Drug Abuse Prevention and Community Readiness

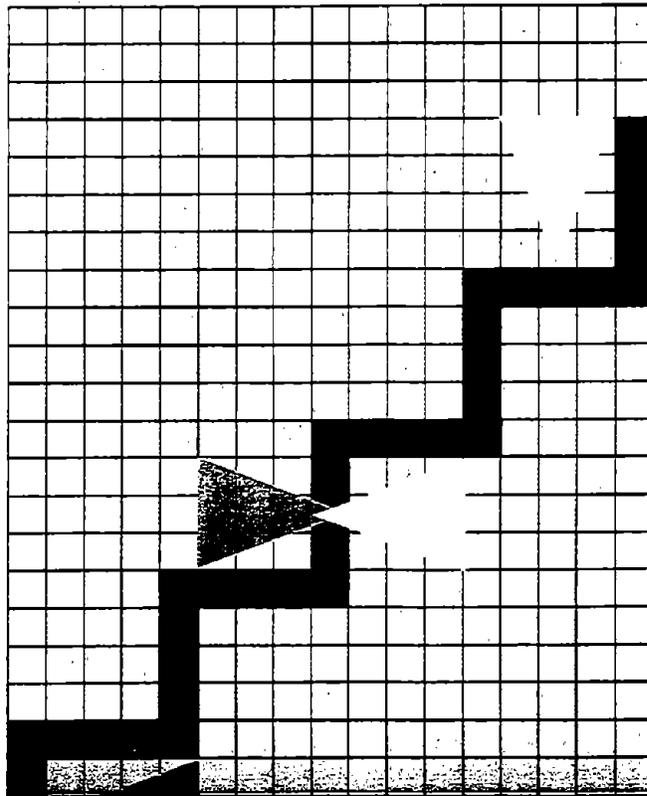## Training Facilitator's Manual

National Institutes of Health

National Institute on Drug Abuse

Drug Abuse Prevention and Community Readiness

Training Facilitator's Manual

U.S. Department of Health and Human Services
National Institutes of Health

ACKNOWLEDGMENTS

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HOW TO USE THE DRUG ABUSE PREVENTION
RESEARCH DISSEMINATION AND APPLICATIONS MATERIALS

Despite the best efforts of the Federal, State, and local governments, drug abuse continues to pose serious threats to the health, and social and economic stability of American communities. The causes of and factors associated with drug abuse are complex and vary across different segments of the population. To be effective, prevention programs must address not only the drug abuse behavior itself but also the relevant cultural, ethnic, regional, and other environmental and biopsychosocial aspects of the population segments being targeted for the prevention efforts. Therefore, it is important to match the program with the population it is to serve and the local community context within which it is to be implemented. The challenge for prevention practitioners is to select, modify, or design prevention strategies that will meet the needs of their constituencies, whether they comprise a whole community or specific segments within a community.

The Drug Abuse Prevention Research Dissemination and Applications (RDA) materials, of which this training facilitator's manual is a part, are designed to help practitioners plan and implement more effective prevention programs based on evidence from research about what works. These materials provide practitioners with the information they need to prepare their communities for prevention programming and to select and implement drug abuse prevention strategies that effectively address the needs of their local communities. These materials are intended for use by prevention practitioners who vary in their training and experience in the field but who are interested in developing prevention programs in their communities. The target audience for these documents includes prevention program administrators, prevention specialists, community volunteers, community activists, parents, teachers, counselors, and other individuals who have an interest in drug abuse and its prevention.

This training manual, *Drug Abuse Prevention and Community Readiness: Training Facilitator's Manual*, is a 9-hour, modular training curriculum, designed for use by training facilitators in introducing prevention practitioners and community members to the basic theory of drug abuse prevention and three prevention strategies. The facilitator's manual also provides them with the skills to assess and increase the readiness of a community to launch a prevention effort. The curriculum includes talking points for lectures, instructions for conducting discussions and exercises, and overheads and handouts. In addition to this training manual, the core set of materials also includes three other documents:

- A *brochure* describes the contents of this set of RDA materials and provides information about how prevention practitioners can obtain these materials.

- *Drug Abuse Prevention: What Works* is an introductory handbook that provides an overview of the theory and research on which these materials are based. It

includes a definition of prevention, descriptions of substance abuse risk and protective factors and a discussion of the key features of three prevention strategies—universal, selective, and indicated—that have proven effective. The handbook also explains how prevention efforts can be strengthened by using knowledge gained through research.

- *Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools* is a resource manual that introduces the concept of community readiness for drug abuse prevention programming. The manual defines community readiness and provides a rationale for assessing a community's readiness prior to the planning or implementation of substance abuse prevention activities. It then identifies seven factors for assessing a community's readiness and offers strategies for increasing readiness factors found to be deficient.

These four core components are intended to be used together as a set. Three stand-alone documents provide more intensive guidance on implementing the three prevention models introduced in the core set of materials. Each manual provides more detailed information about the strategy, including a rationale for its use and a description of a research-based program model that illustrates the strategy. Information is provided on the key elements of the program, issues that need to be addressed to implement the program successfully, and resources that practitioners can access for more information about the program. These models have been selected because National Institute on Drug Abuse (NIDA) research indicates that these programs have been effective in preventing adolescent substance abuse. The following are the three stand-alone resource manuals:

- *Drug Abuse Prevention for the General Population* discusses the history and key features of universal prevention programs. The Project STAR Program—a communitywide program designed to teach adolescents the skills necessary to counteract the psychosocial influences that increase the likelihood of substance abuse—is described as an illustration of a universal prevention strategy.

- *Drug Abuse Prevention for At-Risk Groups* discusses the history and key features of selective prevention programs. The Strengthening Families Program—a family-focused program targeting children ages 6 to 10 whose parents are substance abusers—is described as an illustration of a selective prevention strategy.

- *Drug Abuse Prevention for At-Risk Individuals* discusses the history and key features of indicated prevention programs. The Reconnecting Youth Program—a school-based program targeting 9th- through 12th-grade students who are at risk for dropping out of school, substance abuse, and suicidal behavior—is described as an illustration of an indicated prevention strategy.

These examples of universal, selective, and indicated prevention illustrate how different communities have implemented these approaches effectively and show how the models can be varied in different settings. Their inclusion in these materials does *not* imply an endorsement by NIDA. More information on these program models can be found in a video prepared by NIDA titled *Coming Together on Prevention*, which is available from the National Clearinghouse for Alcohol and Drug Information (NCADI). (See appendix A.) If prevention practitioners determine that one or more of these case examples might be appropriate for their communities, they can use the relevant resource manual as a supplement to the RDA core package. The stand-alone resource manuals are not included as part of the RDA core package and have to be ordered separately. Figure 1 shows how a practitioner might use the documents in this set of RDA materials.

These RDA materials are not intended to be an all-inclusive discourse on drug abuse prevention and programming. The programs presented as illustrations of the three prevention strategies all target children or adolescents. This selection is purposeful because this population has been the major thrust of policy, research, and program efforts. This does not imply that there are no effective drug abuse prevention efforts targeting adults, only that this topic is beyond the scope of these materials.

Throughout this facilitator's manual and the other documents in the drug abuse prevention RDA materials, *substance abuse* is used to refer to illicit drug and alcohol abuse and to the use of tobacco products. Trainers unfamiliar with the substance abuse and prevention terms used throughout this facilitator's manual are referred to the Center for Substance Abuse Prevention (CSAP) *Prevention Primer: An Encyclopedia of Alcohol, Tobacco, and Other Drug Prevention Terms* available from NCADI.

Figure 1

Drug Abuse Prevention

Research Dissemination and Applications Materials

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      │ Community Readiness │◄─────►│  Prevention/Community   │
      │ Resource Manual     │       │  Readiness Training     │
      │                     │       │  Manual                 │
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| Prevention for the General Population Resource Manual | and/or | Prevention for At-Risk Groups Resource Manual | and/or | Prevention for At-Risk Individuals Resource Manual |
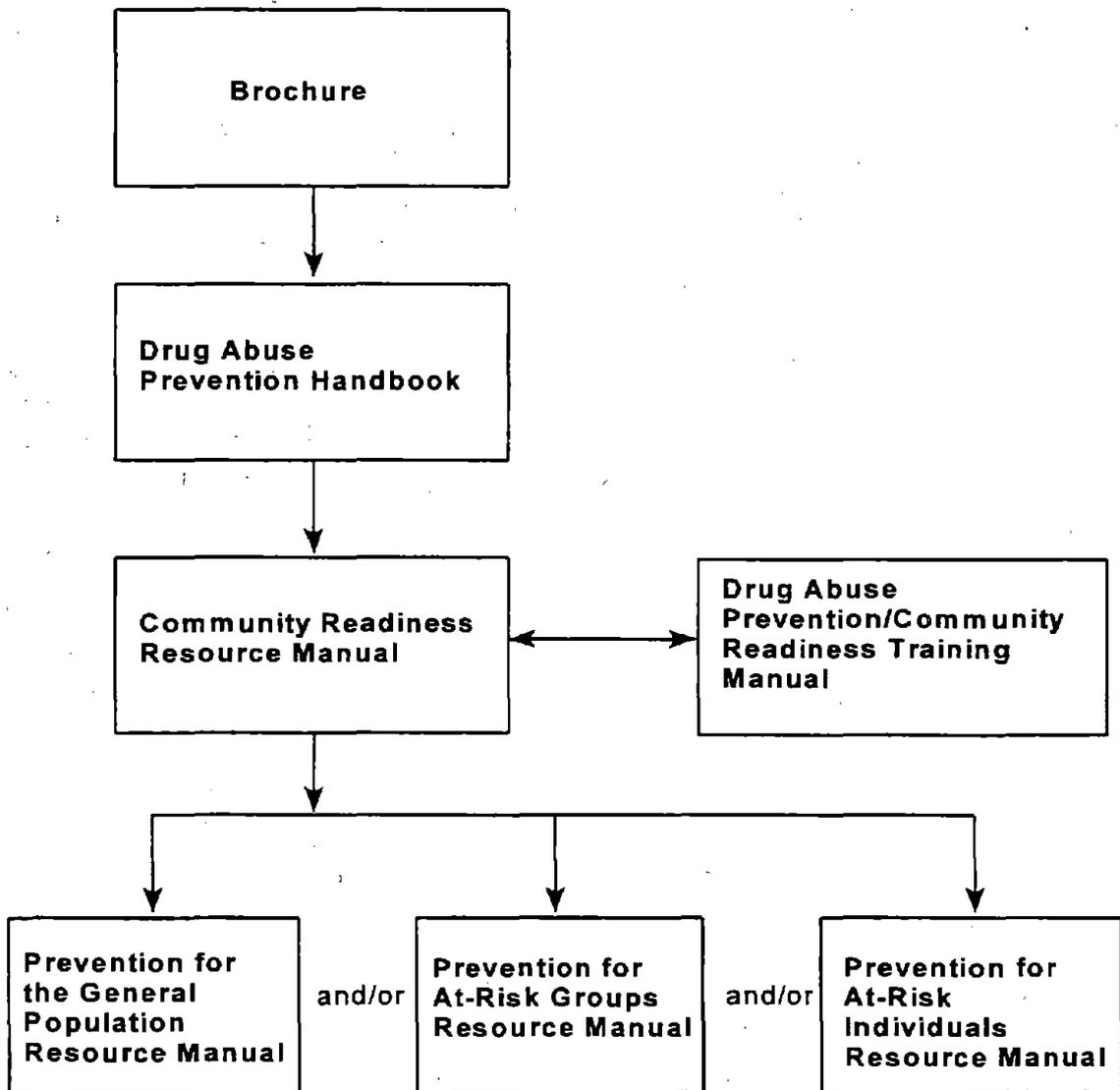
OVERVIEW OF THE DRUG ABUSE PREVENTION AND COMMUNITY READINESS TRAINING FACILITATOR'S MANUAL

PURPOSE

The purpose of this training is to introduce participants to drug abuse prevention and enhance their ability to assess and increase the readiness of a community to begin drug abuse prevention programming. The facilitator's manual contains all the materials needed to plan and conduct training on drug abuse prevention and community readiness, including a schedule, lecture outlines, exercise instructions, overheads, and handouts.

This training explores drug abuse prevention, strategies, and programs. It also introduces the concept of community readiness, describes nine stages of readiness, identifies seven factors associated with successful substance abuse prevention programming, raises questions to ask when ascertaining whether a factor is present within a community, and suggests strategies for increasing readiness when any of the seven factors is weak.

LEARNING OBJECTIVES

As a result of participation in this training, participants will be able to:

- Distinguish between universal, selective, and indicated prevention approaches; describe the integral components of each; and describe programs that illustrate each;

- Describe risk and protective factors related to substance abuse;

- Identify prevention programs designed to strengthen families, schools, or communities;

- Define the concept of community readiness in assessing a community's ability to start substance abuse prevention programming;

- List nine stages of readiness and explain how to determine the level of readiness;

- Explain the importance of assessing a community's readiness to begin drug abuse prevention programming;

- Name seven key factors associated with a community's readiness to start substance abuse prevention programming;

- Demonstrate skills in assessing whether any or all of the seven factors are present within a community; and

- Identify at least one strategy for strengthening factors that are weak.

INTENDED AUDIENCE

This training program is designed for substance abuse prevention program administrators, prevention specialists, community volunteers, community activists, and other individuals who have an interest in drug abuse prevention.

HOW TO USE THIS MANUAL

This training manual is intended to provide materials and instructions for conducting a 1-day training session on drug abuse prevention and community readiness for prevention programming. The material is divided into five modules, each lasting approximately 90 minutes to 2 hours. Trainers should examine all materials and activities before conducting the training. The manual also includes lecture topics and key points, questions for discussion, recommended materials and methods for implementing the training, suggested overheads, and handouts. The overheads may be copied onto overhead transparencies and used during the training. Alternatively, if an agency does not have an overhead projector or the means to make transparencies, the overheads can be copied (in advance) onto newsprints. In addition to the handouts, copies of the overheads also can be made and handed out to participants.

Trainers should use their own resources, illustrations, and anecdotes to design an engaging and worthwhile learning experience for participants. If necessary, trainers also may want to role model some of the exercises for participants having trouble understanding the instructions. Trainers should adjust content and examples to be personally relevant and appropriate to participants and their communities. Special consideration should be given to the ethnic and cultural differences among participants and their clients.

Each module begins with an overview of the material contained in the module and the following information about the process:

- Time needed
- Methods of instruction
- Goal
- Objectives
- Key points
- Materials needed
- Overhead transparencies

- Handouts
- Prepared newsprints

This information should be reviewed prior to conducting the training, and the trainer should be familiar with each module's goals, objectives, and key points. Materials should be obtained, handouts copied, and newsprints prepared in advance of the training. Note that the overview of the training module lists "prepared newsprints," "overheads," and "handouts," and the training plan for the module indicates places where they are to be used. In preparation for training, trainers should write each newsprint topic at the top of a page; participants' comments should be recorded on the page during group brainstorming sessions and discussions. The trainer should prepare and practice the lectures and be familiar with the instructions for exercises and questions for discussion.

Each training module also includes a schedule that lists activities, allotted times, and the training methods to be used. The actual content of the modules is contained on pages with two columns. The left-hand column includes:

- The activities
- Training methods
- Time allotments, with subactivity times indicated in parentheses
- References to overhead transparencies
- References to handouts
- References to prepared newsprints

The right-hand column contains directions for conducting activities, including lecture material, instructions for exercises, and questions for discussion.

MAJOR TOPICS

Five major components comprise the Drug Abuse Prevention and Community Readiness Training Curriculum. They are:

- Introduction to Drug Abuse Prevention Programming
- Drug Abuse Prevention Programming—What Works
- Assessing Community Readiness for Drug Abuse Prevention Programming
- Factors Associated With the Success of Drug Abuse Prevention Programs
- Strengthening Community Readiness

METHODS

This training curriculum uses a combination of adult learning techniques and contains activities that focus on specific objectives and provide opportunities for learners to participate. Techniques are varied to maintain learner interest. These include:

- Brief lectures
- Small-group assignments
- Large-group discussion
- Exercises
- Case studies

TIME AND ORGANIZATION

The total time for this training program is about 9 hours. With 1 hour for lunch and two 15-minute breaks, the total workshop time is about 10½ hours. The curriculum is composed of five modules: Three are approximately 2 hours in length, and two are about 90 minutes. However, time requirements for presenting the training may be affected by many factors, such as the number of participants, their level of knowledge and experience, and the amount of time available.

While the curriculum is designed so that presentation time can be increased or reduced to meet the demands of the situation, suggested time allotments are included in each section. Time allotments are based on an optimal group size of 15. If there are considerably more or fewer than 15 participants in a training session, times allotted to some exercises will vary considerably. In addition, programs may want to schedule additional time for participants to practice what they have learned, particularly in using the community assessment checklist.

An alternate training format would be to present one or two modules over a series of evening time slots or one module during a lunchtime slot over a period of 5 days. To maintain momentum and continuity, it is recommended that there be no longer than 1 week between presentation of the modules.

CLASS SIZE—TRAINER/TRAINEE RATIO

- 1 - 2 trainers
- 9 - 30 trainees

If two trainers are used, one can give instructions while the other records. Alternating trainers promotes participant attention.

TRAINER QUALIFICATIONS

It is recommended that, when possible, two trainers work as a team to present this curriculum. Trainers should be experienced in the issues of substance abuse prevention. It is also desirable that trainers have a basic understanding of substance abuse prevention community coalitions. Given the requirements of this training task, it is important that trainers have the following qualifications:

- Training and group facilitation skills;
- Knowledge of community development/organization;
- Knowledge of adult learning theory;
- Ability to adjust delivery to diverse learner needs; and
- Up-to-date knowledge of drug abuse prevention issues, principles, and practices.

TRAINING AIDS

All the materials developed for this curriculum may be reproduced for instructional purposes. Overhead transparencies and handouts are designated as such in the upper right-hand corner of pages. Trainers should make additional copies of handouts and overhead transparencies as needed prior to delivering the training, as well as preparing the newsprints. Alternatively, trainers may want to consider developing a separate participant manual that includes any or all of the handouts and overheads provided in the curriculum, as well as additional readings, homework assignments, and so forth, including excerpts from *Drug Abuse Prevention: What Works; Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools*; or other materials in the NIDA Drug Abuse Prevention RDA set of materials.

ROOM AND EQUIPMENT REQUIREMENTS

- Meeting room large enough to hold the group or breakout rooms, so participants can work in small group teams
- U-shape or conference-style seating arrangement
- Prepared newsprints and easel
- Markers
- Tape
- Notepads and pencils
- Overhead projector
- Screen
- Overhead transparencies
- VCR player and monitor
- Watch

RESOURCES

The following resources are available to trainers from NCADI (800-729-6686). They provide sufficient background information from which to develop lectures and facilitate group exercises.

- *Drug Abuse Prevention: What Works*, from the NIDA Drug Abuse Prevention RDA package, NCADI Order No. PREVPK

- *Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools*, from the NIDA Drug Abuse Prevention RDA package, NCADI Order No. PREVPK.

- *Coming Together on Prevention Video*, NCADI Order No. VHS66.

- *Prevention Primer: An Encyclopedia of Alcohol, Tobacco, and Other Drug Prevention Terms*, NCADI Order No. PHD627.

SCHEDULE OF TRAINING

SCHEDULE FOR MODULE I: INTRODUCTION TO DRUG ABUSE PREVENTION PROGRAMMING

	Activity	Time	Methodology
1.	Introductions and Overview of the Training	20 minutes	Lecture
2.	Personal Case Study	30 minutes	Exercise
3.	Overview of Module I	5 minutes	Lecture
4.	What Is Prevention	10 minutes	Discussion
5.	Three Prevention Strategies	20 minutes	Discussion
6.	Applying Prevention Strategies	20 minutes	Exercise
7.	Summary and Personal Assessment	5 minutes	Exercise

TOTAL TIME: **1 hour and 50 minutes**

SCHEDULE FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS

	Activity	Time	Methodology
1.	Overview of Module II	5 minutes	Lecture
2.	Risk Factors in Prevention	20 minutes	Lecture
3.	Protective Factors in Prevention	15 minutes	Lecture/Exercise
4.	Designing Prevention Programs	30 minutes	Exercise
5.	Model Programs	15 minutes	Lecture
6.	Optional Video	30 minutes	Video/Discussion
7.	Summary and Personal Assessment	5 minutes	Exercise

TOTAL TIME: 2 hours

SCHEDULE FOR MODULE III: ASSESSING COMMUNITY READINESS FOR DRUG ABUSE PREVENTION PROGRAMMING

	Activity	Time	Methodology
1.	Overview of Module III	5 minutes	Lecture
2.	Community Readiness	15 minutes	Lecture
3.	Assessing Community Readiness	45 minutes	Exercise
4.	Group Reports	10 minutes	Discussion
5.	Summary and Personal Case Study	10 minutes	Lecture/ Individual Activity

TOTAL TIME: 1 hour and 25 minutes

SCHEDULE FOR MODULE IV: FACTORS ASSOCIATED WITH THE SUCCESS OF DRUG ABUSE PREVENTION PROGRAMS

	Activity	Time	Methodology
1.	Overview of Module IV	5 minutes	Lecture
2.	What Factors Contribute to Readiness?	15 minutes	Lecture
3.	Assessing Factors That Contribute to Readiness	20 minutes	Exercise
4.	Key Readiness Factors: Group Reports	45 minutes	Discussion
5.	Summary and Personal Assessment	5 minutes	Exercise
	TOTAL TIME:	**1 hour and 30 minutes**	

SCHEDULE FOR MODULE V: STRENGTHENING COMMUNITY READINESS

	Activity	Time	Methodology
1.	Overview of Module V	5 minutes	Lecture
2.	Using the Readiness Checklist	15 minutes	Exercise
3.	Using the Readiness Checklist: Group Reports	15 minutes	Discussion
4.	Strengthening the Key Factors	15 minutes	Lecture
5.	Developing Strategies To Strengthen Key Factors	15 minutes	Exercise
6.	Strategies To Develop Key Factors: Group Reports	15 minutes	Discussion
7.	Putting It All Together: Action Planning	30 minutes	Exercise
8.	Closing Remarks	10 minutes	Lecture
	TOTAL TIME:	**2 hours**	

MODULE I: INTRODUCTION TO DRUG ABUSE PREVENTION PROGRAMMING

Overview

Traditionally prevention programs have been organized into a continuum of primary, secondary, and tertiary prevention, but these definitions have resulted in some confusion and disagreement about what differentiates prevention from intervention and treatment.

This module provides another model for understanding prevention. Classifications used are universal, selective, and indicated prevention. Under this classification system, prevention programs are organized along a targeted audience continuum—that is, the degree to which any person is identified as an individual at risk for substance abuse. The at-risk determination is based on a combination of risk and protective factors associated with substance abuse.

Time Needed:	1 hour and 50 minutes
Methods:	Lecture (25 minutes) Discussion (30 minutes) Exercise (55 minutes)
Goal:	To introduce participants to a prevention classification system—universal, selective, and indicated—so they can be more effective when designing prevention programs in their communities.
Objectives:	By the end of module I, participants will be able to: ● Distinguish between supply reduction and demand reduction prevention strategies; ● Define universal, selective, and indicated prevention; and ● Identify the key features of universal, selective, and indicated prevention strategies.
Key Points:	● Efforts to reduce drug abuse have concentrated on supply reduction and demand reduction strategies. ● Prevention programs are demand reduction strategies.

Key Points (Continued)	• A new prevention classification system developed by the Institute of Medicine (IOM) addresses issues inherent in the traditional public health classification system. • The IOM system organizes prevention programs based on risk and protective factors of targeted audiences.
Materials Needed:	• Prepared newsprints and easel • Markers • Tape • Notepads and pencils • Overhead projector • Screen • Overhead transparencies • Watch
Overhead Transparencies:	• 1.1 Drug Abuse Prevention and Community Readiness/Purpose of the Training • 1.2 Drug Abuse Prevention and Community Readiness/Learning Objectives • 1.3 Introductions • 1.4 Module I Objectives • 1.5 Antidrug Strategies and Targets • 1.6 Prevention Focuses • 1.7 Classification Systems of Prevention
Handouts:	• 1.1 Drug Abuse Prevention and Community Readiness/Training Outline • 1.2 Prevention Programming Personal Case Study—Part One • 1.3 Prevention Strategies • 1.4 Prevention Matrix • 1.5 Prevention Programming Personal Case Study—Part Two
Prepared Newsprints:	• 1.1 Hopes • 1.2 Fears • 1.3 Prevention Programming Experiences • 1.4 Supply Reduction Strategies • 1.5 Universal Prevention Approaches • 1.6 Selective Prevention Approaches • 1.7 Indicated Prevention Approaches

SCHEDULE FOR MODULE I: INTRODUCTION TO DRUG ABUSE PREVENTION PROGRAMMING

	Activity	Time	Methodology
1.	Introductions and Overview of the Training	20 minutes	Lecture
2.	Personal Case Study	30 minutes	Exercise
3.	Overview of Module I	5 minutes	Lecture
4.	What Is Prevention	10 minutes	Discussion
5.	Three Prevention Strategies	20 minutes	Discussion
6.	Applying Prevention Strategies	20 minutes	Exercise
7.	Summary and Personal Assessment	5 minutes	Exercise
	TOTAL TIME:	**1 hour and 50 minutes**	

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TRAINING PLAN FOR MODULE I: INTRODUCTION TO DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
ACTIVITY 1: LECTURE 20 minutes	**Introductions and Overview of the Training** The trainers should introduce themselves, describing briefly their backgrounds related to drug abuse prevention and, if appropriate, their training and experience in community development/organization. Explain that participants will be asked to introduce themselves, but first it is important to provide a brief overview of the training.
OVERHEAD 1.1 DRUG ABUSE PREVENTION AND COMMUNITY READINESS/ PURPOSE OF THE TRAINING	Display overhead 1.1, "Drug Abuse Prevention and Community Readiness/Purpose of the Training." Read the purpose and elaborate as needed. ● The purpose of this training is to introduce participants to drug abuse prevention and enhance their ability to assess and increase the readiness of a community for drug abuse prevention programming.
OVERHEAD 1.2 DRUG ABUSE PREVENTION AND COMMUNITY READINESS/LEARNING OBJECTIVES	Display overhead 1.2, "Drug Abuse Prevention and Community Readiness/Learning Objectives." Review the objectives by reading and elaborating on each objective. Solicit participants' questions related to the purpose and objectives and respond to them as appropriate.
HANDOUT 1.1 DRUG ABUSE PREVENTION AND COMMUNITY READINESS/TRAINING OUTLINE	Refer participants to handout 1.1, "Drug Abuse Prevention and Community Readiness/Training Outline."

TRAINING PLAN FOR MODULE I: INTRODUCTION TO DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	Present an overview of the content and flow of the curriculum, focusing on the key elements of the curriculum. Solicit participants' questions about the training outline and respond to them as appropriate.
OVERHEAD 1.3 INTRODUCTIONS	Display overhead 1.3, "Introductions" and prepared newsprints 1.1, "Hopes," and 1.2, "Fears."
PREPARED NEWSPRINT 1.1 HOPES **PREPARED NEWSPRINT 1.2 FEARS**	Ask participants to introduce themselves, including their names, their positions in their agencies, how long they have been working at the agencies, how long they have been working in substance abuse prevention, and one hope and one fear they have for the entire training program.
	Tell them that as they state their hopes and fears, you will be recording them on the newsprint.
	Ask participants to report their hopes and their fears for the training program; record them on the appropriate newsprint.
	When all participants have introduced themselves, acknowledge their experience and the work they do at their agencies and in their communities.
	Respond to their hopes and fears by noting that the training will respond to many of their hopes and their fears. If there are any hopes that the training clearly cannot address, indicate that at this time.
	Let the participants know that you will be checking with them regularly to make sure the training is responding to their needs.

TRAINING PLAN FOR MODULE I: INTRODUCTION TO DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
ACTIVITY 2: EXERCISE **30 minutes** **HANDOUT 1.2 PREVENTION PROGRAMMING PERSONAL CASE STUDY—PART ONE** **(20 minutes)**	**Personal Case Study** Distribute handout 1.2, "Prevention Programming Personal Case Study—Part One." Ask participants to think about a specific instance when they have been involved in a substance abuse prevention program, to think about its successes and areas of concern or difficulty. Tell them they may choose a specific prevention activity (such as a neighborhood media campaign or a fundraising effort) or a large communitywide program. If any participants have not been involved in prevention programs, ask them to think about a prevention program they are aware of or to work with a partner who is involved in prevention programming. Ask them to complete the worksheet. After 10 minutes, ask participants to find another participant and tell their partner about their prevention experience. Tell them they will have 5 minutes, and then they will switch roles. After 5 minutes call time and have partners switch roles. After 5 more minutes, call time.
PREPARED NEWSPRINT 1.3 PREVENTION PROGRAMMING EXPERIENCES **(10 minutes)**	Display prepared newsprint 1.3, "Prevention Programming Experiences." Ask participants to share elements of their stories that stood out and record them on prepared newsprint 1.3. Examples might include: ● Community meetings where few people attended.

TRAINING PLAN FOR MODULE I: INTRODUCTION TO DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	• School programs that met resistance from administrators. • Successful programs for which there was no evaluation method to demonstrate results. After there is a list of at least 6 to 8 items, review the items and explain how understanding and applying the concepts and skills taught in this course will address those kinds of issues. Emphasize benefits and consequences. Concentrate on aspects of this curriculum. For example: • Understanding how to conduct a community readiness evaluation. • Increasing community readiness. Allow 10 minutes for this discussion. Tell participants they will be returning to this case study throughout the training to apply what they are learning to this case.
ACTIVITY 3: **LECTURE** **5 minutes**	**Overview of Module I** Present an overview of the content and flow of module I, focusing on the key issues. Inform participants that they will: • Discuss what prevention is. • Learn about three prevention models. • Explore how to apply those models to specific communities or groups.

TRAINING PLAN FOR MODULE I: INTRODUCTION TO DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
OVERHEAD 1.4 MODULE I OBJECTIVES	Display overhead 1.4, "Module I Objectives." Review module objectives by reading and elaborating on each objective. Solicit participants' questions related to the objectives and respond to them.
ACTIVITY 4: DISCUSSION **10 minutes**	**What Is Prevention** Explain that: ● This section will explore briefly two types of antidrug strategies, namely supply reduction and demand reduction. ● It also will cover the three major types of prevention strategies—universal, selective, and indicated.
OVERHEAD 1.5 ANTIDRUG STRATEGIES AND TARGETS	Display overhead 1.5, "Antidrug Strategies and Targets." Explain: ● There are two major antidrug strategies, supply reduction and demand reduction. There are three major targets of antidrug strategies: the host (the individual), the agent (the drug), and the environment. ● Prevention strategies can focus on any of these three targets. ● Attempts to alter the host's or individual's desire for the drug are demand reduction strategies. ● Attempts to change the agent or availability of drugs are supply reduction strategies.

TRAINING PLAN FOR MODULE I: INTRODUCTION TO DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	● Environmental strategies focus on changing the surroundings of the drug user, such as their community, school, or workplace to make them less hospitable to drug abuse. ● Environmental strategies can be used for either supply or demand reduction. ● Supply reduction strategies include, for example, changes in laws that make it more difficult or expensive to purchase tobacco or alcohol and law enforcement activities aimed at intercepting drugs or thwarting their sale.
PREPARED NEWSPRINT 1.4 SUPPLY REDUCTION STRATEGIES	Display prepared newsprint 1.4, "Supply Reduction Strategies." Note that supply reduction strategies include any method used to reduce the availability of drugs. These may be directed either at the drug itself or the environment. Ask participants to list supply reduction strategies. Record their answers on newsprint. For illegal drugs, examples include: Supply Reduction Strategies Aimed at Agent ● Destruction of drug crops; ● Confiscation of drug shipments; and ● Police actions. Supply Reduction Strategies Aimed at Environment ● Border patrols; and ● Criminal penalties for drug use and dealing.

TRAINING PLAN FOR MODULE I: INTRODUCTION TO DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	Participants may concentrate only on illegal drugs. If so, ask them to think about legal drugs, like alcohol and tobacco, as well.
	For legal drugs, such as alcohol and tobacco, examples include:
	● Increasing taxes;
	● Increasing the legal age of use;
	● Increasing law enforcement;
	● Reducing advertising;
	● Reducing the number of sales outlets; and
	● Imposing penalties for sales to minors.
	Note that over the past 15 years, the Federal Government has earmarked more funding for supply reduction approaches than for demand reduction. However, the focus is now turning to demand reduction strategies.
	State that:
	● Demand reduction strategies include prevention and treatment approaches designed to reduce the person's demand for illegal drugs.
	● Prevention attempts to reduce demand by decreasing risk factors or enhancing protective factors associated with drug abuse.
	● Environmental demand reduction strategies focus on changing local norms that support drug use.

TRAINING PLAN FOR MODULE I: INTRODUCTION TO DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	• Treatment is designed to decrease demand by stopping drug abuse in the addicted or abusing individual.
OVERHEAD 1.6 PREVENTION FOCUSES	Display overhead 1.6, "Prevention Focuses." Emphasize that: • There are five major sites at which prevention activities are typically focused: the individual, family, peers, school, and community (including the workplace). • Research suggests that increased effectiveness results when more than one of these sites is targeted in a comprehensive prevention program.
OVERHEAD 1.7 CLASSIFICATION SYSTEMS OF PREVENTION	Display overhead 1.7, "Classification Systems of Prevention." Provide the following overview: • Prevention is a part of demand reduction. In the 1970s and 1980s, prevention was organized into a continuum of primary, secondary, and tertiary prevention. • Primary prevention programs target people who have not begun to use illegal drugs to decrease the incidence of new users. • Secondary prevention programs are designed to treat people who have begun to abuse drugs, thus reducing the prevalence of drug abuse. • Tertiary prevention programs, often called treatment, are designed to treat chronic drug abuse and related health problems.

TRAINING PLAN FOR MODULE I: INTRODUCTION TO DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	• This classification system has been criticized as being confusing, particularly in distinguishing prevention from treatment. Make a transition to the next section with the following information: • The Institute of Medicine (IOM) has proposed a new classification of prevention that has been adopted by NIDA. • The new prevention classification uses the terms *universal, selective,* and *indicated* prevention described later. • The IOM classification system clearly distinguishes prevention from treatment.
ACTIVITY 5: DISCUSSION **20 minutes**	**Three Prevention Strategies** Universal Prevention Universal prevention strategies address the entire population; they are strategies that will benefit everyone regardless of risk. Ask participants to give examples of universal prevention approaches. To get the discussion going, list the following examples: • School, community, or family-based programs delivered to large groups of youth or families without any prior screening for at-risk status; • Programs delivered to entire schools or to entire grades, such as life-skills training; and • Peer- and media-resistance training.

TRAINING PLAN FOR MODULE I: INTRODUCTION TO DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
PREPARED NEWSPRINT 1.5 UNIVERSAL PREVENTION APPROACHES	Display prepared newsprint 1.5, "Universal Prevention Approaches." Ask participants what they think are the features of universal prevention approaches that make it different from other approaches. Record answers on the newsprint. Examples include: ● Developed for general populations who share the same general risk to drug abuse; ● Individual risk is not assessed; ● Considered desirable for everyone in the population; and ● An attempt is made to provide prevention services to a large group of people for a relatively low cost per person. Selective Prevention Explain that selective prevention programs are those aimed at members of an entire at-risk subgroup of the population, regardless of individual risk. Ask participants to give examples of selective prevention approaches. Examples you may give include: ● Education and skills training programs designed specifically for children of alcoholics;

TRAINING PLAN FOR MODULE I: INTRODUCTION TO DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	• Mentoring, tutoring, sports, and youth leadership programs for school dropouts or students who are failing academically; and • Cultural competency training for low income youth.
PREPARED NEWSPRINT 1.6 SELECTIVE PREVENTION APPROACHES	Display prepared newsprint 1.6, "Selective Prevention Approaches." Ask participants what they think are the features of selective prevention approaches that make them different from other types of approaches. Record their answers on the newsprint. Examples include: • Targeted to specific subgroups believed to be of greater risk than others. • Individuals in the subgroup are not assessed. • Risk factors could be at the individual, family, peer group, or community level. • Generally more costly per participant than universal approaches because they usually last longer than universal programs. • Often operated as programs in schools or community agencies.

TRAINING PLAN FOR MODULE I: INTRODUCTION TO DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	Indicated Prevention Indicated prevention strategies are directed at specific at-risk individuals. Ask participants to give examples of indicated prevention approaches. Examples may include: ● Student assistance programs, where teachers and counselors refer students showing academic, behavioral, and emotional problems to counseling groups. ● Family-focused programs, such as family skills training or parent self-help groups.
PREPARED NEWSPRINT 1.7 INDICATED PREVENTION APPROACHES	Display prepared newsprint 1.7, "Indicated Prevention Approaches." Ask participants what they think are the features of indicated prevention approaches that make them different from other types of approaches. Record their answers on the newsprint. Examples include: ● Generally more costly, more intensive and involve staff with more clinical training. ● Focused on individuals who are already manifesting drug use or other maladaptive behaviors yet do not warrant a clinical diagnosis of drug abuse or drug dependence according to DSM-III-R or DSM-IV.

TRAINING PLAN FOR MODULE I: INTRODUCTION TO DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	• Requires a precise assessment of an individual's risk of drug abuse. • Individuals also may manifest other behaviors such as rapid decline in school grades, being a school dropout, acting-out, and signs of juvenile depression. \ • Individuals can be referred to indicated prevention programs by parents, teachers, school counselors, school nurses, youth workers, friends, relatives or other caring persons, or the courts.
ACTIVITY 6: EXERCISE **20 minutes**	**Applying Prevention Strategies** Introduce this section by informing participants that they now will have the opportunity to apply the information they have just learned by designating sample programs as universal, selected, or indicated prevention strategies.
HANDOUT 1.3 PREVENTION STRATEGIES **(12 minutes)**	Distribute handout 1.3, "Prevention Strategies." Ask participants to form into groups of five to six. Ask each group to choose a facilitator to direct its discussion and present its statements to the larger group. Explain that there are 10 different substance abuse prevention programs listed on the handout. Each small group is to determine which prevention strategy is represented by each example and to identify the key characteristics that determine in which classification the program belongs. Give participants 10 minutes to complete the exercise. After 10 minutes, call time and reconvene the group.

TRAINING PLAN FOR MODULE I: INTRODUCTION TO DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	Ask each group to report:
	● Its answers for the first item; and
	● The reasons the group classified its answer the way it did.
	Repeat the process for all 10 items.
	If groups disagree on the classification of items, discuss the discrepancy and see whether the large group can come to consensus.
HANDOUT 1.4 PREVENTION MATRIX (2 minutes)	Distribute handout 1.4, "Prevention Matrix." Review the material briefly with participants. Ask whether there are any questions about the information, and answer questions as appropriate.
HANDOUT 1.5 PREVENTION PROGRAMMING PERSONAL CASE STUDY—PART TWO (6 minutes)	Refer participants back to handout 1.5, "Prevention Programming Personal Case Study—Part Two." Ask them to consider the prevention program they are or were associated with and to complete questions 8 and 9. Allow 5 minutes for this exercise. After 5 minutes, call time. Summarize the discussion, and note that this information will be key when the group begins to discuss community readiness later in the training.

TRAINING PLAN FOR MODULE I: INTRODUCTION TO DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
ACTIVITY 7: EXERCISE **5 minutes** **OVERHEAD 1.4 MODULE I OBJECTIVES**	**Summary and Personal Assessment** Display overhead 1.4, "Module I Objectives," and review module I learning objectives. Ask participants to make a personal assessment of what they have learned. Go around the room and ask each participant to state one thing that he or she has learned during this module. Introduce module II by telling participants that the next session will present information about risk and protective factors and programs that have proved effective in drug abuse prevention.
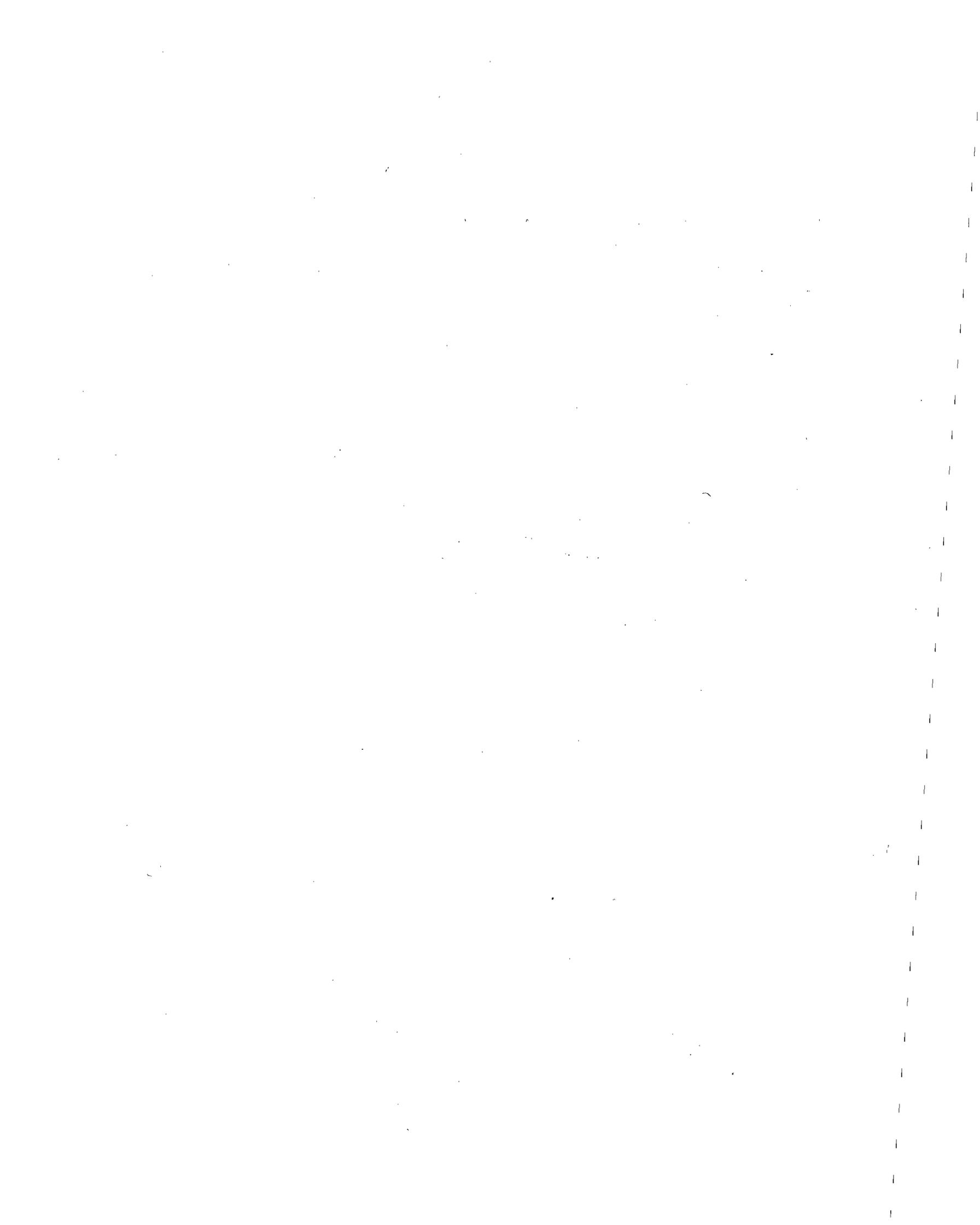
Drug Abuse Prevention and Community Readiness

Purpose of the Training

The purpose of this training is to introduce participants to drug abuse prevention and enhance their ability to assess and increase the readiness of a community for drug abuse prevention programming.

Drug Abuse Prevention and Community Readiness
Learning Objectives

As a result of participation in this training, participants will be able to:

- Distinguish between universal, selective, and indicated prevention approaches, describe the integral components of each, and describe programs that illustrate each.

- Describe risk and protective factors related to substance abuse.

- Identify prevention programs designed to strengthen families, schools, or communities.

- Define the concept of community readiness in assessing a community's ability to start drug abuse prevention programming.

Drug Abuse Prevention and Community Readiness Learning Objectives (Continued)

- List nine stages of readiness and explain how to determine the level of readiness.

- Explain the importance of assessing a community's readiness to begin drug abuse prevention programming.

- Name seven factors associated with a community's readiness to start substance abuse prevention programming.

- Demonstrate skills in assessing whether any or all of the seven factors are present within a community.

- Identify at least one strategy for strengthening factors that are weak.

Introductions

- Name

- Position at agency

- How long at the agency

- How long in prevention

- Hope/Fear

Module I Objectives

By the end of module I, participants will be able to:

- Distinguish between supply reduction and demand reduction prevention strategies.

- Define universal, selective, and indicated prevention.

- Identify the key factors of universal, selective, and indicated prevention strategies.
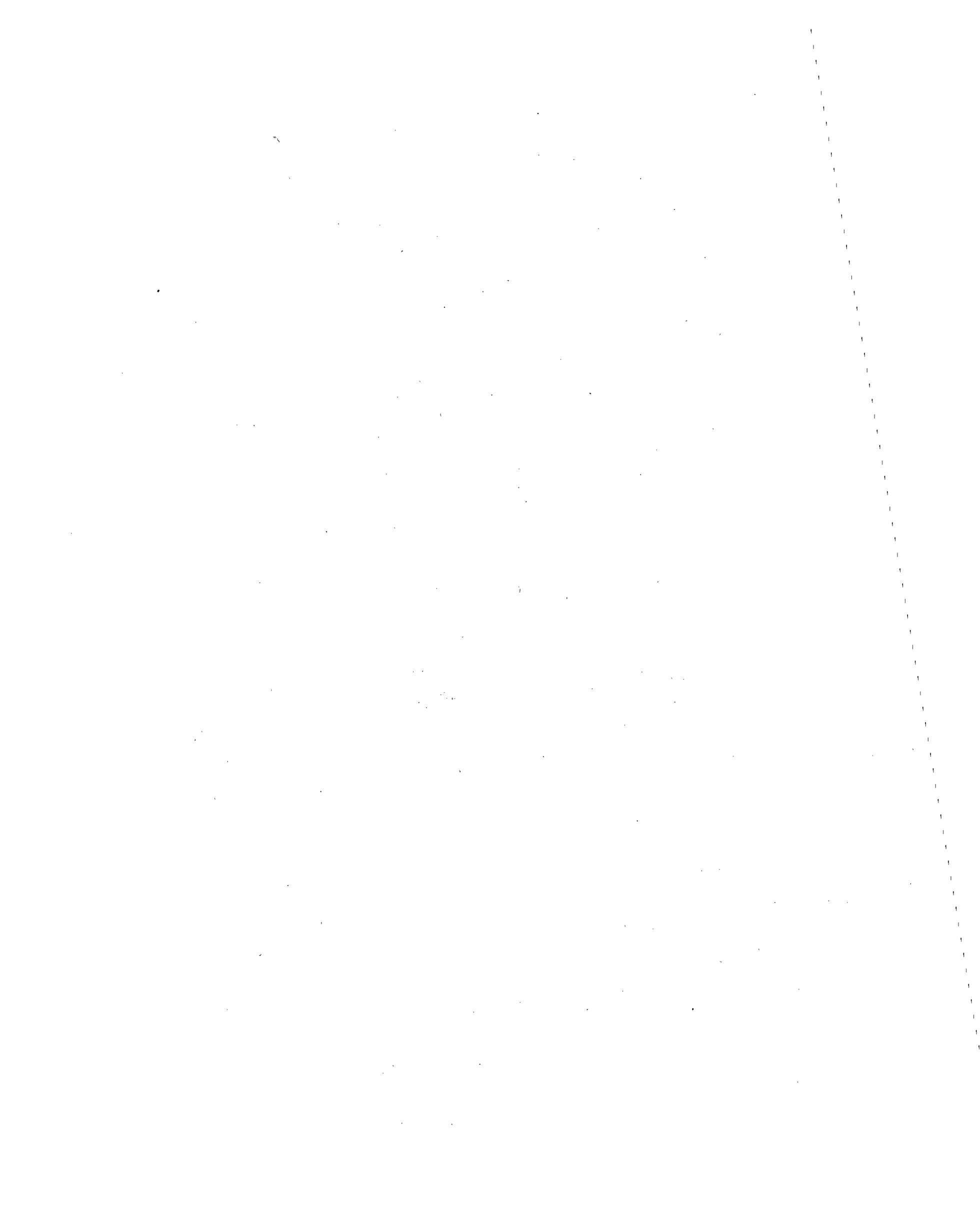
Antidrug Strategies and Targets

Strategy	Targets
• Demand Reduction	— Host (individual)
	— Environment
• Supply Reduction	— Agent (drug)
	— Environment

Prevention Focuses

- Individual

- Family

- Peer Relationships

- School

- Community

Classification Systems of Prevention

Public Health Classification

- Primary prevention

- Secondary prevention

- Tertiary prevention

IOM Classification

- Universal prevention

- Selective prevention

- Indicated prevention

DRUG ABUSE PREVENTION AND COMMUNITY READINESS TRAINING OUTLINE

SCHEDULE FOR MODULE I: INTRODUCTION TO DRUG ABUSE PREVENTION PROGRAMMING

	<u>Activity</u>	<u>Time</u>	<u>Methodology</u>
1.	Introductions and Overview of the Training	20 minutes	Lecture
2.	Personal Case Study	30 minutes	Exercise
3.	Overview of Module I	5 minutes	Lecture
4.	What Is Prevention	10 minutes	Discussion
5.	Three Prevention Strategies	20 minutes	Discussion
6.	Applying Prevention Strategies	20 minutes	Exercise
7.	Summary and Personal Assessment	5 minutes	Exercise

TOTAL TIME: **1 hour and 50 minutes**

SCHEDULE FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS

	Activity	Time	Methodology
1.	Overview of Module II	5 minutes	Lecture
2.	Risk Factors in Prevention	20 minutes	Lecture
3.	Protective Factors in Prevention	15 minutes	Lecture/Exercise
4.	Designing Prevention Programs	30 minutes	Exercise
5.	Model Programs	15 minutes	Lecture
6.	Optional Video	30 minutes	Video/Discussion
7.	Summary and Personal Assessment	5 minutes	Exercise

TOTAL TIME: 2 hours

SCHEDULE FOR MODULE III: ASSESSING COMMUNITY READINESS FOR DRUG ABUSE PREVENTION PROGRAMMING

	Activity	Time	Methodology
1.	Overview of Module III	5 minutes	Lecture
2.	Community Readiness	15 minutes	Lecture
3.	Assessing Community Readiness	45 minutes	Exercise
4.	Group Reports	10 minutes	Discussion
5.	Summary and Personal Case Study	10 minutes	Lecture/Individual Activity

TOTAL TIME: 1 hour and 25 minutes

SCHEDULE FOR MODULE IV: FACTORS ASSOCIATED WITH THE SUCCESS OF DRUG ABUSE PREVENTION PROGRAMS

	Activity	Time	Methodology
1.	Overview of Module IV	5 minutes	Lecture
2.	What Factors Contribute to Readiness?	15 minutes	Lecture
3.	Assessing Factors That Contribute to Readiness	20 minutes	Exercise
4.	Key Readiness Factors: Group Reports	45 minutes	Discussion
5.	Summary and Personal Assessment	5 minutes	Exercise

TOTAL TIME: 1 hour and 30 minutes

SCHEDULE FOR MODULE V: STRENGTHENING COMMUNITY READINESS

	Activity	Time	Methodology
1.	Overview of Module V	5 minutes	Lecture
2.	Using the Readiness Checklist	15 minutes	Exercise
3.	Using the Readiness Checklist: Group Reports	15 minutes	Discussion
4.	Strengthening the Key Factors	15 minutes	Lecture
5.	Developing Strategies To Strengthen Key Factors	15 minutes	Exercise
6.	Strategies To Develop Key Factors: Group Reports	15 minutes	Discussion
7.	Putting It All Together: Action Planning	30 minutes	Exercise
8.	Closing Remarks	10 minutes	Lecture
	TOTAL TIME:	**2 hours**	

Prevention Programming Personal Case Study
Part One

Choose a substance abuse prevention program you are currently working on or a program you have been involved with previously. Answer the following questions.

1. What were the goals of the program? Who was the target audience? To what extent were they achieved? Why or why not?

2. What worked? What did not? Why?

3. What were the program's outcomes? Successes? Accomplishments? What factors contributed to them?

4. What were the program's failures or shortcomings? What factors contributed to them?

5. Who in the community supported or helped? How did staff and others feel about the program and each other?

6. What could the program have done to be more effective?

7. What would you do differently knowing what you know now?

Prevention Strategies

Following are 10 different substance abuse prevention interventions. As a group, determine which type of intervention (universal, selective, or indicated) is represented by each example and discuss the key characteristics that determine the type of intervention.

	U	S	I
1. Student assistance groups for children who lives are affected by a drug user, where anyone may attend.			
2. Red ribbon campaigns.			
3. Afterschool programs for children in public-subsidized housing communities.			
4. Peer- and media-resistance campaigns delivered through schools.			
5. Strengthening families programs implemented through community churches.			
6. Personal growth curriculum for young persons already involved in negative and destructive behaviors.			
7. Clean and sober afterprom parties.			
8. Student assistance groups for young persons identified as being involved in drug use.			
9. Drug education and counseling programs in jails.			
10. Life-skills training in schools.			

Prevention Matrix
SCHOOL-, FAMILY-, AND COMMUNITY-BASED PREVENTION STRATEGIES

	UNIVERSAL PREVENTION	SELECTIVE PREVENTION	INDICATED PREVENTION
SITE OF THE INTERVENTION	*General Population*	*At-Risk Subgroups*	*At-Risk Individuals*

School	Information/education
	• Media campaigns
	• Health education curriculums
	• School assemblies
	
	Competency/skills training
	• Social influence
	• Normative education
	• Life/social skills training
	  - Assertiveness training
	  - Communication skills
	  - Decisionmaking
	  - Anger/stress management
	
	School management changes
	• School policies
	• Instructional changes
		Alternative programs
		• Skills training
		• Afterschool classes
		• Special club/groups
		  - Children of Alcoholics
		• Sports/recreation
		• Mentoring
		
		Competency/skills training
		• Cultural pride
		• Tutoring
		
		Peer leadership
		
		Peer resistance
		
		Parent/peer groups
			Alternative programs
			• Mentoring
			
			Peer leadership/resistance
			
			Parent-peer groups
			
			Peer counseling
			• Student assistance
			• Student crisis/hotlines
			• School support group
			
			Competency/skills training
			• Cultural pride
			• Tutoring
			
			Inschool suspension
			
			Alternative classes/schools

	UNIVERSAL PREVENTION	SELECTIVE PREVENTION	INDICATED PREVENTION
SITE OF THE INTERVENTION	*General Population*	*At-Risk Subgroups*	*At-Risk Individuals*
Family	Parent education • Groups • Lectures • Curricula Parent involvement programs Parent skills training Family skills training	Parenting skills training Family skills training Family case management Parent support groups	Family skills training Parent/peer groups for troubled youth • *Tough Love* Parent self-help groups Structured family therapy • Family therapy/counseling • Family case management
Community	Public awareness campaigns Information clearinghouses Community coalitions • Community task forces • Church-sponsored youth groups Health policy change	Alternative programs • Youth/teen clubs • Mentoring Tutoring	Alternative programs • Rites of passage • Gang and delinquency prevention Skills training • Job skills training • Job apprenticeships

Prevention Programming Personal Case Study
Part Two

8. What type of prevention strategy was used—universal, selective, or indicated?

9. Would a different approach have been more suitable given the target population? Why or why not?

MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS

Overview

As drug abuse prevention has matured, many programs have focused on risk and protective factors. There are factors in communities, families, peer groups, and among individuals that heighten the potential for drug abuse. There are also qualities that can be fostered to provide protection against drug abuse. Understanding those factors has become an essential component of many prevention efforts.

This module provides an introduction to risk and protective factors and presents information about model programs that have been shown to be effective. Participants will be able to use risk and protective factors to design a program for their own areas. They also will have the opportunity to view a video, *Coming Together on Prevention*, which illustrates three types of prevention intervention approaches.

Time Needed:	2 hours
Methods:	Lecture (40 minutes) Exercise (50 minutes) Discussion (30 minutes)
Goal:	To introduce participants to the concepts of risk and protective factors in drug abuse prevention programming and describe model prevention programs that have been shown to be effective.
Objectives:	By the end of module II, participants will be able to: ● Identify and discuss at least three factors that increase risk for substance abuse; ● Identify and discuss at least three factors that protect against risk of substance abuse; and ● Describe three model prevention programs and explain those features that make them effective.

Key Points:	•	Risk factors that seem to contribute to drug use and protective factors that seem to mitigate risk factors have been defined.
	•	Prevention programs that incorporate the reduction of risk factors and the increase of protective factors have been found to be effective.
	•	Universal programs target the general population. An example is Project STAR.
	•	Selective programs target at-risk subgroups. An example is the Strengthening Families Program.
	•	Indicated programs target at-risk individuals. An example is the Reconnecting Youth Program.
Materials Needed:	• • • • • • • • • •	Prepared newsprints and easel Markers Tape Notepads and pencils Overhead projector Screen Overhead transparencies VCR player and monitor *Coming Together on Prevention* video Watch
Overhead Transparencies:	• • • • • • • • • • • • • •	2.1 Module II Objectives 2.2 Definition of Risk Factor 2.3 Individual and Interpersonal Risk Factors 2.4 Peer Group Risk Factors 2.5 Family Risk Factors 2.6 School Risk Factors 2.7 Community Risk Factors 2.8 Definition of Protective Factors 2.9 Definition of Resiliency 2.10 Resiliency—Personality and Temperament Factors 2.11 Resiliency—Life Skills 2.12 Universal Prevention 2.13 Project STAR 2.14 Selective Prevention

Overhead Transparencies: (Continued)	• 2.15 Strengthening Families Program • 2.16 Indicated Prevention • 2.17 Reconnecting Youth Program
Handout:	• 2.1 Risk Factors Related to Substance Abuse
Prepared Newsprints:	• 2.1: Protective Factors • 2.2: The Resilient Person • 2.3: Individual • 2.4: Peer Group • 2.5: Family • 2.6: School • 2.7: Community

SCHEDULE FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS

	Activity	Time	Methodology
1.	Overview of Module II	5 minutes	Lecture
2.	Risk Factors in Prevention	20 minutes	Lecture
3.	Protective Factors in Prevention	15 minutes	Lecture/Exercise
4.	Designing Prevention Programs	30 minutes	Exercise
5.	Model Programs	15 minutes	Lecture
6.	Optional Video	30 minutes	Video/Discussion
7.	Summary and Personal Assessment	5 minutes	Exercise

TOTAL TIME: **2 hours**

TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
ACTIVITY 1: **LECTURE** **5 minutes** **OVERHEAD 2.1** **MODULE II OBJECTIVES**	**Overview of Module II** Display overhead 2.1, "Module II Objectives." Review module objectives by reading and elaborating on each objective. Solicit participants' questions related to the objectives and respond to them as appropriate. Present an overview of the content and flow of module II, focusing on the key issues. Inform participants that they will: ● Discuss risk and protective factors in substance abuse prevention; ● Discuss model prevention programs; and ● Practice ways to address risk and incorporate protective factors into prevention program designs.
ACTIVITY 2: **LECTURE** **20 minutes** **OVERHEAD 2.2** **DEFINITION OF RISK FACTOR**	**Risk Factors in Prevention** Display overhead 2.2, "Definition of Risk Factor." Introduce this section about risk factors by noting that: ● A *risk factor* is an association between some characteristic or attribute of an individual, group, or environment and an increased probability of certain disorders or disease-related phenomena at some point in time. ● This section reviews literature relating to risk factors.

TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	• Given the right circumstances, almost anyone could develop a drug abuse problem at some time in their lives, but some individuals are more at risk than others.
	• Prevention approaches must address the risk factors of drug abuse to be effective.
	State that:
	• A number of research studies have found a number of risk factors related to substance abuse.
	• Those risk factors are found among individuals, peer groups, families, schools, and communities.
HANDOUT 2.1 RISK FACTORS RELATED TO SUBSTANCE ABUSE	Distribute handout 2.1, "Risk Factors Related to Substance Abuse," and display overhead 2.3, "Individual and Interpersonal Risk Factors."
OVERHEAD 2.3 INDIVIDUAL AND INTERPERSONAL RISK FACTORS	Review the following individual risk factors: • Genetic susceptibility; • Antisocial behavior in late childhood and early adolescence; • High sensation-seeking behavior; • Low self-esteem; • Favorable attitudes toward drug use; • Misperception of social disapproval and harmful consequences of drug abuse; • Low commitment to school; • Academic failure; • Low social bonding; • Conduct problems; • Aggressiveness; and • Shyness, alienation, and rebelliousness.

TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
OVERHEAD 2.4 PEER GROUP RISK FACTORS	Display overhead 2.4, "Peer Group Risk Factors." Review the following peer group risk factors: ● Bonding to a peer group that uses alcohol and drugs; ● Bonding to a peer group that engages in other delinquent activities; ● Social clique influence; ● Peer pressure; ● Deliberate selection of alcohol- or other drug-using peers; and ● Rejection in elementary school and friendship of other rejected children.
OVERHEAD 2.5 FAMILY RISK FACTORS	Display overhead 2.5, "Family Risk Factors." Review the following family risk factors: ● Family conflict; ● Coercive discipline style; ● Inconsistent parental discipline; ● Parental rejection (e.g., being an unwanted child); ● Lack of adult supervision/monitoring; ● Lack of family rituals (e.g., Thanksgiving family gatherings); ● Lack of extended family or support systems; ● Low level of family bonding; ● Poor family management or communication; ● Stress and dysfunction caused by death, divorce, incarceration of parent or low income; ● Sexual and physical abuse; ● Parental or sibling substance abuse; and ● Perceived parental permissiveness toward drug/alcohol use.

TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
OVERHEAD 2.6 SCHOOL RISK FACTORS	Display overhead 2.6, "School Risk Factors." Review the following school risk factors: • Lack of appreciation for school; • Academic failure; • Less school involvement, possibly because of poor school climate or discrimination; • Lack of opportunities for involvement and reward; • Norms conducive to use of drugs; • Lack of support from school environment/teachers; and • Low student/teacher morale.
OVERHEAD 2.7 COMMUNITY RISK FACTORS	Display overhead 2.7, "Community Risk Factors." Review the following community risk factors: • Not feeling a part of the community; • Being in a community that condones substance abuse; • Disorganized neighborhoods lacking active community institutions/leadership; • Lack of youth involvement in positive ways; • High rates of crime and substance abuse; • Poverty and lack of employment opportunities; • Availability of drugs and alcohol; • Stress from social situations; • Lack of economic mobility; • Lack of social supports; • High-population density; • Transient populations; and • Physical deterioration.

TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	Remind participants that:
	• This is a simplified presentation and contains only a partial list of risk factors identified by researchers.
	• Those who are interested in obtaining more information can read *Drug Abuse Prevention: What Works* which is part of this RDA set of materials.
ACTIVITY 3: LECTURE/EXERCISE **15 minutes** **(5 minutes)**	**Protective Factors in Prevention** Introduce this section about protective factors by noting that: • Recently, an additional emphasis is being placed on increasing protective factors and resilience to substance abuse in youth, particularly when youth live in high-risk environments where it would be difficult to reduce their exposure to risk factors. • Risk researchers have discovered that the more risk factors youth have, the more likely they are to abuse drugs; likewise, it is thought that the more protective factors youth have, the more likely they are not to use drugs.
OVERHEAD 2.8 DEFINITION OF PROTECTIVE FACTORS	Display overhead 2.8, "Definition of Protective Factors."

TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	Tell participants that:
	• *Protective factors* inoculate or protect persons and can strengthen their determination to reject or avoid substance abuse. Protective factors can inhibit self-destructive behaviors and situations that advance drug abuse.
	• Protective factors are not necessarily the opposite of risk factors.
PREPARED NEWSPRINT 2.1 PROTECTIVE FACTORS	Display prepared newsprint 2.1, "Protective Factors." Ask participants to suggest some protective factors. Make sure the list includes:
	• Family bonding; • Warm, supportive parent (or surrogate); • Positive peer relationships; and • Academic success.
OVERHEAD 2.9 DEFINITION OF RESILIENCY **(5 minutes)**	Display overhead 2.9, "Definition of Resiliency." Read the definition: • The ability to bounce or spring back into shape or position; the ability to recover strength or spirits quickly; or the ability to recover in the face of hardship or trouble. Divide the participants into groups of five to six. Ask them to create a list of qualities they would associate with a child who is resilient, that is, to create the profile of a resilient child.

TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	Ask each group to choose a facilitator who will report the group's responses to the large group. Tell them they will have 5 minutes for this exercise. After 5 minutes, call time.
PREPARED NEWSPRINT 2.2 THE RESILIENT PERSON **(5 minutes)**	Display prepared newsprint 2.2, "The Resilient Person." Ask each facilitator to give one item from their profile. Record their answers on newsprint. Repeat this process until the newsprint is full. Examples can include: ● Ability to solve problems; ● Ability to get along well with others; ● A sense of humor; ● Demonstration of empathy; ● A vision for the future; and ● Ability to make plans. Tell participants that: ● The study of protective factors and resilience has emerged from findings that some children who have been exposed to a variety of negative risk factors for substance abuse not only did not use drugs, they excelled in life areas. ● Research has shown that many of these children share common factors that include personality and temperament features. Remind participants that: ● Each person has the potential to be resilient.

TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	• It is important *not* to assume that resilience is a trait that will help the individual adapt to a variety of situations in different environments throughout his or her life. • Resilience may be more specific to circumstances, environment, and life problems. This means that a person who is resilient in one situation may not be resilient in a different situation, environment, or life stage.
OVERHEAD 2.10 RESILIENCY— PERSONALITY AND TEMPERAMENT FACTORS	Display overhead 2.10, "Resiliency—Personality and Temperament Factors." There are seven major personality and temperament factors that characterize increased resiliency in youth. They are: • Optimism; • Empathy; • Insight; • Intellectual competence; • Self-esteem; • Direction or mission; and • Determination and perseverance.
OVERHEAD 2.11 RESILIENCY—LIFE SKILLS	Display overhead 2.11, "Resiliency—Life Skills." State that the following major life skills are shown by resilient children: • Emotional management skills; • Interpersonal social skills; • Intrapersonal reflective skills; • Academic and job skills; • Ability to restore self-esteem; • Planning skills; and • Problem solving ability.

TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	State that: • More research studies are needed to identify resilience factors and processes more clearly and integrate this information with findings and other protective factors. • It is becoming increasingly evident that resilient youth are those with at least one significant person in their early lives who really cared for them and supported their positive development.
ACTIVITY 4: EXERCISE **30 minutes**	**Designing Prevention Programs** Introduce this section by stating that through direct experience, the prevention field has learned: • No one program or approach will stop all drug abuse. • Effective prevention approaches are tailored to each at-risk group and often designed with input from those involved. Inform participants that they now will have the opportunity to apply what they have learned. Divide the participants into five groups. Assign each group one of the following topics: • Individual • Family • Peer Group • School • Community

TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
PREPARED NEWSPRINT 2.3 INDIVIDUAL **PREPARED NEWSPRINT 2.4 PEER GROUP** **PREPARED NEWSPRINT 2.5 FAMILY** **PREPARED NEWSPRINT 2.6 SCHOOL** **PREPARED NEWSPRINT 2.7 COMMUNITY**	Distribute prepared newsprints 2.3, "Individual"; 2.4, "Peer Group"; 2.5, "Family"; 2.6, "School"; and 2.7, "Community,"—one to each group. Ask each group to choose a recorder who will report their information to the large group. Provide the following instructions: ● Each group should review the previous material about risk and protective factors and should brainstorm ideas about how to increase protective factors and decrease risk factors. ● Each group should record their ideas on their newsprint sheets. Participants might recommend specific programs or activities. ● Each group also should be prepared to explain how those programs or activities would increase protective factors and/or decrease risk. Tell them they will have 10 minutes for this exercise. After 10 minutes, call time. Reconvene the large group. Ask for a reporter to discuss one group's responses. Acknowledge that group's work. Continue until all five groups have reported. Summarize the information in the presentations.

TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	Encourage participants in their prevention programs to continue to ask how they can design programs and activities that will increase protective factors and decrease risk in individuals, peer groups, families, schools, and communities.
ACTIVITY 5: LECTURE **15 minutes**	**Model Programs** Tell participants that this section will highlight three drug abuse prevention programs that have been found to be effective. Although there are many prevention programs to choose from, this training focuses on these three because they represent the inclusion of risk and protective programming and because they represent the three categories of prevention approaches discussed in the previous module: universal, selected, and indicated.
OVERHEAD 2.12 UNIVERSAL PREVENTION	Display overhead 2.12, "Universal Prevention." Remind participants of the features of universal prevention: ● The mission of universal prevention is to delay or prevent the onset of substance abuse by providing all individuals with the information and skills to prevent the problem. ● All members of the population are targeted because they share the same general risk for substance abuse, although the risk may vary greatly among individuals. ● Universal programs are delivered to large groups without any prior screening for substance abuse risk. The degree of individual risk is not assessed.

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TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	● Participants are not recruited to participate.
	● The programs usually have lower staff-to-audience ratios than selective or indicated programs and may require less time and effort from the audience.
	● Staff members can be professionals from other fields, such as teachers or school counselors, who have been trained to deliver the program.
	● Costs are spread over a large group and tend to be lower on a per-person basis than selective or indicated programs.
OVERHEAD 2.13 PROJECT STAR	Display overhead 2.13, "Project STAR."
	Report the following:
	● Project STAR (Students Taught Awareness and Resistance) is an example of a community-based universal prevention program that has been implemented in both Kansas City, and in Indianapolis.
	● It is an integrated, multicomponent communitywide substance abuse prevention program for adolescent students in grades 7 and 8.
	● It is a broad-based prevention program that uses the school, family, and community environments as the launch points for prevention programming.

TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
)	• The programming is designed to reach large populations and is not suited to meet all the individual prevention needs of persons with high substance abuse vulnerability. • The program has five key elements: — A school-based program; — Media programming; — A parent program; — Community organization; and — Health policy change. • The Project STAR school program includes students, parents, school administrators, and teachers. • The support of school principals and school district personnel is critical to the implementation of the program. • Teachers participate in an extensive 3-day training session to acquaint them with Project STAR teaching methods. • Over a 2-year period, students participate in a 13-lesson core social influence curriculum the first year, followed by a 5-lesson booster curriculum the second year. Each lesson requires approximately 45 minutes of class time.

TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	• The media is used to introduce, promote, and reinforce the program's anti-drug-abuse message. The media provides the most effective way to communicate the prevention message throughout the community. This component begins at the same time as the school component and continues throughout Project STAR.
	• Parents are encouraged to participate by helping their children with homework assignments. The program includes a parent skills training to help parents support their children's drug-free behavior skills. Also, the program establishes a school-based parent organization that organizes activities, raises funds, and supports local policy changes.
	• The community component is the glue that holds Project Star together. It is designed to draw support from all sectors. Through the formation of a community task force and special subcommittees, the program addresses specific community needs.
	• The health policy component of Project STAR is the development and implementation of local health policies that affect alcohol, tobacco, and drug laws. Policy changes can include establishing drug-free school zones, stricter drunk driving laws, establishment of neighborhood watch groups, and drug-free workplace policies.
	• In both Kansas City and Indianapolis, Project STAR has reduced youth substance abuse and changed students' attitudes toward alcohol and drug use.

TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
OVERHEAD 2.14 SELECTIVE PREVENTION	Display overhead 2.14, "Selective Prevention." Remind participants of the features of selective prevention: ● Selective prevention is designed to delay or prevent drug abuse. ● Selective prevention programs target subgroups of the general population that are deemed to be at risk for substance abuse by virtue of their membership in a particular segment—for example, children of alcoholics, dropouts, or students who are failing academically. ● Recipients are known to have specific risks for substance abuse and are recruited to participate in the prevention effort because of that group's risk profile. ● The degree of individual risk is not assessed; vulnerability is presumed based on the individual's membership in the at-risk-group. ● Programs address specific risk factors of the subgroup. ● Selective prevention programs generally run for a longer period of time and require more time and effort from participants than do universal programs. ● They require skilled staff because they target multiproblem youth, families, and communities. ● The programs may be more expensive per person than universal programs because they require more time and effort.

TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	• The Program activities generally are more involved in the daily lives of the participants and attempt to change the participants in specific ways, for example, by increasing their communication skills.
OVERHEAD 2.15 THE STRENGTHENING FAMILIES PROGRAM	Display overhead 2.15, "The Strengthening Families Program."

Report the following:

• The Strengthening Families Program is a selective program that reduces risk factors through three key elements:

   — A parent skills training program;

   — A children's skills training program; and

   — A family skills training program.

• It targets 6- to 10-year-old children of substance abusers.

• It is designed to prevent the initial onset of substance abuse behaviors by children living in homes of substance abusing parents.

• The children are not individually assessed to be at-risk for substance abuse. They are presumed as a subgroup to be so because of their parents' history of substance abuse.

• The Strengthening Families Program was developed to help substance-abusing parents improve their parenting skills and reduce risk factors in their children. |

TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	• The program is presented in 14 weekly sessions, each lasting 2 to 3 hours.
	• In the first hour parents and children meet separately in groups. In the second hour parents and children meet together in the family skills training portion of the program. After the second hour, participants may meet for dinner and a speaker, film, or entertainment related to drug abuse prevention.
	• Since its inception, the program has been made culturally sensitive for African-American families, Asian/Pacific Islander families, and low socioeconomic status families, regardless of race or ethnicity.
	• Evaluations have shown that the program reduces family conflict, improves communication, improves youth behavior, decreases aggressiveness, and decreases depression.
OVERHEAD 2.16 INDICATED PREVENTION	Display overhead 2.16, "Indicated Prevention." Remind participants of the features of indicated prevention:
	• Indicated prevention programs target individuals who are experiencing early signs of substance abuse and other related problem behaviors, although they have not reached the point where a clinical diagnosis of substance abuse, as defined by DSM-III-R or DSM-IV, can be made.
	• Programs are designed to stem the progression of substance abuse and related disorders.

TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	• Programs require a precise assessment of an individual's personal risk and level of problem behaviors, rather than relying on the person's membership in an at-risk subgroup.
	• Individuals are specifically recruited for the program.
	• Individual risk factors and problem behaviors are specifically addressed by the program.
	• Programs can target multiple behaviors simultaneously.
	• Programs are frequently extensive and highly intensive. They typically operate for longer periods of time (months), at greater frequency (1 hour per day, 5 days a week), and require greater effort on the part of the participants than do universal or selective programs.
	• Programs require highly skilled staff that have clinical training and counseling or other clinical intervention skills.
	• Programs may be more expensive per person to operate than either universal or selective programs because they require more intensive work with individuals and small groups and more highly skilled staff.
OVERHEAD 2.17 THE RECONNECTING YOUTH PROGRAM	Display overhead 2.17, "The Reconnecting Youth Program."

TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES

	Report the following:
	
	 • Reconnecting Youth: A Peer Group Approach to Building Life Skills is an indicated school-based prevention program targeting youth in the 9th- through 12th-grades.
	
	 • Students are individually assessed and recruited and must meet criteria that address multiple risk factors such as substance abuse, school failure, depression, and suicide.
	
	 • There are three key elements of the Reconnecting Youth Program
	
	    — The Personal Growth Class (PGC) combines positive peer group support and life skills training in four topic areas. PGC was originally developed as a semester curriculum but has been modified for use as a yearlong course, if desired;
	
	    — Social activities and school bonding; and
	
	    — A school-system crisis response plan.
	
	 • Through daily 55-minute classroom sessions, which occur as part of the youth's school curriculum, students learn skills to improve their school performance and personal relationships and interact with a positive peer group struggling with the same life situations.
	
	 • An adult leader (trained teacher or counselor) guides students in developing new skills and, with the support of the peer group, offers hope and positive feedback as students explore solutions to their problems.

| TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	• The PGC life skills training consists of four units: — Self-esteem enhancement; — Decisionmaking; — Personal control; and — Interpersonal communications. • Students are given key concepts and strategies for improving specific skills. After receiving instructions on the skills, students are encouraged to apply the skills to real-life situations. Periodic booster activities reinforce understanding and use of the newly learned skills. • The social activities and school bonding program element is intended to teach students how to positively expand their recreational and social activities, develop friendships, work with others to solve problems, and practice the social skills they are taught in class. • The crisis-response plan addresses the potential for suicide or accidental death and other crisis situations. • Program evaluation indicates that exposure to the program increases school achievement and school bonding and significantly reduces adolescent drug abuse. Remind participants that this is a very simplified presentation about these model programs and those who are interested in obtaining more information can read *Drug Abuse Prevention: What Works*, which is part of this RDA set of materials.

TRAINING PLAN FOR MODULE II: DRUG ABUSE PREVENTION PROGRAMMING—WHAT WORKS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
ACTIVITY 6: VIDEO/DISCUSSION **30 minutes** *COMING TOGETHER ON PREVENTION* **VIDEO** **ACTIVITY 7: EXERCISE** **5 minutes** **OVERHEAD 2.1 MODULE II OBJECTIVES**	**Optional Video** Remind participants that each of these programs is described on a prevention video titled *Coming Together on Prevention*, which is available from *NCADI* (800-729-6680). Show the 26 minute video. **Summary and Personal Assessment** Display overhead 2.1, "Module II Objectives," and review module II learning objectives. Ask participants to make a personal assessment of what they have learned. Go around the room and ask each participant to state one thing that he or she has learned during this module. Introduce module III by telling them that the next session will present information about determining whether a community is ready to undertake a prevention program.

Module II Objectives

By the end of module II, participants will be able to:

• Identify at least three factors that increase risk for drug abuse

• Identify at least three factors that protect against risk of drug abuse

• Describe three model prevention programs and explain features that make them effective
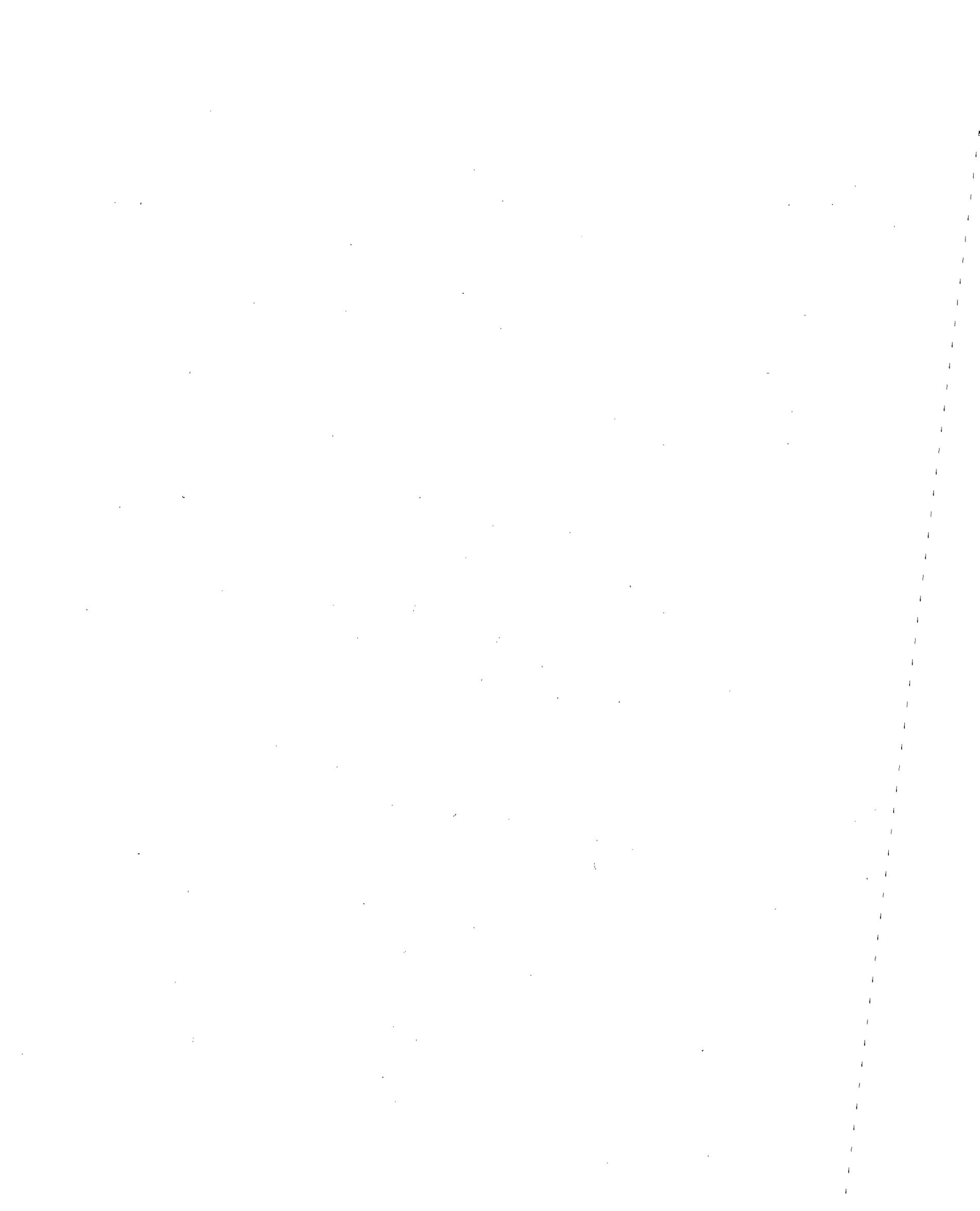
Definition of Risk Factor

A *risk factor* is an association between some characteristic or attribute of an individual, group, or environment and an increased probability of certain disorders or disease-related phenomena at some point in time.

