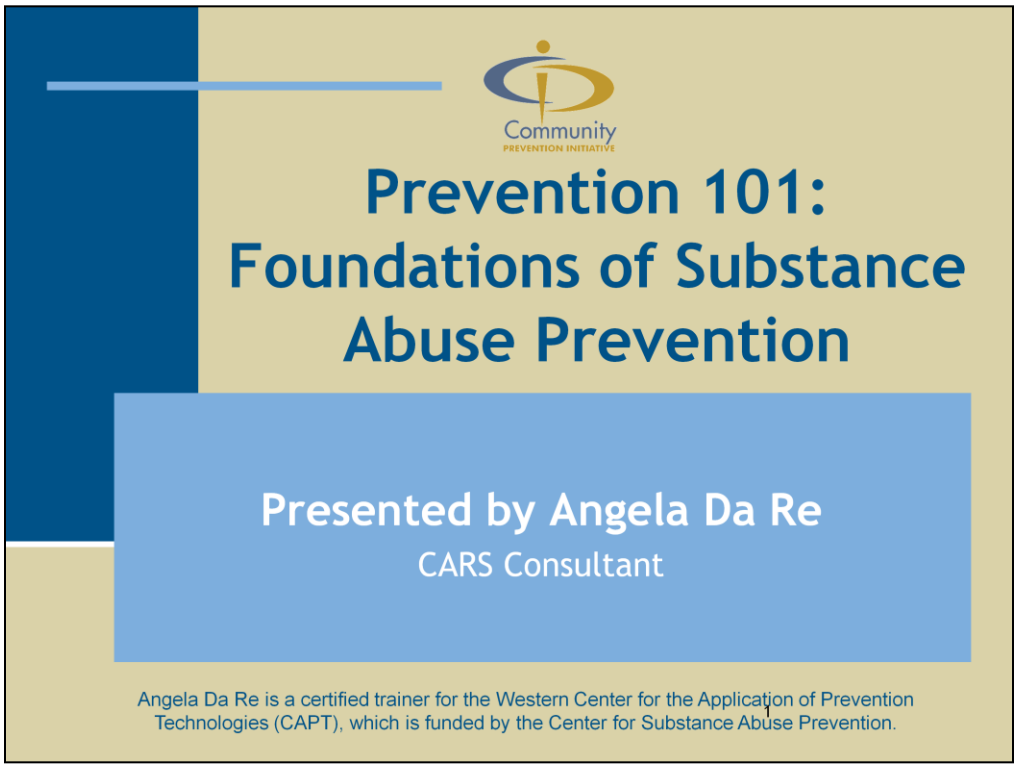
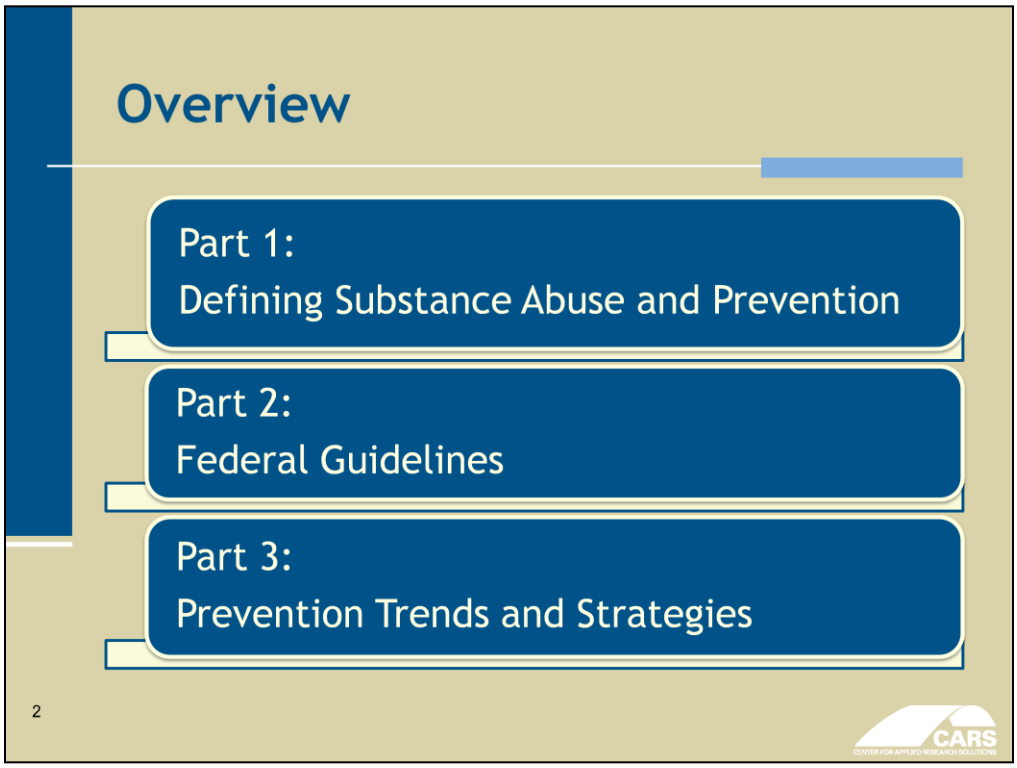

Community
PREVENTION INITIATIVE
Prevention 101:
Foundations of Substance Abuse Prevention
Presented by Angela Da Re
CARS Consultant
Angela Da Re is a certified trainer for the Western Center for the Application of Prevention Technologies (CAPT), which is funded by the Center for Substance Abuse Prevention.

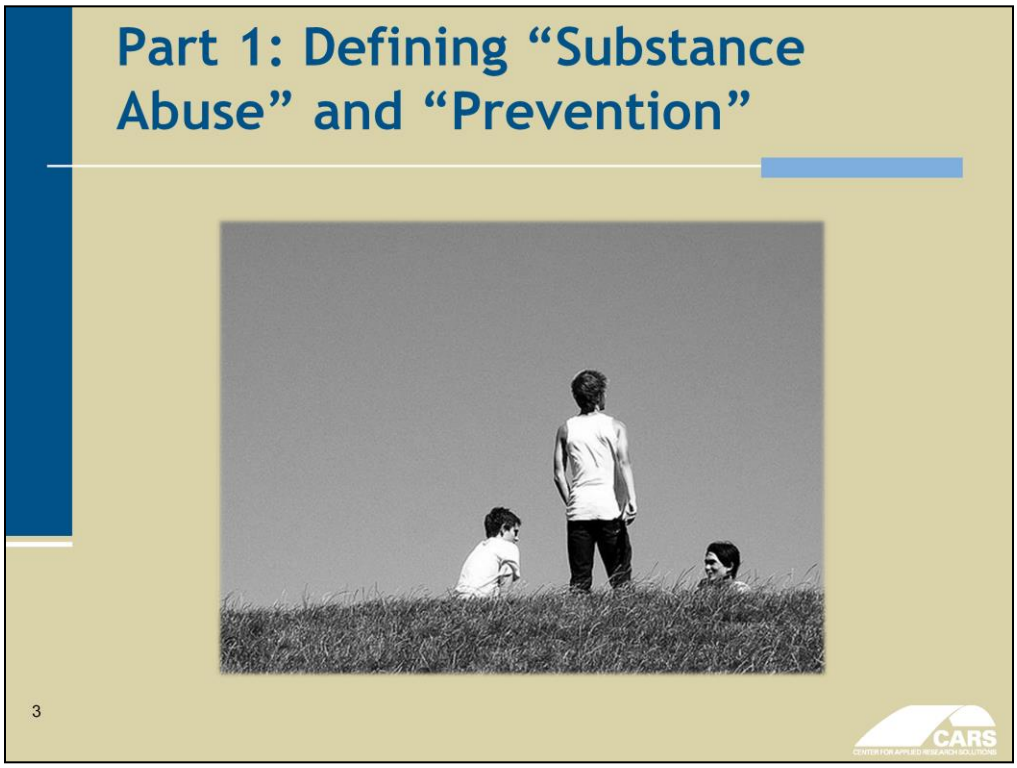


This is our agenda for today.

We'll start this morning by defining AOD and prevention, including current trends in AOD use, and key concepts and theories behind major prevention strategies.

