see the topic in which you are interested listed here, call (301) 4682600 or write NCADI at P.O. Box 2345, Rockville, MD 20852 for the latest information.

NCADI Resource Lists-1989

MS249 ***Occupational /Employee Assistance Programs: Update,*** (1987). Annotated bibliography covers subject areas such as program models, cost effectiveness, prevention, unions, program evaluation, and health insurance. 9 pp.

MS305 ***Prevention of Alcohol Problems: Update,*** (1985). Focuses on problem areas and populations, education and training, and evaluations of primary prevention programs. 14 pp.

MS306 ***Alcohol and the Elderly: Update, (1985).*** Contains an annotated reading list on the elderly covering topics such as prevalence, special characteristics, biomedical and psychosocial effects, and prevention, intervention, and treatment. 6 pp.

MS309 ***Alcohol and Hispanics: Update,*** (1985). Presents information on publications, audiovisuals, and relevant organizations. 6 pp.

MS311 ***Alcohol and Safety: Update,*** (1985). Includes descriptions of publications and organizations involved with safety topics such as automotive, aviation, home and recreational, boating, and occupational accidents. 9 pp.

MS319 ***Alcohol and Black Americans: Update,*** (1985). Presents information on publications, audiovisuals, and relevant organizations. 7 pp.

MS321 ***Children of Alcoholics: Update,*** (1988). Lists relevant publications, audiovisuals, and organizations. 11 pp.

MS326 ***Alcohol and Crime: Update,*** (1986). Includes statistical information and an annotated list of books, articles, and conference papers on various aspects of alcohol and crime. 9 pp.

MS335 ***Alcohol and AIDS: Update,*** (1987). An annotated reading list on the topic of the potential relationships between alcohol consumption and AIDS. 8 pp.

MS336 ***Alcohol and Nutrition: Update,*** (1987). An annotated reading list designed primarily for the clinician on the topic of the interaction between alcohol and specific nutrients. 13 pp.

MS340 ***Medical Education and Substance Abuse: Fact Sheet,*** (1987). Annotated bibliography of recent research and curriculum guides pertaining to education in alcohol and other drug abuse, and related medical complications. Prepared by the Association for Medical Education and Research in Substance Abuse. Most of the entries focus on education of primary care physicians. 27 pp.

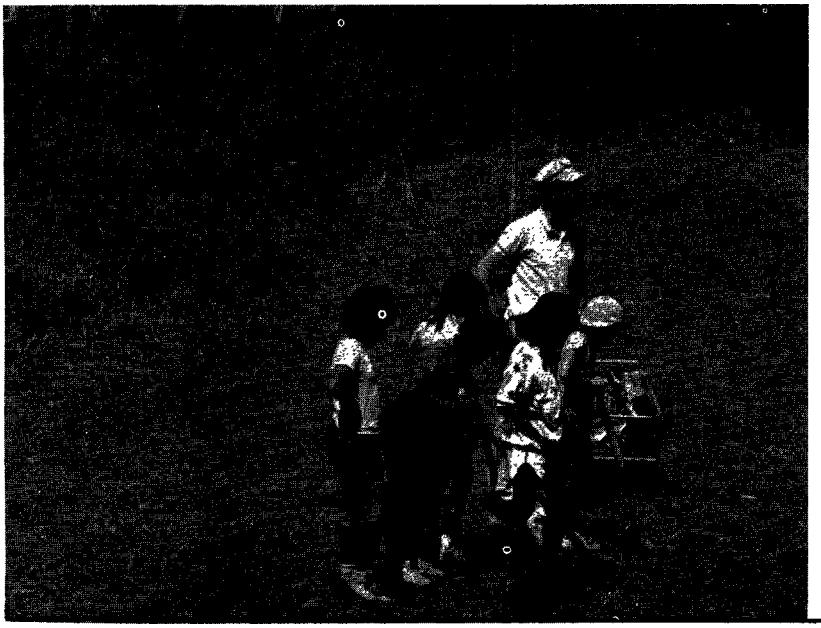
MS349 ***The Fact Is...You Can Prevent Alcohol and Other Drug Problems Among Elementary School Children,*** (1988). Includes audiovisuals, program descriptions, and professional and organizational resources to assist educators and parents of young children. 17 pp. (See MS364 for older students.)

MS353 ***The Fact is...Alcohol and Other Drugs Can Harm an Unborn Baby, (1988).*** Provides background information on the effects of alcohol, illegal drugs, and other substances on a developing baby. A list of resources for patient and professional education is also included. 13 pp.

MS364 ***The Fact Is...You Can Prevent Alcohol and Other Drug Use Among Junior and Senior High School Students, (1988).*** Provides information on intervention and prevention programs. Includes resources for students, parents, and teachers on organizations and materials for individual, class or group use.

MS373 ***The Fact Is...Employee Assistance Contacts Are Available in Every State, (1988).*** Provides the names, addresses and telephone numbers for employee assistance contacts throughout the States.

MS374 ***The Fact Is...You Can Form a Student Assistance Program, (1988).*** Provides information to school professional staff on the different types of student assistance programs, and where to obtain further information on forming a program.



Appendix L

Peer Programs: The Lodestone to Prevention

By Bonnie Benard

A Few Words About Prevention Program Evaluation Research

Seldom can we read a review of prevention research without the author concluding we need more, carefully done program evaluations. Under pressure from legislators, communities, parents, and schools-groups all concerned with substance abuse among youth-the prevention field is also clamoring for more evaluated programs to serve as models for planning prevention efforts. Both research and field folks are specifically wanting to determine the answers to the questions Michael Goodstadt so cogently asked a few years back, "(1) What forms of drug education are effective, (2) in influencing what outcome variables, (3) through what mediating variables, (4) over what time-frames, and (5) for which individuals?" (p. 440).