Individual and Interpersonal Risk Factors

- Genetic susceptibility

- Antisocial behavior in late childhood and early adolescence

- High sensation-seeking behavior

- Low self-esteem

- Favorable attitudes toward drug use

- Misperception of social disapproval and harmful consequences of drug abuse

- Low commitment to school

- Academic failure

- Low social bonding

- Conduct problems

- Aggressiveness

- Shyness, alienation, and rebelliousness

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Peer Group Risk Factors

- Bonding to a peer group that uses alcohol and drugs

- Bonding to a peer group that engages in other delinquent activities

- Social clique influence

- Peer pressure

- Deliberate selection of alcohol- or other drug-using peers

- Rejection in elementary school

- Friendship of other rejected children

Family Risk Factors

- Family conflict

- Coercive discipline style

- Inconsistent parental discipline

- Parental rejection

- Lack of adult supervision/monitoring

- Lack of family rituals

- Lack of extended family or support systems

- Low levels of family bonding

- Poor family management or communication

- Stress and dysfunction caused by death, divorce, incarceration of parent, or low income

- Sexual and physical abuse

- Parental or sibling substance use

- Perceived parental permissiveness toward drug/alcohol use

School Risk Factors

- Lack of appreciation for school

- Academic failure

- Less school involvement

- Lack of opportunities for involvement and reward

- Norms conducive to use of drugs

- Lack of support from school environment/teachers

- Low student/teacher morale

Community Risk Factors

- Not feeling a part of the community

- Being in a community that condones substance abuse

- Disorganized neighborhoods lacking active community institutions/leadership

- Lack of youth involvement in positive ways

- High rate of crime and substance abuse

- Poverty and lack of employment

- Availability of drugs and alcohol

- Stress from social situations

- Lack of economic mobility

- Lack of social supports

- High-population density

- Transient populations

- Physical deterioration

Definition of Protective Factors

Protective factors inoculate or protect persons and can strengthen their determination to reject or avoid substance abuse. Protective factors can inhibit self-destructive behaviors and situations that advance substance abuse.
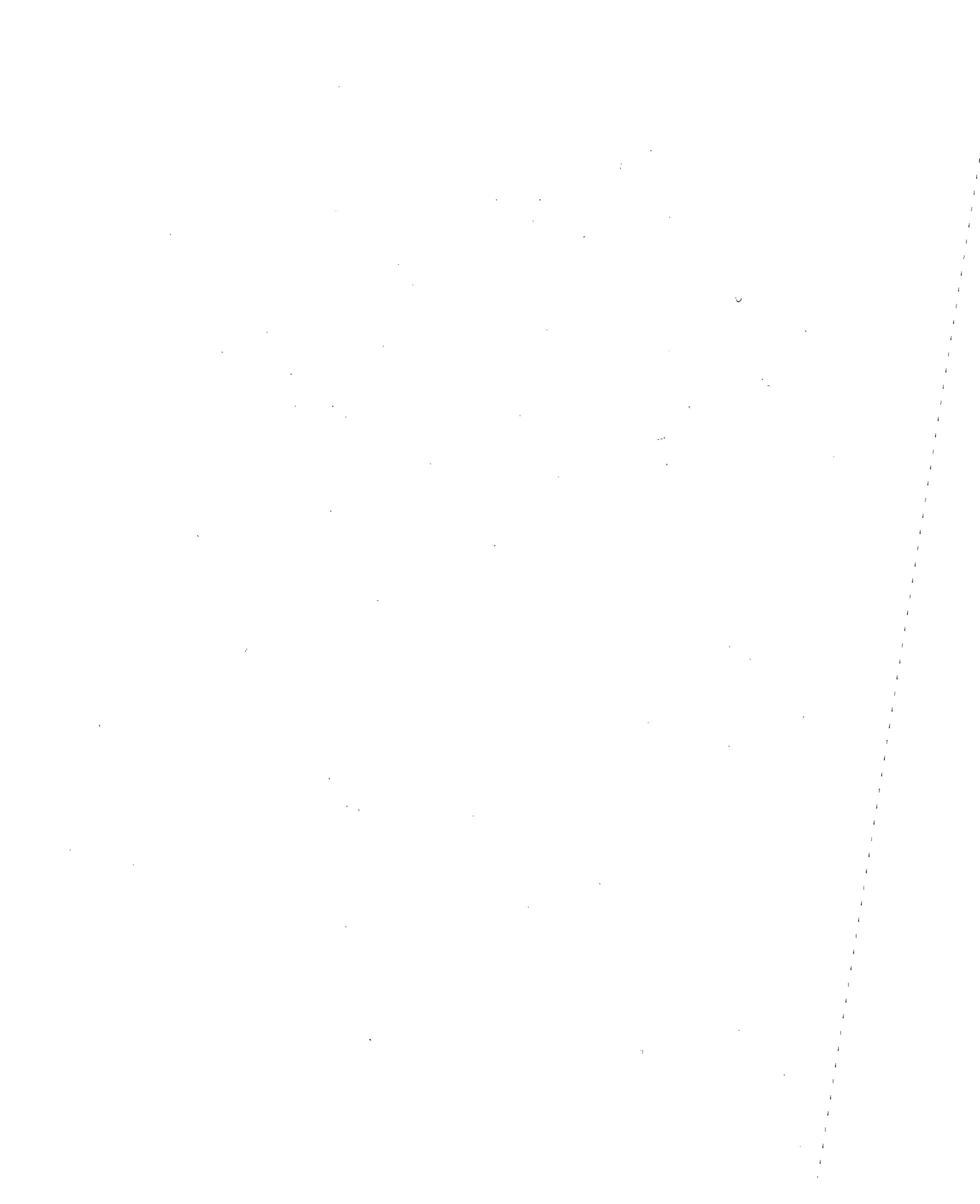
Definition of Resiliency

The ability to bounce or spring back into shape or position; the ability to recover strength or spirits quickly; or the ability to recover in the face of hardship or trouble.

Resiliency—Personality and Temperament Factors

- Optimism

- Empathy

- Insight

- Intellectual Competence

- Self-Esteem

- Direction or Mission

- Determination and Perseverance
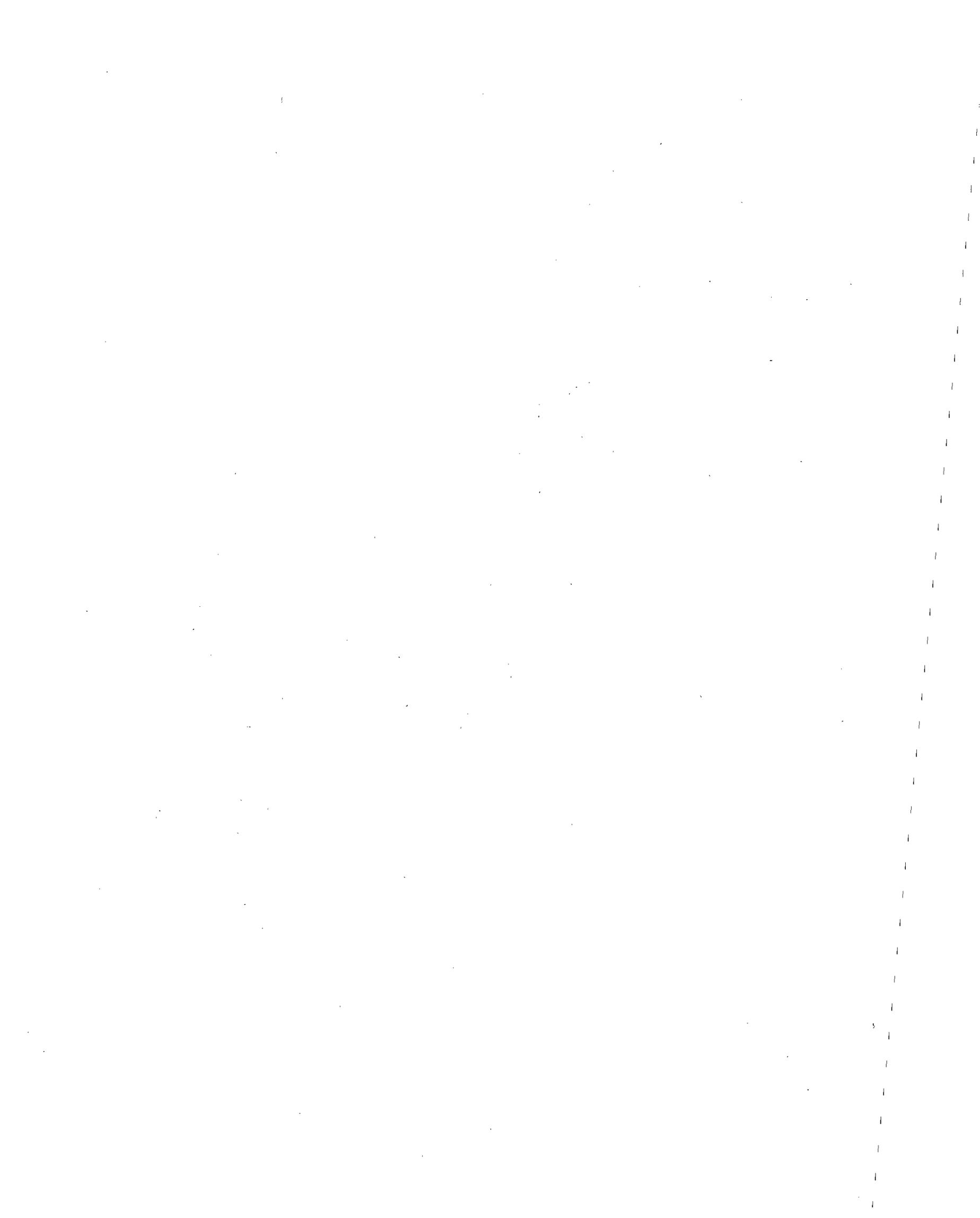
Resiliency—Life Skills

- Emotional Management Skills

- Interpersonal Social Skills

- Intrapersonal Reflective Skills

- Academic and Job Skills

- Ability to Restore Self-Esteem

- Planning Skills

- Problem Solving Ability

Universal Prevention

- Delay or prevent the onset of substance abuse.

- Target the entire population.

- All share the same general risk; individual risk is not assessed.

- Participants not recruited.

- Lower staff-to-audience ratios.

- Require less audience time and effort.

- Staff can be from many fields.

- Lower per-person costs.

Project STAR

- A community-based universal prevention program.

- A multicomponent communitywide program for early adolescent students in grades 7 and 8.

- Uses the school, family, and community environments as the launch points.

- Designed to reach large populations.

- Has five key elements:

  - A school-based program
  - Media programming
  - A parent program
  - Community organization
  - Health policy change.

- Includes students, parents, school administrators, and teachers.

Project STAR
(Continued)

- Teachers participate in a 3-day training session to acquaint them with Project STAR.

- Over a 2-year period, students participate in a 13-lesson core curriculum, followed by a 5-lesson booster curriculum.

- The media is used to introduce, promote, and reinforce the program's anti-drug message.

- The program also includes parent skills training and establishes a school-based parent organization.

- A community task force and special subcommittees address specific community needs.

- Participants develop and implement local health policies that affect alcohol, tobacco, and drug laws.

- Evaluation research suggests that exposure to the program has reduced adolescent use of tobacco, alcohol, and marijuana.
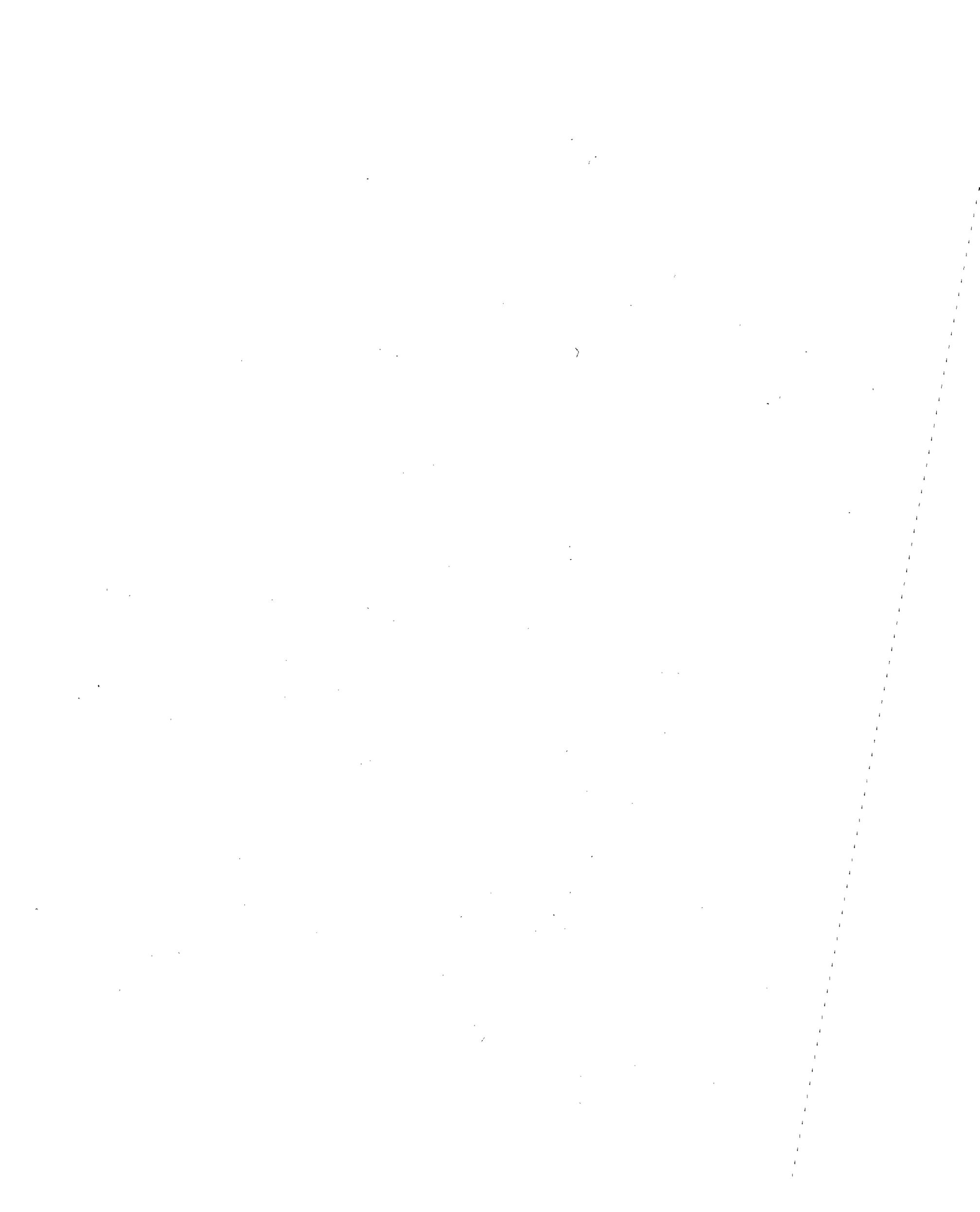
Selective Prevention

● Delay or prevent substance abuse.

● Selective prevention targets the entire subgroup regardless of their individual risk.

● The subgroup can be determined by a number of characteristics that significantly increase their risk of substance abuse.

● Recipients are recruited to participate.

● Programs address specific subgroup risk factors.

● Programs run for longer periods of time and usually require more participant time and effort then do universal programs.

● Programs require skilled staff.

● Costs of selective prevention programs are usually greater per person than those of universal prevention programs.

The Strengthening Families Program

- A family-focused selective prevention program that targets 6- to 10-year-old children of substance abusers.

- Designed to prevent onset of substance abuse behaviors by children.

- Children are not individually assessed for substance abuse risk.

- Developed to help substance-abusing parents improve their parenting skills and reduce risk factors in their children.

- Three key elements:

    — Parent skills training program;
    — Children's skills training program; and
    — Family skills training program.

- Presented in 14 weekly sessions, each lasting 2 to 3 hours.

- The program has been made culturally sensitive.

- Research indicates the program reduces family conflict, improves communication, improves youth behavior, decreases aggressiveness, and decreases depression.

Indicated Prevention

- Targets individuals experiencing early signs of substance abuse and other related problem behaviors, but without a clinical diagnosis.

- Stems the progression of substance abuse and related disorders.

- Recipients are individually assessed and recruited into the program.

- Risk factors and problem behaviors are specifically addressed by the program.

- Programs can target multiple behaviors simultaneously.

- Programs are extensive and intensive.

- Programs require highly skilled staff.

- Indicated prevention strategies may be more expensive on a per-person basis than are universal or selected prevention strategies.
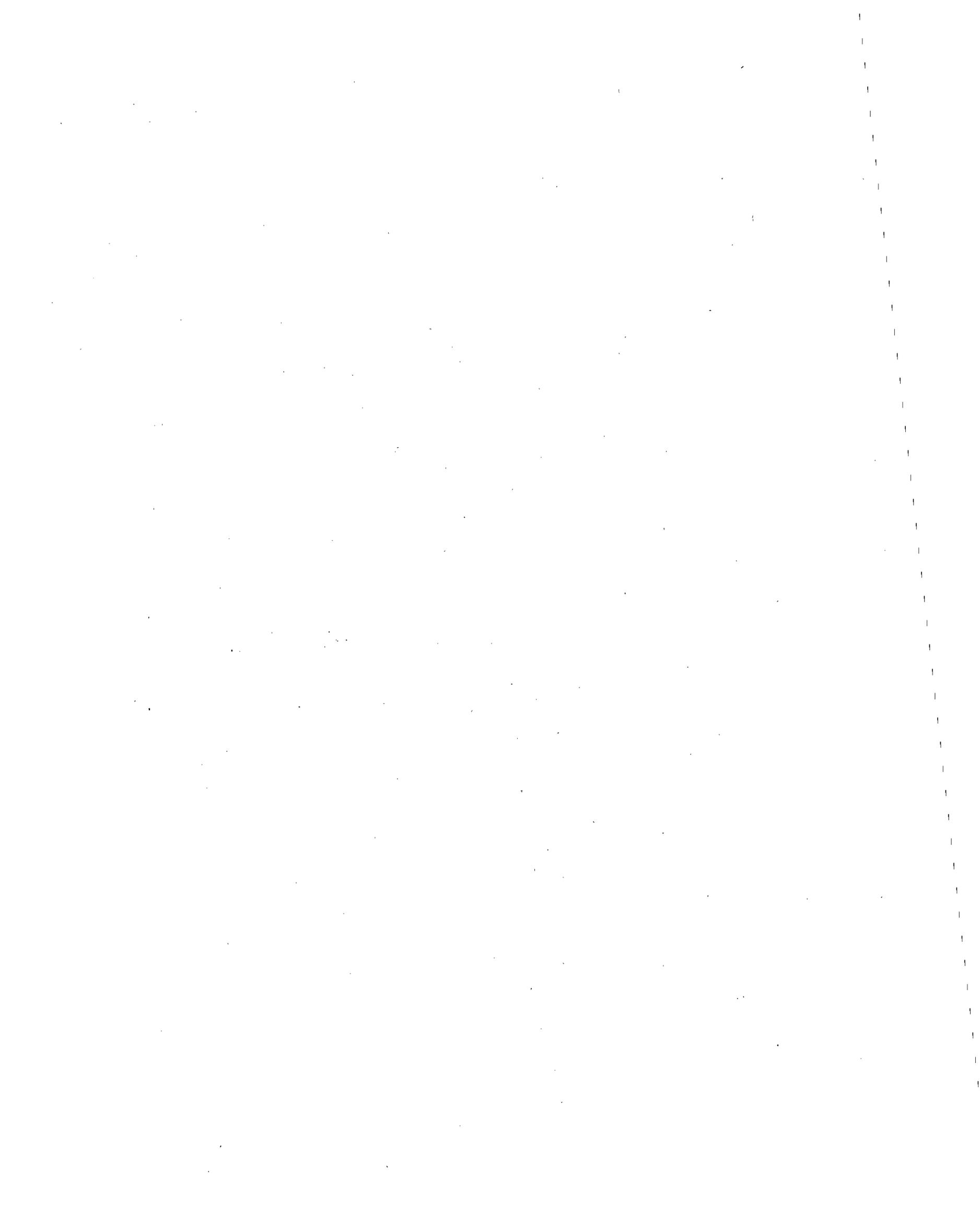
The Reconnecting Youth Program

- An indicated school-based prevention program that targets youth in the 9th- through 12th-grades.

- Students are individually assessed and recruited based on risk criteria such as substance abuse, school failure, depression, and suicide.

- Though in daily 55-minute classroom sessions, students learn skills to improve their school performance and personal relationships and interact with a positive peer group.

- An adult leader guides students and, with peer support, offers hope and positive feedback.

- The Reconnecting Youth Program has three key elements:

  — The Personal Growth Class (PGC) that combines positive peer group support and life skills training;
  — Social activities and school bonding; and
  — A school-system crisis response plan.

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The Reconnecting Youth Program
(Continued)

- PGC consists of four life skills training units:

  — Self-esteem enhancement;
  — Decisionmaking;
  — Personal control; and
  — Interpersonal communications.

- Students are given key concepts and strategies for improving specific skills

- Social activities and school bonding teach students how to expand recreational/social activities, develop friendships, work with others to solve problems, and practice social skills.

- The crisis-response plan addresses suicide or accidental death potential and other crisis situations.

- Program evaluation indicates that exposure to the program increases school achievement and bonding significantly reduces adolescent drug abuse.

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Risk Factors Related to Substance Abuse

1. **Individual and Interpersonal Risk Factors** include genetic susceptibility; antisocial behavior in late childhood and early adolescence; high sensation-seeking behavior; low self-esteem; favorable attitudes toward drugs; misperception of social disapproval and harmful consequences of drug abuse; low commitment to school; academic failure; low social bonding; conduct problems; aggressiveness; and shyness, alienation, and rebelliousness.

2. **Peer Group Risk Factors** include bonding to a peer group that uses alcohol and drugs and engages in other delinquent activities; social clique influence; peer pressure; deliberate selection of alcohol- or other drug-using peers; and rejection in elementary school and friendship of other rejected children.

3. **Family Risk Factors** include family conflict; coercive discipline style; inconsistent parental discipline; parental rejection (e.g., being an unwanted child); lack of adult supervision/monitoring; lack of family rituals (e.g., family gatherings); lack of extended family or support systems; low level of family bonding; poor family management or communication; stress and dysfunction caused by death, divorce, incarceration of parent, or low income; sexual and physical abuse; parental or sibling substance use; and perceived parental permissiveness toward drug/alcohol use.

4. **School Risk Factors** include lack of appreciation for school; academic failure; less school involvement possibly because of poor school climate or discrimination; lack of opportunities for involvement and reward; norms conducive to use of drugs; lack of support from school environment/teachers; and low student/teacher morale.

5. **Community Risk Factors** include not feeling a part of the community; being in a community that condones substance abuse; disorganized neighborhoods lacking active community institutions/leadership; lack of opportunities for youth involvement in positive ways; high rates of crime and substance abuse; poverty and lack of employment opportunities; availability of drugs and alcohol; stress from social situations; lack of economic mobility; lack of social supports; high population density; transient populations; and physical deterioration.

MODULE III: ASSESSING COMMUNITY READINESS FOR DRUG ABUSE PREVENTION PROGRAMMING

Overview

Communities most affected by drug abuse are often the least likely to have the elements in place to respond with appropriate interventions. A community overwhelmed by drug abuse and other problems often finds it difficult or impossible to raise hope for improvement, willingness to act, or resources for the effort. However, the potential for successful intervention lies in every community. Therefore, it is imperative that the prevention specialist understand and have the skills to assess community readiness.

This module will train participants to assess a community's readiness to implement drug abuse prevention programming. Participants will learn what essential factors determine whether a community is ready to intervene in existing drug abuse problems. If any of these essential factors is missing, a community's chances for successfully meeting its program goals and objectives are lessened.

Time Needed:	1 hour and 25 minutes		
Materials:	Lecture (30 minutes) Exercise (45 minutes) Discussion (10 minutes)		
Goal:	To train participants to assess a community's readiness to implement drug abuse prevention programming.		
Objectives:	By the end of module III, participants will be able to: ● List nine stages of readiness in order; ● Describe the process for assessing a community's readiness; and ● Given simulated information about a hypothetical community, determine its stages of readiness and recommend a course of action appropriate to that stage.		

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Key Points:	• A community's readiness to initiate effective drug abuse prevention depends on the seriousness of the problem, the existence of community barriers, and community norms regarding substance abuse.
	
	• Dr. Eugene Oetting at the Tri-Ethnic Center in Colorado and his staff have identified nine - developmental stages through which communities evolve:
	
	    — Community Tolerance
	    — Denial
	    — Vague Awareness
	    — Preplanning
	    — Preparation
	    — Initiation
	    — Institutionalization
	    — Confirmation/Expansion
	    — Professionalization
	
	• A community's stage of readiness can be determined by interviewing key informants and posting their comments on a set of six validated scales.
	
	• Identifying the stage of readiness can help program designers determine what goals or strategies to undertake first, thus improving the chances of success and minimizing costs.

Materials Needed:	• Newsprint and easel • Markers • Masking tape • Notepads and pencil • Overhead projector • Screen • Overhead transparencies • Exercise materials: Simulated Information and Worksheets • Handouts • Watch

Overhead Transparencies:		3.1	Module III Objectives
	●	3.2	Community Readiness
	●	3.3	Stages of Readiness
	●	3.4	Readiness Assessment Process
Handouts:	●	3.1	Nine Stages of Readiness
	●	3.2	Key Informants Interview Questionnaire
	●	3.3	Readiness Descriptive Statement
	●	3.4	Appropriate Strategies for Each Stage of Readiness
	●	3.5	Readiness Exercise
	●	3.6	Readiness Rating Form
	●	3.7	Prevention Programming Personal Case Study—Part Three

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SCHEDULE FOR MODULE III: ASSESSING COMMUNITY READINESS FOR DRUG ABUSE PREVENTION PROGRAMMING

	Activity	Time	Methodology
1.	Overview of Module III	5 minutes	Lecture
2.	Community Readiness	15 minutes	Lecture
3.	Assessing Community Readiness	45 minutes	Exercise
4.	Group Reports	10 minutes	Discussion
5.	Summary and Personal Case Study	10 minutes	Lecture/ Individual Activity

TOTAL TIME: **1 hour and 25 minutes**

TRAINING PLAN FOR MODULE III: ASSESSING COMMUNITY READINESS FOR DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
ACTIVITY 1: LECTURE 5 minutes OVERHEAD 3.1 MODULE III OBJECTIVES	Overview of Module III Display overhead 3.1, "Module III Objectives." Review and elaborate on each objective. Solicit questions from participants and answer them as appropriate. Inform participants that they will learn: ● Why it is important to assess community readiness before launching a new drug abuse prevention effort; ● Nine developmental stages through which communities often evolve; ● A process for assessing readiness; and ● Which strategies are more important at each stage of development.
ACTIVITY 2: LECTURE 15 minutes OVERHEAD 3.2 COMMUNITY READINESS	Community Readiness Display overhead 3.2, "Community Readiness." Tell participants that: ● Community readiness is the extent to which a community is adequately prepared to implement a prevention effort, that is, the extent to which community leaders are available to take the necessary actions to prevent substance abuse.

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TRAINING PLAN FOR MODULE III: ASSESSING COMMUNITY READINESS FOR DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	● Community readiness for prevention programming exists when there is some consensus that a program is needed, support exists for a program, and resources for implementing a program exist. These factors will be discussed in more detail in module IV. This module will focus on stages of readiness.
	● There is widespread agreement among practitioners that a community's readiness is a deciding factor in the success of prevention programs, and some research supports this belief.
OVERHEAD 3.3 STAGES OF READINESS	Display overhead 3.3, "Stages of Readiness," and distribute handout 3.1, "Nine Stages of Readiness."
HANDOUT 3.1 NINE STAGES OF READINESS	Tell participants that: ● Dr. Eugene Oetting and his colleagues at the Tri-Ethnic Center in Colorado have, through extensive research funded by NIDA, identified nine stages of readiness through which prevention programs may evolve. They are: — Stage 1: Community Tolerance In this stage, community norms actively support substance abuse, although the behavior may be expected of one group and not others (e.g., by social class, race, or age).

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TRAINING PLAN FOR MODULE III: ASSESSING COMMUNITY READINESS FOR DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	— Stage 2: Denial
	Although there is recognition that substance abuse can be a problem, there is no recognition of a local problem or any belief that anything needs to be done locally.
	— Stage 3: Vague Awareness
	There is awareness that a local problem exists but no strong motivation to do anything about it.
	— Stage 4: Preplanning
	There is recognition that there is a local problem and some information about the nature and extent of the problem.
	— Stage 5: Preparation
	There is recognition of a problem, and efforts are under way to implement a program. There are committed individuals, a program may have started, and funding is being sought.
	— Stage 6: Initiation
	A program is under way but still may have weaknesses.
	— Stage 7: Institutionalization
	A program is in place and running, the community supports it, and it is widely accepted as a valuable activity.

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TRAINING PLAN FOR MODULE III: ASSESSING COMMUNITY READINESS FOR DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	— Stage 8: Confirmation/Expansion Programs are in place and have the full support of local authorities including funding for routine data collection, a knowledge base of effective strategies, and trained staff. — Stage 9: Professionalization There are detailed and sophisticated data on the local problem. Programs are designed to target different population segments and to address different aspects of the problem. There is widespread support from all corners of the community and highly trained staff.
OVERHEAD 3.4 READINESS ASSESSMENT PROCESS HANDOUT 3.2 KEY INFORMANTS INTERVIEW QUESTIONNAIRE HANDOUT 3.3 READINESS DESCRIPTIVE STATEMENTS HANDOUT 3.4 APPROPRIATE STRATEGIES FOR EACH STAGE OF READINESS	Display overhead 3.4, "Readiness Assessment Process," and distribute handout 3.2, "Key Informants Interview Questionnaire"; handout 3.3, "Readiness Descriptive Statements"; and handout 3.4, "Appropriate Strategies for Each Stage of Readiness." Dr. Oetting's group has developed and validated a simple process for assessing community readiness. It involves three steps: 1. Identify key informants, preferably including: ● A school counselor; ● A community authority (e.g., mayor); ● A local media representative, preferably a newspaper editor; and ● A community leader in the area of drug abuse prevention.

TRAINING PLAN FOR MODULE III: ASSESSING COMMUNITY READINESS FOR DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	2. Schedule and conduct interviews with each of the key informants, and interview them using the questions in handout 3.2. Allow several weeks to schedule and complete the interviews.
	3. Get together with colleagues and rate responses on the six sets of descriptive statements provided in handout 3.3.
	• Prevention programming; • Knowledge about prevention programming; • Leadership; • Knowledge about the problem; • Funding for prevention; and • Community climate.
	For each of these six readiness dimensions, there is a corresponding set of readiness descriptive statements—each of the nine statements is linked to the nine stages of readiness. For each dimension, the team finds the statement that most closely describes the responses of key informants to dimension-specific questions in the Key Informants Interview Questionnaire.
	Note that the set(s) of descriptive statements to use for each question is (are) indicated in parentheses on the questionnaire. There is normally considerable consistency among the responses given by key informants in a community and among the scales.
	After the stage of readiness has been determined, the next step is to decide what to do. Handout 3.4 summarizes the goals and strategies that are most suitable at each stage. Modules IV and V cover this in more detail.

TRAINING PLAN FOR MODULE III: ASSESSING COMMUNITY READINESS FOR DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
ACTIVITY 3: EXERCISE **45 minutes** **HANDOUT 3.5 READINESS EXERCISE** **HANDOUT 3.6 READINESS RATING FORM**	**Assessing Community Readiness** Divide participants into four to five groups of four to five people each, and distribute handout 3.5, "Readiness Exercise," and enough copies of handout 3.6, "Readiness Rating Form," for each group to rate each key informant interview. Instruct participants to review the materials, which include simulated responses from key informants in a hypothetical community, and to rate the responses as a group. Rating each interview on handout 3.6, each group should determine the level of readiness for each of the six dimensions using the readiness descriptive statements in handout 3.3. Ask each group to determine the community's stage of readiness, based on the responses and corresponding ratings. In addition, using handout 3.4, each team should decide what strategy the community should pursue. Ask each team to select a spokesperson to present the team's conclusions to the large group.
ACTIVITY 4: DISCUSSION **10 minutes**	**Group Reports** Reconvene the group and ask each small group to report. Ask groups to report on: 1. The community's stage of readiness; and 2. The most appropriate course of action.

| TRAINING PLAN FOR MODULE III: ASSESSING COMMUNITY READINESS FOR DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	The stage of readiness is most likely "2. Denial." The most appropriate next step would probably be to educate community leaders through one-on-one meetings where local incidents that illustrate the harmful consequences of substance abuse are discussed. Tell participants that: ● Oetting's work is but one model of defining and assessing community readiness. Other researchers have also been looking at these concepts. ● For example, Dr. Abraham Wandersman at the University of South Carolina has developed a key leader's survey described in the *Community Readiness: Issues, Tips and Tools* document which is part of this RDA core package.
ACTIVITY 5: LECTURE/INDIVIDUAL ACTIVITY **10 minutes** **HANDOUT 3.7 PREVENTION PROGRAMMING PERSONAL CASE STUDY—PART THREE**	**Summary and Personal Case Study** Distribute handout 3.7, "Prevention Programming Personal Case Study—Part Three," and ask participants to apply the readiness assessment process they have just learned to the case study they started in module 1. They should answer questions 10 through 14 and decide (1) whom they would have selected as key informants, (2) the probable responses key informants would have given if interviewed, (3) the community's probable stage of readiness, and (4) the most appropriate course of action.

TRAINING PLAN FOR MODULE III: ASSESSING COMMUNITY READINESS FOR DRUG ABUSE PREVENTION PROGRAMMING	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
OVERHEAD 3.1 MODULE III OBJECTIVES	Display overhead 3.1, "Module III Objectives," and review module III learning objectives.
	Ask participants to make a personal assessment of what they have learned. Go around the room and ask each participant to state one thing that he or she has learned during this module.
	Explain that in the next module, participants will be introduced to seven specific factors that contribute to readiness.

Module III Objectives

By the end of module III, participants will be able to:

- List nine stages of readiness in order;

- Describe the process for assessing a community's readiness; and

- Given simulated information about a hypothetical community, determine its stage of readiness and recommend a course of action appropriate to that stage.
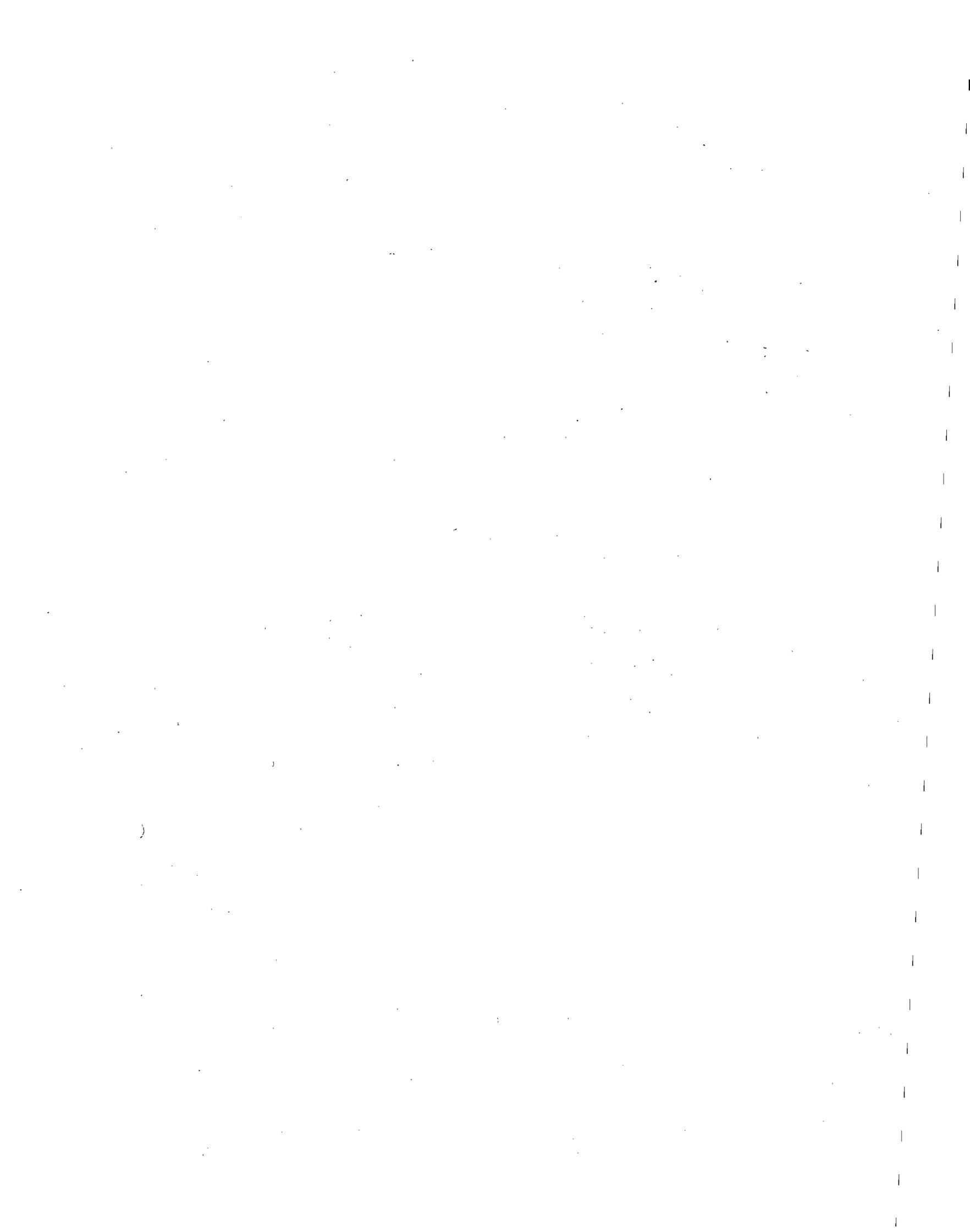
Community Readiness

Community readiness is the extent to which a community is adequately prepared to implement a prevention effort, that is, the extent to which community leaders are available to take the necessary actions to prevent substance abuse.

Stages of Readiness

1. Community Tolerance

2. Denial

3. Vague Awareness

4. Preplanning

5. Preparation

6. Initiation

7. Institutionalization

8. Confirmation/Expansion

9. Professionalization

Readiness Assessment Process

1. Identify key informants

2. Interview key informants

3. Rate responses

Nine Stages of Community Readiness

Stage 1: Community Tolerance

Community norms actively tolerate or encourage the behavior, although the behavior may be expected of one group and not another (e.g., by gender, race, social class, or age). The behavior, when occurring in the appropriate social context, is viewed as acceptable or as part of the community norm. Those who do not engage in the behavior may be tolerated but might be viewed as somewhat deviant.

Stage 2: Denial

There is usually recognition that the behavior is or can be a problem. Community norms usually would not approve of the behavior, but there is little or no recognition that this might be a local problem. If there is some idea that it is a problem, there is a feeling that nothing needs to be done about this locally or that nothing can be done about it.

Stage 3: Vague Awareness

There is a general belief that there is a local problem and that something ought to be done about it. Knowledge about local problems tends to be stereotypical and vague or linked only to a specific incident or two. There is no immediate motivation to do anything. No identifiable leadership exists, or leadership lacks energy or motivation.

Stage 4: Preplanning

There is clear recognition that there is a local problem and that something should be done about it. There is general information about local problems, but ideas about etiology or risk factors tend to be stereotyped. There are identifiable leaders, and there may be a committee, but no real planning.

Stage 5: Preparation

Planning is going on and focuses on practical details. There is general information about local problems and about the pros and cons of prevention programs, but it may not be based on formally collected data. Leadership is active and energetic. The program may have started on a trial basis. Funding is being actively sought or has been committed.

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Stage 6: Initiation

Enough information is available to justify a prevention program, but knowledge of risk factors is likely to be stereotyped. A program has been started and is running, but it is still on trial. Staff are in training or just have finished with training. There may be great enthusiasm because limitations and problems have not yet been experienced.
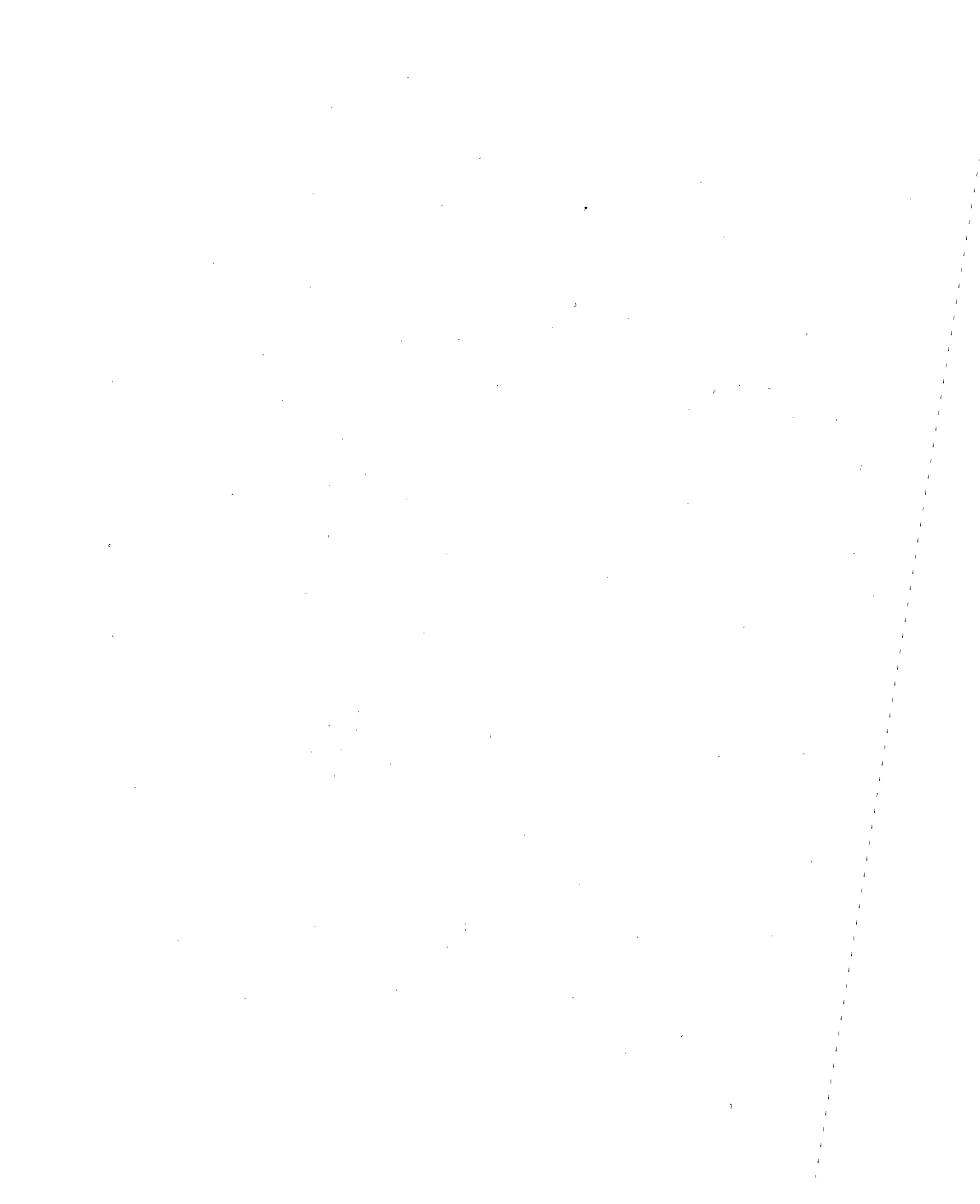
Stage 7: Institutionalization

One or two programs are running, supported by administration, and accepted as a routine and valuable activity. Staff are trained and experienced. There is little perceived need for change or expansion. Limitations may be known, but there is not much sense that the limitations suggest a need for change. There may be some form of routine tracking of prevalence. There is not necessarily permanent funding, but there is established funding that allows the program the opportunity to implement its action plan.

Stage 8: Confirmation/Expansion

Standard programs are viewed as valuable, and authorities support expanding or improving programs. New programs are being planned or tried out to reach more people, those thought to be more at risk or in different demographic groups. Funds for new programs are being sought or are committed. Data are obtained regularly on the extent of local problems, and efforts are made to assess risk factors and the causes of the problem.

Stage 9: Professionalization

Detailed and sophisticated knowledge of prevalence, risk factors, and etiology exists. Some programs may be aimed at general populations, whereas others may be targeted at specific risk factors and/or at-risk groups. Highly trained staff are running programs, authorities are supportive, and community involvement is high. Effective evaluation is used to test and modify programs.

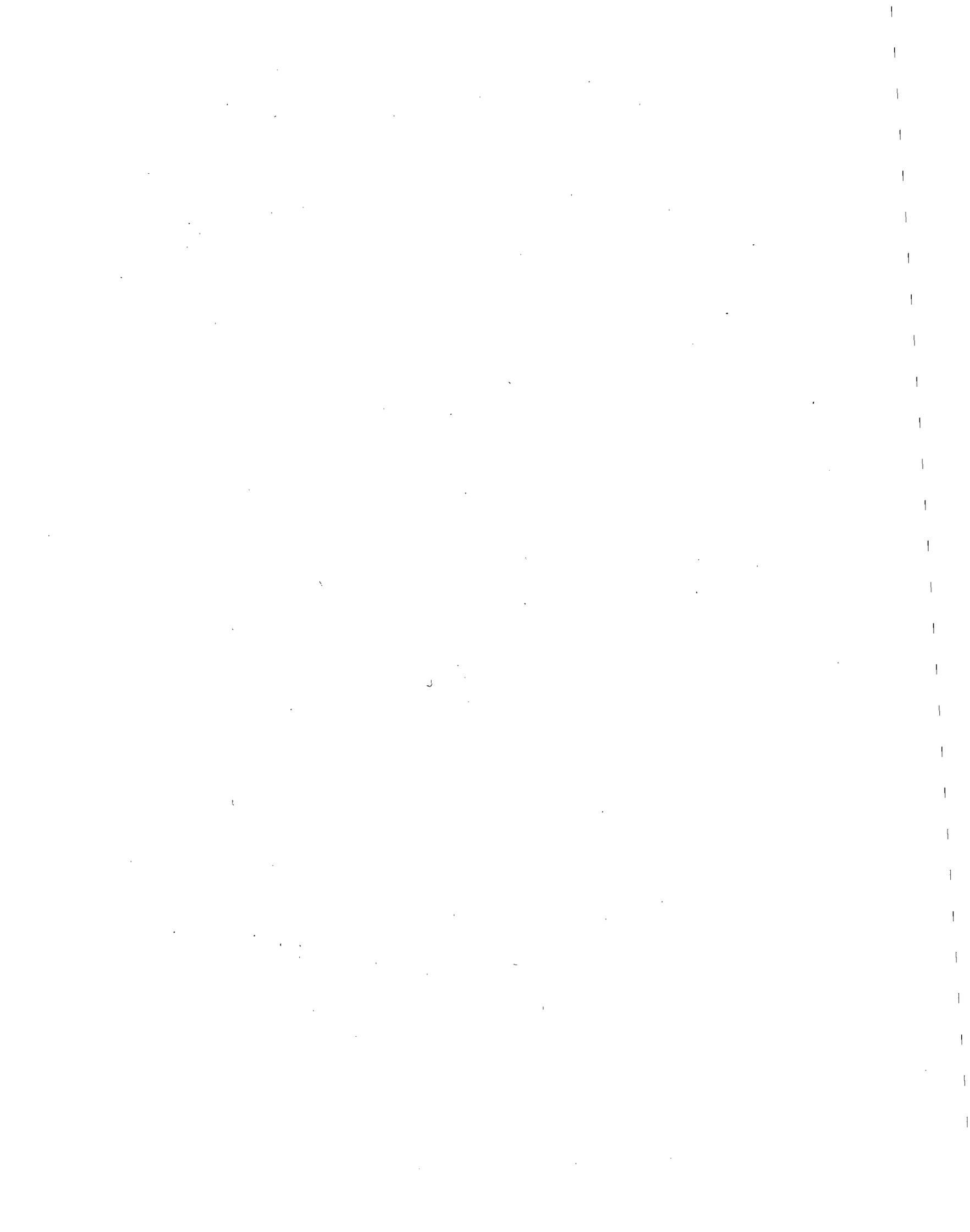## Key Informants Interview Questionnaire

Readiness Dimensions

1. PREVENTION PROGRAMMING

2. KNOWLEDGE ABOUT PREVENTION PROGRAMS

3. LEADERSHIP

4. KNOWLEDGE ABOUT THE PROBLEM

5. FUNDING FOR PREVENTION

6. COMMUNITY CLIMATE

Questions (Numbers in parentheses indicate the program dimension(s) above to which each question relates.)

1. What types of substance aubse prevention programs or activities have occurred in your community? (1&2)

   a. How long have these programs been in your community? (1&2)

   b. Who is served by these programs? (1&2)

   c. Is there a need to expand these services? If no, why not? (1&2)

   d. Are there plans to expand? If yes, what are the plans? (1&2)

   e. How are these programs viewed by the community? (2&6)

2. What is the general attitude about substance abuse in your community? (3,4,&6)

   a. Does the community see substance abuse as a problem? (3,4,&6)

   b. Would or does the community support a prevention plan? If yes, how? (3&6)

   c. Are the leaders in your community involved in prevention efforts (list)? (3)

   d. What community organizations have a focus on prevention? (3)

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3. Is there information available on local substance abuse prevalence? If yes, from whom? (4)

4. How is that information disseminated? And to whom? (4)

5. Who provides funding for these programs, and how long will it continue? (5)

6. What is the community's attitude/belief about funding prevention programs? (5&6)

7. Is your community aware of the costs of running a prevention program? (4&5)

8. Are you aware of any proposals that have been written that address the issue of prevention? (5)

   Are any funded or waiting? (5)

9. Is the lack of community involvement a major obstacle in your prevention efforts? (6)

10. Is there a sense of apathy or hopelessness among community members regarding substance abuse? (6)

11. What are the primary obstacles to prevention efforts in your community? (6)

12. What is the next step your community needs to take in the area of prevention? (general—all 6 dimensions)

READINESS DESCRIPTIVE STATEMENTS

1. PREVENTION PROGRAMMING

Level 1.   No plans for prevention are likely in the near future.

Level 2.   No plans for prevention are likely in the near future.

Level 3.   There aren't any immediate plans, but will probably do something sometime.

Level 4.   There have been community meetings or staff meetings, but no final decisions have been made about what we might do.

Level 5.   One or more programs are being planned and staff are being selected and trained for them.

Level 6.   One or more prevention programs are being tried out now.

Level 7.   One or more programs have been running for several years and are fully expected to run indefinitely, no specific planning for anything else.

Level 8.   Several different programs in both the community and schools are running, covering different age groups and reaching a wide range of people.

Level 9.   Evaluation plans are routinely used to test effectiveness of many different programs, and the results are being used to change and improve programs constantly.
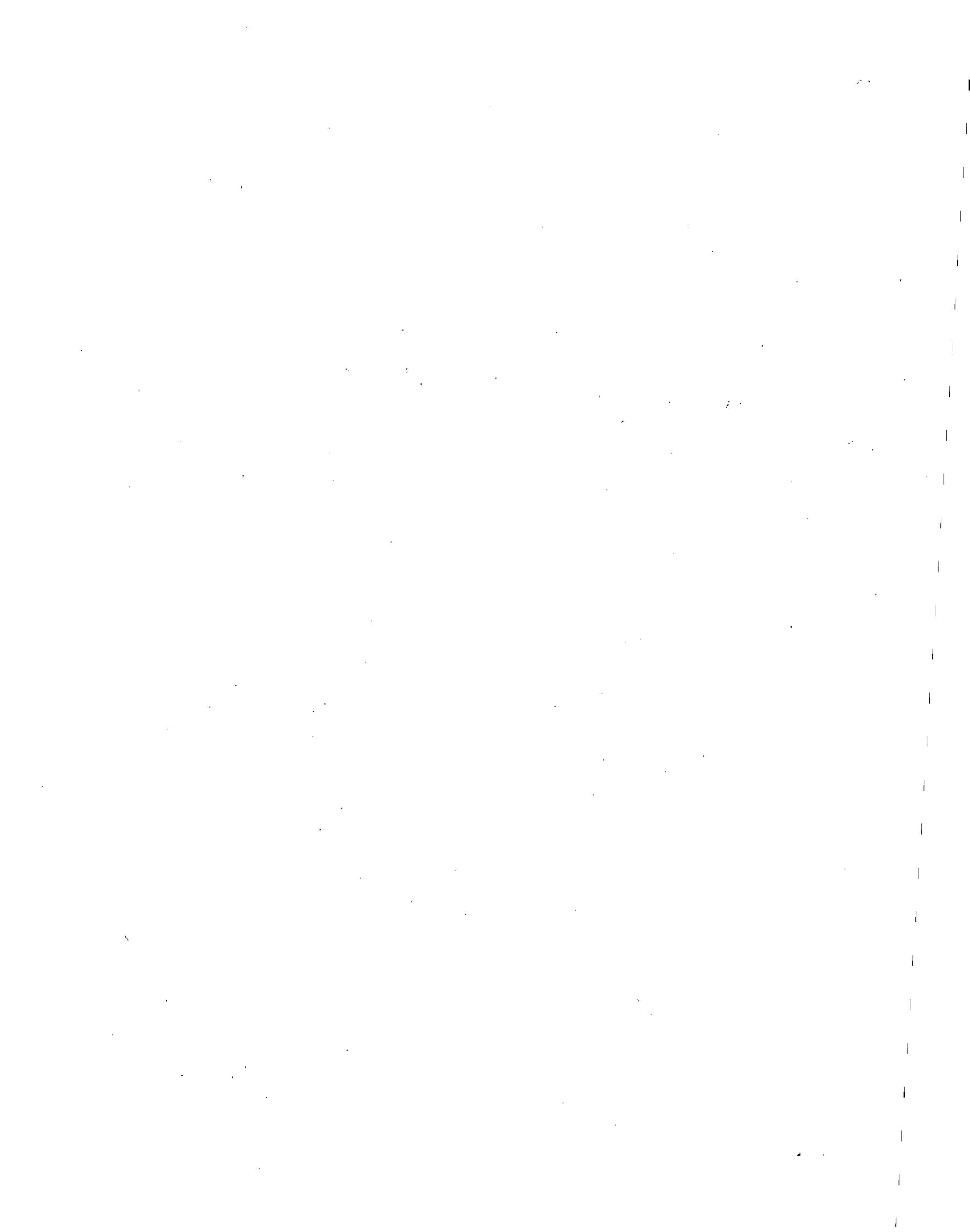
READINESS DESCRIPTIVE STATEMENTS

2. KNOWLEDGE ABOUT PREVENTION PROGRAMS

Level 1.   No knowledge about prevention program.

Level 2.   No knowledge about prevention program.

Level 3.   Heard about prevention programs, but no real information about what is done in the programs or how it is done.

Level 4.   Some leaders are actively seeking information about prevention programs.

Level 5.   Program staff know generally about the content of standard program, who runs them and who the clients would be.

Level 6.   Program staff have an exaggerated belief in the effectiveness of a local program, or stereotyped general belief without supporting data that a program is a failure.

Level 7.   Program staff have specific knowledge of local programs or programs including staffing, training of staff, clients involved, etc., but minimal awareness of need for other programs.

Level 8.   Program staff have considerable knowledge about a variety of different programs that are being run.

Level 9.   Program staff have accurate knowledge about how well local programs are working, their benefits and limitations; a lot of information about programs aimed at other age groups or risk groups.
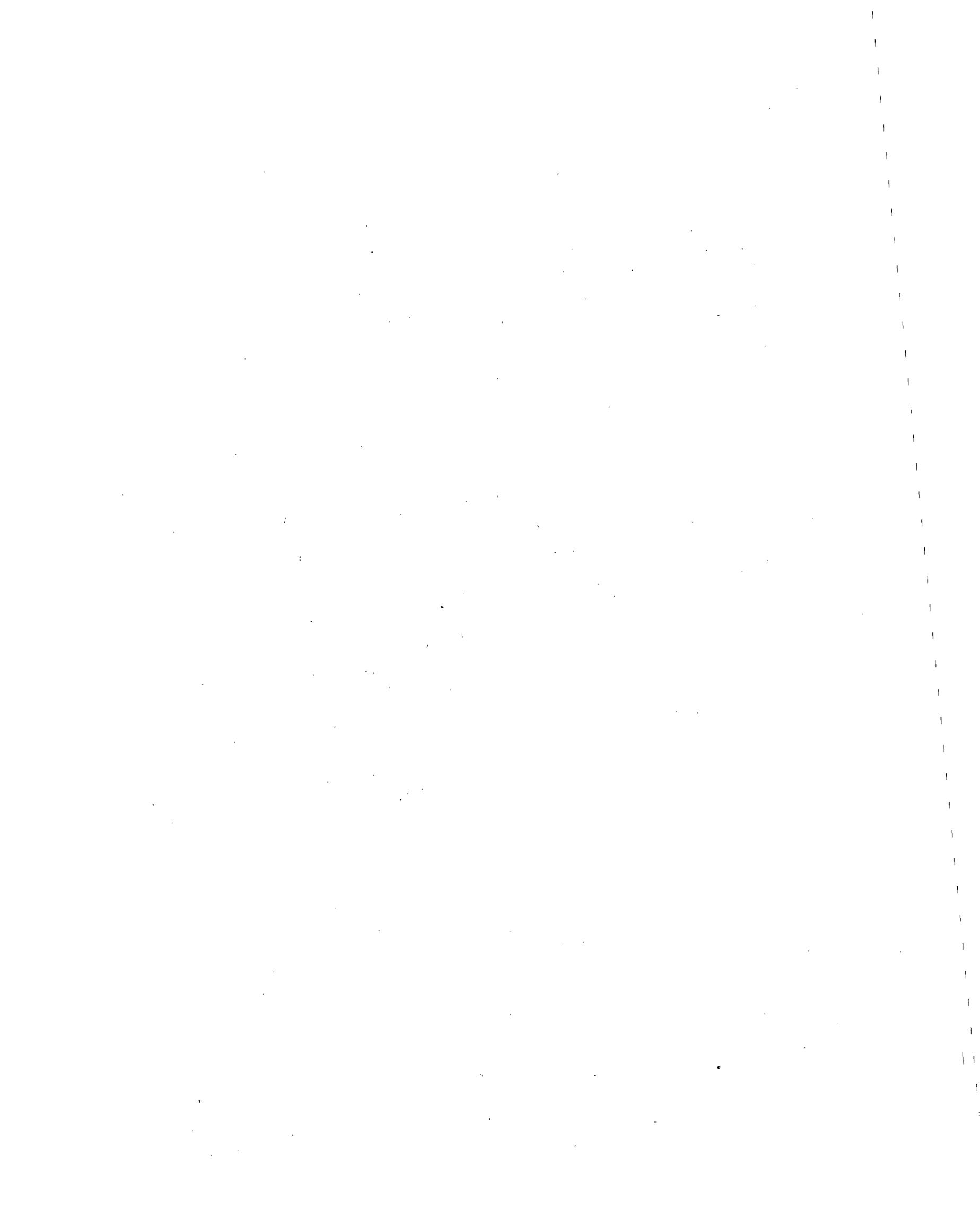
READINESS DESCRIPTIVE STATEMENTS

3. LEADERSHIP

Level 1.   No evidence of potential leadership, in relation to the problem.

Level 2.   No evidence of potential leadership, in relation to the problem.

Level 3.   People have talked about doing something, but so far there is no one who has really "taken charge." There may be a few concerned people, but they are not influential.

Level 4.   There are identifiable leaders who are trying to get something started, a meeting or two may have been held to discuss problems.

Level 5.   Leaders and others have been identified; a committee or committees have been formed and are meeting regularly to consider alternatives and make plans.

Level 6.   Program or programs are being run and supported by their own groups or committees; little coordination or overall planning.

Level 7.   School authorities and political leaders are solid supporters of a continuing basic program.

Level 8.   School authorities, program staff and community groups are generally supportive of existing programs and of extending efforts to reach other people.

Level 9.   School authorities support programs, staff are highly trained, community leaders and volunteers are involved with programs and an independent evaluation team is functioning.
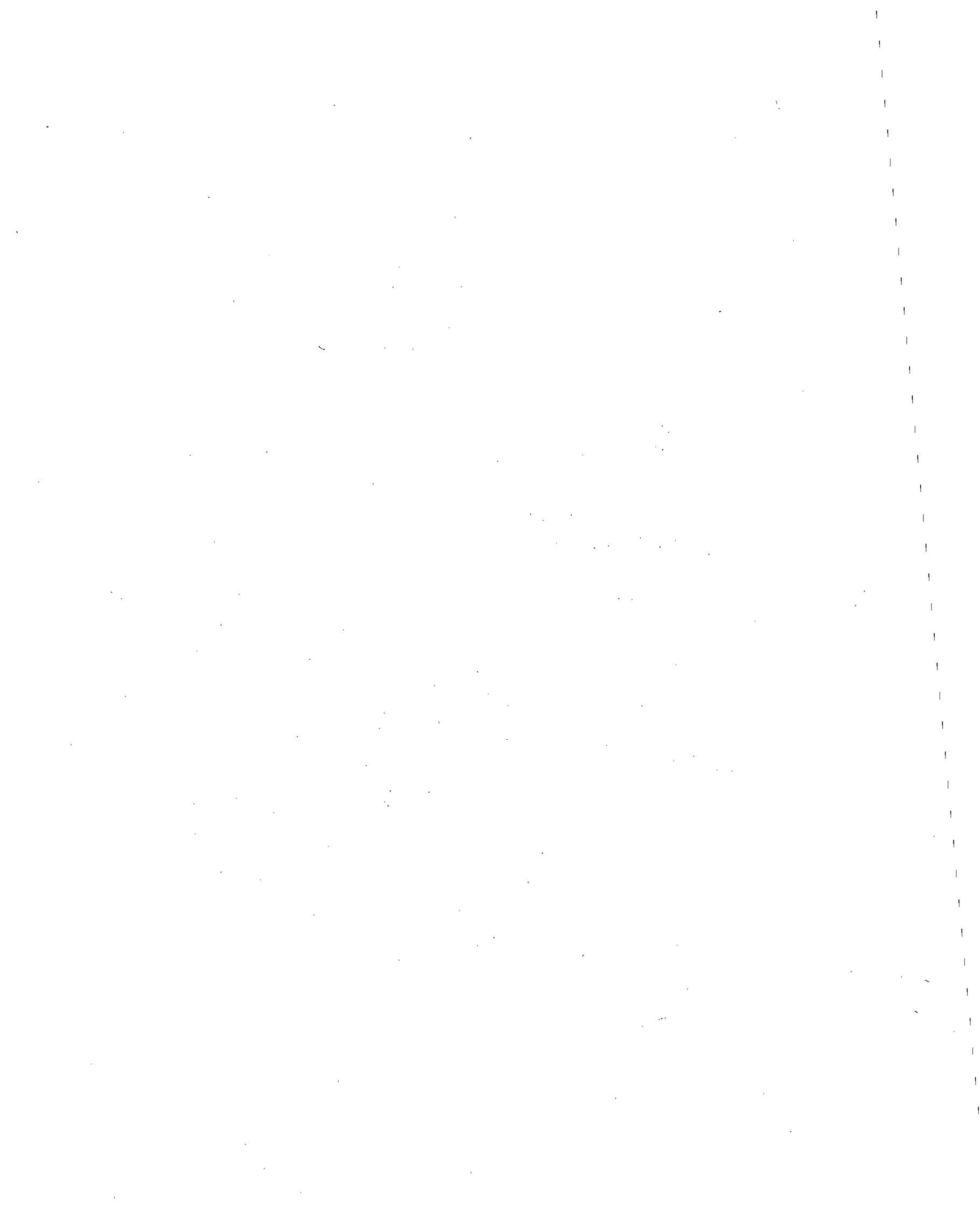
READINESS DESCRIPTIVE STATEMENTS

4. KNOWLEDGE ABOUT THE PROBLEM

Level 1.   No knowledge about the problem.

Level 2.   No knowledge about the problem.

Level 3.   Awareness that some people here may have this problem, but no details known.

Level 4.   There is clear recognition that there is a local problem, but detailed information is lacking or depends on stereotypes.

Level 5.   Information on local prevalence is available, but only the broad outlines have been published or presented to the community at large.

Level 6.   Information on local prevalence has been widely disseminated to both community leaders and the general community.

Level 7.   Detailed information about local prevalence is available; it has been disseminated widely and people know where to get specific information.

Level 8.   There is considerable specific knowledge about prevalence and of etiology, risk factors, and consequences.

Level 9.   Specific information about the problem is being used to target high-risk groups and plan the types of prevention programs needed.

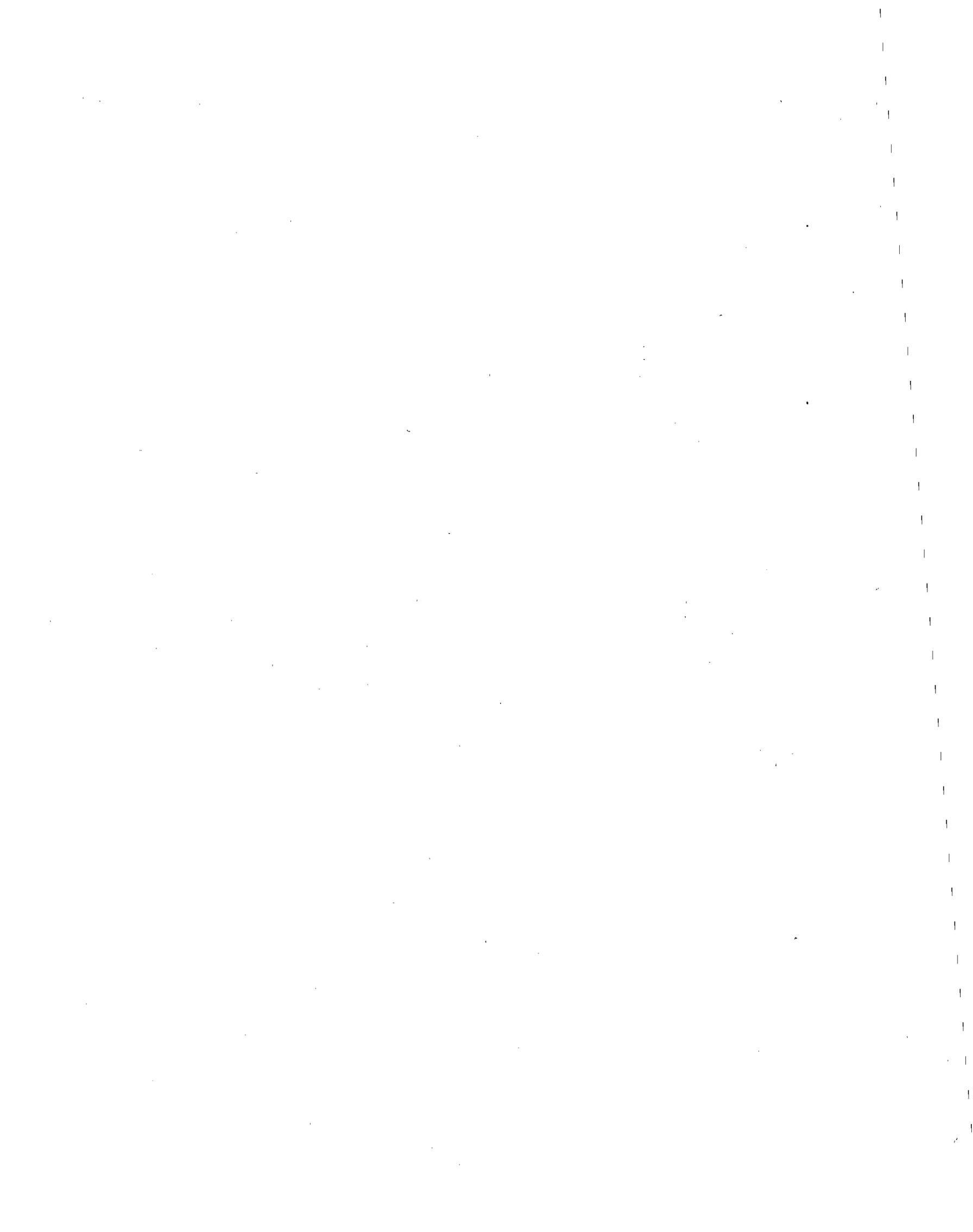# READINESS DESCRIPTIVE STATEMENTS

5. FUNDING FOR PREVENTION

Level 1.   No information or ideas about funding.

Level 2.   No information or ideas about funding.

Level 3.   It should be possible to fund a program, but not sure how much it would cost or where the money would come from.

Level 4.   A committee or person is finding out how much this would cost and is considering where funds might come from.

Level 5.   Costs in staff time and dollars are known. A proposal for funding has been written, submitted, and may have been approved.

Level 6.   There is funding for a running program, but it is only from grant funds, outside funds, or a specific one-time donation.

Level 7.   A considerable part of support of ongoing program is from local sources that are expected to provide indefinite and continuous funding.

Level 8.   There is continuous and secure funding for at least two basic programs and some for funding additional prevention efforts.

Level 9.   There is a continuous and secure funding for basic programs, evaluation is routinely funded, and there are substantial funds for trying new programs.

READINESS DESCRIPTIVE STATEMENTS

6. COMMUNITY CLIMATE

Level 1.   The community does not see this as a problem in the community. Therefore, the community does not view prevention efforts as important. For many, this is an accepted part of community life.

Level 2.   There is some recognition that this might be a problem, but prevailing attitudes are "why try to prevent it" or "there's nothing we can do" or "only 'those' people do that." The community may feel they have tried, but it doesn't work.

Level 3.   The community is passive or apathetic. They do not support nor do they hinder prevention efforts.

Level 4.   There is a group in the community that is concerned and demonstrates interest in prevention efforts. Among them, there is the attitude that something needs to be done and the community is ready for interventions.

Level 5.   There is enough community support for prevention efforts. There still may be a few individuals in the community who are antagonistic or try to interfere but general support is high enough to maintain programs.

Level 6.   Same as Level 5.

Level 7.   Same as Level 5.

Level 8.   Same as Level 5.

Level 9.   Same as Level 5.

Appropriate Strategies for Each Stage of Readiness

STAGE	STRATEGIES
1. Community Tolerance	a. Small-group and one-on-one discussions with community leaders to identify perceived benefits of substance abuse and how norms reinforce use. b. Small-group and one-on-one discussions on the health, psychological, and social costs of substance abuse with community leaders to change perceptions of those most likely to be part of the initiation set that begins development of programs.
2. Denial	a. Educational outreach programs on the health, psychological, and social costs of substance abuse to community leaders and community groups interested in sponsoring local programs. b. Use of local incidents that illustrate harmful consequences of substance abuse in one-on-one discussions and educational outreach programs.
3. Vague Awareness	a. Educational outreach programs on national and State prevalence rates of substance abuse and prevalence rates in other communities with similar characteristics to community leaders and possible sponsorship groups. Programs should include use of local incidents that illustrate harmful consequences of substance abuse. b. Local media campaigns that emphasize consequences of substance abuse.

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STAGE		STRATEGIES
4. Preplanning	a.	Educational outreach programs that include prevalence rates and correlates or causes of substance abuse to community leaders and sponsorship groups.
	b.	Educational outreach programs that introduce the concept of prevention and illustrate specific prevention programs adopted by other communities with similar profiles.
	c.	Local media campaigns emphasizing the consequences of substance abuse and ways of reducing demand for illicit substances through prevention programming.
5. Preparation	a.	Educational outreach programs open to the general public on specific types of prevention programs, their goals, and how they can be implemented.
	b.	Educational outreach programs for community leaders and local sponsorship groups on prevention program, goals, staff requirements, and other startup aspects of programming.
	c.	A local media campaign describing the benefits of prevention programs for reducing consequences of substance abuse.
6. Initiation	a.	Inservice educational training for program staff (paid and/or volunteer) on substance abuse consequences, correlates, and causes and the nature of the problem in the local community.
	b.	Publicity efforts associated with the kickoff of the program.
	c.	A special meeting to provide an update and review of initial program activities with community leaders and local sponsorship groups.

STAGE	STRATEGIES
7. Institutionalization	a. Inservice educational programs on the evaluation process, new trends in drug abuse, and new initiatives in prevention programming. Either trainers are brought in from the outside or staff sent to programs sponsored by professional societies. b. Periodic review meetings and/or special recognition events for local supporters of the prevention program. c. Local publicity efforts associated with review meetings and recognition events.
8. Confirmation/Expansion	a. Inservice educational programs on conducting localized epidemiologies to target specific groups in the community for prevention programming. Either trainers are brought in from the outside or staff are sent to programs sponsored by professional societies. b. Periodic review meetings and/or special recognition events for local supporters of prevention programs. c. Results of research and evaluation activities of the prevention program are presented to the public through local media and/or public meetings.
9. Professionalization	a. Continued inservice training of staff. b. Continued assessment of new drug-related problems and reassessment of targeted groups within community. c. Continued evaluation of program effort. d. Continued update on program activities and results for the benefit of community leaders and local sponsorship groups and periodic stories through local media and/or public meetings.

Readiness Exercise

Instructions

Attached are three sets of "key informant" interviews for fictional respondents in a hypothetical community.

Review the responses (in italics) and decide as a group (using the Readiness Descriptive Statements) what the community's stage of readiness is. Be prepared to defend your responses.

- Each question in the Key Informants Interview Questionnaire (handout 3.2) is followed by a number in parentheses. This number refers to one of the six readiness dimensions—prevention programming, knowledge about prevention programs, leadership, knowledge about the problem, funding for prevention, and community climate.

- For each of the six dimensions, review the interview responses (handout 3.5) for that dimension. Look at the readiness descriptive statements for the appropriate dimension (handout 3.3). Based on the responses to the relevant questions, decide which descriptive statement level (from 1 through 9) best matches the interview responses.

- When all key informant interviews have been rated on all six dimensions (handout 3.6), review the nine stages of readiness (handout 3.1)—community tolerance, denial, vague awareness, preplanning, preparation, initiation, institutionalization, confirmation/expansion, and professionalism—and decide which one best describes the community of which the key informants are a part.

Then decide what course of action would be most appropriate (handout 3.4).

Readiness Exercise
Key Informants Interview Questionnaire

Name: A. Hofstetter
Title: Counselor, Walt Whitman High School

<u>Readiness Dimensions</u>

1. PREVENTION PROGRAMMING

2. KNOWLEDGE ABOUT PREVENTION PROGRAMS

3. LEADERSHIP

4. KNOWLEDGE ABOUT THE PROBLEM

5. FUNDING FOR PREVENTION

6. COMMUNITY CLIMATE

<u>Questions</u> (Letters in parentheses indicate dimension(s) to which each question relates.)

1. What types of substance abuse prevention programs or activities have occurred in your community? (1&2)

   I'm not sure. We provide 2 weeks of drug education to all students once each year, and sometimes the local police send a speaker. I just started this job this past fall, and I'd like to implement a Red Ribbon Week like the one we had in college. I've got some catalogues, so I may order some posters. It looks as if there are some publications with some ideas for Red Ribbon Week.

   a. How long have these programs been in your community? (1&2)

   I think the school's education program has been in place for a long time, since the 1970s or 1980s.

   b. Who is served by these programs? (1&2)

   All students.

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c. Is there a need to expand these services? If no, why not? (1&2)

I'd like to do something, but I don't know what. Some of the kids seem to be involved with drugs, and I get the impression that drug use is increasing; we've had some incidents involving LSD lately. But only a few students have been involved.

d. Are there plans to expand? If yes, what are the plans? (1&2)

Nothing formal; we've been kicking some ideas around.

e. How are these programs viewed by the community? (2&6)

I don't think the community knows much about what we are doing vis-a-vis drug prevention.

2. What is the general attitude about substance abuse in your community? (3,4,&6)

People are generally opposed to drugs, but they tend to see drug abuse as a big city, urban problem—not something relevant to us.

a. Does the community see substance abuse as a problem? (3,4,&6)

In general, yes, but it's probably not considered much of a problem here except in a couple of neighborhoods in the poor section of town.

b. Would or does the community support a prevention plan? If yes, how? (3&6)

I doubt that people see the need for anything more than what we're doing.

c. Are the leaders in your community involved in prevention efforts? (list) (3)

Not that I know of.

d. What community organizations have a focus on prevention? (3)

The Police Department; maybe some of the churches..

3. Is there information available on local substance abuse prevalence? If yes, from whom? (4)

I'm not aware of any.

4.   How is that information disseminated? And to whom? (4)

Don't know.

5.   Who provides funding for these programs and how long will it continue? (5)

Our funding comes out of general school funds from taxes. I don't know what other sources of funding are used in the community.

6.   What is the community's attitude/belief about funding prevention programs? (5&6)

Right now, the community is pretty worked up about the decision of RDC Enterprises to relocate its operation here. There is a lot of concern about losing the natural beauty of the area to urban development and all the problems that accompany the change. On top of that, our latest crime statistics show a sharp increase especially in juvenile crime. So the public is up in arms about that and worried that the economic growth will only make it worse. I'm afraid if we talked about drug abuse, it would just add fuel to the fire by giving citizens another reason to oppose economic growth. I don't think people here see drug abuse as a problem right now and probably wouldn't view it as a priority. They'd rather that we spent more money building schools and roads to relieve the inevitable congestion that will come with the population growth and economic expansion in the area and that we do something about the growing juvenile crime problem.

7.   Is your community aware of the costs of running a prevention program? (4&5)

I don't know.

8.   Are you aware of any proposals that have been written that address the issue of prevention? (5)

I don't know.

Are any funded or waiting? (5)

I don't know.

9. Is the lack of community involvement a major obstacle in your prevention effort? (6)

    Yes, it is.

10. Is there a sense of apathy or hopelessness among community members regarding substance abuse? (6)

    Not really hopelessness; more like apathy. People just don't see it as a problem.

11. What are the primary obstacles to prevention efforts in your community? (6)

    I'm not sure people think there's a big enough problem. It would take a lot of time and money that people don't have right now to devote to something that may be important, but not a top priority.

12. What is the next step your community needs to take in the area of prevention? (general- all 6 dimensions)

    It might be worthwhile to find out exactly what kind of a drug abuse problem we have and do some research to find out what drugs are being used, trends, and so on.

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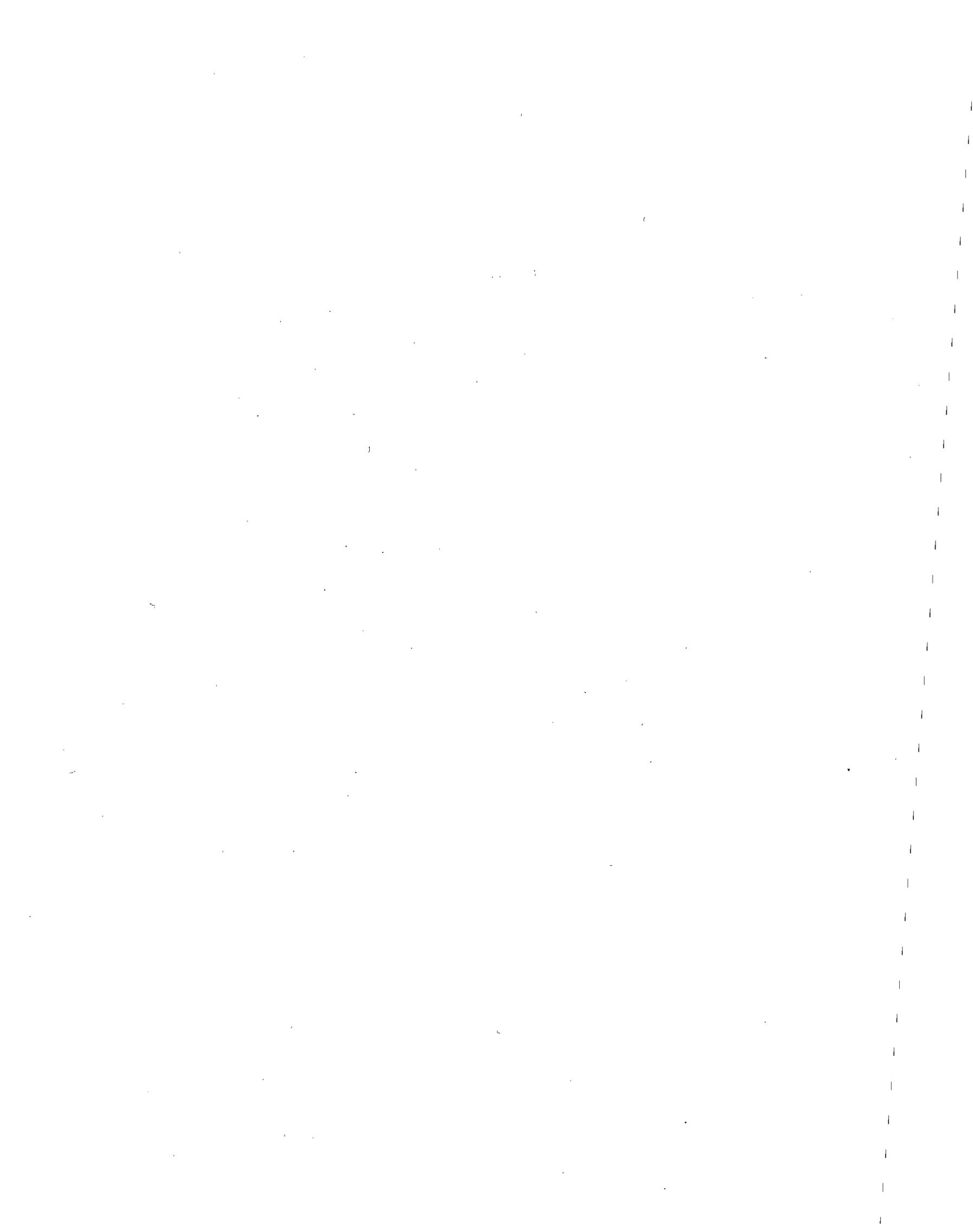
Key Informants Interview Questionnaire

Name: **T. Carlyle**
Title: **City Councilman**

<u>Readiness Dimensions</u>

1.   PREVENTION PROGRAMMING

2.   KNOWLEDGE ABOUT PREVENTION PROGRAMS

3.   LEADERSHIP

4.   KNOWLEDGE ABOUT THE PROBLEM

5.   FUNDING FOR PREVENTION

6.   COMMUNITY CLIMATE

<u>Questions</u> (Letters in parentheses indicate dimension(s) to which each question relates.)