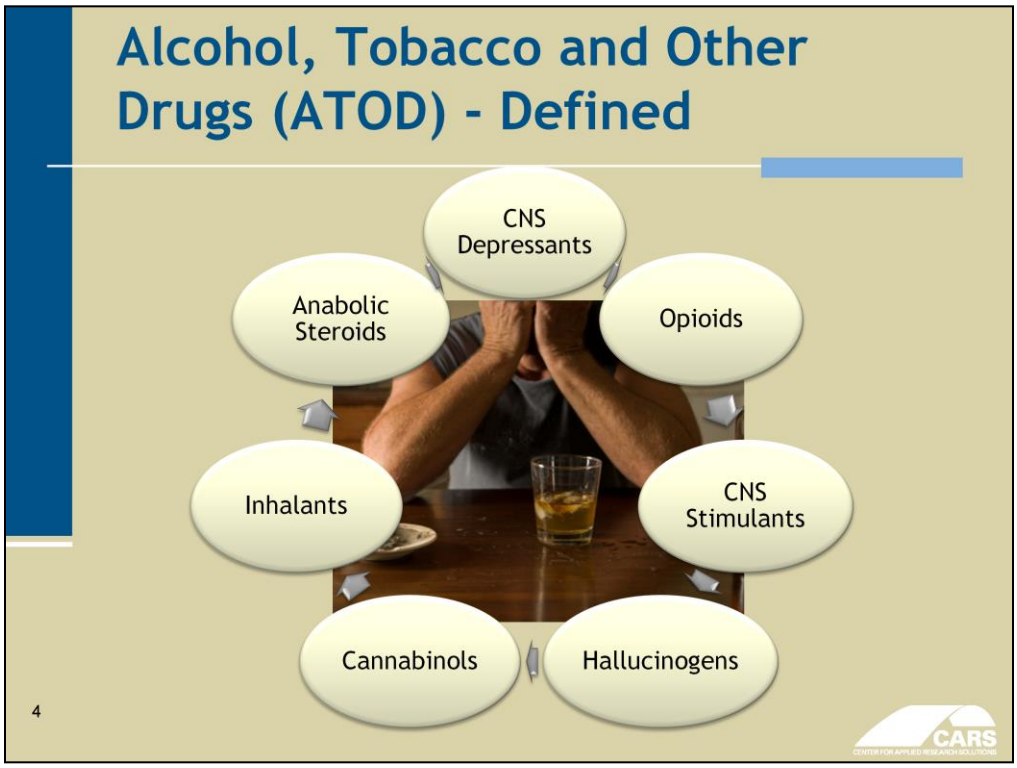
By mid-morning we will move on to the federal funding guidelines, such as SPF, IOM, and CSAP6, which are of great importance to you as you administer your programs.

In the afternoon we will examine trends in the field of prevention, and evidence-based strategies. We'll tell you about resources available to keep you informed.



Introduce Part 1:

We’ll begin by establishing exactly what we mean when we use the terms “substance abuse” and “prevention.”



ATOD is an all-encompassing word that refers to alcohol, tobacco, prescription drugs, over-the-counter drugs, and illegal drugs. Typically, these substances are addressed in three distinct areas:

1) alcohol with respect to alcoholism and alcohol abuse
2) tobacco in all its forms
3) drug abuse with respect to illegal drugs and abuse of legal drugs.

The acronym "ATOD" stands for "alcohol, tobacco, and other drugs." It is common to view tobacco as a separate area of interest from alcohol and drugs; therefore the acronym "AOD" is used, and meaning "alcohol and other drugs."

With respect to drugs other than alcohol and tobacco, the following classifications are commonly used:

Central Nervous System Depressants

Opioids

Central Nervous System Stimulants

Hallucinogens

Cannabinols

Inhalants

Anabolic Steroids

Each classification of drugs corresponds to a different set of effects on the human body.

The word "abuse" fits into a continuum of terms: Use, Misuse, Abuse, and Addiction.

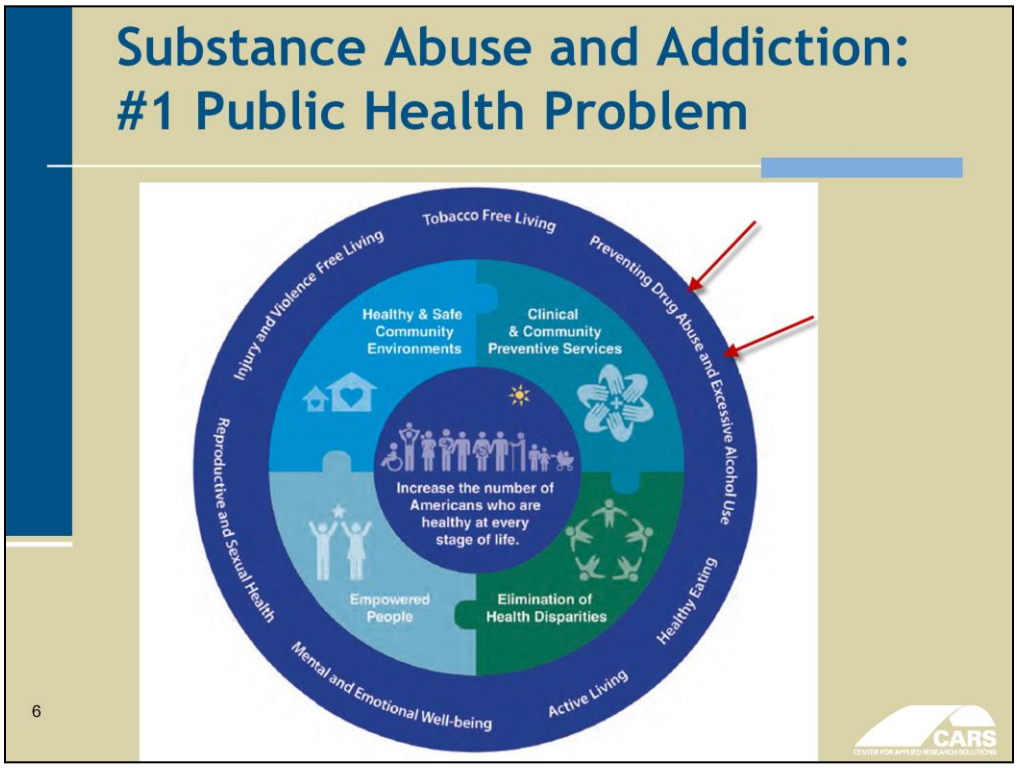
"Use" of alcohol and drugs is not considered by most people to be a problem with respect to moderate use of alcohol and prescribed use of legal drugs. For example, most people recognize the wonderful medical benefits available in drug therapies.

"Misuse," however, is a term used to describe the use of alcohol or drugs in a way that begins to have negative impacts on the individual or others around the individual. Any use of alcohol by minors and any use of illegal drugs by minors or adults is considered misuse. Excessive use of alcohol by adults is also considered misuse because it is associated with medical problems, impaired driving ability, relationship problems, and other maladies.

The term **"abuse"** is often used to describe a higher degree of misuse whereby the person continues to use alcohol or drugs despite the presence of negative impacts. Often, these negative impacts grow in consequence and become serious problems for the individual and others around the individual.

"Addiction" or "dependence" is defined as the compulsive use of alcohol or other drugs despite the presence of serious negative consequences. Addiction is viewed by many as a disease state with physiological dimensions. Addiction clearly calls for treatment.

Substance abuse prevention aims to reinforce abstinence or proper use of alcohol and drugs, prevent use from becoming misuse, prevent misuse from becoming abuse, and prevent abuse from becoming addiction.



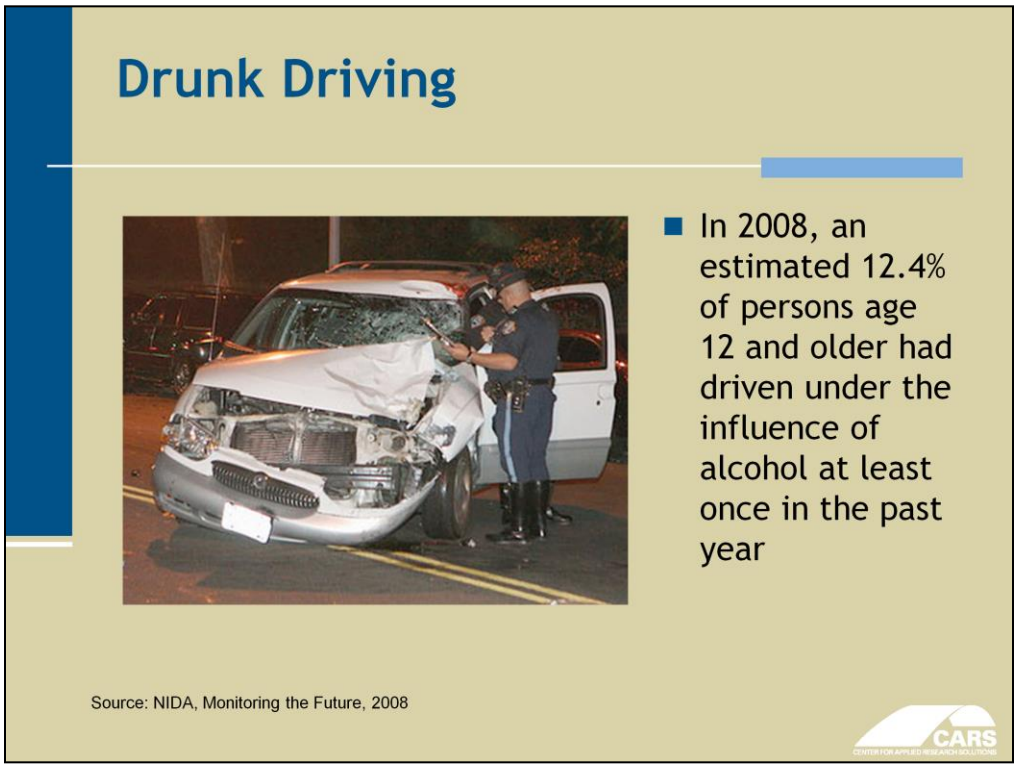
In order to better understand the need and context in which prevention operates, it good to understand the scope of the problem.