Unfortunately, the majority of evaluation studies of individual programs-not only in prevention research but in all of social science research-have failed to find positive outcomes for psychosocial interventions, thus making the transfer of research findings to the field of psychology, mental health, social services, and of course prevention, particularly problematic. One author commenting on this lack of technology transfer has observed, "One of the most serious impediments of putting evaluation results to use is their dismaying tendency to show that the program has had little effect" (Weiss, p. 126). Another author concludes that, "Whether one refers to evaluative studies in psychology, psychiatry, social work or corrections, the

results have been preponderantly negative. Unfortunately, one significant outcome of this situation is a tendency for some critics to forcefully denounce entire programs of professional practice" (Feldman, p. 115). One example of this from the substance abuse field I particularly recall was the Napa Drug Abuse Prevention Project's negative conclusion that the prevention strategy of providing greater attention to students' affective needs does not "enhance constructive social attitudes, norms, and competencies which in turn will decrease acceptance of and involvement in drug use" (Schaps, b, p. 31). Instead of examining the various levels at which their evaluation might have failed, the researchers concluded a basic tenet of prevention philosophy should be discarded (Benard).

According to Stanley Greenspan, a researcher in the infant development field, we are asking the wrong questions in much of our research. Instead of asking questions about what type of intervention is most effective, we're pursuing whether any type of preventive intervention is warranted; this is a question "primarily of values which can be informed by, but will not be completely resolved by data" (p. 3). He borrows a quote from a European researcher which is especially relevant to the state of prevention research today:

> 'You Americans have a funny way of looking at evaluation. First you confuse research and politics. There are some things that are not research questions; that is, issues such as should there be equity in health care? These are basic questions of social philosophy that the country must answer. Research can determine if this equity is taking place. But one does not research whether or not people should have a place to live or food to eat. In addition, in the United States you evaluate programs to decide whether or not to withdraw financial support. This differs from the Attitude in much of Europe, where the basic thrust of a program is assumed to be correct and the evaluation is used to improve it, or to determine why it did not accomplish what it set out to do" (p. 3).

-Add to this -common negative bias of social science research not only the other problems inherent in achieving

positive outcomes in prevention evaluation research, such as lack of long-term follow-up to account for delayed efforts and measurement of only a narrow range of effects, but also the difficulty of even assessing-let alone of applying-the often conflicting results of prevention evaluation research studies-especially in the field of substance abuse. The result is that substance abuse prevention planners still are often forced to base their programs on their own common sense and intuition instead of on careful, comprehensive evaluation research findings.

As the body of evaluation studies continues to grow, the process of reading these individual reports and trying to unify, synthesize, and integrate their findings into systematic prevention planning becomes increasingly awesome. While occasionally one comes across one of those wonderful literature reviews that summarizes and interprets this research in a meaningful way to the prevention field (like those by Cowen and Gesten and Jason) and even to the substance abuse prevention field (like the NIDA Research Monograph series), the narrative forms used in these literature surveys have several limitations. First of all, the programs selected are usually based on the bias of the reviewer. Secondly, the programs are usually described individually, in isolation from each other, and not compared across studies. Individual studies, however, may have flaws of design and implementation (especially sampling errors, errors of measurement, and range variation) which bias the findings. Thirdly, when studies are compared to other studies, no systematic methodology is used for objectively comparing "the different program strategies, target populations, outcome measures, intensities, implementations, and research designs" (Tobler, p. 538). Consequently, the end result of these narrative reviews is that "the reader is often left more confused than enlightened" (Tobler, p.538) and we are no closer to answering the questions Goodstadt posed for the field: what forms . . . what conditions . . . when . . . and for whom.

If prevention program evaluation research is to be useful to the prevention field "internally as a program management tool or externally as a policy-making tool" (Schaps, a, p. 50), then systematic compilations of program effects are a necessity. Until last year, only one systematic analysis of alcohol/drug abuse prevention programs had been done. The review of 127 drug abuse prevention programs done by Schaps et al. in 1980 was a

significant contribution to the field in that we found out how little we really knew about the components of effective prevention programming. Other than positive findings from studies which "coupled intensive service programs with fairly rigorous evaluation" and studies which focused on "affective and/or peer group intervention," Schaps et al concluded, "We are unable to identify any useful patterns or commonalities in program design or implementation procedure... or to generate much meaningful information bearing on the question of how to construct an effective prevention program" (pp. 46-47).

Last year, however, the first "meta-analysis" of secondary school alcohol/drug prevention programs was published. Nancy Tobler's "Meta-analysis of 143 Adolescent Drug Prevention Programs" makes a significant contribution to the field in several ways. First, it's the first time a quantitative statistical procedure (i.e., meta-analysis) has been applied to program evaluations in the substance abuse field, a procedure which alleviates much of the subjective bias in evaluating program effects. Second, through meta-analysis we have an empirical framework for "accumulating evidence both within single research studies and across studies of the same phenomena done at different times by different researchers" (Hunter, p. 8). According to Tobler, in using me&analysis, "the computation of the effect size is not dependent on statistically significant results which are seldom found in drug studies." Instead of discounting the studies whose results do not reach statistical significance—as would be the case in a literature review-"the quantitative results of each study are converted into a common metric, thereby, allowing comparison of results across studies while removing the influence of the size of the target population on attainment of statistical significance" (p. 539). A third contribution Tobler's meta-analysis makes, and the one most salient to prevention program planning, is that it allows us to identify specific program modalities, i.e., strategies, most effective for reducing adolescent alcohol/drug use.

The following discussion will first summarize the highlights of this excellent article, although I encourage anyone involved in prevention program planning to read Tobler's analysis in full. Secondly, we'll discuss the implication of her finding for substance abuse prevention program planning.

Overview of Meta-Analysis

Number of Programs/Program Modalities

Tobler located over 240 programs evaluated during 1972-84. Of these, 98 studies, encompassing 143 different program modalities (although half reported only single modalities), met her selection criteria.

Selection Criteria

Programs included in this analysis had the following characteristics:

1. quantitative measurements of outcome measures (including mediating variables — i.e., risk factors)
2. control or comparison group
3. focus on grades 6 (if incorporated into middle or junior high school) through 12
4. primary prevention as goal (i.e., assisting youth to develop mature, positive attitudes, values, behaviors, skills, and life styles).

Sources

The majority (64 percent) of the studies were from published literature: 30.5 percent from unpublished reports; and 5.5 percent from dissertations. Almost all programs were university-sponsored.

Target Group Characteristics

1. Setting: most programs (93.3 percent) were school-based
2. Geographic location: most were evenly split between urban and suburban
3. Class: about 1/3 middle class; l/3 were unidentified
4. Sex: most were for males and females
5. Special populations: only 12.6 percent served special populations (large minorities, substance abusers, and those with school problems)
6. Grade level: twice as many junior as senior high programs.