1.   What types of substance abuse prevention programs or activities have occurred in your community? (1&2)

There's an education program in the school and the police department has a program it puts on in the schools.

    a.   How long have these programs been in your community? (1&2)

The school program has been going on for a long time—maybe 15 years. The police program is more recent, but it's been around for maybe as long as 10 years.

    b.   Who is served by these programs? (1&2)

Mostly students.

c.   Is there a need to expand these services? If no, why not? (1&2)

I don't think so. We don't have much of a drug problem compared to other places.

d.   Are there plans to expand? If yes, what are the plans? (1&2)

No plans that I'm aware of.

e.   How are these programs viewed by the community? (2&6)

The police program is very popular. I've heard my kids talk favorably about it.

2.   What is the general attitude about substance abuse in your community? (3,4,&6)

Not much concern right now. We don't have the crime some of our neighboring cities have.

a.   Does the community see substance abuse as a problem? (3,4,&6)

I don't see it as much of a problem here. One student died last year from inhalants, but it was a very unusual occurrence.

b.   Would or does the community support a prevention plan? If yes, how? (3&6)

I don't think a plan is needed.

c.   Are the leaders in your community involved in prevention efforts? (list) (3)

Some probably are through their churches or other voluntary activities.

d.   What community organizations have a focus on prevention? (3)

The police department's education program is the one that comes to mind. I think there's also some kind of program for youths who have been arrested.

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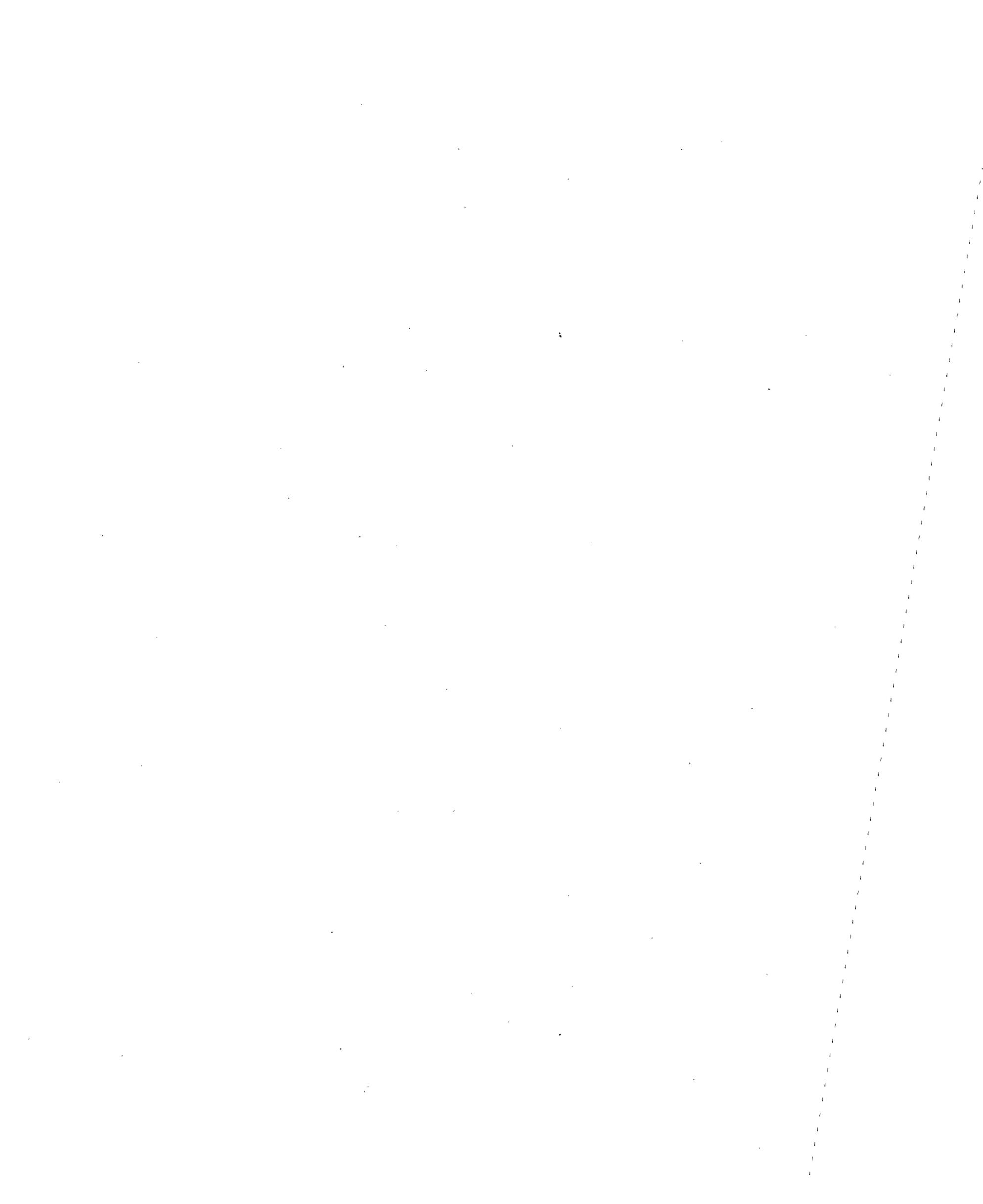
3. Is there information available on local substance abuse prevalence? If yes, from whom? (4)

   I saw some local drug data reported in a proposal last year. I don't know where they came from. I'm not aware of any special effort to track drug trends locally. Maybe someone at the university is doing something or has access to data.

4. How is that information disseminated? And to whom? (4)

   I don't think it's published necessarily, although the media might be interested.

5. Who provides funding for these programs, and how long will it continue? (5)

   I think programs are being run with agency funds, for example, school funds, police department funds.

6. What is the community's attitude/belief about funding prevention programs? (5&6)

   They'd probably view it as a low priority, given some of the other problems we're experiencing.

7. Is your community aware of the costs of running a prevention program? (4&5)

   I think some of the community agencies—the probation office and some treatment centers—put together a proposal for a grant to provide drug services to incarcerated people.

8. Are you aware of any proposals that have been written that address the issue of prevention? (5)

   I don't know.

   Are any funded or waiting? (5)

   Not that I'm aware of.

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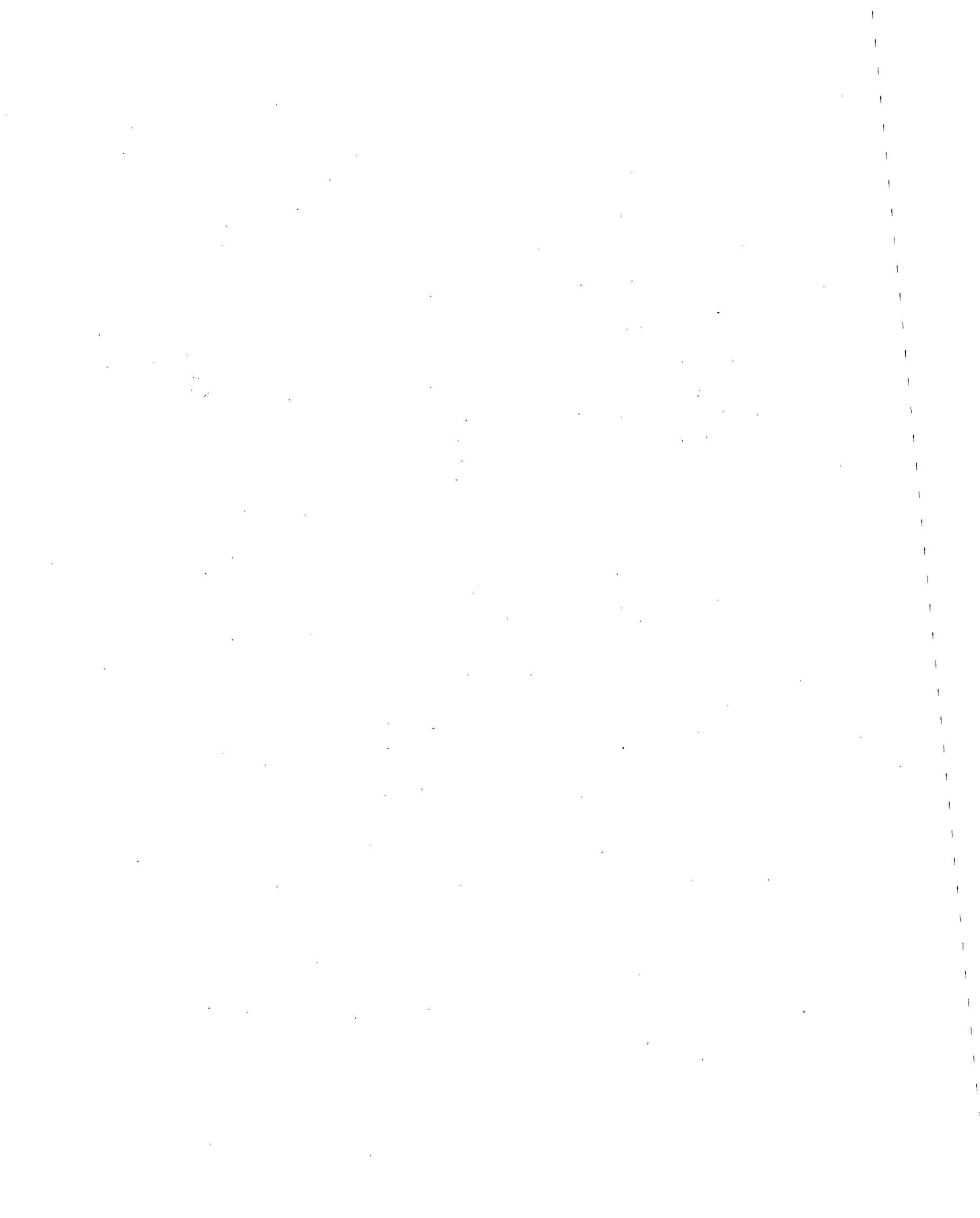
9. Is the lack of community involvement a major obstacle in your prevention efforts? (6)

   I don't think it's lack of involvement so much as it is the fact that we just don't have the problems other communities have.

10. Is there a sense of apathy or hopelessness among community members regarding substance abuse? (6)

    Not really.

11. What are the primary obstacles to prevention efforts in your community? (6)

    We don't have a big enough population in trouble because of drugs to warrant the expenditure of funds. There isn't enough money. I don't think we have facilities or personnel, either.

12. What is the next step your community needs to take in the area of prevention? (general-all 6 dimensions)

    I'm not sure we should be doing anything except monitoring drug trends to make sure the problem doesn't get worse and catch us off guard. We don't need any of those big city problems coming here.

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Key Informants Interview Questionnaire

Name: **L. Moreno**
Title: **Substance Abuse Prevention Coordinator, Willow County Youth Detention Program**

Readiness Dimensions

1. PREVENTION PROGRAMMING

2. KNOWLEDGE ABOUT PREVENTION PROGRAMS

3. LEADERSHIP

4. KNOWLEDGE ABOUT THE PROBLEM

5. FUNDING FOR PREVENTION

6. COMMUNITY CLIMATE

Questions (Letters in parentheses indicate dimension(s) to which each question relates.)

1. What types of substance abuse prevention programs or activities have occurred in your community? (1&2)

    There isn't much. They do a little bit of education in the schools, and the police department has a program. We run a program here for kids who have been arrested and who are drug-involved.

    a. How long have these programs been in your community? (1&2)

    This program has been in place only a little over a year. We got a grant from the Department of Justice to do it.

    b. Who is served by these programs? (1&2)

    Our program is aimed solely at juveniles who have been arrested.

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c.   Is there a need to expand these services? If no, why not? (1&2)

We've been thinking about getting a coalition together. It's clear there's a need. Ninety-five percent of the kids who come through here are abusing drugs, and they talk about how common it is. The rise in crime clearly indicates the need for a program, too, since the link between crime and drug abuse is well documented.

d.   Are there plans to expand? If yes, what are the plans? (1&2)

There aren't any formal ideas yet. We are thinking of applying for another Federal grant, but we need to get better organized first and get some community support.

e.   How are these programs viewed by the community? (2&6)

I don't think the community is very aware of what we're doing.

2.   What is the general attitude about substance abuse in your community? (3,4,&6)

I don't think the community is aware of the drug problem. It's there, but there's a lot of denial. It'll take a tragedy to get the community's attention.

a.   Does the community see substance abuse as a problem? (3,4,&6)

People here are very conservative and very opposed to drugs. They just don't see it as a problem here.

b.   Would or does the community support a prevention plan? If yes, how? (3&6)

I don't think people recognize the seriousness of the problem. If they did, they would want something done about it.

c.   Are the leaders in your community involved in prevention efforts? (list) (3)

As I said, we're trying to get together a coalition to go after some Federal funds. Not really.

d.   What community organizations have a focus on prevention? (3)

   None, really, except ours.

3.   Is there information available on local substance abuse prevalence? If yes, from whom? (4)

   As I said, we're trying to get together a coalition to go after some Federal funds.

4.   How is that information disseminated? And to whom? (4)

   I don't think it is disseminated, except informally.

5.   Who provides funding for these programs, and how long will it continue? (5)

   Our funding is from a Federal grant. That money will run out in another year. We need to find some other funding to keep it going.

6.   What is the community's attitude/belief about funding prevention programs? (5&6)

   I don't think it's viewed as a local priority right now. The Federal Government and the State know it's a problem and provide funding for innovative programs. I've also heard some foundation money is available. One of my colleagues said the father of one of our graduates might come up with some money, too. He's a wealthy businessman and he was pretty impressed with the turnaround his son made after coming through our program.

7.   Is your community aware of the costs of running a prevention program? (4&5)
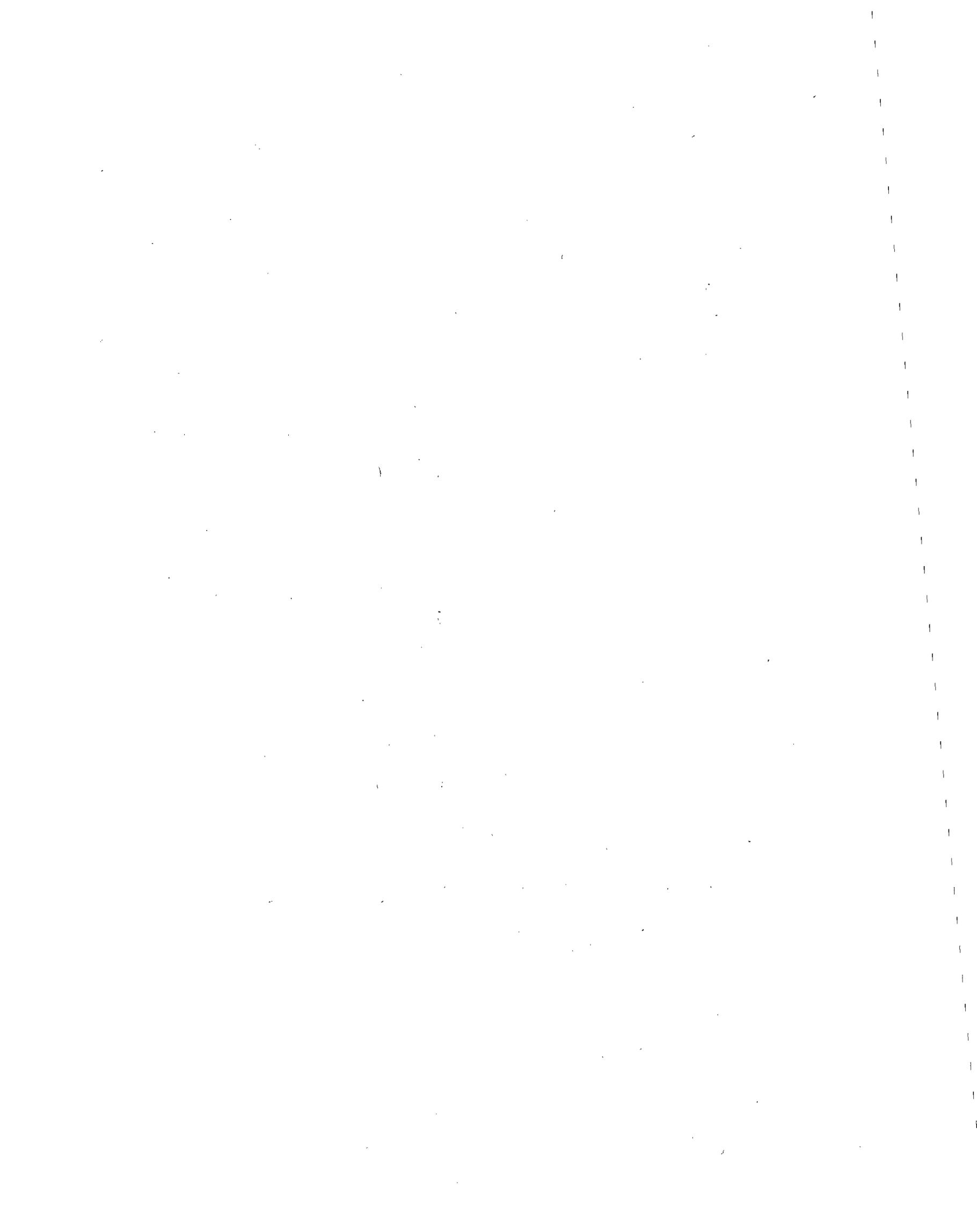
   Probably not.

8.   Are you aware of any proposals that have been written that address the issue of prevention? (5)

   None except the one we wrote.

   Are any funded or waiting? (5)

   None I'm aware of other than this one.

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9. Is the lack of community involvement a major obstacle in your prevention efforts? (6)

   I think the lack of involvement is due to the lack of awareness.

10. Is there a sense of apathy or hopelessness among community members regarding substance abuse? (6)
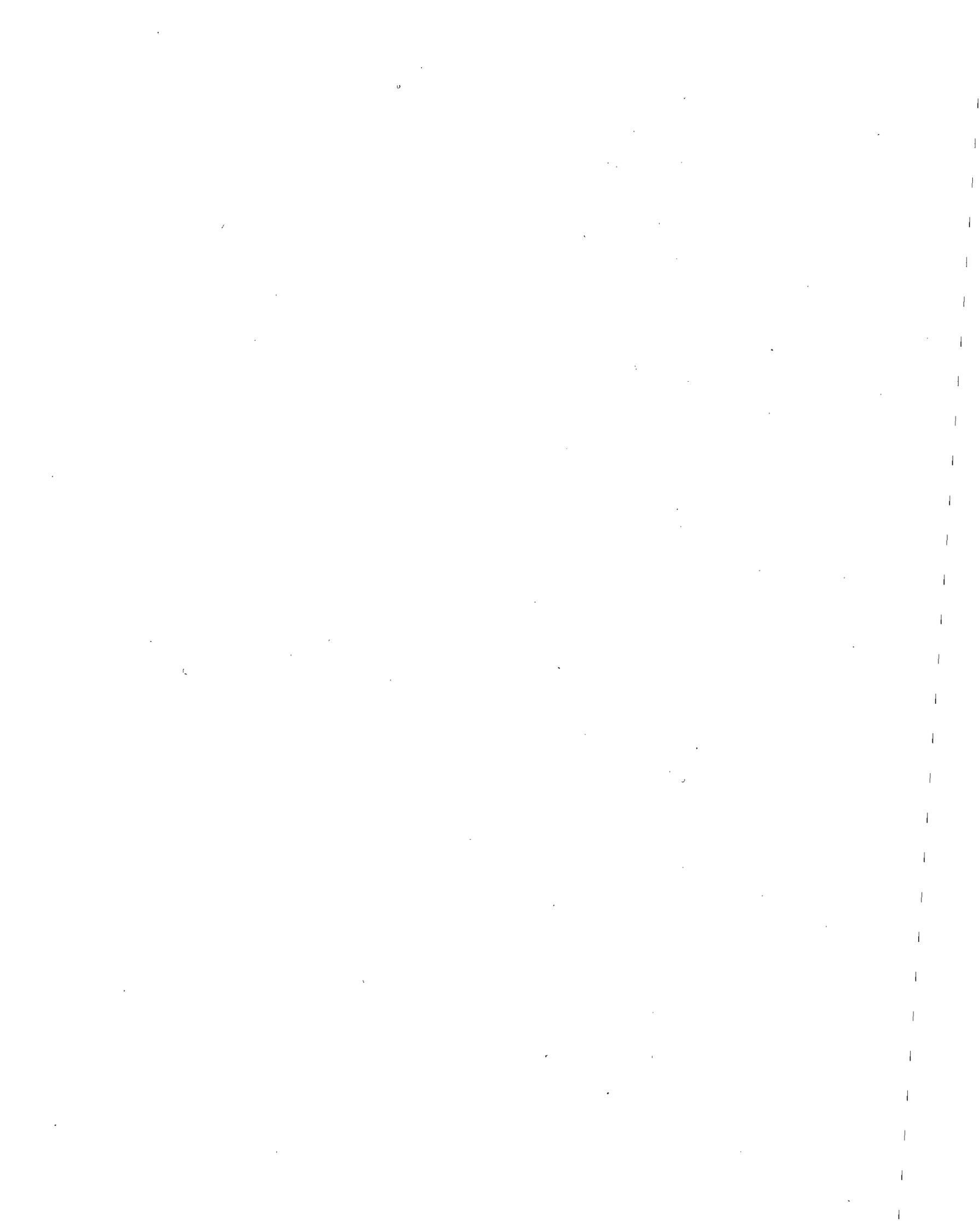
    If people were more aware, they wouldn't be so apathetic.

11. What are the primary obstacles to prevention efforts in your community? (6)

    Lack of awareness.

12. What is the next step your community needs to take in the area of prevention? (general- all 6 dimensions)

    We need better documentation of the problem, and we need to build awareness.

Readiness Rating Form

Key Informant: _____

	Level								
Dimension	1	2	3	4	5	6	7	8	9
1. Prevention Programming									
2. Knowledge About Prevention Programs									
3. Leadership									
4. Knowledge About the Problem									
5. Funding for Prevention									
6. Community Climate									

Prevention Programming Personal Case Study
Part Three

Think back to the prevention effort you were involved in, and answer the following questions.

10.   Whom would you have selected as key informants? Why?

11.   What do you think their responses would have been if interviewed?

12.   What do you believe the community's readiness was? Why?

13.   What steps should the community have taken? Why?

MODULE IV: FACTORS ASSOCIATED WITH THE SUCCESS OF DRUG ABUSE PREVENTION PROGRAMS

Overview

In addition to determining a community's stage of readiness, it is also important to assess factors that contribute to a community's readiness and a prevention program's ultimate success. Knowledge about the strength of these factors can be used to increase a program's readiness.

This module covers seven factors that are associated with readiness. Participants will learn what essential factors determine whether a community is ready to intervene in existing drug abuse problems. If all the community readiness factors are assessed before a prevention program is planned and implemented and if all are strong, the program will have a greater likelihood of being implemented as planned and being successful in affecting the target population.

Time Needed:	1 hour and 30 minutes
Methods:	Lecture (20 minutes) Exercise (25 minutes) Discussion (45 minutes)
Goal:	To introduce participants to factors that contribute to community readiness for drug abuse prevention programming and how to asses them.
Objectives:	By the end of module IV, participants will be able to: ● Name seven factors that are associated with community readiness for substance abuse prevention programming; and ● Describe the process of assessing the strength of the seven factors in a community.
Key Points:	● Before a community implements drug abuse prevention programming, these seven key factors should be strong:

Key Points (Continued)	1. Problem defined by current needs assessment; 2. Recognition of problem by community; 3. Existence of and access to resources; 4. Vision and Plan; 5. Energy to mobilize and sustain prevention activities; 6. Networking with and support of stakeholders; and 7. Talent; leadership structure; sense of community.
Materials Needed:	● Prepared newsprints and easel ● Markers ● Tape ● Notepads and pencils ● Overhead projector ● Screen ● Overhead transparencies ● Watch
Overhead Transparencies:	● 4.1 Module IV Objectives ● 4.2 Seven Factors That Contribute to Community Readiness ● 4.3 Community Readiness Assessment
Handouts:	● 4.1 Elements Commonly Found in Drug Abuse Prevention Programs ● 4.2 Seven Factors That Contribute to Community Readiness ● 4.3 Key Factor 1: Problem Definition ● 4.4 Key Factor 2: Recognition of Problem by Community ● 4.5 Key Factor 4: Existence of and Access to Resources ● 4.6 Key Factor 4: Vision and Plan ● 4.7 Key Factor 5: Energy to Mobilize and Sustain Prevention Activities ● 4.8 Key Factor 6: Networking With and Support of Stakeholders ● 4.9 Key Factor 7: Talent; Leadership Structure; Sense of Community ● 4.10 Community "A" Neighborhood Concern ● 4.11 Community "B" Neighborhood Concern

Handouts: (Continued)	● 4.12	Community "C" Neighborhood Concern
	● 4.13	Community Readiness Questions
	● 4.14	Prevention Programming Personal Case Study—Part Four
Prepared Newsprints:	● 4.1	Key Elements in Prevention
	● 4.2	Key Factor 1: Problem Definition
	● 4.3	Key Factor 2: Recognition of Problem By Community
	● 4.4	Key Factor 3: Existence of and Access to Resources
	● 4.5	Key Factor 4: Vision and Plan
	● 4.6	Key Factor 5: Energy to Mobilize and Sustain Prevention Activities
	● 4.7	Key Factor 6: Networking With and Support of Stakeholders
	● 4.8	Key Factor 7: Talent; Leadership Structure; Sense of Community

SCHEDULE FOR MODULE IV: FACTORS ASSOCIATED WITH THE SUCCESS OF DRUG ABUSE PREVENTION PROGRAMS

	Activity	Time	Methodology
1.	Overview of Module IV	5 minutes	Lecture
2.	What Factors Contribute to Readiness?	15 minutes	Lecture
3.	Assessing Factors That Contribute to Readiness	20 minutes	Exercise
4.	Key Readiness Factors: Group Reports	45 minutes	Discussion
5.	Summary and Personal Assessment	5 minutes	Exercise
	TOTAL TIME:	**1 hour and 30 minutes**	

TRAINING PLAN FOR MODULE IV: FACTORS ASSOCIATED WITH THE SUCCESS OF DRUG ABUSE PREVENTION PROGRAMS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
ACTIVITY 1: **LECTURE** **5 minutes** **OVERHEAD 4.1** **MODULE IV OBJECTIVES**	**Overview of Module IV** Display overhead 4.1, "Module IV Objectives. Review module objectives by reading and elaborating on each objective. Solicit participants' questions about the objectives and respond to them as appropriate. Inform participants that they will learn: - About the importance of community readiness in prevention programming; and - Seven factors important for community readiness. Tell them that in the next module they will learn strategies to apply to increase community readiness for prevention programs in factors assessed to be deficient.
ACTIVITY 2: **LECTURE** **15 minutes**	**What Factors Contribute to Community Readiness?** Tell participants that: - Understanding drug abuse prevention is the beginning of community readiness. - Community readiness is more difficult to define than to identify in practice, but research has shown that several factors are associated with the successful implementation and delivery of substance abuse prevention programming.

TRAINING PLAN FOR MODULE IV: FACTORS ASSOCIATED WITH THE SUCCESS OF DRUG ABUSE PREVENTION PROGRAMS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	Explain that participants now will look at elements that are commonly found in substance abuse prevention programs and will determine which of those elements are key for successful programs.
HANDOUT 4.1 ELEMENTS COMMONLY FOUND IN SUBSTANCE ABUSE PREVENTION PROGRAMS	Distribute handout 4.1, "Elements Commonly Found in Substance Abuse Prevention Programs." Ask participants to circle the elements they think are the key factors in successful substance abuse prevention programs. Allow approximately 1 minute for this exercise. Call time.
PREPARED NEWSPRINT 4.1 KEY ELEMENTS IN PREVENTION	. Display prepared newsprint, 4.1, "Key Elements in Prevention," and ask participants to identify aloud those elements they think are the key factors. As items are suggested, record them on the newsprint. Emphasize that although each element might be important for a specific program, these elements should be key to the success of all programs. When the list is complete, explain that successful drug abuse prevention programs rely on elements such as: • Broad popular awareness of a problem; • Belief that improvement is possible; • Widespread sense of community, identified in most cases with readily recognized geographic boundaries or social characteristics; • Leadership structure;

TRAINING PLAN FOR MODULE IV: FACTORS ASSOCIATED WITH THE SUCCESS OF DRUG ABUSE PREVENTION PROGRAMS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	• Willingness to act; • Access to at least a necessary minimum of resources; • Networking among stakeholders; and • Plans for immediate and long-range future.
OVERHEAD 4.2 SEVEN FACTORS THAT CONTRIBUTE TO COMMUNITY READINESS **HANDOUT 4.2 SEVEN FACTORS THAT CONTRIBUTE TO COMMUNITY READINESS**	Display overhead 4.2, "Seven Factors That Contribute to Community Readiness," and distribute handout 4.2, "Seven Factors That Contribute to Community Readiness." Tell participants that these seven factors can be summarized as the acronym PREVENT. • Problem Definition; • Recognition of Problem by Community; • Existence of and Access to Resources; • Vision and Plan; • Energy to Mobilize and Sustain Prevention Activities; • Networking With and Support of Stakeholders; and • Talent; Leadership Structure; Sense of Community. Conduct a brief discussion about the seven key factors by asking the following questions: • Why are these seven items considered important to community readiness for prevention programming? • Why are they more important than other items on the list? • What can happen if one or more of these factors is not considered?

TRAINING PLAN FOR MODULE IV: FACTORS ASSOCIATED WITH THE SUCCESS OF DRUG ABUSE PREVENTION PROGRAMS	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	Tell participants that it is ill advised to attempt to implement a new drug abuse prevention program in a community that: • Lacks a sense of community and togetherness; • Denies a need for drug abuse prevention; • Lacks recognition of a need for the proposed program; • Opposes the particular prevention activities proposed; • Lacks resources to successfully attract participants, house the program, and staff the program; • Lacks resources to sustain the prevention program after the external funds end; and • Lacks leadership. Tell participants that, using the seven key factors, the community should ask some of these questions when deciding to make a "Go" or "No Go" decision for drug abuse prevention programming. • Is the need for prevention documented? • Do leaders decide to adopt proposed prevention strategies? • Do leaders recognize any need for the program? • Do planners agree? • Are implementors prepared for program delivery? • Is a leadership structure in place?

TRAINING PLAN FOR MODULE IV: FACTORS ASSOCIATED WITH THE SUCCESS OF DRUG ABUSE PREVENTION PROGRAMS	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	Tell participants that if all these community readiness aspects are assessed before a program is implemented and all these factors are positive, there will be a greater likelihood that the program will be: ● Implemented as planned; and ● Successful in impacting the target population. Explain to participants, however, that: ● Community readiness is a developmental process, and the seven factors are not merely present or absent. ● Each factor may run the gamut from minimally present to optimally present, and the readiness status can change over time. ● Therefore, community readiness is not a static process; it is a dynamic process. ● Consequently, readiness assessment is not a static process; but is ongoing.
ACTIVITY 3: EXERCISE **20 minutes**	**Assessing Factors That Contribute to Readiness** Divide participants into seven groups. Direct each group to select a recorder who will record their responses and a reporter who will report their responses to the large group. Assign each of the seven groups a handout with a key factor. (For example, group #1 will be given handout 4.3, "Problem Definition.")

TRAINING PLAN FOR MODULE IV: FACTORS ASSOCIATED WITH THE SUCCESS OF DRUG ABUSE PREVENTION PROGRAMS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	Distribute the appropriate handout to each group:
HANDOUT 4.3 KEY FACTOR 1: PROBLEM DEFINITION	Handout 4.3, "Key Factor 1: Problem Definition";
HANDOUT 4.4 KEY FACTOR 2: RECOGNITION OF PROBLEM BY COMMUNITY	Handout 4.4, "Key Factor 2: Recognition of Problem by Community"; Handout 4.5, "Key Factor 3: Existence of and Access to Resources";
HANDOUT 4.5 KEY FACTOR 3: EXISTENCE OF AND ACCESS TO RESOURCES	Handout 4.6, "Key Factor 4: Vision and Plan"; Handout 4.7, "Key Factor 5: Energy to Mobilize and Sustain Prevention Activities"; Handout 4.8, "Key Factor 6: Networking With and Support of Stakeholders"; and
HANDOUT 4.6 KEY FACTOR 4: VISION AND PLAN	Handout 4.9, "Key Factor 7: Talent; Leadership Structure; Sense of Community."
HANDOUT 4.7 KEY FACTOR 5: ENERGY TO MOBILIZE AND SUSTAIN PREVENTION ACTIVITIES	
HANDOUT 4.8 KEY FACTOR 6: NETWORKING WITH AND SUPPORT OF STAKEHOLDERS	
HANDOUT 4.9 KEY FACTOR 7: TALENT; LEADERSHIP STRUCTURE; SENSE OF COMMUNITY	

TRAINING PLAN FOR MODULE IV: FACTORS ASSOCIATED WITH THE SUCCESS OF DRUG ABUSE PREVENTION PROGRAMS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
HANDOUT 4.10 COMMUNITY "A" NEIGHBORHOOD CONCERN **HANDOUT 4.11 COMMUNITY "B" NEIGHBORHOOD CONCERN** **HANDOUT 4.12 COMMUNITY "C" NEIGHBORHOOD CONCERN** **OVERHEAD 4.3 COMMUNITY READINESS ASSESSMENT/KEY FACTOR 1: PROBLEM DEFINITION**	Distribute handout 4.10, "Community "A" Neighborhood Concern; handout 4.11, "Community "B" Neighborhood Concern; and handout 4.12, "Community "C" Neighborhood Concern." Randomly assign Community A, B, or C to each group. If a case study does not fit the participants, do not use it; distribute only two. Display overhead 4.3, "Community Readiness Assessment/Key Factor 1: Problem Definition." Tell participants that: ● Each group will develop three additional questions for its assigned key factor specific to their case study and record them at the bottom of their handouts. ● For example, the group that has key factor 1 should develop additional questions related to defining the problem. ● They should use their assigned communities to generate additional questions specific to those communities. ● They should brainstorm as many questions as they can and then choose the three that seem most appropriate. Tell them they will have 5 minutes for this exercise. After 5 minutes, call time.

TRAINING PLAN FOR MODULE IV: FACTORS ASSOCIATED WITH THE SUCCESS OF DRUG ABUSE PREVENTION PROGRAMS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
ACTIVITY 4: DISCUSSION **45 minutes** (5 minutes)	**Key Readiness Factors: Group Reports** Distribute the appropriate prepared newsprints to each group: prepared newsprint 4.2, "Key Factor 1: Problem Definition"; prepared newsprint 4.3, "Key Factor 2: Recognition of Problem by Community"; prepared newsprint 4.4, "Key Factor 3: Existence of and Access to Resources"; prepared newsprint 4.5, "Key Factor 4: Vision and Plan"; prepared newsprint 4.6, "Key Factor 5: Energy to Mobilize and Sustain Prevention Activities"; prepared newsprint 4.7, "Key Factor 6: Networking With and Support of Stakeholders"; prepared newsprint 4.8, "Key Factor 7: Talent; Leadership Structure; Sense of Community." Tell the groups to record on the newsprint the three questions they added to their lists. Allow 3 minutes for this exercise. After 3 minutes, call time.
PREPARED NEWSPRINT 4.2 KEY FACTOR 1: PROBLEM DEFINITION (5 minutes)	Display prepared newsprint 4.2, "Key Factor 1: Problem Definition." Ask the reporter from the group working on "Key Factor 1: Problem Definition" to state the additional three questions the group agreed on. If participants are unclear as to how to assess key factor 1, use the questions listed below as examples. 1. <u>Problem Definition: What is the problem?</u> ● Has a needs assessment been conducted that would identify the problem? ● Are there existing sources of information to define the type and extent of the problem?

TRAINING PLAN FOR MODULE IV: FACTORS ASSOCIATED WITH THE SUCCESS OF DRUG ABUSE PREVENTION PROGRAMS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	• Who has the primary problem? Where is the problem mainly occurring?
	• What are the primary precursors?
	• Have risk and protective factors been identified?
	• Where could the community intervene most cost-effectively?
	Repeat the process for the other six key readiness factors.
	Examples of questions follow.
PREPARED NEWSPRINT 4.3 KEY FACTOR 2: RECOGNITION OF PROBLEM BY COMMUNITY (5 minutes)	2. <u>Recognition of Problem by Community</u> • Is there a widespread awareness of a substance abuse problem by the community? • Is there any impetus or community event involving drug abuse that demands a response from the community or prevention providers? • Is there currently media coverage of the drug abuse problem?
PREPARED NEWSPRINT 4.4 KEY FACTOR 3: EXISTENCE OF AND ACCESS TO RESOURCES (5 minutes)	3. <u>Existence of and Access to Resources</u> • Do the stakeholders or key leaders have the necessary staff and funding resources to support the development and institutionalization of drug abuse prevention programs needed by the community?

TRAINING PLAN FOR MODULE IV: FACTORS ASSOCIATED WITH THE SUCCESS OF DRUG ABUSE PREVENTION PROGRAMS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	• Do the proposed prevention provider agencies have the necessary resources to implement the proposed prevention approaches in terms of staff, access to the clients, facilities, equipment, and program materials?
	• Are there any possible local, State, or national funding sources?
	• Could funds be redirected from some other programs or combined to address the drug problem?
	• How much time would prevention providers as well as community volunteers be willing to donate, if needed, because of limited funding, to mobilize the necessary staff resources?
PREPARED NEWSPRINT 4.5 KEY FACTOR 4: VISION AND PLAN (5 minutes)	4. <u>Vision and Plan</u> • Who has the vision or the dream? Does this person or group have the time, talent, resources, and willingness to act to develop and implement this plan?
	• Does the community being addressed share a similar dream, or would it at least be likely to support such a dream?
	• Does the proposed solution match the prevention approaches suggested by the research literature as effective in dealing with the drug abuse problem in this community?
	• Is there evidence that the risk factors and protective factors addressed by the proposed prevention approach match those in the target population?

TRAINING PLAN FOR MODULE IV: FACTORS ASSOCIATED WITH THE SUCCESS OF DRUG ABUSE PREVENTION PROGRAMS	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	• What prevention services are already in place and operating in the community? What is missing?
	• Do universal, selective, and indicated approaches exist to address general population youth, at-risk youth, and youth already manifesting problems?
	• Are there school-based, family-based, and community-based prevention programs?
	• Are there planners capable of developing a detailed yet flexible plan?
	• Would grassroots citizens (parents and youth) be willing to contribute to the planning by participating in focus groups and planning teams and supporting the implementation of the plan?
	• Are there local researchers and evaluators who could be involved in the planning process to help with the conceptualization to ensure that measurable objectives are selected?
PREPARED NEWSPRINT 4.6 KEY FACTOR 5: ENERGY TO MOBILIZE AND SUSTAIN PREVENTION ACTIVITIES **(5 minutes)**	5. <u>Energy to Mobilize and Sustain Prevention Activities</u> • Do the organizers have the energy, time, talent, resources, and willingness to act to develop and implement this plan? • Do community members, likewise, have the time, energy, and commitment to support prevention activities?

TRAINING PLAN FOR MODULE IV: FACTORS ASSOCIATED WITH THE SUCCESS OF DRUG ABUSE PREVENTION PROGRAMS	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	• Is it likely that significant barriers (e.g., lack of trust, fear, intimidation by drug dealers, denial, lack of time, lack of accessibility, lack of transportation, lack of child care) to participation by volunteers or clients can be overcome?
	• Can benefits for staff and volunteer participation be increased to overcome costs of participation? Benefits could include information sharing, increased networking and friendships, making a contribution, enjoying the prevention work, personal recognition, and increasing one's skills and knowledge.
	• Can prevention providers interested in participation have their job duties redefined so they are able to participate?
	• Is this a bottom-up prevention plan supported by the community and likely to be maintained after the initial funding has ended?
	• Are key leaders hopeful, and do they believe that improvement is possible?
	• What types of prevention approaches do they believe work or do not work?
	• Do the proposed prevention approaches match prevention providers' philosophy of prevention? Are local prevention providers likely to support one type of prevention approach over another (e.g., universal, selective, or indicated approaches within schools, communities, or families)?

TRAINING PLAN FOR MODULE IV: FACTORS ASSOCIATED WITH THE SUCCESS OF DRUG ABUSE PREVENTION PROGRAMS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	● What types of drug abuse prevention efforts are currently supported by or exist in the community? Where are the gaps?
	● Do the stakeholders or key leaders have the necessary talent and competencies to develop and sustain drug abuse prevention programs?
PREPARED NEWSPRINT 4.7 KEY FACTOR 6: NETWORKING WITH AND SUPPORT OF STAKEHOLDERS **(5 minutes)**	6. <u>Networking With and Support of Stakeholders</u> ● Do the community leaders or stakeholders support drug abuse prevention? ● Are key leaders hopeful, and do they believe that improvement is possible? ● What types of prevention approaches do they believe work or do not work? ● Do the proposed prevention approaches match prevention providers' philosophy of prevention? Are local prevention providers likely to support one type of prevention approach over another (e.g., universal, selective, or indicated approaches within schools, communities, or families)? ● What types of substance abuse prevention efforts are currently supported by or exist in the community? Where are the gaps? ● Do the stakeholders or key leaders have the necessary talent and competencies to develop and sustain drug abuse prevention programs?

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TRAINING PLAN FOR MODULE IV: FACTORS ASSOCIATED WITH THE SUCCESS OF DRUG ABUSE PREVENTION PROGRAMS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
PREPARED NEWSPRINT 4.8 KEY FACTOR 7: TALENT; LEADERSHIP STRUCTURE; SENSE OF COMMUNITY **(5 minutes)**	7. Talent; Leadership Structure; Sense of Community ● Is there a strong sense of community with members feeling they want to preserve or create a drug-free community? ● Have members of the community resided in the community for some time, and do they feel a dedication to the community? Are they civic-minded, and do they believe in public service? ● Are there key leaders in the community willing to act to reduce drug abuse? ● Does the community have the necessary talent and competencies to develop and sustain drug abuse prevention programs? Summarize the key points of the presentations. Emphasize that a community that has assessed readiness in all these seven areas stands a much better chance of succeeding than a community that has addressed only a few or none of these issues.
HANDOUT 4.13 COMMUNITY READINESS INVENTORY	Distribute handout 4.13, "Community Readiness Inventory." Instruct participants that these questions provide a framework for assessing key factors in a community.

TRAINING PLAN FOR MODULE IV: FACTORS ASSOCIATED WITH THE SUCCESS OF DRUG ABUSE PREVENTION PROGRAMS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
HANDOUT 4.14 PREVENTION PROGRAMMING PERSONAL CASE STUDY—PART FOUR HANDOUT 1.2 PREVENTION PROGRAMMING PERSONAL CASE STUDY—PART ONE HANDOUT 1.5 PREVENTION PROGRAMMING PERSONAL CASE STUDY—PART TWO (5 minutes)	Distribute handout 4.14, "Prevention Programming Personal Case Study—Part Four." Refer participants back to handout 1.2, "Prevention Programming Personal Case Study—Part One," and handout 1.5, "Prevention Programming Personal Case Study—Part Two." Ask them to consider the prevention program they are or were associated with and to complete questions 14 and 15. Allow 3 minutes for this exercise. After 3 minutes, call time: Ask for volunteers to discuss key factors of community readiness that were or were not in place when they began their programs. Discuss their answers briefly.
ACTIVITY 5: EXERCISE 5 minutes OVERHEAD 4.1 MODULE IV OBJECTIVES	**Summary and Personal Assessment** Display overhead 4.1, "Module IV Objectives" and review module IV learning objectives. Ask participants to make a personal assessment of what they have learned. Go around the room and ask each participant to state one thing that he or she has learned during this module. Introduce module V by telling them that the next session will present strategies to strengthen key factors if they are weak.

Module IV Objectives

By the end of module IV, participants will be able to:

- Name seven factors that are associated with community readiness for drug abuse prevention programming; and

- Describe the process of assessing the strength of the seven factors in a community.

Seven Factors That Contribute to Community Readiness

Problem Definition
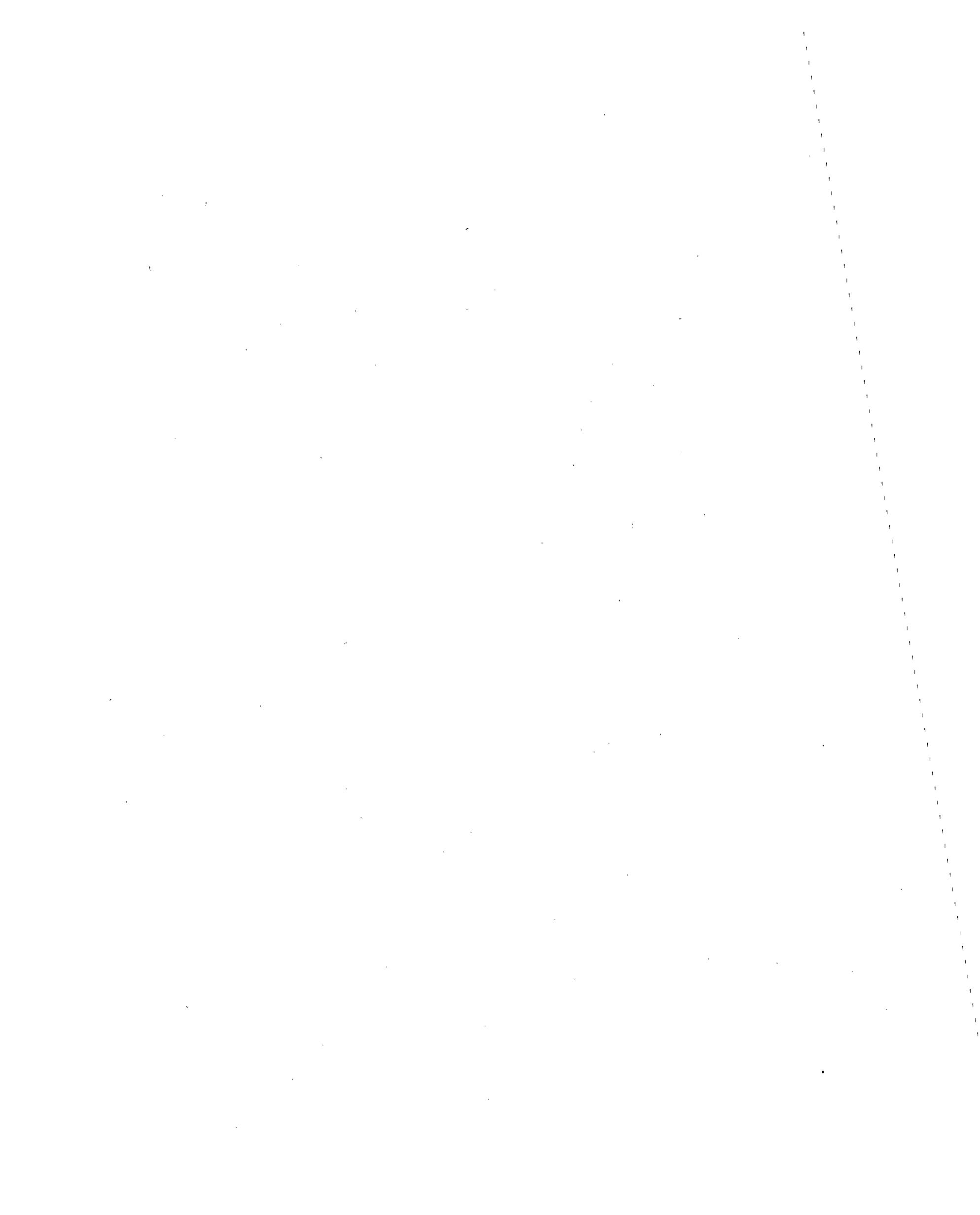
Recognition of Problem by Community

Existence of and Access to Resources

Vision and Plan

Energy to Mobilize and Sustain Prevention Activities

Networking With and Support of Stakeholders

Talent; Leadership Structure; Sense of Community

Community Readiness Assessment

Key Factor 1: Problem Definition

- Has a needs assessment been conducted that has identified the problem?

- Are there existing sources of information to define the type and extent of the problem?

What are some other questions that should be asked to assess the extent of the drug abuse problem in your community?

1. _____

   _____

   _____

2. _____

   _____

   _____

3. _____

   _____

   _____
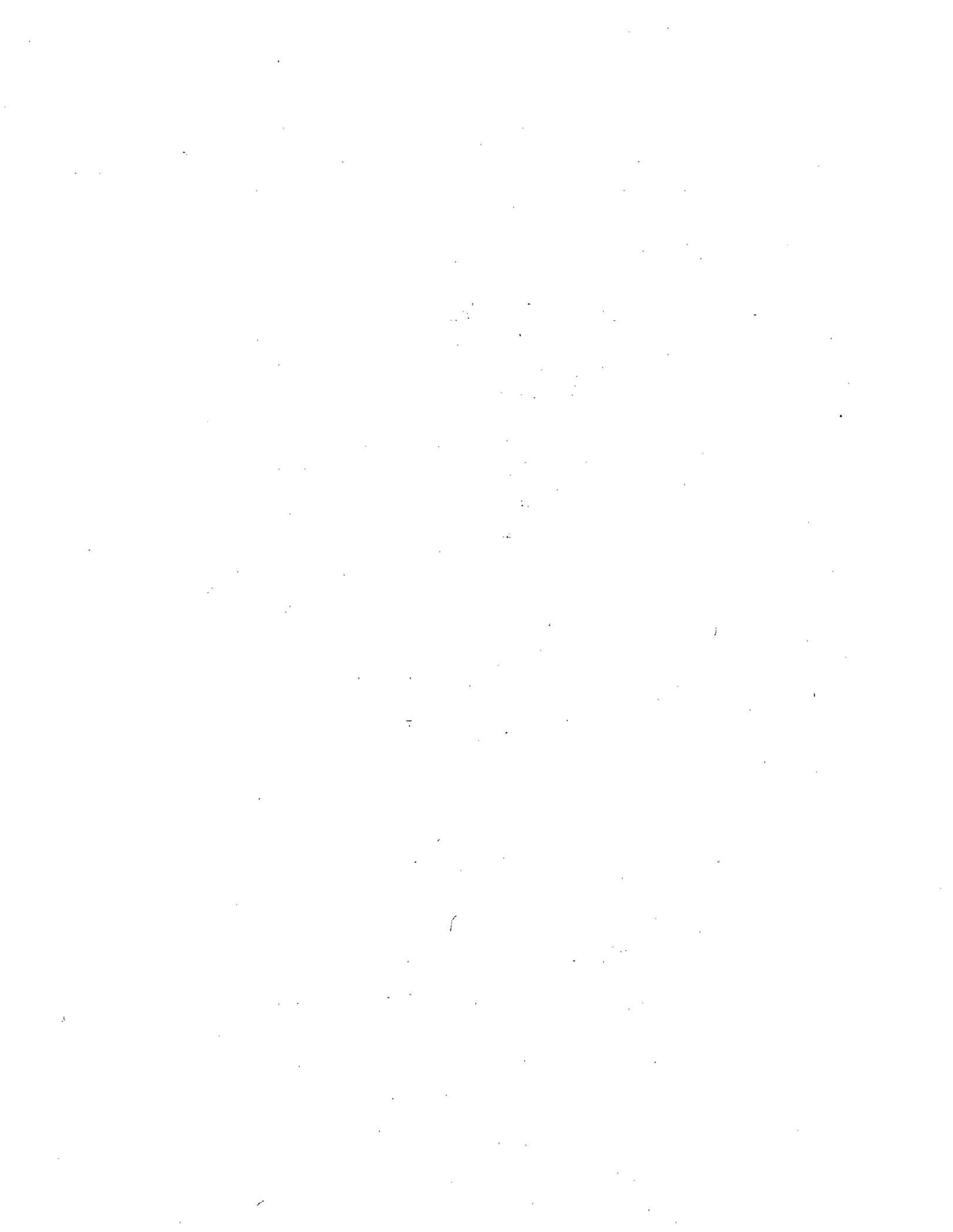
Elements Commonly Found in Substance Abuse Prevention Programs

- Dissemination Methods

- Evaluation Methods

- Problem Defined

- Program Development

- Referral Resources

- Grant Writing

- Recognition of Problem

- Counseling/Treatment

- Job Skills Training

- Existence of Funding Sources

- Alcohol-Free Alternatives Programming

- Vision/Plan

- Energy to Mobilize/Sustain Prevention Activities

- Parenting Skills Training

- Stay-in-School Programs

- Networks With Stakeholders

- Marketing/Advertising

- Talent/Leadership

- Program Revision

- Drug-Resistance Training

- Peer Counselors

Seven Factors That Contribute to Community Readiness

Problem Definition: need documented by assessment such as recent survey or data collection.

Recognition of Problem by Community: broad popular awareness of the problem.

Existence of and Access to Resources: availability of people, material, and money.

Vision and Plan: a roadmap that extends into the future.

Energy to Mobilize and Sustain Prevention Activities: belief that improvement is possible.

Networking With and Support of Stakeholders: involvement of key players.

Talent; Leadership Structure; Sense of Community: widespread sense of community with identified local talent.

A community is not ready to implement a new prevention program if the community:

- Lacks a sense of community and togetherness;
- Denies a need for drug abuse prevention;
- Lacks recognition of a need for the proposed program;
- Opposes the particular prevention activities proposed;
- Lacks resources to successfully attract funding and participants, house the program, and staff the program;
- Lacks resources to sustain the prevention program after external funding ends; and
- Lacks leadership.

Problem Definition

Key Factor 1: Problem Definition

- Has a needs assessment been conducted that has identified the problem?

- Are there existing sources of information to define the type and extent of the problem?

What are some other questions that should be asked to assess the extent of the drug abuse problem in your community?

1. _____

   _____

   _____

2. _____

   _____

   _____

3. _____

   _____

   _____

Recognition of Problem by Community

Key Factor 2: Recognition of Problem by Community

- Is there a widespread awareness of a drug abuse problem by the community?

- Has there been a drug abuse-related incident that has attracted the public's attention?

What are some additional questions that show a community has recognition of a drug abuse problem?

1. _____

_____

_____

2. _____

_____

_____

3. _____

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_____

Existence of and Access to Resources

Key Factor 3: Existence of and Access to Resources

- Do the stakeholders or key leaders have the staff and funding resources to support drug prevention programs?

- Are there any possible local, State, or national funding sources?

What are additional questions that show whether a community has adequate resources?

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____

Vision and Plan

Key Factor 4: Vision and Plan

- Who has the vision, mission, or plan?

- Does the community being addressed share a similar dream? Is it likely to support such a vision?

What additional questions will help develop a vision and a roadmap for success?

1. _____

   _____

   _____

2. _____

   _____

   _____

3. _____

   _____

   _____

Energy to Mobilize and Sustain Prevention Activities

Key Factor 5: Energy to Mobilize and Sustain Prevention Activities

- ● Do the organizers have the energy, time, talent, resources, and willingness to act to develop and implement the dream/plan?

- ● Is it likely that any significant barriers (e.g., lack of trust, fear, intimidation by drug dealers, lack of transportation, child care) to participation by coalition members can be overcome?

What additional questions will help determine whether a community has the energy and will for drug abuse prevention programming?

1. _____

   _____

   _____

2. _____

   _____

   _____

3. _____

   _____

   _____

Networking With and Support of Stakeholders

Key Factor 6: Networking With and Support of Stakeholders

- Do the key leaders or stakeholders support drug abuse prevention?

- Do stakeholders believe prevention works?

What additional questions will help determine whether a network of stakeholders exists?

1. _____

    _____

    _____

2. _____

    _____

    _____

3. _____

    _____

    _____

Talent; Leadership Structure; Sense of Community

Key Factor 7: Talent; Leadership Structure; Sense of Community

- Does the community have the necessary talent and competencies to develop and sustain drug abuse prevention programs?

- Are key leaders and stakeholders motivated to help lead and direct volunteer efforts?

What additional questions will help determine whether sufficient talent and leadership exist at the local level?

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____
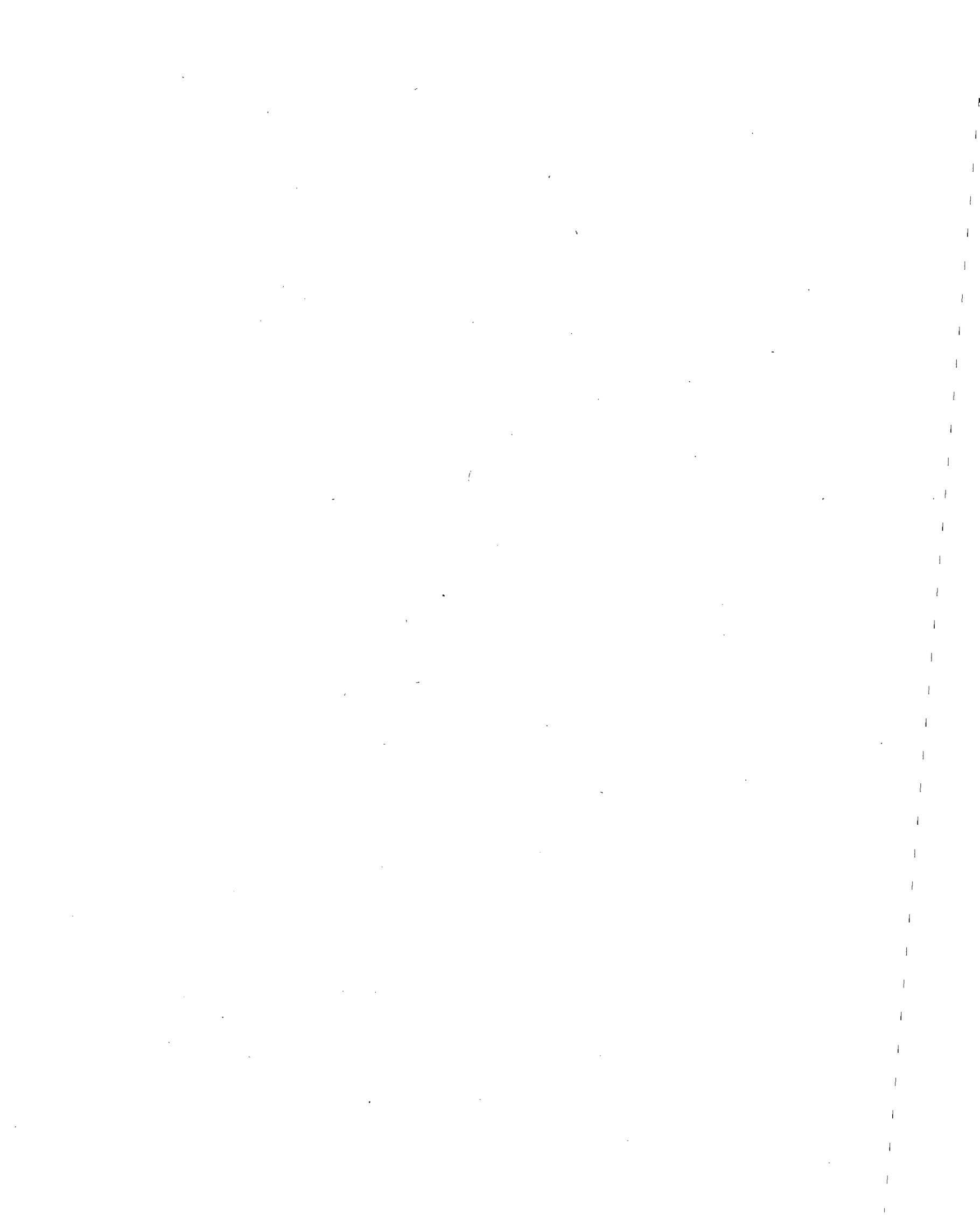
NEIGHBORHOOD CONCERN
COMMUNITY "A" - FIVE CORNERS

Demographics:

Setting: This is a 30-block residential community that, although generally self-sustaining, is part of a large metropolitan area.

Population: Forty years ago this community was comprised largely of European immigrants and their families. Today there is a mix of residents: persons who were born in the neighborhood, African-Americans who moved into this area, and immigrants from Mexico and Puerto Rico. Many residents maintain a strong sense of ethnic pride. Most of the people are working class. Thirty percent of the people live in poverty.

Other: The businesses in this area are mostly family operated. Two rival high schools serve this community. There are a number of churches representing many faiths. There is one federally subsidized housing community. Two city councilmembers live in this neighborhood. There is one outpatient alcohol and drug treatment facility.

On a Friday evening in October, five women and three men, all long-time residents of this urban community known as Five Corners, met in the basement of the local Methodist church to talk about the drug problem. They all were a little disappointed. Mrs. Longnecker had made coffee, and Mr. Gladden had brought cookies and cakes for 75 people. Mr. Gladden and Mrs. Longnecker had distributed 500 fliers, some in local stores, some on telephone poles, and others under doors throughout the neighborhood, covering a 15-block area. Mr. Gladden paid for the fliers himself and set the October meeting after getting permission from the minister of the church.

Concerns about the drug problem had been raised among many community members for many years. Concern crystallized for Mr. Gladden 4 months earlier when his 13-year-old daughter was mugged and assaulted on the way to school by a 17-year-old who was looking for money to buy crack. The youth was apprehended and convicted, but the incident so incensed Mr. Gladden that he had been on a mission ever since to get the dealers and users out of the neighborhood. The neighborhood is known throughout the city as a quick and convenient place to score and throughout the years has had numerous drug raids, shootings, and turf wars between rival drug gangs. The burglary and robbery rates are high, but police attribute this to a large and growing number of homeless people who live in boarded-up and abandoned buildings in the area.

Mr. Gladden was encouraged by the local police when they said that the new crime bill had a lot of drug prevention money in it and that all he had to do was to get a group of people together to form some kind of committee and the Feds will give them money to fight drugs. Mr. Gladden thought that sounded good and has been trying to get a committee together. He works as a social worker for the Social Services Department in the Food Stamp Division and feels he can effectively lead a community drug prevention program.

Mr. Gladden had spent most of his evenings since his daughter's mugging canvassing the neighborhood, trying to get support for a community drug prevention program. He talked with some local social agencies and found that a group, sponsored by the local health clinic, called "Say Yes To Life" had secured a Federal Government grant that ran for 3 years. The group no longer operates. In his canvass Mr. Gladden found one drug treatment program in the area, an alcohol and drug outpatient clinic on Center Avenue called "Stay Free."

After the meeting Mr. Gladden made some telephone calls and found that you are the prevention specialist who works in this area of the city. You have just been assigned to this position, and you have been looking for an entry into the community. Mr. Gladden asks you to attend the next meeting and advise his group on how to proceed.

Answer the following questions:

What key factors related to community readiness seem to be present and which seem to be missing or need to be strengthened?

What questions related to community readiness need to be asked?

What actions could be taken immediately to begin to increase community readiness?

NEIGHBORHOOD CONCERN
COMMUNITY "B" - WEST SIDE

Demographics:

Setting: This is a 50-block residential, business, and industrial community that is part of a moderate sized metropolitan area.

Population: This is a racially mixed, generally middle-income community. Most people in the neighborhood have moved to this area in the last 40 years. In the residential areas they know their neighbors and participate in community watch programs. Thirty percent of the people live in poverty.

Other: Many professional people in this neighborhood work in other areas of the city. Children in this community attend schools in many different parts of the city. There is one federally subsidized housing project here, and there are three drug treatment programs in the area.

On a warm night in July, a group of 12 concerned citizens met at the Baptist church to form a coalition for the purpose of applying for a Federal Community Drug Prevention Grant. One of their members, Mr. Allen, a local attorney, had written for an application form. Mr. Allen also has been instrumental in getting this group together with the express purpose of getting a drug prevention program in this neighborhood on the west side of the city. Its proximity to the edge of town has made it a haven for people coming from the suburbs for a quick score of drugs, principally cocaine, crack, and heroin. This situation has existed for several years, and police efforts have been only sporadically effective.

Mr. Allen is convinced that local residents can take back their streets and wants to apply for funds from the Federal Government. He has convinced this group of his concerned neighbors that they can apply for and get funds to help the police clean up the streets by a two-pronged approach: citizen patrols and afterhours activities for adolescents.

Mr. Allen has developed a plan for financing, including local businesses, to match Federal funds. He also believes he can get city matching funds once his antidrug coalition has started. He has gone so far as to submit his proposal to the local Community Board for approval, a step necessary to secure city matching funds.

Mr. Allen's motivation for his antidrug involvement stems from his belief that an entire generation of youth has been lost to drugs and if the cycle is not broken, another generation will be lost.

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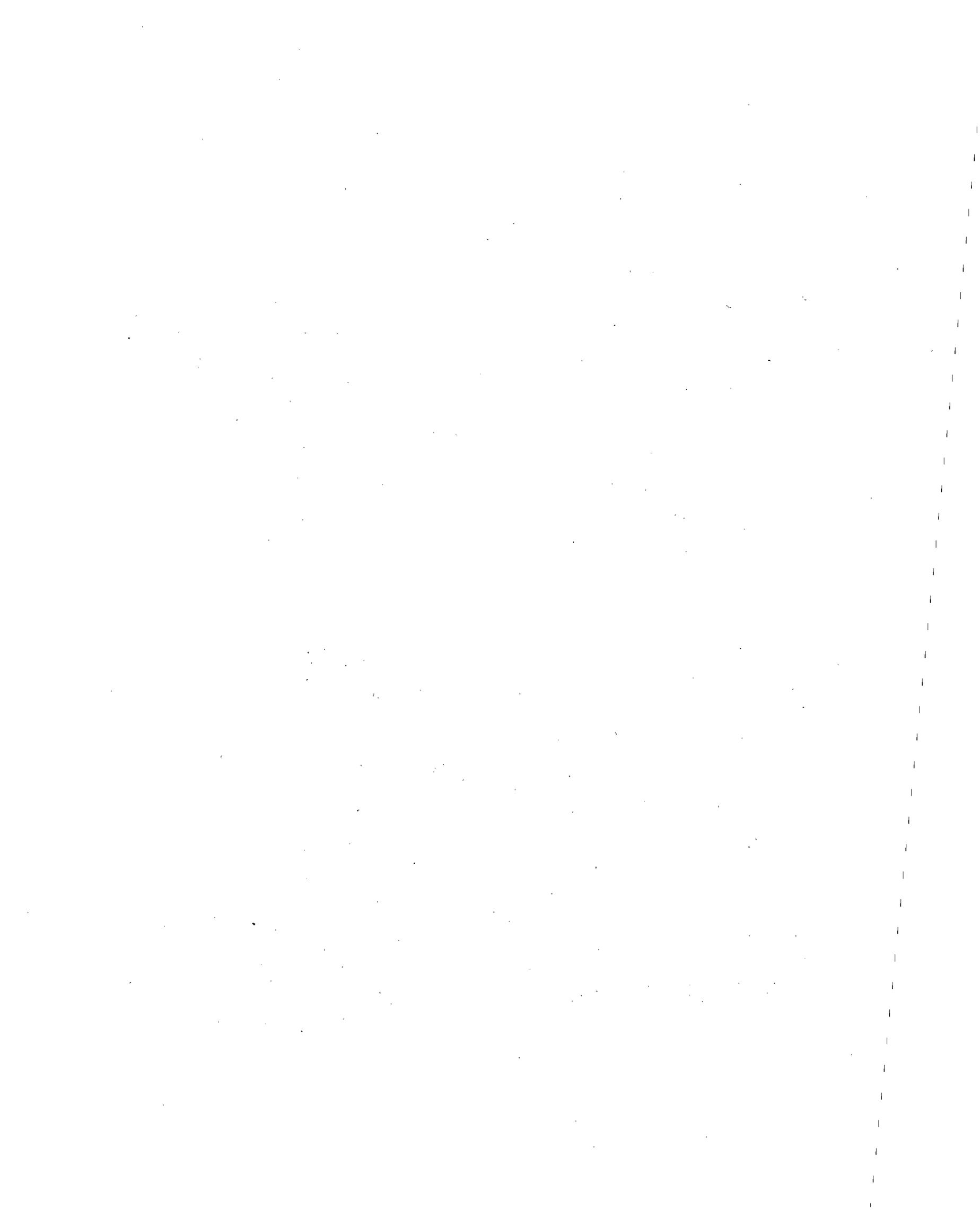
There are three drug treatment programs in the area: an inpatient therapeutic community, a methadone maintenance program, and an outpatient drug and alcohol clinic. There have been three community block grants awarded to this community in the past 10 years, but none of these organizational structures that the grants had supported exist today.

Mr. Allen was excited by the enthusiasm he saw at the meeting. One of the members told him about a prevention specialist who already operates in the area. You have just been assigned to this position, and you have been looking for some inroads into the community. Mr. Allen asks you to attend the next meeting and advise his group on how to proceed.

Answer the following questions:

What key factors related to community readiness seem to be present and which seem to be missing or need to be strengthened?

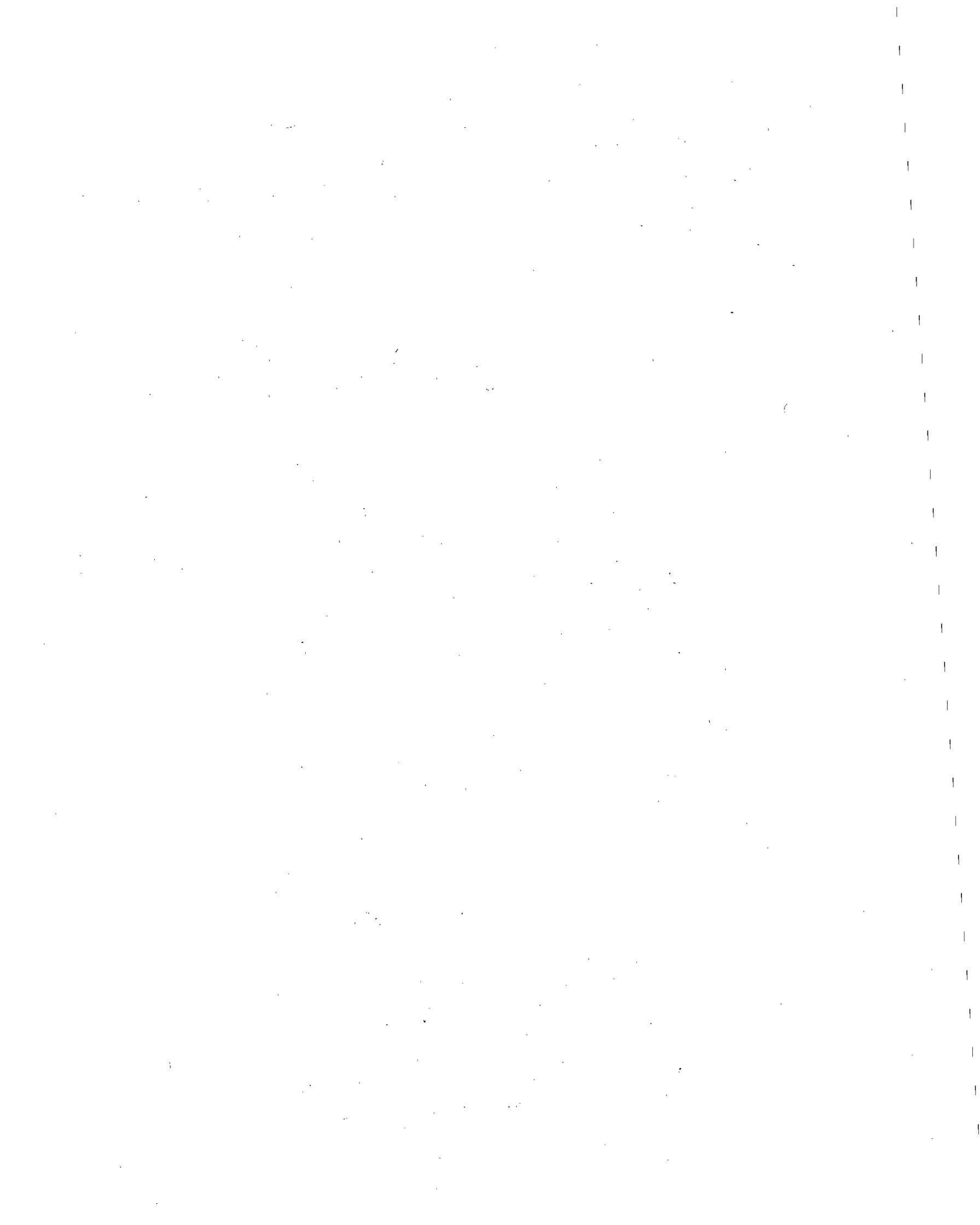What questions related to community readiness need to be asked?

What actions could be taken immediately to begin to increase community readiness?

NEIGHBORHOOD CONCERN
COMMUNITY "C" - LANDS END

Demographics:

Setting: This is a rural community that includes a town of 8,000 residents and 2,000 square miles of largely unincorporated farm land.

Population: This is a racially mixed area: generally people have middle to lower incomes. Most families are farm people who have lived in this area for generations. Forty percent of the people live in poverty. They are generally suspicious of government involvement and accept as little government support as possible.

Other: The businesses in the town are mostly family operated. There is one high school that serves this community. There are a number of small churches representing many faiths.

On a Wednesday evening in October at the local Baptist church, Evelyn Carpenter tells her women's group that her son, who lives in Lincoln and works for State government, told her about government grants that are available to rural communities such as hers to combat drug and alcohol abuse. The women have discussed at length their concern for the young people who hang out at the local drive-in and drink. Last year three high school seniors were killed in a drunken-driving accident on a county road after a ball game.

Mrs. Carpenter says it will be necessary to form a community group to demonstrate that there is concern in the community. The women agree that should not be a problem because each of them knows ministers and teachers and business owners who can be recruited to join their "Lands End Save Our Youth" program. They start making a list of all the people they know who can be recruited.

This area has never had a drug prevention program although the school has an active dropout prevention program, and the mental health clinic has a pregnancy prevention program that is active. Most of the churches have youth groups, and there is a summer parks program that provides athletic opportunities for young people.

After the meeting Mrs. Carpenter makes some telephone calls and finds that you are the prevention specialist who works in this part of the county. You have just been assigned to this position, and you have been looking for some inroads into the community. Mrs. Carpenter asks you to attend the next meeting and advise her group on how to proceed.

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Answer the following questions:

What key factors related to community readiness seem to be present, and which seem to be missing or need to be strengthened?

What questions related to community readiness need to be asked?

What actions could be taken immediately to begin to increase community readiness?

COMMUNITY READINESS INVENTORY

1. PROBLEM DEFINITION

Assessment Questions	Information Sources	Findings and Recommendations
● What risk factors are present (e.g., transient population, norms supporting drug abuse, drug dealing/crime, absence of alternatives, disorganization)?		
● What types of drugs are abused?		
● By whom?		
● Where in the community does drug-abusing behavior occur?		
● What data are available about the nature and extent of the local drug problem?		
● What new data can be collected?		
● By whom?		
● Who will fund the data collection?		
● Is drug abuse tolerated in some areas?		
● What protective factors are present?		
● What prevention activities already exist? What are the gaps in services?		
● What areas (or groups) of the community are most affected by drug abuse?		
● Has any previous needs assessment been conducted that could provide information?		
● Where could the community intervene most effectively to address the problem?		

LOW	MOD	HIGH
READINESS		

COMMUNITY READINESS INVENTORY

2. RECOGNITION OF PROBLEM BY COMMUNITY

Assessment Questions	Information Sources	Findings and Recommendations
• To what extent does the community believe there is a drug problem?		
• What are the perceptions of the drug problem? How accurate are they?		
• Has there been an event or incident that has aroused concern?		
• How do key leaders perceive the drug problem?		
• How are drugs portrayed by local media?		
• Do media articles clearly indicate when drug or alcohol abuse has been involved in some piece of news?		
• How often do stories disclose the consequences of drug-abuse-related problem behaviors?		
• What types of drug abuse problems are currently reported?		
• What are perceptions of the causes of/possible solutions to the problem?		

LOW	MOD	HIGH
READINESS		

COMMUNITY READINESS INVENTORY		
3. EXISTENCE OF AND ACCESS TO RESOURCES		
Assessment Questions	Information Sources	Findings and Recommendations
• What human resources are available to staff a prevention project (e.g., professional, volunteer, other)?		
• How much time can they commit?		
• What facilities and equipment are available to support the effort?		
• What potential funding exists for the effort (e.g., Federal or State grants, private foundations or corporations, agencies)?		
• What *pro bono* help is available (e.g., legal, accounting, advertising, research design/evaluation)?		
• What in-kind services are available (e.g., word processing, duplication, mail, telephones, computer time, other)?		
• Can funds be redirected from or combined with those of other programs to address the drug problem?		
• Are prevention services providers, as well as community volunteers, willing to commit additional time to the program effort if funds are limited?		

LOW	MOD	HIGH
READINESS		

COMMUNITY READINESS INVENTORY

4. VISION AND PLAN

Assessment Questions	Information Sources	Findings and Recommendations
• Is there a vision that embraces drug abuse prevention?		
• Who has the vision? How widely is the vision shared?		
• How do members of the community perceive the vision?		
• Will the community support the vision?		
• Are there people with planning skills available? Do they have the time, talent, resources, willingness to act to develop and implement the program?		
• Are community members, for example, parents and youth, willing to contribute to the planning process by participating in needs assessment activities and supporting the implementation of the plan?		
• Are there local evaluators who can be involved in the planning process to help design the plan and ensure that appropriate and measurable program objectives are identified?		
• Are the approaches/methods implied by the vision logical? Are they consistent with research findings on effective strategies?		
• Are the approaches suitable for the target population?		
• Is there evidence that the risk and/or protective factors addressed by the proposed prevention approach match those in the target population?		

LOW	MOD	HIGH
READINESS		

COMMUNITY READINESS INVENTORY

5. ENERGY TO MOBILIZE AND SUSTAIN PREVENTION ACTIVITIES

Assessment Questions	Information Sources	Findings and Recommendations
• Is the community motivated/committed to addressing the problem? Is there long-term commitment?		
• Are primary stakeholders involved?		
• What events have mobilized the community?		
• Are there leaders with energy, time, and talent?		
• Are there community members with time, energy, and talent?		
• What barriers are there to participation (e.g., intimidation by drug dealers, denial of the problem, lack of time, lack of commitment, lack of funds, and lack of accessibility)?		
• What benefits can be offered people for becoming involved (e.g., information-sharing, increased networking and new friendships, personal recognition, increased knowledge and skills)? What do people want to get out of their involvement?		
• Can prevention providers interested in participation have their job duties redefined to allow for greater participation?		
• Is the effort likely to be sustained after the initial excitement dies down?		
• Will resources be available over time or diminish radically when any major funding ends?		

LOW	MOD	HIGH
READINESS		

COMMUNITY READINESS INVENTORY		
6. NETWORKING WITH AND SUPPORT OF STAKEHOLDERS		
Assessment Questions	**Information Sources**	**Findings and Recommendations**
● What *ad hoc* neighborhood groups exist in the community that could become part of the effort?		
● What other community organizations should/can be included?		
● Does the effort have the blessing of key leaders?		
● Is the prevention effort likely to have support from leaders of other organizations?		
● Do leaders believe in prevention? Do they believe that improvement is possible?		
● Do the stakeholders believe that prevention works?		
● What types of prevention approaches do they believe work or not work?		
● Do the proposed prevention approaches match prevention providers' philosophy of prevention? Are local prevention providers likely to support one type of prevention approach over another?		