Our federal government identifies substance abuse and addiction as the number one public health problem in the nation (Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.) In 2011, the National Prevention Council (Office of the Surgeon General) named "Preventing Drug Abuse and Excessive Alcohol Use" as one of their 7 priority areas (see slide image)

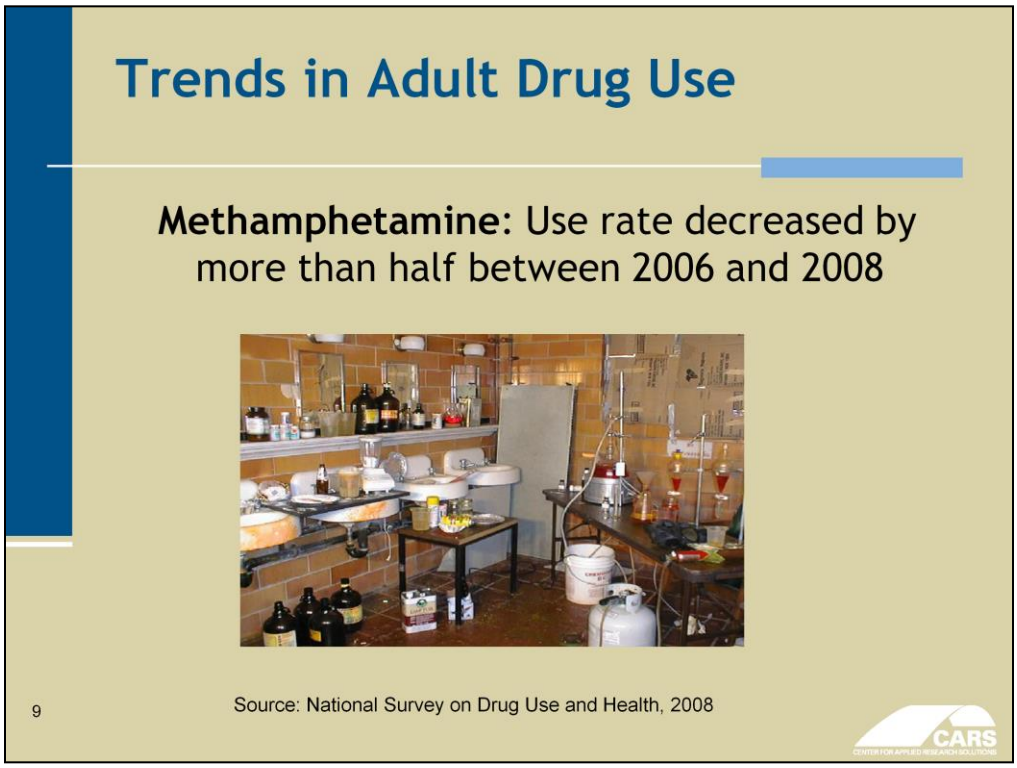
The reason that substance abuse prevention has matured as a science, a community of practice, and a profession is because the problem is so large.

Let's review some of the current data and trends in substance abuse and addiction. There is a lot of new research, and emerging issues based on research and data. We won't have time to cover every new piece of data, but we will give you some websites where you can keep up to date.

According to a study performed by the National Highway Traffic and Safety Administration more than 16% of weekend, nighttime drivers tested positive for illegal, prescription, or over-the-counter medication in 2007.



According to a 2008 study by NIDA, an estimated 12.4% of persons age 12 and older had driven under the influence of alcohol at least once in the past year.



Let's examine current trends in adult drug use.

According to the 2008 National Survey on Drug Use and Health, the number of past-month methamphetamine users age 12 and older decreased by over half between 2006 and 2008.

The survey also found that past-month nonmedical use of prescription-type drugs among young adults aged 18 to 25 increased from 5.5 percent in 2002 to 6 percent in 2007. This was primarily due to an increase in pain reliever use, which was 4.1 percent in 2002 and 4.6 percent in 2007.

Trends in Adult Drug Use

Heroin: Numbers are low but increasing:

- Up to 213,000 in 2008
- 114,000 first-time users in '08.

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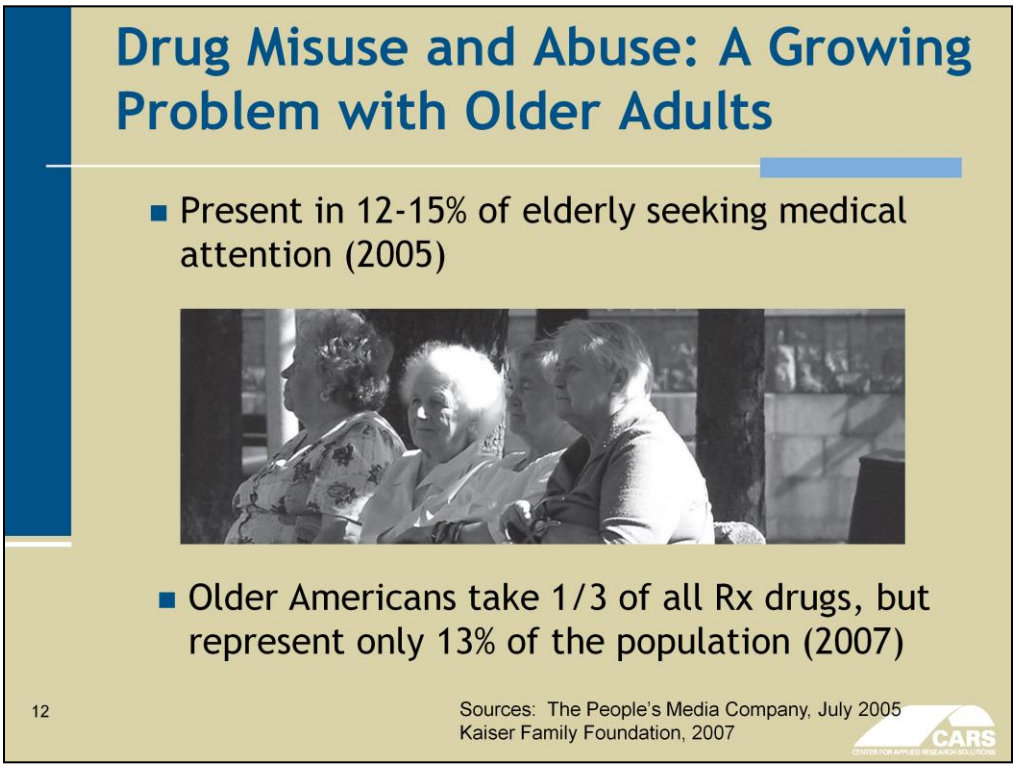
Source: National Survey on Drug Use and Health, 2008

The number of current (past-month) heroin users aged 12 or older in the United States increased from 153,000 in 2007 to 213,000 in 2008 (that's a 72% increase). This includes 114,000 first-time users of heroin aged 12 or older in 2008.