Program Modalities

Tobler identified *16* strategies which she collapsed into the following five categories:

1. ***Knowledge*** only-presentation by teacher of legal, biological, and psychological effects of drug abuse; scare tactics
2. ***Affective*** only-self-esteem building, self-awareness, feelings, values clarification, experiential activities
3. Peer ***programs-positive*** peer influence; peer teaching; peer counseling, helping, and facilitation; peer participation-subdivided into those focusing on re***fusal skills*** (saying no) and those concentrating ***on interpersonal and intrapersonal Zife skills***
4. ***Knowledge plus*** affective-combination of 1) and 2)
5. ***Alternatives-activities*** more appealing than drug use-subdivided into those focusing on community involvement activities and those concentrating on increasing basic competency skills for at-risk youth.

Outcome Measures

Effect sizes were computed on five different outcome measures:

1. ***Knowledge*** gains
2. ***Attitudes*** and values in general and attitudes toward drug use
3. Use of alcohol/drugs
4. ***Skills*** relevant to alcohol/drug use (affective, assertiveness, decisionmaking, and self-esteem)
5. ***Behavior*** both directly measured by actual drug use as observed by principal, parent, and police incident reports; arrests; hospitalizations; and indirectly measured by school grades, attendance, comprehensive tests.

Process Measures (Program Implementation)

Although most of the studies failed to report implementation data, six factors were identified which affected how well the program was delivered:

1. teacher training (offered for 45 percent of the programs)
2. teacher-staff conferences
3. peer teachers
4. peer-staff supervision
5. curriculum (available in most programs)
6. text or written/audio-visual aids (present in one-third of the programs).

Major Findings

According to Tobler, "If decreased drug use is the ultimate aim of the drug prevention programs, the final criteria should be measured on the use outcome measure" p. 555). Looking at the results on this measure, Tobler's major conclusions are as follows:

1. For the average adolescent, ***"Peerprograms are dramatically more effective than all the other programs"*** even at the lowest levels of intensity (hours spent in prevention programming) (p. 555).
2. For the ***high-risk (special populations)*** adolescent, ***alternatives*** showed an effect size "for increasing skills and changing behavior in both direct drug use and indirect correlates of drug use" equivalent to that obtained by peer programs for the average youth (p. 561).

Implications for Substance Abuse Prevention Programming

Tobler discusses three major implications for future school-based adolescent substance abuse prevention programming:

1. discontinue knowledge-only and affective-only programs for average adolescents
2. focus on peer programs which emphasize peer refusal skills as well as communication and decision-making skills
3. for at-risk youth, peer programs should be supplemented with additional alternatives (such as

community activities, physical adventure, mastery learning, job skills, etc.).

Let's look at each of these more closely.

Knowledge-only or Affective-only Programs

Tobler is emphatic in advocating the elimination of programs using **only** the strategy of giving information or of building self-esteem and clarifying values as *substance abuse* prevention strategies. Her research, like that of Schaps' and other individual studies, bears out the lack of effects on substance use behavior of programs based on the assumption that knowledge changes will lead to attitude changes with corresponding behavior changes. Tobler's research also confirms prior research findings that significant results can occur in drug use *without* attitude changes (Resnick). Concomitantly, program evaluations that use as outcome measures only knowledge or attitude changes are not using valid measures of program effectiveness. "The inclusion of relevant drug use measures [must be] the final criteria for success" (Tobler, p. 560). Obviously, in the substance abuse prevention field, "old habits die hard," for in spite of the solid research evidence contradicting knowledge-only or affective-only programs (and even those combining these two approaches), far too many programs are still based on these ineffective modalities.

Peer Programs

Tobler's research clearly and convincingly identifies the effectiveness and *cost-effectiveness* of even low-intensity school-based peer programs for reducing drug abusing behaviors among the general adolescent population. While neither time nor space allow for a review of the peer program approach, I encourage you to read the excellent overview of peer programs for substance abuse prevention done by Resnick and Gibbs ("Types of Peer Program Approaches"). This article is a clearly written, comprehensive overview of the peer program concept, approaches, and specific examples. While peer programs come in a variety of overlapping shapes and sizes (which they collapse into the four broad categories of positive peer influence, peer teaching, peer counseling/facilitating, and peer participation), the following discussion summarizes the characteristics Gibbs and Resnick identify as

distinguishing peer programs from other prevention modalities:

- **Goals**
  Peer programs usually espouse at least one of these goals:
  1. to generate meaningful involvement, activities, and responsibilities for youth
  2. to channel both negative peer pressure to engage in self-destructive behaviors (substance use, sexual promiscuity, delinquency) and the "normal energies and risk-taking tendencies of youth" toward constructive ends
  3. to build personal and social competency skills.

- **Context**
  No matter "whatever the goal or particular approach of a peer program, peer programs are [ultimately] distinguished from other kinds of programs by an emphasis on young people in the context of the peer group" (p. 49).

- **Settings**
  Peer programs "tend to be located in settings where groups of young people commonly occur, either naturally and spontaneously or as a result of society's conventions and laws" (p. 51). Schools are the most common setting with community agencies a not too close second.

- **Elements**
  The critical elements of a peer program are the dynamics of peer pressure, peer influence, and group interaction.

- **Adult role**
  The type of peer program (counseling, teaching, participation, influence) is far less important than the *attitude* and *style* of the adults involved. "In any peer program, the role of the adult program leader [ultimately] can make the difference between the program being a peer program or being simply an adult-dominated group" (p. 53). The attitude of the adult, then, must be one of acceptance and comfort with youth interacting freely in small informal groups and of confidence in the ability of

> young people to accept responsibility. The style of the adult should be facilitating and guiding-not controlling-and should reflect "conscious role-modeling" of appropriate group behavior-careful listening and caring, non-judgmental statements.

In addition to identifying peer programming as the most effective substance abuse prevention modality, Tobler's meta-analysis further postulates that the critical component of peer programs in preventing substance abuse is the direct emphasis on behavior through the teaching of peer refusal skills as well as other direct behavior skills (general assertiveness, communication, problem-solving, decisionmaking, etc.). Her meta-analysis thus provides verification of the positive results already found for substance abuse prevention programs based on a social-psychological model such as C. Anderson Johnson's Project SMART and Gilbert Botvin's Life Skills Training Program. While these two program models include knowledge and attitude change components, their main emphasis is on skill-building-both resistance and general skills.