LOW	MOD	HIGH
READINESS		

COMMUNITY READINESS INVENTORY		
7. TALENT; LEADERSHIP STRUCTURE; SENSE OF COMMUNITY		
Assessment Questions	Information Sources	Findings and Recommendations
● Are community members civic-minded?		
● Are there key leaders willing to act?		
● Do leaders have the power and organizational capabilities needed?		
● Can the leaders establish and maintain a prevention program?		
● How homogeneous is the community?		
● To what extent do community members share the same values?		
● Is there a strong sense of community, with members feeling they want to preserve or create a drug-free community?		
● Does the community have any history of working together?		
● How stable is the community? Are there: — Long-term residents? — Homeowners?		
● What leadership exists in the community?		

LOW	MOD	HIGH
READINESS		

Prevention Programming Personal Case Study
Part Four

Answer the following questions for the case study that you began in module I.

14. What factors that contribute to community readiness were in place when you began this program?

15. What factors associated with community readiness were *not* in place when you began this program?

MODULE V: STRENGTHENING COMMUNITY READINESS

Overview

A community readiness assessment is important because it is useful in determining whether a community is mobilized and ready to implement a particular prevention strategy successfully. It also provides the opportunity to address deficiencies in community readiness. Because community readiness is a dynamic process, the status of the readiness factors can change over time. Assessing community readiness not only identifies where more work is needed but also suggests steps that can be taken to improve community readiness for drug abuse prevention programming.

This session will train participants to implement a community readiness assessment and to deal with issues that arise during the implementation phase. Emphasis will be placed on strengthening community readiness factors found to be deficient.

Time Needed:	2 hours
Methods:	Lecture (30 minutes) Discussion (30 minutes) Exercise (60 minutes)
Goal:	To increase participants' knowledge of strategies to increase community readiness.
Objectives:	By the end of module V, participants will be able to: ● Implement a Community Readiness Assessment using the Readiness Checklist. ● Develop at least one strategy to strengthen each key factor that is found to be weak. ● Apply this information to their own programs and communities.
Key Points:	● Assessing community readiness to implement drug abuse prevention programming is important because, if any factor is missing, the likelihood of program success is lessened. ● Before a community implements drug abuse prevention programming, the seven key factors should be strong.

Materials:		
	●	Prepared newsprints and easel
	●	Markers
	●	Tape
	●	Notepads and pencils
	●	Overhead projector
	●	Screen
	●	Overhead transparencies
	●	Watch
	●	RDA brochures
Overhead Transparencies:	● 5.1	Module V Objectives
	● 5.2	Readiness Checklist Instructions
	● 5.3	Strategies to Strengthen Key Factors
	● 5.4	Strategies to Strengthen Key Factor 1: Problem Definition
	● 5.5	Strategies to Strengthen Key Factor 2: Recognition of Problem by Community
	● 5.6	Strategies to Strengthen Key Factor 3: Existence of and Access to Resources
	● 5.7	Strategies to Strengthen Key Factor 4: Vision and Plan
	● 5.8	Strategies to Strengthen Key Factor 5: Energy to Mobilize and Sustain Prevention Activities
	● 5.9	Strategies to Strengthen Key Factor 6: Networking With and Support of Stakeholders
	● 5.10	Strategies to Strengthen Key Factor 7: Talent; Leadership Structure; Sense of Community
	● 5.11	Action Planning Principles
Handouts:	● 5.1	Substance Abuse Prevention Community Readiness Checklist
	● 5.2	Strategies to Strengthen Key Factors
	● 5.3	Sample Action Plan
	● 5.4	Prevention Programming Personal Case Study—Part Five

Prepared Newsprints:			
	●	5.1	Problem Definition
	●	5.2	Recognition of Problem by Community
	●	5.3	Existence of and Access to Resources
	●	5.4	Vision and Plan
	●	5.5	Energy to Mobilize and Sustain Prevention Activities
	●	5.6	Networking With and Support of Stakeholders
	●	5.7	Talent; Local Leadership Structure; Sense of Community

SCHEDULE FOR MODULE V: STRENGTHENING COMMUNITY READINESS

	Activity	Time	Methodology
1.	Overview of Module V	5 minutes	Lecture
2.	Using the Readiness Checklist	15 minutes	Exercise
3.	Using the Readiness Checklist: Group Reports	15 minutes	Discussion
4.	Strengthening the Key Factors	15 minutes	Lecture
5.	Developing Strategies To Strengthen Key Factors	15 minutes	Exercise
6.	Strategies To Develop Key Factors: Group Reports	15 minutes	Discussion
7.	Putting It All Together: Action Planning	30 minutes	Exercise
8.	Closing Remarks	10 minutes	Lecture

TOTAL TIME: **2 hours**

TRAINING PLAN FOR MODULE V: STRENGTHENING COMMUNITY READINESS	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
ACTIVITY 1: LECTURE 5 minutes OVERHEAD 5.1 MODULE V OBJECTIVES	**Overview of Module V** Display overhead 5.1, "Module V Objectives." Review module objectives by reading and elaborating on each objective. Solicit participants' questions about the objectives and respond to them as appropriate. Present an overview of the content and flow of the module, focusing on the key issues. Inform participants that: ● They will learn to implement a community readiness assessment using the Readiness Checklist. ● They will develop strategies to strengthen each key factor that is found to be weak.
ACTIVITY 2: EXERCISE 15 minutes HANDOUT 5.1 SUBSTANCE ABUSE PREVENTION COMMUNITY READINESS CHECKLIST	**Using the Readiness Checklist** Distribute handout 5.1, "Substance Abuse Prevention Community Readiness Checklist." Explain to participants how to use the Readiness Checklist, using the sample communities (handouts 4.10 through 4.12) and the questions they developed in the previous module to assess the status of the seven key factors.

TRAINING PLAN FOR MODULE V: STRENGTHENING COMMUNITY READINESS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
HANDOUT 4.10 COMMUNITY "A" NEIGHBORHOOD CONCERN	Tell the participants that they should check "low," "moderate," or "high" on the "Community Readiness Inventory" (handout 4.13) for the status of each key factor in their target community.
HANDOUT 4.11 COMMUNITY "B" NEIGHBORHOOD CONCERN	Inform participants that:
HANDOUT 4.12 COMMUNITY "C" NEIGHBORHOOD CONCERN	● For some communities, "low," "moderate," or "high" is not sufficient to describe the state of a particular community readiness factor.
HANDOUT 4.13 COMMUNITY READINESS INVENTORY	● A prevention team or coalition might determine that most elements of a key factor are present; however, the support of one integral person whose support would almost guarantee success is missing.
	● They should feel free to revise the form as needed for use in their own communities.
	Instruct participants to divide into the same seven groups as before and use the "Readiness Checklist" to assess readiness of their sample community to start drug abuse prevention programming.
	Direct each group to select a reporter who will report their responses to the large group.
OVERHEAD 5.2 READINESS CHECKLIST INSTRUCTIONS	Display overhead 5.2, "Readiness Checklist Instructions," and tell reporters that they should be prepared to answer these questions when they make their presentations.
	Tell the groups that they will have 10 minutes to complete this exercise.
	After 10 minutes, call time.

TRAINING PLAN FOR MODULE V: STRENGTHENING COMMUNITY READINESS	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
ACTIVITY 3: DISCUSSION **15 minutes**	**Using the Readiness Checklist: Group Reports** Ask the reporters from each small group to share with the large group the readiness status of the key factors that were deficient in their groups' assessment of their sample community. (They may record their responses on newsprint.) Ask each reporter: ● How did your group determine the readiness status of key factors? ● What strategy/activity would you use to develop deficient key factors? ● Who will be responsible for implementing the strategy/activity? ● When will the strategy/activity to develop the key factor be implemented?
ACTIVITY 4: LECTURE **15 minutes**	**Strengthening the Key Factors** Tell participants that specific strategies can be developed to enhance community readiness for factors found to be deficient on initial assessment.
OVERHEAD 5.3 STRATEGIES TO STRENGTHEN FACTORS	Display overhead 5.3, "Strategies to Strengthen Factors," and distribute handout 5.2, "Strategies to Strengthen Key Factors."
HANDOUT 5.2 STRATEGIES TO STRENGTHEN KEY FACTORS	Explain that: ● There are steps and strategies for strengthening each key factor that may be found to be deficient on the initial assessment.

TRAINING PLAN FOR MODULE V: STRENGTHENING COMMUNITY READINESS	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
	● A strategy will be presented for each key factors as follows: — Step 1. Conduct a Community Needs Assessment — Step 2. Increase Problem Recognition — Step 3. Access Community Resources — Step 4. Develop a Strategic Plan — Step 5. Maintain Momentum — Step 6. Mobilize the Community — Step 7. Choose an Organizational Structure Tell participants that these steps do not suggest an order in which communities should tackle deficient readiness factors. Rather, their presentation order merely corresponds with the PREVENT acronym. Ask participants as they listen to this information to think about which strategies apply to their case study community and to think about strategies that may apply to their communities where they are currently providing prevention programming.
OVERHEAD 5.4 STRATEGIES TO STRENGTHEN KEY FACTOR 1: PROBLEM DEFINITION	Display overhead 5.4, "Strategies to Strengthen Key Factor 1: Problem Definition." Tell participants that, for example, when key factor 1 is not optimally present, information to define the problem can be collected from sources, such as: ● Collectible data from the census, agency annual reports, social and health statistical reports, police records, social service, health, and mental health records, and educational system records.

TRAINING PLAN FOR MODULE V: STRENGTHENING COMMUNITY READINESS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	• Focus groups with prevention professionals, community leaders, or members of the general public.
	• Direct mail, telephone or in-person surveys, such as community attitude and opinion surveys, key leader surveys, or print media assessments.
OVERHEAD 5.5 STRATEGIES TO STRENGTHEN KEY FACTOR 2: RECOGNITION OF PROBLEM BY COMMUNITY	Display overhead 5.5, "Strategies to Strengthen Key Factor 2: Recognition of Problem by Community." Tell participants that when key factor 2 is not optimally present, public awareness can be raised by: • Create a communications advisory group. • Starting a media campaign. • Developing a public awareness marketing plan that identifies: — The problem; — Proposed solutions; — The group goals; — What can be achieved with available resources; and — How the group can use the media strategically to meet its goals. • Using public service announcements (PSAs) on radio or TV. • Paying for media time or using donated commercial time: — Free news releases; — Talk shows; — Local documentary coverage. • Designing newsworthy activities.

TRAINING PLAN FOR MODULE V: STRENGTHENING COMMUNITY READINESS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	● Using local community organizations (e.g., Rotary clubs). ● Hiring an advertising firm.

OVERHEAD 5.6 STRATEGIES TO STRENGTHEN KEY FACTOR 3: EXISTENCE OF AND ACCESS TO RESOURCES	Display overhead 5.6, "Strategies to Strengthen Key Factor 3: Existence of and Access to Resources."
	
	 Tell participants that when key factor 3 is not optimally present, resources need to be accessed and increased by:
	
	 ● Establishing the need with a valid, recent needs assessment.
	 ● Establishing a funding development working-group.
	 ● Establishing a long-range funding plan.
	 ● Having startup resources in place.
	 ● Identifying funding sources, such as:
	
	    — Public agencies;
	    — Federal, State, and local grants or contracts; and
	    — Private funding (e.g., foundation or corporate grants, private donations, direct solicitation).
	
	 ● Maintaining relationships for access to future resources.

OVERHEAD 5.7 STRATEGIES TO STRENGTHEN KEY FACTOR 4: VISION AND PLAN	Display overhead 5.7, "Strategies to Strengthen Key Factor 4: Vision and Plan." Tell participants that when key factor 4 is not optimally present, a vision and long-range plan can be developed by:

TRAINING PLAN FOR MODULE V: STRENGTHENING COMMUNITY READINESS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	• Establish a planning team for the immediate short-term (3 to 6 months), and long-range (9 to 24 months) future. Be sure the plan covers:
	— What is the problem? — Who is the target? — What is pressing? — What are resources? — What are goals and objectives? — What is likely to work? — How much will it cost?
	• Ensuring the vision is shared by the key people.
OVERHEAD 5.8 STRATEGIES TO STRENGTHEN KEY FACTOR 5: ENERGY TO MOBILIZE AND SUSTAIN PREVENTION ACTIVITIES	Display overhead 5.8, "Strategies to Strengthen Key Factor 5: Energy to Mobilize and Sustain Prevention Activities." Tell participants that when key factor 5 is not optimally present, energy to mobilize and sustain prevention activities comes when a community substance abuse prevention organization can accomplish several of the following.
	• Develop formal rules, roles, and procedures. • Retain professional staff. • Recruit nonprofessional community members. • Recruit reluctant members. • Offer various ways to participate. • Increase benefits and reduce costs of membership. • Decrease barriers to participation. • Increase member/team efficacy sense of role importance among members. • Identify and resolve agency/personnel conflict. • Continually recruit, orient, and train new members.

TRAINING PLAN FOR MODULE V: STRENGTHENING COMMUNITY READINESS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	• Prepare leaders-in-waiting. • Identify and raise funds. • Remember that things take time. • Build a resource databank.

OVERHEAD 5.9 STRATEGIES TO STRENGTHEN KEY FACTOR 6: NETWORKING WITH AND SUPPORT OF STAKEHOLDERS	Display overhead 5.9, "Strategies to Strengthen Key Factor 6: Networking With and Support of Stakeholders."
	
	Tell participants that when key factor 6 is not optimally present, networking with stakeholders is achieved by:
	
	• Involving those with a direct interest in the problem and its resolution.
	
	• Recruiting long-time homeowner/residents to participate in the prevention effort.
	
	• Identifying and recruiting diverse groups from the community, including:
	
	    — Lower income groups;
	    — Young people; and
	    — Elderly persons.
	
	• Using multiple recruitment strategies, including direct invitations.
	
	• Orienting and training members.
	
	• Matching tasks with member skills.
	
	• Using events to increase motivation.

TRAINING PLAN FOR MODULE V: STRENGTHENING COMMUNITY READINESS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
OVERHEAD 5.10 STRATEGIES TO STRENGTHEN KEY FACTOR 7: TALENT; LEADERSHIP STRUCTURE; SENSE OF COMMUNITY	Display overhead 5.10, "Strategies to Strengthen Key Factor 7: Talent; Leadership Structure; Sense of Community." Tell participants that when key factor 7 is not optimally present, talent and leadership can be recruited from: ● Existing leadership structures, such as: — Volunteer neighborhood organizations; — Human services coordinating structure; — Communitywide initiatives or coalitions; and — Self-help/support groups. ● Existing leadership types such as: — Single prominent leader; — Multiple leaders; or — Broad-based leadership, such as a steering committee. Tell participants that there are several models of leadership, such as: ● Professional model with paid staff; ● Grassroots or layperson model; and ● A balance of both. Tell participants that there are a number of places from which to recruit leaders, such as: ● Schools; ● Law enforcement; ● Substance abuse prevention agencies; ● Volunteers; ● Treatment providers; and ● Local government.

TRAINING PLAN FOR MODULE V: STRENGTHENING COMMUNITY READINESS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	Summarize this material by noting that:
	● Each factor is important.
	● Factors that are deficient might jeopardize a community's prevention efforts.
	● A community that does all these things will have a greater probability of succeeding.
ACTIVITY 5: EXERCISE **15 minutes** **HANDOUT 5.1 SUBSTANCE ABUSE PREVENTION COMMUNITY READINESS CHECKLIST**	**Developing Strategies To Strengthen Key Factors** Instruct the participants to divide into the same seven groups as before and use the "Substance Abuse Prevention Community Readiness Checklist" to identify strategies and activities for each factor that was deficient in their sample community. Explain: ● For example, if Key Factor 1: Problem Definition is not optimally present in their sample community, they should have checked "low." ● Now they should move to the right side of the chart to identify the strategies and/or activities necessary to develop the deficient key factor. ● They should identify the person or persons who will be responsible for implementing the strategies. ● They should set the timeframes within which the deficient key factor will be developed. ● They should repeat the process for any of the seven factors found to be weak.

TRAINING PLAN FOR MODULE V: STRENGTHENING COMMUNITY READINESS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	Direct each group to select a reporter who will report their responses to the large group. Tell the group that they will have 10 minutes to complete this exercise. After 10 minutes, call time.
ACTIVITY 6: DISCUSSION **15 minutes** **PREPARED NEWSPRINT 5.1 PROBLEM DEFINITION** **PREPARED NEWSPRINT 5.2 RECOGNITION OF PROBLEM BY COMMUNITY** **PREPARED NEWSPRINT 5.3 EXISTENCE OF AND ACCESS TO RESOURCES** **PREPARED NEWSPRINT 5.4 VISION AND PLAN** **PREPARED NEWSPRINT 5.5 ENERGY TO MOBILIZE AND SUSTAIN PREVENTION ACTIVITIES**	**Strategies To Develop Key Factors: Group Reports** Display prepared newsprints 5.1, "Problem Definition"; 5.2, "Recognition of Problem by Community"; 5.3, "Existence of and Access to Resources"; 5.4, "Vision and Plan"; 5.5, "Energy to Mobilize and Sustain Prevention Activities"; 5.6, "Networking With and Support of Stakeholders"; and 5.7, "Talent; Leadership Structure; Sense of Community." Ask the reporters from each small group to share with the large group the strategy/activity their group identified to develop each key factor that is missing in their sample community. As reporters present their materials, record strategies/activities on appropriate newsprints, and conduct a discussion by asking questions, such as: ● Why did your group select a particular strategy/activity? ● Why was that strategy better than others? ● Was this the consensus of the group? If not, why not? ● Was it easy or difficult to come to consensus?

TRAINING PLAN FOR MODULE V: STRENGTHENING COMMUNITY READINESS	
TIME, MEDIA AND MATERIALS	OUTLINE OF TRAINING ACTIVITIES
PREPARED NEWSPRINT 5.6 NETWORKING WITH AND SUPPORT OF STAKEHOLDERS PREPARED NEWSPRINT 5.7 TALENT; LEADERSHIP STRUCTURE; SENSE OF COMMUNITY ACTIVITY 7: EXERCISE 30 minutes OVERHEAD 5.11 ACTION PLANNING PRINCIPLES	**Putting It All Together: Action Planning** Display overhead 5.11, "Action Planning Principles." Explain to participants that there are important principles that must be considered when planning actions to implement drug abuse prevention programming. These principles include: ● Clear problem identification and definition; ● Realistic goal setting; ● Establishing measurable objectives; ● Clear definition of tasks; ● Establishing specific and realistic dates for task completion; ● Assigning responsibility; and ● Identifying resources that are available.
HANDOUT 5.3 SAMPLE ACTION PLAN	Distribute handout 5.3, "Sample Action Plan." Tell participants that this is an example of an action plan they could use as they design strategies to develop any deficient key community readiness factors in their communities.

TRAINING PLAN FOR MODULE V: STRENGTHENING COMMUNITY READINESS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
HANDOUT 4.3 PROBLEM DEFINITION HANDOUT 1.2 PREVENTION PROGRAMMING PERSONAL CASE STUDY—PART ONE HANDOUT 1.5 PREVENTION PROGRAMMING PERSONAL CASE STUDY—PART TWO HANDOUT 3.7 PREVENTION PROGRAMMING PERSONAL CASE STUDY—PART THREE HANDOUT 4.14 PREVENTION PROGRAMMING PERSONAL CASE STUDY—PART FOUR HANDOUT 5.4 PREVENTION PROGRAMMING PERSONAL CASE STUDY—PART FIVE	Refer participants back to handout 4.3, "Problem Definition"; handout 1.2, "Prevention Programming Personal Case Study—Part One"; handout 1.5, "Prevention Programming Personal Case Study—Part Two"; handout 3.7, "Prevention Programming Personal Case Study—Part Three"; and handout 4.14, "Prevention Programming Personal Case Study—Part Four." Distribute handout 5.4 "Prevention Programming Personal Case Study—Part Five." Ask them to consider the prevention program they are or were associated with and to complete questions 16, 17 and 18. Allow 15 minutes for this exercise. After 15 minutes, call time. Ask for volunteers to discuss the key questions they identified, what could have been done to strengthen key factors of community readiness that were not optimally in place when they began their programs, and what they might have done to make their programs more effective. Discuss their answers. Acknowledge answers that support their current efforts. Summarize the discussion. Explain that this training was a means to begin to familiarize participants with the concepts of community readiness.

TRAINING PLAN FOR MODULE V: STRENGTHENING COMMUNITY READINESS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	Tell participants that this information may trigger more questions.
	For more information, refer them to *Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools*.
OVERHEAD 5.1 MODULE V OBJECTIVES	Display overhead 5.1, "Module V Objectives," and review module V learning objectives.
	Ask participants to make a personal assessment of what they have learned. Go around the room and ask each participant to state one thing that he or she has learned during this module.
ACTIVITY 8: LECTURE **10 minutes**	**Closing Remarks** Make appropriate closing remarks. Acknowledge participants for their participation. Briefly summarize what was accomplished during the training. Hand out certificates, certification credits, or other appropriate paperwork. Stress that: • Universal, selective, and indicated prevention models provide three different strategies for addressing drug abuse problems, depending on the risk factors targeted and other factors. • Knowledge and consideration of risk and protective factors are integral to designing effective drug abuse prevention programs.

TRAINING PLAN FOR MODULE V: STRENGTHENING COMMUNITY READINESS	
TIME, MEDIA AND MATERIALS	**OUTLINE OF TRAINING ACTIVITIES**
	● It is important to assess the readiness of a community to respond to drug abuse prevention efforts; deficient readiness factors can be strengthened.
RDA BROCHURE	Remind participants that they can find more information about the topics introduced in this training by consulting the other materials that comprise the Drug Abuse Prevention RDA set of materials. Distribute copies of the brochure and review briefly what is covered in each manual.
	Thank participants for their participation
	Adjourn.

Module V Objectives

By the end of module V, participants will be able to:

- Implement a Community Readiness Assessment using the Readiness Checklist;

- Develop at least one strategy for each factor that is found to be weak; and

- Apply this information to their own programs and communities.
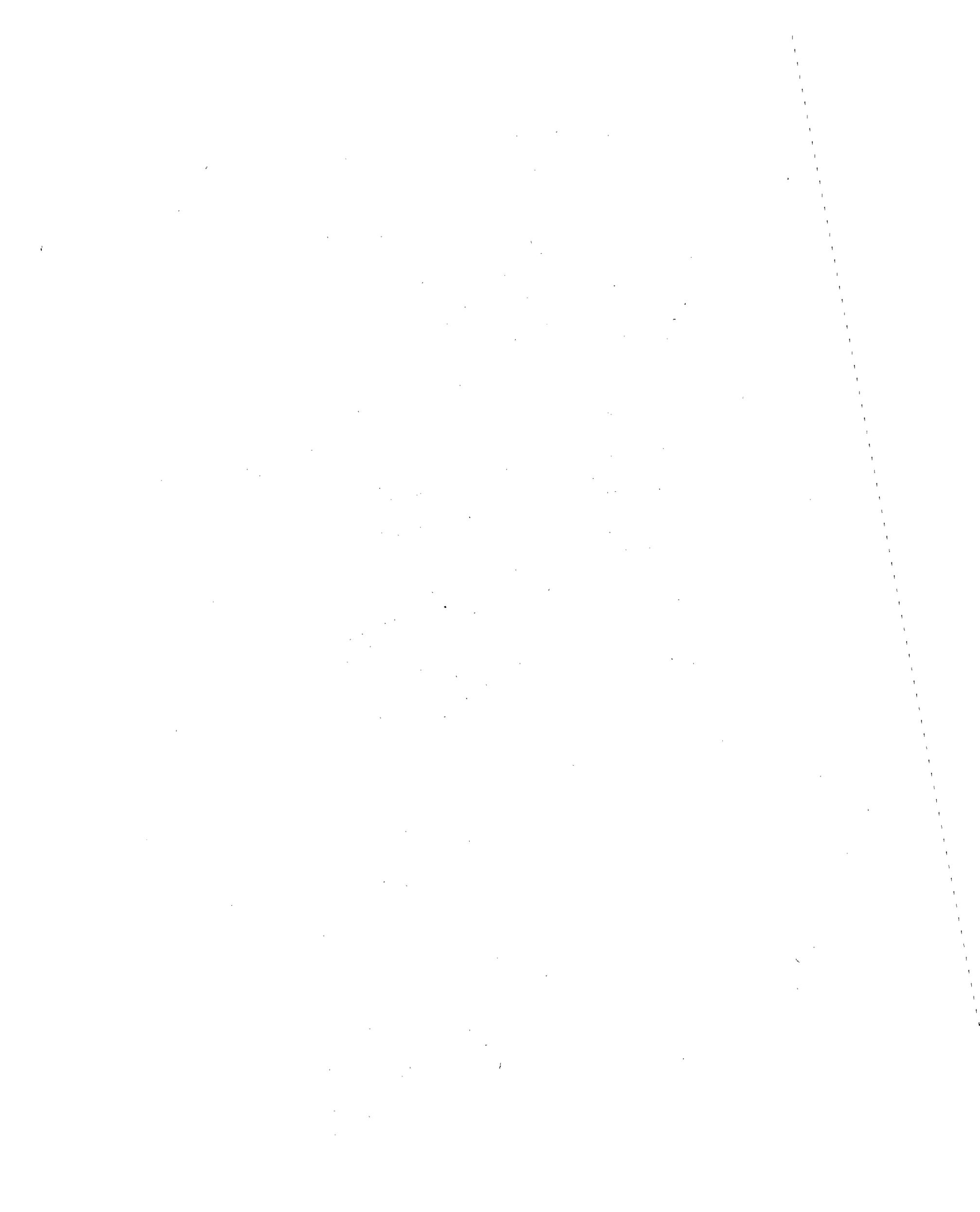
Readiness Checklist Instructions

- How did your group determine the readiness status of the key factors?

- What strategy/activity would you use to develop deficient key factors?

- Who will be responsible for implementing the strategy/activity?

- When will the strategy/activity be implemented?

Strategies to Strengthen Key Factors

- **Step 1.** Conduct a Community Needs Assessment

- **Step 2.** Increase Problem Recognition

- **Step 3.** Access Community Resources

- **Step 4.** Develop a Strategic Plan

- **Step 5.** Maintain Momentum

- **Step 6.** Mobilize the Community

- **Step 7.** Choose an Organizational Structure

Strategies to Strengthen Key Factor 1: Problem Definition
⇓
Conduct a Needs Assessment

- Check Collectible Data Sources

- Convene Focus Groups

- Conduct Direct Surveys and Other Assessments

Strategies to Strengthen Key Factor 2: Recognition of Problem by Community
⇓
Increase Problem Recognition

- Create a communications advisory group

- Start a media campaign

- Develop a public awareness marketing plan

- Use public service announcements (PSAs)

- Pay for media time or use donated commercial time

- Design newsworthy activities

- Use local community organizations

- Hire an advertising agency

Strategies to Strengthen Key Factor 3:
Existence of and Access to Resources
⇓
Access Community Resources

- Establish the need with a valid, recent needs assessment

- Establish a funding development working-group

- Establish a long-range funding plan

- Have startup resources in place

- Identify funding sources

- Maintain relationships for access to future resources

Strategies to Strengthen Key Factor 4:
Vision and Plan
⇓
Develop a Strategic Plan

- Establish a Planning Team

- Develop a Three-Phase Planning Process

- Ensure Vision Is Shared by Key People

- Ensure Important Issues Are Addressed

Strategies to Strengthen Key Factor 5: Energy to Mobilize and Sustain Prevention Activities

⇓

Maintain Momentum

- Develop formal rules, roles, and procedures

- Retain professional staff

- Recruit nonprofessional community members

- Recruit reluctant members

- Offer various ways to participate

- Increase benefits and reduce costs of membership

- Decrease barriers to participation

Strategies to Strengthen Key Factor 5:
Energy to Mobilize and Sustain Prevention Activities
⇓
Maintain Momentum
(Continued)

- Increase member/team efficacy and sense of role importance among members

- Identify and resolve agency/personnel conflict

- Continually recruit, orient, and train new members

- Prepare leaders-in-waiting

- Identify and raise funds

- Remember that things take time

- Build a resource databank

Strategies to Strengthen Key Factor 6: Networking With and Support of Stakeholders
⇓
Mobilize the Community

- Involve those with direct interest

- Recruit long-term homeowners/residents

- Identify and recruit diverse groups

- Use multiple recruitment strategies/direct invitations

- Orient and train members

- Match tasks with members skills

- Use events to increase motivation

Strategies to Strengthen Key Factor 7: Talent; Leadership Structure; Sense of Community
⇓
Choose an Organizational Structure

- Leadership Structures

- Leadership Types

- Leadership Models

- Where to Recruit Leadership

Action Planning Principles

- Clear problem identification and definition

- Realistic goal setting

- Establishing measurable objectives

- Clear definition of tasks

- Establishing specific and realistic dates for task completion

- Assigning responsibility

- Identifying resources that are available

Substance Abuse Prevention Community Readiness Checklist

Key Factor	Readiness Status			Strategy/Activity	Person(s) Responsible	To Be Done By When
	Low	Mod.	High			
Problem Definition						
Recognition of Problem by Community						
Existence of and Access to Resources						
Vision and Plan						
Energy to Mobilize and Sustain Prevention Activities						
Networking With and Support by Stakeholders						
Talent; Leadership Structure; Sense of Community						

Strategies To Strengthen Key Factors

PROBLEM DEFINITION ⇒ CONDUCT A NEEDS ASSESSMENT

- Check collectible data from:

  - Census data
  - Agency annual reports
  - Social and health statistical records
  - Police records
  - Social service, health, and mental health agency records
  - Educational systems records

- Convene focus groups

  - Prevention professionals
  - Community leaders
  - General public

- Conduct direct surveys (mail, telephone, inperson) and other assessments

  - Community attitudes and opinion surveys
  - Key leader surveys
  - Print media assessments

RECOGNITION OF PROBLEM BY COMMUNITY ⇒ INCREASE PROBLEM RECOGNITION

Raise public awareness by:

- Creating a communications advisory group
- Starting a media campaign
- Developing a public awareness marketing plan to identify:

  - What is the problem?
  - What are the proposed solutions?
  - What are the groups goals?
  - What can be achieved with available resources?
  - How can the group use the media strategically to meet its goals?

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- Use public service announcements on radio and TV
- Paying for media time
- Using donated commercial time

  — Free news releases
  — Talk shows
  — Local documentary coverage

- Designing newsworthy activities
- Using local community organizations (e.g., Rotary clubs)
- Hiring an advertising agency

EXISTENCE OF AND ACCESS TO RESOURCES ⇒ ACCESS COMMUNITY RESOURCES

- Establish the need with a valid, recent needs assessment
- Establish a funding development working group
- Establish a long-range funding plan
- Have startup resources in place
- Identify funding sources

  — Public agency funds
  — Federal, State, and local grants or contracts
  — Private funding (foundation or corporate grants, private donations, direct solicitation)

- Maintain relationships for access to future resources

VISION AND PLAN ⇒ DEVELOP STRATEGIC PLAN

- Establish a planning team
- Develop a three-phase planning process

  — Implementation (immediate)
  — Short-term (3-6 months)
  — Long-term (9-24 months)

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- Ensure the vision is shared by key people
- Ensure important issues are addressed

  - What is the problem?
  - Who is the target?
  - What is pressing?
  - What are the goals and objectives?
  - What are the resources?
  - What is likely to work?
  - How much will it cost?

ENERGY TO MOBILIZE AND SUSTAIN PREVENTION ACTIVITIES ⇒ MAINTAIN MOMENTUM

- Develop formal rules, roles, and procedures
- Retain professional staff
- Recruit nonprofessional community members
- Recruit reluctant members
- Offer various ways to participate
- Increase benefits and reduce costs of membership
- Decrease barriers to participation
- Increase member/team efficacy and sense of role importance among members
- Identify and resolve agency/personnel conflict
- Continually recruit, orient, and train new members
- Prepare new leaders-in-waiting
- Identify and raise funds
- Remember that things take time
- Build a resource databank

NETWORKING WITH AND SUPPORT OF STAKEHOLDERS ⇒ MOBILIZE THE COMMUNITY

- Involve those with a direct interest in the problem and its resolution
- Recruit long-time homeowners and residents to participate in the prevention effort
- Identify and recruit diverse groups from the community, including:

  - Lower income groups
  - Young people
  - Elderly persons

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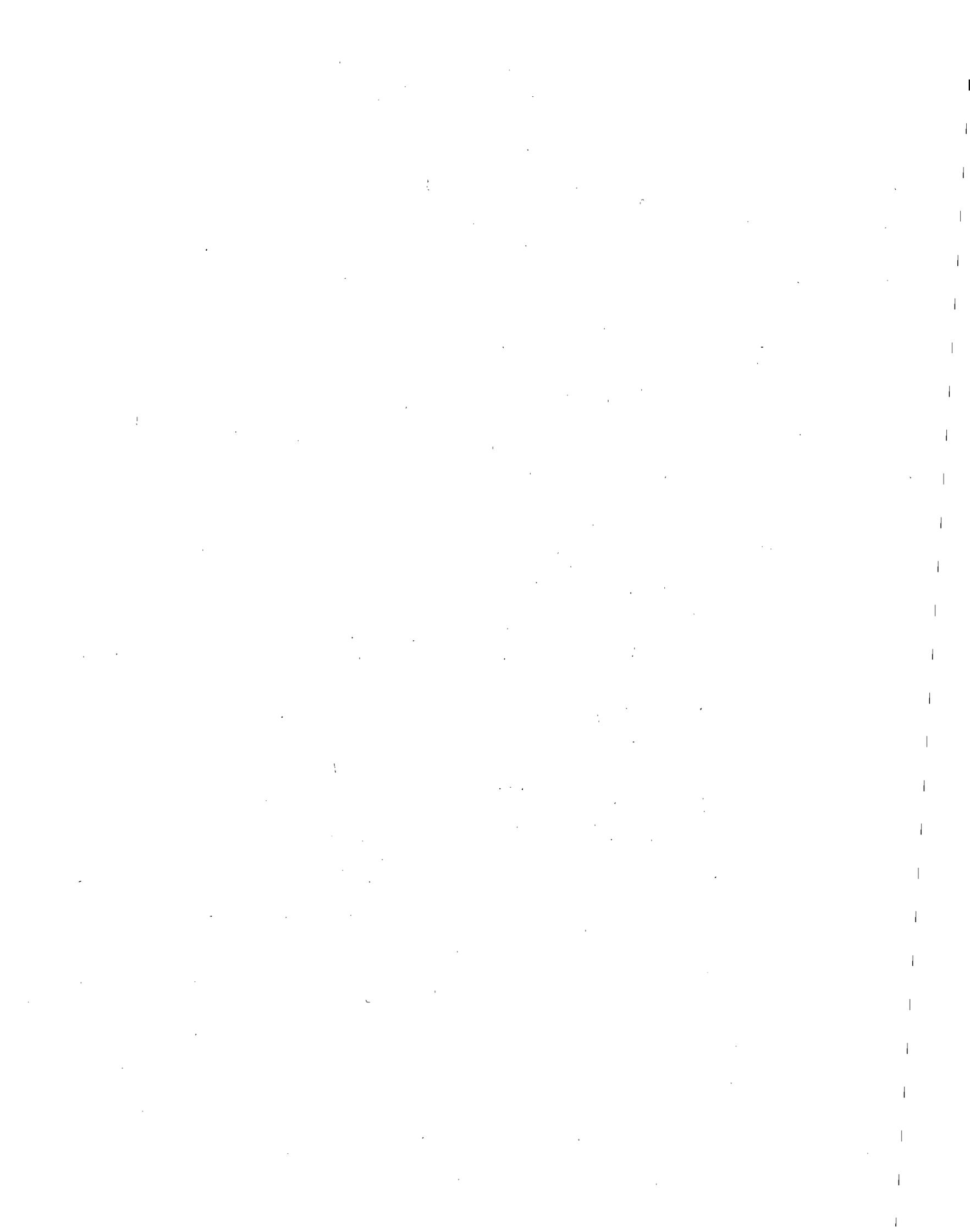
- Use multiple recruitment strategies, including direct invitations.
- Orient and train new members
- Match tasks with members skills
- Use events to increase motivation

TALENT; LEADERSHIP STRUCTURE; SENSE OF COMMUNITY ⇒ CHOOSE AN ORGANIZATIONAL STRUCTURE

- Leadership Structures

    — Volunteer neighborhood organizations
    — Human services coordinating structures
    — Communitywide initiatives or coalitions
    — Self-help/support groups

- Leadership Types

    — Single prominent leader
    — Multiple leaders
    — Broad-based leadership/steering committee

- Leadership Models

    — Professional model with paid staff
    — Grassroots or laymen model
    — Balance of both

- Where to Recruit Leadership

    — Schools
    — Law enforcement
    — Substance abuse prevention agencies
    — Volunteers
    — Treatment providers
    — Local government

SAMPLE ACTION PLAN

GOAL: Develop Local Leadership

OBJECTIVE: Recruit three local residents to serve on steering committee

Tasks/Activities	Date Due?	By Whom?	What Resources?
1. Call local treatment provider			
2. Place ad in paper			
3. Call four people to ask whether they will help			
4. Call the local police precinct for local DARE officer's name			
5.			
6.			
7.			
8.			

Prevention Programming Personal Case Study
Part Five

Answer the following questions for the case study that you began in module I.

16.   As you review the community readiness questions, identify important questions and the answers to those questions to provide insight about your prevention program.

17.   What could have been done to increase key factors of community readiness that were not in place when you began this program?

18.   Based on information from this workshop, what might you do to make this program more effective?

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National Institute on Drug Abuse

Drug Abuse Prevention: What Works

U.S. Department of Health and Human Services
National Institutes of Health

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ACKNOWLEDGMENTS

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HOW TO USE THE DRUG ABUSE PREVENTION
RESEARCH DISSEMINATION AND APPLICATIONS MATERIALS

Despite the best efforts of the Federal, State, and local governments, the abuse of drugs continues to pose serious threats to the health, and social and economic stability of American communities. The causes of and factors associated with drug abuse are complex and vary across different segments of the population. To be effective, prevention programs must address not only the drug abuse behavior itself but also the relevant cultural, ethnic, regional, and other environmental and biopsychosocial aspects of the population segments being targeted for the prevention efforts. Therefore, it is important to match the program with the population it is to serve and the local community context within which it is to be implemented. The challenge for prevention practitioners is to select, modify, or design prevention strategies that will meet the needs of their constituencies, whether they comprise a whole community or specific segments within a community.

The Drug Abuse Prevention Research Dissemination and Applications (RDA) materials, of which this handbook is a part, are designed to help practitioners plan and implement more effective prevention programs based on evidence from research about what works. These materials provide practitioners with the information they need to prepare their communities for prevention programming and to select and implement substance abuse prevention strategies that effectively address the needs of their local communities. These materials are intended for use by prevention practitioners who vary in their training and experience in the field but who are interested in developing prevention programs in their communities. The target audience for these documents includes prevention program administrators, prevention specialists, community volunteers, community activists, parents, teachers, counselors, and other individuals who have an interest in drug abuse and its prevention.

This handbook, *Drug Abuse Prevention: What Works,* provides an overview of the theory and research on which these materials are based. It includes a definition of prevention, descriptions of substance abuse risk and protective factors and a discussion of the key features of three prevention strategies—universal, selective, and indicated—that have proven effective. The handbook also explains how prevention efforts can be strengthened by using knowledge gained through research. In addition to this introductory handbook, the core set of materials also includes three other documents:

- A *brochure* describes the contents of this set of RDA materials and provides information about how prevention practitioners can obtain these materials.

- *Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools* is a resource manual that introduces the concept of community readiness for substance abuse prevention programming. The manual defines community readiness and provides a rationale for assessing a community's readiness prior to the planning or

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implementation of substance abuse prevention activities. It then identifies seven factors for assessing a community's readiness and offers strategies for increasing readiness factors found to be deficient.

● *Drug Abuse Prevention and Community Readiness: Training Facilitator's Manual* is a 9-hour, modular training curriculum, designed for use by training facilitators in introducing prevention practitioners and community members to the basic theory of drug abuse prevention and the three prevention strategies. The facilitator's manual also provides them with the skills to assess and increase the readiness of a community to launch a prevention effort. The curriculum includes talking points for lectures, instructions for conducting discussions and exercises, and overheads and handouts.

These four core components are intended to be used together as a set. Three stand-alone documents provide more intensive guidance on implementing the three prevention models introduced in the core set of materials. Each manual provides more detailed information about the strategy, including a rationale for its use and a description of a research-based program model that illustrates the strategy. Information is provided on the key elements of the program, issues that need to be addressed to implement the program successfully, and resources that practitioners can access for more information about the program. These models have been selected because National Institute on Drug Abuse (NIDA) research indicates that these programs have been effective in preventing adolescent substance abuse. The following are the three stand-alone resource manuals:

● *Drug Abuse Prevention for the General Population* discusses the history and key features of universal prevention programs. The Project STAR Program—a communitywide program designed to teach adolescents the skills necessary to counteract the psychosocial influences that increase the likelihood of substance abuse—is described as an illustration of a universal prevention strategy.

● *Drug Abuse Prevention for At-Risk Groups* discusses the history and key features of selective prevention programs. The Strengthening Families Program—a family-focused program targeting children ages 6 to 10 whose parents are substance abusers—is described as an illustration of a selective prevention strategy.

● *Drug Abuse Prevention for At-Risk Individuals* discusses the history and key features of indicated prevention programs. The Reconnecting Youth Program—a school-based program targeting 9th- through 12th-grade students who are at risk for dropping out of school, substance abuse, and suicidal behavior—is described as an illustration of an indicated prevention strategy.

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These examples of universal, selective, and indicated prevention illustrate how different communities have implemented these approaches effectively and show how the models can be varied in different settings. Their inclusion in these materials does *not* imply an endorsement by NIDA. More information on these program models can be found in a video prepared by NIDA titled *Coming Together on Prevention*, which is available from the National Clearinghouse for Alcohol and Drug Information (NCADI). (See appendix A.) If prevention practitioners determine that one or more of these case examples might be appropriate for their communities, they can use the relevant resource manual as a supplement to the RDA core package. The stand-alone resource manuals are not included as part of the RDA core package and have to be ordered separately. Figure 1 shows how a practitioner might use the documents in this set of RDA materials. Appendix A provides information on how to order the RDA core package, the stand-alone manuals, the video, and other materials on the three programs.

These RDA materials are not intended to be an all-inclusive discourse on drug abuse prevention and programming. The programs presented as illustrations of the three prevention strategies all target children or adolescents. This selection is purposeful because this population has been the major thrust of policy, research, and program efforts. This does not imply that there are no effective substance abuse prevention efforts targeting adults, only that this topic is beyond the scope of these materials.

Purpose of This Handbook

Given the nature and extent of the problem of drug abuse, this handbook is designed to provide the reader with a basic understanding of the concept of drug abuse prevention. This handbook is intended for use by prevention practitioners who are interested in developing, modifying, or expanding existing prevention efforts.

The primary objectives of this handbook are to:

- define drug abuse prevention in ways that are useful for the development of prevention initiatives;

- give an overview of some important concepts and models in drug abuse prevention;

- provide empirically-based information to demonstrate that drug abuse prevention works;

- offer a framework for thinking about and organizing prevention initiatives at the community level;

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- provide working examples of effective prevention programs for practitioners who may be considering implementing one or more of the prevention models described in this set of materials; and

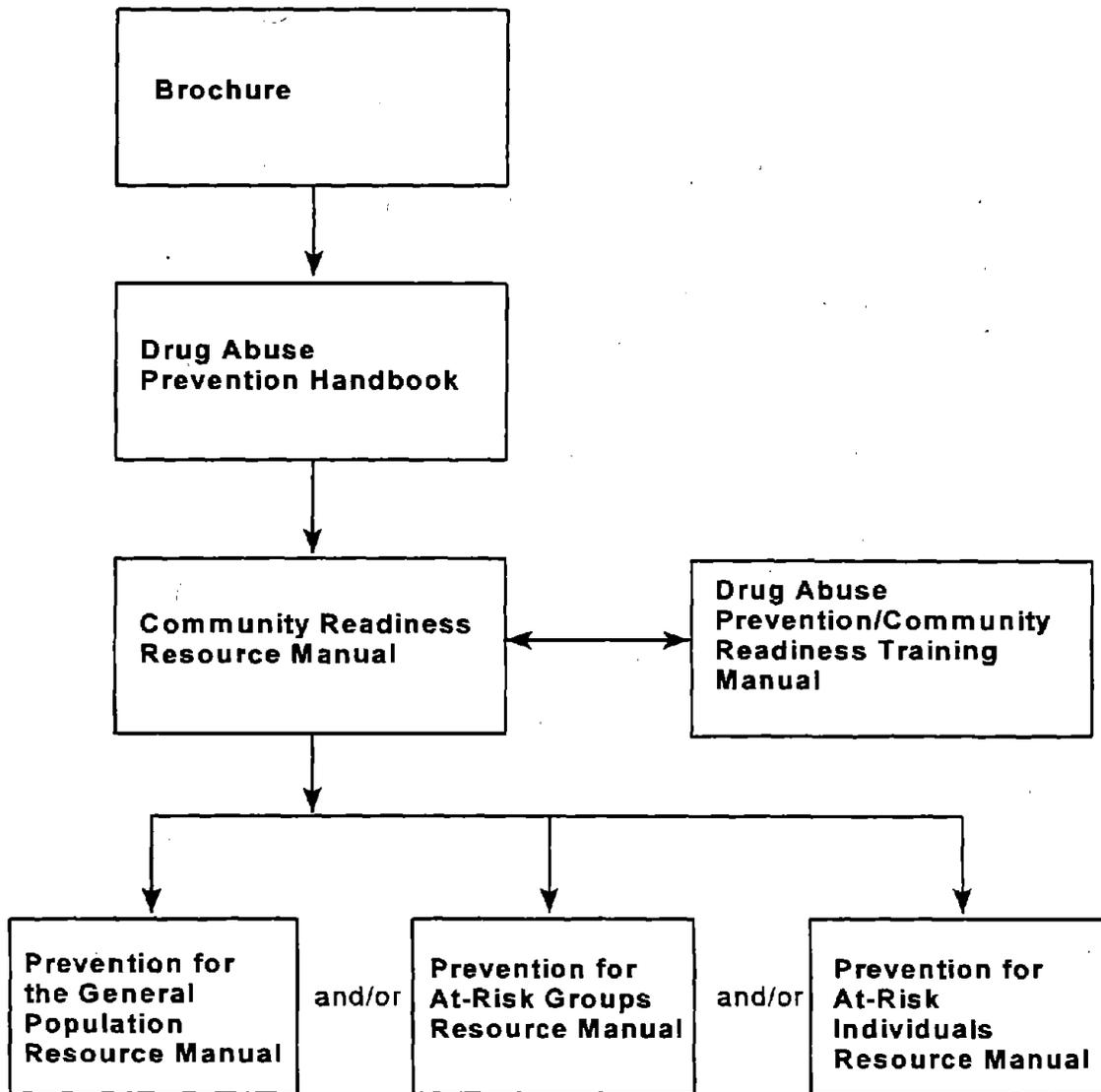- motivate readers to consider initiating and/or participating in prevention efforts.

This handbook begins with a summary of the drug abuse problem in the United States and a discussion of drug abuse prevention, followed by a description of two types of antidrug strategies: supply reduction and demand deduction. This discussion introduces a new nomenclature for the classification of demand reduction strategies—universal, selective, and indicated prevention. This handbook reviews relevant literature on research-based theory for substance abuse prevention programming, including a summary of research findings on risk and protective factors associated with substance abuse. This handbook presents some general prevention approaches and guidelines for effectively addressing those factors and concludes with a summary of each of the program models used in these RDA materials to illustrate universal, selective, and indicated substance abuse prevention strategies.
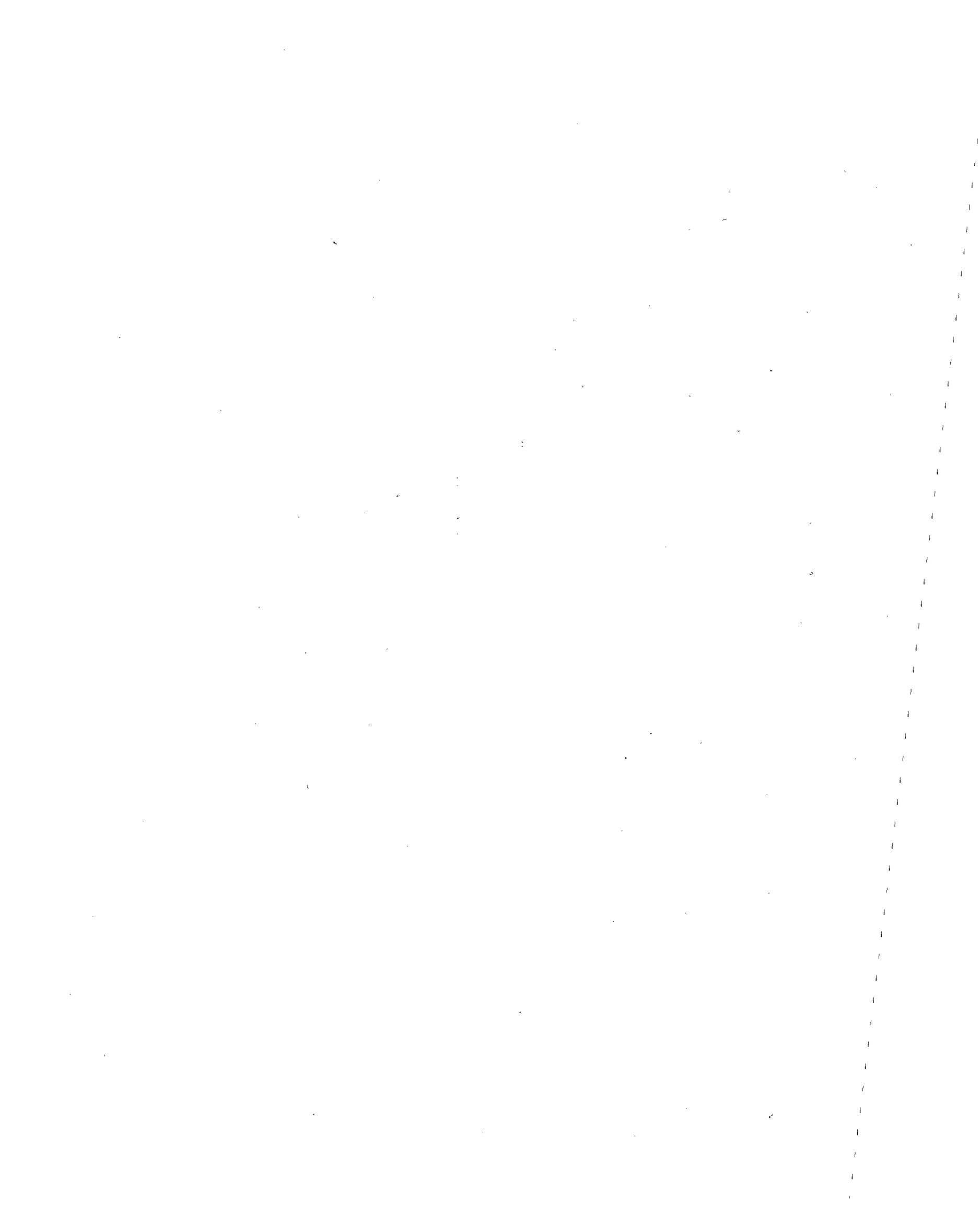
Throughout this handbook and the other documents in the drug abuse prevention RDA materials, *substance abuse* is used to refer to illicit drug and alcohol abuse and to the use of tobacco products. Readers unfamiliar with the substance abuse and prevention terms used throughout this handbook are referred to the Center for Substance Abuse Prevention (CSAP) *Prevention Primer: An Encyclopedia of Alcohol, Tobacco, and Other Drug Prevention Terms* referenced in appendix A.

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Figure 1

Drug Abuse Prevention

Research Dissemination and Applications Materials

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│  Drug Abuse         │
│  Prevention Handbook│
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│                     │          │  Drug Abuse         │
│  Community Readiness│◄────────►│  Prevention/Community│
│  Resource Manual    │          │  Readiness Training │
│                     │          │  Manual             │
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Prevention for the General Population Resource Manual	and/or	Prevention for At-Risk Groups Resource Manual	and/or	Prevention for At-Risk Individuals Resource Manual

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INTRODUCTION TO PREVENTION AND EXTENT OF THE PROBLEM

Drug abuse among young people and adults is a serious national health and social problem despite the efforts of Federal, State, and local governments during the past decade. National Household Survey data show a steady decline in the use of illegal drugs for Americans aged 12 and older from a peak of 24 million in 1972 to 11.4 million in 1992 (NIDA 1993). Although occasional cocaine use has decreased since 1985 and occasional alcohol use has decreased since 1988, frequent cocaine use and heavy drinking have remained unchanged. According to findings from NIDA, illegal drug use is most prevalent among 18- to 25-year-olds. Most drug abusers (76 percent or 8.7 million people) are white males who are unemployed, have not completed high school, and reside in large cities (NIDA 1993).

Although progress seemed to have been made between 1982 and 1992 with decreased substance abuse among high school seniors, increased substance abuse among eighth, tenth and twelfth graders in the subsequent three years has been confirmed by the Monitoring the Future Survey (NIDA 1996). Findings from a recent Office of National Drug Control Policy (ONDCP) symposium on causes for this upturn in adolescent use suggest many possible causes: popular youth culture, music glorifying the use of substances, reduced concern about the negative consequences of substance abuse, and significantly decreased levels of substance abuse prevention activity in schools.

Prevention of substance abuse is important to the health, social, and economic stability of this country, because the cost of substance abuse affects the well-being of Americans in all of these areas. The estimated cost of substance abuse in 1988 was $144.1 billion (Rice 1991), with roughly 60 percent of this cost resulting from alcohol abuse and 40 percent due to other drug abuse.

Substance abuse contributes significantly to rising health care costs in the treatment of alcoholism and drug addiction, as well as other diseases—such as diabetes, cirrhosis, cardiovascular disease, cancer, and fetal and neonatal disorders—that are associated with alcohol, tobacco, and other drugs. In one county in Florida, an estimated 11-15 percent of all pregnant women had been exposed to an illegal substance (Chasnoff et al. 1990). Such exposure has been associated with damage to a developing fetus and with other post partum disorders in infants and young children. Insufficient funding and lack of available treatment facilities for addicted women continue to hamper efforts to reduce this problem. The high correlation found between substance abuse and mental disorders further complicates drug treatment. In addition, substance abuse cure rates are low and relapse rates are very high.

From an economic and social perspective, substance abuse affects work productivity and unemployment, incidences of violence, family deterioration, and academic and other problems among young people. Reduced work productivity and unemployment correlate to substance abuse. According to the 1985 National Household Survey on Drug Abuse (NIDA 1985),

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employees who abuse substances have been found to exert a greater negative impact on the workplace than employees who do not. For example, substance abusers are late to work three times more often, they are 3.6 times more likely to have accidents, and they request sick leave three times more often than nonabusers.

Drug-related violence and gang activity are increasingly being reported in urban schools and neighborhoods. Poverty, lack of opportunities for youth, neighborhood disorganization, and deterioration in family circumstances all relate to increased illegal drug trafficking and increased drug susceptibility among youth from at-risk environments (Fagan 1987). Urban youth from low socioeconomic backgrounds are more vulnerable to becoming drug dealers (Elliott et al. 1989), and dealing often leads to substance abuse.

Huizinga and colleagues (Huizinga et al. 1991) found considerable overlap between delinquency, school failure, substance abuse, and teen pregnancy among several thousand youth in high-risk communities. Delinquency correlated significantly with drug abuse and early sexual activity, particularly among girls. The authors concluded that "targeting delinquency and substance abuse simultaneously in . . . prevention programs will more likely enhance the effectiveness of such programs in each problem area than will programs that focus uniquely on either substance abuse or delinquency." Therefore, increasing prevention activities should be a priority for communities in addressing the health, social, and economic consequences associated with substance abuse (Huizinga et al. 1991).

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PREVENTION: WHAT IS IT?

Although there is no single definition of *prevention*, practitioners often agree that, as an antidrug strategy, "prevention offers communities an opportunity to stop . . . drug problems before they start, and provides hope for effecting community change to support healthy behaviors" (CSAP 1993). This chapter introduces two primary antidrug strategies: those designed to reduce the supply of illegal drugs and those designed to reduce the demand for drugs. Most of the chapter focuses on demand reduction strategies and describes the general universal, selective, and indicated prevention approaches (Gordon 1987; Institute of Medicine 1994). The key features of these methods are then summarized. The chapter concludes with a discussion of the difference between prevention and treatment.

Supply Reduction Strategies

Supply reduction strategies include any method used to reduce the availability of drugs, such as the destruction of drug crops, confiscation of drug shipments, border patrols, and criminal penalties for drug use and dealing. Within the realm of legal substances, such as alcohol and tobacco, supply reduction strategies include increasing taxes, increasing the legal age of use, increasing law enforcement, reducing product advertising, reducing the number of sales outlets, and imposing penalties for sales of these products to minors.

Since 1980, the *War on Drugs* has been fought with increasingly more funding earmarked by Congress for supply reduction approaches. The national budget for antidrug activities has risen from $1.5 billion in 1981 to $13.8 billion in 1996. In the late 1980s and early 1990s, approximately two-thirds of the drug control budget was allocated to supply reduction strategies and one-third to demand reduction activities.

Demand Reduction Strategies

Demand reduction strategies are designed to reduce the demand for illegal drugs. Prevention and treatment are part of demand reduction. Prevention attempts to reduce demand by decreasing risk factors and increasing protective factors associated with substance abuse. These factors are defined and discussed in the next chapter. Treatment is designed to decrease demand by stopping the substance abuse in the addicted or abusing individual.

In general, prevention may have any of five targets: the individual, the peer group, the school, the family, and the community. Prevention programs can be implemented in a variety of settings. For instance, a program targeting a peer group can be set up in a school, and a program targeting the family can be conducted in a community setting, such as a church or neighborhood center. Prevention programs for youth have tended to focus on only one of these five areas. Recent research results suggest that the effectiveness of prevention programs increases when more

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than one area is targeted in a comprehensive community prevention program. These RDA materials focus on three of these target areas: the school, the family, and the community.

The Public Health Classification System

Within the traditional public health classification of disease prevention, first proposed by the Commission on Chronic Illness (1957), antidrug strategies may target:

- the agent—the substance itself: alcohol, tobacco, and other drugs;

- the host—a person and his or her biological, psychological, and social susceptibilities to alcohol and other drug problems, as well as the knowledge and attitudes that influence the substance using behavior; and

- the environment—the setting in which the substance using behavior occurs, including the community mores, or norms, that shape the behavior.

Prevention strategies can focus on any of these targets. Attempts to change the agent are considered supply reduction strategies; attempts to alter the individual's desire for the substance are demand reduction strategies. Environmental strategies focus on the surroundings of the substance abuser: the community, school, or workplace. Environmental prevention strategies can be used for supply and demand reduction.

Within the public health classification of prevention, antidrug efforts have been organized along a continuum of primary, secondary, and tertiary prevention (Commission on Chronic Illness 1957; CSAP 1991). The goal of primary prevention is to protect individuals who have not begun to use substances, thereby decreasing the incidence of new users. The goal of secondary prevention (also called *early intervention*) is to intervene with persons in the early stages of substance abuse or exhibiting problem behaviors associated with substance abuse to reduce and/or eliminate substance use. The goal of tertiary prevention is to end substance dependency and addiction and/or ameliorate the negative effects of substance abuse through treatment and rehabilitation. In this model, tertiary prevention is most often referred to as *treatment*, but also includes rehabilitation and relapse prevention. The public health classification of prevention has been criticized by practitioners as confusing, particularly in its failure to distinguish secondary prevention (early intervention) from primary prevention or tertiary prevention (treatment).

The Institute of Medicine Classification System

In a 1994 report on prevention research, the Institute of Medicine (IOM 1994) proposed a new framework for classifying prevention based on Gordon's (1987) operational classification of disease prevention. The IOM model divides the continuum of care into three parts:

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prevention, treatment, and maintenance. The prevention category is divided into three classifications—universal, selective, and indicated prevention interventions, which replace the confusing concepts of primary, secondary, and tertiary prevention. NIDA has adopted this classification system. Although the IOM system distinguishes between prevention and treatment, *intervention* in this context is used in its generic sense and should *not* be construed to imply an actual treatment protocol. The last section of this chapter discusses the interface of prevention, treatment, and maintenance.

Within the IOM classification system, prevention programs are organized along a targeted audience continuum—that is, the degree to which any person is identified as an individual at risk for substance abuse. The at-risk determination is based on a combination of risk and protective factors associated with substance abuse. A *risk factor* is an association between some characteristic or attribute of an individual, group, or environment and an increased probability of certain disorders or disease-related phenomena at some point in time (Berman and Jobes 1991). *Protective factors* inoculate, or protect persons and can strengthen their determination to reject or avoid substance abuse. Protective factors can inhibit self-destructive behaviors and situations that advance substance abuse. These are discussed in the next chapter. The universal, selective, and indicated prevention interventions represent the population groups to whom the interventions are directed and for whom they are thought to be optimal, given an assessment of risk and protective factors.

Universal prevention strategies address the entire population (national, local community, school, neighborhood), with messages and programs aimed at preventing or delaying the abuse of alcohol, tobacco, and other drugs. Selective prevention strategies target subsets of the total population that are deemed to be at risk for substance abuse by virtue of their membership in a particular population segment—for example, children of adult alcoholics, dropouts, or students who are failing academically. Indicated prevention strategies are designed to prevent the onset of substance abuse in individuals who do not meet DSM-III-R or DSM-IV criteria for addiction, but who are showing early danger signs, such as falling grades and consumption of alcohol and other gateway drugs.

These three types of prevention interventions do not correspond well with the public health model of primary, secondary and tertiary prevention. The overall aim of all of these strategies is to reduce the number of new cases of substance abuse, as defined by the DSM-III-R or DSM-IV. These interventions are designed to reduce the length of time that the early signs of substance abuse continue and to halt the severity and intensity of the progression of substance abuse. These interventions also are intended to reduce the severity and intensity of the problem so that the individuals at risk for substance abuse do not go on to require a clinical diagnosis of the disorder.

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Universal Preventive Intervention Strategies

A universal preventive intervention is one that is desirable for all members of a given population. For example, it would include the general population and subgroups such as pregnant women, children, adolescents, and the elderly. The mission of universal prevention is to deter the onset of substance abuse by providing all individuals the information and skills necessary to prevent the problem. All members of the population share the same general risk for substance abuse, although the risk may vary greatly among individuals. Universal prevention programs are delivered to large groups without any prior screening for substance abuse risk. The entire population is assessed as at-risk for substance abuse and capable of benefiting from prevention programs (IOM 1994).

The risk and protective factors addressed in universal prevention programs may reflect some individual or subgroup characteristics, but primarily reflect environmental influences such as community values, school support, economic and employment stability, and so on. For example, some individuals may be physically and emotionally happy; they may be academically successful and have a wide circle of friends who also are academically successful; they may be involved in a variety of positive school activities; they may have families who are supportive and have solid positive values; and they may have high self-esteem and a sense of purpose in life. All these factors would serve to protect these individuals from drug abuse. Other individuals may be failing in school or work and come from dysfunctional families. All of these people may live in communities where there is a high rate of crime, drug dealing, and community dysfunction. Regardless of their individual risk for substance abuse, all of these people could benefit from universal prevention strategies.

General examples of universal preventive interventions include the use of seat belts, immunizations, prenatal care, and smoking prevention (IOM 1994). Examples of universal preventive interventions for drug abuse include substance abuse education for all children within a school district, media and public awareness campaigns within inner-city neighborhoods, and school policy changes regarding drug-free zones.

Universal prevention programs vary in type, structure, and design and can include school-family-, and community-based programs. An example of a school-based universal program is the life skills training program described by Botvin and colleagues (Botvin et al. 1990a). Universal family-based programs include dissemination efforts to families within the general population, such as the *Preparing for the Drug-Free Years (PDFY)* program of Hawkins and colleagues (Hawkins et al. 1987). This program was implemented through school and community agencies in Oregon. An example of a community-based universal prevention approach that involves multiple program elements that are delivered within a broad community context is the *Midwestern Prevention Project (Project STAR)* developed by Pentz and colleagues (Pentz et al.

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1990). This program is described in more detail later in this handbook and in the stand-alone document *Drug Abuse Prevention for the General Population.*

Key Features of Universal Prevention Programs

Regardless of the specific focus of universal prevention programs, they all share common characteristics. These include the following:

- The programs are designed to reach the entire population, without regard to individual risk factors, and they generally are designed to reach a very large audience;

- They are designed to delay or prevent substance abuse;

- Participants are not recruited to participate in the programs;

- The degree of individual substance abuse risk of the program participants is not assessed—the program is communicated to everyone in the population regardless of whether they are at risk for substance abuse;

- The programs usually have lower staff-to-audience member ratios than selective or indicated programs and may require less time and effort from the audience;

- Staff members can be professionals from other fields, such as teachers or school counselors, who have been trained to deliver the program; and

- Costs are spread over a large group and tend to be lower on a per-person basis than selective and indicated programs.

Selective Preventive Intervention Strategies

Selective prevention interventions target specific subgroups that are believed to be at greater risk than others. Risk groups may be identified on the basis of biological, psychological, social, or environmental risk factors known to be associated with substance abuse (IOM 1994), and targeted subgroups may be defined by age, gender, family history, place of residence such as high drug-use or low-income neighborhoods, and victimization by physical and/or sexual abuse. Selective prevention targets the entire subgroup regardless of the degree of risk of any individual within the group. One individual in the subgroup may not be at personal risk for substance abuse, while another person in the same subgroup may be abusing substances. The selective prevention program is presented to the entire subgroup because the subgroup as a whole is at higher risk for substance abuse than the general population. An individual's personal risk is not specifically

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assessed or identified and is based solely on a presumption given his or her membership in the at-risk subgroup.

The risk factors assessed and addressed in selective prevention programs reflect both individual and subgroup characteristics (for example, high sensation seekers, delinquent peer-group associations, familial substance abuse), as well as environmental influences like high rates of crime, unemployment, and community disorganization. For example, one subgroup may have physical or mental health problems, experience academic difficulties and school failure, yet live in neighborhoods with low crime rates and high employment (protective factors). They share risk factors with the subgroup as a whole and are considered part of the subgroup for purposes of selective preventive interventions.

General examples of selective preventive interventions include home visitation and infant daycare for low birth-weight children and annual mammograms for women with a family history of breast cancer (IOM 1994). Examples of selective preventive interventions for substance abuse include special clubs and groups for children of alcoholics, rites of passage programs for at-risk males, and skills training programs that target young children of substance-abusing parents. The children may be drug-free but are at risk of subsequently developing drug abuse.

Generally, selective prevention programs are operated in schools or community agencies. Some selective prevention programs include education and skills training programs. Other selective prevention approaches include mentoring and tutoring. The *Strengthening Families Program* developed by Kumpfer and colleagues (Kumpfer et al. 1989) is an example of a family-focused selective prevention program. This program is described later in this handbook and is presented in a separate stand-alone document *Drug Abuse Prevention for At-Risk Groups*.

<u>Key Features of Selective Prevention Programs</u>

Key features shared by selective prevention programs include the following:

- Programs target subgroups of the general population that are determined to be at risk for substance abuse;

- They are designed to delay or prevent substance abuse;

- Recipients of selective prevention are known to have specific risks for substance abuse and are recruited to participate in the prevention effort because of that group's risk profile;

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- The degree of individual vulnerability or personal risk of members of the targeted subgroup generally is not assessed, but vulnerability is presumed on the basis of their membership in the at-risk group;

- Knowledge of specific risk factors within the target group allows program designers to address specific risk reduction objectives;

- Selective prevention programs generally run for a longer period of time and require more time and effort from participants than universal programs;

- Selective programs require skilled staff because they target multiproblem youth, families, and communities that are at risk for substance abuse;

- The programs may be more expensive per person than universal programs because they require more time and effort; and

- The program activities generally are more involved in the daily lives of the participants and attempt to change the participants in specific ways, for example, by increasing participants' communication skills.

Indicated Preventive Intervention Strategies

The mission of indicated prevention is to identify individuals who are exhibiting early signs of substance abuse and other problem behaviors associated with substance abuse and to target them with special programs. The individuals identified at this stage, though showing signs of early substance use, have not reached the point where a clinical diagnosis of substance abuse, as defined by DSM-III-R or DSM-IV criteria, can be made. They are exhibiting substance abuse-like behavior, but at a subclinical level (IOM 1994). Indicated prevention approaches are used for individuals who may or may not be abusing substances, but exhibit risk factors—such as school failure, interpersonal social problems, delinquency, and other antisocial behaviors, and psychological problems such as depression and suicidal behavior—that increase their chances of developing a drug abuse problem. Indicated prevention programs address risk factors associated with the individual, such as low self-esteem, conduct disorders, and alienation from parents, school, and positive peer groups. Less emphasis is placed on assessing or addressing environmental influences, such as community values. The aim of indicated prevention programs is not only the reduction in first-time substance abuse, but also reduction in the length of time the signs continue, delay of onset of substance abuse, and/or reduction in the severity of substance abuse. Individuals can be referred to indicated prevention programs by parents, teachers, school counselors, school nurses, youth workers, friends, or the courts. Young people may volunteer to participate in indicated prevention programs.

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General examples of indicated prevention in the health field include training programs for children experiencing early behavioral problems, medical control of hypertension, and regular examinations of persons with a history of basal cell skin cancer (IOM 1994). In the field of substance abuse, an indicated preventive intervention would be a substance abuse program for high school students who are experiencing a number of problem behaviors, including truancy, falling academic grades, juvenile depression, suicidal ideation, and early signs of substance abuse. Other examples of indicated substance abuse prevention programs include student assistance programs, where teachers and counselors refer students showing academic, behavioral, and emotional problems to counseling groups and family-focused programs for the prevention of substance abuse.

An example of a family-focused indicated prevention program is the *Structural Family Therapy* program developed by Szapocznik and colleagues (Szapocznik et al. 1989a). An example of a school-based indicated prevention program is the *Reconnecting Youth Program* developed by Eggert and colleagues (Eggert et al. 1990). This school-based program is designed for youth already engaged in substance abuse and/or other negative behaviors, such as truancy, emotional distress, and acting-out. This program is described later in this handbook and in the stand-alone document *Drug Abuse Prevention for At-Risk Individuals.*

Key Features of Indicated Prevention Programs

The key features shared by indicated prevention programs include the following:

- Programs target individuals who are experiencing early signs of substance abuse and other related problem behaviors;

- Programs are designed to stem the progression of substance abuse and related disorders;

- Programs can target multiple behaviors simultaneously;

- Individuals are specifically recruited for the prevention intervention;

- The individual's risk factors and problem behaviors are specifically addressed;

- Programs require a precise assessment of an individual's personal risk and level of related problem behaviors, rather than relying on the person's membership in an at-risk subgroup;

- Programs are frequently extensive and highly intensive; they typically operate for longer periods of time (months), at greater frequency (one hour per day, five days

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a week), and require greater effort on the part of the participants, than do selective or universal programs;

- Programs attempt to change the participants' behaviors;

- Programs require highly skilled staff that have clinical training and counseling or other clinical intervention skills; and

- Programs may be more expensive per person to operate than either universal or selective programs because they require more intensive work with individuals and small groups and more highly skilled staff.

Prevention Versus Treatment

Prevention and treatment are both designed to reduce the demand for drugs. Prevention attempts to reduce demand by decreasing risk factors and increasing protective factors associated with substance abuse, and treatment addresses clinically diagnosed substance abuse and reduces the negative effects associated with drug dependency and addiction. The essential difference between these strategies is that prevention addresses a problem *before* it occurs, and treatment addresses the problem *after* it occurs and is clinically diagnosed. IOM (1994) divides treatment into two components: case identification and standard treatment for known disorders.

In the IOM nomenclature, neither treatment nor maintenance plays a part in prevention. In fact, the sole focus of prevention efforts is on decreasing the degree of vulnerability to substance abuse of the target audience. Within this system, vulnerability is defined by the relative balance between the risk and protective factors of the target audience.

The IOM classification system views prevention and treatment on a spectrum of intervention that concludes with maintenance. According to IOM (1994), maintenance interventions are supportive, educational, and/or pharmacological in nature and are provided on a long-term basis to persons who have met the DSM-III-R or DSM-IV diagnostic criteria for substance abuse. In the drug abuse field, maintenance includes relapse prevention efforts to deter recurrence and aftercare and rehabilitation programs to reintegrate into society.

This chapter has identified prevention as one type of antidrug abuse strategy: namely, demand reduction. The discussion presented the rationale for establishing three categories of research-based prevention approaches—universal, selective, and indicated. The key features of each of these prevention approaches were listed, and the relationship of risk and protective factors to the use of universal, selective, and indicated prevention program strategies was described. The chapter concluded with a discussion of the distinction between substance abuse prevention and treatment.

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The next chapter will discuss risk and protective factors and who is at risk for substance abuse and related problems. The chapter will briefly examine the focus of prevention programs on resiliency and then will describe some effective prevention program strategies. Finally, some guidelines for effective prevention programming will be presented.

PREVENTION: WHAT WORKS?

This chapter reviews key literature on research-based prevention programming, specifically the types of risk and protective factors that make youth vulnerable to drug abuse and related problems. Next, the chapter examines some current trends in prevention research and programming, including prevention strategies that focus on the school, family, and community. The chapter concludes with a brief discussion of comprehensive community coalitions and an overview of guidelines for effective substance abuse prevention.

There is growing support within the drug abuse prevention field and among program funders for prevention efforts to be based on the results of empirical research regarding the causes of substance abuse as well as the effectiveness of prevention programs. A new emphasis on tailoring prevention programs to be culturally, developmentally, and geographically appropriate has caused prevention programs to proliferate. The challenge now is to determine the primary risk and protective factors for the populations targeted by these programs and to develop prevention approaches that will have the greatest effect on the most important risk and protective factors. This tailored approach requires knowledge and understanding about the factors that cause substance abuse, methods for assessing risk and protective factors, knowledge of potential prevention strategies, and the ability to make those strategies most effective for prevention program participants. This approach to prevention, therefore, requires an empirical research base.

The primary reason to base the choice of a prevention approach on empirical research is to improve effectiveness. Guessing about what causes substance abuse is not an effective way to select the best prevention strategy. Practitioners can take some specific steps to guide their selection of the prevention approach that has the most potential to help the targeted population. The Prevention Strategies table discussed in this chapter (pages 26 and 27) summarizes effective substance abuse prevention strategies based on available prevention research. The practitioner must apply what is known about effective prevention strategies in the selection of a prevention program for the community.

Drug abuse prevention efforts should be focused on risk factors (and the individuals and groups that are at risk) and their reduction, on protective factors and their increase or maintenance, or on risk and protective factors in the same program. Substance abuse has many causes and differs among individuals and subgroups. Alcohol and drug dependencies are caused by complex interactions of biological, social, and psychological factors that change with developmental stage. However, an understanding of the reasons for substance abuse is critical to the design of successful prevention efforts. It is no longer sufficient to justify prevention programs on the basis of philosophical or political beliefs, a scientific basis for prevention programs is needed.

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Who is at Risk?

Given the right circumstances, anyone can develop a substance abuse problem. Some individuals and groups are at greater risk for developing the problem than others, but it is not always possible to distinguish those at risk for substance abuse from those who are not.

As the prevention field has matured, researchers have learned a great deal about the origins of substance abuse. They continue to acquire more information on risk and protective factors and what can be applied in real life settings. For instance, researchers know that some individuals are more susceptible to using illicit drug than others and have developed a variety of means to identify youth and adults at risk for substance abuse (Kumpfer 1989). This research has enabled prevention practitioners to develop effective programs for their communities.

One issue which continues to be investigated is what factors are associated with an individual going beyond initial drug use to drug abuse and then what is associated with chronic drug abuse. Fortunately, the majority of initial drug use does not lead to chronic drug abuse with its profound consequences. The factors that predispose a person to initial drug use are somewhat distinct from those that predispose an individual to chronic drug abuse. In general, initial drug use and infrequent drug involvement, which neither escalate nor have major negative consequences, are a function of social and peer factors, while chronic drug abuse appears to be more related to biological and psychological processes (Glantz and Pickens 1992).

Although the biological components of substance abuse can be demonstrated in animals within controlled laboratory conditions, it is more difficult to determine the nature and extent of this factor in humans in real life settings. For example, results from studies focusing upon drug abuse rates of monozygotic (identical) twins, dizygotic (non-identical) twins and adopted children clearly demonstrate that there is a genetic contribution to substance abuse. The exact nature of this influence has not yet been determined, although it is likely that the magnitude of this contribution is less than was previously hypothesized (Pickens et al. 1991). Many psychiatric disorders are known to have biological if not genetic factors. Many drug abusers have comorbid psychiatric disorders and the children of people with certain psychiatric disorders are more likely to become drug abusers (Kessler 1995). The relationship between these psychiatric disorders and drug abuse, however, is far from clear.

These findings are further complicated because parents contribute social and environmental in addition to genetic factors to their children. Although biological and genetic factors play an important role in drug abuse, it is also clear that these factors interact in complicated ways with psychological, social, and environmental factors to ultimately determine avoidance of drug use or drug abuse. Prevention researchers are attempting to integrate these scientific findings to better understand the processes associated with drug abuse and to develop cost-effective interventions to prevent drug abuse.

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Substance abuse has many causes and involves a complex interaction of risk factors. These risk factors can be categorized in several ways. One way is to group them in the same five areas that prevention programs target (Hawkins et al. 1992a):

- Individual and interpersonal risk factors: low self-esteem, genetic susceptibility, sensation seeking, aggressiveness, conduct problems, shyness, rebelliousness, alienation, academic failure, low commitment to school, and so on.

- Peer group risk factors: associating with individuals who use illegal drugs, rejection in elementary grades, friendship with other rejected children, bonding with peers who abuse alcohol and drugs and engage in other delinquent activities (Kumpfer and Turner 1990, 1991; Newcomb et al. 1986), influence of the social clique (Oetting and Beauvais 1986), peer pressure to use substances, and association with peers who abuse substances (Bailey et al. 1992). Associating with substance-abusing peers is the final determinant of substance abuse among many youth (Kumpfer and Turner 1990/1991). Resistance to peer pressure can be increased through involvement in peer resistance training programs (Pentz et al. 1989).

- Family risk factors: alcoholic parents; perceived parent permissiveness toward drug/alcohol use; lack of or inconsistent parental discipline; negative communication patterns; conflict; low bonding; stress and dysfunction caused by death, divorce, incarceration of parent(s), or low income; lack of extended family or support systems; emotionally disturbed parent(s); parenting problems; lack of skills to cope with family problems; parental rejection (for example, the unwanted child); lack of adult supervision; lack of family rituals (such as holiday family gatherings); poor family management and communication; physical and/or sexual abuse; and parental or sibling substance abuse (Kumpfer and Alvarado 1995). Strengthening families can reduce the negative effects of family environmental influences on youth for substance abuse. Prevention strategies can include conducting parenting programs, providing family support, and providing family skills training. Family therapy has been found to reduce the effects of substance abuse risk factors including delinquency, misconduct, and depression (Kumpfer and Alvarado 1995).

- School risk factors: lack of support for positive school values and attitudes; school dysfunction; high rates of substance abuse and prosubstance abuse norms; drug-using gang members; low teacher and student morale; school climate that provides little encouragement and support; student perceptions that teachers do not care about them; lack of appreciation for school and the educational process; academic failure; lack of involvement in school (Downs and Rose 1991) due to

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discrimination, lack of opportunities for involvement and reward, perceived unfair rules, and norms that are conducive to substance abuse (Hawkins et al. 1992a). School climate improvement programs, such as *Project PATHE* and *HIPATHE* (Kumpfer et al. 1991), have been effective in reducing the negative effects of adolescent substance abuse.

● Community risk factors: high crime rate, high population density, physical deterioration, availability, norms supporting alcohol and other drug abuse, ambivalent or prosubstance abuse community values and attitudes; community dysfunction, transient populations; lack of active community institutions; lack of feeling part of the community; being in a community that condones substance abuse; disorganized neighborhoods lacking leadership; lack of opportunities for youth involvement in positive activities; high rates of substance abuse; poverty and lack of employment opportunities (Hawkins et al. 1992b); easy availability of drugs and alcohol; and lack of economic mobility and social supports. Increased opportunities for positive community involvement may reduce the effects of the negative environmental influences on youth for substance abuse.

Survey research studies often are used also as the basis for identifying risk factors based on demographic factors. Demographic risk factors include: gender; ethnicity; age; socioeconomic status; employment; income; education; and location of residency.

Many prevention programs target individuals who are at risk for substance abuse solely on the basis of demographic risk factors, such as race or ethnicity. Indeed, the common belief that ethnic youth are more at risk for substance abuse than other youth has led to the development of many prevention programs for them. Therefore, communities need to be sure that local demographic information indicates that the groups or individuals targeted for prevention efforts are the right ones. A community might find that the major risk factor for substance abuse may be an at-risk neighborhood with high rates of substance abuse and crime, not ethnic group, age, unemployment, or educational level.