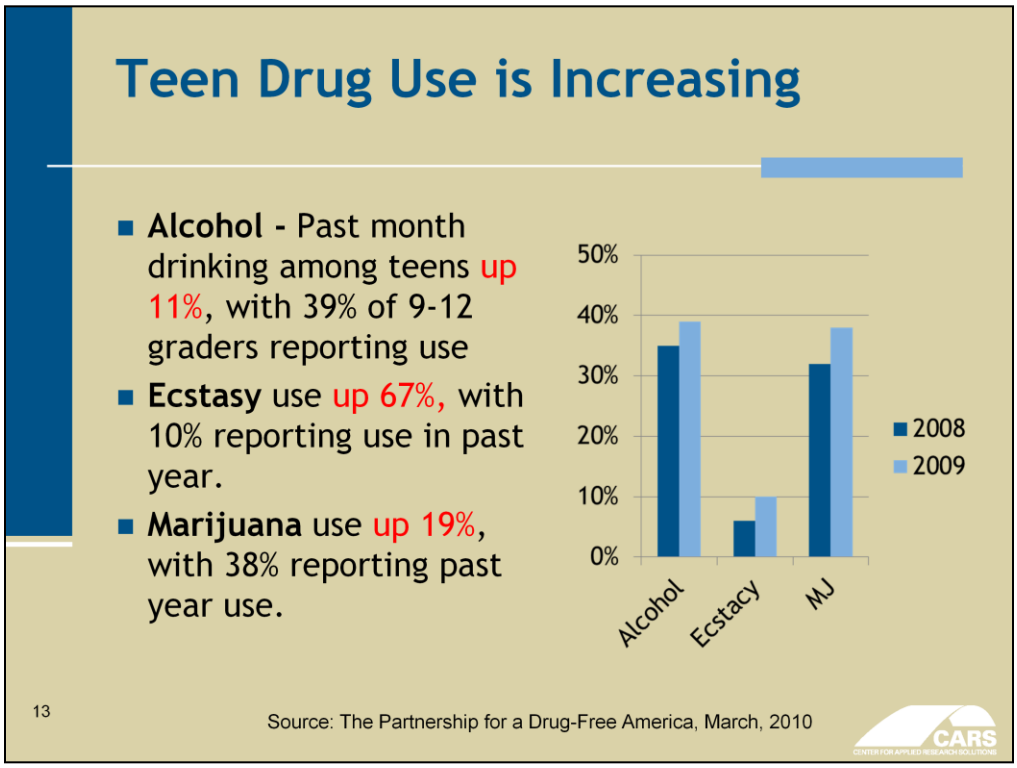


Drug misuse and abuse in the elderly is of special concern because it can cause cognitive and physical impairment, putting this population at greater risk of falls, motor vehicle accidents, and making them generally less able to care for their daily needs.

Elderly are particularly vulnerable to prescription drug misuse. Misuse is defined as non-adherence to prescription directions and can be either willful or accidental.

(1) Citation in Prevention Tactic: The People's Media Company, July, 2005.

(2) Citation in Prevention Tactic: Kaiser Family Foundation, 2007.



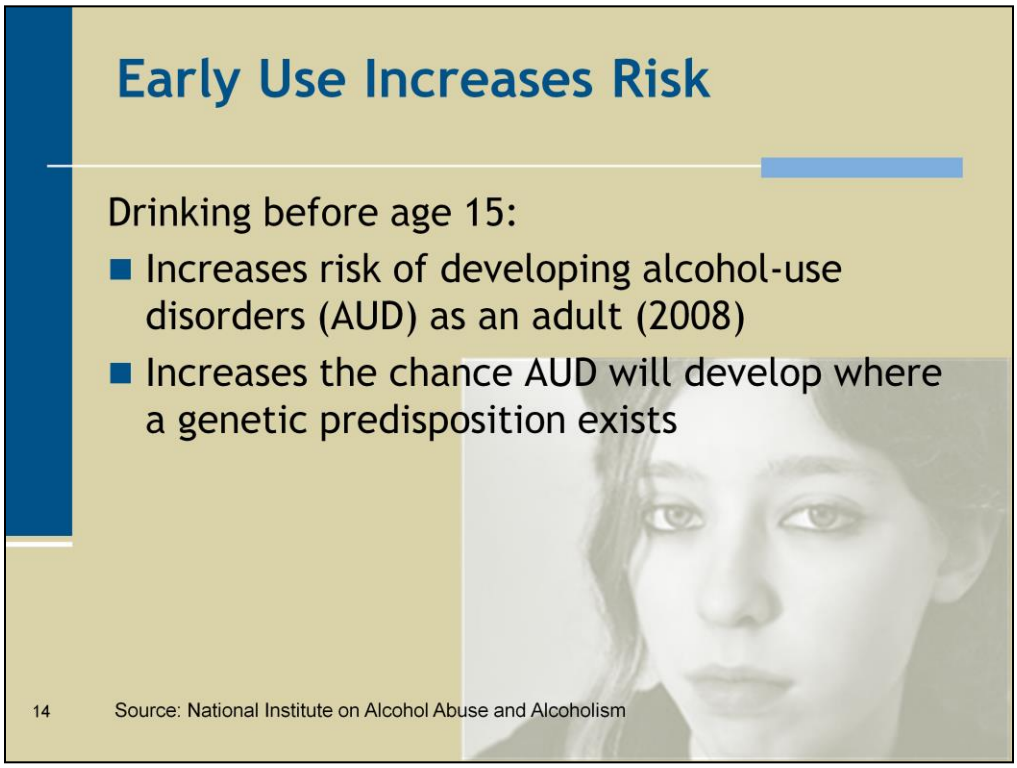
Now, let's consider current trends for youth. Teen drug use is rising. Marked upswings are a reversal in past steady declines.

Alcohol - Marked upswings in use of drugs by teens. Past month drinking up 11%, with 39% of 9-12 graders reporting use

Ecstasy use up 67%, with 10% reporting use in past year.

Marijuana use up 19%, with 38% reporting past year use.

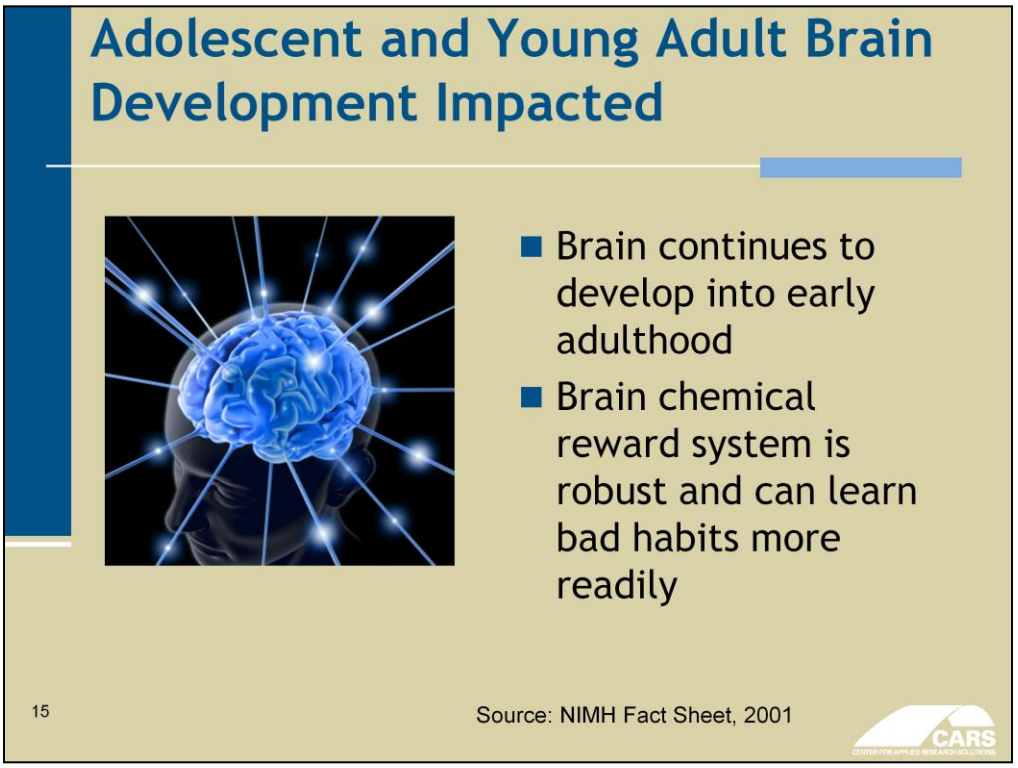
Source: The Partnership for a Drug-Free America, March, 2010



New research on age of first drink and risk of developing alcohol-use disorders during adulthood found risk is greater when age of first drink is lower than 15.

If there is a genetic predisposition toward AUD, early use increases the likelihood AUD will develop.

Source: National Institute on Alcohol Abuse and Alcoholism, Press Release



The adolescent and young adult brain develops into the mid 20s. White matter circuitry and frontal lobe/cortex still develops till about age 25.