Another recently evaluated program, Say It Straight, is focused directly on changing adolescent problem behaviors and can be used not only as a substance abuse prevention strategy but in delinquency, teen pregnancy, and AIDS prevention as well. According to the developer, Paula Englander-Golden, "SIS training is a school-based program [5 days, 50 minutes a day] which has been used since 1982 to give students the opportunity to learn straightforward communication skills and positive peer support, thereby enhancing their self-esteem" (Englander-Golden, c, p. 1). In her study focused on substance abuse prevention, Englander-Golden found "not a single alcohol/drug related school suspension during an entire school year in one middle school where an almost totally trained milieu was attained in the first month of the 1984-85 school year" (c, p. 1). Furthermore, in a recent study she extended SIS training to high school students and measured juvenile police offenses. Over a 1 ½ year follow-up the untrained students had about 4.5 times as many juvenile criminal offenses as the trained students (c).

The focus of SIS is on building honest, assertive communication skills, based on the principles of Virginia

Satir, through extensive role-playing of interpersonal situations in which students find themselves, such as "How do I say no to a friend? How do I say 'I have quit' to a group of friends? How do I say 'I don't like what I see you doing' to a friend?"

Two significant issues to consider about SIS training are that (1) no factual information is given and no discussion of alcohol/drugs occurs, and (2) the students ***choose the content*** of the situations to be explored. According to Englander-Golden, "Nowhere in [SIS training] are students told what their deep wishes or new choices should be.... Since freedom is one of the most important values to young people, the trainers minimize the risk of rebellious reaction to the training by avoiding debate and respecting the students' freedom" (pp. 20 & 24).

Thus, SIS training appears to get at the essence of peer programming's effectiveness-providing youth the opportunity to participate in activities meaningful to their lives for which they assume responsibility and over which they have some control.

Alternatives

Tobler's finding that alternative programs are proving highly successful in reducing drug-abusing behaviors of at-risk adolescents such as drug abusers, juvenile delinquents, or students experiencing school problems is a significant contribution to the current debate over what approaches work best with this "nearly implacable population" (Tobler, p. 561). Tobler hypothesizes that, "Perhaps this type of program helps to put an [at-risk] child in ***control*** of some part of his [or her] life for the first time" (p. 561). Conversely, she accounts for the small-effect size of this strategy for white, middle-class youth as follows: "The adventure of mountain climbing or mastering reading is not a new experience for most of the teenagers. Somewhere in the average child's life their environments have already provided these advantages; therefore, programs of this type will add little extra to average teenagers' lives" (p. 561).

In a recent review of substance abuse prevention programming for high-risk adolescents, Hawkins et al also concur with Tobler's finding concerning the efficacy of peer programming for mainstream adolescents and of alternatives programming for high-risk youth. Based on their extensive review of existing research, they

recommend the following specific alternatives interventions, which address the underlying risk factors for substance abuse (Tobler's "indirect correlates"):

- early childhood education
- parent involvement
- parent training
- school-based life skills training
- substance abuse prevention programs in late elementary and junior high grades that address not only peer influence but also family, media, and community influences
- enhancement of instruction to encourage academic success
- school-based health'clinics (pp. 102-110).

Two major concerns in planning alternative interventions go beyond the scope of Tobler's analysis and yet demand our attention. The first centers on the issue of identifying at-risk youth. The early identification of at-risk youth is problematic for two main reasons: (1) the absence of effective, "fool-proof" early identification instruments-most procedures still result in too many "false positives," that is, the identification of children who will ***not*** engage in serious problem behaviors; and (2) the serious, self-fulfilling consequences of labeling a child as a future substance abuser, delinquent, etc.

Hawkins proposes a solution to the dilemma of how to provide preventive interventions to at-risk youth without labeling them as such by recommending we target at-risk ***groups*** as opposed to individuals: "Target preventive programs on neighborhoods, schools, or communities with high proportions of high-risk individuals, rather than simply on high-risk individuals" (p. 102). Furthermore, to avoid any ethical issues involving labeling of future behaviors, Hawkins suggests focusing on the risk factors—the already existing problems such as antisocial behavior, school failure, or family management practices that correlate with future problem behaviors by establishin;, the

alternative preventive interventions described earlier. One problem, however, with addressing only high-risk groups is that youth at-risk such as children from alcoholic or abusive homes cross all socio-economic and geographic boundaries.

A second concern in planning prevention programs for at-risk youth not addressed by Hawkins is the need for these youth to interact with their prosocial peers. Research from the delinquency field is providing strong evidence for the efficacy of peer programs, which meet the following criteria:

> "1) only one or two antisocial youths are integrated into small groups that consist essentially of prosocial peers; 2) such groups concentrate on recreational, academic, work, and social activities that the youths are likely to encounter in their daily lives, and 3) the programs are located in community-based agencies whose public identity is recreational or educational rather than correctional or rehabilitative" (Feldman, pp. 46-47).

According to Feldman, whose own successful project—the St. Louis Experiment--was based on these principles:

> "Previous group treatment efforts have failed largely because the structural preconditions for promoting [desired behavior changes among antisocial youths] have been absent. Instead, nearly all treatment groups are comprised solely of clients who are referred for abnormal behavior of one kind or another. Therefore, the peer composition of such groups results in formidable countertherapeutic pressures, including deviant role models, strong rewards and reinforcements for deviant behavior, and adverse labeling, and stigmatization" (p. 46).

Unfortunately, both in the substance abuse and education field, the modus operandi has been the isolation of "problem" youth from their nonproblem peers in, ironically, so-called "alternative" programs and schools. Since research has demonstrated the almost across-the-board failure of this approach, it behooves prevention programmers planning interventions for at-risk youth to consider

not only addressing the early risk factors associated with the later development of problem behaviors as suggested by Hawkins but also to create the opportunities in all our schools and communities for these youth to be integrated into positive peer groups via strategies such as cooperative learning groups in the school or via mentor programs in the community.

Peer Programs = Empowerment = Prevention

The extremely positive results of peer programs in reducing substance abuse among adolescents as identified in Tobler's meta-analysis and in other substance abuse program evaluations along with research on youth in treatment such as Feldman's suggest the power of the peer group as a socializing agent in developing positive behaviors. As mentioned earlier, the critical element in the success of the peer program approach may be the sense of connectedness (participation in meaningful activities) and control (assumption of responsibility) that youth experience. Another word for this process is empowerment.