What can be confusing is that there are so many factors that have been determined to put a child at risk for drug use. To integrate these findings in a meaningful way, it is important to remember that when a child is born, he/she is born not only into a family, but also a community and a society. The child also is born with characteristics that have been shaped by the uterine environment as well as by family characteristics. The child's potential to become a functional member of the community is the outcome of numerous interactive processes with a large variety of sources of influence. Various influencing factors also will have differing importance throughout the child's lifetime.

Reviewing the risk factors for drug using behaviors, it is clear that some aspects of the child's social and psychological developmental process are more important than others. For instance, primary caregivers serve an essential role in providing nurturing stimulation and opportunities for the infant to communicate with the world around them. Failure to form such a relationship during early development has been linked to poor language skills and cognitive abilities as well as inappropriate self-regulatory behaviors in early childhood. The child's family during his or her early development also is the major socialization agent to learn interpersonal skills. All these abilities ease the transition from the shelter of the family environment to that of the school and community. Failure in any of these processes may increase the child's risk to fail in another stage and can handicap the child when making necessary transitions. Furthermore, successive failures from one life transition to another can accumulate, and the child's adaptation to the community and society may be so impeded that he or she becomes alienated and does not assume appropriate roles.

Other drug abuse prevention research focuses on identifying the more immediate processes associated with drug use. This research has identified the age period at which drug use is initiated and the processes involved in the progression from illegal use of licit substances such as tobacco and alcohol to the use of illicit drugs such as marijuana (Chen and Kandel 1995; Kandel and Yamaguchi 1985). Such efforts have found that children who understand the negative physical, psychological, and social effects of drugs are often protected for initiating drug use. Research also continues to examine the formation of peer groups and their role in introducing negative behaviors such as drug use among preadolescents and adolescents.

Protective Factors as a Focus of Prevention Programs

Recent research has focused upon identifying factors and processes that protect the child against such failures. Although the concept of protection clearly counters that of risk, protective factors and processes are not necessarily the exact opposite of risk factors. For instance, not having an alcoholic parent (a possible risk factor for substance abuse) may be positive but not necessarily protective. Findings from research on protective factors is still emerging and the relative impact of these protective factors and processes on overcoming risk factors is yet unclear.

There also has been an emerging trend in the drug abuse prevention field to introduce the concept of resilience and to review its applicability to drug abuse. The resilience movement grows out of a literature that explores individuals' responses to stressors such as schizophrenia, poverty, and physical or psychological trauma. This research has found that there are children who have been exposed to these negative risk factors yet who exhibit positive, adaptive behaviors rather than maladaptive behaviors and outcomes (Werner 1989). The interest in resilience among drug abuse researchers emerged as they examined children who are considered to be vulnerable to drug abuse due to the number of risk factors they have but who do not succumb to drug abuse. The research then attempted to determine what made these children resilient compared to others

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exposed to similar negative risk factors. Findings indicate that personality and temperament are important. These characteristics include:

- optimism;
- empathy;
- insight;
- intellectual competence;
- self-esteem;
- direction or mission;
- and determination and perseverance.

Other research indicates that the child having purposes in life and the skills to achieve these purposes play a role. These life skills include:

- emotional management;
- interpersonal social skills;
- intrapersonal reflective skills;
- academic and job skills;
- ability to restore self-esteem;
- planning skills; and
- life skills and problem-solving ability.

Although the concept and research findings on resilience illustrate positive adaptation to life situations, environments and transitions, there are some issues about this concept which need to be further explored and clarified. As mentioned above, the concept of resilience has been frequently viewed as an individual trait or characteristic which will help the individual positively adapt to a variety of situations in different circumstances and environments at a number of periods or transitions throughout the person's life. It has not yet been determined whether this assumption is accurate. Resilience may be more specific to situations, circumstances, environment and different life transitions or problems. Certain resilience skills may work with a particular problem or transition at a particular age in certain circumstances and environments, but may not be effective with other transitions at other ages or with other circumstances, risk factors or environments.

Clearly, the resilience concept has intuitive appeal, but further research is needed to clarify its role and refine its application to drug abuse prevention efforts. More important to prevention is the integration of these findings with those on protective factors, such as family bonding, a warm supportive parent (or surrogate), child relationships, academic success and positive peer relationships. This integration would be within a developmental framework that examines the achievement of resilience and adaptation skills in the family, school, peer and environmental

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domains. It would also address interactions across these domains to reinforce these skills and the cumulative impact of successes towards protecting youth against drug abuse.

Effective Prevention Strategies

Prevention professionals need to incorporate this wealth of research information together with what they know about the specific characteristics of persons who use and abuse drugs in communities and with known age-relevant methods to impact children's attitudes and behaviors in order to design an effective prevention intervention.

Several major targets of prevention activities are the individual, the peer group, the family, the school, and the community. Prevention programs have tended to focus on one area at a time. However, research has suggested that the effectiveness of prevention activities increases when the activities focus on more than one area: that is, when individuals and subgroups are targeted through more comprehensive prevention efforts that focus simultaneously on the family, the school, and the community.

Because of the intractable nature of substance abuse in the 1990s, prevention efforts have taken this broader approach. Substance abuse prevention has come a long way from the days of short-term educational programs to more comprehensive strategies. Through research and experience, prevention specialists have learned that:

- No one program or approach will eliminate all substance abuse; and

- Effective prevention approaches are tailored to the needs of each at-risk target group and are designed with input from those groups.

In recent years, effective prevention programs have been designed based on the results of thorough needs assessments. These needs assessments have included analyses of the family, school, and community environments that influence youth, as well as assessments of individual risk and protective factors. Individuals from at-risk groups have become active participants in the identification, planning, and sometimes the implementation and evaluation of the prevention strategies designed for them.

School, Family, and Community Prevention Strategies

Table 1 on pages 26 and 27 provides an overview of universal, selective, and indicated approaches to prevention as they have been applied in prevention programs focused on the school, family, and community. Examples are provided of the types of prevention programs that have been effectively implemented for general populations (universal programs), targeted at-risk subgroups (selective programs), and individuals who are experiencing problem behaviors

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(indicated programs). The table offers guidance in the selection of each type of prevention approach. For example, information and education programs, such as media campaigns, have been effectively implemented in schools when the programs have targeted the general school population.

Parent skills training programs, however, have been effectively implemented with families within the general population (universal programs) and within specific subgroups (selective programs for dysfunctional and substance-abusing families, for example). The essential distinction between these parent skills training programs is not the content of the programs, but the targets of the programs: universal family skills training programs for every family in the population regardless of risk status versus selective family skills training programs for at-risk groups of families.

The intervention site can be selected on the basis of which risk and protective factors need to be addressed. Individual and peer group risk factors can be addressed in any of these sites—the family, the school, or the community. Universal, selective, or indicated prevention strategies are selected on the basis of the target audience. The following discussion provides more detailed information about universal, selective, and indicated approaches in school, family, and community prevention programs. See also *Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools,* and *Drug Abuse Prevention and Community Readiness: Training Facilitator's Manual.*

School-Based Prevention Strategies

School-based substance abuse prevention strategies have served as the primary method for reaching young people. These approaches include information and education programs, prevention education and skills training, school management changes including changes in policies and instruction, tutoring and mentoring programs, and parent-peer groups. The most common school programs for substance abuse prevention have used health education curricula that involve the use of informational sessions about substances. Life skills and peer resistance training programs are generally conducted with students in the fifth through eighth grades. Some States have developed mandatory programs.

Information or education programs using scare tactics are used less often because research and experience have demonstrated that they are either counterproductive or ineffective and that students learn better with a low fear appeal message and with a credible communicator.

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Table 1

SCHOOL-, FAMILY-, AND COMMUNITY-BASED PREVENTION STRATEGIES

	UNIVERSAL PREVENTION	SELECTIVE PREVENTION	INDICATED PREVENTION
SITE OF THE INTERVENTION	*General Population*	*At-Risk Subgroups*	*At-Risk Individuals*

School	Information/education
	• media campaigns
	• health education curricula
	• school assemblies
	
	Competency/skills training
	• social influence
	• normative education
	• life/social skills training
	  - assertiveness training
	  - communication skills
	  - decision making
	  - anger/stress management
	
	School management changes
	• school policies
	• instructional changes
		Alternative programs
		• skills training
		• after school classes
		• special club/groups
		  - Children of Alcoholics
		• sports/recreation
		• mentoring
		
		Competency/skills training
		• cultural pride
		• tutoring
		
		Peer leadership
		
		Peer resistance
		
		Parent-peer groups
			Alternative programs
			• mentoring
			
			Peer leadership/resistance
			
			Parent-peer groups
			
			Peer counseling
			• student assistance
			• student crisis/hot lines
			• school support group
			
			Competency/skills training
			• cultural pride
			• tutoring
			
			In-school suspension
			
			Alternative classes/schools

Table 1 Continued

	UNIVERSAL PREVENTION	SELECTIVE PREVENTION	INDICATED PREVENTION
SITE OF THE INTERVENTION	*General Population*	*At-Risk Subgroups*	*At-Risk Individuals*
Family	Parent education ● groups ● lectures ● curricula Parent involvement programs Parent skills training Family skills training	Parenting skills training Family skills training Family case management Parent support groups	Family skills training Parent peer groups for troubled youth ● *Tough Love* Parent self-help groups Structured family therapy ● Family therapy/counseling ● Family case management
Community	Public awareness campaigns Information clearinghouses Community coalitions ● community task forces ● church-sponsored youth groups Health policy change	Alternative programs ● youth/teen clubs ● mentoring Tutoring	Alternative programs ● rites of passage programs ● gang and delinquency prevention Skills training ● job skills training ● job apprenticeships

Information and Education Programs

These types of programs represent universal approaches and rely on mass dissemination of information about the health consequences of substance abuse. They include media campaigns, health education curricula, and school assemblies, and are low-cost approaches. Programs that use an information dissemination strategy provide knowledge and awareness of:

- the pharmacological effects of substances;

- the health, psychological, and social consequences of abuse;

- community attitudes, norms, and legal sanctions; and

- general health education.

Information and education approaches increase students' knowledge about drugs, but whether they have any impact on decreasing or delaying the initiation of substance abuse is not known because most information programs do not measure these objectives (Moskowitz 1983). Programs providing information about substance abuse consequences may be most effective in deterring youth who are at low risk for substance initiation, particularly initiation of substances that are highly addictive or have well-accepted negative effects, such as designer drugs. Information programs also help persons living with substance abusers and persons wanting information about the signs of substance abuse, intervention methods, and referral resources.

Information-only approaches to prevention have been criticized on the following grounds:

- Knowledge alone may not change behavior. The theory underlying prevention assumes that a change in knowledge will affect a change in attitudes that affect behavior. Several studies have provided little empirical support for this theory (Wallach and Barrows 1981; Goodstadt 1981) although there is support for a relationship between belief in the harmful consequences of substance abuse and reduced abuse (Johnston 1991).

- Youth most at risk for substance abuse are school dropouts. They will be missed by most school-based information programs.

- The information source may not be credible.

- Most information-only programs are too short to produce behavior change.

- Often drug information is not designed to match local cultural and ethnic traditions.

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Prevention Education and Skills Training Programs

This approach includes interaction between the educator and the participants. These programs are designed to target social, cognitive, or psychological competencies or skills and to change attitudes and beliefs about substance abuse. These programs are more intensive (more hours per person and greater effort by participants) than information-only programs and, therefore, cost more per participant. Examples of effective prevention education and skills training strategies include life skills training, peer and media resistance training, peer leadership/peer helper programs, children of substance abuse groups, and parenting and family skills training classes. Youth or adult involvement in the design, implementation, and evaluation of these educational training programs is encouraged (National Assembly 1994).

Skills training approaches help students learn appropriate and adaptive social skills so they are able to resist pressures to use substances. Research has shown that youth who possess a variety of social competencies are more resistant to substance abuse. To improve their effectiveness, skills training programs often are incorporated into comprehensive programmatic efforts or a curriculum is expanded to include the training program. The currently popular skills training programs, known as social competency programs, approach prevention from three perspectives:

- Social influence approaches involve resistance training to media persuasion and social skills training for resistance to peer influences (Pentz 1983; Pentz et al. 1989);

- Normative education approaches encourage adoption of antidrug use norms and correct inflated estimates about the number of youth who use substances (Hansen 1992; Hansen and Graham 1991); and

- Life skills and social skills approaches teach communication skills; stress-, anger-, and anxiety-management skills; and the skills to select nonsubstance using friends, and to resist media and peer pressure to use substances (Botvin et al. 1990 a,b; Botvin and Botvin 1992). Skills development programs often include training in assertiveness techniques to help youth avoid negative influences.

Young people who have a variety of social competencies are more resistant to substance abuse. Social competencies often included in youth skills training programs are assertiveness to avoid negative influences to use substances, communication skills, decision making, ability to restore self-concept, anger and stress management, and social skills to make friends.

A wide variety of techniques are employed in these programs. Many programs employ behavioral skills training techniques involving demonstrations of effective and ineffective behaviors and participant role plays with feedback and reinforcement for behavior change.

The IOM (1994, p. 264) review of substance abuse prevention concluded that, when combined, the peer resistance and normative education approaches appear to have some effectiveness in "producing modest significant reductions during early adolescence in the onset and prevalence of cigarette smoking, alcohol, and marijuana use across a number of experimental studies conducted by a variety of investigators (Ellickson and Bell 1990; Hansen et al. 1988; McAlister et al. 1980; see Hansen 1992 for a recent review)." Peer-led classes appear to be more effective than teacher-led classes (Botvin et al. 1990a; Goplerud 1993; Klepp et al. 1986; McAlister 1983; Perry et al. 1989, 1990).

To improve effectiveness, these programs often are imbedded within a supportive, comprehensive program or the curriculum is expanded. A 24-session version of Botvin's *Life Skills Training Program,* implemented in Philadelphia alternative schools, was found to increase knowledge about tobacco and alcohol use, increase negative attitudes towards marijuana use, and decrease school problems, incidents of drunken aggression, and legal problems. Although the Super II (Atlanta, Georgia) program with 11- to 16-year-olds was only an eight-session curriculum (because it is part of a larger development program), the program was able to increase substance abuse knowledge and self-esteem and to decrease substance abuse and related problems.

School-based universal programs are not without potential risks for at-risk or substance-abusing students. Several studies have found increased use of tobacco and alcohol in students who were already using (Ellickson and Bell 1990; Gottfredson 1990; Moskowitz 1989). The IOM (1994) concluded that school campaigns that show substance abuse as non-normative behavior may isolate students who are already using substances. Selective prevention approaches are needed to avoid isolating students who are at risk from positive, nonusing friends.

Prevention education and skills training programs can be universal, selective, or indicated. If every student in a school is given assertiveness training, then the training program is a universal prevention effort. If only at-risk subgroups are given the training, the program is a selective prevention effort. If specific students are given the assertiveness training because they are experiencing early signs of substance abuse or other behavior problems, the training is aimed at those and related behaviors and the training program is an indicated prevention effort.

Tutoring Programs

Selective and indicated tutoring programs are used as prevention approaches to reduce early signs of substance abuse in youth who have academic problems and who are at risk by improving academic achievement, decreasing peer rejection, and decreasing disruptive behavior

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(Coie and Krehbiel, 1984). Some tutoring programs employ a cross-age approach in which older students tutor younger students. Other programs use adult mentors, college students, or teachers to tutor students, either during or after school hours.

Mentoring Programs

Mentoring programs attempt to convey positive values, attitudes, and life skills through the development of a one-to-one relationship with a positive role model. The mentor may be a community volunteer who is matched for cultural similarity to the youth or a college student, parent, or business professional. This approach is typically part of a more comprehensive program. Some effective intergenerational programs have used retired people as mentors, and some programs have combined big brother/big sister program models with wilderness outings. The SMARTmoves program, for example, a substance abuse prevention curriculum based on a peer resistance skills training model, has been effectively implemented in public housing communities by Boys and Girls Clubs (Schinke et al. 1992).

Peer-Oriented Programs

Peer-oriented programs offer an important and effective prevention strategy for youth because association of vulnerable youth with substance-using peers has been shown to be a significant immediate risk factor for substance abuse (Dielman et al. 1989a; Newcomb et al. 1986; Swaim et al. 1989). Many prevention programs include some form of peer-oriented approach, such as peer resistance training or normative education. Resistance to peer pressure can be increased through the involvement of young people in peer resistance training programs that have been shown to delay initiation of substance abuse (Dielman et al. 1989b; Pentz et al. 1989). Research suggests that peer programs may increase the effectiveness of prevention efforts by focusing on strategies and providing guidance that help youth learn to select more appropriate peers. For information on criteria for selecting peers for peer-oriented training programs, contact the researchers cited.

Family-Based Prevention Strategies

Parent and family universal, selective, and indicated programs are important drug abuse prevention approaches for youth, because parents are the primary agents for the socialization of children. Coombs and colleagues (Coombs et al. 1991) found parental influence for 9- to 17-year-old Hispanic/Latino and white youth to be more important than peer influence in the youth's reasons for not abusing substances.

Family-based universal approaches include parent education programs, parent involvement programs, and parent and family skills training programs. Selective and indicated family-based approaches include parent and family skills training programs; parent support groups; parent-peer

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groups such as *Tough Love* for troubled youth; family case management and home visits; family counseling; and structured family therapy. For more information on family therapy approaches to drug abuse prevention, especially structured family therapy, see the *Handbook for Program Administrators* in the NIDA *Working with Families to Support Recovery* RDA package and the *Family Dynamics and Interventions Clinical Report.*

Until recently few efforts were made to involve large numbers of parents in the general population in universal family-based prevention programs (Rohrbach et al., in press). Therefore, outcome data on the effectiveness of universal family-focused efforts are scant. One example is *Preparing for the Drug-free Years* (Hawkins et al. 1987), a five-session program for junior-high school students and their parents. A version of this program is designed to improve school success of second graders, lead to lower rates of school failure, aggressive behavior, delinquency, and alcohol abuse by the time students reached the fifth grade (Hawkins et al. 1992b).

Parenting and Family Skills Training and Counseling Programs

These types of programs have been shown to be effective in reducing individual and family risk factors for substance abuse among children whose substance-abusing parents were either in treatment (Catalano et al., in press; DeMarsh and Kumpfer 1986; Kumpfer 1993; Kumpfer et al. 1996) or not in treatment (Kumpfer 1990). Most parenting and family skills training programs can demonstrate immediate reductions in depression, aggression, conduct disorders, poor family management, intentions to use tobacco and alcohol (DeMarsh and Kumpfer 1986; Bry 1983), and school achievement and delinquency in pre-adolescents (Fraser et al. 1988; Patterson et al. 1982; Patterson et al. 1992). Work by DeMarsh and Kumpfer (1986) suggests that parent-child relationships improve more when programs involve work with the entire family than when only the parents receive training or when the program involves separate child skills training and parent training. Overall, family-focused strategies have been shown to be superior to child-only approaches (McMahon 1987).

Several variations of family skills training have been developed that can be tailored to the needs of a family. Family counseling, in which a therapist monitors the changes in parent and child interaction patterns throughout the counseling process, has been useful for many families at risk. Lipsey (1992) found that family counseling was effective with young people at risk for substance abuse. Skills-oriented counseling had the greatest effect on youth at risk for substance abuse. Family skills training, where the target child and other family members participate in structured activities designed to modify interaction patterns, appears to be the most promising family-focused approach to prevention.

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Structured Family Therapy Programs

Indicated prevention programs have been used with young people who have initiated substance abuse or manifested other behavioral problems. Effective family programs include the *Family Effectiveness Training Program (FET)*, the *Bicultural Effectiveness Training Program (BET)*, and *Structural Family Therapy* programs developed by Dr. Jose Szapocznik at the University of Miami (Santisteban et al. 1993; Szapocznik et al. 1989a,b). The *Handbook for Program Administrators* in the NIDA *Working with Families to Support Recovery* RDA package and the *Family Dynamics and Interventions Clinical Report* are good resources on indicated family approaches.

A number of prevention researchers support structured family-based prevention strategies as necessary components of any comprehensive prevention plan for delinquency (Fraser et al. 1988; Loeber and Stouthammer-Loeber 1986; McMahon 1987) and substance abuse (Kaufman and Kaufman 1979; Kaufman 1986; Kaufman and Borders 1988). As noted by Kazdin (1993), prevention programs with early and broad impact, such as parent and family programs, are critically important to the success of prevention.

Community-Based Prevention Strategies

Broad-based community prevention efforts have kept substance abuse issues in a prominent place on the public agenda. Community prevention efforts have produced a constituency to press for more comprehensive policies to address substance abuse issues at the Federal, State, and local levels.

Strengthening community environments entails two distinct prevention efforts: the first targets individuals and groups, and the second targets settings and circumstances associated with substance abuse problems. In the first instance, prevention efforts are initiated through community agencies and organizations that focus on prevention goals for at-risk individuals and groups. These types of efforts are represented by the selective and indicated prevention approaches described in this handbook. In the second instance, prevention initiatives are directed toward factors within the community (such as substance related policies and community norms) that support or are otherwise associated with, the substance abuse problem. These types of initiatives are described in the discussion of universal prevention; the most salient example being the health policy change component of Project STAR.

Community-based approaches address substance abuse prevention through a number of points of contact, including community organizations, governmental and nongovernmental agencies and organizations, religious and educational institutions, and the workplace. The most effective community approaches touch on all these contact points and include public awareness

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campaigns; information clearinghouses; alternative programs such as youth clubs, sports, and recreation; mentoring and rites of passage programs; and skills training programs.

Public Awareness Programs

Public awareness programs are the primary universal approaches for providing community-based prevention for adults. Such programs include media campaigns, films, pamphlets, clearinghouse resource centers, radio and television public service announcements, health fairs, advertisements, hot lines, and speakers' bureaus. The general consensus among prevention researchers is that, when combined with other community prevention strategies, media campaigns provide needed information and positively affect a community's social norms (Wallach 1985).

Alternative Programs

Selective alternative approaches to substance abuse prevention are provided through recreational, athletic, cultural, and educational activities that are sponsored by community organizations or schools for individuals at risk for substance abuse. The rationale for alternative programs is that they reduce substance abuse by providing young people with alternatives that are incompatible with substance abuse. Because research supports a link between thrill seeking and substance abuse (Hawkins 1992a), many alternative programs involve experiential education activities such as wilderness experiences, ropes courses, mountain climbing, rappelling, and rafting.

Alternative indicated programs include gang and delinquency prevention and cooperative community service programs, such as removing graffiti from public buildings and developing community murals, building homes, and volunteering (Tobler 1986). One alternative program, *Amazing Alternatives*, developed by Murray and Perry (1985) is a systematic approach to prevention that helps youth identify health-enhancing alternatives to meet their needs.

Rites of Passage Programs

Rites of passage programs focus on skills development through strategies designed to build resiliency. These programs encourage the development of responsibility in young people as members of the adult community. They also emphasize the importance of values and youth's link with the community. Some selective and indicated prevention programs include group discussions, while others focus on skills training and competency development.

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Comprehensive Community Coalitions

Prevention professionals have begun to take a broader view of substance abuse by emphasizing a shared responsibility for prevention throughout the community. To maximize their effectiveness, substance abuse prevention programs have been included in efforts to create community coalitions. Community coalitions bring together diverse groups and resources to plan and implement comprehensive, local prevention efforts. Such efforts are designed to strengthen school, family, and community environments.

The community coalition, as an organizing strategy for substance abuse prevention, has moved the prevention field to a greater consideration of multiple, comprehensive local prevention strategies that are more likely to be effective. The underlying premise of this comprehensive approach is that one prevention approach that affects only one area of influence on youth is not likely to be as effective as a comprehensive program that addresses multiple sources of influence, such as families, peers, school staff, community members, churches, employers, and coworkers. Comprehensive community coalitions incorporate groups and activities as diverse as substance abuse prevention task forces and church-sponsored youth groups.

Although they increase resources and the availability of substance abuse prevention services, coalitions require specific strategies to improve the school, family, and community environments of young people to reduce their risk for substance abuse. Determining the right prevention strategy for a group or individual can be accomplished most effectively if the strategy is selected to address risk factors within the individual and his or her environment. Community prevention approaches aimed at vulnerable groups and individuals focus on three primary sites for intervention: schools, families, and communities.

An effective comprehensive community coalition for substance abuse prevention is the *Midwestern Prevention Project* (Pentz et al. 1989, 1990), which is highlighted in this handbook and described in greater detail in *Drug Abuse Prevention for the General Population*.

Guidelines for Effective Drug Abuse Prevention

There is no single, best prevention program, but some programs will be more effective with certain target groups. The following general guidelines are based on current research.

- Comprehensive, multicomponent prevention approaches are more effective than single element approaches for modifying a broader range of risk factors.

- Long-term prevention programs have a longer lasting impact on at-risk groups.

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- The higher the level of risk the greater the intensity of the prevention effort required for maximum effectiveness.

- Tailoring the prevention strategy to the cultural traditions of the population is critical to success.

- Theory-based prevention programs that address risk and protective factors from a developmental perspective by targeting the most receptive ages or strategic times are likely to have greatest impact.

- Prevention strategies applied early in life are likely to be more effective for children in at-risk environments.

- Family-focused prevention efforts may have a greater impact than strategies that are only child-focused or parent-focused.

- Prevention programs in which staff are warm, empathetic, genuine, competent, and non-substance-abusing are more effective than programs whose staff do not possess these characteristics.

This chapter has examined the myriad risk and protective factors associated with substance abuse that affect the outcomes of prevention programming efforts. Having described who is at risk and some of the factors that protect against substance abuse, the chapter presented examples of effective school-, family-, and community-based prevention programs and strategies that can be used to address those risk and protective factors. Finally, this chapter listed some general guidelines for prevention practitioners to use in selecting programs for different target groups.

Substance abuse and its related problems raise complex issues, including the types of substances (alcohol, cocaine, heroin, and marijuana) used and the potential costs in addressing them. Efforts to address the resolution of these problems will require appropriate and well-thought-out intervention strategies. When implementing substance abuse prevention programs, practitioners should consider the research on which prevention programs are based. The following chapter provides some guidance for practitioners in their consideration and selection of research-based prevention approaches that may be appropriate for their particular communities. A more detailed discussion of funding to cover the cost of prevention initiatives is provided in another document in this RDA package, *Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools*.

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The following chapter will discuss the rationale for the use of empirical research in the selection and implementation of substance abuse prevention strategies and programs. The chapter will focus on some of the issues to consider and specific steps that prevention practitioners can take when choosing research-based prevention programs.

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WHY RESEARCH-BASED PREVENTION?

Research findings are an important guide to which prevention strategies work and, more important perhaps, which do not. The history of medicine, social work, psychiatry, and other helping professions is full of well-intentioned plans, programs, and projects that their advocates believed had to work, but that later research found made no difference or made matters worse. Only theory-based, carefully planned, well-executed, and critically analyzed research can determine what works and what does not.

This chapter discusses some of the issues that research indicates practitioners should consider in the selection and implementation of substance abuse prevention programs. The chapter then presents specific steps for choosing research-based prevention programs. The chapter concludes with a discussion of issues to consider in the use of selective and indicated prevention program approaches.

Knowledge gleaned from research of issues involved in implementing prevention programs at the community level can help practitioners make important decisions that can affect program outcomes. Some program implementation issues include:

- tailoring program components for maximum benefit;

- targeting programs to the most appropriate groups;

- determining comparability of program effects; and

- understanding the importance of program evaluation.

Tailoring Program Components for Maximum Benefit

Practitioners must consider not only research findings on a specific program element (for example, an educational program or an alternative recreational program), but also the effects that may occur when several strategies (that may not be especially powerful individually) are combined into a comprehensive, coordinated program. In a comprehensive program, the whole may be greater than the sum of its parts. Additionally, research results that suggest a program has no effect in one group do not mean that the program will not work for another group. For example, a resistance skills training program aimed at a subset of at-risk students in one school may not have much effect, but the same program offered to all students in the school may be effective in lowering the overall incidence of substance abuse in the total school population.

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Targeting Programs to Appropriate Groups

Federal government research policies require that studies be conducted with diverse populations in terms of gender and race/ethnicity, which is important to ensure that all groups are studied as fully as possible. However, it is reasonable to expect that prevention programs will have different effects on various groups because cultural, psychological, and other factors will affect how people respond to different prevention efforts. For example, the pressures to smoke crack or its availability may be quite different for adolescents living in inner-city neighborhoods than for those living in suburban or rural areas. Therefore, a selective prevention program that works in one setting may not be as effective in another, even though the age group, gender, and racial/ethnic origins of the program participants are the same.

Determining Comparability of Program Effects

What does all this mean for decision making about effective prevention programs? Although it is important to determine whether a program concept has been evaluated using a rigorous research approach, it is important to look beyond whether the research showed positive findings. The prevention practitioner must consider who was enrolled in the study to determine if the population and setting are comparable to the local situation. If they are comparable, then outcomes comparable to those achieved in the study should be expected. However, if the population and setting are not comparable, then perhaps the program can be adjusted to fit the local situation. For example, an indicated school-based peer education program may be effective in one community but impractical in another where a large proportion of commuting students preclude an afterschool program for most of the students who would be eligible. However, the same basic approach might be developed in the context of recreational athletics, a community center, or religious institution.

The Relevance of Program Evaluation

Lack of research support, or even negative findings, may not mean a program idea that has not been empirically proven to work should be ignored. Sometimes the most important ingredient in program success is the commitment and enthusiasm of the providers and the community that wants to launch it. An approach that seems to make a lot of sense, given the problems in the community, might be worth pilot testing to learn whether the program seems to work for the particular environment and target audience.

This may not be as difficult as it sounds. NIDA has developed an RDA package on program evaluation, *How Good is Your Drug Treatment Program?*, that is available to help agencies and organizations without major resources conduct their own program evaluations. Although the RDA package on program evaluation focuses on evaluating treatment programs,

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some of the concepts and discussion in the package are relevant to prevention programs. For information about how to obtain this RDA package, see appendix A.

One of the most important aspects of the evaluation process is deciding what the program should accomplish and how to determine if the program is working. The program's goal then becomes a guidepost in determining its effectiveness.

Steps for Choosing Research-Based Prevention Programs

The following steps are guidelines for choosing a prevention program based on empirical research.

- *Step 1. Identify effective substance abuse prevention models and programs.*

  A good place to begin is to read reviews of the literature on the causes of substance abuse to become familiar with the most recent research. Some excellent sources include a review by Hawkins and colleagues (Hawkins et al. 1992b); *Communities That Care* (Hawkins et al. 1993) and *The Making of a Drug-Free America* (Falco 1993). Identify prevention programs that research has shown to be effective and discuss the possible advantages of those strategies within the particular community.

- *Step 2. Gather local data.*

  To obtain information about the local substance abuse problem, the prevention practitioner can:

  — Contact other substance abuse prevention specialists within State or county government substance abuse agencies for any local household or school surveys that may contain clues to why certain youth abuse substances;

  — Determine who the substance abusers are and what sorts of problems (consequences) attach differentially to their abuse of substances;

  — Determine the characteristics of at-risk groups in terms of age, gender, race/ethnicity, education, and income, and whether these characteristics change for different substance abusers; and

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— Find out if any geographic analyses have been conducted to determine at-risk neighborhoods. The Geographic Information System (GIS), a computer program for analyzing census data, can be used to determine demographic correlates of substance abuse by specified neighborhoods within a community. For more information on the GIS, see *Community Readiness for Substance Abuse Prevention: Issues, Tips and Tools.*

● *Step 3. Determine local causes of substance abuse.*

In choosing a research-based prevention program, practitioners need to determine which strategies will alter the causes of substance abuse in local at-risk populations. Local research studies may be useful resources for relevant information. This information may be obtained by contacting researchers at local colleges or universities who may have conducted such studies. The State's division on substance abuse often will have information about the best researchers to contact.

It is possible that no studies have been conducted to determine why vulnerable individuals in the local population abuse substances. National research studies may be a useful source of research information. To establish the local validity of national research results, focus groups might be conducted with local community residents—parents, teachers, youth workers, therapists, and/or young people themselves—to determine why persons at high risk use substances. Surveys developed with the help of local researchers also may yield useful information.

● *Step 4. Determine the at-risk population(s).*

Once a determination is made of the major groups of substance abusers, the groups and/or individuals at risk can be targeted for prevention programs. The focus of the prevention efforts may be the entire community, specific subgroups, or individuals.

● *Step 5. Determine where to target prevention efforts.*

At this point, a practitioner can determine where to target the prevention effort. Decisions must be made about whether prevention efforts should occur:

— Before any risk indicators appear in the general population—*universal* approaches would be called for;

— At the point where specific subgroups have been identified to be at risk—*selective* approaches would be appropriate; or

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— At the point where individuals have early signs of substance abuse or problems associated with substance abuse, such as poor grades, isolation, or antisocial behavior—*indicated* approaches would be required.

- *Step 6. Determine where to focus prevention efforts.*

   Next, the practitioner must decide where to focus prevention efforts. The Prevention Strategies table 1 (pages 26 and 27) is useful for helping to determine whether to focus a prevention effort on the school, the family, or the community and where the best access to the at-risk groups and individuals can be achieved.

- *Step 7. Determine if the community is ready for prevention efforts.*

   The extent to which the community is ready to undertake a prevention program is critical to the overall success of the effort. The practitioner must objectively assess community readiness. In areas where the community is determined *not* to be ready, *Community Readiness for Drug Abuse Prevention: Issue, Tips and Tools* and *Drug Abuse Prevention and Community Readiness: Training Facilitator's Manual* in this *Drug Abuse Prevention* RDA package are available to provide guidance.

- *Step 8. Choose a prevention approach.*

   Choosing a type of prevention approach will depend on the information gathered in the seven preceding steps. For example, the practitioner will need to determine which approach(es) will best address the problem precursors and whether the necessary resources are available to implement a strong, effective prevention program. The practitioner may find the stand-alone resource manuals for universal, selective, and indicated prevention in this set of RDA materials to be particularly useful.

Considerations in Planning a Selective Prevention Intervention

Because of increasing evidence that some youth who are at risk for substance abuse can be identified as early as the first grade (for example, certain types of aggressive youth, see Kellam and Brown 1982; Kellam et al. 1991), prevention research is being focused on the long-term support needs and environmental modifications that can reduce the degree of vulnerability among this highly vulnerable group (Coie et al. 1994). Thus, selective prevention strategies can begin as early as kindergarten for youth who have been identified by teachers and/or parents as being at risk for subsequent behavior problems. In some cases the implementation of selective programming at earlier ages for at-risk group members will delay or eliminate the need for indicated programming at some time in the future because the selective program addresses risk

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factors before symptomatic problem behaviors emerge. Parent and family skills training are selective prevention approaches that can be implemented early before the problems have a chance to increase in severity.

Special Issues in Implementing an Indicated Prevention Program

Several important issues need to be considered when planning an indicated prevention program:

- Using valid and reliable measures of risk factors and symptomatic behaviors to ensure that actual at-risk youth are recruited for the program and to help monitor improvements related to program participation;

- Negative labeling and the potential for stigmatizing youth in indicated prevention programs; and

- How to begin prevention programming.

Some prevention specialists (Hawkins et al. 1987) believe that prevention efforts should target at-risk and problem-prone schools, neighborhoods, or communities rather than individuals, because of concern about labeling individuals. The broad targeting of schools or neighborhoods may be one solution to attracting and recruiting vulnerable youth into prevention programs without labeling them as at-risk. Involving some youth and families in prevention programs that they do not need and that may have negative effects is not only costly and ineffective, it is potentially unethical. However, if the concern about labeling is not addressed, then youth may be denied services from which they might benefit.

Assessment of the presence of behavioral or emotional precursors of substance abuse (such as conduct disorders, depression, and delinquency) and early signs of substance abuse are important considerations for prevention practitioners when designing indicated prevention programs. The practitioner must determine that potential program participants possess the factors that place them at risk for substance abuse. Such assessment can be accomplished through a number of means. Teachers and school counselors or parents can administer standardized test batteries that can be used to diagnose problems. Risk assessment instruments also can be used to determine who is at risk. One strategy might be to have youth who are suspected of having a problem referred to an indicated prevention program based on a risk assessment. Then indicated prevention activities can be created that address each risk factor and associated problem behavior.

This chapter has presented an overview of research-based prevention, including a discussion of some of the important factors that practitioners should consider when implementing substance abuse prevention programs. The chapter discussed the rationale for tailoring prevention program components for maximum benefits and targeting prevention program activities to

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appropriate audiences. The importance of determining the comparability of research-based program efforts for particular population groups and the relevance of evaluating the effects of prevention programming efforts were also discussed. This chapter presented specific steps for choosing research-based prevention programs and some issues to consider in the use of selective and indicated prevention program approaches.

The following chapter will present an overview of the three program models highlighted in this set of drug abuse prevention RDA materials that are case examples of universal, selective, and indicated prevention strategies. Project STAR, the Strengthening Families Program, and the Reconnecting Youth Program are each described according to their key elements.

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OVERVIEW OF PREVENTION PROGRAM MODELS

The research presented in this handbook has shown that individuals in at-risk populations are more likely to be exposed to certain biological, psychological, social, and environmental factors that place them at increasingly higher risk for substance abuse than individuals who have not been exposed to those factors and/or possess protective factors that increase their resilience. Prevention research indicates that theory-based prevention models and programs that focus on risk and protective factors can prevent adolescent substance abuse. The following substance abuse prevention program models are examples of research-tested universal, selective, and indicated prevention approaches. The programs described here are variations of the models introduced in the preceding chapter. These descriptions show how the models can be adapted to different situations.

These three examples are presented for illustrative purposes because they have demonstrated effectiveness in preventing substance abuse. They are examples of programs that prevention practitioners might consider implementing in their communities. These model programs are *not* being endorsed by NIDA. More detailed information on these program models can be found in a video prepared by NIDA entitled *Coming Together on Prevention* and in the following resource manuals, which can be ordered separately:

- *Drug Abuse Prevention for the General Population*;

- *Drug Abuse Prevention for At-Risk Groups*; and

- *Drug Abuse Prevention for At-Risk Individuals*.

Each of these manuals contains a resource section. The resource information includes the names, addresses, and telephone numbers of persons to contact for specific information about the respective programs; training and technical assistance opportunities and resources; and other information about the model programs including costs and available program-related materials.

Universal Prevention: Project STAR

The Midwestern Prevention Project, Project STAR (Pentz et al. 1989, 1990), is a communitywide, multicomponent universal substance abuse prevention program for students in early adolescence, in grades seven and eight. Project STAR (Students Taught Awareness and Resistance), which uses the school, family, and broader community environments as the launch sites for prevention programming, began in 1984 in Kansas City, Missouri and was later replicated in Indianapolis, Indiana. The Kansas City program is referred to as Project STAR and

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the Indianapolis program as Project I-STAR. Unless otherwise specified, the term Project STAR refers to both programs.

This research-based, universal prevention program has the following five elements:

- a school-based program;

- mass media programming;

- a parent program;

- community organization; and

- health policy change.

Project STAR is a universal prevention program because an entire community receives the prevention messages through the media, and all the residents benefit from the community organization and health policy changes. All of the children in the designated grades receive the school program and their families receive the parent program without regard to their individual risk status or their membership in an at-risk subgroup.

The five elements of Project STAR are designed to be implemented in the sequence given. The school-based program and mass media programming are implemented concurrently, and the media component continues throughout the project. These are followed by the parent program, community organization, and the health policy change component. Some overlap occurs in the implementation of all these elements. This sequencing is recommended to increase the visibility and support and, ultimately, the impact of the project at all levels within the community. Each element is briefly described in the following paragraphs.

School-Based Program

The core of the school-based program is a *social influence curriculum* that is integrated into classroom instruction by trained teachers over a two-year period. During the first year, a 13-lesson core curriculum is taught, followed by a five-lesson booster curriculum in the second year. Each of the lessons takes approximately 45 minutes of class time to complete. Classroom work is supplemented by homework that is completed by both students and parents. Teachers are given an intensive three-day training (two days for the basic curriculum, one day for the booster curriculum) during which they learn the Project STAR teaching methods and strategies to encourage homework participation. This educational component focuses on increasing students' resistance skills. In the process, an antidrug climate is established throughout the school and community. This is accomplished through other interrelated facets of the school program,

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specifically, the active support of the school administration—principals and school district personnel—and student skill leaders who serve as role models for various aspects of skill development.

Mass Media Programming

Mass media programming is used to introduce, promote, and reinforce the implementation and maintenance of Project STAR. The media component, which begins at the same time as the school component and continues throughout Project STAR, is designed to provide the most effective means to disseminate the prevention message throughout the community. It also increases exposure of the project and relevant substance abuse issues. Representatives from the media initially are encouraged to attend a two-hour overview session conducted by program staff. A media representative is then encouraged to participate formally in the community organization component of the program. Contact is maintained with the print, television, and radio media through press releases and other public relations strategies. Program staff work with advertising agencies and communications or public relations departments in businesses or universities to develop the content for public service announcements and educational or training tapes.

Parent Program

The parent program involves parents in several ways to increase student participation and expand the educational reach of the project. Parents are encouraged to participate in the school component by working with their children on homework assignments that they are required to complete together. Parents are encouraged to participate in a school-based parent organization that organizes initiatives and activities that limit youths' accessibility to substances, supports fundraising efforts, and backs local school policies on substances. The parents are also given training opportunities that help develop effective communication, substance use resistance skills, and other techniques that support their children's substance-free behaviors. This parent skill training program consists of two 2-hour sessions conducted at the school site. Parents are encouraged to participate in the community organization component of Project STAR.

Community Organization

Community organization is the glue that holds Project STAR together. It is a formal organization designed to develop support for Project STAR among volunteers and leaders from all sectors of the community and to oversee the implementation and maintenance of the program. Community organization involves local leaders who work to ensure the integrity of the project, provide direction regarding the development of health policies concerning illicit drugs, help maintain communitywide support for substance abuse prevention, develop community campaigns to complement other program components, and help identify sources of consistent funding.

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<u>Health Policy Change</u>

The health policy change component of Project STAR is the mechanism used to develop and implement local health policies that affect drug, alcohol, and tobacco laws. Policy development is one of the tasks of community organization. Policy changes can include monitoring drug-free school zones, setting policies for drug-free workplaces, restricting smoking in public places, and establishing guidelines for teacher referral of students to substance abuse counseling programs.

The results of extensive evaluations in Kansas City and Indianapolis indicate that Project STAR is an effective multicomponent, communitywide universal prevention strategy for reducing youth substance abuse and changing students' attitudes toward drug and alcohol abuse. Specifically, the Kansas City project results showed a significant decrease in alcohol, tobacco, and marijuana use among the students who participated in the project one year following their participation. This decrease in tobacco, alcohol, and marijuana abuse was maintained for more than three years after program participation.

Similar results from the Indianapolis project showed that students who participated in the program were less likely to smoke marijuana, drink alcohol, and abuse illegal drugs than students who did not participate in the program. The overall effectiveness of the Midwestern Prevention Project is discussed in greater detail in *Drug Abuse Prevention for the General Population*. As a result of the significant impact of the project on substance abuse among youth in those two midwestern cities, other jurisdictions have implemented and are beginning to evaluate community substance abuse prevention programs like Project STAR.

Selective Prevention: The Strengthening Families Program

The Strengthening Families Program (Kumpfer 1987; Kumpfer et al. 1989) is an example of a multicomponent, family-focused selective prevention program for 6- to 10-year-old children of substance abusers. This is a selective prevention program because the parents of these children have abused substances and the children as a group share this familial risk factor for future substance abuse. The children involved in the program are *not* individually assessed to be at risk for substance abuse. The Strengthening Families Program (SFP) began in 1983 as an effort to help substance-abusing parents improve their parenting skills and reduce the risk factors for their children. The SFP provides prevention services through a group modality strategy that includes the following three elements:

● a parent training program;

● a children's skills training program; and

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●   a family skills training program.

The SFP is presented in 14 consecutive weekly sessions, each lasting from two to three hours. Each week focuses on a different topic. In the first hour, the parents and children meet separately in their respective skills training groups. During the second hour, the parents and children come together for family skills training. Announcements before the training begins, breaks between groups, and meals can take an additional hour. The optimal parent group consists of six to eight sets of parents (or eight to twelve individual parents), and the optimal children's group consists of six or seven children. After the second hour, participants have dinner and listen to a speaker, film, or other entertainment related to substance abuse prevention. Descriptions of the three elements follow.

Parent Training Program

The parent training program is designed to improve parenting skills and diminish the parent's substance abuse. Parents work with trained program implementers or therapists to learn appropriate ways to deal with their children's problem behaviors and alternative ways to increase positive interactions with their children. They use a structured parent handbook that contains worksheets, activity sheets, contracts, and plans for group activities. They are guided through group exercises by the therapists.

Children's Skills Training Program

The children's skills training program is designed to decrease negative behaviors and develop more socially acceptable behaviors in the children of substance-abusing parents. The children work with trained program therapists to learn appropriate social and behavioral skills to enhance positive interactions with their parents that will serve to improve the family environment. The children use a structured children's handbook that contains worksheets, activity sheets and stories, and are guided through group exercises and activities by the therapists.

Family Skills Training Program

The family skills training program is designed to change the family environment by involving the parents and their children in learning and practicing together as a family the new behaviors they are learning in their skills training programs. Family members are given exercises to practice at home to reinforce the behaviors they have learned during the training. Family sessions are designed to help parents develop a better understanding of the emotional needs of their children while learning to enjoy them. At the same time, the supportive and nonpunitive environment helps the children learn to express the feelings that are often suppressed in their efforts to cope with their stressful family environments.

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The SFP model has been adapted for use with diverse racial/ethnic groups, and training manuals have been developed for these adaptations. Although the program was developed for predominantly white, middle-class families in and around Salt Lake City, the SFP has been made culturally appropriate for use with urban and rural African-American families, Asian/Pacific Island families, Hispanic/Latino families, and families from low socioeconomic status regardless of race/ethnicity. The program is being evaluated for use with 10- to 14-year-olds as well.

Evaluations of the SFP indicate that it is an effective, family-focused, selective prevention strategy for enhancing family relationships. The SFP was shown to be effective in reducing family conflict, improving family communication and organization, and improving the behavior of the children by reducing conduct disorders, aggressiveness, and emotional problems. The overall effectiveness of the Strengthening Families Program is discussed in greater detail in *Drug Abuse Prevention for At-Risk Groups*.

Indicated Prevention: The Reconnecting Youth Program

The Reconnecting Youth Program (Eggert et al. 1990) is an example of a school-based indicated prevention program that targets youth in the ninth through twelfth grades, with multiple risk factors for substance abuse and signs of multiple problem behaviors such as substance abuse, depression, and suicidal ideation. The program teaches skills to build resilience to risk factors and to moderate the early signs of substance abuse. This is an indicated prevention program because students are individually assessed and must meet the following criteria to qualify for the program:

- Below average credits earned for the student's expected grade level;

- In the top 25th percentile for class absences per semester; and

- A pattern of declining grades with a grade point average (GPA) less than 2.3 (on a 4.0 scale), or a precipitous drop in GPA of 0.7 or greater.

Any student meeting *either* of the following criteria also qualifies for the program:

- Prior school dropout status; or

- A referral from any school personnel—teacher, counselor, school nurse, secretary, administrator—as being in serious jeopardy of school failure *and* meeting one or more of the preceding criteria.

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The Reconnecting Youth Program is based on a psychoeducational model and incorporates social support and life-skills training in which students acquire skills through a positive peer group approach, nonconventional teaching methods, and flexible teaching environments. This research-based program consists of the following elements:

- Personal Growth Class (PGC);

- Social activities and school bonding; and

- School system crisis response plan.

Personal Growth Class

The PGC combines positive peer group work with life skills training. The life skills training curriculum is incorporated into the regular classroom and is offered as a 20-week course that meets five days a week for 55 minutes each day. It is recommended that the class be offered for credit, although typically it is offered as an elective. The life skills training curriculum teaches four skills described below. Each skill is designed to be taught in four-week units, with a two-week introductory overview, or *getting started* unit, at the beginning of the course, and a two-week *wrap-up* unit at the end. Through the daily classroom sessions, students learn skills to improve their school performance and personal relationships, and to interact with a new peer group struggling with the same life situations. The life skills training units are as follows:

- Self-esteem enhancement;

- Decision making;

- Personal control; and

- Interpersonal communication.

Self-Esteem Enhancement

The self-esteem enhancement unit is designed to help group members appreciate the meaning of, and processes for, enhancing their self-esteem. The group learns what self-esteem is and how it affects their daily lives. They learn and practice skills of *positive self-talk* and self-appraisal, and they learn how to accept responsibility for their actions, how to handle criticism, and how to set personal goals for self-improvement. The group members learn specific

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skills—visualization, self-praise, group praise, and relaxation techniques—for increasing self-esteem, and they learn how to apply the skills in a variety of situations. These skills are used in teaching the other three units.

Decision Making

The decision-making unit is designed to teach group members skills for effective decision making as a strategy for personal empowerment. They learn that decisions have consequences and how to base decisions on the consequences rather than impulse. Students learn how to make, set, and achieve goals, and they learn how to make decisions as a group. They also learn strategies for reaching agreement in a group, resolving conflicts, and making individual and group contracts.

Personal Control

The personal control unit is designed to teach the group to use problem-solving skills to reduce stress and manage anger and depression. The group learns that moods are inner reactions to outside events and personal experiences. They learn to be aware of and to identify moods, and then to practice the strategies they have learned to manage these reactions more constructively.

Interpersonal Communication

The interpersonal communications unit is designed to foster strategies for effective interpersonal communication and conflict resolution. Group members learn about verbal and nonverbal communication, and they learn to apply effective communication strategies in negotiating with friends, teachers, and parents. Finally, the group learns and practices skills for effectively resolving conflict.

Positive Peer Culture

In addition to the life skills training, a second feature of the PGC involves developing a positive peer culture. Skills training is presented in a structured sequence, within a positive peer group in which students are given key concepts and strategies for improving specific skills. Students are given an opportunity to practice those skills with real-life situations. An adult leader guides the students in the development of these new skills and provides feedback as they practice the new ideas and concepts.

The PGC employs group dynamics as a major aspect of the learning process, and the group experience provides the motivation and direction for learning to occur. As the group develops, the issues raised in the group become the basis for introducing and working on specific skills. By using group work and discussion skills, the leader is able to relate the students' issues to the

planned skills training session and activities. The challenge for the group leader is to balance the students' daily needs and crises with related skills building, skills application, and group problem-solving applied to the students' current concerns and real-life issues. The curriculum allows flexibility as long as the class does not become a crisis management hour rather than a class designed to teach specific skills.

Social Activities and School Bonding

The second key element of the Reconnecting Youth Program, social activities and school bonding, is a practical extension of the life-skills training. The intent of this program element is to:

- reinforce health-promoting activities and teach students how to expand their repertoires of recreational and social activities;

- teach students to see service as an opportunity for growth; and

- provide the students with opportunities for developing close friendships and bonding to their school.

Social activities and school bonding activities differ in their purposes. Social activities occur outside of the school setting. Through participation in such activities, students learn to work with others to solve dilemmas and practice social skills they are taught in class. Substance-free weekends, in which students engage in an activity such as attending a sporting event together, are a cornerstone of the social activities element of the Reconnecting Youth Program. School bonding activities reconnect participating youth to the larger institution. The key for successfully bonding students with the school is to use the students' strengths to meet identified needs within the school. For example, students who relate well to others can act as mentors for younger students to demonstrate skills the younger students can use to build their resilience.

Crisis Response Plan

The third element of the Reconnecting Youth Program is a school-system crisis response plan for addressing suicide or accidental death due to the association between suicidal thoughts and substance abuse. The plan details methods for preventing suicide, responding to suicide or accidental death, and preparing for postsuicidal interventions. The plan provides guidelines for assessing suicidal behavior, making appropriate interventions, and responding to suicidal or accidental death. Information is included on how to train staff, students, and parents to recognize signs of suicidal thinking and to intervene appropriately.

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Parents are encouraged to become involved in supporting the program through classroom activities; this may include providing assistance with at-home activities. They also are encouraged to learn the signs of substance abuse so they will be able to intervene early if their child develops a substance abuse problem.

Finally, the involvement of the broader community is encouraged as a means for supporting youth in the program. For example, school administrators and teachers are encouraged to establish links and form alliances with community groups, especially agencies and organizations that work with young people who are at risk for substance abuse and other problems, to strengthen the curriculum and the base of support within the community.

Evaluations of the Reconnecting Youth Program indicate that it is an effective strategy for reaching youth early in their substance abuse and antisocial activity before they drop out of school. The program was shown to be effective in reducing illegal drug abuse, reducing drug abuse progression, and decreasing drug abuse control problems and adverse use consequences. The program demonstrated its efficacy in enhancing personal control, reducing depression and suicide-risk behaviors, and improving the school performance and bonding of students with the school. The overall effectiveness of the program is discussed in greater detail in *Drug Abuse Prevention for At-Risk Individuals*.

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SUMMARY AND CONCLUSIONS

Prevention practitioners and members of school and community task forces and coalitions are seeking the best prevention approaches for their local populations. This handbook has reviewed many causes of drug abuse and several prevention approaches. The root causes of drug abuse differ from person to person, and prevention approaches must accommodate these differences. The task for local prevention practitioners is to use the information in this handbook and other documents in the *Drug Abuse Prevention* RDA materials to select, modify, or design prevention programs to address these differences effectively. Prevention strategies must be developmentally appropriate, locally appropriate, gender-sensitive, and culturally relevant.

This handbook has provided an empirical basis for drug abuse prevention strategies and presented simple ideas to help practitioners:

- identify the relevant drug abuse issues in their communities;

- define a theory of prevention that will apply to the local community;

- determine the type of prevention programming that will be most appropriate for the community; and

- outline program implementation steps that can be undertaken for drug abuse prevention at the local level.

Equipped with this kind of information, a community can choose with greater confidence a prevention approach that stands a good chance of being effective in meeting its needs. There are a number of approaches, and combinations of approaches, that prevention practitioners can take in addressing drug abuse problems. This handbook provides guidance in determining which approach(es) will be most effective: universal prevention for the entire community, selective prevention for specific at-risk subgroups, and/or indicated prevention for individuals demonstrating subclinical signs of substance abuse behaviors and other related problems. The most effective prevention program for drug abuse problems is the one that gets the job done. When the prevention program has been properly selected and implemented, then it can be successful.

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APPENDIX A: RESOURCES

CONTACTS AND RESOURCES: RESEARCH-BASED PREVENTION MODELS FOR DRUG ABUSE

The following drug abuse prevention program models are highlighted in the *Drug Abuse Prevention RDA* set of materials. The name and address of the principal investigator conducting the research for each model is provided, followed by information on the availability of training manuals, formal training services, consultation, and technical assistance.

Project STAR, a communitywide prevention program:

Mary Ann Pentz, Ph.D.
Department of Preventive Medicine
University of Southern California
1540 Alcazar Avenue, Suite 207
Los Angeles, CA 90033
Phone: (213) 342-2582
Fax: (714) 494-7771

Manuals, training, and technical assistance services are available from the research group at the University of Southern California, as follows:

- School component—teacher and peer leader training, manuals, and parent-child workbook;
- Parent component—parent and school principal training, manuals, and parent-child workbook;
- Community organization component—training;
- Policy component—training;
- Media component—training; and
- Evaluation—evaluation instruments, services, and data collection training tape.

Training costs are $150 to $250 per person per day, from a minimum of $1,500 up to a maximum of $2,500 per day, depending on the nature of the presentation. Technical assistance costs are negotiated on a case-by-case basis. Further information about materials, training, or technical assistance also can be obtained by contacting:

Project I-STAR
5559 West 73rd Street
Indianapolis, IN 46268
Phone: (317) 291-6844

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Strengthening Families, a family-focused prevention program for children of substance-abusing parents:

> Karol L. Kumpfer, Ph.D.
> Department of Health Education
> HPERN-215
> University of Utah
> Salt Lake City, UT 84112
> Phone: (801) 581-7718
> Fax: (801) 581-5872

Manuals, training, and evaluation services and instruments are available from the program developers, evaluators, or implementors by contacting Dr. Kumpfer. A 3-day training costs $2,000 plus travel for a group of up to 16 participants.

Costs for program materials are:

Family Training Therapist Manual	$ 25
Parents' Skills Training Manual	25
Parent Handbook	25
Children's Skills Training Manual	25
Children's Handbook (6 to 12 years)	25
Implementation Manual	25
Evaluation Package	_25_
7-Manual Package Total:	$175
African-American Parent Handbook	_25_
8-Manual Package Total:	$200

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Reconnecting Youth, a school-based prevention program for at-risk youth:

Leona L. Eggert, Ph.D., R.N.
Psychosocial and Community Health Department
P.O. Box 357263
University of Washington
Seattle, WA 98195
Phone: (206) 543-9455 or 543-6960
Fax: (206) 685-9551
e-mail: eggert@u.washington.edu

Consultation and technical assistance are available by contacting Dr. Eggert. Materials and training are also available. Program awareness can be gained in a day. Full-scale training requires 3 to 5 days and is limited to small groups. Prices for the training vary depending on the number of people to be trained. Rates are structured on an honorarium-plus-expenses basis. A curriculum and leaders' guide, *Reconnecting Youth: A Peer Group Approach to Building Life Skills*, is available for $139. For materials and training, contact:

Susan Dunker or Peter Brooks
National Educational Service
1252 Loesch Road
P.O. Box 8
Bloomington, IN 47402-0008
Phone: (812) 336-7700
Toll Free: (800) 733-6786
Fax: (812) 336-7790

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CONTACTS AND RESOURCES: COMMUNITY READINESS FOR DRUG ABUSE PREVENTION

Eugene R. Oetting, Ph.D.
Scientific Director
Barbara Plested,
Research Associate
Tri-Ethnic Center for Prevention Research
Colorado State University
C79 Clark Building
Fort Collins, CO 80523
Phone: (800) 835-8091
Fax: (970) 491-0527

Abraham Wandersman, Ph.D.
Professor
Department of Psychology
University of South Carolina
Columbia, SC 29208
Phone: (803) 777-7671
Fax: (803) 777-0558

SOURCES OF INFORMATION ON COMMUNITY COALITIONS

The Anti-Drug Abuse Act of 1988 provided congressional authorization and funding for the Center for Substance Abuse Prevention (CSAP) to create more than 250 community partnerships nationwide (Davis 1991). Additional community substance abuse prevention coalitions and community action groups have been implemented by:

- State and local governments, for example, Rhode Island (Florin et al. 1992) and Oregon (Hawkins et al. 1992a);

- National foundations, for example, Henry J. Kaiser Family Foundation (Tarlov et al. 1987) and Robert Wood Johnson Foundation Fighting Back and Join Together coalitions (Robert Wood Johnson Foundation 1989);

- Federal Public Health Service agencies, for example, the National Cancer Institute's COMMIT and ASSIST tobacco and cancer reduction programs (Best et al. 1988; Shopland 1989), the Planned Approach to Community Health (PATCH) health promotion program of the U.S. Centers for Disease Control and Prevention (Kreuter 1992), and the Weed and Seed Program of the Bureau of Justice Assistance; and

- Schools and universities, for example, the university coalitions sponsored by the Department of Education/Fund for the Improvement of Post-Secondary Education (DOE/FIPSE) and local school boards.

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POTENTIAL FUNDING SOURCES

Federal Grants

Most Federal substance abuse funding is provided as either demonstration and evaluation grants or prevention research grants. These funding mechanisms require evaluations and data collection processes to determine the effectiveness of the programs. These are *not* service grants (See list of Federal Government agencies).

Potential Federal funding sources for *demonstration grants* include:

- Center for Substance Abuse Prevention (CSAP);

- Center for Substance Abuse Treatment (CSAT);

- Office of Juvenile Justice Delinquency Prevention (OJJDP);

- Bureau of Justice Assistance (BJA);

- U.S. Department of Housing and Urban Development (HUD); and

Potential Federal funding sources for *research grants* include:

- National Institute on Drug Abuse (NIDA);

- National Institute on Alcohol Abuse and Alcoholism (NIAAA); and

- National Institute of Mental Health (NIMH).

Other Grants

Service grants are available through individual State block grant mechanisms or through local county funding sources.

FEDERAL GOVERNMENT AGENCIES

Bureau of Justice Assistance (BJA)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 20531
Phone: (202) 514-6278

Implements national and multistate programs, offers training and technical assistance, establishes demonstration programs, and conducts research to reduce crime, enforce drug laws, and improve the functioning of the criminal justice system. Offers the following information clearinghouse:

Bureau of Justice Assistance Clearinghouse (BJAC): (800) 688-4252

Bureau of Justice Statistics (BJS)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 29531
Phone: (202) 307-0765

Focuses on drugs and crime data and covers law enforcement and crime rates. Offers the following information clearinghouses:

BJS Automated Information System
National Criminal Justice Reference Service (NCJRS)
Box 6000
Rockville, MD 20849-6000
Phone: (202) 307-6100

Offers drug- and crime-related information and materials. Fax-on-demand and Internet services also available.

BJS Clearinghouse
National Criminal Justice Reference Service (NCJRS)
Box 6000
Rockville, MD 20849-6000
Phone: (202) 307-6100

Distributes drug- and crime-related publications.

Center for Substance Abuse Prevention (CSAP)
U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Rockwall II, 5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-0365

Focuses attention and funding on the prevention of substance abuse. Offers the following hotline:

Drug-Free Workplace Helpline (DFWH): (800) 843-4971

Center for Substance Abuse Treatment (CSAT)
U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Rockwall II, 5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-5052

Focuses attention and funding on the development and assessment of treatment techniques and models. Offers the following hotline:

CSAT's National Drug Information and Treatment Referral Hotline: (800) 662-4357

Centers for Disease Control and Prevention
U.S. Department of Health and Human Services
1600 Clifton Road, N.E.
Atlanta, GA 30333
Phone: (404) 639-3311 or 3534

Researches and develops cures for diseases worldwide. Offers the following information clearinghouse:

CDC National AIDS Clearinghouse
P.O. Box 6003
Rockville, MD 20849-6003
Phone: (800) 458-5231

Offers information on AIDS-related resources and services. Publications are also available on substance abuse issues related to HIV.

Crime Prevention and Security Division
U.S. Department of Housing and Urban Development
451 Seventh Street, S.W.
Washington, DC 20410
Phone: (202) 708-1197

Awards drug elimination grants each year. Offers the following information clearinghouse:

> Drug Information and Strategies Clearinghouse
> P.O. Box 6424
> Rockville, MD 20849
> Phone: (800) 578-3472

Distributes materials on substance abuse prevention in public housing.

U.S. Department of Housing and Urban Development (HUD)
451 Seventh Street, S.W.
Washington, DC 20410
Phone: (202) 708-0685

Focuses on all aspects of housing. Community programs target at-risk youth and work to improve neighborhoods.

Fund for the Improvement of Post-Secondary Education (FIPSE)
U.S. Department of Education
Seventh and D Streets, S.W.
Room 3100
Washington, DC 20202-5175
Phone: (202) 708-5750

Funds drug and violence prevention programs aimed at students enrolled in institutions of higher education. Program encourages colleges and universities to develop programs to prevent alcohol and other drug use for their students and staff.

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U.S. Government Printing Office (GPO)
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954
Phone: (202) 783-3238
Fax: (202) 512-2250

Publishes and makes available numerous publications on many topics, including substance abuse. Many publications are available free of charge.

National Clearinghouse on Child Abuse and Neglect (NCCAN) Information
P.O. Box 1182
Washington, DC 20013-1182
Phone: (703) 385-7565
Phone: (800) 394-3366

Serves as a major resource center for the acquisition and dissemination of child abuse and neglect materials; free publications catalog on request.

National Clearinghouse for Alcohol and Drug Information (NCADI)
P.O. Box 2345
Rockville, MD 20847-2345
Phone: (800) 729-6686
TDD: (800) 487-4889

Houses and catalogs numerous publications on all aspects of substance abuse. Provides computerized literature searches and copies of publications, many free of charge.

National Institute of Justice (NIJ)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 20531
Phone: (202) 307-2942

Conducts research and sponsors the development of programs to prevent and reduce crime and improve the criminal justice system.

National Institute of Mental Health (NIMH)
U.S. Department of Health and Human Services
5600 Fishers Lane
Room 7C-02
Rockville, MD 20854
Phone: (301) 443-4513

Focuses on research in mental health and related issues.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)
U.S. Department of Health and Human Services
National Institutes of Health
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-3860

Focuses attention and funding on research on alcohol abuse and alcoholism and their treatment.

National Institute on Drug Abuse (NIDA)
U.S. Department of Health and Human Services
National Institutes of Health
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-6245

Contacts: William J. Bukoski, Ph.D.
Chief, Prevention Research Branch
Division of Epidemiology and Prevention Research
Room 9A-53
Phone: (301) 443-1514

Susan L. David, M.P.H.
Coordinator, Epidemiology and Prevention Research
Division of Epidemiology and Prevention Research
Room 9A-53
Phone: (301) 443-6543

Focuses attention and funding on research on substance abuse and its treatment and on the dissemination and application of this research.

National Technical Information Service (NTIS)
Order Desk
5285 Port Royal Road
Springfield, VA 22161
Phone: (703) 487-4650
Fax: (703) 321-8547
Fax Receipt Verification: (703) 487-4679
RUSH Service: (800) 553-NTIS (additional fee)

Makes available numerous publications on many topics, including substance abuse.

Office of Justice Programs (OJP)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 20531
Phone: (202) 307-5933

Operates many programs to prevent and treat substance abuse-related crime.

Office of Juvenile Justice Delinquency Prevention (OJJDP)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 20531
Phone: (202) 307-5911

Focuses on program development and research to prevent and treat delinquency in at-risk youth. Offers the following information clearinghouse:

Juvenile Justice Clearinghouse
National Criminal Justice Reference Service (NCJRS)
Box 6000
Rockville, MD 20849-6000
Phone: (800) 638-8736

Provides publications on juvenile crime and drug-related issues.

Office of National Drug Control Policy (ONDCP)
Executive Office of the President
Washington, DC 20500
Phone: (202) 467-9800

Is responsible for national drug control strategy; sets priorities for criminal justice, drug treatment, education, community action, and research. Offers the following information clearinghouse:

> Drugs and Crime Clearinghouse
> 160 Research Boulevard
> Rockville, MD 20850
> Phone: (800) 666-3332

> Distributes statistics and drug-related crime information.

Safe Drug-Free School Program
U.S. Department of Education
600 Independence Avenue, S.W.
Washington, DC 20202
Phone: (202) 260-3954

Funds drug and violence prevention programs that target school-age children. Training and publications are also available.

OTHER PREVENTION PROGRAMS AND ORGANIZATIONS

The following list of programs, organizations, and hotlines is provided for the reader seeking additional resources. Inclusion on this list should not be construed as an endorsement by NIDA.

Community Anti-Drug Coalition of America (CADCA)
901 North Pitt Street
Suite 300
Alexandria, VA 22314
Phone: (703) 706-0560
Fax: (703) 706-0565

A membership organization for community alcohol and other drug prevention coalitions, with a current membership of more than 3,500 coalition members. Provides training and technical assistance and publications and advocacy services and hosts a National Leadership Forum annually.

Narcotics Education
6830 Laurel Street, N.W.
Washington, DC 20012
Phone: (202) 722-6740
Phone: (800) 548-8700

Publishes pamphlets, books, teaching aids, posters, audiovisual aids, and prevention materials designed for classroom use on narcotics and other substance abuse.

National Center for the Advancement of Prevention
11140 Rockville Pike
Suite 600
Rockville, MD 20852
Phone: (301) 984-6500

Produces documents on a variety of prevention and community mobilization and readiness topics.

National Families in Action
2296 Henderson Mill Road, Suite 300
Atlanta, GA 30345
Phone: (404) 934-6364

Maintains a drug information center with more than 200,000 documents; publishes *Drug Abuse Update*, a quarterly journal containing abstracts of articles published in journals, academic articles, and newspapers on drug abuse and other drug issues.

Parents Resource Institute for Drug Education, Inc. (PRIDE)
3610 Dekalb Technology Parkway, Suite 105
Atlanta, GA 30303
Phone: (770) 458-9900
Phone: (800) 241-9746

Offers drug prevention consultant services to parent groups, school personnel, and youth groups. In addition, provides drug prevention technical assistance services, materials, and audio and visual aids.

Partnership for a Drug-Free America
405 Lexington Avenue
16th Floor
New York, NY 10174
Phone: (212) 922-1560

Conducts advertising and media campaigns to promote awareness of substance abuse issues.

Prevention First Inc.
2800 Montvale Drive
Springfield, IL 62704
Phone: (312) 793-7353

Produces a variety of print and audiovisual products on various prevention topics.

TARGET
National Northwest Federation of State High School Associations
11724 Plaza Circle
P.O. Box 20626
Kansas City, MO 64195
Phone: (816) 464-5400

Offers workshops, training seminars, and an information bank on substance use and prevention.

Toughlove International
P.O. Box 1069
Doylestown, PA 18901
Phone: (215) 348-7090
Phone: (800) 333-1069

National self-help group for parents, children, and communities, emphasizing cooperation, personal initiative, avoidance of blame, and action. Publishes a newsletter, brochures, and books. Holds workshops.

Hotlines

Al-Anon Family Group Headquarters
Phone: (800) 356-9996

Provides printed materials specifically aimed at helping families dealing with the problems of alcoholism. Available 9 a.m. to 4:30 p.m. EST.

Alcohol and Drug Hotline
Phone: (800) 821-4357
Phone: (801) 272-4357 in Utah

Provides referrals to local facilities where adolescents and adults can seek help. Operates 24 hours.

Child Help USA
Phone: (800) 422-4453

Provides crisis intervention and professional counseling on child abuse. Gives referrals to local social services groups offering counseling on child abuse. Operates 24 hours.

Covenant House Nineline
Phone: (800) 999-9999

Crisis line for youth, teens, and families. Locally based referrals throughout the United States. Help for youth and parents regarding drugs, abuse, homelessness, runaway children, and message relays. Operates 24 hours.

Depression, Awareness, Referral and Treatment (D/ART)
Phone: (800) 421-4211

Provides free brochures about the symptoms of depression, its debilitating effects on society, and information about where to get effective treatment. Operated by the National Institute on Mental Health. Operates 24 hours.

Grief Recovery Institute
Phone: (800) 445-4808

Provides counseling services on coping with loss. Available 9 a.m. to 5 p.m. PST.

National Mental Health Association (NMHA)
Phone: (800) 969-6642

Provides a recorded message for callers to request a pamphlet that includes general information about the organization, mental health, and warning signs of illness. Available 9 a.m. to 5 p.m. EST.

GENERAL PUBLICATIONS ON PREVENTION

The following publications are available from:

Join Together
441 Stuart Street, 6th Floor
Boston, MA 02116
Phone: (617) 437-1500
e-mail: jointogether.org

Alcohol and Drug Abuse in America: Policies for Prevention, 1995.
Recommendations on how communities can prevent alcohol and drug abuse.

Community Action Guide to Policies for Prevention, 1995.
Steps communities can take to strengthen prevention efforts.

How Do We Know We Are Making A Difference? 1996.
Eighty-six page substance abuse indicator's handbook to help communities assess substance abuse problems.

Substance Abuse Strategies in America's 20 Largest Cities, 1996.
Efforts against alcohol and drugs in 20 cities in the United States.

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GOVERNMENT PUBLICATIONS

National Institute on Drug Abuse
Research Dissemination and Application Packages (NIDA RDA Packages)

NIDA RDA packages are available from the National Clearinghouse for Alcohol and Drug Information (NCADI), the National Technical Information Service (NTIS), and/or the U.S. Government Printing Office (GPO). (See list of Federal Government agencies.) NCADI, NTIS, and GPO publication numbers and costs are listed for each RDA package.

Drug Abuse Prevention Package (4 publications), NCADI Order No. PREVPK

This package is designed to help prevention practitioners plan and implement more effective prevention programs based on evidence from research about what works. The core package should be ordered and read first because it provides the information needed to prepare communities for prevention programming. Three stand-alone resource manuals then can be ordered. These manuals each provide information and guidance on implementing a specific prevention strategy introduced in the core package. The core package is available free of charge from NCADI (Order No. PREVPK) while supplies last.

- *Brochure*
- *Drug Abuse Prevention: What Works*
- *Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools*
- *Drug Abuse Prevention and Community Readiness Training Facilitator's Manual*

Drug Abuse Prevention Resource Manuals

These manuals are available free of charge from NCADI while supplies last.

- *Drug Abuse Prevention for the General Population*, NCADI Order No. BKD200

- *Drug Abuse Prevention for At-Risk Groups*, NCADI Order No. BKD201

- *Drug Abuse Prevention for At-Risk Individuals*, NCADI Order No. BKD202

How Good Is Your Drug Abuse Treatment Program Package (4 publications)

This package deals with treatment program evaluation; however, much of it is applicable to substance abuse prevention programming.

- NTIS #PB95-167268/BDL: $44.00 (domestic) + postage; $88.00 (foreign) + postage

- GPO #017-024-01554-7: $33.00 (foreign rate add 25-percent surcharge for special handling. If by airmail, an additional cost is added.)

Working With Families To Support Recovery Package (4 publications), NCADI Order No. FAMILYPK

This package is designed to disseminate research-based family therapy treatment approaches to the drug abuse field. It is available free of charge from NCADI while supplies last.

National Institute on Drug Abuse
Clinical Reports (NIDA Clinical Reports)

All NIDA Clinical Reports are available from NCADI. (See list of Federal Government agencies.) NCADI publication numbers are listed for each clinical report.

Family Dynamics and Interventions, NCADI Order No. BKD147

Mental Health Assessment and Diagnosis of Substance Abusers, NCADI Order No. BKD 148

National Institute on Drug Abuse
Research Monographs

All NIDA Research Monographs are available from NCADI. (See list of Federal Government agencies.) NCADI order numbers are listed for each research monograph.

Drugs and Violence: Causes, Correlates, and Consequences. NIDA Research Monograph 103, NCADI Order No. M103

Drug Abuse Prevention Intervention Research: Methodological Issues. NIDA Research Monograph 107, NCADI Order No. M107

Methodological Issues in Epidemiological, Prevention, and Treatment Research on Drug-Exposed Women and Their Children. NIDA Research Monograph 117, NCADI Order No. M117

Advances in Data Analysis for Prevention Intervention Research. NIDA Research Monograph 142, NCADI Order No. M142

Adolescent Drug Abuse: Clinical Assessment and Therapeutic Interventions. NIDA Research Monograph 156, NCADI Order No. M156

National Institute on Drug Abuse
Videotapes for Prevention Practitioners

These videotapes are available from NCADI. (See list of Federal Government agencies.) Order numbers are provided for each tape.

Coming Together on Prevention, 1994, 27 minutes, NCADI Order No. VHS66, $8.50

Dual Diagnosis, 1993, NCADI Order No. VHS58, $8.50

Adolescent Treatment Approaches, 1991, NCADI Order No. VHS40, $8.50

National Institute on Drug Abuse
Other Publications

There are various other NIDA publications and products on various prevention and other related topics, some of which are listed below. For a full list, contact NCADI for a catalog. (See list of Federal Government agencies.) In addition, future products related to prevention will be announced through flyers and the *NIDA Notes* newsletter. Readers with access to computers can find out about new materials by calling up NIDA on its World Wide Web homepage at *http://www.nida.nih.gov/*

Drug Use Among Racial/Ethnic Minorities, NCADI Order No. BKD180

Monitoring the Future Survey—Prevalence of Various Drugs for 8th, 10th, and 12th Graders, 1996, NCADI Order No. BKD213

Center for Substance Abuse Prevention (CSAP) Publications

CSAP has a wide range of prevention products addressing various prevention topics and targeted populations. These products include resource guides, manuals, pamphlets, posters, videotapes, and data reports. Target populations include educators, community leaders, families, health professionals, and youth. Publications are also available in Spanish. CSAP products are available from NCADI. (See list of Federal Government agencies.) For a full list, contact NCADI for a catalog. Publications cited in this *Drug Abuse Prevention RDA package* are given below. NCADI publication numbers are listed for each publication.

Communicating About Alcohol and Other Drugs: Strategies for Reaching Populations at Risk. CSAP Prevention Monograph 5. Rockville, MD: NCADI Pub. No. BK170, 1993

Conducting Focus Groups With Young Children Requires Special Consideration and Techniques. CSAT Technical Assistance Bulletin. Rockville, MD: NCADI Pub. No. MS501, 1991 (Reprint 1994)

Cultural Competence for Evaluators: A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working With Ethnic/Racial Communities. Center for Substance Abuse Prevention. DHHS Pub. No. (ADM)92-1884A. Rockville, MD, 1992

Handbook for Evaluating Drug and Alcohol Prevention Programs: Staff/Team Evaluation of Prevention Programs (STEPP). U.S. Department of Health and Human Services. DHHS Pub. No. (ADM)87-1512, Rockville, MD, 1987

Measurements in Prevention: A Manual on Selecting and Using Instruments To Evaluate Prevention Programs. CSAP Technical Assistance Report 8. Rockville, MD: NCADI Pub. No. BK213, 1993

Prevention Plus II: Tools for Creating and Sustaining a Drug-Free Community, Rockville, MD: NCADI Pub. No. BK159, 1991

Prevention Plus III: Assessing Alcohol and Other Drug Prevention Programs at the School and Community Level. Rockville, MD: NCADI Pub. No. BK18, 1991

Prevention Primer: An Encyclopedia of Alcohol, Tobacco, and Other Drug Prevention Terms. Rockville, MD: NCADI Pub. No. PHD627, 1994

You Can Manage Focus Groups Effectively for Maximum Impact. CSAP Technical Assistance Bulletin. Rockville, MD: NCADI Pub. No. MS495, 1991 (Reprint 1994)

Center for Substance Abuse Treatment (CSAT)
Publications

CSAT has two series of publications, some of whose issues address topics of interest to substance abuse prevention professionals. Topics include dual diagnosis, assessment and treatment of adolescents, and so forth. The two series are called Technical Assistance Publications Series (TAPS) and Treatment Improvement Protocol Series (TIPS). CSAT publications are available from NCADI. (See list of Federal Government agencies.) For a full list, contact NCADI for a catalog.

Other Government Publications

The following publications are available from the agencies. (See list of Federal Government agencies.)

Supporting Substance-Abusing Families: A Technical Assistance Manual for the Head Start Management Team. Washington, DC: Department of Health and Human Services, Administration for Children and Families, Head Start Bureau, 1994

Working With Parents: Grades 9-12, Learning To Live Drug Free: A Curriculum Model for Prevention. Washington, DC: Department of Education, May 1990.

National Institute on Drug Abuse

Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools

U.S. Department of Health and Human Services
National Institutes of Health

National Institute on Drug Abuse
Office of Science Policy and Communications
Public Information Branch
5600 Fishers Lane
Rockville MD 20857

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ACKNOWLEDGMENTS

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CONTENTS

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FIGURES AND EXHIBITS

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HOW TO USE THE DRUG ABUSE PREVENTION
RESEARCH DISSEMINATION AND APPLICATIONS MATERIALS

Despite the best efforts of the Federal, State, and local governments, drug abuse continues to pose serious threats to the health, and social and economic stability of American communities. The causes of and factors associated with drug abuse are complex and vary across different segments of the population. To be effective, prevention programs must address not only the substance abuse behavior itself but also the relevant cultural, ethnic, regional, and other environmental and biopsychosocial aspects of the population segments being targeted for the prevention efforts. Therefore, it is important to match the program with the population it is to serve and the local community context within which it is to be implemented. The challenge for prevention practitioners is to select, modify, or design prevention strategies that will meet the needs of their constituencies, whether they comprise a whole community or specific segments within a community.

The Drug Abuse Prevention Research Dissemination and Applications (RDA) materials, of which this resource manual is a part, are designed to help practitioners plan and implement more effective prevention programs based on evidence from research about what works. These materials provide practitioners with the information they need to prepare their communities for prevention programming and to select and implement substance abuse prevention strategies that effectively address the needs of their local communities. These materials are intended for use by prevention practitioners who vary in their training and experience in the field but who are interested in developing prevention programs in their communities. The target audience for these documents includes prevention program administrators, prevention specialists, community volunteers, community activists, parents, teachers, counselors, and other individuals who have an interest in drug abuse and its prevention.

This resource manual, *Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools*, introduces the concept of community readiness for substance abuse prevention programming. The manual defines community readiness and provides a rationale for assessing a community's readiness prior to the planning or implementation of substance abuse prevention activities. It then identifies seven factors for assessing a community's readiness and offers strategies for increasing readiness factors found to be deficient. In addition to this resource manual, the core set of materials also includes three other documents:

- A *brochure* describes the contents of this set of RDA materials and provides information about how prevention practitioners can obtain these materials.

- *Drug Abuse Prevention: What Works* is an introductory handbook that provides an overview of the theory and research on which these materials are based. It includes a definition of prevention descriptions of substance abuse risk and protective factors and a discussion of the key features of three prevention

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strategies—universal, selective, and indicated—that have proven effective. The handbook also explains how prevention efforts can be strengthened by using knowledge gained through research.

- *Drug Abuse Prevention and Community Readiness: Training Facilitator's Manual* is a 9-hour, modular training curriculum, designed for use by training facilitators in introducing prevention practitioners and community members to the basic theory of substance abuse prevention and the three prevention strategies. The facilitator's manual also provides them with the skills to assess and increase the readiness of a community to launch a prevention effort. The curriculum includes talking points for lectures, instructions for conducting discussions and exercises, and overheads and handouts.