Psychoactive drugs that enter that environment tap into a much more robust habit-forming ability that adolescents have, compared to adults. Addiction has been shown to be essentially a form of learning, and adolescents and young adults are at a stage when learning is accelerated and lifelong habits can be formed.

Source: NIMH Fact Sheet, 2001

Current research has also found that military personnel are at increased risk for drug and alcohol abuse.

Exposure to combat = increased risk of new-onset heavy weekly and binge drinking, and alcohol-related problems.

Source: JAMA (Vol. 300 No. 6, August 13, 2008

43% self-report binge drinking, producing more adverse health and social consequences.

Source: American Journal of Prevention Medicine, 2009

Military Personnel at Risk

- 40% of veterans have potentially hazardous alcohol use
- 22% positive for possible alcohol use disorder
- Only 31% of those with hazardous drinking behavior reported being counseled to cut back or to not drink alcohol

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Sources: JAMA (Vol. 300 No. 6, August 13, 2008)
American Journal of Prevention Medicine, 2009

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40% of Iraq and Afghanistan veterans who were screened with a validated tool were positive for potentially hazardous alcohol use

22% screened positive for possible alcohol use disorder (AUD).

Surprisingly, only 31% of those with hazardous drinking behavior reported being counseled to cut back or to not drink alcohol.

Special Populations: Youth in Foster Care

- Higher rates of illegal drug use: 33.6% of youth in foster care vs. 21.7% of general population youth

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Source: National Survey on Drug Use and Health, 2005

Youth in foster care are a group who are at higher risk for substance abuse than the general youth population.

Data indicates that more than 1 in 10 children in the United States under the age of 18 were living in homes with a substance-dependent or substance-abusing parent.

Combined data from 2002 to 2007 indicates that over 8.3 million children under 18 years of age (11.9 percent) lived with at least one parent who was dependent on or abused alcohol or an illicit drug during the past year.

Source: National Survey on Drug Use and Health, April, 2009

Defining Prevention

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IF only the electropathic belt were still available…..there would be no need for prevention of any sort!

We use the term "prevention" as shorthand for substance abuse prevention. We should recognize, however, that "prevention" is applied to several issues and problems in our society, including juvenile delinquency, dropping out of school, teen pregnancy, violence, and suicide. Many of the strategies and program models for tackling these other issues are similar to those used for substance abuse prevention. Substance abuse prevention professionals work along side colleagues who are applying prevention principles and practices to these other problem areas. In fact, some prevention programs take on more than one issue, working to prevent some or all of these negative outcomes.

Historically, prevention has been a community practice, but in the last decade or so, we have evolved into a profession.

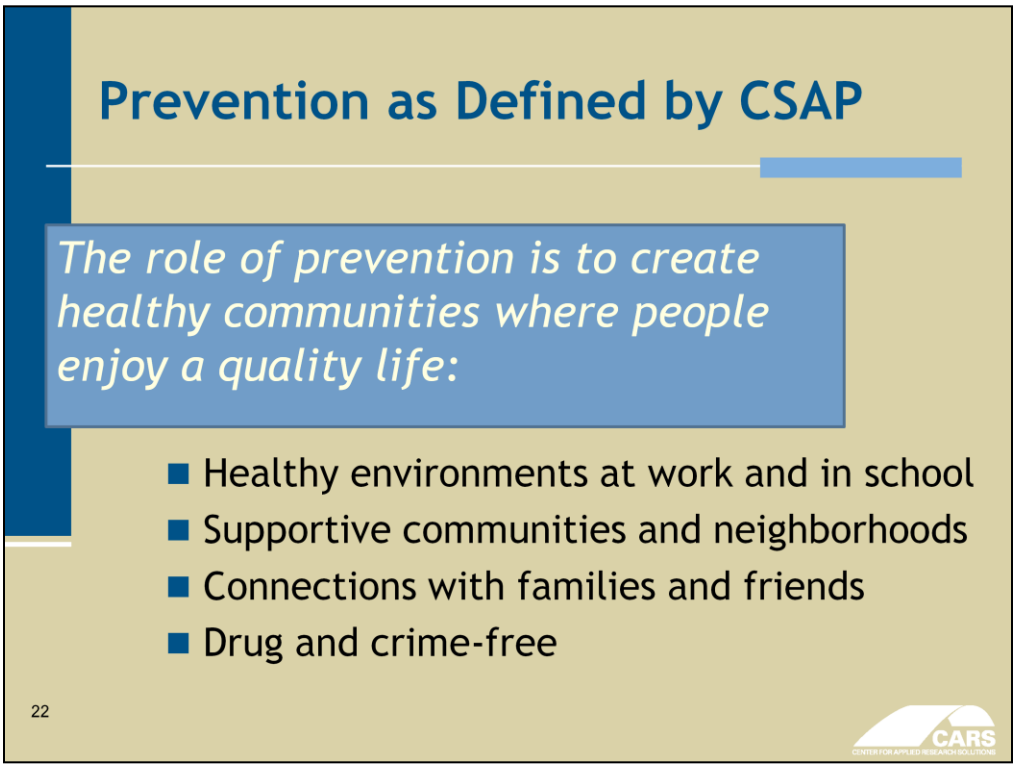
The prevention field promotes "science-based or evidence-based prevention." This means practicing prevention in a way that is based on good science and is consistent with the results of scientific research.

There are many "core sciences" that contribute to prevention as a science. These include neuroscience, genetics, epidemiology, psychiatry, and behavioral sciences. Prevention also has close ties to the field of mental health in that substance abuse and dependence are diagnosable mental health disorders.

Those who work in the field do so in a variety of settings across private, non-profit and government sectors.

Prevention is separate from the treatment and recovery field, although there is obvious crossover.

The profession is growing and offers a professional certification as a Prevention Specialist.

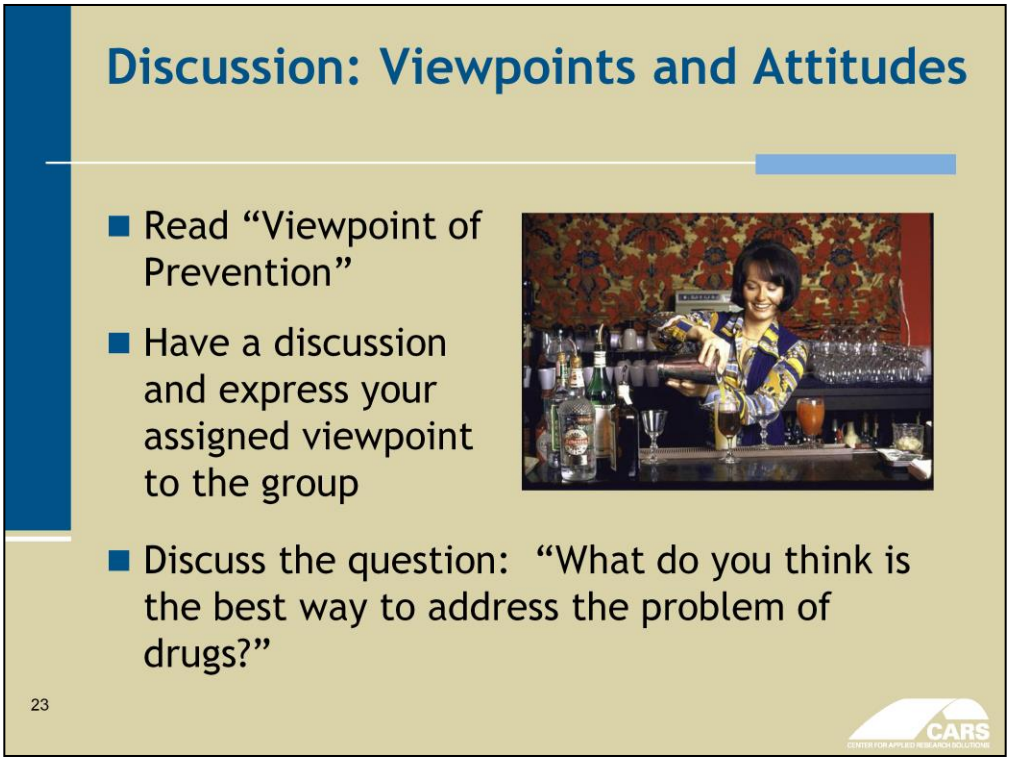


The Center for Substance Abuse Prevention (CSAP), part of the federal government's Substance Abuse and Mental Health Services Administration (SAMHSA), provides a foundation of research and helps to define the work and the field.