There is some debate in the community psychology and prevention literature as to whether prevention and empowerment are mutually inclusive or exclusive concepts-discussion which relates directly to how we go about prevention programming. While I agree with Swift's and Levin's ***definition of empowerment*** as both a process and a goal involving ***"activities directed to increasingpeople's control over their lives"*** (p. 73), we should not accept their limited view of prevention as consisting of the public health model of disease prevention nor their dichotemizing of empowerment and prevention as concepts encompassing opposite attributes: "positive vs. negative, starting vs. stopping, developing vs. arresting, and future vs. past" (p. 80). As a field, it's imperative we see the ***prevention*** of individual and social problems like school failure, substance abuse, delinquency, teen pregnancy, and child abuse, can only result through the ***empowerment*** of people.

Prevention cannot be limited by the parameters of the public health model of disease prevention. Delinquency, teen pregnancy, school failure, and child abuse are ***not*** diseases. While much research supports the view that alcoholism is a disease, that psychosocial factors play a role

in its etiology is admitted even by those adhering to a biological viewpoint. Furthermore, the interrelationship of these problem behaviors with each other and with substance abuse necessitates we adhere to a much broader *definition of prevention.*

We must maintain that prevention *is* empowerment and that the following general principles of empowerment as conceptualized by Julian Rappaport are also the necessary components of a preventive intervention:

> "[Prevention] interventions are *collaborative,* concerned with providing or *facilitating* resources to free self-corrective capacities, delivered in a context that avoids the one-down position of many helper-helpee relationships, and *sensitive to the culture* and traditions of the settings and individuals" (p. 128).

While many programs are called "prevention" that do not empower, there is no better way to insure that prevention is empowerment than to make peer programs-in their truest sense of providing opportunities for meaningful participation and responsibility-the major approach in prevention programs for not only children and youth but for all groups along the lifespan. The burgeoning literature on the *concept of* ***social*** support-certainly the major attribute of the peer programming process-has demonstrated the critical role this ***"protective factor"*** plays in the health and well-being of vulnerable groups of all ages in our society such as teen parents, new parents, recovering alcoholics/addicts, children of alcoholics/addicts, newly divorced adults, children of divorce, the bereaved, etc. In fact, that the self-help peer group approach a la the Alcoholics Anonymous model and its numerous offshoots demonstrates the only effective relapse prevention modality for AOD dependency, further testifies to the efficacy of peer programming as an empowering process that can prevent the tremendous suffering and costs associated with alcohol and other drug abuse in our society.

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Appendix M

The Alcohol Policy Bill of Rights: **Recommendations** for Public Policy Reform

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Presentation made at the Second National Conference on Alcohol Abuse and Alcoholism, sponsored by the United States Department of Health and Human Services, San Diego, CA, November 1988.

Please note: Written text may differ slightly from oral remarks made at the Conference.

THE ALCOHOL POLICY BILL OF RIGHTS

PREAMBLE

Alcoholic beverages pose substantial risks to the health and safety of individuals, communities and society. Public policies regarding alcohol consumption, availability and problems should therefore be designed to minimize these risks. The following principles should guide alcohol policy:

1. Abstention is accepted in all circumstances;

2. ***Any*** alcohol consumption in high-risk settings is actively discouraged;

3. Heavy consumption is discouraged in all situations;

4. Moderate consumption in low-risk situations is accepted.

These principles should be manifested in the following fundamental rights for **all** citizens of our nation:

I.

THE RIGHT TO KNOW

Consumers have the right to accurate and easily accessible information about alcohol:

- alcohol warning and ingredient labeling and posters, so that consumer knows the potential health risks of alcohol;
- equal time for public health counteradvertising, to provide accurate and balanced information concerning alcohol over the public airwaves;
- the elimination of deceptive alcohol advertising.

II.

THE RIGHT TO SAFE ROADWAYS AND COMMUNITIES

Citizens have the right to collective protection from the drinking acts of individuals:

- certain and swift enforcement of strict DUI laws;

- mandated server intervention programs and dram shop liability laws, to ensure that those selling and serving alcoholic beverages are minimizing the risk that patrons will harm themselves or others;

- local and State availability regulations that control the number, location, and types of outlets such that high-risk settings are prohibited and responsible business practices are mandated;

- adequate funding of Alcoholic Beverage Control Agencies and strict enforcement of all alcohol availability laws;

- insurance incentives for sober driving and responsible business practices.

III.

THE RIGHT TO HEALTH-ENHANCING ALCOHOL PRICING

Society has the right to alcohol prices which minimize health risks and which accurately reflect the social costs associated with alcohol consumption:

- adequate tax rates, so that high-risk alcohol consumption is discouraged and the price of alcohol reflects the true cost of alcohol problems to society;

- equalized tax rates across alcoholic beverages, so that the public knows that all forms of alcohol pose risks to health.

Iv.

THE RIGHT TO PROTECT OUR YOUTH

Society has the right and responsibility to take measures to halt the epidemic of alcohol-related deaths and injuries among youth:

- adequate funding for alcohol education programs;

- nationwide minimum-age drinking laws set at 21;

- no alcohol promotions aimed at youth, including no alcohol promotional activities on college or university campuses.

V.

THE RIGHT TO SAFE WORKPLACES

Employees have a right to workplaces free of pressures to consume alcohol:

- an end to the use of alcohol as part of conducting business;
- an end to Federal tax subsidies for corporate alcohol use;
- adequately funded employee assistance programs for all employees seeking help in overcoming personal alcohol problems;
- an end to government subsidies for alcohol in the armed forces.

VI.

THE RIGHT TO HEALTH SERVICES

Citizens have a right to adequate health services for the alleviation of suffering associated with alcohol-related problems:

- effective, low-cost recovery services available to the entire public;
- recovery programs which complement environmental prevention strategies and provide community leadership in addressing the institutional bases of alcoholism and alcohol-related problems;
- victim assistance programs that provide financial reimbursement and emotional and medical support for those who suffer at the hands of alcohol consumers.