These four components are intended to be used together as a set. Three stand-alone documents provide more intensive guidance on implementing the three prevention models introduced in the core set of materials. Each manual provides more detailed information about the strategy, including a rationale for its use and a description of a research-based program model that illustrates the strategy. Information is provided on key elements of the program, issues that need to be addressed to implement the program successfully, and resources that practitioners can access for more information about the program. These models have been selected because National Institute on Drug Abuse (NIDA) research indicates that these programs have been effective in preventing adolescent drug abuse. The following are the three stand-alone resource manuals:

- *Drug Abuse Prevention for the General Population* discusses the history and key features of universal prevention programs. The Project STAR Program—a communitywide program designed to teach adolescents the skills necessary to counteract the psychosocial influences that increase the likelihood of substance abuse—is described as an illustration of a universal prevention strategy.

- *Drug Abuse Prevention for At-Risk Groups* discusses the history and key features of selective prevention programs. The Strengthening Families Program—a family-focused program targeting children ages 6 to 10 whose parents are substance abusers—is described as an illustration of a selective prevention strategy.

- *Drug Abuse Prevention for At-Risk Individuals* discusses the history and key features of indicated prevention programs. The Reconnecting Youth Program—a school-based program targeting 9th- through 12th-grade students who are at risk for dropping out of school, substance abuse, and suicidal behavior—is described as an illustration of an indicated prevention strategy.

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These examples of universal, selective, and indicated prevention illustrate how different communities have implemented these approaches effectively and show how the models can be varied in different settings. Their inclusion in these materials does *not* imply an endorsement by NIDA. More information on these program models can be found in a video prepared by NIDA titled *Coming Together on Prevention*, which is available from the National Clearinghouse for Alcohol and Drug Information (NCADI). (See appendix A.) If prevention practitioners determine that one or more of these case examples might be appropriate for their communities, they can use the relevant resource manual as a supplement to the RDA core package. The stand-alone resource manuals are not included as part of the RDA core package and have to be ordered separately. Figure 1 shows how a practitioner might use the documents in this set of RDA materials. Appendix A provides information on how to order the RDA core package, the stand-alone manuals, the video, and other materials on the three programs.

The RDA materials are not intended to be an all-inclusive discourse on drug abuse prevention and programming. The programs presented as illustrations of the three prevention strategies all target children or adolescents. This selection is purposeful because this population has been the major thrust of policy, research, and program efforts. This does not imply that there are no effective substance abuse prevention efforts targeting adults, only that this topic is beyond the scope of these materials.

Throughout this resource manual and the other documents in the drug abuse prevention RDA materials, *substance abuse* is used to refer to illicit drug and alcohol abuse and the use of tobacco products. Readers unfamiliar with the substance abuse and prevention terms used throughout this manual are referred to the Center for Substance Abuse Prevention (CSAP) *Prevention Primer: An Encyclopedia of Alcohol, Tobacco, and Other Drug Prevention Terms* referenced in appendix A.

Figure 1

Drug Abuse Prevention

Research Dissemination and Applications Materials

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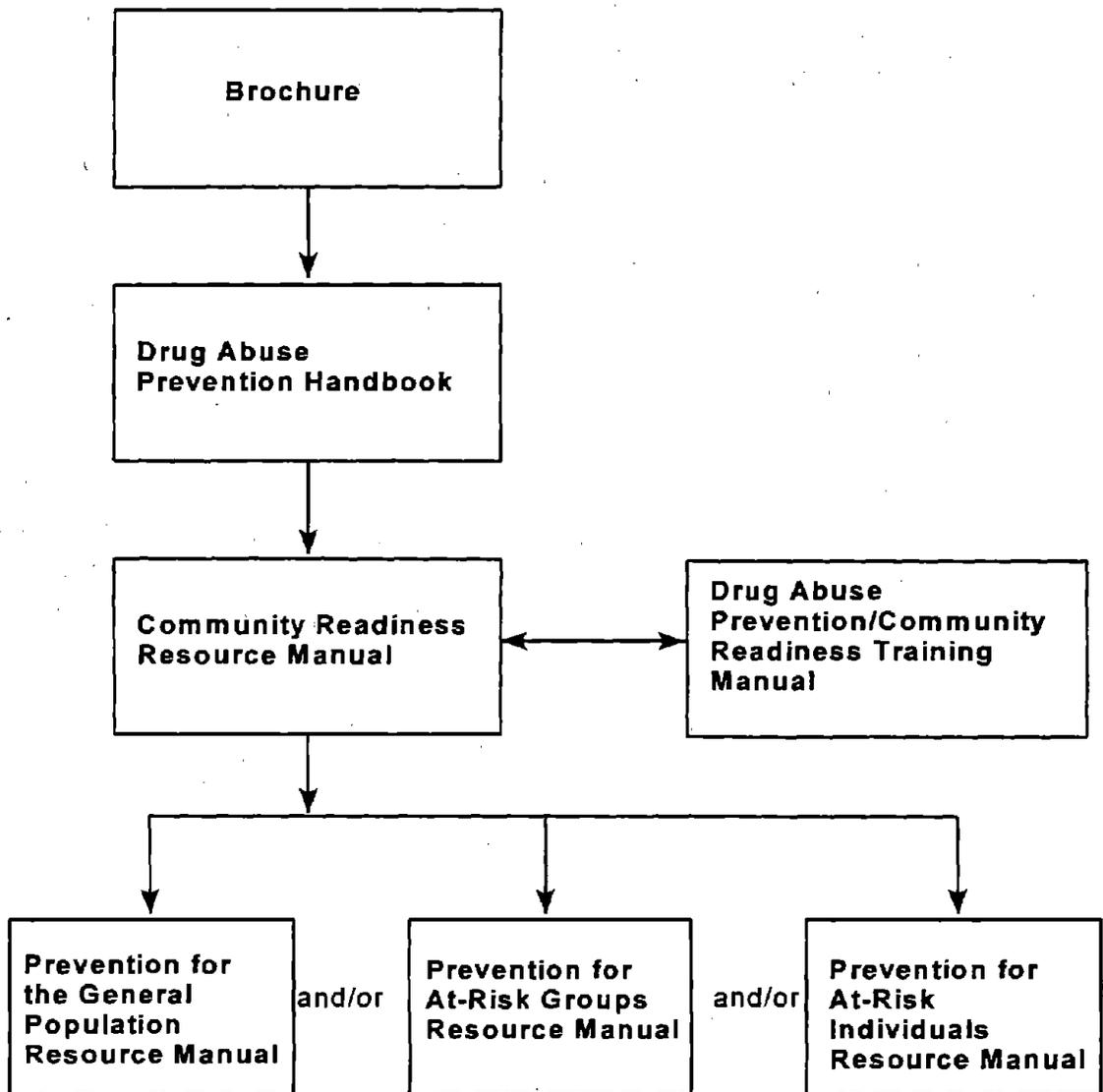
INTRODUCTION

In large metropolitan areas and in rural communities, drug abuse has become a major issue throughout this country. Drug abuse among youth and adults is a serious national health and social problem despite the best efforts of the Federal, State, and local governments. For example, although progress appeared to have been made in decreasing substance abuse among high school seniors in the decade between 1982 and 1992, increased substance abuse among eighth, tenth and twelfth graders in the subsequent 3 years has been confirmed by the Monitoring the Future Survey (NIDA 1996). The findings from this survey suggest possible causes for this upturn in adolescent use, including reduced concern for the negative consequences of substance abuse among youth and significantly decreased levels of substance abuse prevention activity at the local community level.

Substance abuse seriously affects the economic and social stability of communities, contributing to rising health care costs and to the increased costs of alcohol and drug abuse treatment. For example, Rice (1991) estimated that nationally the economic cost of substance abuse in 1988 exceeded $144 billion dollars, with roughly 60 percent of that cost resulting from alcohol abuse. In addition, reduced work productivity and unemployment are heavily correlated with substance abuse. According to the 1985 National Household Survey on Drug Abuse (NIDA 1985), employees who abuse substances have a greater negative impact on the workplace than employees who do not. Drug-related violence and gang activity, poverty, lack of opportunities for youth, and community disorganization are increasing problems in urban communities that are impacted by increased illegal drug trafficking and use and increased drug susceptibility among youth from high-risk environments (Fagan 1987). Youth from low socioeconomic backgrounds are more vulnerable to becoming drug dealers (Elliott et al. 1989), which often leads to substance abuse. Research also has shown considerable overlap between delinquency and school failure and drug abuse among youth in high-risk communities (Huizinga et al. 1991).

Because communities, in many respects, are microcosms of the larger society, the social and economic impacts of substance abuse nationally can be overwhelming on the local community level. However, prevention can play an important role in maintaining community stability. To this end, prevention professionals have begun to take a broader perspective of both the problem and its solution. Rather than viewing substance abuse as a problem whose prevention is the responsibility of a single isolated community segment (e.g., the schools), prevention professionals now emphasize the need to view substance abuse as a problem of the larger community whose members must share collectively in the responsibility for substance abuse prevention. In this view, prevention efforts must reach across and involve multiple and diverse segments of the community (e.g., the schools, the family, religious institutions, grassroots neighborhood organizations, and businesses) and include the segments typically underinvolved, such as business and labor (Join Together 1993). Research has shown that the successful reduction of drug abuse requires the wide-scale involvement of multiple segments of the community (Pentz et al. 1986).

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A key reason for including many community segments in prevention programming is that numerous research studies also have shown that developing a consistent communitywide message not to use drugs has proven to be more effective than individual prevention strategies. Single-shot, uncoordinated drug abuse prevention efforts (e.g., short media blitzes, lectures in schools, alternative youth activities, self-esteem enhancement programs) are often ineffective or have limited, short-term benefits (Moskowitz 1989; Goodstadt 1980; 1987).

This communitywide approach to drug abuse prevention allows individual communities to tailor prevention efforts to their local needs and resources. Prevention programs created by local citizens are more likely to succeed and continue operating than programs dictated from outside the community (Heller 1990). Therefore, because local solutions are more likely to have a greater impact in reducing the problem of drug abuse at the local level, it is essential that communities possess the capacity and capabilities that are required to address and prevent drug abuse. Communities must be adequately prepared to initiate substance abuse prevention efforts. Thus, community readiness is vital if a prevention effort is to have a reasonable chance for success at the community level.

Community readiness is more difficult to define than to identify in practice. Essentially, community readiness is the extent to which a community is adequately prepared to implement a prevention effort, that is, the extent to which community leaders are available to take the necessary actions to prevent substance abuse. A community's readiness to undertake prevention programming significantly impacts its success. Regardless of whether communities implement full-scale, comprehensive, communitywide prevention efforts or small-scale neighborhood or organizational efforts, such as by schools or clubs, the support and cooperation of multiple stakeholders is essential for success. Therefore, undertaking a community readiness assessment before implementing any new prevention program makes good sense.

Purpose of This Resource Manual

The purpose of this resource manual is to make the reader aware of the importance of readiness when planning a prevention program and to provide practical tools that communities can use to improve their readiness and implement successful programs. This manual is intended for prevention practitioners and other community members who vary in their training and experience in the area of substance abuse prevention but who are interested in either initiating or expanding their prevention efforts. Thus, the target audience for this document includes prevention program administrators, prevention specialists, community volunteers and community activists, parents, teachers, business and labor leaders, and other individuals and groups who have an interest in substance abuse and its prevention. The primary objectives of this resource manual are to:

- present the concept of community readiness for substance abuse prevention;

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- describe nine stages of community readiness;

- describe seven key factors associated with community readiness;

- provide guidance in the application of procedures to assess community readiness;

- describe seven steps for increasing community readiness;

- provide guidance in the application of the strategies to increase community readiness; and

- motivate the reader to consider community readiness issues in the planning for community prevention efforts.

Figure 2 provides a conceptual framework for the discussion of readiness presented in this manual. It depicts nine stages of readiness through which communities invariably evolve. Communities move sequentially through the nine stages but may fall back to lower stages periodically because of changes in funding, loss of support, talent drain, or disagreements about the mission. Factors associated with program success (shown surrounding the middle stages of readiness and highlighted with the letters P-R-E-V-E-N-T) all should optimally exist for a community to fully achieve what Oetting and colleagues (Oetting et al. 1995) refers to as actualization (i.e., reaching the stage of professionalization at the top of this readiness hierarchy). However, these factors coexist and interrelate with each other and with the nine stages of community readiness—that is, the relationship among factors is not linear nor linked with any specific stage of community readiness. Therefore, to assess a community's readiness, it is important to examine not only its stage of development but also the factors associated with prevention programming success.

The next chapter discusses the nine stages of readiness in more depth, tells how a community's stage of readiness is determined, and suggests strategies for advancing along the readiness continuum. The subsequent chapters discuss indepth seven factors associated with prevention programming success and present strategies for overcoming deficiencies and bolstering community capabilities so that a successful prevention effort can be launched.

Figure 2
Community Readiness for
Prevention Programming

COMMUNITY EVOLUTION

**PRE
PROGRAM**

TOLERANCE

↓

DENIAL

– –

PLANNING

↓

AWARENESS

← **P**ROBLEM DEFINITION

↓

PRE PLANNING

← **R**ECOGNITION

← **E**XISTENCE OF RESOURCES

– –

IMPLEMENTATION

↓

PREPARATION

← **V**ISION

↓

INITIATION

← **E**NERGY TO MOBILIZE

↓

INSTITUTIONALIZATION

← **N**ETWORKING, ORGANIZING

↓

EXPANSION

← **T**ALENT, LEADERSHIP

– –

ACTUALIZATION

↓

PROFESSIONALIZATION

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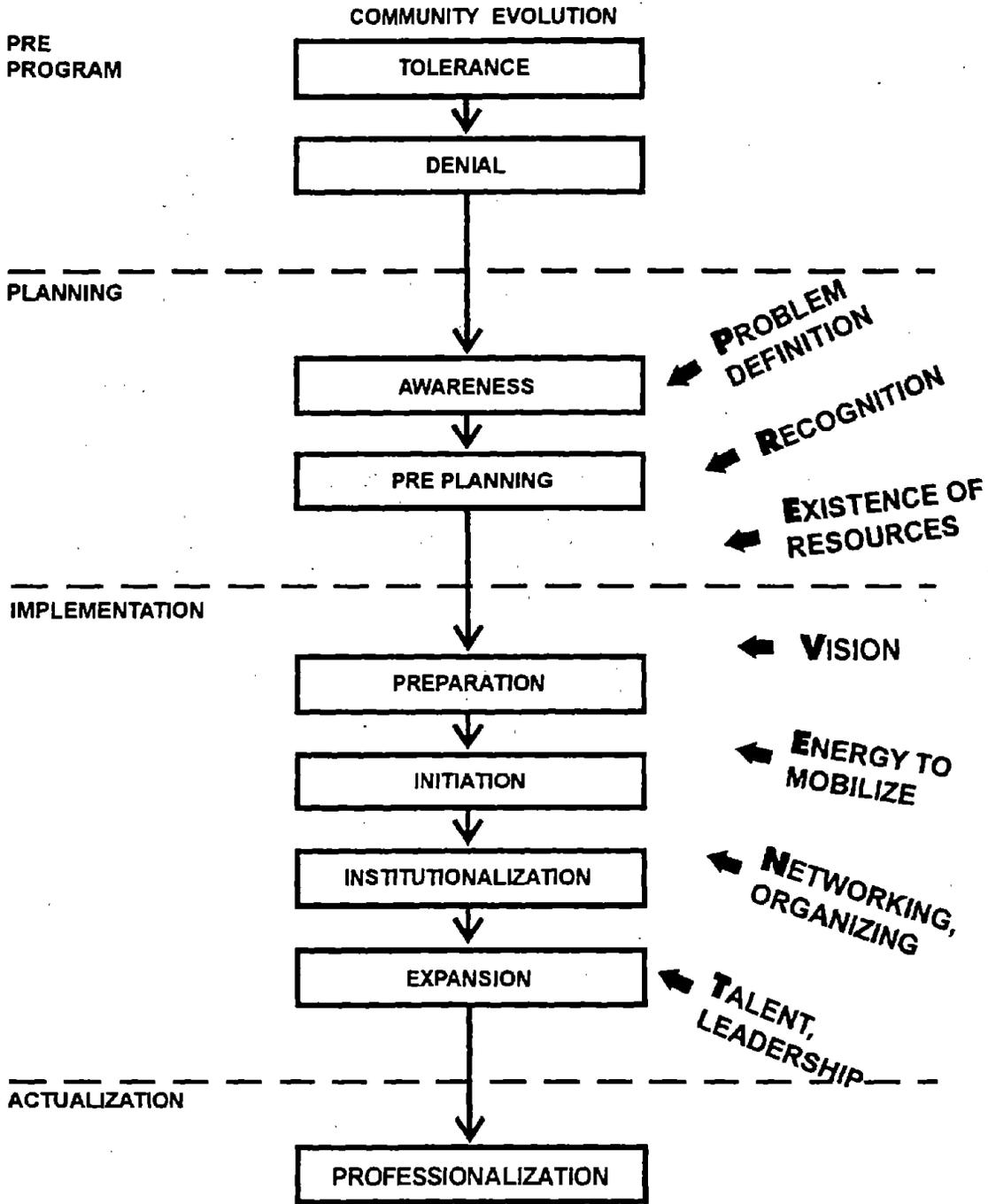
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COMMUNITY READINESS: WHAT IS IT?

Definition of Community

The term *community* is used here to refer to any group of people who share common interests, problems or needs, and may include neighborhoods, schools, clubs, or groups of people such as children of adult alcoholics. A *sense of community* is the degree of bonding or perceived feelings of attachment to the community of its individual members. One's sense of community is usually strongest at the point closest to one's geographical home or other common social characteristic or affinity (e.g., block or neighborhood, ethnic community, church, school, business). It becomes weaker as the circle is widened. The level of community most effectively targeted for prevention efforts is the one with which people identify most strongly and believe they have the most capacity to influence change.

According to Sarason (1974), some basic ingredients of a sense of community are:

- The perception of the degree of similarity to others within the community;

- An acknowledged interdependence with other members of the community;

- A willingness to maintain this interdependence by giving to or doing for others what one expects from them; and

- The feeling that one is part of a larger dependable and stable community.

No matter how small the community is or how narrowly defined the boundaries are, it is always worthwhile to assess readiness before engaging in full-scale planning and implementation of a prevention program. Although the examples here tend to focus on large-scale efforts that encompass an entire metropolitan area, readiness is equally important for smaller, more targeted efforts, such as selective or indicated programs implemented in individual schools.

Variables Influencing Sense of Community

There are a several variables that influence a person's sense of community, and these variables play a role in how successful a community's efforts will be to increase the sense of belonging among its members. For example, whereas feelings of belonging can be strengthened by staging community events more often and by encouraging members to work together for common goals, some factors that influence individuals' sense of community are difficult to change. These factors include:

- Mobility, length of time in the community and home or business ownership;

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- Demographic homogeneity or similarity of community members and similarity of values among community residents;

- Class status and community norms concerning participation, perceptions of interdependence and need to cooperate; and

- Perceived safety of participation and environmental features of community encouraging interaction.

Mobility

A high level of mobility will work against a sense of community. Mobility is most notable in areas with high levels of rental housing. Short-time residents often have little or nothing invested in the community because they are the community residents most likely to move out. Mobility causes difficulty in bonding with longer term residents who may perceive the short-time residents as outsiders. Long-term community residents, usually home or business owners, often feel they have fewer options to move and may choose to stand their ground and fight when conflict arises. For example, participation by long-term community residents in drug abuse prevention efforts may be a product of a desperate determination to defend their turf. Longer term residency increases the probability of a common history among the residents; therefore, these residents may be more motivated to safeguard their community.

Similarity of Community Members

The more similar members of a community are in terms of culture, race or ethnicity, values, and religion, the more likely they will be to work together and create a sense of togetherness. Similarity of interests brings citizens together in a variety of local associations, ranging from religious congregations to hobby clubs and sports teams. Perceived similarity creates a bond of *us*.

Class Status and Community Norms

Class status and community norms related to cooperation and participation in the life of the community also play a role in the sense of community. For example, studies of neighborhood organizations have shown that middle-class females who are homeowners are most ready to participate in community efforts (Prestby et al. 1990). In the past, middle class women had the most time to participate. However, over time, this situation has rapidly changed as more middle income women have joined the workforce. The least affluent, however, should not be written off but should be included as allies and members of the community. Precisely because they have few resources, mobility may not be an option for them. The strains on their time and resources are many, but they may hold a strong attachment to their community and to their neighbors.

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<u>Perceived Safety and Environmental Features</u>

In some communities, members may want to reduce drug dealing and abuse to clean up their neighborhood. However, a major barrier to such participation in high-crime areas may be fear resulting from threats, direct or indirect, on the lives of leaders and volunteers. The design of the buildings and location of meetings also can influence participation and community readiness. Meetings well publicized, but held in unsafe and unsecured locations, are not likely to attract many participants.

Effectiveness of Community Prevention Approaches

As discussed below, the effectiveness of community prevention approaches has been empirically demonstrated by research in health promotion, crime and delinquency prevention and community development. Because of these research findings in other prevention fields, community involvement approaches have become popular in the field of substance abuse prevention (Kumpfer and Durant 1991; Kumpfer and Hopkins 1993; Robert Wood Johnson Foundation 1989). Approaches can take many forms—from organized coalitions or partnerships to more limited community-focused strategies. Community coalitions are one strategy that has been used to bring different segments of a community into planning and implementing a prevention effort. Community coalitions or partnerships are groups composed of community-based organizations and individual volunteers who form to bring about large-scale change within their communities. For example, to increase resources and action for drug abuse prevention, community leaders have begun to team with prevention providers to encourage the participation of professionals and local citizen volunteers in community prevention efforts. Research in the areas of health promotion and disease prevention (Florin 1989; Green 1986, 1987; Yin 1977), and drug abuse prevention (Hawkins et al. 1992; Pentz 1986; Pentz et al. 1989) suggests that such coordinated community action is critical to enhancing the effectiveness of these types of community efforts.

Because community coalitions are relatively new in the substance abuse field, there is only limited empirical evidence, beyond anecdotal data, to support their effectiveness in reducing substance abuse (Kumpfer and Hopkins 1993). For example, community psychologists (Florin et al. 1992a; Heller 1990) agree that anecdotal evidence from case studies (Mindick 1986, pp. 250-279; Rich 1986) suggests that some community coalitions are effective. Most research on community substance abuse prevention efforts has been conducted on coalitions that are composed primarily of volunteers from neighborhood block associations (Prestby et al. 1990). However, because of the high dropout rates of these volunteers—as high as 50 percent in some groups (Chavis and Manos 1992)—the research has focused more on factors that contribute to maintenance of coalitions than on factors related to the overall effectiveness of coalitions. Empirical evidence is being gathered about the characteristics of coalition members and coalition operations that contribute to their effective outcomes (Chavis and Wandersman 1990). In

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addition, the work of Oetting and colleagues at Colorado State University (Oetting et al. 1995), as well as that of Donnermeyer and colleagues at The Ohio State University (Donnermeyer et al., in press) is beginning to provide some important insights about the factors that contribute to community readiness to mobilize and implement effective community coalition approaches to substance abuse prevention.

One of the earliest communitywide approaches to substance abuse prevention is the Midwestern Prevention Project (Pentz et al. 1989; 1990), which is highlighted in *Drug Abuse Prevention for the General Population*. This prevention project brought together community leaders in business, education, the media, parents' organizations, and service agencies to address the substance abuse problems in two medium-size midwestern communities. The results of this project demonstrated that a community coalition approach to substance abuse is effective in increasing community readiness, enhancing community mobilization, and implementing a broad-scale substance abuse prevention program.

What Is Community Readiness?

Over the past decade, as interest in the need to reduce drug abuse has increased and research has demonstrated the effectiveness of community prevention approaches, researchers and prevention practitioners have discovered that communities vary widely in their interest, ability, and willingness to initiate drug abuse prevention efforts, that is, in their level of readiness (Oetting et al. 1995). Some communities do not recognize that they have a drug abuse problem or deny that such a problem exists. Other communities have not only recognized a drug abuse problem, they have taken positive steps to address it. In these latter communities, there likely is broad popular awareness of the problem; because of a strong sense of community, the citizens believe that correction of the problem is possible. However, still other communities fall somewhere between these two extremes, for example, recognizing that the community has a drug abuse problem but having little knowledge and understanding and perhaps even less capability to address it effectively.

A major challenge for communities wishing to undertake substance abuse prevention efforts is to determine their level or degree of readiness. Readiness of the community can be influenced by and reflected in the degree of readiness of the individual members of the community and in the norms that operate within the community. For example, some community members, especially the identified leaders or gatekeepers, may, for a variety of reasons (not the least of which may be political), be reluctant to identify the existence of a drug abuse problem publicly. Therefore, they may fail to see or choose not to address the problem.

In some circumstances, high levels of drug abuse may not be perceived as a problem because of the existence of certain community barriers such as acceptance of the problem by community leaders and local norms of the community that are supportive of drug abuse. For

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example, in some rural communities, alcohol use is a rite of passage and is a part of the social environment of the community. In these communities, establishments where alcohol is served are often centerpieces of community activity, and merchants often will allow alcohol and tobacco sales to minors because of close personal relationships with the parents of the minors. Therefore, a community's readiness to initiate effective substance abuse prevention efforts will vary greatly.

Thus, the degree of readiness within a community can be viewed as a stage in the developmental process in the community in which prevention efforts can be either facilitated or thwarted.

Nine Stages of Community Readiness

Through extensive research on community development and substance abuse prevention efforts, Oetting and colleagues (Oetting et al. 1995) have identified nine stages of readiness through which communities develop: the higher the stage of development, the greater the degree of readiness. The following are descriptions of the nine stages and the characteristics of communities at each stage:

Stage 1: Community Tolerance

Community norms actively tolerate or encourage the behavior, although the behavior may be expected of one group and not another (e.g., by gender, race, social class, or age). The behavior, when occurring in the appropriate social context, is viewed as acceptable or as part of community norm. Those who do not engage in the behavior may be tolerated, but might be viewed as somewhat deviant.

Stage 2: Denial

There is usually recognition that the behavior is or can be a problem. Community norms usually would not approve of the behavior, but there is little or no recognition that this might be a local problem. If there is some idea that it is a problem, there is a feeling that nothing needs to be done about this locally, or that nothing can be done about it.

Stage 3: Vague Awareness

There is a general belief that there is a local problem and that something ought to be done about it. Knowledge about local problems tends to be stereotypical and vague, or linked only to a specific incident or two. There is no immediate motivation to do anything. No identifiable leadership exists, or leadership lacks energy or motivation.

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Stage 4: Preplanning

There is clear recognition that there is a local problem and that something should be done about it. There is general information about local problems, but ideas about etiology or risk factors tend to be stereotyped. There are identifiable leaders, and there may be a committee, but no real planning.

Stage 5: Preparation

Planning is going on and focuses on practical details. There is general information about local problems and about the pros and cons of prevention programs, but it may not be based on formally collected data. Leadership is active and energetic. The program may have started on a trial basis. Funding is being actively sought or has been committed.

Stage 6: Initiation

Enough information is available to justify a prevention program, but knowledge of risk factors is likely to be stereotyped. A program has been started and is running, but it is still on trial. Staff are in training or just finished with training. There may be great enthusiasm because limitations and problems have not yet been experienced.

Stage 7: Institutionalization

One or two programs are running, supported by administration, and accepted as a routine and valuable activity. Staff are trained and experienced. There is little perceived need for change or expansion. Limitations may be known, but there is not much sense that the limitations suggest a need for change. There may be some form of routine tracking of prevalence. There is not necessarily permanent funding, but there is established funding that allows the program the opportunity to implement its action plan.

Stage 8: Confirmation/Expansion

Standard programs are viewed as valuable and authorities support expanding or improving programs. New programs are being planned or tried out in order to reach more people, those thought to be more at risk or different demographic groups. Funds for new programs are being sought or committed. Data are obtained regularly on extent of local problems and efforts are made to assess risk factors and causes of the problem.

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Stage 9: Professionalization

Detailed and sophisticated knowledge of prevalence, risk factors and etiology exists. Some programs may be aimed at general populations, while others are targeted at specific risk factors and/or at-risk groups. Highly trained staff are running programs, authorities are supportive, and community involvement is high. Effective evaluation is used to test and modify programs.

Oetting and colleagues (Oetting et al. 1995) have found that as communities achieve successively higher stages, they realize greater improvement in their degree of readiness. Therefore, to increase a community's readiness for prevention programming and thereby improve the likelihood that a prevention effort will succeed, it is important to give careful consideration to these nine stages of community readiness development during the process of conducting an objective assessment of community readiness. Oetting's group's process for assessing stages of readiness, as well as strategies for stage advancement, is discussed more fully at the end of this chapter.

Why Increase Community Readiness?

There are several reasons to increase community readiness. These are presented below under the two key factors of increased program effectiveness and continuity.

Effectiveness

The primary reason for increasing community readiness for substance abuse prevention is effectiveness. Enduring, coordinated, and comprehensive prevention efforts at the local level are more likely to have the desired impact, particularly if substance abuse professionals work with local citizens and community leaders from many segments of the community in planning, coordinating, and implementing the prevention effort (Kumpfer 1989, pp. 194-221; Kumpfer and Durrant 1991). Increasing community readiness for substance abuse prevention by involving many different individuals and organizations from many segments within the community that shape community values, attitudes, and norms can improve a community's understanding of the causes and consequences of drug abuse as well as improve the success of prevention programs.

For example, major changes in community and national norms concerning tobacco use have contributed significantly to the effectiveness of prevention programs in reducing tobacco use in this country. Hansen and Graham (1991) believe prevention programs that are successful in changing community norms will be the most effective in reducing drug abuse. Changing community norms require that all segments of the community be involved in substance abuse

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prevention programs. Howard-Pitney (1990) notes that "There is a growing recognition and belief that major shifts in unhealthy lifestyles and community norms can be accomplished through citizen participation and community development" (pp. 9-10).

An assessment of readiness also can help a community determine the likelihood of a program's effectiveness even though the program is undertaken in a community showing minimal or only marginal readiness or when community readiness is so great that almost any activity will be effective. Often assessments of readiness will help determine how scarce resources can be allocated. The challenge is to distinguish marginal communities from those with many readiness factors already in place, for example, those in which modest amounts of new resources can make a difference in prevention efforts. Communities in social and economic crisis will rarely respond to drug abuse prevention initiatives alone without major supportive efforts to address underlying or associated social and economic problems.

Continuity

A second reason for increasing community readiness is that prevention programs are more likely to succeed and continue to operate when they are created by local citizens and tailored to the needs and resources of the local community. Heller (1990) has called for a *return to community* and increased community empowerment to counteract the observations that "local communities have diminished power and political influence, with decisions and resources flowing downward from the federal level" (p. 12). Prevention programs that are designed by prevention professionals who come from outside of the community and that do not include local input and cultural modifications often do not address the primary reasons why local youth and adults use alcohol and other drugs. Therefore, local substance abuse prevention coalitions are needed to provide the necessary community readiness and community input to increase the effectiveness of prevention efforts.

Increasing community readiness also can serve to provide a basis on which appropriate funding decisions can be made. For example, when universities or community agencies attract Federal, State, or county funding or funding from foundations for prevention programs, they must be sure that the community in which the program will be implemented is receptive and ready for the new program. A careful assessment of community readiness can provide a basis for which decisions can be made for effectively directing funds to one segment of the community or another, and for directing funds most effectively within a particular segment of the community. For example, although a community may not be adequately prepared to implement a prevention program in all of its public housing neighborhoods because it does not have the necessary funding to do so, a community readiness assessment may indicate the one or two neighborhoods where there is community consensus that the prevention program is needed most. Thereby the

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community can gain important insights for directing scarce resources to areas of the community with the greatest needs, the greatest likelihood for impact, and the highest probability for successful outcomes.

Assessing a Community's Stage of Readiness

Oetting and colleagues (Oetting et al. 1995) have collected data throughout the United States from 46 predominantly white communities with populations of 10,000 or fewer, in addition to 60 communities in which ethnic minorities constituted at least 30 percent of the population. They found that most communities fall into one of two stages of readiness:
(1) vague awareness or (2) institutionalization. The process Oetting's group used to assess readiness is discussed below, followed by suggestions on how to strengthen readiness.

The process of assessing the stage of readiness, which Oetting's group has validated, takes three steps (Donnermeyer et al., in press):

- Staff identify key informants, depending on the size of the community and constraints.

- A skilled, knowledgeable interviewer holds semistructured interviews with the key informants.

- The interviewer meets with a team of colleagues to rank responses and determine the stage of readiness.

These steps are designed to help a community assess its readiness quickly with minimal effort. It is suitable where resources do not exist for conducting comprehensive surveys or undertaking other large-scale assessments.

Selecting Key Informants

Individuals from the community presumed to be knowledgeable about prevention or to have an interest or stake in prevention efforts are selected, preferably including: a school counselor or person responsible for alcohol and other drug education or counseling; a community authority, such as the mayor; a local media representative such as the editor of a local newspaper; and a community leader in the area of drug abuse prevention.

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Interviewing Key Informants

Exhibit 1 contains the questionnaire used to interview key informants. Generally, it is recommended that the interviewer be someone who is knowledgeable about prevention strategies and terminology. Interviews are conducted by telephone. Although the interviews take only about 30 minutes to complete, the researchers have found that it takes several weeks from the point of the initial contact to completion of the interviews to allow for callbacks and scheduling.

Ranking Responses

Readiness is assessed on six dimensions:

- prevention programming;
- knowledge about prevention programming;
- leadership;
- knowledge about the problem;
- funding for prevention; and
- community climate.

There are six sets of readiness descriptive statements—one set for each of the six dimensions—and each set contains nine anchor statements linked to the nine stages of readiness. For each dimension, the team finds the anchor statement that most closely describes the responses of the key informants to dimension-specific questions in the Key Informants Interview Questionnaire. The researchers have found much consistency in responses among key informants and among the six dimensions. The anchor statements were determined through a validation process that involved the development and ranking of statements by a group of experts. Exhibit 2 presents the readiness descriptive statements for one of the six dimensions—Prevention Programming. The reader is referred to appendix A for further information on obtaining the descriptive statements from the researchers.

Another community readiness assessment approach has been developed by Goodman and Wandersman at the University of South Carolina (Wandersman et al. 1991; 1996). This approach utilizes a community key leader survey, as shown in exhibit 3. The key leader survey measures three areas—awareness, concern, and action across multiple community levels. Key leaders respond to questions in these three areas both on a personal level and a perceptual level of their organization's responses. The reader is referred to appendix A for further information on contacting the researchers.

Strategies for Improving Readiness

Based on Oetting's approach, exhibit 4 lists strategies communities can take to strengthen their prevention programming, depending on their stages of readiness. In general, communities at the lower stages of readiness need to focus on building awareness. For communities at the very bottom—in which drug abuse is tolerated—much activity will occur behind the scenes through one-on-one and small-group meetings intended to make people aware of the harmful effects of drug abuse in general. As the community develops, the type of awareness-building activity shifts to building awareness of specific consequences in the community and letting people know about programs and resources available to address the problem. Publicity campaigns involving broad information dissemination are most appropriate only after the community has moved beyond denial.

Communities in the preparation and initiation stages benefit most from systematic and complete information about the local drug problem and from planning activities. Staff training usually is needed during the initiation stage. Communities at the institutionalization stage need to focus on self-evaluation and revision; training continues to be important. Continued networking with other leaders and community organizations and continued training also are important at the higher stages.

Exhibit 1

Key Informants Interview Questionnaire

<u>Readiness Dimensions</u>

1. PREVENTION PROGRAMMING

2. KNOWLEDGE ABOUT PREVENTION PROGRAMS

3. LEADERSHIP

4. KNOWLEDGE ABOUT THE PROBLEM

5. FUNDING FOR PREVENTION

6. COMMUNITY CLIMATE

<u>Questions</u> (Numbers in parentheses indicate the program dimension(s) above to which each question relates.)

1. What types of drug prevention programs or activities have occurred in your community? (1&2)

   a. How long have these programs been in your community? (1&2)

   b. Who is served by these programs? (1&2)

   c. Is there a need to expand these services? If no, why not? (1&2)

   d. Are there plans to expand? If yes, what are the plans? (1&2)

   e. How are these programs viewed by the community? (2&6)

2. What is the general attitude about substance abuse in your community? (3,4&6)

   a. Does the community see substance abuse as a problem? (3,4&6)

   b. Would or does the community support a prevention plan? If yes, how? (3&6)

   c. Are the leaders in your community involved in prevention efforts (list)? (3)

Exhibit 1
(Continued)

    d.   What community organizations have a focus on prevention? (3)

3.   Is there information available on local substance abuse prevalence? If yes, from whom? (4)

4.   How is that information disseminated? And to whom? (4)

5.   Who provides funding for these programs and how long will it continue? (5)

6.   What is the community's attitude/belief about funding prevention programs? (5&6)

7.   Is your community aware of the costs of running a prevention program? (4&5)

8.   Are you aware of any proposals that have been written that address the issue of prevention? (5)

       Are any funded or waiting? (5)

9.   Is the lack of community involvement a major obstacle in your prevention efforts? (6)

10.   Is there a sense of apathy or hopelessness among community members regarding substance abuse? (6)

11.   What are the primary obstacles to prevention efforts in your community? (6)

12.   What is the next step your community needs to take in the area of prevention? (general—all 6 dimensions)

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Exhibit 2

READINESS DESCRIPTIVE STATEMENTS

1. PREVENTION PROGRAMMING

Level 1.   No plans for prevention are likely in the near future.

Level 2.   No plans for prevention are likely in the near future.

Level 3.   There aren't any immediate plans, but will probably do something sometime.

Level 4.   There have been community meetings or staff meetings, but no final decisions have been made about what we might do.

Level 5.   One or more programs are being planned and staff are being selected and trained for them.

Level 6.   One or more prevention programs are being tried out now.

Level 7.   One or more programs have been running for several years and are fully expected to run indefinitely, no specific planning for anything else.

Level 8.   Several different programs in both the community and schools are running, covering different age groups and reaching a wide range of people.

Level 9.   Evaluation plans are routinely used to test effectiveness of many different programs and the results are being used to change and improve program constantly.

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Exhibit 3

Community Key Leader Survey

		Not at all True	Slightly True	Moderately True	Very True
1.	I am aware of programs in my community which address alcohol and other drug abuse prevention.	1	2	3	4
2.	I spend time collaborating with others concerning the prevention of alcohol and other drug abuse in my community	1	2	3	4
3.	I don't know why preventing alcohol and other drug use is so important for communities to address.	1	2	3	4
4.	I am interested in learning more about community-related alcohol and other drug abuse prevention programs.	1	2	3	4
5.	I believe preventing alcohol and other drug abuse among youth is important.	1	2	3	4
6.	I am not certain why some individuals consider alcohol and other drug abuse prevention important.	1	2	3	4
7.	I am not interested in becoming actively involved in improving alcohol and other drug abuse prevention programs in my community	1	2	3	4
8.	I don't know what programs in my community address alcohol and other drug abuse.	1	2	3	4
9.	I am interested in more information on the time and energy commitments that a community-related alcohol and other drug abuse prevention program would require.	1	2	3	4
10.	I know which alcohol and other drug abuse prevention programs serve my community.	1	2	3	4
11.	I can distinguish the type of services offered by the different alcohol and other drug abuse programs in my community.	1	2	3	4
12.	I am concerned about whether my community has sufficient alcohol and other drug abuse prevention programs.	1	2	3	4
13.	I am not involved with the alcohol and other drug abuse community prevention programs in my community.	1	2	3	4

Exhibit 3
(Continued)

	Decreased a Lot	Decreased a Little	Not Changed	Increased a Little	Increased a Lot
14. In the last 12 months, my personal concern for preventing alcohol and other drug abuse in my community has:	1	2	3	4	5
15. In the last 12 months, my personal knowledge of the risk factors that contribute to alcohol and other drug abuse has:	1	2	3	4	5
16. In the last 12 months, my personal knowledge of community programs that address alcohol and other drug abuse has:	1	2	3	4	5
17. In the past 12 months, my personal involvement in organized activities for the prevention of alcohol and other drug abuse has:	1	2	3	4	5

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Exhibit 3
(Continued)

	Not at all True	Slightly True	Moderately True	Very True	Don't know enough to judge
18. My organization is involved with alcohol and other drug abuse prevention programs in our community.	1	2	3	4	5
19. Members of my organization are currently learning what alcohol and other drug abuse community prevention programs exist in our community.	1	2	3	4	5
20. My organization has a written policy concerning the use of alcohol or other drugs by employees.	1	2	3	4	5
21. In general, staff in my organization know which alcohol and other drug abuse programs serve our community.	1	2	3	4	5
22. As part of its mission, my organization is concerned with preventing alcohol and other drug abuse among youth.	1	2	3	4	5
23. Members of my organization are assigned to collaborate with others concerning the prevention of alcohol and other drug abuse in our community.	1	2	3	4	5
24. My organization is interested in information on the time and energy commitments that a community related alcohol and other drug abuse prevention program would require.	1	2	3	4	5
25. In general, staff in my organization can distinguish the types of services offered by different alcohol and other drug prevention programs in our community.	1	2	3	4	5
26. In general, staff in my organization are aware of community programs that address alcohol and other drug abuse prevention.	1	2	3	4	5

Directions: For the following questions, circle the number of the response that DESCRIBES YOUR ORGANIZATION

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Exhibit 3
(Continued)

	Decreased a Lot	Decreased a Little	Not Changed	Increased a Little	Increased a Lot	Don't know enough to judge
27. In the past 12 months, our organization's involvement in our community for addressing alcohol and other drug abuse has:	1	2	3	4	5	6
28. In the last 12 months, our organization's exchange of information with other organizations concerning the prevention of alcohol and other drug abuse has:	1	2	3	4	5	6
29. In the last 12 months, our organization's referrals to or from other organizations concerning the prevention of alcohol and other drug abuse has:	1	2	3	4	5	6
30. In the last 12 months, our organization's sharing of resources (e.g. equipment, supplies) with other organizations concerning the prevention of alcohol and other drug abuse has:	1	2	3	4	5	6
31. In the last 12 months, our organization's co-sponsoring events with other organizations concerning the prevention of alcohol and other drug abuse has:	1	2	3	4	5	6
32. In the last 12 months, our organization's coordinating services with other organizations concerning the prevention of alcohol and other drug abuse has:	1	2	3	4	5	6
33. In the last 12 months, our organization's undertaking joint projects with other organizations concerning the prevention of alcohol and other drug abuse has:	1	2	3	4	5	6
34. In the last 12 months, our organization's participation in media coverage concerning the prevention of alcohol and other drug abuse has:	1	2	3	4	5	6

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Exhibit 3
(Continued)

Directions. For the following questions, circle the number of the response that best fits YOUR PERSONAL OPINION

	Not at all True	Slightly True	Moderately True	Very True
35. I am aware of specific programs offered to employees and their families in the workplace which address alcohol and other drug abuse prevention.	1	2	3	4
36. I am aware of specific programs offered to employees and their families in the workplace which address child and spouse abuse prevention.	1	2	3	4
37. It is very effective to offer alcohol and other drug abuse prevention resources to employees and their families at their Workplace.	1	2	3	4
38. It is very effective to offer child and spouse abuse prevention resources to employees and their families at their Workplace.	1	2	3	4
39. My organization would be quite willing to make available alcohol and other drug abuse prevention resources to employees and their families.	1	2	3	4
40. My organization would be quite willing to make available child and spouse abuse prevention resources to employees and their families.	1	2	3	4
41. I am aware of the POWER Workplace program.	1	2	3	4

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Exhibit 3
(Continued)

Directions: Please take a moment to circle the answer to the following questions about yourself.

42. GENDER - Which one describes your sex?

    1. Male
    2. Female

43. AGE - Which of the following categories include your age?

    1. Under 20 years old
    2. 20 to 29 years old
    3. 30 to 39 years old
    4. 40 to 49 years old
    5. 50 to 59 years old
    6. 60 to 69 years old
    7. Over 70 years old

44. RACE - Which of the following describes your race?

    1. African-American (Black)
    2. American Indian
    3. Asian
    4. Caucasian (White)
    5. Hispanic
    6. Other (please specify)_____

45. EDUCATION - What is the highest level of education that you completed?

    1. Eighth grade or less
    2. Some high school
    3. High school graduate
    4. Vocational school beyond high school
    5. Some college
    6. College graduate education
    7. Some graduate education
    8. Graduate degree

46. OCCUPATION - Which of the following categories describes your occupation?
    (Circle the best one choice)

    1. Executive, Director or Services Manager
    2. Professional
    3. Technical
    4. Sales
    5. Administrative support (e.g., clerical, secretarial)
    6. Service
    7. Industrial
    8. Homemaker
    9. Unemployed
    10. Other (please specify)_____

47. TYPE OF ORGANIZATION - Which of the following categories describes your organization?
    (Circle the best one choice)

    1. Private Business (for profit)
    2. Government Agency
    3. Non-Profit Private Social Agency
    4. Religious Organization
    5. School
    6. Other (please specify)_____

48. LENGTH OF TIME IN CURRENT POSITION - Which of the following categories describes the length of time you've been in your current position?
    (Circle the best one choice)

    1. Less than 1 year
    2. 1 - 2 years
    3. 3 - 5 years
    4. 5 - 10 years
    5. More than 10 years

Thank you for your time and effort. Please place survey in return envelope. No postage is necessary. All responses are treated with confidentiality.

Exhibit 4

Appropriate Strategies for Each Stage of Readiness

STAGE		STRATEGIES
1. Community Tolerance	a.	Small-group and one-on-one discussions with community leaders to identify perceived benefits of substance abuse and how norms reinforce use.
	b.	Small-group and one-on-one discussions on the health, psychological, and social costs of substance abuse with community leaders to change perceptions with those most likely to be part of the initiation set that begins development of programs.
2. Denial	a.	Educational outreach programs on the health, psychological, and social costs of substance abuse to community leaders and community groups interested in sponsoring local programs.
	b.	Use of local incidents that illustrate harmful consequences of substance abuse in one-on-one discussions and educational outreach programs.
3. Vague Awareness	a.	Educational outreach programs on national and State prevalence rates of substance abuse and prevalence rates in other communities with similar characteristics to community leaders and possible sponsorship groups. Programs should include use of local incidents that illustrate harmful consequences of substance abuse.
	b.	Local media campaigns that emphasize consequences of substance abuse.

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Exhibit 4
(Continued)

STAGE	STRATEGIES
4. Preplanning	a. Educational outreach program that include prevalence rates and correlates or causes of substance abuse to community leaders and sponsorship groups. b. Educational outreach programs that introduce the concept of prevention and illustrate specific prevention programs adopted by other communities with similar profiles. c. Local media campaigns emphasizing the consequences of substance abuse and ways of reducing demand for illicit substances through prevention programming.
5. Preparation	a. Educational outreach programs open to the general public on specific types of prevention programs, their goals, and how they can be implemented. b. Educational outreach programs for community leaders and local sponsorship groups on prevention program, goals, staff requirements, and other startup aspects of programming. c. A local media campaign describing the benefits of prevention programs for reducing consequences of substance abuse.
6. Initiation	a. Inservice educational training for program staff (paid and/or volunteer) on substance abuse consequences, correlates, and causes and the nature of the problem in the local community. b. Publicity efforts associated with the kickoff of the program. c. A special meeting to provide an update and review of initial program activities with community leaders and local sponsorship groups.

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Exhibit 4
(Continued)

STAGE	STRATEGIES	
7. Institutionalization	a.	Inservice educational programs on the evaluation process, new trends in substance abuse, and new initiatives in prevention programming. Either trainers are brought in from the outside or staff sent to programs sponsored by professional societies.
	b.	Periodic review meetings and/or special recognition events for local supporters of prevention program.
	c.	Local publicity efforts associated with review meetings and recognition events.
8. Confirmation/Expansion	a.	Inservice educational programs on conducting localized epidemiologies to target specific groups in the community for prevention programming. Either trainers are brought in from the outside or staff are sent to programs sponsored by professional societies.
	b.	Periodic review meetings and/or special recognition events for local supporters of prevention programs.
	c.	Results of research and evaluation activities of the prevention program are presented to the public through local media and/or public meetings.
9. Professionalization	a.	Continued inservice training of staff.
	b.	Continued assessment of new drug-related problems and reassessment of targeted groups within community.
	c.	Continued evaluation of program effort.
	d.	Continued update on program activities and results for the benefit of community leaders and local sponsorship groups and periodic stories through local media and/or public meetings.

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The preceding discussion on the nine stages of readiness through which communities evolve tends to focus on the psychological concepts (e.g., awareness of, need, willingness to explore options, commitment to action) of a community's readiness to implement prevention programming. Hence, the assessment and strategy components of the discussion address ways to determine a community's readiness stage along this continuum to undertake prevention efforts and make suggestions for advancing along the evolutionary path.

Another way to look at community readiness is derived from research discussed previously on health promotion, crime and delinquency prevention, and community development. Looking at this information allows a focus on the organizational or systems aspects of community readiness. This perspective identifies seven factors associated with successful prevention efforts (the PREVENT acronym in figure 2):

- **P**roblem Definition
- **R**ecognition of Problem by Community
- **E**xistence of and Access to Resources
- **V**ision and Plan
- **E**nergy to Mobilize and Sustain Prevention Activities
- **N**etworking With and Support of Stakeholders
- **T**alent; Leadership Structure; Sense of Community

As shown in figure 2 on page 8, these factors overlap with the nine stages of community development. This paradigm represents an attempt to explain this interface; it is not based on empirical research. The remainder of this resource manual looks at community readiness from this perspective. The following two chapters discuss at length these seven factors and how to assess them. If any are deemed to be deficient, specific steps are then presented on how to enhance them. Again, the reader should not presume linearity in the order in which the factors or steps are discussed. The PREVENT acronym has been developed solely to help readers remember the seven factors associated with prevention programming success.

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ASSESSING COMMUNITY READINESS

Seven factors consistently have been found to be associated with the successful implementation and maintenance of substance abuse prevention efforts. These factors are believed to be key in determining a community's readiness for prevention programming and its ability to progress smoothly through the developmental stages to professionalism. This chapter identifies and describes these factors and discusses how to assess each of them. The next chapter on increasing community readiness provides guidance on specific steps that can be taken to strengthen factors deemed deficient on assessment.

The seven factors associated with community readiness are:

- Key Factor 1: Problem Definition

- Key Factor 2: Recognition of Problem by Community

- Key Factor 3: Existence of and Access to Resources

- Key Factor 4: Vision and Plan

- Key Factor 5: Energy to Mobilize and Sustain Prevention Activities

- Key Factor 6: Networking With and Support of Stakeholders

- Key Factor 7: Talent; Leadership Structure; Sense of Community

The listing of each of these key factors is not intended to imply that they actually occur in any particular order, either chronological or otherwise. However, as listed above, the first letter of the beginning of each of the seven key factors spells the acronym PREVENT, providing an easy way to remember the seven key readiness factors. The factors can be reordered as necessary for any particular community.

It is also important to understand that although community readiness is a developmental process, these seven readiness factors are not merely present or absent. Each may run the gamut from minimally present to optimally present, and the readiness status can change over time. Therefore, community readiness is not a static process; it is a dynamic process. Consequently, readiness assessment also is not a static process, but is ongoing.

If all the factors of community readiness are assessed before a prevention program is planned and implemented and if all are strong, then the program will have a greater likelihood of being implemented as planned and of being successful in affecting the target population. Each factor is discussed below, and the discussion is followed by a list of possible questions that can be used to assess the readiness of a community on that particular factor.

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Key Factor 1: Problem Definition

In assessing community readiness to implement any kind of substance abuse prevention program, it is necessary to determine whether there is enough evidence that a substance abuse problem exists in the community. This information is needed by program funders and to guide the choice of the most appropriate type of research-based prevention program.

Beyond identifying the type of drug problem (e.g., cocaine, alcohol, marijuana), it is critical in prevention planning to determine the extent of the problem (i.e., incidence and prevalence), who has the problem, where in the community the problem exists, and the risk and protective factors that could be changed by the prevention effort. Identifying the factors that place people at greater risk or reduce their susceptibility to substance abuse within their local community context determines the types of prevention efforts that would best address the identified need.

Risk factors are those circumstances and processes that place an individual at risk for developing substance abuse problems, whereas protective factors are those circumstances and processes that protect an individual from developing drug abuse problems. For the risk and protective factors associated with substance abuse, research has shown that certain individual and community influences, along with early drug use, are the most significant predictors of substance abuse. Examples of individual and community influences that contribute to drug abuse include negative social behavior or aggressive behavior, early onset of substance abuse, lack of participation in social activities, social norms of drug acceptance, and exposure to situations and environments where drugs are readily available. Examples of individual or community influences that protect against drug abuse can be the converse of the risk factors, such as strong family values that support abstinence from substance abuse, positive social behavior or behavior consistent with positive social activities, early rejection of drug abuse, active participation in prosocial activities such as Boys and Girls Clubs, school environment and norms that reject substance abuse, and exposure to situations and environments where drugs are not readily available or accessible. Therefore, in assessing the definition of the drug abuse problem within a community, it is important to include identifying the possible risk and protective influences at play among the members of the populations to whom prevention efforts will be targeted. For a more detailed discussion of risk and protective factors, the reader is referred to the handbook *Drug Abuse Prevention: What Works.*

Existing social and/or health data, often called indicators, will help the assessment. If information from previous surveys or other kinds of data are not sufficient for clear identification of the substance abuse problem, it may be necessary to conduct a formal needs assessment.

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Readiness Assessment Questions

The following are examples of questions that might be included in a community's assessment of its substance abuse problem:

- What risk factors are present?
  - — Transient population
  - — Norms supporting drug abuse
  - — Drug dealing/crime
  - — Absence of alternatives
  - — Disorganization
- What types of drugs are abused?
- By whom?
- Where in the community does drug-abusing behavior occur?
- What data are available about the nature and extent of the local drug problem?
- What new data can be collected?
- By whom?
- Who will fund the data collection?
- Is drug abuse tolerated in some areas?
- What protective factors are present?
- What prevention activities already exist? What are the gaps in services?
- What areas (or groups) of the community are most affected by substance abuse?
- Has any previous needs assessment been conducted that could provide information?
- Where could the community intervene most effectively to address the problem?

Several different methods can be used, including telephone or face-to-face interviews with key leaders, youth, parents, business leaders, teachers, and others within the community. Surveys conducted by mail also can be used.

An important consideration for a needs assessment is whether the local community has the expertise to conduct a needs assessment. This is a major readiness consideration because an assessment conducted by an outside expert can be expensive. However, if funding is limited for the needs assessment, costs can be reduced by training local volunteers or students to collect the needed data. Involving community members in the needs assessment can increase local commitment and involvement. The strategy of using community volunteers to collect needs

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assessment data has proven to be successful for the Centers for Disease Control health promotion program (Kreuter 1992). A more detailed discussion of community needs assessment will be presented in the next chapter on improving community readiness.

Key Factor 2: Recognition of Problem by Community

Implementing a new drug abuse prevention program requires community support. Support will increase if the community members and prevention specialists alike recognize the problem and participate in the implementation of appropriate prevention strategies to address them. Communities in which there is broad popular awareness of the problem have a greater chance of prevention programming success than those in which there is only limited, specialized, or no awareness of the problem.

Readiness Assessment Questions

To determine whether community recognition of a substance abuse problem exists, the following are examples of the types of questions that can be addressed:

- To what extent does the community believe there is a drug problem?
- What are the perceptions of the drug problem? How accurate are they?
- Has there been an event or incident that has aroused concern?
- How do key leaders perceive the drug problem?
- How are drugs portrayed by local media?
- Do media articles clearly indicate when drug or alcohol abuse has been involved in some piece of news?
- How often do stories disclose the consequences of drug-abuse-related problem behaviors?
- What types of drug abuse problems are currently reported?
- What are perceptions of the causes of/possible solutions to the problem?

A community can assess the degree of recognition of a drug problem through a variety of methods, including conducting community attitude surveys, conducting focus group discussions with citizens, conducting surveys of key community leaders, listening to remarks at public meetings, and analyzing stories in the local media, including newspapers, radio, and television. Information about possible resources that can be used for conducting community attitude and key leaders' surveys can be found in appendix A.

A survey of local newspapers, magazines, newsletters, and other similar publications can provide a rough gauge of public concern. Newspaper archives at the local public library are a valuable resource for communities that want to assess media coverage of substance abuse issues. There are a many issues that a community can consider in surveying the media, such as how frequently newspaper headlines and photo captions refer explicitly to the substance abuse problem, whether articles and editorials clearly indicate when drug or alcohol abuse is associated with a

news item, and whether a particular event has aroused general public concern. Newspaper stories and other media coverage also provide a good gauge of community attitudes. The tone of a story—whether positive or negative—how a story involving drugs is portrayed, and other factors can provide a sense of how the community views drug abuse.

Key Factor 3: Existence of and Access to Resources

Beginning a prevention program requires access to at least a minimum of resources. Therefore, an important consideration in determining the readiness of a community to be involved in and maintain effective prevention programs is whether there currently exists, or will continue to exist, sufficient community resources. In this context, resources are broadly defined to include staff (both professional and volunteer), money, space and program materials.

Professional Staff Resources

In addition to needing monetary resources, prevention programs need knowledgeable professionals who have training in substance abuse prevention or at least a background in the delivery of social services to the target population. An assessment can be conducted of existing professional support that can be recruited for the prevention program, including paid staff, volunteers, consultants, or staff reassigned from community agencies or businesses to participate on advisory or working groups. A community also can consider support that could be found through local colleges and universities and private consulting firms and can assess the availability and capabilities of these professionals to assume responsibility for working on a community prevention effort.

Volunteer Resources

The overall level of community readiness will greatly influence the willingness of community volunteers, both professionals and grassroots citizens, to participate in the planned prevention effort. Therefore, the community can determine the likelihood of attracting the level of volunteer support needed to maintain the prevention effort and determine what must be done to increase the benefits and decrease the costs of volunteer participation in the effort.

Funding Resources

Existing funding within community agencies can be reallocated or new funding can be attracted from outside the community to support the prevention effort. The community can identify a grantwriter or funding development specialist to help with the effort to attract the necessary funding. Some community members may have the skills and capabilities to develop successful funding proposals and be willing to write proposals for little or no cost.

Facilities and Equipment

A major factor in community readiness for implementing any type of prevention effort is availability and adequacy of needed facilities and equipment. Although staffing deficiencies often can be overcome with funding from local, State, or Federal sources, it is difficult to locate funding

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Readiness Assessment Questions

To determine whether adequate resources exist and are accessible, the following are examples of the types of questions that the community can address in an assessment:

- What human resources are available to staff a prevention project?
  - Professional?
  - Volunteer?
  - Other?
- How much time can they commit?
- What facilities and equipment are available to support the effort?
- What potential funding exists for the effort?
  - Federal or State grants?
  - Private foundations or corporations?
  - Agencies (out of existing budgets)?
- What *pro bono* help is available?
- Legal?
  - Accounting?
  - Advertising?
  - Research design/evaluation?
- What in-kind services are available?
  - Word processing
  - Duplication
  - Mail
  - Telephones
  - Computer time
  - Other
- Can funds be redirected from or combined with those of other programs to address the drug problem?
- Are prevention services providers, as well as community volunteers, willing to commit additional time to the program effort if funds are limited?

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for space, furniture, or equipment. Some prevention efforts have been substantially hindered because of the inadequacy of the facilities and materials needed to run the program. The

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availability, accessibility, and security for program participants, as well as staff, are major issues to be carefully considered when assessing the adequacy of proposed facilities.

Key Factor 4: Vision and Plan

A community readiness assessment must determine whether or not the community has an idea or dream whose pursuit will provide a mission and rallying point for the prevention activity. A shared community vision of substance abuse prevention will provide the necessary direction for strategic planning actions and enhance the effectiveness of the prevention program. Therefore, community readiness will require that the community establish and engage in a strategic planning process that will produce a plan of action for implementing the prevention effort. The plan, at a minimum, can identify the objectives to be met, specific actions that will be taken, party or parties who will be responsible for implementing the various parts of the plan, and timeframes within which objectives will be accomplished.

<u>Readiness Assessment Questions</u>

The following are examples of the types of vision and strategic planning questions that a community can ask in assessing its readiness and capability to undertake substance abuse prevention activities:

- Is there a vision that embraces drug abuse prevention?
- Who has the vision? How widely is the vision shared?
- How do members of the community perceive the vision?
- Will the community support the vision?
- Are there people with planning skills available? Do they have the time, talent, resources, willingness to act to develop and implement the program?
- Are community members, for example, parents and youth, willing to contribute to the planning process by participating in needs assessment activities and supporting the implementation of the plan?
- Are there local evaluators who can be involved in the planning process to help design the plan and ensure that appropriate and measurable program objectives are identified?
- Are the approaches/methods implied by the vision logical? Are they consistent with research findings on effective strategies?
- Are the approaches suitable for the target population?
- Is there evidence that the risk and/or protective factors addressed by the proposed prevention approach match those in the target population?

A community's vision for substance abuse prevention programming may be as simple as a desire to see penalties increased for violations of laws prohibiting driving while under the

influence of alcohol or other drugs. Or they may be as complex as the desire to eliminate substance use among all youth under the age of 18. However, the essential factor of a community's vision is that it is shared by the major segments of the community, that is, the major stakeholders who have a vested interest in seeing the vision realized and will represent the driving force behind the effort to achieve it.

Key Factor 5: Energy to Mobilize and Sustain Prevention Activities

An assessment of community readiness also can determine the ability of the community to mobilize its members to begin prevention efforts as well as to maintain them over time. Considerations in any readiness assessment include the energy and commitment of initiators in planning and developing the prevention approach and recruiting and retaining the staff, volunteers, and program participants. The time, energy, benefits, and costs of participation all can be assessed.

Readiness Assessment Questions

Examples of questions that can be addressed in assessing the ability of a community to mobilize and sustain prevention activities include the following:

- Is the community motivated/committed to addressing the problem? Is there long-term commitment?
- Are primary stakeholders involved?
- What events have mobilized the community?
- Are there leaders with energy, time, and talent?
- Are there community members with energy, time, and talent?
- What barriers are there to participation (e.g., intimidation by drug dealers, denial of the problem, time commitment, cost, accessibility)?
- What benefits can be offered people for becoming involved (e.g., information-sharing, increased networking and new friendships, personal recognition, increased knowledge and skills)? What do people want to get out of their involvement?
- Can prevention providers interested in participation have their job duties redefined to allow for greater participation?
- Is the effort likely to be sustained after the initial excitement dies down?
- Will resources be available over time or diminish radically when any major funding ends?

It has been observed that prevention efforts that are strongly desired by the community in general, not just the prevention providers and primary stakeholders, are the ones that last. Although the nonprofessional members of the community and parents often need prevention

professionals to help them make their dreams a reality, it is the commitment of the community that makes a program endure. Solutions to drug abuse problems that are imposed on a community by external forces, for example, funders or researchers, are less likely to be maintained once the external force is no longer present. One example of this type of circumstance was a coalition approach in a community where it was observed that after the Federal funding ended, the only prevention approaches still being implemented were those strongly supported by the community, not necessarily those advocated by policymakers.

Key Factor 6: Networking With and Support of Stakeholders

To make changes in any community, it is important to involve the community leaders, that is, those persons who have a direct stake in the community, before attempting to mobilize the citizens. New substance abuse prevention programs must have the blessing of the community leaders to be successful in attracting staff as well as participants in the prevention activities. Two important issues in community readiness are involved in this aspect of the assessment: a belief that improvement is possible and a willingness to act.

A belief that improvement is possible is difficult to assess from existing resources. Nevertheless, a careful review of newspaper and magazine coverage, and television and radio commentaries or news reports can suggest trends. For example, explanations of the causes of drug abuse might include discussions of causes that can be addressed through community action. Editorials, both print and broadcast, often will be the best indicators of whether local sentiment about drug abuse is hopelessness or willingness to act. Radio and especially television stations often are eager to document their community-mindedness and civic responsibility and will allow reviews of their programming logs. Letters to the editor also can be reviewed for indications of public opinion trends, such as whether concern about a problem is growing, stable, or declining.

It may be worthwhile to telephone local religious leaders or the program chairs of local civic clubs to ask whether sermons or public speakers within the last year have addressed the need for action against drug abuse. The weekly program calendars of civic and religious events in major newspapers and community newsletters may provide valuable indicators of public opinion, as well as the names of potential program supporters. A community may want to determine whether there is widespread skepticism about the effectiveness of prevention efforts or whether doubts exist that they can work in the community.

Belief that change can occur also can be assessed through the use of focus groups, a survey of key leaders, and community attitudes surveys. A random sample of citizens can be selected and approached in different ways, for example, directly in their homes, in group settings, on the street or in other public places, by telephone, or by mail, to solicit their opinions about the problem. Each of these techniques has its advantages and disadvantages. However, it is best to consult a survey research consultant when planning to gather community survey information. A

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community needs to assess what attitudes about the problem are apparent, that is, hopelessness or a willingness to mobilize and act.

The existence of a willingness to mobilize to address substance abuse problems can be assessed through a variety of data-gathering methods. A community can look for signs that there are ad hoc neighborhood efforts to organize for action. There may be existing community groups that are devoting at least some attention to the drug abuse problem, and some civic groups and local religious congregations may have had programs that focused on the problem.

Alternatively, a lack of willingness to act also needs to be assessed. For example, some communities may want to launch new efforts at substance abuse prevention, but there may be deterrents on the willingness of the citizens to act, such as personal fears of involvement (e.g., threats of personal injury or death, possible loss of friendships, fear for safety of family), lack of time (i.e., concern that the time commitment will interfere with other obligations to jobs, family, or friends), or concern that they have nothing to contribute to the prevention effort in terms of useful skills, competencies, or resources.

Readiness Assessment Questions

Examples of questions that can be asked to assess the willingness of community stakeholders to mobilize to support prevention efforts include the following:

- What *ad hoc* neighborhood groups exist in the community that could become part of the effort?
- What other community organizations should/can be included?
- Does the effort have the blessing of key leaders?
- Is the prevention effort likely to have support from leaders of other organizations?
- Do leaders believe in prevention? Do they believe that improvement is possible?
- Do the stakeholders believe that prevention works?
- What types of prevention approaches do they believe work or not work?
- Do the proposed prevention approaches match prevention providers' philosophy of prevention? Are local prevention providers likely to support one type of prevention approach over another?

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Key Factor 7: Talent; Leadership Structure; Sense of Community

The type of organizational leadership structure selected for the implementation of a prevention program will depend to a great extent on the existence of a sense of community (see previous chapter for more information). A sense of community is an important factor related to community readiness (Chavis and Wandersman 1990) and contributes to the establishment, maintenance, and value of a strong local leadership structure. McMillan and Chavis (1986) have concluded that people are more likely to participate in a community prevention effort when:

- They feel that they belong to the community;

- They share similar values and goals with the community;

- They feel that they can influence the community; and

- They share an emotional or spiritual connection with others in the community that has developed through a history of working together for common goals or some significant shared event.

<u>Readiness Assessment Questions</u>

Examples of the kinds of questions that can be asked to assess the sense of community and the type of leadership structure that would best support a community prevention program include the following:

- Are community members civic minded?
- Are there key leaders willing to act?
- Do leaders have the power and organizational capabilities needed?
- Can the leaders establish and maintain a prevention program?
- How homogeneous is the community?
- To what extent do community members share the same values?
- Is there a strong sense of community, with members feeling they want to preserve or create a drug-free community?
- Does the community have any history of working together?
- How stable is the community? Are there:
  — Long-term residents?
  — Homeowners?
- What leadership exists in the community?

Models of leadership structures for prevention activities can vary from a professional model to a grassroots volunteer model. (These models are described in the following chapter in the discussion on choosing an organizational structure to increase community readiness.) In practice, most prevention programs involve a combination of both professionals and volunteers. If there is little sense of community or history of community volunteerism, it will be difficult to implement a grassroots organization successfully; if the prevention program lacks representation from the community it serves, it may fail. It is particularly important to include opinion leaders from the community—people others in the community trust and turn to for advice.

Matching the Program to the Community Context

The foregoing discussion has provided a framework for assessing community readiness for substance abuse prevention. All these community readiness factors should be assessed *before* a community attempts to implement a prevention program. If all of these factors are found to exist within the community, and the program is implemented, then the program will have a greater likelihood of being implemented as planned and of being successful in addressing the community's drug abuse problem. Nothing spells doom for a prevention effort more than an attempt to implement the effort in a community that is not ready. However, often the community that is most acutely aware of a problem is the one that is least likely to have the other necessary readiness factors to successfully implement a prevention effort. A community overwhelmed by substance abuse and other problems often finds it difficult to mobilize its citizens to act or garner the necessary resources for the effort. In practice, most communities fall somewhere between extreme need and minimal readiness on the one hand and minimal need and great readiness on the other, thus, the need for an objective assessment of a community's readiness.

Once a community has been assessed and deemed ready to proceed with prevention programming, it is still not enough to select a specific substance abuse prevention program to implement simply because that program was found to be effective in another community. To have an effective prevention program, a community must match the program to the community's characteristics and local needs. Excellent programs have failed because of a mismatch with the social or political circumstances of the community. Research suggests that model programs are more likely to be adopted, implemented, and maintained when they are consistent with existing organizational practices or culture (Rogers 1983; McLeroy et al. 1993). In addition, programs are more likely to be adopted and maintained when they can be modified or adapted to the local community needs and become an integral part of the agency or organization that sponsors them (Steckler et al. 1992).

When selecting a prevention program, prevention practitioners must understand and be sensitive to a community's norms and degree of readiness to accept the particular program. They also must ensure that their understanding of the substance abuse problem matches the problem as experienced by the residents of that community. Prevention practitioners also can assess and build

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the capacity of the community to maintain the prevention effort and not just provide short-term services. Minkler (1989) and others have suggested that increasing the capacity of families, social networks, neighborhoods, organizations, and communities to solve their own social and health problems can be the goal for prevention practitioners. Prevention programs that are adopted by a community can support but cannot become a substitute for a community's ability to solve its own problems (McLeroy 1993).

Sometimes a mismatch can occur between external funding and community readiness. Occasionally a community may receive funding for drug abuse prevention efforts on the basis of a well-developed proposal that was created by a writer who was hired from outside the community. In such a case, the writer may overstate the involvement of community members in the prevention program planning process. Then if the community does not support the prevention approach or does not trust the program implementers, the program may fail. One example of a poorly planned prevention effort that was not sensitive to the needs of the community was a program proposed by researchers at a major university. The researchers proposed creating a parenting clinic for inner-city mothers that would be housed at the university's research facilities. When the proposal was funded, none of the mothers targeted for the program would participate. Had the researchers interviewed the parents in the target population prior to selecting the prevention program approach, they would have learned that the parents did not trust the university, did not like the intimidating research facility, and did not believe that they needed to improve their parenting skills. In this instance the community clearly was not ready to initiate that particular type of prevention effort.

In some cases, communities may be poised and ready to mobilize or may already be mobilized but lack a number of other key community readiness factors that would allow them to proceed with effective prevention activities. A community is not ready for prevention if it:

- Lacks a clear definition of the problem and/or recognition of a need for the proposed program;

- Denies substance abuse problems exist and/or a need for substance abuse prevention programming;

- Lacks support of primary stakeholders and resources to attract funding and participants, staff the program, and house the program;

- Lacks vision or opposes the particular prevention activities proposed;

- Lacks resources to sustain the prevention program after the external funding end;

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- Lacks a sense of community and togetherness; and

- Lacks capable leadership or has leaders who are apathetic or intimidated.

The following are hypothetical examples of how these community readiness deficiencies can compromise prevention efforts:

- *Lack of problem definition.* A community agency serving female drug abusers wanted to implement a prevention program for the children of their clients but did not have enough information about the extent of the problem among the target children to convince funders to support the proposed prevention approach.

- *Denial of substance abuse problems by the community.* A community prevention agency did everything right in involving the community in developing a proposal for a comprehensive prevention program but failed to attract funding because it could not overcome the pervasive perception in the local community that the targeted population did not have substance abuse problems.

- *Lack of support by primary stakeholders.* An ethnic community ready and committed to act to reduce drug problems was not funded by its local drug abuse prevention coalition because the funding agency did not agree that substance abuse problems in that particular ethnic community were its highest priority.

- *Lack of ability to attract needed community resources and funding.* Several multiethnic gang- and drug-ridden neighborhoods that were mobilized primarily by parents failed to receive major Federal funding because the parents lacked the capability to write a convincing proposal to attract needed funds.

- *Lack of a community-supported vision or plan.* A coalition of city leaders and community drug prevention providers serving a low-income neighborhood built a new youth services center but did not consult the parents of the youth concerning the perceived safety of the location; hence, few youth ever came to the center.

- *Lack of energy to mobilize and sustain the prevention activities.* A school-based coalition developed by several teachers operated successfully for about 2 years but failed when significant burnout was experienced by the core leaders who actively participated in the prevention activities in addition to meeting their full-time teaching responsibilities.

- *Lack of a strong leadership structure and sense of community.* A dedicated grassroots community and provider planning group in a public housing

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neighborhood worked hard for 2 years to mobilize a fragile, disconnected, and disenfranchised community, only to have their most prominent leaders drop out after receiving death threats from local drug dealers.

It is clear from these examples that many elements of readiness must be addressed if prevention programs are to be planned and implemented successfully. There may be instances in which many different prevention programs are operating simultaneously within a given community, but for each program to have the best chance of success, all the community readiness factors should be present. Although it is reasonable to conclude that some key readiness factors may have greater importance for some types of prevention programs than other factors, the research on community readiness does not yet make it possible to identify precisely which key factors are more or less important for which types of programs.

This chapter has focused on the assessment of factors associated with readiness for successful drug abuse prevention programming. Exhibit 5 contains a readiness inventory that summarizes the assessment questions asked regarding each factor. Exhibits 6 through 8 contain vignettes illustrating the assessment of readiness in different communities. The next chapter discusses strategies that communities can use to improve readiness in areas determined to be deficient. Appendix B contains a detailed case study of a large-scale effort illustrating how readiness can be assessed and programs developed based on the assessment.

Exhibit 5

COMMUNITY READINESS INVENTORY

1. PROBLEM DEFINITION

Assessment Questions	Information Sources	Findings and Recommendations
• What risk factors are present (e.g., transient population, norms supporting drug abuse, drug dealing/crime, absence of alternatives, disorganization)?		
• What types of drugs are abused?		
• By whom?		
• Where in the community does drug-abusing behavior occur?		
• What data are available about the nature and extent of the local drug problem?		
• What new data can be collected?		
• By whom?		
• Who will fund the data collection?		
• Is drug abuse tolerated in some areas?		
• What protective factors are present?		
• What prevention activities already exist? What are the gaps in services?		
• What areas (or groups) of the community are most affected by substance abuse?		
• Has any previous needs assessment been conducted that could provide information?		
• Where could the community intervene most effectively to address the problem?		

LOW	MOD	HIGH
READINESS		

Exhibit 5
(Continued)

COMMUNITY READINESS INVENTORY		
2. RECOGNITION OF PROBLEM BY COMMUNITY		
Assessment Questions	Information Sources	Findings and Recommendations
• To what extent does the community believe there is a drug problem?		
• What are the perceptions of the drug problem? How accurate are they?		
• Has there been an event or incident that has aroused concern?		
• How do key leaders perceive the drug problem?		
• How are drugs portrayed by local media?		
• Do media articles clearly indicate when drug or alcohol abuse has been involved in some piece of news?		
• How often do stories disclose the consequences of drug-abuse-related problem behaviors?		
• What types of drug abuse problems are currently reported?		
• What are perceptions of the causes of/possible solutions to the problem?		

LOW	MOD	HIGH
READINESS		

Exhibit 5
(Continued)

COMMUNITY READINESS INVENTORY		
3. EXISTENCE OF AND ACCESS TO RESOURCES		
Assessment Questions	Information Sources	Findings and Recommendations
● What human resources are available to staff a prevention project (e.g., professional, volunteer, other)?		
● How much time can they commit?		
● What facilities and equipment are available to support the effort?		
● What potential funding exists for the effort (e.g., Federal or State grants, private foundations or corporations, agencies)?		
● What *pro bono* help is available (e.g., legal, accounting, advertising, research design/evaluation)?		
● What in-kind services are available (e.g., word processing, duplication, mail, telephones, computer time, other)?		
● Can funds be redirected from or combined with those of other programs to address the drug problem?		
● Are prevention services providers, as well as community volunteers, willing to commit additional time to the program effort if funds are limited?		

LOW	MOD	HIGH
READINESS		

Exhibit 5
(Continued)

COMMUNITY READINESS INVENTORY		
4. VISION AND PLAN		
Assessment Questions	**Information Sources**	**Findings and Recommendations**
• Is there a vision that embraces drug abuse prevention?		
• Who has the vision? How widely is the vision shared?		
• How do members of the community perceive the vision?		
• Will the community support the vision?		
• Are there people with planning skills available? Do they have the time, talent, resources, willingness to act to develop and implement the program?		
• Are community members, for example, parents and youth, willing to contribute to the planning process by participating in needs assessment activities and supporting the implementation of the plan?		
• Are there local evaluators who can be involved in the planning process to help design the plan and ensure that appropriate and measurable program objectives are identified?		
• Are the approaches/methods implied by the vision logical? Are they consistent with research findings on effective strategies?		
• Are the approaches suitable for the target population?		
• Is there evidence that the risk and/or protective factors addressed by the proposed prevention approach match those in the target population?		

LOW	MOD	HIGH
READINESS		

Exhibit 5
(Continued)

COMMUNITY READINESS INVENTORY

5. ENERGY TO MOBILIZE AND SUSTAIN PREVENTION ACTIVITIES

Assessment Questions	Information Sources	Findings and Recommendations
● Is the community motivated/committed to addressing the problem? Is there long-term commitment?		
● Are primary stakeholders involved?		
● What events have mobilized the community?		
● Are there leaders with energy, time, and talent?		
● Are there community members with time, energy, and talent?		
● What barriers are there to participation (e.g., intimidation by drug dealers, denial of the problem, time, commitment, cost, accessibility)?		
● What benefits can be offered people for becoming involved (e.g., information-sharing, increased networking and new friendships, personal recognition, increased knowledge and skills)? What do people want to get out of their involvement?		
● Can prevention providers interested in participation have their job duties redefined to allow for greater participation?		
● Is the effort likely to be sustained after the initial excitement dies down?		
● Will resources be available over time or diminish radically when any major funding ends?		

LOW	MOD	HIGH
READINESS		

Exhibit 5
(Continued)

COMMUNITY READINESS INVENTORY		
6. NETWORKING WITH AND SUPPORT OF STAKEHOLDERS		
Assessment Questions	Information Sources	Findings and Recommendations
• What *ad hoc* neighborhood groups exist in the community that could become part of the effort?		
• What other community organizations should/can be included?		
• Does the effort have the blessing of key leaders?		
• Is the prevention effort likely to have support from leaders of other organizations?		
• Do leaders believe in prevention? Do they believe that improvement is possible?		
• Do the stakeholders believe that prevention works?		
• What types of prevention approaches do they believe work or not work?		
• Do the proposed prevention approaches match prevention providers' philosophy of prevention? Are local prevention providers likely to support one type of prevention approach over another?		

LOW	MOD	HIGH
READINESS		

Exhibit 5
(Continued)

COMMUNITY READINESS INVENTORY

7. TALENT; LEADERSHIP STRUCTURE; SENSE OF COMMUNITY

Assessment Questions	Information Sources	Findings and Recommendations
● Are community members civic minded?		
● Are there key leaders willing to act?		
● Do leaders have the power and organizational capabilities needed?		
● Can the leaders establish and maintain a prevention program?		
● How homogeneous is the community?		
● To what extent do community members share the same values?		
● Is there a strong sense of community, with members feeling they want to preserve or create a drug-free community?		
● Does the community have any history of working together?		
● How stable is the community? Are there: — Long-term residents? — Homeowners?		
● What leadership exists in the community?		

LOW	MOD	HIGH
READINESS		

Exhibit 6
Vignette #1

Citywide Prevention Program
Sunnyville

Sunnyville is a city with a population of approximately 650,000 located more than 200 miles from the next city. Because of economic expansion, the city has spread to encompass some small towns that had been on the outskirts. The economy is largely agricultural with some light manufacturing and a growing electronics industry; there is one university and two colleges. The population is predominantly white, with small percentages of African-Americans, Hispanics, and American Indians. There also is a growing Asian population, mostly recent immigrants from Southeast Asia.

Historically, the community has not perceived much of a problem with drug abuse. Although there has been some heroin and cocaine abuse, it has been restricted to certain neighborhoods characterized by high mobility and a transient population, including seasonal farm workers; low income families; and generally more crime than in the rest of the area. Recently, there was an incident in which a high school youth from an upper-middle-class family died from butane inhalation while at a party. Investigations of the death produced many anecdotes of recreational drug abuse, particularly inhalants, such as Glade and Scotchguard, but also some marijuana and LSD. This information has caused some alarm among parents and has captured the media's attention. However, city leaders believe the incident was an aberration and that there is no serious drug problem. They believe funds are better spent on economic development, which will benefit everyone, rather than on drug prevention. Parents and community members express some confusion; it is not clear to them whether there is a serious drug problem.