CSAP works with States and communities to develop comprehensive prevention systems that create healthy communities in which people enjoy a quality life. This includes supportive work and school environments, drug-and crime-free neighborhoods, and positive connections with friends and family.

This is how CSAP defines prevention.

Source: *CSAP website, March 2010*



The continuum of use, misuse, abuse, and addiction/dependence raises an important point for prevention specialists to consider: that attitudes and assumptions about the consumption of alcohol, tobacco, and other drugs vary greatly among people. This is true whether you are working in the prevention field or are a participant in a prevention program.

It's worth a moment to explore your own attitudes and assumptions on this topic and consider the range of attitudes and assumptions that others might have.

Give instructions for small-group discussion:

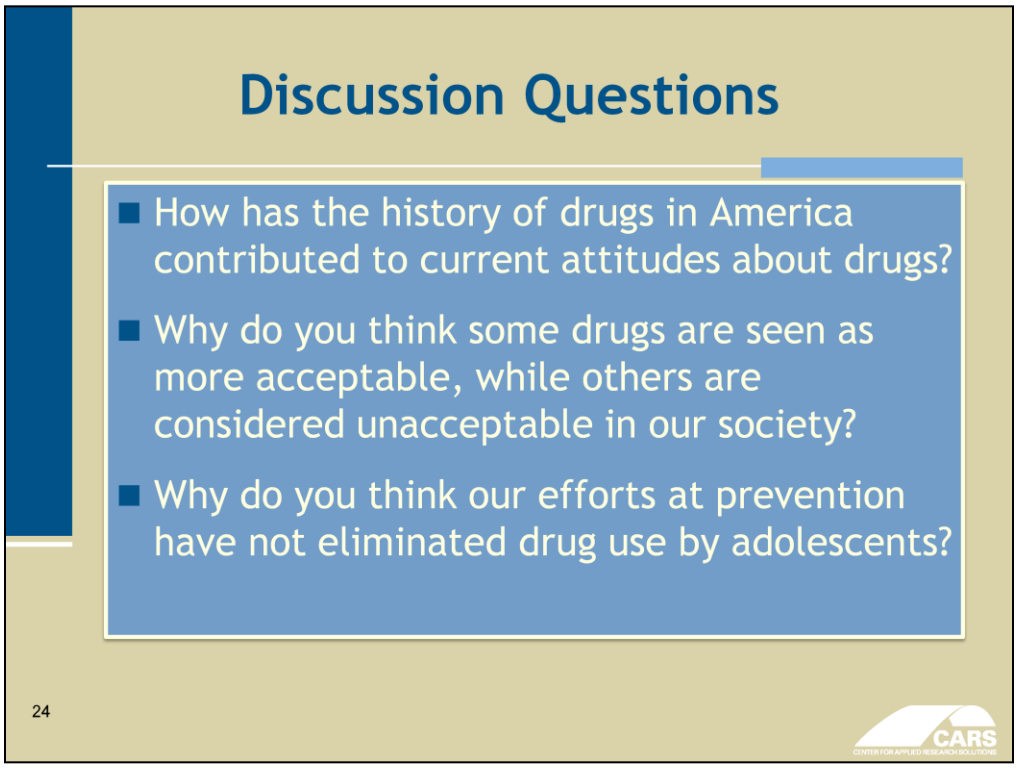
This work sheet describes six prototypical viewpoints of prevention. I'd like you to read the viewpoint corresponding to your assigned number. After you have read your viewpoint, I'd like you to have a discussion in your group. I want you to represent your viewpoint as faithfully as you can. Try to get inside the head of the person representing that viewpoint, and then express your views to the rest of the group from that point of view. Remember, these are not isolated viewpoints; these six systems of thought represent millions of people. During the discussion, you can be flexible—you can even change your mind—but be sure that you initially speak

from the point of view assigned to you. And please use the Ground Rules we established earlier for your discussion. The question for discussion before your group is very simple: What do you think is the best way to address the problem of drugs? You will have 15 minutes for your discussion.

Debrief small-group discussion. Ask:

- Did your group reach any consensus?
- How difficult was it to represent a viewpoint different from your own?
- What insights did you get from listening to other people, as well as to yourself?
- How might culture might influence individuals' or groups' viewpoints of prevention?
- Why do you think it is important for prevention professionals to be familiar with points of view that they may consider wrong?

Reassure participants by humorously reminding them that they were only role-playing and that they are not to be held liable for their point of view in real life. Point out that viewpoints of prevention also occur within cultural context. Conclude by noting that as prevention professionals, they will be coming into contact with people who hold these views, and it is important to be prepared to encounter and address them.



Continue large group discussion with these questions from Viewpoints and Attitudes reading.

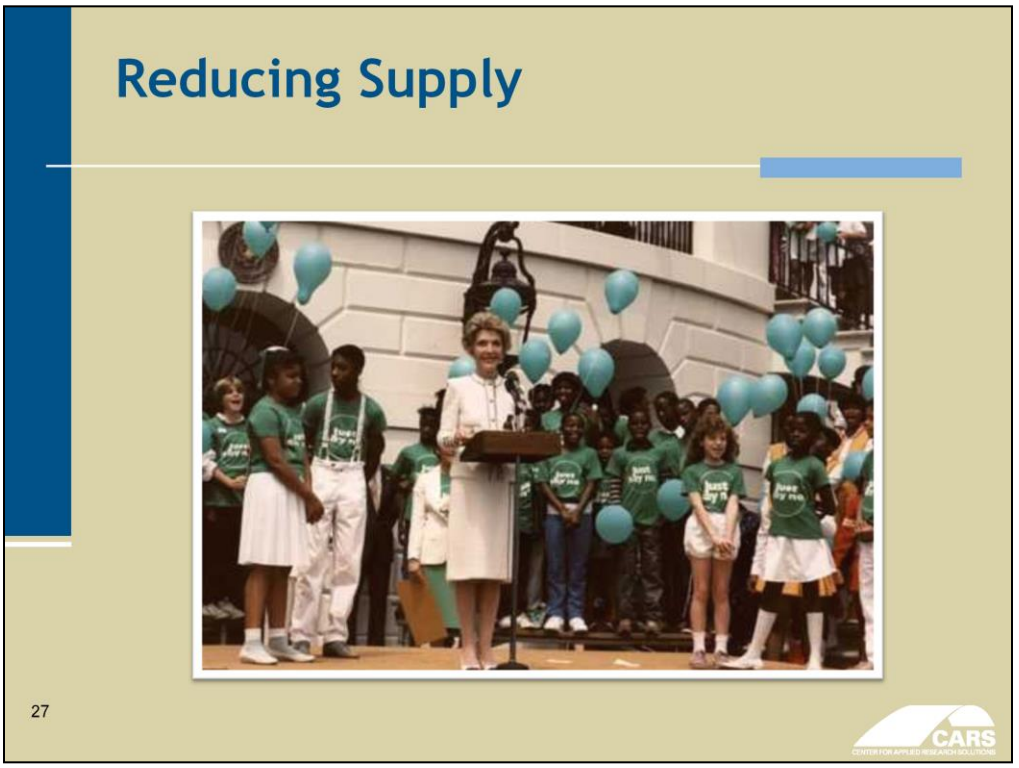
Our discussions made clear that there are many different points of view about substance use, and that these views evolve. Laws, policies, and norms seen in society have shifted dramatically over time.

For example, our approaches to prevention at one time were fairly simplistic, consisting of legal prohibitions and fear-based public information campaigns. Prevention has evolved to be much more sophisticated than that.

The problem of substance abuse has been approached from two angles: by restricting supply, and by reducing demand.

The supply of drugs has been addressed through activities, programs and policies, for example for legal drugs consider these approaches: increasing taxes on the product (cigarette taxes), increase law enforcement related to sales practices, advertising and the number of sales outlets, imposing penalties for sales to minors.

For illegal drugs: destruction of crops, confiscation of drug shipments, and criminal penalties.



For legal substances, a major strategy has been to make it harder for people to buy alcohol and tobacco. These barriers work to suppress demand, which in turn results in manufacturers supplying less product. In this sense, supply reduction and demand reduction go hand-in-hand.

In the 1980s and 1990s, the War on Drugs as a national policy was heavily weighted toward supply reduction, with two-thirds of the drug control budget (totaling approximately $14 billion) allocated to supply reduction strategies and one-third to demand reduction activities.

But to address the substance abuse problem, it is equally critical to address the demand for substances. Prevention focuses heavily on the demand side of the supply and demand dynamic. If individuals choose not to engage in substance abuse behavior, the problem has been addressed at a root level. Demand reduction, coupled with reasonably aggressive strategies to constrain supply, is the current focus of the prevention field.