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This Second Annual Conference on Alcohol Abuse and Alcoholism represents continued progress in the alcohol policy field. Last year, Secretary Bowen was able to cite HHS's report on the efficacy of warning labels.' This year, he was able to report the field's success in Congress. After more than a decade of intense effort, we have overcome the powerful alcohol lobby on Capitol Hill and enacted health warning label legislation. Beginning in one year, the intense and deceptive marketing practices of the industry will be tempered by a label on all alcoholic beverages informing consumers of the risks of alcohol-related birth defects, drinking-driving, and other health problems. The Center for Science in the Public Interest and the National Council on Alcoholism, as well as the more than one hundred organizations that fought for this legislation, should be congratulated for this hard-fought victory.

The new legislation is just one sign of progress. For example, this year at the conference we are having a plenary session on public policy recommendations. As some of you may know, last year the conference's planning subcommittee on prevention developed a public policy report, which was itself a major watershed.[2] The report's recommendati,ons played only a minor role in last year's conference and remain, in large measure, under consideration but not endorsed. They are, however, being presented to the conference in this plenary session, a clear indication of their legitimacy and importance as a topic for discussion and debate.

My purpose today, then, is to present the major recommendations of the original planning subcommittee, their rationale and purpose, the major barriers to implementation, and steps needed to overcome those barriers. Because we believe these recommendations constitute fundamental rights of the American people, we have summarized them in an Alcohol Policy Bill of Rights,[3] which all of you should have before you and which I will use as a framework for presentation.

In so doing, I want to take up. Secretary Bowen's challenge from last night and lay out-a framework for policy development in the new Administration.

Environmental Factors as Contributors to Alcohol-Related Problems

Let me begin by reviewing briefly the advances in our thinking regarding prevention that have occurred during the last decade, particularly regarding the role of social forces-what has become known as the individual's environment-on individual drinking behavior.

At the most immediate level, we now know that an individual's family is an integral part of the diagnosis for an alcohol problem and is critical in the recovery process. The Children of Alcoholics' movement has sensitized us to the family's potentially devastating contribution to alcohol problems among both children and adults.

Prevention specialists have come to realize that, just as the individual cannot be isolated from his or her family in understanding, preventing, and treating an individual's alcohol problem, so the individual and family cannot be isolated from their neighborhood, community, workplace and broader society.

Peer pressure among our children is not a spontaneous force. It is a predictable outcome of the myths we hold as adults regarding the role of alcohol in the adult world, myths that are carefully and cynically manipulated in over $2 billion a year of alcohol marketing.

Efforts by schools and some parents to promote abstinence among teenagers cannot succeed in a societal environment that expresses relief when a young person substitutes the drug alcohol for an illicit drug. E.T. would have been shocked if he had landed in the midst of our War on Drugs and discovered that the phrase "drug-free America" excluded the six pack of Coors beer that caused his intoxication.

Drinking-driving is not merely a problem of deviant individuals. Individuals live in and are shaped by a culture which often supports and encourages heavy drinking in combination with virtually any activity, including driving.

This broader understanding casts new light on alcohol-related problems in our Nation's low-income and minority neighborhoods. The tragic cycle of homelessness, poverty, racism, and alcohol-related death and disease can only be addressed in the context of programs that address housing needs, racial discrimination, and economic development.

Cleo Malone, a member of the clergy and an activist here in San Diego, has posed the problem well. In white neighborhoods, he states, alcohol is sold in small sections of large food stores. In Black neighborhoods, food is sold in small sections of large alcohol stores. Strong economic forces from the dominant society create the climate that labels alcohol outlets the "most likely to succeed" businesses in inner-city communities. Alcohol products are indeed both cheap and profitable, a consequence of broader economic forces.

These broad and powerful forces must be addressed in any comprehensive prevention program. Specialists in the field now recognize that the various systems or levels of the environment that influence an individual's drinking behavior-family, community, workplace, society, media-must all be addressed. Programs are needed at all levels that give consistent messages and are complementary to each other.*

Public Policy: Tools for Shaping the Alcohol Environment

How do we address these broad and intractable social forces? A shift to addressing environmental as well as individual contributors to alcohol-related death and social disruption requires the development of new prevention strategies. Our alcohol environment is shaped by institutions: the alcohol industry at all levels; other businesses; churches; schools; the media; the sports industry; local, State, and Federal Governments; and so on. Institutional change requires reform in public policy, a critical aspect of prevention.

"Public policy," or "alcohol policy," includes, but is not limited to, governmental activities-statutes, laws, and regulations. But policy change is far more inclusive. Corporate alcohol policies affecting alcohol availability in the workplace; school policies; even a social host's policies regarding how alcohol is made available at a private party -these are all elements of a comprehensive alcohol policy.

This point was well illustrated during a meeting of the Presbyterian U.S.A Church's Task Force on Alcohol Problems, on which I served. A minister and fellow task force member told the following story to drive home the need for a church alcohol policy: Early in his recovery from

alcoholism, he attended a social function at his church. During the break, refreshments were served, and to his surprise, only beer and wine were made available. Being an obstreperous fellow, and feeling the event offered a chance to educate other church members, he asked in a loud voice, Where is there something for me to drink?" There was an embarrassed silence, since everyone knew of his recovery. The person serving the drinks left the room in search of a nonalcoholic beverage. When he finally returned, he offered the minister prune juice, the only nonalcoholic beverage he could find.

Similar stories are everyday occurrences. For example, my dinner table two nights ago at the Bahia Hotel restaurant here in San Diego was the beneficiary of a free bottle of wine, compliments of the management. No nonalcoholic beverage alternative was offered.

Alcohol policy reform, then, can happen at all levels of our society. Each of us has a responsibility to act in shaping our alcohol environment—in our homes, at our jobs, and in our communities.

Working at the community level to change community environments is a critical part of my work at the new Marin Institute. It involves creative community organizing, coalition building, program evaluation, outreach, and attention to both informal and formal policy mechanisms. Our work to date demonstrates that all sectors of the community, including the alcohol retail industry, can work together to promote a positive community environment.

As I turn to the Alcohol Policy Bill of Rights, I want to focus particularly on State and Federal policies, which hamper this community focus. The emphasis on the State and Federal level is particularly appropriate, I believe, given the upcoming election and the potential for social change in the new Administration.