There are a few isolated programs that provide drug prevention services in Sunnyville: a YMCA, a couple of church programs, and an afterschool program. Once a year the police visit each school to make a presentation on drugs. In addition, drug prevention topics are covered annually in health classes.

Concerned parents in the neighborhood where the death occurred have organized and conducted an assessment of the city's readiness to launch a major prevention effort. The results were:

Problem	There is little factual information about the type or extent of drug abuse in the community— only anecdotal evidence. There is no process in place for tracking drug trends.	**LOW Readiness**

Exhibit 6
(Continued)

Recognition	City leaders do not believe there is a problem, and other community members are unsure.	**LOW Readiness**
Existence of Resources	There are good resources: There are already some programs in the area poised to provide services. The university and colleges have faculty and students available to support the effort. There are several professional organizations available to provide support, either through donations or in-kind contributions.	**HIGH Readiness**
Vision	There is generally a vision of what the community should be, and the organizers have a vision for the prevention program; however, there is no communitywide common shared vision. However, there are good planners available to help develop a plan.	**MEDIUM Readiness**
Energy	The community has many long-term residents with a history of involvement. They have successfully organized before to establish a sex-education program in the schools.	**HIGH Readiness**
Networking	The community has several existing organizations that could support the effort.	**MEDIUM Readiness**
Talent/Leadership	There are several leaders among those who have organized and many strong candidates elsewhere in the community.	**HIGH Readiness**

Based on this assessment, the organizers concluded that they should focus on increasing the community's readiness by gathering more information about the problem and working on building awareness. Once armed with facts, the organizers believe they will be able to convince leaders that a problem exists. If they have the support of top leaders, they believe they can mobilize the community and enlist the help of the existing organizations.

Although it is premature to be planning which model of prevention to implement—universal, selected, indicated, or a combination—the organizers think a universal program may be most appropriate initially. The results of the needs assessment will give them clearer information about what type of program would be most suitable for the community.

Exhibit 7
Vignette #2

Neighborhood Prevention Program
Southside

Southside, a suburb of Sunnyville, has a long history of substance abuse problems. The community has many long-term residents who own their homes. However, the homes and neighborhoods are run down. A lot of drug activity is clearly visible to youth, including sales of drugs. Incomes are low; crime is high; gang activity is increasing. Some of the population is transient. Long-term residents abhor the changes they have seen in their neighborhood but feel powerless to do anything about the growing problem. They have never organized before.

There is a church program and a YMCA program that try to offer alternatives to youth. The school counselor has become frustrated by the problems he has seen and has approached the church and the YMCA to discuss setting up a program in the neighborhood.

Because of the neighborhood's characteristics, residents believe all the youth living in the area would benefit by a program; but they are particularly concerned about reaching youth who are performing poorly in school, have had some behavioral problems, or otherwise exhibit risks associated with substance abuse.

A team of residents has conducted a readiness assessment with the following results.

Problem	The problem is fairly well understood in this neighborhood, and there are good statistics available on who is most at risk—for example, attendance records, grades, probation records.	**HIGH Readiness**
Recognition	Members of the local community are well aware of the drug problem.	**HIGH Readiness**
Existence of Resources	There are few resources available in this poor neighborhood—no professional businesses to provide *pro bono* services, no corporations to make donations, and few people with the time and energy to volunteer.	**LOW Readiness**
Vision	The team has a strong vision, but no one on the team has planning skills or experience.	**MEDIUM Readiness**
Energy	The community doubts its ability to mobilize and has no history of organizing.	**LOW Readiness**

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Exhibit 7
(Continued)

Networking	The team has a strong informal network with the various organizations but no strong links with city leaders who would be able to help the cause.	**MEDIUM** **Readiness**
Talent/Leadership	There are a couple of strong leaders available on the team but they lack some of the expertise needed for the job.	**MEDIUM** **Readiness**

Based on this assessment, the team has concluded that it needs to work on building a stronger base before starting a prevention program. It will start by getting leaders trained in planning techniques and prevention strategies. Then the team will work on building stronger ties among organizations in the community. The team is considering a fundraising strategy that would use neighborhood volunteers. It would be comparatively easy to organize and would give community members an opportunity to work together; most important, it would give a sense of success and achievement, which would strengthen the community's energy to mobilize.

Team leaders are fairly certain they want a universal program aimed at all youth in the neighborhood; however, they also want a selective program targeting students in junior high who are at risk because of truancy, poor grades, family situation, or association with substance abusers.

Exhibit 8
Vignette #3

School Program
Matthew Arnold High School

Matthew Arnold High School is located on the border between a wealthy, upper-middle-class neighborhood and a much poorer neighborhood. Because of the strong tax base in the wealthier neighborhood, the school has money for special programs, equipment, and materials. The school superintendent has urged the principal to implement a drug program, and the PTA strongly supports it. In response, the principal has appointed a task force of teachers, parents, and the school counselor to plan a program. The task force decided to start by conducting a readiness inventory.

Problem	There are good data available on students at risk for drug abuse by virtue of where they live, association with students who use drugs, history of behavioral problems, truancy, and poor or dropping grades; in addition, data is available on students who are on probation for crimes such as shoplifting. There is little information available about the drug abuse patterns and needs of the total student population, but a small group of students is known to use drugs.	**MEDIUM Readiness**
Recognition	There is general agreement that a prevention program is needed and awareness that some students already are abusing drugs.	**MEDIUM Readiness**
Existence of Resources	There is money as well as facilities for a program. However, staff are already fully committed, and there is no one with the time to take on the additional responsibility of planning and running a prevention program. Nor is there anyone with the formal training that might be required.	**MEDIUM Readiness**
Vision	People know they want to do something but are unsure of what. There are resources, but it is unclear how they should be used or who can actually plan and implement the program.	**LOW/ MEDIUM Readiness**
Energy	There is plenty of interest among parents, teachers, students, and others, including the police department.	**HIGH Readiness**

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Exhibit 8
(Continued)

Networking	The entire school community has given its support to the project—the superintendent, principal, parents, and police.	**HIGH Readiness**
Talent/Leadership	Although there are many leaders involved, none of them has the time to commit to the project.	**LOW Readiness**

The biggest problem in this school is finding someone with the time and knowledge base needed to run an effective prevention program. The task force believes an indicated program focusing on students already involved with drugs might be the best starting place, but such a program will require at least one full-time teacher/counselor. The PTA also wants a universal program to educate all students on the dangers of drug abuse.

After completing the readiness inventory, the task force recommended to the principal one of two courses of action: (1) reorganize to free up talent to run the program or (2) recruit a drug prevention education/counseling specialist to run the program. However, before taking any action, the task force recommends a weekend planning retreat to decide definitely on the goals of the program. It recommends hiring an outside consultant with planning expertise to facilitate the planning session.

IMPROVING COMMUNITY READINESS

The seven key factors presented in the previous chapter address the elements of community readiness and ways to assess the readiness of a community to implement prevention activities to reduce substance abuse. But what happens when it is determined that one or more of the factors is weak, for example, when the community is not ready, and work is needed to increase community readiness before a prevention effort can begin? This chapter describes steps that a community can take to improve or increase each readiness factor to implement prevention strategies successfully.

In the previous chapter, a variety of techniques were identified for assessing each key factor associated with community readiness. However, it is important that the reader understand that many of these techniques can be used to assess as well as improve more than one key readiness factor. For example, information acquired through surveys of key community leaders and assessments of the local print media also can help improve the definition of the local substance abuse problem, increase the community's recognition of the problem, and increase the support of the primary stakeholders in the prevention effort. Therefore, if prevention program implementors can begin to recognize the broad utility of their data collection strategies and information, they can achieve a greater impact from their data collection efforts and dollars.

The discussion of the following steps for improving community readiness is presented in a specific order to correspond to the seven key readiness factors in the preceding chapter. The intention is not to focus on the order in which a community should tackle deficient factors but on the specific actions that a community might take to improve a particular key readiness factor that, on assessment, was found to be deficient. The following strategies can be used to improve readiness:

- Step 1. Conduct a Community Substance Abuse Needs Assessment

- Step 2. Increase Problem Recognition

- Step 3. Access Community Resources

- Step 4. Develop a Strategic Plan

- Step 5. Maintain Momentum

- Step 6. Mobilize the Community

- Step 7. Choose an Organizational Structure

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Step 1. Conduct a Community Drug Abuse Needs Assessment

If it is determined that there is no clear definition of the substance abuse problem within the community, there are specific strategies that can be used to strengthen this important readiness factor. A community's need for a substance abuse prevention effort can be determined from primary and secondary data sources. Primary data sources include those from which information is gathered directly from individuals through such mechanisms as focus groups, attitude and opinion studies, and epidemiologic surveys. Secondary data sources are those from which information is gathered through review of data that have been collected and are maintained by various governmental and/or other community service agencies. In practice, using secondary data sources may be difficult for nonprofessional community members. For example, unless these efforts are associated either with those of recognized community officials or prevention professionals, community members may find access to existing data sources hindered or blocked by agency procedures. Access to data in agency files also can be hindered by the amount of staff time required to retrieve and assemble the data in a usable format. However, there are several important sources of collectible data that communities can tap.

<u>Primary Data Sources</u>

A preliminary understanding of the nature and extent of a local substance abuse problem can be achieved through the collection and analysis of data that are gathered through mechanisms such as focus group discussions and face-to-face meetings with concerned professionals, surveys of key community leaders and other members of the general population of the community, and analyses of the community's print media. These sources of data can provide a wealth of information about the perceptions local residents have of the drug abuse problem and can answer important questions about who has the problem, the existence of possible unreported or undetected users, and the social context in which the problem occurs. These kinds of data also can help a community determine the reasons the respondents think certain persons use drugs and how they think the drug abuse problem could be solved or reduced. Several primary sources for data collection include:

- Focus groups;

- Needs assessment surveys;

- Community attitudes and opinions surveys;

- Key leader surveys; and

- Print media assessments.

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Focus Groups

Individual face-to-face or telephone interviews provide a useful means for accessing information that respondents may not want to share with other members of the community or information that may be of a confidential nature. However, these types of interviews can be expensive and timeconsuming. Therefore, focus group discussions with 8 to 10 participants at a time, representing professionals, community leaders, and members of the general public, provide an alternative mechanism for getting necessary information. Although confidential information may be more difficult to obtain in focus groups than in individual interviews, focus groups nevertheless do have advantages. For example, when several participants are asked to address the same questions in a group situation, all are able to share their perspectives on the problem, learn about the perspectives of other community members, learn how their understanding of the problem may be the same or different from that of their neighbors, and react to opinions expressed by others. One of the chief advantages of focus groups is that they foster interactions among participants that sometimes yield insights that could not be obtained through other means.

Much literature on conducting focus groups exists, although it is directed primarily toward applications in commercial marketing and political campaigns. However, the Center for Substance Abuse Prevention (CSAP) has published two four-page factsheets of tips on how to conduct focus groups (*The Fact Is . . . You Can Manage Focus Groups Effectively for Maximum Impact*, and *The Fact Is . . . Conducting Focus Groups With Young Children Requires Special Consideration and Techniques*), available through NCADI. See appendix A for further information. Conducting a focus group is different from conducting a meeting or panel discussion. Therefore, if professional direction is not available, volunteer leaders should be trained by a professional on the basic dynamics of focus group interaction. Advertising agencies and marketing consulting firms usually can be productive sources of information on conducting focus groups.

Needs Assessment Surveys

Needs assessment surveys are an extremely important method for collecting information that can be used for developing immediate community involvement and raising public awareness of the need for substance abuse prevention. There are several types of surveys that can be conducted to assess community needs depending on the time, money, and other resources available to develop appropriate survey instruments. However, conducting a needs assessment can be a difficult process. Therefore, it is a good idea to solicit advice from professionals who are experienced in designing and conducting needs assessments. A good place to start is with the research staff of the local county or State substance abuse agency. They are familiar with survey sampling methods and questionnaire construction and are able to identify other experts at universities or private companies who could assist the process. There are several different types of needs assessment methods that a community might use. These include direct surveys of community attitudes and opinions and surveys of key community leaders.

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Community Attitudes and Opinions Surveys

These are surveys that are conducted for the purpose of soliciting the opinions and measuring the attitudes of community residents about particular issues or topics. The types of people who can be surveyed include residents and community service providers, such as physicians, nurses, social workers, and drug abuse treatment providers. They will be familiar with many of the important aspects of local substance abuse problems. A survey of community perceptions about local problems and needs will yield several important dividends. In addition, a survey of community perceptions can be designed to gather information needed to better interpret the meaning of other existing data. A direct survey of community members can, for example, shed light on the reasons they think their youth are dropping out of school and using drugs.

Community attitude surveys can have multiple uses to assess the presence of several community readiness factors. For example, the survey can address community readiness factors such as level of sense of community, beliefs that prevention can work, level of concern, willingness of community members to volunteer, barriers to participation, and reasons about the causes of the substance abuse problem. In addition, community surveys can be used as a baseline against which to measure success in changing public attitudes and increasing public awareness by comparing the results of an initial survey with the results of a survey that is conducted after a public awareness campaign.

Community surveys can be administered in several ways: by mail, by telephone, and in person (e.g., house to house, on the street or in groups). Each method has advantages and disadvantages. In general, mail surveys take longer to collect and have a low response rate because respondents often do not return the survey. However, the cost per response to conduct a mail survey is low relative to other methods. Problems arise with telephone surveys because community members who do not have telephones are excluded from the survey population, and therefore any information from the survey will be biased. Household surveys generally can be expensive unless they are conducted by trained but unpaid volunteers. A needs assessment advisor can help community members determine the best method to use for their particular situation. A guide for reviewing survey methods and community survey instruments, such as *Measurements in Prevention: A Manual on Selecting and Using Instruments to Evaluate Prevention Programs* also can be helpful (see Appendix A).

A community survey will indicate what aspects of substance abuse are perceived by the community as pressing problems. This information is essential for enlisting community participation. The mere fact that a survey is being conducted will of itself be local news, especially if a broad spectrum of community associations, churches, clubs, and other organizations is involved in administering the survey. Conducting the survey also

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raises community awareness. Specific information about the local community, especially as it compares with State and national data, will have immediate news value. It will provide a productive basis for initiating contacts with local print and broadcast media. A final advantage of a community survey is that local prevention providers will be seen as coming to the community with questions and not with a predetermined prescription for *what this community needs*. A willingness to listen on the part of surveyors helps solve problems and gain goodwill.

Key Leader Surveys

Surveys of key leaders within the community have advantages similar to those of direct surveys of community attitudes and opinions. A survey of key leaders can include key elected and appointed officials, heads of civic and business organizations, prominent business executives, and religious and educational leaders. The key leader survey is usually best conducted as a series of structured interviews carried out by senior members of agency staff or by members of a community drug abuse prevention advisory board. Key leaders are busy people; therefore, requests for appointments with them should be explicit as to the purpose of the interview, the organization sponsoring the survey activity, and the amount of time that will be required to complete the survey. It is important to remember that the more senior and influential the leaders, the less time they will likely have to devote to the task. Interviewers should be prepared to listen and really hear what the leaders have to say. People who are accustomed to being listened to may be quickly alienated if it appears that someone has come to educate them.

Interviewers can ask respondents to identify others within the community who also are working on the problem, who else can be contacted as part of the survey, and where else the interviewer can look for relevant information. By explicitly asking these types of questions, the interviewer will often discover important referrals to other data sources.

Finally, during the interview process, the interviewer also can compile a list of private associations and public and private agencies directly or indirectly concerned with substance abuse, associated problems, or relevant target populations. This information later will be essential for determining how well needs are being met and what gaps in services still exist. It is useful for increasing access to community resources and in the community strategic planning process.

Print Media Assessments

A survey of local newspapers, magazines, newsletters, and other forms of popular media can help define the drug abuse problem within a community. For example, some events, like robberies, are likely to involve physical harm beyond the drug abuser and affect innocent third

parties. How such situations are reported by the media will help determine how the problem is perceived within the community. Drugs and alcohol may be identified as the causes or major contributors to automobile accidents, spouse or child abuse, assault, or use of violence during robbery or burglary, and gang activities may be related to the sale of illegal drugs. Whether an event becomes a watershed event in community awareness is related as much to previous community experiences as to the severity of the event. For example, detection of possession of marijuana in a school locker might be a significant event in a small town but may be so routine in a large urban school as to attract almost no attention.

Prevention practitioners and community volunteers conducting needs assessments can maintain logs of drug-related stories as an indication of the types of drug abuse problems that are examined by the media. Such logs might note the date, the particular drug involved, whether the offender is an adult or youth, and any related criminal activity. A typical log entry might read as follows: January 17, 1994, crack, youth, stabbing at party. A review of the log often will show a pattern in press attention and thus public concern. However, this may not necessarily correspond to actual drug use. Press attention may be directed to a particular kind of local activity, for example, a police drug raid, or to national trends or events, such as National Red Ribbon Day. Media assessments also may identify geographic locations of drug incidents or the gender, ethnicity, or other demographic characteristics of persons involved in the incidents.

Finally, what media articles suggest about the causes of drug abuse problems and their possible solutions will be additional information that a community can use. This type of information often will appear toward the end of an article; after the writer has addressed the who, what, when, where, why, and how, he or she concludes with human interest material to complete the story. The reporter's speculations may be unscientific, but often they will reflect local assumptions about why these sorts of things happen. A content analysis also may be performed on local news stories and other media coverage to determine how much coverage there is, how drug stories are portrayed, and the general tone. This kind of analysis can show trends and also yield important insights into local perceptions of the problem.

Secondary Data Sources

One of the first steps in a community needs assessment is to determine what data already exist that would help define the extent, nature, and location of the substance abuse problem. Existing data from prior household, school, business, and community surveys or agency records are classified as social indicator data. These include:

- Census data;

- Agency annual reports;

- Social and health statistical records;

- Police records;

- Social service, health, and mental health agency records; and

- Educational system records.

Census Data

Census data are available through State and county planning offices and public and university libraries. These data provide valuable information about the characteristics of the population that are relevant to the drug abuse prevention effort. State or county planning agencies may assist communities to analyze census data, using Geographic Information System (GIS) computer software, to determine such factors as the level of substance abuse, number and reasons for arrests, income and education levels, number of single parent families, average size of families, and other demographic correlates of substance abuse by specified neighborhoods within a community. These are only a few of the more obvious examples of useful data that can be collected from census sources, often down to the street or block level of detail. These kinds of data are essential in targeting the largest problem areas for action. This information can be used to choose a neighborhood to work in or determine characteristics of the population, including risk and protective factors, to address in the strategic planning process.

Agency Annual Reports

Reports that address drug abuse problem behaviors are often published or prepared by agencies for purposes of internal review of agency activities. These reports may contain descriptions of the drug problem, providing information on the extent or nature of the problem, including incidence, prevalence, type of drugs used, and characteristics of the users. Schools; Federal, State, and local law enforcement agencies; and health and social service agencies are examples of the types of agencies that are likely to have these kinds of reports.

Social and Health Statistical Records

Statistical records, or fact books, are prepared by some State drug abuse agencies on the extent of alcohol and drug abuse and abuse within different populations within the State. These records also can include information on the extent of social problems related to substance abuse, such as the number of births to unwed mothers, level of poverty, family assistance program utilization, and crisis hotline utilization in a community.

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Police Records

Records relating to types and prevalence of crime by neighborhood, such as drug-related crime, delinquency, vandalism, and domestic violence, are important sources of data. State or local police departments often compile criminal activity reports annually by jurisdiction that include such information as drug and alcohol arrests or crimes involving drugs and alcohol, location and time of arrests, and types of individuals involved. Police departments in small jurisdictions may not have these records computerized for easy analysis, but local summary data are often submitted to the State law enforcement agency and then compiled into the Uniform Crime Reports of the Federal Bureau of Investigation. Annual summary reports and some computerized data can be made available to local communities.

Social Service, Health, and Mental Health Agency Records

These types of records and summary reports can provide important detailed information about the population of a community, such as incidence of child abuse and neglect; incidence of domestic violence; number of emergency room, outpatient, and psychiatric hospital admissions by diagnosis including drug and alcohol abuse; and other diagnoses associated with substance abuse, such as depression.

Educational System Records

Information maintained and summary reports prepared by the public school system are sources of data related to standardized test results, dropout rates, truancy, absences, disciplinary actions, school policies, and existing prevention efforts. Data also may be available on student academic performance, such as grade point averages by grade and rates of school failure.

Using Multiple Sources of Data

Data from several different agencies can be combined in one annual report or in municipal yearbooks. Therefore, the data search can begin with the most comprehensive collections of information that are readily available and then work as far down to the collecting agency level as is necessary to capture information that is specific enough for the intended purpose. Data that have not already been compiled by an agency for public dissemination may be difficult or impossible to obtain. In addition, because unpublished data, even if obtained, will frequently be in raw form, that is, not summarized, interpretation may be difficult without significant participation and guidance by staff from the particular agency.

Because the sources of data will be many and relationships among community agencies often complex, the availability of any data mapped by geographic location should be explored with particular care. Geographic mapping, such as GIS data mentioned previously, makes correlation

of data from multiple sources considerably easier and puts the resulting compiled data in the format most likely to be effective in community advocacy efforts.

An example of a GIS map created from crime and arrest data is shown in figure 3. This map, prepared for a city housing authority, shows the location of public housing within the city as bounded by streets and neighborhood districts. The darkest shading indicates the highest crime areas; the medium shading shows a lower degree of criminal activity. Applying this example to other communities, areas might be color coded to represent varying degrees of drug- crime severity, ranging, for example, from minimal to extreme. Areas also can be shaded to represent housing areas where the number of gun-related violent crimes occur on the premises of the public housing residences. If desired, the actual pin-point locations of arrests for crimes and drug activity can be illustrated. Likewise, similar data collection performed for health, schools, and social service agencies could be graphically illustrated to help planners determine needs.

Step 2. Increase Problem Recognition

If the key readiness factor of recognition of the problem by the community is determined to be deficient, the results of the comprehensive needs assessment to define the problem can be used to increase community awareness and problem recognition. The needs assessment results will describe the nature of the problem and help provide ideas of what the community can do about it. As mentioned in the previous section, the process of conducting a needs assessment can have a secondary result of increasing community awareness of the problem. Efforts to increase awareness of drug problems, such as public media campaigns, always can be paired with messages of hopefulness, that is, with messages that community action can reduce or eliminate the problem (Arkin and Funkhouser 1990). There are several important steps that a community can take in raising public awareness through media campaigns. These include:

- Creating a communications advisory group;

- Deciding on the message;

- Defining and focusing the message;

- Developing a public awareness marketing plan; and

- Implementing the marketing plan.

Figure 3
GIS Map
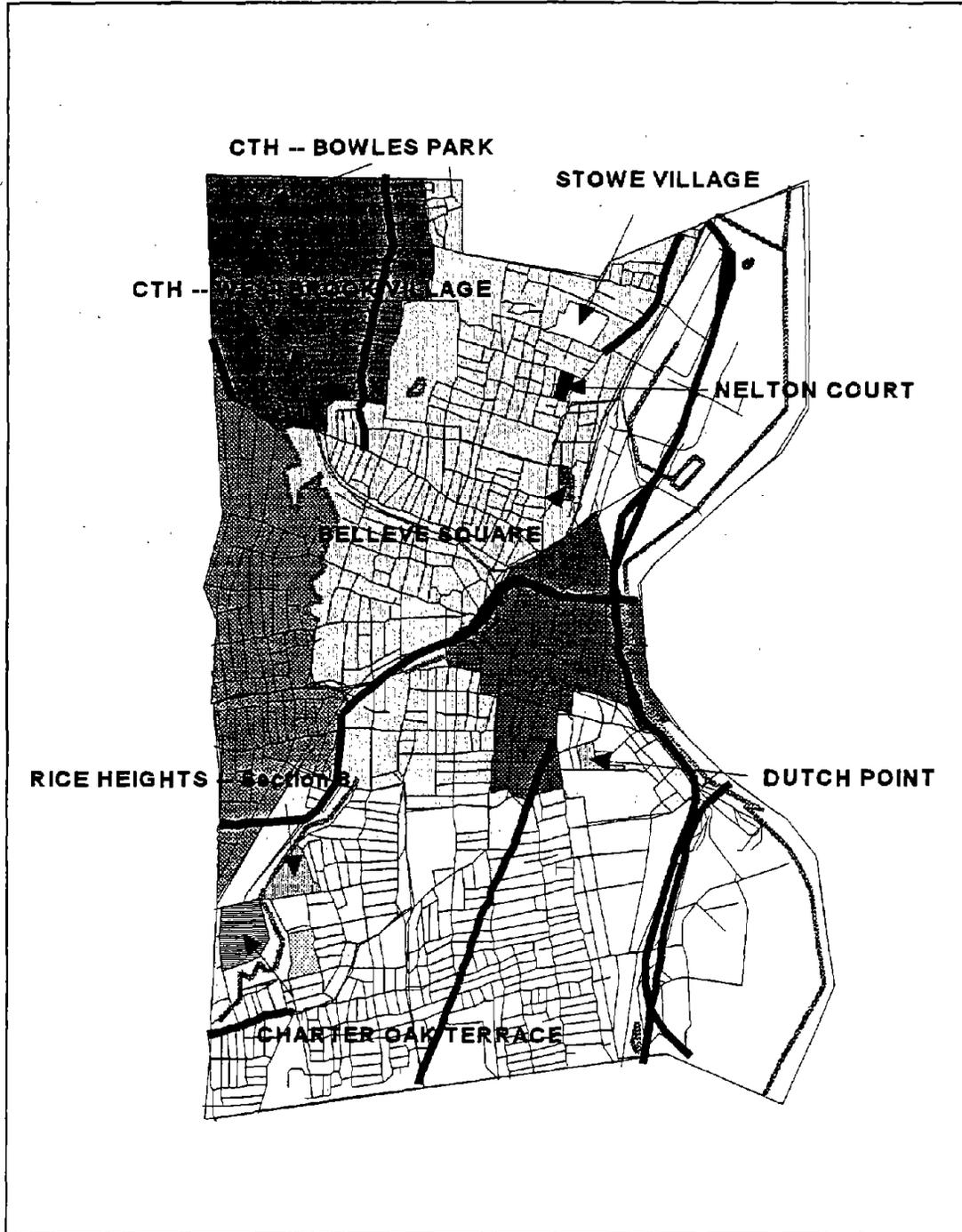
Example GIS map of drugs and violent crime offenses in a Northeastern city.

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<u>Creating a Communications Advisory Group</u>

The assistance of media professionals is essential to a successful campaign. An advisory group of local communications, marketing, and advertising professionals can be created. Prevention providers should resist the temptation to design the campaign themselves. The time expended in identifying and recruiting concerned professionals will be more than worthwhile. Local television and radio stations, advertising agencies, and associations of communications professionals all will show some willingness to help deliver a public service message of interest in their community. Often, these media outlets will have either a legal or professional responsibility to provide community service that can be met by working on the campaign. An advantage to creating a communications advisory group is that it can increase the involvement of the media in the local prevention effort, involvement that is often lacking but is extremely valuable (Robert Wood Johnson Foundation 1989).

The communications advisory group can be asked to design and target news releases, paid media efforts, and public service announcements. Advisory group members can specifically advise the media about what needs to be communicated and to whom. Specific information can be provided about the attitude change that is desired in the target audience and how to prepare for or produce this change. The media also can be provided specific information about what they can do to support the campaign.

Research by Winsten and DeJong (1989) on media campaigns aimed at substance abuse prevention among youth has shown that there are several important elements that make media campaigns successful. These authors have concluded that the most successful approaches are those that incorporate the following elements:

- Long-term campaigns of 1 year or more starting with a media blitz to get attention and community mobilization;

- Carefully tested media messages of public concern;

- Clearly identified target audiences;

- Messages that build on the current knowledge of the target audience;

- A media plan that guarantees exposure of the target audience to the messages; and

- Extensive use of needs assessment data and research.

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Media campaigns in health promotion (Farquhar 1985) and substance abuse prevention (Pentz et al. 1989) are highly successful when used in conjunction with other community substance abuse strategies such as drug education in the schools, parent programs, and advocacy for anti-drug-abuse health policies. The media can be used to shape public opinion, increase community readiness, educate the public on possible problem solutions, help recruit members for the advisory group, and solicit contributions. However, experience suggests that few community members will be solicited through advertisements for volunteers. Volunteers respond to more personal and direct contacts from the prevention organization.

Deciding on the Message

Media specialists in substance abuse prevention recommend that prevention messages should contain more than just the horrors of the problem; otherwise, feelings of hopelessness may be created. Therefore, public awareness campaigns should:

- Convey messages of hope;

- Alter negative perceptions of the persons at risk;

- Present the problem solutions in a positive light;

- Encourage volunteerism; and

- Build community and social support for action.

For additional tips on public awareness strategies, the reader is referred to *Persuasive Communication and Drug Abuse Prevention* (Donohew et al. 1991) and *Communicating About Alcohol and Other Drugs: Strategies for Reaching Populations at Risk* (Arkin and Funkhouser 1990). The latter publication is available through NCADI (see appendix A).

Defining and Focusing the Message

The results of needs assessments provide a foundation for defining the nature of local substance abuse problems and targeting and accurately focusing messages intended to raise community awareness. In general, the broader the focus of community awareness efforts, in terms of both the public to be addressed and the substance abuse problems to be described, the less effective these efforts will be. Messages simply saying that "somebody, somewhere, has a problem" will not be heard and accepted in a media marketplace crowded with thousands of other messages.

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A successful effort requires identifying the target audience, determining the appropriate message (one that will be noticed and believed), and identifying the correct media to deliver the message. In many cases, this will force a prioritization of communities or neighborhoods and problems to be addressed. Resources are rarely adequate to address every segment of the population, and approaches that are too broad are seldom effective.

<u>Developing a Public Awareness Marketing Plan</u>

Once a series of prevention messages has been developed and segments of the community to be targeted have been defined, a marketing plan can be developed. Marketing plans come in many varieties, but certain topics find their way into every plan. The following topics should be included in the public awareness marketing plan for a substance abuse prevention effort:

- Situation analysis (background of the problem or need);

- Goals and objectives;

- Strategy statements;

- Action steps;

- Budget; and

- Controls.

Situation Analysis

Situation analysis is a description of the current circumstances within the community that have prompted the members of the community to take action. In essence, the description is a definition of the problem or need based on the major findings of the community needs assessment.

Goals and Objectives

The situation analysis defines where the community stands at a specific point in time. The next step in the marketing planning effort is to develop a statement of where the community should go in addressing its identified problem. Goals define where the community should be, and the objectives define interim accomplishments along the way to accomplishing the goals.

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Strategy Statements

These represent the broad outline of the means by which the goals and objectives of the community prevention effort will be achieved, including general approaches and underlying philosophy. Although these are not descriptions of specific action steps to be taken in implementing the prevention effort, they are descriptions of major areas or issues toward which the proposed prevention efforts should be directed. In the development of these strategy statements, prevention planners must enlist the input and cooperation of people who will carry some responsibility for helping the community achieve its prevention goals.

Action Steps

If the strategy statements are the broad outline for how a community proposes to achieve its prevention goals, the action steps are the specific prevention activities that will be taken to achieve the objectives. As specific activities are identified, so also are specific individuals and/or groups identified who will be responsible for ensuring that the activities occur.

Budget

The budget is a numerical description of the actual and/or anticipated costs associated with each activity to be undertaken in the prevention effort and should be developed to give consideration to anticipated as well as unanticipated program costs.

Controls

Finally, controls are procedures and activities designed to monitor the implementation of the marketing plan and evaluate the outcome of the marketing effort for the goal of substance abuse prevention.

Regardless of the size of the marketing budget available to local prevention providers, it will be minuscule in comparison with the marketing budgets of commercial advertisers. In many cases, local prevention providers will have no advertising budget at all, but a number of marketing campaign strategies can be employed, several of which can be used at the same time in a media blitz. These strategies include:

- Paid media time;

- Donated commercial time;

- Public radio and television;

- Newsworthy prevention activities; and

- Local community organizations.

Paid Media Time

Paid media efforts must be targeted carefully if they are to have any discernible effect. There may be a place for paid television messages, but production and air-time costs will usually make them prohibitive. The production costs for a short advertisement or community message can be as high as $70,000, depending on the complexity of the production. Less glamorous, but also less expensive, are radio, newspapers, billboards, bus cards, posters and flyers, T-shirts, calendars, and other means of getting prevention messages across. Most of these advertising outlets typically will allow communities to target their audience, for example, by age, ethnicity, or income, more precisely than television can and at a much lower cost. Similarly, community newspapers will offer much more frequent exposure than a general citywide newspaper and again allow the message to be more precisely targeted to the appropriate audience.

Donated Commercial Time

Donated time for public service announcements (PSAs) is available from both radio and television stations. The times for the PSAs are typically brief, and there is no control over when the messages will be aired or how frequently. This is particularly true of television stations where prime time carries a premium price. Nevertheless, this outlet should not be overlooked, particularly if an appropriate celebrity will act as spokesperson for the prevention effort or if the community can locate appropriate existing videos or film clips to air. The Partnership for a Drug-Free America has developed antidrug messages that can sometimes be used with permission granted by the Partnership in New York City (see Appendix A). In addition, NIDA has produced PSAs that are available through NCADI. When using PSAs developed by someone else, it is important to test them on the local population to ensure their effectiveness.

Public Radio and Television

The impact of educational media programming falls somewhere between paid broadcast air time and PSAs. The audience typically will be much smaller, but it also will be self-selected and especially attentive to the message. Clearly, many audiences will not be reached through this medium, but if station listenership corresponds to target groups, public broadcasting presents an extremely effective medium and at virtually no cost. Public broadcasting also effectively reaches community opinion leaders whose goodwill and active support may be essential to success.

Newsworthy Prevention Activities

By far the greatest return on effort will be obtained by learning how to make local prevention information and efforts newsworthy. Getting free news, talk show, or documentary coverage is the best television or radio coverage possible because it provides indepth coverage at no cost and is aired during desirable times. Local prevention services providers can establish a designated contact person or spokesperson who can answer questions from journalists. Establishing a track record for accuracy and responsiveness is absolutely essential. News outlets work on tight deadlines; therefore, the contact person always should ask when the material on the prevention activity is needed. The media contact person can learn to supply text, graphics and photos in the form required by the media. Having this kind of material ahead of time, that is, on file, will facilitate the effort to be responsive.

It is necessary to learn to anticipate when a prominent lead story will prompt local journalists to look for supplementary information. Meeting the needs of journalists can help increase access to the media. Having a speakers bureau to supply resource people to broadcast community affairs, public issues forums, and talk shows also can be effective. Members of the local communication advisory group can instruct prevention program staff in all aspects of media relations.

Local Community Organizations

Finally, communicating with the target populations through local community organizations is extremely important. Media efforts may best be understood as supporting or reinforcing the efforts of these local organizations. Most organizations will have regular meetings and publish newsletters, and program chairs and newsletter editors always are looking for material to put on their meeting agendas and to fill their newsletter pages. An offer to provide meeting speakers or newsletter stories, especially if carefully tuned to the interests of the organizations, will rarely be refused.

Addressing local groups will produce the greatest benefits when it is directed to people with an established interest and a stake in the community. These individuals will be an important resource in helping shape plans and garner the necessary community participation in prevention efforts. These organizations exist because their members want them to; therefore, association with them can give important credibility to the prevention efforts. In meeting presentations and newsletter articles, it is necessary to allow time to communicate the seriousness of the drug abuse problem, a sense of hope that the problem can be solved, and the need for broad community participation in solving it.

<u>Implementing the Marketing Plan</u>

The final steps in an effective media campaign are to implement the campaign and assess its effectiveness. If a community prevention organization has sufficient funds earmarked for community awareness efforts, it may choose to hire an advertising agency to help implement the marketing plan. An advertising agency can create logos, graphics for T-shirts, posters, billboards, and flyers as well as television spots. Occasionally, an advertising agency will work on a prevention campaign for low or no cost. Selection of the best agency for the particular needs of the community can be difficult, and the communications advisory group can be helpful; but some selection criteria may include similarity and quality of previous work of the agency, specific expertise in the area of prevention, and comprehensiveness of services. An evaluation will help the program organization determine ways to improve the campaign approaches used over time. Media specialists can help in this effort by designing an evaluation approach that can measure the impact of the public awareness efforts in changing opinions and behaviors. Some outcomes that can be measured include respondents' exposure to and recall of the ads, impact of the ads on telephone calls for help or to volunteer, and participation of community members in publicized community events.

Step 3. Access Community Resources

If a community is found deficient on the key readiness factor related to the existence of and access to adequate resources, there are specific strategies that can strengthen resources so that substance abuse prevention programming can be implemented successfully. The ability to marshal resources is a significant sign and an essential prerequisite for the continued vitality of a coalition. A coalition of prevention agencies can accomplish worthwhile objectives simply through periodic meetings of its members; but this limited level of cooperation is enhanced if the coalition is able to garner financial resources of its own. For example, the contributions of volunteers can be made significantly more productive if even modest funds are acquired for equipment and materials. The significant test of a vital coalition is not whether its individual members contribute funds to a single budget but whether the coalition can apply the funds and other resources to accomplish the coalition's objectives.

<u>Raising Financial Support</u>

Although financial and human resources are necessarily interrelated, the financial challenge to a coalition initially can be the most daunting. Financial support can be obtained either through the budgets of participating agencies or by asking directly for other public and private support.

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Startup Resources

The successful launch of a coalition requires an initial commitment of resources, usually in the form of contributions of material and services from the initiating agencies and members. The most modest beginnings requires meeting and office space, duplicating and printing facilities, and limited staff support. As a practical matter, the work of creating a coalition is greatly enhanced if some time of agency staff is made available to commit to the coalition. These contributions, even of volunteer time to stuff envelopes, can be recorded because they form an important demonstration of the initiators' commitment when they present their case for new and external support. Many Federal grant applications require matching funds, which can be provided through in-kind contributions, such as the provision of office space, word processing support or duplication services.

The Role of Agency Funds

The most promising source of funds for the prevention effort is contributions from the participating organizations. Private funding sources generally provide seed money or startup funding to launch an effort; they rarely fund ongoing operations and cannot be depended on for continuous funding. Similarly, most government grants are designed to test new ideas or to provide startup funding, with the expectation that other funding support will be obtained to ensure the program's continuation. (The requirement for a plan to continue the program after funding ceases is often a condition of grant funding.) Whatever the source of initial funding, coalitions must plan for their continued funding. Participating agencies may agree to contribute a portion of their budgets (if their bylaws permit it).

Pursuing New Funding

The active pursuit of new sources of funding is a never-ending quest of community coalitions. To maintain their viability and grow, coalitions must establish funding as a priority activity. Therefore, strategies must be developed to address this significant need.

Create a Funding-Development Working Group

Volunteers from local development offices of hospitals, foundations, universities, and some private, nonprofit agencies are experts in raising money. Therefore, these experts can be tapped to participate on a funding- development working group of the coalition. These experts know local and national foundations and corporations, private donors, and ways to conduct fundraising events. Because their employers expect them to raise money for their own agencies, it is important to choose members for the coalition's funding-development working group who raise funds for nonprofit organizations that are not engaged in drug abuse prevention or social service activities, for example, a local symphony or arts group.

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The charge of the funding-development working group might be to review the coalition's strategic plan and develop appropriate funding strategies to support the plan. A plan for long-range funding needs to be developed, particularly if any existing Federal or State funding for the coalition is short term. Beginning early, years before current funding ends, is essential to the longevity of the coalition and its overall efforts.

Potential Funding Sources

Many different potential sources for money, equipment and/or staff can be considered, including:

- Federal grants;

- State and/or local grants/contracts;

- Foundation and/or corporation grants; and

- Private donations and direct solicitation.

Federal Grants

Funds can sometimes be obtained by direct grant from Federal agencies supportive of substance abuse prevention activities. In addition, funds can be obtained through Federal grants to States or local governments, which allow for the release of matching State and local funding to support prevention activities. Most Federal grant funding for substance abuse prevention is earmarked for demonstration/evaluation projects or prevention research projects designed to stimulate the development and test the effectiveness of specific strategies or approaches with specific target populations. These Federal funding mechanisms require comprehensive evaluations and data collection mechanisms designed to determine the effectiveness of the funded projects. In other words, these grants are not intended to be used for service delivery. Service delivery grants are available through State and/or county funding mechanisms. Some funding is available for training or conferences through the Federal Center for Substance Abuse Prevention. A list of potential Federal funding agencies is included in appendix A.

State and/or Local Grants/Contracts

State, county, and local (city, township) budget appropriations can be pursued for service grants in prevention. State and county agencies typically have little new funding because most of their funding from Federal or State sources is already allocated to existing prevention service providers. However, occasionally new coalitions may be given a

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chance to compete directly for community development block grants. These are funds provided in lump sums (blocks) by the Federal government to State and municipal governments; they are awarded for community development projects at the discretion of the recipient governmental entity. (Current congressional plans call for directing more money to State block grants and less to Federal programs, so block grants may prove to be a better source of funding for prevention activities in the future.) Sometimes, State and county agencies have unspent funds at the end of a year that they may be willing to allocate to a community coalition for short-term projects. Maintaining communication with these agencies will help increase the possibility of obtaining such funding.

Foundation and/or Corporation Grants

A lot of time may be saved by engaging the skills of a professional fundraiser as a volunteer or paid consultant in approaching local corporations and foundations. However, an interested staff member or volunteer with writing skills can master the essentials of grant writing. With the exception of grants from major national foundations that have specific programmatic interests and whose grants are fiercely competitive, foundations, like corporations, tend to give to their own local communities. Therefore, local foundations and locally owned corporations also may be helpful sources for funding.

Foundations and corporations prefer letters requesting funding, which succinctly outline the goals, objectives, program strategies, and populations to be served by the program. This information should be supported by a summary of the proposed program budget and an indication of other sources of program support. Although foundations and corporations will look for some evidence that the proposed program will be evaluated, they will be more interested in assurance that the activities, if successful, will be adopted and maintained by the local community. They do not usually require the elaborate, technical research and evaluation plans needed to secure Federal research grants.

When approaching corporations, it is important to remember that recognition and good publicity with their target markets is extremely important to them. Therefore, the coalition leaders should consider who these target audiences are and how the coalition can offer the corporate donors favorable publicity with them. However, these opportunities for publicity must not be oversold. Corporations may prefer to make in-kind contributions to the prevention efforts in the form of products, meeting or office space, or services such as printing that can be done during company off-time.

Private Donations and Direct Solicitation

Some community organizations exist primarily on private donations and direct solicitations (requests for donations) for funding. Being listed as a United Way agency is one way of receiving funding. When private funding is pursued, reallocation of existing coalition member agency resources demonstrates a commitment to the mission and goals of the coalition. It says "Look what we have done with what we have." This approach can be quite persuasive when the coalition is seeking funding from private sources.

Building Momentum

Coalition members should remember the recurring need to make their case and document their commitment in the pursuit of additional funding from both public and private sources. For public sources, the case usually should be made by agency heads, but coalition members need to supply the necessary supporting materials and may, in some cases, participate in public budget hearings. Coalition commitment to long-term and productive relationships with mayors, council members, commissioners, governors, and State or local legislators is as important as this year's budget.

Given the tendency of funding organizations to ask, "Who else is backing you?," the initial allocation of coalition resources becomes a powerful demonstration of commitment with which to approach private funding sources. Success with private sources also can be used to demonstrate public concern. Resources already committed set the effort apart from the much larger number of good ideas looking for a start. However modest, these resources are an important element of the case for additional support. Finally, breadth of support is another important factor in making the case for additional funding from government and especially from foundations and corporations. A broad base of support from seriously committed community organizations and agencies is an important asset.

Step 4. Develop a Strategic Plan

When a community has a variety of substance abuse prevention programs and activities operating but no clear idea how these various efforts are related or coordinated, the community is deficient in its readiness to implement prevention programming because it lacks a coherent vision or a plan. Therefore, the community can improve this readiness factor by initiating a process to develop a strategic plan. A strategic plan is a document that outlines not only the community's vision for drug abuse prevention but the strategies for making that vision a reality. In effect, it is a roadmap that provides guidance to the community in its efforts to implement effective programming. A strategic plan requires that a community develop, at least, the following:

- A theory about the problem, that is, developing an understanding of the psychological and social factors affecting the problem and the interrelationships among the risk and protective factors associated with the problem;

- A theory about which prevention approach to take, that is, community members becoming knowledgeable about previous approaches to the problem and the relative effectiveness of these approaches with different cultural groups and target populations; and

- An awareness of the program context, that is, community members becoming aware of the organizational, community, and cultural situations in which the prevention program will operate.

An effective strategic planning approach to substance abuse prevention requires consideration of the degree of match between proposed prevention programs and important factors operating within the community. These community factors, including community norms, attitudes, and values; a sense of community or belonging among community residents; a willingness to act through collaborative efforts; the level of commitment; and a host of other factors, all affect community readiness. A prevention approach that simply provides services to meet community needs can actually intensify the problem by focusing on service provision rather than on strengthening the capacity of a community to solve its own problems (McLeroy et al. 1993). For example, providing additional youth services staff to work with troubled youth rather than increasing the capacity of parents to improve the behavior of their children misses an important opportunity for parental growth and increased parental effectiveness. Therefore, prevention services should not become a substitute for increasing the local community's capacity to handle its own problems.

A strategic planning approach can take different forms and involve a variety of activities. For example, one strategic planning approach is a 12-step planning model for substance abuse coalitions, part of the Strengthening Communities Program (Kumpfer et al. 1991). Another strategic planning process is reflected in the Planning Guide provided in appendix C. Regardless of the particular strategic planning model adopted by a community, the planning process should incorporate the following activities:

- Identification of who will develop the strategic plan through the formation of a strategic planning team and task forces to work on specific aspects of the plan;

- Development of a common base of knowledge among the planning team members;

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- Assignment of responsibility to the planning team members and task forces; and

- Development of the written plan.

Identification of Who Will Develop the Strategic Plan

The development of a strategic plan for a community will be a massive and complex undertaking, involving diverse segments of the community. Therefore, a first step in the strategic planning process should be the establishment of a strategic planning team whose responsibility it will be to develop a plan for addressing local prevention needs. In addition, it is often wise to designate task teams to work on specific aspects of the strategic plan, such as resources, organizational structure, and public awareness.

The formation of task teams can be accomplished in several ways. Based on information provided by the people who attend the first organizing meeting of the coalition (see Step 7), the areas of interest and expertise of the coalition members can be used as the basis for their assignment to particular teams. Some teams, for example, can be established on the basis of the characteristics of the populations that are targeted for prevention, such as school-aged youth, college students, business employees, senior citizens, ethnic minorities, and families at risk. Specific planning efforts are thereby focused on each defined target population and then integrated into a total community strategic plan. This strategy works well in geographically large communities, that is, cities or other major metropolitan jurisdictions. An alternative approach is to establish task teams on the basis of small geographic neighborhoods and then combine the plans into a comprehensive plan for the community. This strategy would be appropriate for smaller communities and towns.

The work of the task teams can be either short or long term or both depending on the particular issue their planning efforts are designed to address. For example, a task team may be established for a short time to address a particular issue such as resources. However, it may later develop that this issue is of such magnitude and importance to the coalition that it will require the team's involvement over a longer time. Thus, the short-term planning team takes on a long-term effort. On the other hand, a planning team initially may be established to address a long-term issue such as public awareness of substance abuse and its prevention. It will be the responsibility of the leadership body of the coalition (see Step 7) to coordinate the planning work and the results of each task team's efforts.

Some task teams may be established to plan prevention strategies for selected risk factors, such as antisocial peer influence or family dysfunction. Other planning approaches might involve teams working on issues relevant to particular subgroups, such as drug abuse and pregnancy, drug-free schools, or driving under the influence of alcohol and drugs. Regardless of the particular basis for the establishment of the task teams, the individuals recruited to work on each

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team should, to the extent possible, be representative of agencies, associations, and citizens groups that have an expressed interest or stake in the issues of the target populations of the planning efforts.

Development of a Common Base of Knowledge

An important consideration in any strategic planning process is determining the level of knowledge and experience of those who will constitute the strategic planning team. If the coalition is composed entirely or predominantly of prevention providers but with broad participation from the community at large, then strategic planning can proceed quickly, drawing on members' shared professional knowledge and skills in substance abuse and its prevention. However, if nonprofessional community members or professionals from outside of the prevention arena play a prominent role in the planning process, then the process will likely proceed more slowly, requiring essential time devoted to educating the planners about substance abuse prevention. Any coalition that expects to obtain support from nonprofessional members of the broader community will need to ensure that their participation is not taken for granted and that meeting discussions are not weighed down with the use of professional jargon or other terms that are unfamiliar to these members and tend to exclude or ignore their needs. Even if the plan is developed solely by professionals who are from different segments of the community, they too will need to develop a common base of knowledge in prevention.

Educating the Planners

It is desirable to have an organized effort to educate planning team members in the planning process, that is, in how to plan. Different planning models can be used, and many exist. However, the principle idea is that the planners be instructed in the specific planning process the organization will use and what the final product, that is, the plan, will look like.

Whether professional or lay members dominate the planning team or whether there is a balance among the types of members, strategic planning will require the same basic steps. The planning teams must:

- Determine what aspects of substance abuse are most pressing within the community;

- Determine the goals and objectives of the prevention effort; and

- Choose prevention approaches that are likely to succeed and possible to implement with the available resources.

Introducing Planners to What Works in Prevention

Planners should select prevention approaches that have demonstrated effectiveness; but to do that, they need to be exposed to the range of successful and promising prevention strategies. The goal of such exposure is to develop a common base of knowledge so that all members of the strategic planning team end up speaking the same language of prevention. Some planning team members already may have ideas about what the prevention approach should be, and unique or new solutions to substance abuse should be respected and considered. However, to avoid premature closure on any particular approach, the planning team should be exposed to many different successful prevention strategies. This can be accomplished through a variety of mechanisms, including:

- A kick-off conference, including a training course on prevention ("Prevention 101") and workshops describing local prevention programs;

- Attendance at State or national conferences that showcase strategies and approaches that work in substance abuse prevention. Lists of such conferences can be obtained from some of the agencies identified in appendix A;

- Visits to local or national prevention programs to observe their operations;

- Discussion groups and presentations by planning team members on completed assignments to locate promising prevention programs;

- Review of relevant research studies on effective prevention programs gathered from city or university libraries and by conducting literature searches; and

- Discussions with prevention specialists in the area.

The handbook contained in this RDA package, *Drug Abuse Prevention: What Works*, can serve as a guide for planners to learn about effective research-based prevention strategies. It will be important to present as wide a range of alternatives as possible and to avoid prematurely narrowing the range of potential program options.

<u>Assignment of Responsibility</u>

At this point in the planning process, the planning team will begin the work of creating a written plan to increase the community's capacity or readiness to implement drug abuse prevention programs. It is at this point that the coalition, through its governing body, will give the planning team its charge, that is, a specific direction with regard to what its task will entail and the products or results it is expected to produce. The principal reason for team members'

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collaborative efforts should not be to have endless planning meetings, but to support capacity building, that is, to plan ways to support the community to implement effective, research-based substance abuse prevention programs and services that will address the local problems and needs.

Short-Term Planning Teams

Short-term planning teams may be established at any time throughout the life of a coalition, but they are especially important during the formative months of the coalition. Such short-term planning teams are established for specific goals, the results of which may be generally applicable to the entire coalition. For example, they may be established to identify problems, plan courses of action, identify and access resources, or evaluate a coalition activity. Members of short-term planning teams should understand that the life of their particular team is short, perhaps only a few weeks or a few months. The outcome of their work will be preliminary reports or recommendations to the coalition council (see step 7 for a full discussion of coalition subunits). If the recommendations of these short-term planning teams are adopted for implementation, the members may, but need not, continue with that project. Planning teams can be prepared to report their best assessment of the problem in their community, points and strategies for effective action, and resources required and available for relevant action.

Long-Term Planning and Implementation Teams

These teams are charged with the responsibility for making the strategic plan a reality, or implementing it. Their work may include attracting the necessary funding (e.g., applying for coalition funding, using committed agency funding, or attracting outside resources and funds) to implement the proposed prevention strategies. If this approach is followed, the coalition structure must be organized to support these efforts. This is an exciting and invigorating element in the planning process. Knowledge that what they plan can really happen increases the team members' commitment and enthusiasm for the difficult planning process. However, knowing that they are responsible for implementing or attracting staff to implement their prevention plan will infuse an important element of reality into their plans.

Defining Planning Activities

The long-term planning teams may address a range of prevention activities, such as community education and public awareness campaigns; school-based skills development, parenting education and skills development, and family communication skills development programs; and employee assistance programs. However, the choice of the specific activities to be implemented should be based on the coalition council's assessment of political feasibility, from the perspective of both prevention provider agencies and the broader community. Drawing on the reports and recommendations of the short-term planning teams, council members should agree on the priority of the problems to be addressed by the coalition and how responsibility for the work is to be

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shared among the various segments of the coalition. Council members face a difficult task in this decision, recognizing the interrelatedness of many substance abuse problems and the planning teams assigned to address them. The prevention strategies must be as comprehensive as possible yet focused enough to avoid the risk of dissipating resources and having little measurable impact on the community.

Activities of the Planning Team

When the planning team begins its work, it should start with an statement of the goals of its work, that is, the changes in substance use and abuse behavior it hopes to achieve. From this point, the team can then work backward to identify prevention approaches that are both appropriate to the identified community needs, risk, and protective factors and affordable with the community's resources. Team members can begin by asking, "If we are successful in our efforts, what will be different in our community, and how will we know?" Team members need to understand each other's concerns and support each other to find research-based strategies that respond to those concerns. Team members also must be able to identify and avoid planning strategies that have little chance for success in their community or which even have been demonstrated to have negative effects so that the coalition will avoid wasting valuable resources on losing propositions.

The planning team may need to have a modest budget to allow it access to appropriate literature on subjects of relevance to its work and to draw on the experience of other agencies and coalitions. Telephone calls and visits to programs are an important resource for the planning team to avoid pitfalls identified from the experiences of others. Direct observation can give inexperienced planning team members a more concrete appreciation of what a given prevention approach may mean in practice.

Development of the Written Plan

The strategic planning process can result in a formal written document that presents in specific detail the plan that will guide the implementation of the communitywide substance abuse prevention effort. An outline for the strategic planning document can be developed and provided to each planning group. The outline will help focus the work of the planning team on the specific issues to be addressed during the planning process and serve as an organizing framework for a strategic planning document. A planning guide is provided in appendix C. The strategic plan should address, at a minimum, the following issues:

- *The problem*: a statement of the problem or problems to be addressed by the planning team. This statement should be based on the findings from the community needs assessment previously discussed;

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- *Goals and objectives*: a discussion of the desired change in behavior, including long-term goals as well as immediate and shorter term outcomes of the proposed prevention effort;

- *Prevention strategies*: a description of the specific prevention activities chosen for implementation and a summary of the reasons for their selection; and

- *Resources*: a list of all the resources that are expected to be required to implement the prevention approach, including the necessary staff, facilities, equipment,and other resources. This point was discussed previously in step 3.

Using a Logic Model

Logic models are one-page graphic summaries of the essential elements of strategic plans. They can be used in any kind of strategic planning process where it is important to determine whether the proposed activities are logically related to the expected results of the program. Logic models depict visually the assumptions underlying the program's structure, that is, assumptions about which strategies will be most effective in achieving the objectives and what resources are needed to implement the strategies effectively. Specifically, logic models specify:

- All the resources that will be needed for the effort;

- The specific prevention program/activities that will be implemented;

- The anticipated immediate or short-term effects (objectives) of the activities; and

- The anticipated long-term outcomes or goals achieved by the participants in the effort.

Logic models can help focus the planning process and ensure consensus among the planners and groups that have a vested interest in the prevention effort; everyone needs to agree on the goals and objectives of the project and the strategies that will be implemented to achieve them. Logic models also are required by some funding agencies and often are used in Federal evaluations of programs. To learn more about how to create a logic model, see *Measurements in Prevention* (Kumpfer and Hopkins 1993) or contact the Center for Substance Abuse Prevention (see appendix A).

Criteria for Selection of Prevention Programs

There are perhaps as many prevention programs as there are communities wishing to implement them, and a community may have a difficult time determining which programs will be appropriate for its particular circumstances. To provide some guidance in the selection of appropriate prevention programs and/or activities, communities should apply the following three major criteria in determining which prevention strategies to develop:

- *Technical/scientific criteria*: determining whether planning team members have a good grasp of why the problem is occurring (have a theory of the problem) and whether team members have a theory of the prevention approach (a research-based justification for why the particular prevention approach was selected to address the identified problem);

- *Political criteria*: determining whether the selected prevention approach will be accepted in the community and whether local citizens will give enough support to the prevention approach for it to have a chance of success; and

- *Cost criteria*: determining how costly a particular prevention approach will be in relation to the size of the expected benefits and whether the community has the necessary fiscal and staff resources to implement a particular approach.

In addition, the planning team should determine the level of knowledge of its members about the variety of factors, such as intrapersonal, interpersonal, organizational, community, cultural, and public policy factors associated with substance abuse and by extension its prevention. Knowledge of these kinds of issues will provide a framework within which planning team members can assemble and summarize all the information they have learned about:

- The causes of the problem from the needs assessments and literature reviews that will help them to create a theory of the problem;

- The theory of the prevention approach to be used based on research findings of what works in substance abuse prevention; and

- The community's readiness for program adoption and potential places to intervene with cost-effective prevention approaches (McLeroy et al. 1993).

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Reconciling Individual Plans

In considering the implementation within the community of the plans developed by each planning team, the coalition council will be concerned primarily with determining where there is interface between the plans, that is, determining how the work of one task team will affect and be affected by the work of other teams. Questions of practical interface will necessarily arise and will need to be carefully considered by the coalition. For example, if one team's plan calls for afterschool activities in the school and another team's plan calls for afterschool activities in the home, how can these separate activities be coordinated? How can different aspects of a strategic plan be reconciled?

Resource allocation will pose a particularly thorny challenge for the coalition. Limited resources, such as money, space, and volunteer time, will necessarily require careful planning. Decisions must be made about which program activities to pursue and which to defer until further resources become available. Therefore, the coalition's strategic plan can include recommendations about program priorities to guide resource allocation decisions. Program implementation timelines that are based on budget considerations that include the specific activities, their costs, and expected sources of funding will help facilitate the resource allocation process.

Council members should not ignore the desirability of achieving some early successes from the coalition's efforts, even if they are modest, to provide a sense of positive movement and reinforce the cooperation and political support of coalition members. Therefore, prevention activities that have a good chance of showing early positive effects may be given higher priority for implementation than activities that will take a long time to show positive results. Council members also should remember the importance of continuing to acknowledge coalition achievements that can be documented and celebrated at public events.

Writing for Community Acceptance

Finally, it is recommended that the strategic plan be written in language that is appropriate for the coalition, planning agency, or funding sources. Technical appendixes that provide great specificity and detail can be included. If the plan is for general community review, the finished product will be an essential tool for rallying support and commitment in the wider community. It is important in this case that the plan speak clearly to the community's hopes and fears on the emotionally charged matter of substance abuse. A strategic plan that is unintelligible to its readers will fail in its objective of rallying community support.

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Step 5. Maintain Momentum

If the degree of readiness of a community to mobilize and sustain the prevention activities is found to be deficient, the following discussion presents strategies by which this key readiness factor can be strengthened. Community organizations are frequently less successful at sustaining the momentum of the organization after the more glitzy and exciting mobilization phase of the prevention effort (see Step 6). Therefore, mechanisms will need to be created for the coalition

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MAINTAINING COALITION MOMENTUM

- Develop formal rules, roles, and procedures

- Retain professional staff

- Retain nonprofessional community members

- Retain reluctant members

- Offer various ways to participate

- Increase benefits and reduce costs associated with membership

- Decrease barriers to participation

- Increase sense of role importance among members

- Identify and resolve agency and personal conflicts

- Continually recruit, orient, and train new members

- Prepare new leaders-in-waiting

- Identify and raise funds

- Remember that things take time

- Build a resource databank

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to maintain the momentum of the prevention effort. The activities listed in the chart below have been found to be important mechanisms for maintaining the necessary momentum of the organization. However, a significant aspect of maintaining the momentum of a coalition has to do with the retention of coalition members—professional, nonprofessional, and reluctant members—and with increasing the benefits and reducing the costs associated with coalition membership.

Rules, Roles, and Procedures

A formal structure that includes an organization chart with clearly specified roles and responsibilities and organizational operating procedures is an invaluable tool. Not only does it add to the credibility of the organization when approaching potential funding agencies or others; it also helps establish the structure that staff (including volunteers) need to feel comfortable and to understand the contribution their work makes to the total effort. The formal structures can include:

- Job descriptions, defining specific duties and performance standards;
- Job classifications and salary scales that delineate career paths in the organization and establish an objective base for making salary determinations;
- A formal bookkeeping and recordkeeping system;
- Policies and forms for reimbursement (e.g., for travel expenses);
- Policies and procedures for handling a variety of situations, including for example inquiries from the press.

Depending on the nature of the organizational structure, it may be necessary to establish formal bylaws to govern such things as the selection of board members and policies for hiring the executive director.

Coalition Member Retention

The requirements for retention in the coalition differ for professional and nonprofessional members, and each is discussed separately below.

Professionals

The active participation of professionals is important for prevention activity success. If their personal needs are not reasonably met, they are likely to abandon active, contributing participation. For example, in the case of prevention professionals who are employed by member agencies and organizations, it is desirable to obtain their formal assignment to work with the coalition, perhaps incorporating the new prevention activities into their current job descriptions.

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Failure to obtain these redefinitions of work responsibilities runs the risk that coalition membership will be seen as something extra, the first task to be ignored if time pressures build within their "real" jobs.

Nonprofessionals

In some cases implementing a prevention effort may not be as difficult as maintaining the interest of nonprofessional community volunteers over time (Prestby and Wandersman 1985). The rewards for community members often are intangible or at least not immediate. Participation must feel productive in achieving the members' objectives within the community at large, within the organization they represent, as well as personally. Community prevention organizations often have a difficult time maintaining the participation of community volunteers once the initial enthusiasm has worn off (Miller et al. 1979). Dropout rates as high as 50 percent have been reported after initial mobilization activities have been completed (Yates 1973).

It is critical to identify factors that contribute to member satisfaction with and participation in the coalition. Interviews can be conducted with identified leaders within the coalition to gather data about what they do to enhance member participation. For example, Prestby and colleagues (Prestby et al. 1990) found that active members in block associations identified higher personal benefits and lower costs of participation as important factors in their remaining active in the organization.

Reluctant Members

All groups shift toward a more homogeneous membership as the dominant group gives the organization its imprint. Therefore, coalition members who are not part of the dominant group may feel left out. In the worse cases, these members may feel discriminated against or harassed and may drift away from the coalition. Therefore. a conscious effort must be made to recognize and value less influential groups and individuals to retain their membership and support. In addition, recruitment will be easier by working through groups whose purposes suggest interests parallel to those of the coalition.

Types of Participation

Although participation in community coalitions is frequently treated as an all-or-nothing situation, there are different ways in which members can be encouraged to participate. Research has shown that there are different levels or types of participation that members of community coalitions exhibit (Wandersman 1981). For example, participants can:

- Assume positions of leadership where they have power to make decisions;

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- Participate on planning teams to influence decisions about the prevention approaches selected;

- Serve on advisory boards to provide opinions about the choices of prevention approaches to match community needs;

- Serve as staff members or volunteers in implementing the programs; or

- Choose to not participate.

Therefore, when members are being recruited for planning teams for prevention programs, they should be told that they can participate in different way and at different levels of time commitment, depending on their availability. Matching the members' time and interests to specific coalition activities will counteract burnout and ensure continuing participation.

Benefits and Costs of Participation

Recruitment and retention of members to participate in the coalition will depend on increasing perceived benefits of collaboration and decreasing costs of participation. According to Butterfoss and colleagues (Butterfoss et al. 1993), Benard (1989), and Wandersman and Alderman (1993), potential *benefits* of participation in community coalitions include:

- Increased networking and friendships;

- Information sharing and access to resources;

- Contribution to solving an important community problem;

- Enjoyment of the work of the coalition;

- Personal recognition for talents and efforts; and

- Increased personal skills and knowledge.

Potential *costs* of participation can include:

- Time devoted to coalition activities reduces time for family, job, and other obligations;

- Loss of autonomy resulting from collaborative decisionmaking;

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- Perceived lack of leadership within the coalition;

- A feeling that talents are not being utilized;

- Lack of skills to do certain tasks; and

- Lack of appreciation or recognition for work accomplished.

Coalitions must find ways to increase the benefits and decrease the costs of member involvement. A favorable cost-benefit ratio increases the level of members' commitment and participation (Howard-Pitney and Rogers 1992). To improve the cost-benefit ratio, leaders can increase the benefits of membership by increasing information, skills, recognition, friends, networks, satisfaction, and recognition for a job well done. Therefore, organizers of prevention coalitions will have more active community members if they:

- Provide social incentives, such as ensuring that meetings are informational, motivational, and social and that people feel welcome at meetings where leaders stress community responsibility; and

- Reduce personal costs of participation by providing safe transportation and child care and keeping meetings convenient, brief, and not excessively frequent.

In some cases, the importance of providing incentives and benefits is greater than the need to reduce personal costs for members to maintain active participation because many community volunteers consider that the important goals of the organization outweigh many personal inconveniences (Prestby et al. 1990). Training and opportunities to meet people with similar interests provide additional rewards for volunteers. However, volunteers who may be eager to make a difference will eventually move on if the coalition seems to be achieving little. It is important to create the appearance as well as the substance of an effective organization.

Coalition and committee meetings should convene and adjourn promptly and on schedule. Copies of meeting agendas and supporting materials can be distributed to members in advance to allow for their review before the meetings but not so early that they are misplaced. Reminder calls or postcards sent to members before meetings will improve turnout and convey the message that members' participation is important. If members have been inactive, they can be asked whether a particular coalition task or activity would help to reengage them in the work of the coalition. If a member's departure is unavoidable, a handshake, a pat on the back, and a word of thanks are always appropriate and appreciated. An exit interview or discussion with the departing member can be a useful means for getting feedback, both positive and negative, about the things about the coalition and its activities that were important to the member that may be related to the reasons the member is leaving.

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<u>Other Strategies</u>

There are specific factors that are important to the maintenance of active participation by members in the coalition. Although there are both costs and benefits associated with participation in the coalition, substance abuse problems are not new nor are the social problems in which they are rooted. Therefore, an understanding that change will take time and that coalitions require resilience and perseverance for change to occur is important. It is essential that close attention be given to the morale of coalition members and where possible efforts should be made to increase the benefits to be derived from coalition participation for both professional and nonprofessional members. Particular attention should be given to:

- Decreasing barriers to participation;

- Building planning team efficacy; and

- Increasing role importance and sense of empowerment.

Barriers to Participation

There are circumstances and factors that pose barriers to members' active participation in coalitions. These barriers include such things as inconvenient meeting times, lack of transportation for members, lack of perceived or actual safety of meeting locations, and lack of resources for child care. These kinds of barriers can substantially reduce the motivation to be involved in the coalition's drug prevention efforts. These barriers can be anticipated and addressed early in the formation of the prevention effort. For example, plans for carpools and child care can be developed as part of the planning for the first coalition organizing meeting. Meals can be provided during lunch and dinner time meetings to retain coalition members' active participation. In addition, scheduled times for coalition meetings may need to be changed to accommodate members' work schedules and fears members may have about being out after dark.

The physical safety of prevention organizers is important to the success of any prevention program. The environmental features of the community and the meeting locations can be analyzed for security, including physical barriers to unwanted entry, such as walls, fences, or security bars or entry points (Perkins et al. 1990). In addition, there are issues of territoriality (Altman 1975), or in whose territory the meeting will to be held. Some residents will not attend a prevention planning meeting that is held in a neighborhood, public housing community, or school that is different from their own. In addition, participants may be unwilling to attend meetings if they have to pass groups of youth who are unknown to them, prostitutes, or drug dealers loitering at the building entrance or nearby. These circumstances may increase the members' fears of assault (Perkins et al. 1989).

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Team Efficacy

Research suggests that participants in community coalitions are more likely to remain active if they perceive that their efforts are effective, that is, if there is a sense of efficacy among the members (Butterfoss et al. 1993). Expectations of effectiveness in solving community problems increases participation and team satisfaction. According to Zimmerman and Rappaport (1988), a sense of efficacy also increases if participants are successful in organizing people, identifying resources, and developing strategies for achieving goals. Teams also are more satisfied if they have leaders who encourage and support members' ideas and planning efforts, use democratic decisionmaking processes, and encourage networking and sharing.

Role Importance and Sense of Empowerment

Feelings of empowerment lead to increased retention. Empowerment is developed on the basis of experiences within the group. The leader influences these experiences by encouraging positive social relationships and networking, providing encouragement of group members and opportunities for involvement in positive ways, and rewarding members' contributions and participation (Chavis and Wandersman 1990). Research suggests that a sense of personal efficacy would not be sustained long in a negative group situation (Kumpfer et al. 1993). If a group member is treated like an outsider, with little support or reward for participation and contribution of ideas or volunteer efforts, then his or her sense of self-efficacy decreases. Often the group leader sets the tone to make volunteers feel their contributions are as valued as those of the participating professionals.

Step 6. Mobilize the Community

The following discussion provides some strategies for increasing support from stakeholders, if the coalition is deficient in that area. The work of building a community coalition to implement substance abuse prevention programs does not end with creation of the formal organizational structure (see Step 7). Implementation or program development must be considered an ongoing task if the prevention effort is to survive and be effective.

Coalitions are fragile. A majority of members must feel that the returns to their community, their organizations, and themselves warrant the continued commitment of their time and effort. Changes in personal circumstances or disenchantment with some aspect of coalition activity will cause some attrition. New participants continually must be enlisted to take the place of those who leave. Continuing recruitment also will provide an opportunity to ensure the representative character of the coalition.

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<u>Coalition Member Recruitment</u>

Whom to Target

Coalition members can come from prevention agencies or from the general population of the community. Member recruitment for a large coalition, composed mostly of volunteer members, can be a full-time job. Knowing who is likely to volunteer and remain active helps to target solicitation efforts. Research (Prestby et al. 1990) has shown that active members in community coalitions:

- Have a strong sense of community;

- Are likely to be homeowners;

- Have lived in their neighborhoods for some time; and

- Plan to stay at their current address.

Experience has shown that women who are not employed outside the home tend to have more time to be active in their block associations or community councils. Research also has shown that members of active coalitions perceive their organizations as cohesive, task oriented, and organized, and their coalition leaders as democratic, visible, and in control, yet supportive (Moos et al. 1974).

Recommended Recruitment Strategies

The best strategy for recruiting new coalition members is through direct invitations from friends. Coalition members can make a semiannual commitment to invite at least two other friends to join the coalition. Other recruitment strategies that have been used involve media campaigns with call-in telephone numbers for volunteers, letters to neighborhood residents, and requests for volunteers at coalition events, conferences, or training seminars.

Recruiting From Reluctant Constituencies

For a variety of reasons, members of ethnic minorities and lower income groups, young people, and older people frequently are underrepresented on coalitions. Nevertheless, each of these groups has a direct investment in the work of the coalition and important insights to contribute. The business of committees, agendas, and reports may be foreign to their experience and their interests as well. Remedying the absence of these groups is time consuming, and their membership is not assured. However, their involvement will produce important dividends to the coalition because their representation will help ensure the relevance of the programs to the whole

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community. They may be recruited through groups to which they already belong. Such groups provide an already-assembled audience and a channel of communication and improve the chances of recruiting several members from the same group, helping to overcome reluctance to join a group with whom they feel little in common. A concerted effort to identify and remove barriers to participation will be worthwhile. Transportation and the choice of a secure, accessible meeting site may be problems for members of these groups and need to be given careful attention as part of the recruitment process.

Coalition Member Training

Coalition members will value their participation and consider their time well spent if they feel they have made, or can make an effective contribution. Training will improve the likelihood of effective participation and will be seen by many participants as a reward in its own right. Every member's participation can begin with an orientation to the concept and local history of the coalition. Its mission, goals, structure, and membership can be described succinctly in a member handbook prepared for training purposes and should be reinforced in a short orientation program. Such a program can be repeated at regular intervals or whenever there are a sufficient number of new participants.

A process for training new members and helping integrate them effectively into existing teams also is necessary. It may be sufficient to assign each new member to a buddy, someone who has been with the organization long enough to know the rules, for support and encouragement. The senior member may take the responsibility for contacting the new member if he or she misses several meetings or take the initiative in solving transportation or other problems. Ongoing training sessions for all members of a working committee will provide an opportunity for new members to participate on an even footing.

Coalition Member Involvement

Successful involvement of coalition members almost always will depend on engaging them in tasks where their skills can be used effectively. Conduct an inventory of members' professional and nonprofessional skills and interests. A comprehensive checklist is usually the most effective way to obtain this information; and it can anticipate all the activities the coalition will undertake and the skills those activities will require. The resulting information can be compiled into a skills bank for use in organizing activities and events.

A means for reaching all coalition members will be important. For some coalition events, a telephone tree will be suitable. In a telephone tree, members routinely call several other members who, in turn, call several other members until all members are reached. Older volunteers may find a calling list enjoyable. Distinctive postcards are highly effective with a wide range of volunteers. A newsletter can be useful in keeping all members informed of the activities

of the coalition. The newsletter need not be long or elaborate, but the information in it should be accurate, substantial, and current. If the coalition has received outside recognition for its efforts, a newsletter is a good way to ensure that everyone knows.

Coalition Events

Coalition events typically serve the purposes of educating and motivating both inside and outside the coalition. Internally, events provide opportunities to share information in a relaxed setting, to allow members to become better acquainted with each other, and to recognize and celebrate both group and individual achievements. The events can provide an opportunity to invite nonmembers whose future participation or goodwill and support are desired. The most visible and public events will attract the interest of local print and broadcast media and provide an opportunity for favorable publicity. Recognition of achievements at even social events will effectively remind both members and nonmembers of the serious purposes of the coalition.

The mechanics of event planning may be familiar to some members of the coalition who may be willing to staff a core working group responsible for events. Given a suitable checklist, even an inexperienced member can perform these functions. Planning for coalition events should start with a clear understanding of the goals of the event and how they will be achieved. All other decisions can be tested against those goals. Simply producing an event is not an objective in itself. The type of event, its location, sponsorship, guests to be invited, and support (e.g., cash and in-kind donations, activities, music, food, and setup and cleanup) will all fall more easily into place if the goals are clear at the outset. Event organizers should avoid the pitfall of trying to perform all the subtasks themselves because they will run the risk of burnout. Their job can be to recruit community participation, including enlisting the help they need to obtain that participation.

Step 7. Choose an Organizational Structure

Effective drug abuse prevention requires a community effort. Professional efforts without community support can have little lasting effect. This resource manual has previously addressed the benefits of community involvement in assessing needs for substance abuse prevention and suggested the value of treating the community survey as a means of increasing community awareness of substance abuse problems and for preparing the community to participate actively in solving them. An important step in the community prevention effort is the selection of an organizational structure and leadership that will enhance the probability of the success of the prevention effort. Social and health services professionals often miss the importance of this phase, tending to focus more on the need for services to be delivered.

Determining the Type of Organizational Structure

There are many different types of organizational structures that have been used to implement substance abuse prevention efforts. In general, the structure and leadership of a prevention effort is determined primarily by the sponsoring organizations (Robert Wood Johnson Foundation Fighting Back Survey 1989), but other determinants include:

- Membership and leadership;
- Target population;
- Funding source requirements;
- Size of budget;
- Activities that funding can be spent on; and
- Readiness of volunteers to participate.

The various types of community prevention organizational structures fall into the four major categories described below (Wandersman and Florin 1990). This resource manual and the rest of this discussion focus on only one type of organizational structure—communitywide coalitions.

ORGANIZATIONAL STRUCTURES

- Volunteer neighborhood organizations (e.g., block associations, neighborhood councils, church groups, local merchant associations, and youth clubs);

- Human services coordinating structures (e.g., community partnerships, community coalitions, or interagency coordinating councils that comprise service delivery organizations and target substance abuse);

- Communitywide coalitions that comprise representatives of organizations from multiple sectors of the community (e.g., volunteer service agencies, government, business, religious institutions, schools); and

- Self-help or mutual aid groups (e.g., 12-step programs for substance abuse, such as Alcoholics Anonymous, Al-Anon for spouses and significant others of alcoholics, and Al-Ateen for children of alcoholics).

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Definition of Coalition Subunits

Within community coalitions often there are subunits, sometimes called committees, subcommittees, teams, or task forces, that are needed to share responsibility for different tasks of the organization. Subunits can be organized on the basis of:

- *Geography*, that is, communities of people living in close proximity, such as cities, towns, neighborhoods, or public housing areas; or

- *Affinity*, that is, communities of people with personal and working relationships, such as ethnic groups or business or religious organizations (Heller 1989). Community prevention efforts organized by affinity group may be:

  - *Institution-oriented organizations* in which subunits are created on the basis of institutional affiliation (e.g., schools, businesses, churches, and government); and/or

  - *Mission-oriented organizations* in which subunits are created on the basis of the type of issue or target population to be addressed (e.g., youth gangs, homelessness, perinatal addiction, families, and/or older people).

Leadership Type

Central to the issue of organizational structure is the question of who will take, and keep, the initiative. The initiators of a prevention effort may not be the best candidates to maintain the coalition. The leadership may need to change as the organization matures and primary activities and tasks change. Three types of leadership are common among community coalitions for substance abuse prevention as shown below.

Regardless of the type of leadership structure or size, a few core leaders tend to dominate activities (Roberts-DeGenaro 1986). However, the coalition resources and power must be allocated to maintain goodwill and smooth working relationships. If the proposed leadership structure supports a collaborative multiple leader approach with equal power among the major collaborating agencies, coalition members will need to determine who will be the fiscal agent for the organization and how power will be shared. The fiscal agent is the agency that will receive and manage the funds for the prevention project and, therefore, it will have the power to include or exclude coalition member agencies in the fiscal decisionmaking process. Therefore, development of rules supporting shared governance, possibly through memoranda of agreement, will help to promote equal responsibility and shared power. In the formative days of the coalition, members may want to experiment with different configurations of leadership to see which works best.

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TYPES OF LEADERSHIP

- A single prominent leader, for example, the executive director of the agency organizing the community prevention effort or the elected chair of a steering committee or executive committee;

- Multiple leaders, for example, a council (or other governing body) with members representing the primary organizations involved in the prevention effort who have equal votes and equal leadership responsibility; and

- Broad-based leadership, for example, a steering committee and/or an advisory committee as well as a director, program managers, and subcommittee chairs, with leadership shared across a number of management committees.

Leadership Style

Regardless of the type of organization and leadership structure chosen, the choice of a leader or leaders should be considered with care. The leadership type and the leader's style will set the tone for the organization in many significant ways. A leader's characteristics (e.g., personality, organizational ability, and willingness to delegate authority) are critical to positive outcomes. The strength and personal characteristics of coalition leaders are the most important factors in maintaining effective team efforts (Washnis 1976).

Leadership style is particularly critical in prevention organizations that rely heavily on volunteers. Volunteers are not bound by payment and if they feel their talents are not recognized and used effectively, they simply may leave the organization (Kumpfer et al. 1993). Coalitions that rely heavily on committed and charismatic leaders who are capable of mobilizing volunteers from many different segments of the community have been found to have the lowest leadership turnover of all substance abuse coalitions (Robert Wood Johnson Foundation 1989).

Leadership characteristics that are associated with the successful implementation and maintenance of community coalitions include those listed on the next page.

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LEADERSHIP CHARACTERISTICS

- An empowering style of leadership with the ability to promote equal status, encourage collaboration, and support and reward members' efforts (Yates 1973; Mayer and Blake 1981; Kumpfer et al. 1993);

- Decisionmaking skills and flexibility (Miller et al. 1979; Knoke and Wood 1981);

- A high level of networking and visibility of membership in key community organizations and easy access to media and other needed resources (Schoenberg and Rosenbaum 1980);

- Political effectiveness and high level of political knowledge (Yates 1973); and

- Personal competencies such as individual efficiency, high level of education, administrative skills, and interpersonal skills in negotiations, conflict resolution, and problemsolving skills (Butterfoss et al. 1993).

Opportunities for participation in decisionmaking and planning increase members' involvement and satisfaction with the coalition and contribute to increased commitment and outcome effectiveness (Giamartino and Wandersman 1983; Knoke and Wood 1981). From the standpoint of the coalition members, successful leaders:

- Are more visible and involved;

- Promote cohesion and involvement;

- Support members' planning and decisionmaking;

- Provide opportunities for active contributions outside of meetings;

- Are attentive and supportive of members' issues and concerns; and

- Are empowering and supportive of members' efforts.

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<u>Determining the Type of Organizational Model</u>

Before identifying the community leaders and organizational partners for a prevention effort, the initiators must determine the type of organizational model that is to be created. This will affect the balance of professional and nonprofessional persons, prospective partners, the defined community, the organization's scope of activities, and the guiding philosophy and vision for the prevention effort.

Three major types of community organizational models have been adopted by coalitions to address substance abuse and other health problems (Pentz 1986). The three models include:

- A *professional model* consisting primarily of paid professional staff members;

- A *grassroots or lay model* consisting primarily of volunteers and community organizers; and

- A *joint professionally supported community empowerment model* consisting of a balance of both paid professionals and volunteers.