Past Tactics

Fear based advertising:

Tell your children!
Reefer Madness
Fight the menace!
Reefer Madness
Kill the Devil!
Reefer Madness
Save the country!
Reefer Madness
Madness! Madness!
Madness! Madness! Reefer's
made us crazy barking...
Mad!

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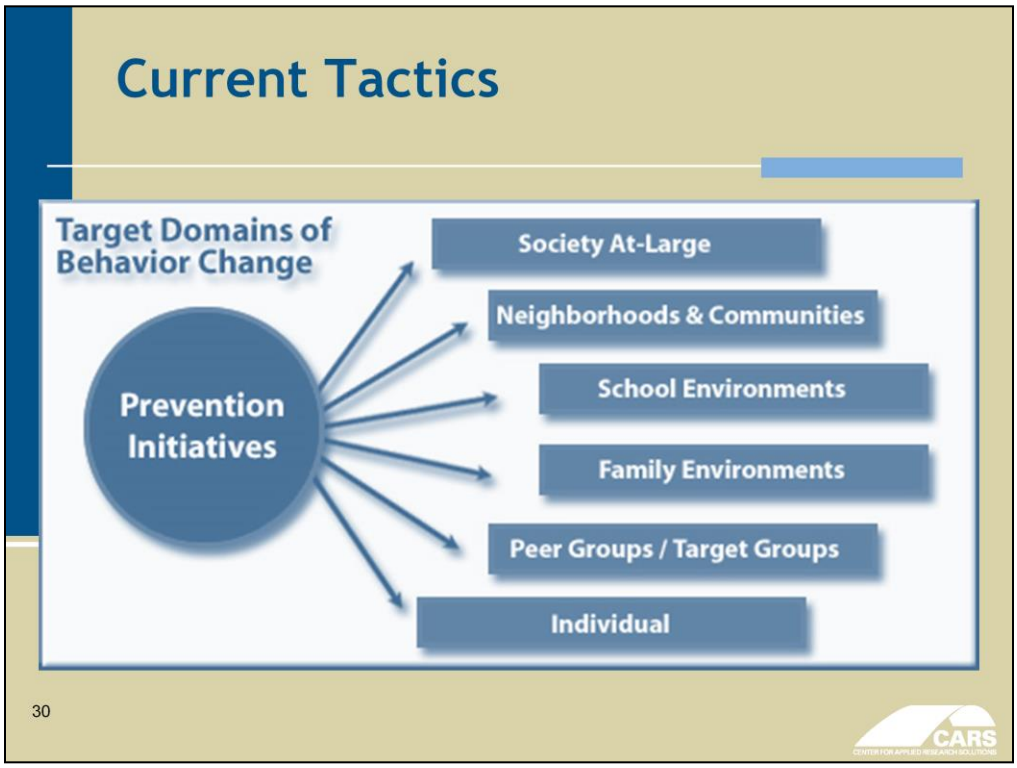
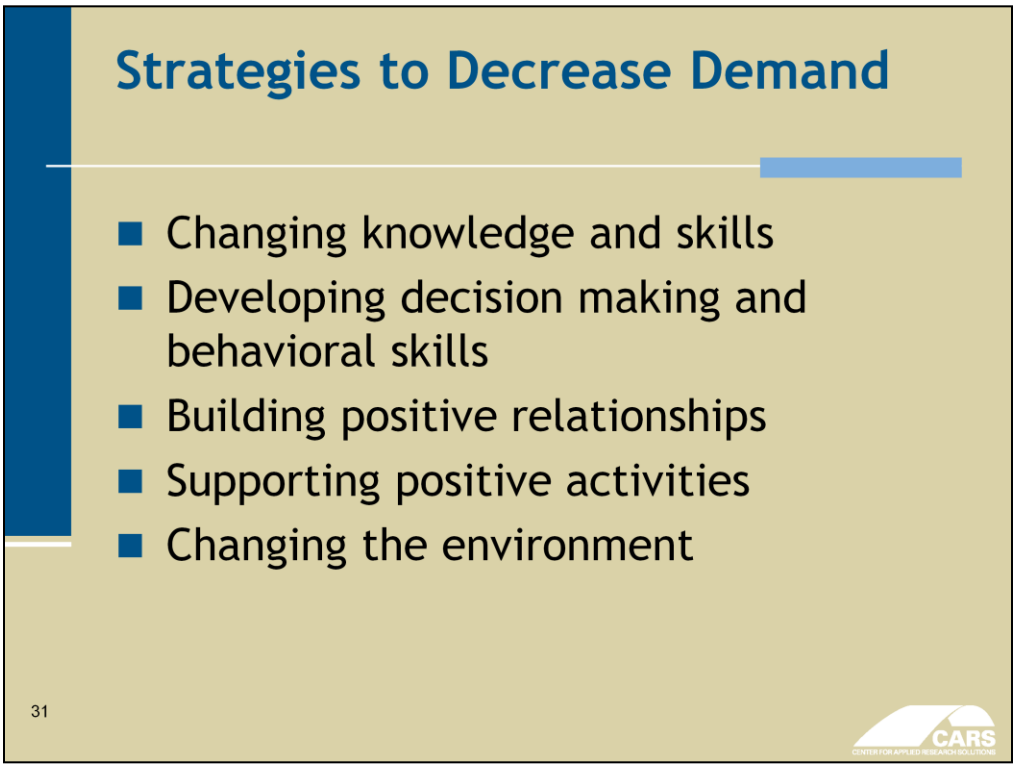
In the past, attempts to reduce demand involved fear-based advertising, such as the 1936 film "Reefer Madness."

Was this effective? Was there an unintentional promotional effect?



Modern substance abuse prevention is practiced through a diverse range of programs and activities that are based on limiting demand.

These programs and activities are found at many levels in our society: individuals, families, selected groups, neighborhoods, whole communities, and whole populations. They are also delivered through many different channels: the media, schools, programs outside schools, faith-based organizations, and community-wide programs. Programs and activities follow a variety of strategies and take many forms.



How does prevention seek to impact the demand for alcohol, tobacco, and other drugs? Broadly speaking, prevention programs and activities employ one or more of the following strategies:

•Changing knowledge levels and attitudes about substance abuse through education and other means

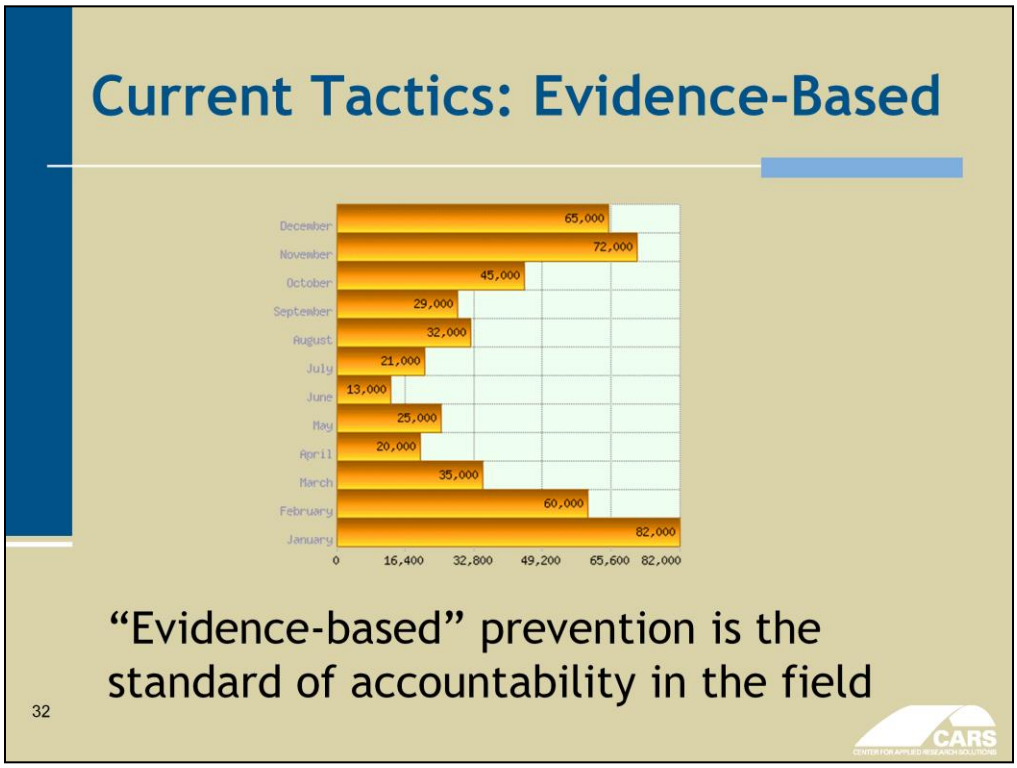
•Developing skills related to substance abuse decisions and behaviors