The Alcohol Policy Bill of Rights

The Council on Alcohol Policy, in cooperation with numerous other groups, developed the Bill of Rights to highlight the need for public policy reform and our beliefs that these reforms flow from basic values of our democratic society. Let me briefly review its major provisions, beginning with the Preamble.

The Preamble: The Preamble is designed to provide principles to guide alcohol policy development at all levels

of society. Four principles are articulated, designed to promote abstention as an accepted alternative in any situation, discourage heavy consumption, discourage any consumption in high-risk situations (before driving a car or heavy equipment, while pregnant, among underage drinkers), and accept moderate consumption in low-risk situation.

These principles are critical for several reasons. First, they make clear that the Bill of Rights rejects prohibition as an acceptable policy option. This has been a consistent position in the alcohol policy field, despite the deceptive and inflammatory charges of the alcohol industry.

Second, in rejecting prohibition, the principles recognize that policy development must balance competing interests in society. This is in sharp contrast to illicit drug and tobacco policy, where the health goals are simple and direct: no consumption. The Bill of Rights' goal, in the context of accepting alcohol as a part of our social fabric, is to protect public health.

Third, the Preamble recognizes that individual responsibility for the consequences of his or her drinking behavior should be a fundamental aspect of any comprehensive prevention policy.

The Right to Know: The body of the Bill of Rights begins with one of our most cherished democratic values—the consumer's right to know. As Dan E. Beauchamp, a leading scholar and spokesperson in the alcohol policy field, has stated: "Our democracy depends directly on the quality and amount of information in the hands of its citizens."[6]

The specific recommendations in this section-for equal time for public health counteradvertising, elimination of deceptive advertising, and health warning labels—stem from this basic democratic value. They seek to increase access to information and reject censorship. Instead, they promote public discussion and informed debate.

The alcohol industry has a virtual stranglehold on the flow of information regarding alcohol in our society through the economic power it exercises in the Nation's media. The industry spends over $2 billion promoting its products as sexy, glamorous, and sophisticated. As a recent study conducted by communications experts found,

the beer industry in particular has succeeded in placing beer as an integral part of male bonding and maturity, capturing our cultural myths and understanding of the male role in our society.[7]

"Tastes great-less filling"; "the night belongs to Michelob"-these and other marketing phrases are now part of popular culture. Yet they are, at their core, misleading and deceptive. We need to mock these slogans that have captured the public mind, to undermine their powerful imagery: The night belongs to Michelob only if you work or are a patient in a hospital emergency room. "Tastes great-keeps killing," or "light beer, does that mean light death?"

Spuds McKenzie, the party animal, is equally familiar to all of you, and his stuffed animal plays particularly well with the three-year-old set such as my daughter Maya. Let's rename him Duds McKenzie, the pathetic party drunk whose life is in shambles. That is a more realistic portrayal.

The airwaves are owned by the public, and a broadcaster's license is a public trust. The Bill of Rights' call for equal time for accurate health messages represents a reasonable and minimal commitment to the public's need for diverse and accurate health information regarding alcohol. Requiring equal time should thus be a high priority for the incoming Administration.

As Beauchamp has stated: "The basic question is the issue of free speech in a democracy, and the notion of democratic discussion. The issue is whether democratic speech is to be limited and constrained by the power of the market and money."[8]

The Right to Safe Roadways and Communities: Section two of the Bill of Rights addresses another fundamental value in our society-the right to safety and the protection from harm caused by others' drinking behavior.

Of particular importance in this section are the recommendations regarding alcohol availability.

Alcohol has become a convenience item in our society. This is a key aspect of the alcohol industry's overall marketing strategy. Alcohol is now routinely sold in a variety of high-risk settings-sports stadiums, gas stations, recreation centers, even laundromats and movie theaters. In many cases, there are virtually no controls on alcohol

sales practices, even when a large portion of the patrons are underage. Irresponsible retailers who repeatedly and illegally serve intoxicated persons and minors do so with little fear of penalty, as Alcoholic Beverage Control (ABC) Agency enforcement staffs have been decimated by budget cuts.[9]

ABC Agencies themselves are dominated by industry concerns. They have lost their health focus and are held hostage by state legislatures that bend to industry lobbying tactics. The Federal Bureau of Alcohol, Tobacco, and Firearms is perhaps the worst example of this phenomenon." A high priority for the new administration should be the shifting of BATF responsibility for alcohol policy to the Food and Drug Administration. Other recommendations, found in section two of the Bill of Rights, that will enhance local communities' ability to assess and regulate alcohol availability within their bound-aries are high priorities for all levels of government.

The Right to Health-Enhancing Alcohol Pricing: Section three involves alcohol pricing policies, a critical issue in the prevention field today. In my youth, beer was two to three times as expensive as soft drinks. Today, cheap beer, available in an ever widening array of retail outlets, is typically cheaper than Coca-Cola, a powerful signal to young people of its acceptability and availability. This dramatic reduction in real price is the direct result of the steady decline in State and Federal alcohol excisetaxes over the last three and a half decades, eroded dramatically by inflation.[11]

Research demonstrates that increased excise taxes on alcoholic beverages will reduce alcohol problems, including beer-related traffic crashes among the Nation's teenagers.[12] Not only will they promote health, alcohol taxes will help defray the $120 billion in annual social costs attributable to alcohol-related death and social disruption, as well as reduce the massive Federal deficit with which we are saddling our children and grandchildren.

The time has come for a responsible, health-oriented alcohol tax policy, as outlined in the Bill of Rights and as detailed by the National Alcohol Tax Coalition. We should not allow the next Administration and Congress to continue to buckle under to the alcohol lobby on these most important tax policy measures.

The Right to Safe Workplaces: The excise tax issue is closely linked to a policy recommendation found in section five of the Bill of Rights, regarding the right to safe workplaces. Income tax policy involving the so-called "business use" of alcohol is equally indefensible. Corporate purchases of alcohol are automatically defined by the IRS as "ordinary and necessary" to the conduct of business regardless of the setting or circumstances.[13]

This policy not only flagrantly ignores the terrible toll ofalcohol problems in the business world, but also deprives the U.S. Treasury of over $4 billion each year. Why, then, does the government provide economic incentives to condone even the most abusive drinking practices in business settings?

Employee Assistance Programs are a key element of a national alcohol policy, as highlighted in the Bill of Rights. But we should urge the next Administration and others in State and Federal Government to examine corporate alcohol policies, including this unwarranted tax giveaway.