Community attitudes will help determine which is the best model. Unfortunately, there are no research data supporting the success of any one model over the others. Some communities have a history of grassroots involvement whereas other communities expect professionals to conduct prevention activities. The type of community organization to be created will impact recruitment of members for the coalition. The composition and percentage of community members versus paid professionals may depend on a number of factors, but the following questions can help guide the decision about which model can be created and who can be invited to participate in the coalition.

- How broad an effort is really desired?

- Do concerned agencies desire a coalition of professionals to lead their efforts?

- Is this professional collaboration all that is desired?

- Is the coalition to be expanded by adding a community advisory element?

- Is the coalition to be a transitional step toward a community organization with professional advisors?

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- Is the ultimate goal a completely independent community organization?

- Will a professionally run coalition exist alongside another model?

Identifying and Selecting Potential Coalition Members

The composition of a prevention coalition may be approached by determining the groups and individuals in the community who have sufficient interest to make a lasting commitment to participating in the coalition, the kinds of resources they likely will commit, and how many of them likely will make a significant commitment to the effort. Many individuals and representatives of community organizations will find it awkward to say no or easy to say yes to requests to participate in an effort so clearly civic- and community-minded, but how many will follow through? Preliminary answers to these questions will tell the coalition initiators how broadly to cast their net in looking for potential coalition members.

A major reason for developing a collaborative community prevention effort is to increase the political will to act and mobilize manpower and fiscal resources. Therefore, each member will bring a different set of resources and skills to the coalition. Diversity enables the coalition to represent and reach a large constituency.

Criteria for Membership

There are three essential characteristics to consider in the determination of whom to invite to participate in the coalition:

- *Diversity*. Include a broad range of agencies and groups with an interest in the problem. The groups can represent a wide range of skills across diverse ethnic and cultural perspectives. Although different backgrounds can put additional stress on shared understandings and communication, diversity is essential to ensure that the cultural norms and realities of the community as a whole are represented adequately and appropriately.

- *Commitment*. The prospective members can manifest commitment to the shared coalition vision over their own vested interests.

- *Clout*. The members can represent their own organizations at a high enough level that they have the authority to act on behalf of and commit resources from their agencies.

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Frequent Partners in Community Coalitions

According to the Robert Wood Johnson Join Together Coalition surveys (Join Together 1993, pp. 1-32), typical members of substance abuse prevention coalitions include representatives from the following sectors of the community. The percentages of time the surveys found these agencies involved in community substance abuse prevention efforts are shown in parentheses.

- Schools (90 percent): Because schools are a major way to access youth with prevention strategies, it is essential to involve them. It is critical to involve the superintendent, principals, school board members, teachers, and PTAs.

- Law Enforcement (85 percent): The chief of police, local Drug Enforcement Administration (DEA) administrator, county sheriff, and highway patrol are important to include in the coalition.

- Alcohol and Drug Abuse Prevention Agencies (76 percent): The directors of the single State and county agencies for substance abuse will be important participants to invite to the coalition. These persons are likely to designate their prevention coordinators to attend coalition meetings. They also will have lists of all prevention providers they support in the local community.

- Parents (72 percent): A good source of parents who are likely to participate in the coalition can be those in parent organizations committed to substance abuse prevention, such as PTAs, Al-Anon, and general parent support groups.

- Volunteers (71 percent): Community volunteers can be sought through fraternities and sororities, civic action groups, and other groups dedicated to community service.

- Treatment Providers (70 percent): State and county substance abuse treatment agencies can provide lists of licensed alcohol and other drug treatment providers in the local community who can be tapped for participation in the coalition.

- Local Governments (67 percent): A governor, mayor, county commissioner, head of health and human services, and substance abuse prevention director can be invited to participate in the coalition. These key leaders may not participate directly but will recognize the coalition by designating a representative to attend coalition meetings.

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- Other groups: According to the Join Together (1993) surveys of coalition participants, the following groups are frequently represented in coalitions:

  — Youth (64 percent);

  — Private business (63 percent);

  — Government/human services (62 percent);

  — Courts/probation staff (61 percent);

  — Religious organizations (61 percent);

  — Government/health services (56 percent);

  — People in recovery (55 percent); and

  — Other concerned citizens (54 percent).

Infrequent Partners in Community Coalitions

According to the Join Together Coalition surveys (1993), labor organizations, the transportation industry, employment services, public assistance agencies, the alcohol and beverage control industry, and citizen action groups were members of fewer than 30 percent of substance abuse coalitions. Other groups represented in fewer than 50 percent of coalitions include:

- Private health and human services agencies;

- Universities;

- Mass media;

- Child protective service agencies;

- Recreation departments;

- Civic or fraternal organizations; and

- Housing organizations.

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<u>Locating Community Associations for Participation</u>

The more localized the definition of the target community, the more closely the community should look within itself for community partners and coalition participants. The organizations identified for possible participation in the coalition, both public and private, will be important channels through which to deliver drug abuse prevention messages and sources for coalition members as well as sources of workers when a job needs to be done. Community associations are identified in a variety of ways, as shown in the chart on the following page.

<u>Anticipating Problems</u>

Recruiting members for the coalition will take time. During this time, strategies should be developed for addressing potential problems and dealing with potential adversaries and turning them into allies. A major hazard to avoid in developing a coalition is not taking the time to involve key players who could easily undermine or stop efforts proposed by the coalition. Other problems relate to the following issues:

- Defining the relevant community;

- Identifying the target populations;

- Determining a shared vision; and

- Starting small.

Defining the Relevant Community

The community or communities to which prevention efforts will be directed must be clearly defined. As indicated earlier, a community can be defined by geographic location or affinity group. If the target community has been chosen on the basis of geographic location, it also will have an element of self-identification, that is, a sense of where we stop and they start. Every resident belongs to and participates in a several overlapping communities. However, the geographic element, corresponding to "our part of town," is likely to be the key determinant of the community to which the citizen belongs.

For example, in a small community, the entire town may be the appropriate unit of community. However, it should be remembered that too ambitious a definition of the target community can increase the difficulty of organizing a coalition and diminish the coalition's chance of having a significant impact.

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LOCATING COMMUNITY ASSOCIATIONS

- *Through lists of existing human services organizations.* Many large and some small municipalities maintain directories of social, health, or human services organizations. These directories are a good place to begin the process of developing a list of potential coalition members. Other sources for lists include reference desks in public libraries and chambers of commerce and telephone Yellow Pages listings of "Associations" and "Organizations."

- *Through inventories of local prevention program providers.* Surveys of community agencies that provide substance abuse prevention and/or treatment services can offer a compilation of information from the general knowledge of program staff. Asking staff members of the identified agencies also can result in the identification of other potential agencies. Respondents can be urged to err on the side of inclusiveness by identifying agencies that have *any* significant contact with at-risk populations.

- *Through newspapers.* Reviews of major and community newspapers may reveal news items and notices of meetings of organizations of interest to the coalition.

- *Through small community-action organizations.* Excursions into the community may reveal places where flyers are posted (e.g., supermarkets, laundromats, libraries, transit stops and neighborhood restaurants). Places where people frequently pass by or spend time in large groups are important sites where community-action organizations should post flyers.

- *Through popular meeting places.* Staff can be contacted in places where groups meet, such as churches, libraries, parks and recreational facilities, and meeting halls of fraternal and civic organizations. It is wise to talk to directors, managers, and/or secretaries in these places who can provide assistance in identifying relevant organizations for the coalition. Churches often sponsor or provide meeting space for substance-abuse-related groups and can be of particular assistance in the search.

- *Through contacts with local citizens.* It is wise to ask people in the community, for example, shop owners, beat police, or teachers in local schools, for help in identifying any organizations that have been omitted from the lists.

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Identifying the Target Populations

In addition to determining the communities within which to work, it is necessary to define the target populations. Will the coalition focus only on youth, or will it also address young adults, adults, and older people? The needs assessment data should help coalition organizers determine where to focus the prevention efforts.

Determining a Shared Vision

At the beginning of the community organizing process, it is important to develop a guiding philosophy that incorporates a shared vision that all agree upon. The initial organizers will find it easier to determine which agencies or partners to recruit if they determine the mission, the guiding philosophy, the unifying theme, and a shared vision of the coalition. These may seem like illusive ideas, but they are important in getting acceptance from potential coalition members.

The mission of most substance abuse prevention coalitions is to reduce substance abuse. Nevertheless, individuals may have different perceptions of the program's ultimate purpose unless it is made explicit and all have an opportunity to develop a sense of ownership. It is important to ensure that everyone shares the same vision, as well as a common philosophy about how to realize it. Do members agree that substance abuse is a problem and needs to be addressed? Do partners agree that collaborative efforts will be encouraged at all times in partnership projects? Once the loyalty of prevention coalition members is confirmed, use of unifying themes, slogans, short phrases, or statements can be used by the coalition to convey and reinforce the prevention message quickly. These slogans are developed locally and convey a message that all agree with and understand. Sometimes slogans are accompanied by a logo for the coalition and put on T-shirts and stationery.

Starting Small

There are significant advantages to starting small and learning lessons and skills that can be enlarged on later. Starting small does not mean that some elements of a larger community must be excluded from participating in the community coalition. Perhaps initially, if staff and other resources are limited, some segments of the community may be excluded. But there is no reason that two or more coalitions cannot ultimately exist side by side in a large city. Not all segments of the community within a given municipality will be equally ready and/or willing to mobilize to participate in a coalition. Therefore, it may be better to start with those who are ready and willing. A successful effort in one community segment will often generate a demand by another segment to be let in.

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Getting Started

The following discussion is intended to help guide a community through the process of organizing and convening the first community meeting to establish a drug abuse prevention coalition. This process is presented only for illustrative purposes and is not intended to be a model undertaken in all community contexts.

Creating an Organizing Committee

After all the preliminary work for a community substance abuse prevention initiative has been accomplished, the next step in the development of a community coalition will be the creation of an organizing committee, consisting of 15 to 20 members, to assume the responsibility for convening an organizing meeting and seeing that the community is broadly and appropriately represented. The organizing committee should comprise two kinds of people—highly visible leaders whose blessing will help ensure success and lower profile leaders or working-level organizers who will actively participate in the effort.

High-Profile Organizers

The participation of highly visible leaders will help lend credibility to the effort in the public's eyes and help improve cooperation within public agencies. The mayor, chief of police, county commissioner, superintendent of schools, and head of the chamber of commerce all fall into this category. Their signature on a letter or presence on the speakers' platform or at an event sends an important message. They probably will be represented at subsequent meetings by staff members whose program responsibilities are directly related to the purpose of the coalition.

Working-Level Organizers

Alcohol and drug abuse prevention agencies can be represented on the organizing committee by a senior official, although not necessarily the agency head. Parent organizations, a broad representation of religious organizations, and the media, business, and education communities all can have senior representatives. One or two independent citizen-activists with a demonstrated interest in substance abuse also should be included as well as other infrequent partners mentioned earlier.

Calling the First Organizing Meeting

With the organizing committee established, coalition initiators can choose a time, date, and meeting place on neutral territory that is readily accessible and has convenient parking. In choosing a hall or room, it should be remembered that only a fraction of those invited will attend;

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therefore, a standing-room-only turnout will convey a more satisfactory message to the community than the same number of people huddled halfway back in a large auditorium. Media can be invited to cover the event and given press packets that have been prepared with the input of the media advisory group. The steps listed in the chart on the next page may be helpful in preparing for the meeting.

Conducting the First Organizing Meeting

The general tone of the first meeting must be carefully designed because it will substantially affect the willingness of some agencies to become involved. A climate of collaboration, inclusion, and shared leadership is desirable. Following the chart listing steps for the first organizing meeting is a sample agenda of major points that can be addressed at this meeting. It is presented here merely as a guide for conducting the meeting. The particular items and their placement on a meeting agenda will be dictated by the needs, interests, and goals of the particular community. Therefore, these sample agenda items should not be considered as standard for all circumstances in which a community is organizing for a substance abuse prevention effort.

Some agenda items are of particular importance for all coalitions and therefore should be specifically addressed during the first organizing meeting. These items include:

- Introduction to the local problem;

- Stating the goal and objectives of the organizing meeting;

- Discussing whether collaboration will work;

- Creating an organizational structure;

- Enlistment and survey of volunteers; and

- Celebrating

Introduction to the Local Problem

A short summary of the results of the needs assessment, including a survey of key leaders and community attitudes, can be presented at the beginning of the meeting. Workers who participated in the data collection for the needs assessment can be acknowledged and the community members who participated in the surveys thanked. If it is available, a short video of the local problem can be interesting and stimulate motivation to participate.

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FIRST ORGANIZING MEETING

- *Letter of invitation.* Formal letters of invitation to the first organizing meeting can be sent to the heads of all the identified groups. The purpose of the meeting, as well as an agenda and details about the date, time, and place should be included. Invitations sent by first class mail will be given more attention than those sent by bulk mail. A reply can be requested, and if possible, the reply can be directed to the office of the highest profile official involved, ideally the mayor but *not* the chief of police so as to avoid the appearance that the proposed prevention effort is primarily a law enforcement issue. The RSVP will increase the seriousness with which the invitation is taken. Although not all who RSVP will attend, and many will attend who do not RSVP, the results will help predict attendance.

- *Community publicity.* Conduct an issue awareness campaign to draw attention to the organization meeting. The broadcast message is that everyone is invited to attend. Radio and television public service announcements, news releases, broadcast media coverage stressing the broad base of sponsorship and notices and articles in community, church, and other organization newsletters will be helpful. The broadest possible participation can be the goal to avoid to the extent possible any appearance or charge of exclusivity. Inclusion of all identifiable ethnic groups is particularly important.

- *Selecting a chairperson for the organizing meeting.* A successful organizing meeting requires a careful balance of structure and spontaneity, of expectation and openness. Above all, it requires a chairperson who is widely respected and also experienced and forceful in the conduct of a public meeting. The chairperson will need to conduct the meeting with openness but also with a determination to move to a productive conclusion within a reasonable time limit. Efficient conduct of the meeting will ensure its productive conclusion. In the likely event the meeting will be held in the evening, ensure that film footage shot during the meeting will be available for the local evening newscast. It may be desirable to identify a chairperson who will *not* have a continuing role in the coalition and therefore more likely will be seen as fair and impartial.

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AGENDA FOR FIRST MEETING

A.   Welcome: Meeting Chairperson and Community Leader (Mayor, Councilperson, et cetera)

B.   Introduction of Organizing Committee Members

C.   Introduction to the Problem

D.   Statement of Goals and Objectives of the Coalition

E.   Discussion: Pros and Cons of Collaboration

F.   Discussion: Possible Organizational Structure

G.   Election of Coalition Officers

H.   Survey of Volunteer Assets

I.   Task Assignments for Next Meeting

J.   Time and Location of Next Meeting

Stating the Goal and Objectives of the Organizing Meeting

The goal and objectives of the organizing meeting should be stated clearly at the outset because they will provide a standard for addressing future issues raised at subsequent meetings. The chairperson can broach the question of whether the problem of substance abuse in the community requires a broad community effort and set an explicit time limit for individual speakers for this phase of the meeting. Participation in this stage of the discussion often will give an indication of the balance between residents and professionals that is likely to emerge in the coalition effort.

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Discussing Whether Collaboration Will Work

Participants can discuss their willingness to work together. The expectations of the major organizational partners must be specified. Preparation for this type of commitment can be made before the meeting by identifying individuals who will agree to make commitments on behalf of their respective organizations at the meeting. The benefits as well as the costs of collaboration can be candidly addressed.

Creating an Organizational Structure

If consensus is to reached to create a community coalition, then, depending on the size of the group, its diversity, and the apparent degree of consensus, it may be appropriate to conclude the meeting with the creation of a governing body, for example, a council of 12 to 15 members. Nominations can be made from the floor and the specific expectations and responsibilities of the council clearly explained that informed nominations can be made. If the number of nominations is large, the simplest election is one in which each person present votes for one name, and the 12 or 15 who receive the largest number of votes are declared elected.

The council can be charged with creating the coalition organization (e.g., a steering committee, executive committee or advisory committees, and subcommittees) and electing a chairperson. Subcommittees can be established to address areas such as needs assessment, communications, strategic planning, programs, and evaluation. If the meeting has gone smoothly, a high degree of consensus is apparent, and if time allows, establishing subcommittees may be done at the organizing meeting. The decision on how and when to organize can be made by the council. The newly elected council members can come forward and take seats in the front of the room so that they are clearly identified.

Enlistment and Survey of Volunteers

Before concluding the meeting, the chairperson can stress the role of the council as that of representing the much larger group of interested individuals and organizations. All attendees can be urged to complete a simple survey of their specific areas of interest in drug abuse prevention and their ability to participate in the work of the coalition and its working groups. The survey forms might include questions about the volunteers' interests in serving on either institution-oriented working groups (e.g., schools, businesses, or churches) or problem-oriented working groups (e.g., youth gangs, pregnant teens, or addicted mothers). A comprehensive survey of volunteer assets can be accomplished through use of a capacity inventory such as that found in *Building Communities From the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets* (Kretzmann and McKnight 1993), which can be ordered from local bookstores. No

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one should leave the organizing meeting feeling that their opinions or contributions are unwanted or unwelcome.

Celebrations

At the end of the first meeting, a celebration can be held and open to all attendees. In some communities, having food and entertainment is a must for almost all community gatherings and creates an atmosphere of friendship, cooperation, and fun. To reflect on progress and reward participants in the early organizing work, some coalitions have taken slides or videos of the volunteers working on the needs assessments, in planning meetings, mailing out the invitations, and other activities and shown them at the celebration. These visuals help acknowledge and reward all the volunteers who have participated in the beginning effort.

Evaluation of Coalition Activities

Finally, an important aspect in the development and maintenance of communitywide prevention efforts and for increasing the effectiveness of the coalition is evaluation. In this context, evaluation refers to the systematic and objective measurement of the process through which the coalition develops as an organization and the outcomes it achieves toward substance abuse prevention. According to Goodman and Wandersman (1994), objective evaluation of all aspects of the prevention effort:

- Is an ongoing and dynamic process;

- Is a collaborative process;

- Keeps coalition expectations simple, realistic and measurable;

- Guides ongoing coalition development; and

- Measures both the processes and outcomes of the coalitions efforts.

Regardless of the specific evaluation methodology used, planning for evaluation can be incorporated into the structure and activities of the coalition from the beginning of the initiative. Professional evaluators also can help the coalition define its goals and objectives in ways that can be measured, support the development of logic models and program plans, advise on the success of prior prevention programs, and provide valuable feedback about the impact of the prevention programs.

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NIDA has produced an RDA package on program evaluation, *How Good is Your Drug Treatment Program?*, that can be useful for community coalitions seeking to evaluate their prevention efforts. Although this program evaluation package was developed for drug abuse treatment programs, it contains important information about evaluation purposes and strategies that also applies to prevention programs. Evaluation guides that focus on prevention programs include *The Handbook for Evaluating Drug and Alcohol Prevention Programs: Staff/Team Evaluation of Prevention Programs (STEPP)* and *Cultural Competence for Evaluators: A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working with Ethnic/Racial Communities.* For information on obtaining these materials, see appendix A.

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SUMMARY AND CONCLUSIONS

The purpose of this resource manual is to present the concept of community readiness for drug abuse prevention programming, describe factors associated with readiness to implement a prevention effort, and suggest strategies or steps communities can take to improve their readiness by strengthening factors that are weak. This manual is intended for use by prevention practitioners, including program administrators, prevention specialists, community volunteers, parents, teachers, businesses, and other groups and individuals concerned about the problems of drug abuse and its prevention. The primary objectives of this resource manual are to provide guidance in the application of the strategies to increase community readiness and motivate members of the target audience to consider community readiness issues in their planning for community prevention efforts. Appendix B provides a detailed case study that illustrates how a community coalition can assess factors associated with readiness and develop strategies for strengthening areas of deficiency and improve readiness.

This resource manual along with the other documents in this NIDA RDA set of materials, is intended to be a guide to help communities address their substance abuse problems through communitywide efforts of professionals, non-professionals, community agencies, and organizations that are committed to prevention. In addition to a presentation of the key factors for assessing and improving community readiness, this manual provides the rationale and step-by-step guidance for the development of a community prevention coalition that can serve as the focal point for the development and maintenance of community prevention activities.

The information provided in this resource manual is extensive, but it is by no means exhaustive. As communities progress in their efforts to implement communitywide substance abuse prevention programs, they undoubtedly will face more questions and challenges. Therefore, it is the intention of NIDA, through this document, to provide a source of guidance and support for communities to assess and increase their readiness for the task that they undertake. Communities that are the most ready for and committed to drug abuse prevention will be those most likely to succeed in their implementation efforts. Although the journey will not always be easy, the ultimate destination to be achieved surely will be worth the trip.

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APPENDIX A: RESOURCES

CONTACTS AND RESOURCES: RESEARCH-BASED PREVENTION MODELS FOR DRUG ABUSE

The following substance abuse prevention program models are highlighted in the *Drug Abuse Prevention RDA* set of materials. The name and address of the principal investigator conducting the research for each model is provided, followed by information on the availability of training manuals, formal training services, consultation, and technical assistance.

Project STAR, a communitywide prevention program:

Mary Ann Pentz, Ph.D.
Department of Preventive Medicine
University of Southern California
1540 Alcazar Avenue, Suite 207
Los Angeles, CA 90033
Phone: (213) 342-2582
Fax: (714) 494-7771

Manuals, training, and technical assistance services are available from the research group at the University of Southern California, as follows:

- School component—teacher and peer leader training, manuals, and parent-child workbook;
- Parent component—parent and school principal training, manuals, and parent-child workbook;
- Community organization component—training;
- Policy component—training;
- Media component—training; and
- Evaluation—evaluation instruments, services, and data collection training tape.

Training costs are $150 to $250 per person per day, from a minimum of $1,500 up to a maximum of $2,500 per day, depending on the nature of the presentation. Technical assistance costs are negotiated on a case-by-case basis. Further information about materials, training, or technical assistance also can be obtained by contacting:

Project I-STAR
5559 West 73rd Street
Indianapolis, IN 46268
Phone: (317) 291-6844

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Strengthening Families, a family-focused prevention program for children of substance-abusing parents:

    Karol L. Kumpfer, Ph.D.
    Department of Health Education
    HPERN-215
    University of Utah
    Salt Lake City, UT 84112
    Phone: (801) 581-7718
    Fax: (801) 581-5872

Manuals, training, and evaluation services and instruments are available from the program developers, evaluators, or implementors by contacting Dr. Kumpfer. A 3-day training costs $2,000 plus travel for a group of up to 16 participants.

Costs for program materials are:

Family Training Therapist Manual	$ 25
Parents' Skills Training Manual	25
Parent Handbook	25
Children's Skills Training Manual	25
Children's Handbook (6 to 12 years)	25
Implementation Manual	25
Evaluation Package	25
7-Manual Package Total:	$175
African-American Parent Handbook	25
8-Manual Package Total:	$200

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Reconnecting Youth, a school-based prevention program for at-risk youth:

Leona L. Eggert, Ph.D., R.N.
Psychosocial and Community Health Department
P.O. Box 357263
University of Washington
Seattle, WA 98195
Phone: (206) 543-9455 or 543-6960
Fax: (206) 685-9551
e-mail: eggert@u.washington.edu

Consultation and technical assistance are available by contacting Dr. Eggert. Materials and training are also available. Program awareness can be gained in a day. Full-scale training requires 3 to 5 days and is limited to small groups. Prices for the training vary depending on the number of people to be trained. Rates are structured on an honorarium-plus-expenses basis. A curriculum and leaders' guide, *Reconnecting Youth: A Peer Group Approach to Building Life Skills*, is available for $139. For materials and training, contact:

Susan Dunker or Peter Brooks
National Educational Service
1252 Loesch Road
P.O. Box 8,
Bloomington, IN 47402-0008
Phone: (812) 336-7700
Toll Free: (800) 733-6786
Fax: (812) 336-7790

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CONTACTS AND RESOURCES: COMMUNITY READINESS FOR DRUG ABUSE PREVENTION

Eugene R. Oetting, Ph.D.
Scientific Director
Barbara Plested,
Research Associate
Tri-Ethnic Center for Prevention Research
Colorado State University
C79 Clark Building
Fort Collins, CO 80523
Phone: (800) 835-8091
Fax: (970) 491-0527

Abraham Wandersman, Ph.D.
Professor
Department of Psychology
University of South Carolina
Columbia, SC 29208
Phone: (803) 777-7671
Fax: (803) 777-0558

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SOURCES OF INFORMATION ON COMMUNITY COALITIONS

The Anti-Drug Abuse Act of 1988 provided congressional authorization and funding for the Center for Substance Abuse Prevention (CSAP) to create more than 250 community partnerships nationwide (Davis 1991). Additional community substance abuse prevention coalitions and community action groups have been implemented by:

- State and local governments, for example, Rhode Island (Florin et al. 1992b) and Oregon (Hawkins et al. 1992);

- National foundations, for example, Henry J. Kaiser Family Foundation (Tarlov et al. 1987) and Robert Wood Johnson Foundation Fighting Back and Join Together coalitions (Robert Wood Johnson Foundation 1989);

- Federal Public Health Service agencies, for example, the National Cancer Institute's COMMIT and ASSIST tobacco and cancer reduction programs (Best et al. 1988; Shopland 1989), the Planned Approach to Community Health (PATCH) health promotion program of the U.S. Centers for Disease Control and Prevention (Kreuter 1992), and the Weed and Seed Program of the Bureau of Justice Assistance; and

- Schools and universities, for example, the university coalitions sponsored by the Department of Education/Fund for the Improvement of Post-Secondary Education (DOE/FIPSE) and local school boards.

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POTENTIAL FUNDING SOURCES

Federal Grants

Most Federal substance abuse funding is provided as either demonstration and evaluation grants or prevention research grants. These funding mechanisms require evaluations and data collection processes to determine the effectiveness of the programs. These are *not* service grants (See list of Federal Government agencies).

Potential Federal funding sources for *demonstration grants* include:

* Center for Substance Abuse Prevention (CSAP);

* Center for Substance Abuse Treatment (CSAT);

* Office of Juvenile Justice Delinquency Prevention (OJJDP);

* Bureau of Justice Assistance (BJA);

* U.S. Department of Housing and Urban Development (HUD); and

Potential Federal funding sources for *research grants* include:

* National Institute on Drug Abuse (NIDA);

* National Institute on Alcohol Abuse and Alcoholism (NIAAA); and

* National Institute of Mental Health (NIMH).

Other Grants

Service grants are available through individual State block grant mechanisms or through local county funding sources.

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FEDERAL GOVERNMENT AGENCIES

Bureau of Justice Assistance (BJA)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 20531
Phone: (202) 514-6278

Implements national and multistate programs, offers training and technical assistance, establishes demonstration programs, and conducts research to reduce crime, enforce drug laws, and improve the functioning of the criminal justice system. Offers the following information clearinghouse:

Bureau of Justice Assistance Clearinghouse (BJAC): (800) 688-4252

Bureau of Justice Statistics (BJS)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 29531
Phone: (202) 307-0765

Focuses on drugs and crime data and covers law enforcement and crime rates. Offers the following information clearinghouses:

BJS Automated Information System
National Criminal Justice Reference Service (NCJRS)
Box 6000
Rockville, MD 20849-6000
Phone: (202) 307-6100

Offers drug- and crime-related information and materials. Fax-on-demand and Internet services also available.

BJS Clearinghouse
National Criminal Justice Reference Service (NCJRS)
Box 6000
Rockville, MD 20849-6000
Phone: (202) 307-6100

Distributes drug- and crime-related publications.

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Center for Substance Abuse Prevention (CSAP)
U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Rockwall II, 5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-0365

Focuses attention and funding on the prevention of substance abuse. Offers the following hotline:

Drug-Free Workplace Helpline (DFWH): (800) 843-4971

Center for Substance Abuse Treatment (CSAT)
U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Rockwall II, 5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-5052

Focuses attention and funding on the development and assessment of treatment techniques and models. Offers the following hotline:

CSAT's National Drug Information and Treatment Referral Hotline: (800) 662-4357

Centers for Disease Control and Prevention
U.S. Department of Health and Human Services
1600 Clifton Road, N.E.
Atlanta, GA 30333
Phone: (404) 639-3311 or 3534

Researches and develops cures for diseases worldwide. Offers the following information clearinghouse:

CDC National AIDS Clearinghouse
P.O. Box 6003
Rockville, MD 20849-6003
Phone: (800) 458-5231

Offers information on AIDS-related resources and services. Publications are also available on substance abuse issues related to HIV.

Crime Prevention and Security Division
U.S. Department of Housing and Urban Development
451 Seventh Street, S.W.
Washington, DC 20410
Phone: (202) 708-1197

Awards drug elimination grants each year. Offers the following information clearinghouse:

> Drug Information and Strategies Clearinghouse
> P.O. Box 6424
> Rockville, MD 20849
> Phone: (800) 578-3472

> Distributes materials on substance abuse prevention in public housing.

U.S. Department of Housing and Urban Development (HUD)
451 Seventh Street, S.W.
Washington, DC 20410
Phone: (202) 708-0685

Focuses on all aspects of housing. Community programs target at-risk youth and work to improve neighborhoods.

Fund for the Improvement of Post-Secondary Education (FIPSE)
U.S. Department of Education
Seventh and D Streets, S.W.
Room 3100
Washington, DC 20202-5175
Phone: (202) 708-5750

Funds drug and violence prevention programs aimed at students enrolled in institutions of higher education. Program encourages colleges and universities to develop programs to prevent alcohol and other drug use for their students and staff.

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U.S. Government Printing Office (GPO)
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954
Phone: (202) 783-3238
Fax: (202) 512-2250

Publishes and makes available numerous publications on many topics, including substance abuse. Many publications are available free of charge.

National Clearinghouse on Child Abuse and Neglect (NCCAN) Information
P.O. Box 1182
Washington, DC 20013-1182
Phone: (703) 385-7565
Phone: (800) 394-3366

Serves as a major resource center for the acquisition and dissemination of child abuse and neglect materials; free publications catalog on request.

National Clearinghouse for Alcohol and Drug Information (NCADI)
P.O. Box 2345
Rockville, MD 20847-2345
Phone: (800) 729-6686
TDD: (800) 487-4889

Houses and catalogs numerous publications on all aspects of substance abuse. Provides computerized literature searches and copies of publications, many free of charge.

National Institute of Justice (NIJ)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 20531
Phone: (202) 307-2942

Conducts research and sponsors the development of programs to prevent and reduce crime and improve the criminal justice system.

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National Institute of Mental Health (NIMH)
U.S. Department of Health and Human Services
5600 Fishers Lane
Room 7C-02
Rockville, MD 20854
Phone: (301) 443-4513

Focuses on research in mental health and related issues.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)
U.S. Department of Health and Human Services
National Institutes of Health
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-3860

Focuses attention and funding on research on alcohol abuse and alcoholism and their treatment.

National Institute on Drug Abuse (NIDA)
U.S. Department of Health and Human Services
National Institutes of Health
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-6245

Contacts: William J. Bukoski, Ph.D.
              Chief, Prevention Research Branch
              Division of Epidemiology and Prevention Research
              Room 9A-53
              Phone: (301) 443-1514

              Susan L. David, M.P.H.
              Coordinator, Epidemiology and Prevention Research
              Division of Epidemiology and Prevention Research
              Room 9A-53
              Phone: (301) 443-6543

Focuses attention and funding on research on substance abuse and its treatment and on the dissemination and application of this research.

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National Technical Information Service (NTIS)
Order Desk
5285 Port Royal Road
Springfield, VA 22161
Phone: (703) 487-4650
Fax: (703) 321-8547
Fax Receipt Verification: (703) 487-4679
RUSH Service: (800) 553-NTIS (additional fee)

Makes available numerous publications on many topics, including substance abuse.

Office of Justice Programs (OJP)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 20531
Phone: (202) 307-5933

Operates many programs to prevent and treat substance abuse-related crime.

Office of Juvenile Justice Delinquency Prevention (OJJDP)
U.S. Department of Justice
633 Indiana Avenue, N.W.
Washington, DC 20531
Phone: (202) 307-5911

Focuses on program development and research to prevent and treat delinquency in at-risk youth. Offers the following information clearinghouse:

Juvenile Justice Clearinghouse
National Criminal Justice Reference Service (NCJRS)
Box 6000
Rockville, MD 20849-6000
Phone: (800) 638-8736

Provides publications on juvenile crime and drug-related issues.

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Office of National Drug Control Policy (ONDCP)
Executive Office of the President
Washington, DC 20500
Phone: (202) 467-9800

Is responsible for national drug control strategy; sets priorities for criminal justice, drug treatment, education, community action, and research. Offers the following information clearinghouse:

> Drugs and Crime Clearinghouse
> 160 Research Boulevard
> Rockville, MD 20850
> Phone: (800) 666-3332

> Distributes statistics and drug-related crime information.

Safe Drug-Free School Program
U.S. Department of Education
600 Independence Avenue, S.W.
Washington, DC 20202
Phone: (202) 260-3954

Funds drug and violence prevention programs that target school-age children. Training and publications are also available.

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OTHER PREVENTION PROGRAMS AND ORGANIZATIONS

The following list of programs, organizations, and hotlines is provided for the reader seeking additional resources. Inclusion on this list should not be construed as an endorsement by NIDA.

Community Anti-Drug Coalition of America (CADCA)
901 North Pitt Street
Suite 300
Alexandria, VA 22314
Phone: (703) 706-0560
Fax: (703) 706-0565

A membership organization for community alcohol and other drug prevention coalitions, with a current membership of more than 3,500 coalition members. Provides training and technical assistance and publications and advocacy services and hosts a National Leadership Forum annually.

Narcotics Education
6830 Laurel Street, N.W.
Washington, DC 20012
Phone: (202) 722-6740
Phone: (800) 548-8700

Publishes pamphlets, books, teaching aids, posters, audiovisual aids, and prevention materials designed for classroom use on narcotics and other substance abuse.

National Center for the Advancement of Prevention
11140 Rockville Pike
Suite 600
Rockville, MD 20852
Phone: (301) 984-6500

Produces documents on a variety of prevention and community mobilization and readiness topics.

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National Families in Action
2296 Henderson Mill Road, Suite 300
Atlanta, GA 30345
Phone: (404) 934-6364

Maintains a drug information center with more than 200,000 documents; publishes *Drug Abuse Update*, a quarterly journal containing abstracts of articles published in journals, academic articles, and newspapers on drug abuse and other drug issues.

Parents Resource Institute for Drug Education, Inc. (PRIDE)
3610 Dekalb Technology Parkway, Suite 105
Atlanta, GA 30303
Phone: (770) 458-9900
Phone: (800) 241-9746

Offers drug prevention consultant services to parent groups, school personnel, and youth groups. In addition, provides drug prevention technical assistance services, materials, and audio and visual aids.

Partnership for a Drug-Free America
405 Lexington Avenue
16th Floor
New York, NY 10174
Phone: (212) 922-1560

Conducts advertising and media campaigns to promote awareness of substance abuse issues.

Prevention First Inc.
2800 Montvale Drive
Springfield, IL 62704
Phone: (312) 793-7353

Produces a variety of print and audiovisual products on various prevention topics.

TARGET
National Northwest Federation of State High School Associations
11724 Plaza Circle
P.O. Box 20626
Kansas City, MO 64195
Phone: (816) 464-5400

Offers workshops, training seminars, and an information bank on substance use and prevention.

Toughlove International
P.O. Box 1069
Doylestown, PA 18901
Phone: (215) 348-7090
Phone: (800) 333-1069

National self-help group for parents, children, and communities, emphasizing cooperation, personal initiative, avoidance of blame, and action. Publishes a newsletter, brochures, and books. Holds workshops.

Hotlines

Al-Anon Family Group Headquarters
Phone: (800) 356-9996

Provides printed materials specifically aimed at helping families dealing with the problems of alcoholism. Available 9 a.m. to 4:30 p.m. EST.

Alcohol and Drug Hotline
Phone: (800) 821-4357
Phone: (801) 272-4357 in Utah

Provides referrals to local facilities where adolescents and adults can seek help. Operates 24 hours.

Child Help USA
Phone: (800) 422-4453

Provides crisis intervention and professional counseling on child abuse. Gives referrals to local social services groups offering counseling on child abuse. Operates 24 hours.

Covenant House Nineline
Phone: (800) 999-9999

Crisis line for youth, teens, and families. Locally based referrals throughout the United States. Help for youth and parents regarding drugs, abuse, homelessness, runaway children, and message relays. Operates 24 hours.

Depression, Awareness, Referral and Treatment (D/ART)
Phone: (800) 421-4211

Provides free brochures about the symptoms of depression, its debilitating effects on society, and information about where to get effective treatment. Operated by the National Institute on Mental Health. Operates 24 hours.

Grief Recovery Institute
Phone: (800) 445-4808

Provides counseling services on coping with loss. Available 9 a.m. to 5 p.m. PST.

National Mental Health Association (NMHA)
Phone: (800) 969-6642

Provides a recorded message for callers to request a pamphlet that includes general information about the organization, mental health, and warning signs of illness. Available 9 a.m. to 5 p.m. EST.

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GENERAL PUBLICATIONS ON PREVENTION

The following publications are available from:

Join Together
441 Stuart Street, 6th Floor
Boston, MA 02116
Phone: (617) 437-1500
e-mail: jointogether.org

Alcohol and Drug Abuse in America: Policies for Prevention, 1995.
Recommendations on how communities can prevent alcohol and drug abuse.

Community Action Guide to Policies for Prevention, 1995.
Steps communities can take to strengthen prevention efforts.

How Do We Know We Are Making A Difference? 1996.
Eighty-six page substance abuse indicator's handbook to help communities assess substance abuse problems.

Substance Abuse Strategies in America's 20 Largest Cities, 1996.
Efforts against alcohol and drugs in 20 cities in the United States.

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GOVERNMENT PUBLICATIONS

National Institute on Drug Abuse
Research Dissemination and Application Packages (NIDA RDA Packages)

NIDA RDA packages are available from the National Clearinghouse for Alcohol and Drug Information (NCADI), the National Technical Information Service (NTIS), and/or the U.S. Government Printing Office (GPO). (See list of Federal Government agencies.) NCADI, NTIS, and GPO publication numbers and costs are listed for each RDA package.

Drug Abuse Prevention Package (4 publications), NCADI Order No. PREVPK

This package is designed to help prevention practitioners plan and implement more effective prevention programs based on evidence from research about what works. The core package should be ordered and read first because it provides the information needed to prepare communities for prevention programming. Three stand-alone resource manuals then can be ordered. These manuals each provide information and guidance on implementing a specific prevention strategy introduced in the core package. The core package is available free of charge from NCADI (Order No. PREVPK) while supplies last.

- *Brochure*
- *Drug Abuse Prevention: What Works*
- *Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools*
- *Drug Abuse Prevention and Community Readiness Training Facilitator's Manual*

Drug Abuse Prevention Resource Manuals

These manuals are available free of charge from NCADI while supplies last.

- *Drug Abuse Prevention for the General Population*, NCADI Order No. BKD200

- *Drug Abuse Prevention for At-Risk Groups*, NCADI Order No. BKD201

- *Drug Abuse Prevention for At-Risk Individuals*, NCADI Order No. BKD202

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How Good Is Your Drug Abuse Treatment Program Package (4 publications)

This package deals with treatment program evaluation; however, much of it is applicable to drug abuse prevention programming.

- NTIS #PB95-167268/BDL: $44.00 (domestic) + postage; $88.00 (foreign) + postage

- GPO #017-024-01554-7: $33.00 (foreign rate add 25-percent surcharge for special handling. If by airmail, an additional cost is added.)

Working With Families To Support Recovery Package (4 publications), NCADI Order No. FAMILYPK

This package is designed to disseminate research-based family therapy treatment approaches to the drug abuse field. It is available free of charge from NCADI while supplies last.

National Institute on Drug Abuse
Clinical Reports (NIDA Clinical Reports)

All NIDA Clinical Reports are available from NCADI. (See list of Federal Government agencies.) NCADI publication numbers are listed for each clinical report.

Family Dynamics and Interventions, NCADI Order No. BKD147

Mental Health Assessment and Diagnosis of Substance Abusers, NCADI Order No. BKD 148

National Institute on Drug Abuse
Research Monographs

All NIDA Research Monographs are available from NCADI. (See list of Federal Government agencies.) NCADI order numbers are listed for each research monograph.

Drugs and Violence: Causes, Correlates, and Consequences. NIDA Research Monograph 103, NCADI Order No. M103

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Drug Abuse Prevention Intervention Research: Methodological Issues. NIDA Research Monograph 107, NCADI Order No. M107

Methodological Issues in Epidemiological, Prevention, and Treatment Research on Drug-Exposed Women and Their Children. NIDA Research Monograph 117, NCADI Order No. M117

Advances in Data Analysis for Prevention Intervention Research. NIDA Research Monograph 142, NCADI Order No. M142

Adolescent Drug Abuse: Clinical Assessment and Therapeutic Interventions. NIDA Research Monograph 156, NCADI Order No. M156

National Institute on Drug Abuse
Videotapes for Prevention Practitioners

These videotapes are available from NCADI. (See list of Federal Government agencies.) Order numbers are provided for each tape.

Coming Together on Prevention, 1994, 27 minutes, NCADI Order No. VHS66, $8.50

Dual Diagnosis, 1993, NCADI Order No. VHS58, $8.50

Adolescent Treatment Approaches, 1991, NCADI Order No. VHS40, $8.50

National Institute on Drug Abuse
Other Publications

There are various other NIDA publications and products on various prevention and other related topics, some of which are listed below. For a full list, contact NCADI for a catalog. (See list of Federal Government agencies.) In addition, future products related to prevention will be announced through flyers and the *NIDA Notes* newsletter. Readers with access to computers can find out about new materials by calling up NIDA on its World Wide Web homepage at *http://www.nida.nih.gov/*

Drug Use Among Racial/Ethnic Minorities, NCADI Order No. BKD180

Monitoring the Future Survey—Prevalence of Various Drugs for 8th, 10th, and 12th Graders, 1996, NCADI Order No. BKD213

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Center for Substance Abuse Prevention (CSAP)
Publications

CSAP has a wide range of prevention products addressing various prevention topics and targeted populations. These products include resource guides, manuals, pamphlets, posters, videotapes, and data reports. Target populations include educators, community leaders, families, health professionals, and youth. Publications are also available in Spanish. CSAP products are available from NCADI. (See list of Federal Government agencies.) For a full list, contact NCADI for a catalog. Publications cited in this *Drug Abuse Prevention RDA package* are given below. NCADI publication numbers are listed for each publication.

Communicating About Alcohol and Other Drugs: Strategies for Reaching Populations at Risk. CSAP Prevention Monograph 5. Rockville, MD: NCADI Pub. No. BK170, 1993

Conducting Focus Groups With Young Children Requires Special Consideration and Techniques. CSAT Technical Assistance Bulletin. Rockville, MD: NCADI Pub. No. MS501, 1991 (Reprint 1994)

Cultural Competence for ·Evaluators: A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working With Ethnic/Racial Communities. Center for Substance Abuse Prevention. DHHS Pub. No. (ADM)92-1884A. Rockville, MD, 1992

Handbook for Evaluating Drug and Alcohol Prevention Programs: Staff/Team Evaluation of Prevention Programs (STEPP). U.S. Department of Health and Human Services. DHHS Pub. No. (ADM)87-1512, Rockville, MD, 1987

Measurements in Prevention: A Manual on Selecting and Using Instruments To Evaluate Prevention Programs. CSAP Technical Assistance Report 8. Rockville, MD: NCADI Pub. No. BK213, 1993

Prevention Plus II: Tools for Creating and Sustaining a Drug-Free Community, Rockville, MD: NCADI Pub. No. BK159, 1991

Prevention Plus III: Assessing Alcohol and Other Drug Prevention Programs at the School and Community Level. Rockville, MD: NCADI Pub. No. BK18, 1991

Prevention Primer: An Encyclopedia of Alcohol, Tobacco, and Other Drug Prevention Terms. Rockville, MD: NCADI Pub. No. PHD627, 1994

You Can Manage Focus Groups Effectively for Maximum Impact. CSAP Technical Assistance Bulletin. Rockville, MD: NCADI Pub. No. MS495, 1991 (Reprint 1994)

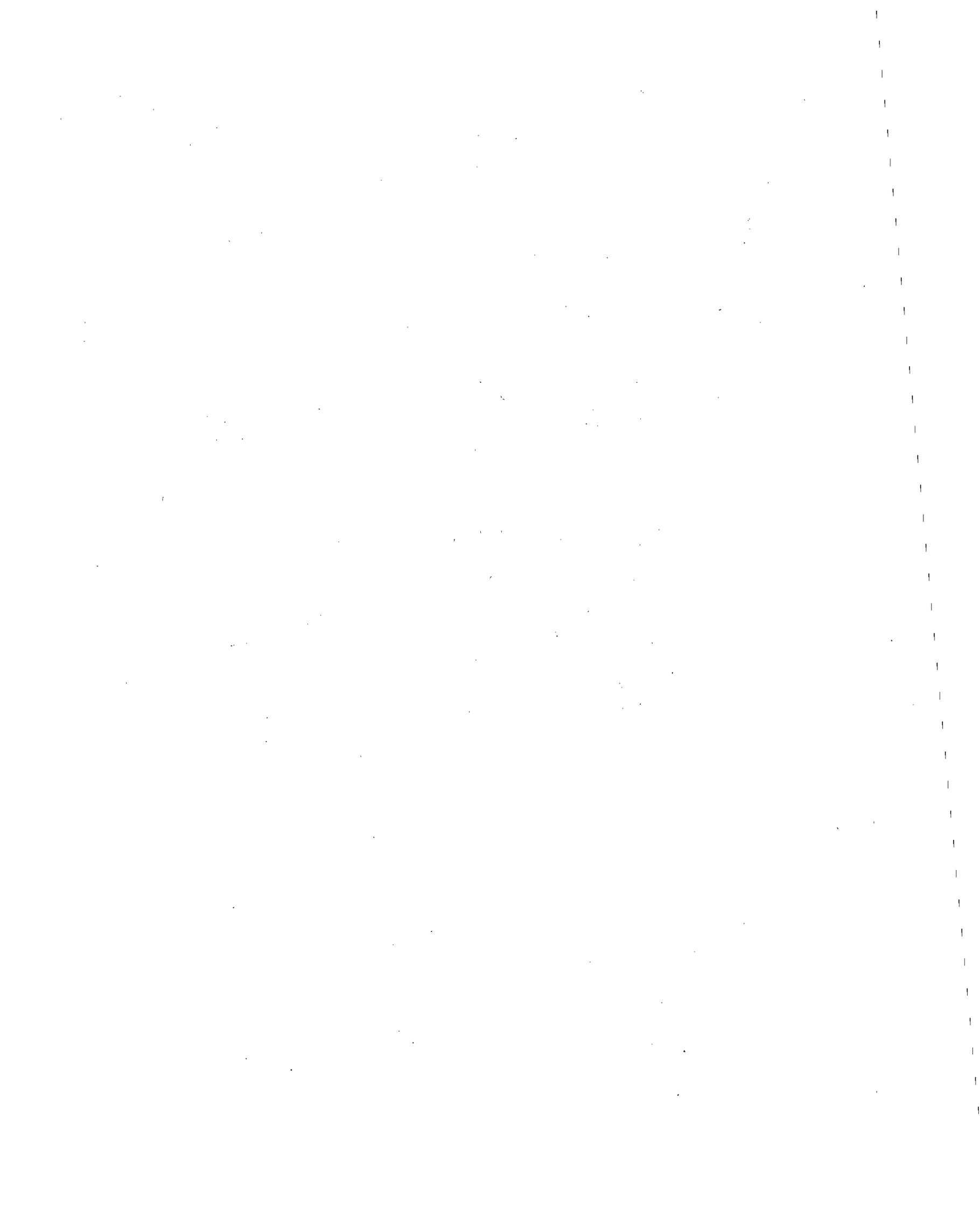## Center for Substance Abuse Treatment (CSAT)
Publications

CSAT has two series of publications, some of whose issues address topics of interest to substance abuse prevention professionals. Topics include dual diagnosis, assessment and treatment of adolescents, and so forth. The two series are called Technical Assistance Publications Series (TAPS) and Treatment Improvement Protocol Series (TIPS). CSAT publications are available from NCADI. (See list of Federal Government agencies.) For a full list, contact NCADI for a catalog.

Other Government Publications

The following publications are available from the agencies. (See list of Federal Government agencies.)

Supporting Substance-Abusing Families: A Technical Assistance Manual for the Head Start Management Team. Washington, DC: Department of Health and Human Services, Administration for Children and Families, Head Start Bureau, 1994

Working With Parents: Grades 9-12, Learning To Live Drug Free: A Curriculum Model for Prevention. Washington, DC: Department of Education, May 1990.

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APPENDIX B: CASE STUDY

Five Corners Community

I.   DESCRIPTION OF THE COMMUNITY

Demographics

Setting. This is a 60-block residential community that, although generally self-sustaining, is part of a large metropolitan area in western United States. This community has an active community council that functions as a liaison with the city government. This neighborhood has a distinct boundary and shares common problems of neighborhood deterioration with one other inner-city neighborhood—West Central City. However, in comparison to West Central, Five Corners exhibits a major potential for revitalization because of its community pride, strength of community leadership, and community involvement. Community-based organizations work together for the common good in this neighborhood.

Population. Because it is a low-income, low-rent neighborhood, Five Corners has always had a racial mix, consisting primarily of European-American (43 percent), Mexican-American (35 percent), and Asian/Pacific Islander (22 percent) ethnic groups. About 22 percent of the residents were not born in the United States. Most of the immigrant population are Mexicans and Asians. Many residents maintain a strong sense of community and ethnic pride. People can be described as working class. Thirty-three percent of the people live in poverty.

Five Corners is a community that is beginning to develop big-city crime problems as a result of significant immigration of gang members from inner-city neighborhoods in the metropolitan area of which Five Corners is a part. Drive-by shootings, gang killings, graffiti, vandalism, and drug-related activities are increasing rapidly. Because of the large number of youth per capita (84 per 100 adults vs. 62 per 100 adults nationally) and high percentage (54 percent) of children raised in single parent families, the juvenile crime rate is already high. Hence, if the youth culture becomes increasingly influenced by antisocial elements or gang culture, this community has a potential for major substance abuse and juvenile delinquency problems.

Educational performance in Five Corners is also relatively lower than performance across the State. In 1990, 54.4 percent of those in the target neighborhood graduated from high school compared with a State average of 85.1 percent. Among ethnic students the high school dropout rate has increased to 85 percent from 63 percent ten years ago. Ethnic students report a negative school climate and increasing discrimination because of increased numbers of elite college preparatory students coming to Five Corners High School.

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Schools in the target neighborhood report high turnover in the student population, averaging between 55 percent and 83 percent. Directly related to student turnover is the markedly low performance on the Standard Achievement Test (SAT) in Five Corners. Students in the fifth and eighth grades average below the 25th percentile on the Total Battery of the SAT. High rates of absenteeism, mobility, and poverty are some the underlying causes for the low test scores.

In 1995 approximately 21 percent of the 15,811 housing units in the target neighborhood were vacant or boarded up. The median home value is $33,425. Compared with 63 percent of the dwellings being owner occupied in 1970, by 1994 only 51 percent of the dwellings were owner occupied. These shifts in housing trends means a more transient, less stable population that has less interest in and commitment to the community. The shift also has contributed to school turnover and poor educational performance.

A higher rate of public assistance reflects the poverty problem in the target neighborhood. The median family annual income in the target neighborhood is $14,533. More than 33 percent of the residents earn incomes considered below the poverty level. Approximately 35 percent of the families in the target neighborhood are single parent families; but 54 percent of the children are being raised in single-parent families. More than 20 percent of the families receive some form of public assistance, and more than 29 percent of the population receives Social Security income.

A disproportionately high percentage of known fugitives is associated with the target neighborhood. The joint Federal, State, and local Violent Crimes Task Force confirmed that 30 percent of the 531 dangerous fugitives who were arrested since October 15, 1994, were arrested here.

Other. The businesses in this area are mostly family operated; however, there are some large warehouses and industrial areas in this neighborhood because the railroad runs through Five Corners. The entire large metropolitan area and region are experiencing an economic boom fueled by large numbers of businesses and people moving in from other parts of the State.

One high school, Five Corners, serves this community. Until 10 years ago, it had been considered the least desirable or prestigious of all city high schools. A new principal and some dedicated new teachers have changed the school around into the best high school. New accelerated college preparatory programs were added to the school curriculum.

There are many churches representing many faiths. There are several federally subsidized housing communities. Two city councilmembers live in this neighborhood. There is one outpatient alcohol and drug treatment facility operated by the community mental health system, colocated in the community health clinic on Center Street.

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Impetus for Action

Drug-related crime and gang activities had been increasing in
this neighborhood for years but recently have become intolerable to residents. Although in the past most drug activities were primarily isolated to a specific local park near the railroad station, recent drive-by shootings, drug-related muggings, and the proliferation of crack-houses and methamphetamine labs have made residents very worried about their personal safety.

On a late Friday afternoon in December 1993, five women and three men, all long-time residents of Five Corners, met in the community meeting room of the local Methodist Church to talk about the drug problem. They all were a little disappointed. Mr. Supi Maniu had made a tropical coconut punch, and Ms. Maria Salazar had brought Mexican cookies and cakes for 75 people. Ms. Salazar and Mr. Maniu had distributed 500 fliers, some in local stores, some on telephone poles, and the others under doors throughout the neighborhood, covering a 15-block area. Ms. Salazar paid for the 500 fliers herself and set the October meeting after Mr. Maniu got permission from the minister of the church.

Concern about the drug problem had been raised among many community members for many years. Concern crystallized for Ms. Salazar when her 13-year-old daughter was mugged on the way to school by a 17-year-old who was looking for money to buy crack. The youth was apprehended and convicted, but the incident so incensed Ms. Salazar that she has been on a mission ever since to get the dealers and users out of the neighborhood. The park in the neighborhood was known throughout the city as a quick and convenient place to score and had, throughout the years, had numerous drug raids, shootings,and turf wars between rival gangs. The burglary and robbery rates were high, but police attributed them to a large and growing number of homeless people who lived in abandoned and boarded-up buildings in the area.

Ms. Salazar was encouraged by local police when they said that the new crime bill had a lot of drug prevention money in it and that all she had to do was to get a group of people together to form some kind of committee; then the Federal Government would give them money to fight drugs. Ms. Salazar thought that it sounded good and has been trying to get a committee together. At this time, she was not working; but she had worked as a social worker and community development specialist for the Social Services Department in another State 10 years ago. She thought she could lead a community drug prevention program effectively and wanted to get more involved in the community once her youngest child was 13 years old.

The Salazar family moved to Five Corners because Mr. Salazar worked at one of the nearby industrial plants and could walk to work. Ms. Salazar was active in her church and on community boards, such as the United Way Board and the local Hispanic youth services agency.

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Hence, she appeared to have some important ties with the community. She was respected for her community and church work and was considered an exceptionally bright, creative, and hard working woman.

Ms. Salazar had spent most of her evenings since her daughter's mugging canvassing the neighborhood trying to get support for a community drug prevention program. She talked to some local social service agencies. She also spoke to the local United Way Board to encourage support of Five Corners. Her rationale for why Five Corners was worth saving was "Yes, Five Corners has just begun big-city crime and violence with inner-city spinoff gangs; however, Five Corners is the type of community where a reasonable effort can make a big difference in reducing gang activity, crime, and substance abuse. We haven't lost the war on drugs and crime here, yet."

In her search for existing substance abuse prevention programs, Ms. Salazar found that a group, sponsored by the local health clinic, called "Say Yes To Life," had secured a 3-year grant from the Federal Government. The group no longer operated. Also, she found one drug treatment program in the area, a community mental health center alcohol and drug outpatient clinic on Center Street called "Stay Free." She found two substance abuse programs operated by two different private, nonprofit youth services agencies with Federal funding, but both would end in a year: 1) an inhome case management program for at-risk immigrant Asian families and 2) an afterschool Hispanic youth leadership and skills training program operated in the schools.

After the disappointing first meeting, Ms. Salazar made some telephone calls and discovered that there was no drug abuse prevention specialist within the city government, only in the county government that deals with neighborhoods outside the city boundaries. She was told by the mayor's office that there was a substance abuse prevention specialist working at a community agency who had years of experience and might be willing to help.

The director, eager to cover Federal and State funding that was slated to end in a year and supported about half the agency's staff, assigned a prevention specialist to search for substance abuse funding opportunities and write proposals for new substance abuse and crime bill funds. The assignment was to help local high-risk neighborhoods mobilize to be successful in attracting new funds. The agency would staff the community mobilization or coalition, conduct needs assessments, support interventions, and evaluate the community-based prevention efforts.

Hence, the prevention specialist wanted some access to a likely high-risk community with good potential for successful action as a target for new Federal and State funds. Ms. Salazar asked the specialist to attend the next meeting to advise her group on how to proceed.

Because getting this grant funded to please the new boss was important to his job, the prevention specialist was careful in his initial enthusiasm in helping this particular neighborhood over other neighborhoods. He recommended *an assessment of community readiness* for

prevention programs by collecting some information on community strengths and problems. This information was needed to determine whether this should be the neighborhood selected to target the agency's time and the Federal funds. In addition, the agency was pleased that the group had contacted it because the group's action indicated some grassroots interest and commitment from a neighborhood that had the reputation for having the most drug-related crime in the city.

II.   ASSESSMENT OF COMMUNITY READINESS

Using the assessment questions in the NIDA resource manual, *Community Readiness for Drug Abuse Prevention: Issues, Tips and Tools*, and adding more that were relevant for the community, the prevention specialist helped the community group at its next meeting assess its community's readiness for substance abuse prevention. Seven factors (which spell PREVENT) and the diagnosis are presented below.

1. Problem Definition: *Minimally Present*

Group members asked themselves the following assessment questions:

What is the drug problem and its extent? Who has the problem? Where? Are there existing needs assessments? What are the risk factors that cause this problem to occur, and what protective or resiliency factors could prevent substance abuse? What services exist to prevent drug problems?

Ms. Salazar's committee concluded it had only a vague problem definition based on personal experiences and what was heard in the media. Committee members had heard that drugs, crime, and gangs were the major problems but had little idea of why these problems were increasing dramatically in their neighborhood. They did not know the actual extent of the drug problem, who had the problem, the types of drugs being used, and to what degree. No formal needs assessment had been conducted; there had been no focus groups, key informant interviews, or collection of existing data. Ms. Salazar conducted an informal assessment of existing substance abuse prevention programs by calling some friends and social services agencies and talking with the United Way to determine whether any drug prevention services existed in Five Corners. (Unfortunately, this focus on substance abuse prevention meant that Ms. Salazar missed many existing services for youth and adults related to delinquency, gang prevention, or other youth problems.)

Joe Bennett, a community resident in the group, said that the police had reported at the last community council meeting that the growing crime rates were due to the increasing numbers of homeless people. After discussing this information the group concluded that increasing drug-related crimes were related to the increasing numbers of organized youth gang members moving

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into Five Corners. The group felt the families of gang members were moving to Five Corners because the economy was strong and new jobs existed and because of the perception that it was a better place to raise children than other parts of the metropolitan area. Mr. Maniu reported that guns were showing up in the elementary schools. He thought it was because of the new gang families moving into the neighborhood.

Also, Juanita Esperanza and Mali Ng discussed how their children felt increasing discrimination against them in the schools because they were Mexican and Asian respectively. The primary gangs—the Mexican Mafia and the Crips—were of the same ethnic backgrounds. They also were having a difficult time getting their children to go to school. Their high school children reported that teachers had less interest in them ever since the school moved to attract more academically elite students from the district to their college preparatory program. The parents speculated that lack of school attachment and school failure might be primary risk factors in youth related to increased substance abuse and gang organization in the community.

2. Recognition of the Problem by the Community: *Moderately Present*

Group members asked themselves the following community assessment questions:

. Is there a broad awareness of the drug problem? Has any mobilizing event occurred? How much do key leaders support the need for prevention? How much do people in the community discuss the drug problem or link it to crime?

The group decided that there appeared to be recognition of the drug problem by some members of the community but did not know how widespread the recognition was. There had been several major incidents or community events involving drugs that demanded a community response: the mugging of Ms. Salazar's daughter, a shoot-out between rival drug gangs at the bus stop in front of the high school, and the killing of several gang-involved teenagers outside a local rock concert. These incidents were extensively covered by the news media, further increasing the public's perception that the drug and gang problems centered in the Five Corners area.

However, there was little impetus to mobilize to solve these problems until Ms. Salazar and Mr. Maniu organized the group. Most parents of the youths involved in these incidents had talked to the media but had done little more. The two community resident council members had been too busy with other citywide issues to act. The group was somewhat concerned about the community's willingness to act, based on the poor showing at the committee meeting at the Methodist Church. However, members had some hunches about why the community-mobilizing approach taken did not work well for them in this ethnically diverse community: 1) the timing was bad as the holidays were approaching, 2) the location was not neutral (it was an Asian church), and 3) a more personal invitational approach than flyers was needed. They decided to

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personally invite members who had access to the talent and resources needed to be successful. Their second meeting was successful: about 80 percent of the key leaders invited to join the committee came and were very committed. A good group dynamic occurred, further enhancing the probability of success.

3. Existence of and Access to Resources: *Moderately Present*

Group members asked themselves the following community assessment questions:

What human resources are available? How much time can they commit? What are their skills? What potential funding exists? What *pro bono* help is available?

Because this was primarily a grassroots citizen group had little knowledge of existing resources, such as services, funding sources, or sources of personnel, paid or unpaid. Ms. Salazar had called several agencies and friends to determine whether a drug prevention program for youth existed in the Five Corners community and conducted an informal key informant survey of prevention services available. Although Ms. Salazar had told the prevention specialist she knew how to write grants, her skill level was unknown. Additional professional support in grantwriting was available from a professor at the university who taught proposal writing and was an expert in substance abuse prevention. She was teaching a grantwriting workshop during the summer for community agencies. The group believed it could find grant writers, program planners, and evaluators in the local community and from several local universities who would work for free if written into the grants. They could help in the grantwriting and needs assessment process. One member of the group told about the student volunteer programs at both the university and community college as a resource to get additional volunteer support. Another person mentioned a university professor who conducted a neighborhood community door-to-door survey of crime and drug problems that could be located and used in the needs assessment.

4. Vision or Plan: *Minimally Present*

Group members asked themselves the following community assessment questions?

Is there a vision? Who has it? How widely is it shared?

Although the group had a vague vision of a safer community, no plan existed except to get substance abuse and crime bill funds to support a community drug prevention program for youth. There was no strategic plan that identified 1) goals and objectives derived from a needs assessment, 2) activities to be undertaken in prioritized and time order, and 3) the source of

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resources to implement the activities. It was unknown whether important stakeholders in the community shared the vision of a safer community and believed that a substance abuse prevention program would address this problem effectively.

5. Energy To Mobilize and Sustain Prevention Activities: *Optimally Present*

Group members asked themselves the following community assessment questions:

Is the community motivated and committed to addressing the problem? Are primary stakeholders involved? What benefits can be offered for participation? Are there any barriers? Can the effort be sustained?

In a preliminary meeting, the members of the group systematically invited the needed members to join the committee. These members rounded out the talents needed. Based on the first formal committee meeting, the group appeared to be committed and to have all the talents needed to implement prevention activities. Although it was unknown how long individuals would be able to sustain their active commitment to this effort, a quick assessment of their perceived benefits and costs in participation suggested longevity for the group. The professionals in the group would support the networking with stakeholders and local leader. The prevention specialist increased the contacts with the local community drug prevention coalition run by the county.

6. Networking With Stakeholders: *Optimally Present*

Group members asked the following community assessment questions:

Does the effort have the blessing of key leaders? What other groups could become involved?

Although this group was not directly connected with any agency or organization, it had the support and backing of the mayor's office that assigned a community liaison to work with the group, United Way, and other social service providers. The new committee structure included the key leaders in the schools and community needed to implement prevention programs successfully. The group had no official connection with any existing agencies or stakeholders, but it had connections to powerful community leaders, residents, and businesses through places of employment.

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7. Talent; Leadership Structure; Sense of Community: *Optimally Present*

Group members asked the following community assessment questions:

How homogeneous is the community? How stable is it? To what extent do community members share the same values? Does the community have a history of working together?

Although mobility was high, with 50 percent to 85 percent of the children in the elementary schools not returning the next year, most families did not move out of the Five Corners area but relocated to other low-rent apartments within Five Corners. Similarity of the residents was low because of the high number of ethnic groups in the area. However, there still was a strong sense of community and pride in the area. The level of community activism had been demonstrated by the fact that the local community council was one of the most active in the city and had the largest number of residents who participated consistently. Because of strong traditional values held by many residents of Five Corners, there were a number of mothers working in the home caring for their children. They were active in their communities and church activities. The group believed that churches could be a major source of support in the development of the prevention activity.

Community Readiness Assessment Summary and What Is Needed

Three community readiness factors were optimally present: Talent; Leadership Structure; Sense of Community, Energy To Mobilize and Sustain Prevention Activities, and Networking With and Support of Stakeholders; two were moderately present: Recognition of the Problem by Community and Existence of and Access to Resources; and two were minimally present: Problem Definition and Vision and Plan.

Although this community group did not have the time or resources needed to implement prevention programs, the community circumstances were right to help them mobilize to locate good resources. Much would depend on the mobilizing abilities of Ms. Salazar and the group of dedicated citizens.

III. STRATEGIES FOR INCREASING COMMUNITY READINESS

Based on the community assessment discussion at the first preliminary meeting of the committee the group determined irs areas of weakness. At the second meeting it determined what

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needed to be done. The group decided that the highest priorities for action were:

- To conduct a *needs assessment*, including reviews of existing needs data, reviewing literature risk and protective factors and processes for substance abuse, and possibly conducting their own community survey of perceptions, attitudes, and current substance use;

- To establish a clear vision by developing a *strategic plan*, including a mission statement, guiding philosophy, goals and objectives, proposed activities, and evaluation strategies;

- To increase *community resources* by identifying potential volunteers with specific kinds of needed skills, locating potential funding sources, and getting support or training in writing proposals; and

- To increase *broad-based awareness* of the substance abuse problem by planning a media campaign and discussing the drug problem and possible solutions with the community council and mayor's office.

1. Conduct a Needs Assessment

The committee decided it would be more efficient to create a Needs Assessment Subcommittee for the collection of existing social, health, and crime statistics. It decided first to contact the university professor who had conducted prior community needs assessments and ask him to staff the committee. Other proposed members included the county prevention specialist, Ms. Salazar, the university substance abuse prevention specialist, a former prevention program social worker, a health statistician from the health maintenance organization, the Volunteers in Service to America (VISTA) volunteer, and the head of the statistics department for the county substance abuse agency and health department. Because of the specialized nature of this committee, the task force had to recruit new data specialists to this subcommittee.

Committee members planned to conduct a search for existing information on the drug problem. They would contact the university professor who did the last volunteer survey and the State and county alcohol and drug abuse services departments for data. They also decided that they wanted to get information directly from residents about their perceptions of the causes of substance abuse in their neighborhood and not rely on external studies. Hence, they planned to design with expert support a face-to-face interview to be conducted in randomly sampled homes by the task force members supplemented by university volunteers working in pairs. They particularly wanted to find data on precursors or causes of substance abuse in high-risk youth to target prevention efforts to reduce those risk factors. Some members of the group said they also

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needed to focus on increasing protective factors, such as family stability and support and to increase resilience to drugs and alcohol in youth.

Archival Data

The Needs Assessment Subcommittee met and decided that the first course of action was to assemble as many sources as possible of existing data on the problems in Five Corners. Members developed a data collection plan that listed all possible kinds of data: medical, health, economic, family status, alcohol and drug abuse, crime, delinquency, gangs, and so forth. They then assigned members to collect the data. The head of the subcommittee combined all existing data into a needs assessment section for the strategic plan.

Research Literature on Risk and Protective Factors of Substance Abuse

The committee also worked with the prevention specialist at the university to conduct a review of national literature on what causes substance abuse in youth and adults. Luckily, the university drug prevention specialist professor had collected data on the causes of substance abuse in 1990 on 2,400 high school students in six high schools, including 400 sophomores and juniors at Five Corners High School. These data were analyzed and published as a causal model of substance abuse. Such data created a basis for determining the degree to which peer influence, poor school bonding, low self-esteem, poor family relations, and poor school climate affected substance abuse in the local youth. The data existed for males and females with peer influence being equal for both. However, separate data did not exist for each ethnic group. A separate analysis for Hispanic students suggested that family was a much stronger influence on the Hispanic students than on students in the general population (mainly white).

School Survey

The committee decided that it would like to collect additional data at the high school to determine whether the causes of substance abuse were different in each major ethnic group. The high school assistant principal was supportive and took charge of the project with the university professor who had done the original survey. They planned to conduct the survey of current sophomores, juniors, and seniors as soon as school research committee approval was obtained. The professor said she would supervise the data collection with students and analyze the data free.

Key Informant and Local Citizen Survey

In addition, the committee decided that it needed additional information that did not exist in the social indicators data, such as the perceptions of the community members about the drug problem, why they thought it was increasing, and what they thought could or should be done about it. A standardized questionnaire was created containing these questions, and 20 community

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key leaders and 50 local residents were interviewed by telephone concerning these issues. The data were tabulated and presented at the first community meeting.

2. Develop a Strategic Plan

The first draft of the strategic plan was created after the analysis of the needs assessment by the community group with help from the university professor and students. Before groups in the community were formed into task teams to write different sections of the community plan, they attended a training event on promising approaches to prevention and how to develop a strategic plan.

Community Drug Prevention Training Event

To educate the community about the drug problem and promising approaches to drug abuse prevention, a major community event was planned. The local university volunteers reserved their Graduate School of Social Work auditorium, library, and classrooms on a Saturday for the event. The Community Meetings and Events Subcommittee planned the event in conjunction with the Member Training Subcommittee. A National Performance Review Laboratory (NPR-L) grant provided some technical assistance and training funds to hire local and national speakers. A nationally known specialist in risk assessment for substance abuse and his staff conducted training on how to mobilize a community coalition and assess risk factors.

Keynote speakers and breakout session speakers (some local volunteers) discussed the needs assessment and locally and nationally effective approaches. A wide variety of approaches were presented. Task teams already had been created to deal with major constituencies of the group, such as those working with juvenile justice, youth, parents, senior citizens, churches, businesses, schools, higher education, each major ethnic group, alcohol and drug treatment, and the recovering community. Each task team was introduced to a strategic planning model in a plenary session and sent to a breakout session to brainstorm goals, objectives, activities to meet these goals and objectives, and resources needed, including recommended funding sources.

Developing the Strategic Plan

After the training event, six community meetings with the total group were held between November 1994 and June 1995. The meetings were held at Five Corners Middle School. Those attending the strategic planning meetings were mostly residents of the target neighborhood. There was representation from diverse groups in the neighborhood. The meetings produced a Strategic Plan for the Five Corners Community Council that, among other things, identified the strengths, weaknesses, opportunities, and threats in the neighborhood; identified and prioritized key issues; formulated objective statements describing what the groups intended to do; listed goals and action

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statements stating how the groups planned to realize their ideas; discussed who was available to help accomplish the goals; and set a schedule for how the goals should be realized.

Reconcile Individual Task Team Plans With a Draft Strategic Plan

Task team plans, typed on standardized forms, were integrated with the strategic plan. Each document was reviewed by the Strategic Planning Committee that met with each task team. Priorities for action were based on funding and facility possibilities, feasibility of the plan, team commitment to action, collaboration among several teams, and total community interest. The priorities from the first community meeting were considered as well as suggestions from focus groups and the key informant needs assessment survey that also included recommendations for action. A few projects with a high likelihood of immediate success were chosen as well as some longer term activities. Grantwriting was clearly needed for many of these plans to attract local, county, State, and Federal funds.

3. Increase Community Resources and Prevention Funds

The group decided after its first meeting that it needed to increase community resources by identifying potential volunteers with specific talents and needed skills. Key players were invited to participate in the committee: representatives from the high school, substance abuse prevention agencies, the mayor's office, the community council, the county substance abuse community coalition, and the police department.

A Funding Development Subcommittee was created and instructed to find potential sources of funding and prepare grant applications. It was successful in writing grants and attracting funds. Ms. Salazar secured a Bureau of Justice Assistance (BJA) Comprehensive Communities grant to create Community Action Teams (CATs) in the neighborhoods, a Family Peace Center, and many community development projects. The university professor and staff wrote a proposal and were awarded one of the five NPR-L grants targeting technical assistance and training for Five Corners in substance abuse and crime prevention. Because of the NPR-L grant award, the community would get priority on many different types of Federal funding. The Center for Substance Abuse Prevention (CSAP) awarded a $50,000 supplemental grant to the County Drug Prevention Coalition to organize a community coalition in Five Corners for substance abuse prevention.

The major's office offered Ms. Salazar a position as director of the comprehensive communities grant. In this new position, she organized a local effort to win the Office of Juvenile Justice Delinquency Prevention (OJJDP) Safe Futures grant. The university professor offered a summer workshop for all Five Corners agencies and citizens who wanted to learn to write grants. About seven grants written by different community agencies were submitted, and three were funded. One was for the Family Investment Centers (FICs) submitted by the Housing Authority of the city to the U.S. Department of Housing and Urban Development (HUD). It was funded

along with a Drug Elimination grant. New drug elimination projects and family and parenting programs began in the housing complexes in Five Corners. The Asian youth services agency also wrote a CSAP grant proposal that was funded to continue its substance abuse prevention efforts with immigrant Asian families. Most important, the county drug prevention specialist wrote a proposal and his community agency was awarded funding from the National Institute of Mental Health (NIMH) to develop a major initiative in Five Corners to reduce family violence and crime related to substance abuse.

The Funding Development Subcommittee also was successful in attracting Weed and Seed site recognition (but no funding). A special meeting was held with all criminal justice personnel in the Five Corners area and several COPS crime bill grants were applied for by and awarded to the police department.

Private funds also were sought by business representatives in the group. A local major businessman in the area was contacted to provide $5 million for a new recreation and community center building in the park. Because this businessman had unsuccessfully urged the university to change its name to his name, he was looking for other community buildings that could be named for him. Based on this new building construction, a new Boys and Girls Club was attracted and is in the process of being developed.

Based on Ms. Salazar's enthusiasm and involvement, the United Way Board raised $1.4 dollars from community businesses and foundations to implement Success by Six, an early intervention project involving home visitors for high-risk pregnant women in the Five Corners neighborhood.

4. Increase Community Awareness

Because area of weakness in the community needs assessment was a broad-based citizen awareness of the substance abuse problem, the committee planned a media campaign and a number of community events, including a multiethnic community festival in the park with ethnic music, dancing, and a potluck dinner; a community resources fair; a National Night Out Against Crime; Red Ribbon Week events or a nonalcohol graduation party at the high school; mocktail contests; a crime and drug watch; graffiti cleanup; a crack house cleanup; neighborhood cleanups; and community gardens.

From the beginning, the residents of Five Corners had been heavily involved in substance abuse prevention, law enforcement, community policing, prevention, early intervention, treatment programs, and neighborhood restoration. Local residents became the driving force behind the effort to develop an ongoing Drug Prevention Coalition for the target neighborhood. After a high school health class project conducted sting operations on local merchants to determine who sold

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tobacco or alcohol to minors, the residents mobilized to patronize the merchants who did not. The local newspaper published a list of these merchants and commended them.

In a drug and crime prevention effort, 250 block leaders were trained to organize their neighborhood and teach block watch volunteers how to communicate effectively using mobile telephones. The local National Guard provided the training. A volunteer Mobile Watch Organization was organized to drive through the area nightly in marked vehicles to report possible crime and drug offenses.

IV. MOVING ON

When the community was ready for substance abuse prevention programming, it implemented some specific universal and selective prevention activities, including:

- **School Climate Improvement Projects.** Five Corners High School organized teams of parents, students, staff, teachers, and business members to conduct a needs assessment, prepare a plan, and implement substance abuse prevention projects. Thirty-five universal, selective and indicated projects to improve the school climate for ethnic students and all high-risk students were implemented and resulted in immediate improvements in grades and dropout rates in high-risk students and reduced reports of discrimination.

- **Afterschool Youth Programs** were implemented in the elementary, junior high, and senior high schools involving skills training curriculums, values and drug education, mentoring, tutoring, and recreation. These reduced the number of latchkey children and reduced crime and substance abuse.

- **Parent and Peer Support Groups** were organized in the sixth to seventh grades where classrooms of students and their parents met to discuss developmentally appropriate issues in this difficult preteen stage.

- **Parenting and Family Skills Training Classes** were offered in elementary and in junior high schools, mental health centers, substance abuse treatment programs, and churches. Treatment centers offered the classes only for parents who abused alcohol and drugs to reduce family conflict and improve supervision, discipline, and parent/child relationships.

- **Kids Coalition** was organized, with support of the health department, and was successful in mobilizing and organizing a major letter-writing campaign before and during the State legislative session to raise taxes on tobacco and remove smoking areas from public places.

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- **Community Policy and Legislation Change Projects** such as writing legislation and getting local sponsors were started as the community became more sophisticated.

- **Emerging Substance Abuse Issues** in the target neighborhood were addressed by *ad hoc* committees of residents as necessary. For example, a committee was formed to address drug problems in a public housing project in the target neighborhood. A plan was devised to make physical improvements to the project, sponsor motivational activities for residents, and encourage residents to become involved with residents of the target neighborhood. Some local residents volunteered to help colead parenting and family skills training classes in the new Family Investment Centers in the housing complex.

APPENDIX C: PLANNING GUIDE

To complete the planning process, assemble a planning team composed of top leaders and decisionmakers. Solicit input from all levels of the organization and all stakeholders. Ask top decisionmakers (with input from others) to determine the mission and goals. Assign task groups to develop objectives and activities to support achievement of goals.

I. Scanning (Situational Analysis)

Gather as much information as possible about what is going on that might affect the program:

- What problem are you trying to correct? Why is your program needed? Who would benefit by your program?

- Are there other organizations doing the same kind of work? How will you be different?

- Are there other things competing for the time or attention of your target audience? What can your program do to attract the audience away from other interests?

- What is happening politically or legislatively that may affect your program? Are there pending regulations that will affect what you do?

- What changes are occurring in the prevention field that may affect your program?

- What is happening in the community (however you define community) that may affect your success? New models? Technological changes?

- Are there any threats to the program?

- What opportunities are there for strengthening or expanding the program?

- What is occurring in your organization that could affect the program? What are the organization's strengths? Weaknesses?

II. Mission

- What is your purpose? What do you hope to achieve as an organization or program?

- Whom will you serve? (What population? Within what boundaries?)

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- What philosophy underlies your program?

- What assumptions underlie your program? (That is, what strategies or approaches do you believe will allow you to realize your vision?)

III. Goals

- What will you have accomplished if you achieve your mission? List all the major things you intend to accomplish. (Be sure to state accomplishments as end results, not as procedures or steps to be taken.)

- What are the priorities among these accomplishments?

- Narrow the list to a manageable size—no more than 8 to 10.

- Be sure to include administrative accomplishments, such as a secure funding base.

IV. Objectives (To be developed by task teams or organizational units)

- For each goal, list all the things that must be accomplished to achieve it. State accomplishments as end results, not procedures or action steps. Prioritize the list.

- For each end result or accomplishment, write a statement as follows:

  — State the desired end result (only one end result);

  — Be sure the end result is realistic, but not too easy to achieve;

  — State any conditions under which the end result must be achieved (e.g., within a certain dollar amount);

  — State the end result in measurable terms, in quantifiable terms. For example, indicate how many people must successfully complete a program, what average score must be achieved on a written objective examination, the percentage of reduction in drug crimes by youth in a certain neighborhood;

  — Indicate the date by which the end result must be achieved.

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V.   Strategies

For each objective, brainstorm different approaches that can be taken to achieve it. While brainstorming, do not eliminate any ideas. Once all of the ideas have been listed, refine the list by combining similar ideas and eliminate ideas that seem too impractical.

Narrow the list to two or three possible approaches. Compare the possible strategies using the following checklist to determine which one appears to be the most viable.

- Do the resources exist to implement this strategy successfully?

- Can this strategy by implemented in time?

- Will this strategy have the support of top decisionmakers and other stakeholders?

- How costly is this strategy compared to others?

- What obstacles are you likely to encounter? How difficult will it be to overcome them?

- What factors work in favor of this strategy? (Are there any strong advantages to using this strategy over others?)

VI.   Action Plan

- For each objective, complete an action plan as follows:

    — List in sequence all steps that must be taken to accomplish the objective.

    — Determine who will be responsible for completing each step.

    — List all resources needed to completed each step.

    — List the date by which each step needs to be completed to ensure that the objective is met.

- Prepare a timeline or Gantt chart listing the steps and showing when each major milestone will be accomplished.

- Prepare an organization chart and staff loading plan showing which people (volunteers included) will be needed each month for each major objective.

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- Prepare a budget broken down by objective and divided by months to show when expenditures will occur.

VII. Logic Model

If required by the funding source or if desired, create a logic model.