The Right to Protect our Youth and the Right to Health Services: Equally important are the Bill of Rights provisions regarding the protection of our youth and the right to health services-sections four and six. Secretary Bowen should be commended for his support of high-quality alcohol education and his work with colleges to restrict alcohol marketing on campuses. Crude and deceptive advertising practices are targeting this most vulnerable population who, in most cases, cannot even purchase alcohol legally. Continued and more assertive action is needed. Washington and Michigan provide models of regulatory action that set strict guidelines on campus marketing practices. These States provide models for future action by the new Administration.

Prevention policies will only be successful in the context of an overall comprehensive program addressing all aspects of alcohol-related death, disease, and social disruption. The Bill of Rights, in section six, therefore endorses effective, low-cost recovery. services available to all persons in need in our population. This goal not only serves a basic ethical obligation of our society. It also acknowl-edges the intimate connection between prevention and treatment strategies. A community that acts to reduce the risks associated with alcohol consumption also

promotes the recovery process, just as individual recovery from alcohol problems enhances the alcohol environment of the community.

Barriers to Action: The Alcohol Industry

These represent the major recommendations found in the Bill of Rights and parallel closely the recommendations found in the report of the prevention planning subcommittee for the Secretary's first annual conference. I believe they provide a sound basis for policy development in the next Administration. We must act now to frame the debate and to develop these and other recommendations to be prepared during the upcoming transition period.

To be successful, we must understand the barriers to implementation, a topic which I now want to address. One would think, based on our inability to enact major policy reforms addressing environmental factors, other than the recent labelling victory, that these recommendations lack public support. This is not the case. Public opinion polls repeatedly show strong support for the major Bill of Rights recommendations.[14] What then stands in the way?

The primary barriers are constructed by the alcohol producers lobby and its allies. We do not have advertising reform because of intense industry lobbying. We do not have alcohol tax reform because of intense industry lobbying. Licensing laws at the State level remain lax because of intense industry lobbying. BATF remains the toothless watchdog at the Federal level because of intense industry lobbying.[15]

Even our most impressive victory, health warning labels, has been seriously undermined by industry lobbying tactics. As Secretary Bowen's labeling report to Congress so eloquently documented, labels will be most effective if they are simple, direct, and specific. The-labelling coalition therefore sought a set of five rotating, specific health warning labels.

In the battle that ensued, the industry, after 15 years of delay, finally relented and sought a compromise to reduce the effectiveness of the labels. The compromise negotiated by the industry does represent a major victory for public health. But we must recognize that the design of the label and its contents, as dictated in the industry's

terms, has rendered it much less effective than our original proposal.

One agenda for the new Administration will be to follow the guidelines set out in the HHS report, withstand the alcohol lobby, and develop more effective labels, thus building on our 1988 victory.

The alcohol producing industry does indeed represent a formidable barrier. We must recognize that it is a high-risk industry, and its measure of success is profitability. The industry resists changing our alcohol environment because those changes interfere with the marketing strategies that have been used to maximize the industry's profits.

It is an industry that targets those at greatest risk for alcohol-related death, disability, and social disruption, an industry that profits from alcohol addiction. Fifty percent of its products are sold to the heaviest drinking 5 percent of the population,[16] a critical marketing target. We know that 5 percent-we've seen them in our emergency rooms, our detox centers, our overtaxed treatment system.

It is an industry whose armies of lobbyists have frustrated our efforts at State and Federal levels to protect our youth from unscrupulous marketing practices. Take for example the wine cooler, a product which one industry executive described as the way to introduce 4 and 5 year olds to wine.[17] The industry's promotion of this product as a healthy, fruity soft drink has been so successful that many people, both adults and children, are unaware that the coolers contain alcohol.

A recent ***Weekly Reader*** survey found that at least half of our 6th graders know that beer, wine, and distilled liquors are a drug, but only 1 in 5 consider wine coolers to be a drug.[18] Consider how devastating this ignorance is, given that coolers are targeted to teenage girls and young women of childbearing age, who have only a minimal knowledge of alcohol-related birth defects.

Health professionals are not the ones telling our children and teenagers that wine coolers are not a drug. It is the industry which is spending hundreds of millions of dollars to saturate the media and marketplace with this most deceptive product.

To their credit, it is not the traditional wine industry itself which has the worst marketing practices for wine

coolers. Distilled liquor and beer producers have flagrantly violated the Wine Institute's voluntary code of advertising standards in order to push their wine coolers on our youth.

The traditional wine industry has its own hidden skeleton, however. They are targeting our most vulnerable population-the homeless. Addiction to alcohol products is rampant in this population, and the industry has developed a special product to help keep it that way. Wine, fortified with distilled alcohol to create an 18 percent alcohol product, sells for the unbelievable price of under one dollar. You will not find it in your local wine boutique or advertised on television. Homeless people do not watch T.V. It is sold and promoted primarily in our skid row neighborhoods. Night Train is one of the popular brands, produced by Gallo, although Gal10 is apparently too embarrassed to put its name on the label.

The industry has successfully fought all efforts to raise the excise taxes since 1951. And yet, their own marketing of addiction taxes the one population in our society least able to pay-the homeless.

Conclusion

As we turn to the future, developing strategies with the new Administration, we must recognize that the marketing and lobbying tactics of this industry must be addressed. The labelling campaign gives us tremendous momentum. But much remains to be done. We must organize, continuing to reach out to groups not traditionally associated with the alcohol field but who are affected by alcohol-related death and social disruption. This includes virtually any group and institution in every community in America concerned with health, safety, productivity, and social justice.

We must learn to work at the community level, addressing community concerns. We must build strong alliances and become effective in the policy process.

We need new research and evaluation, new academic curricula, and new training programs. We will need to become effective advocates. We, will need to learn to be impolite, to ask uncomfortable questions and to insist on straight answers.

We must forge a coalition that puts people before profits; health before illness; safety before trauma; social

justice before discrimination and despair. People, health, safety, and social justice. These are noble goals that are at the heart of our field. Together we can move mountains. We can create a society that values public health and effectively addresses the ethanol epidemic.

I believe we can be successful. It is not only our opportunity, it is our responsibility to ourselves, our children, our families, our communities and our society.

Thank you.

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