•Creating and supporting positive relationships

•Creating and supporting opportunities for positive activities, and

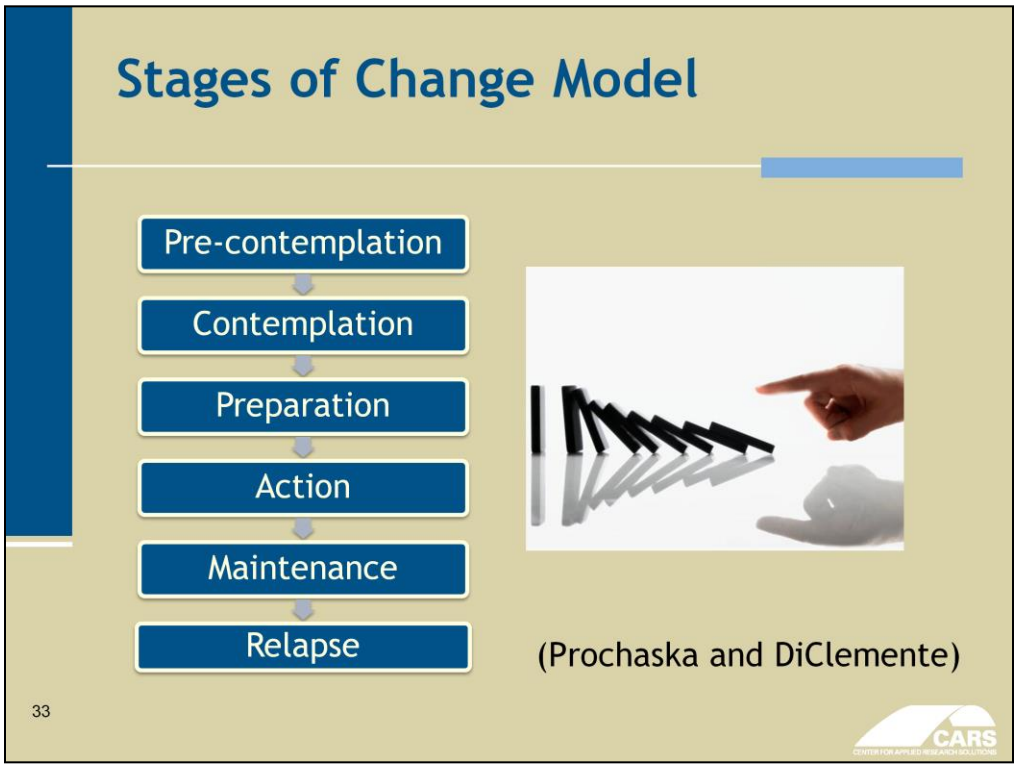
•Changing the environment related to substance abuse: community norms, accessibility, and policy.

We will discuss all of these topics this afternoon during Part 3.



What is consistent through all approaches is that prevention efforts must be based on research, and be "evidence-based." Evidence-based prevention is the standard of accountability in the field.

Let's examine some of the models of prevention currently in use.



There are a number of theories on how and why people change their behavior. One that has influenced the prevention field is **Prochaska and DiClemente's Stages of Change Model.**

Pre-contemplation

Contemplation

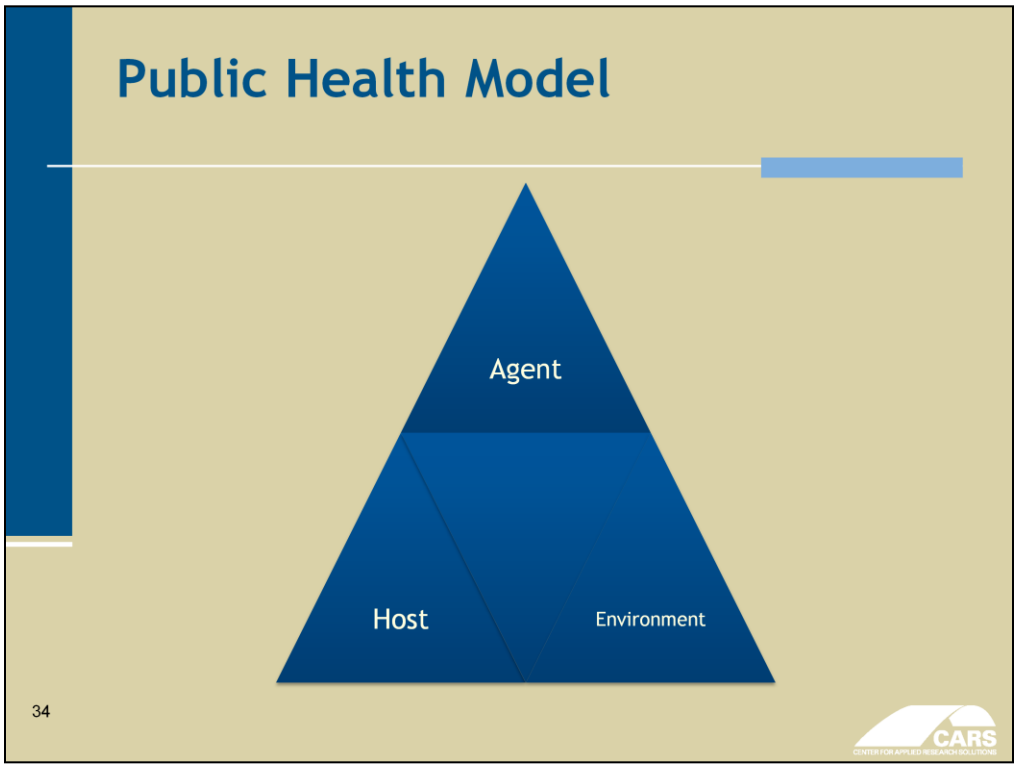
Preparation

Action

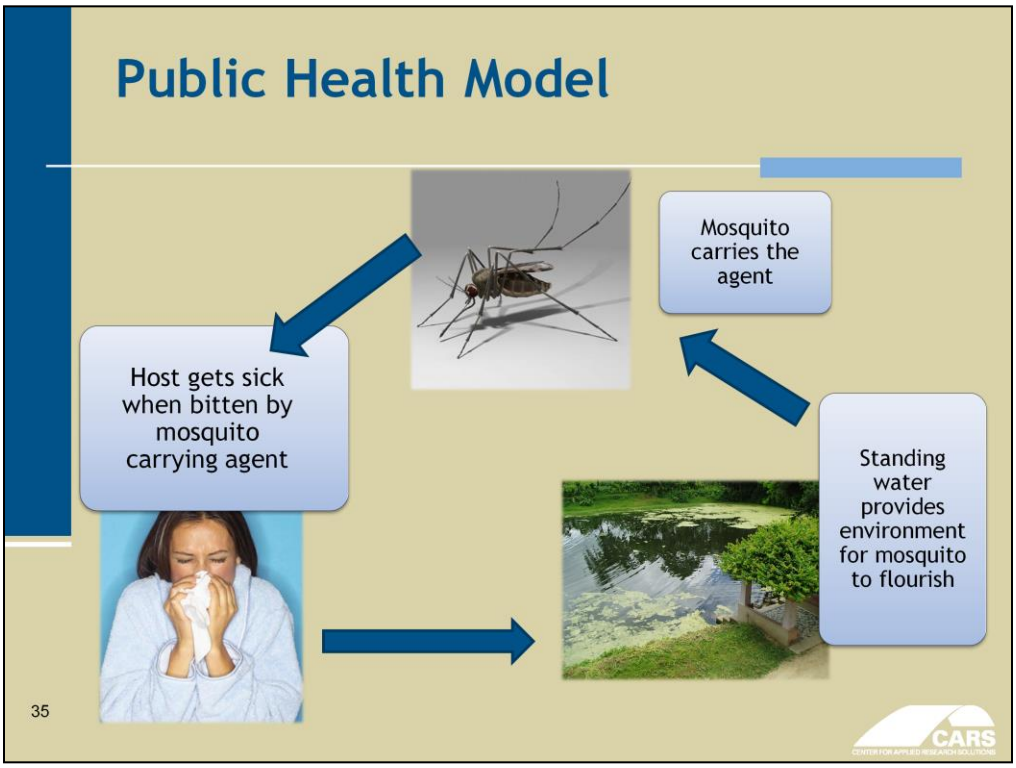
Maintenance

Relapse

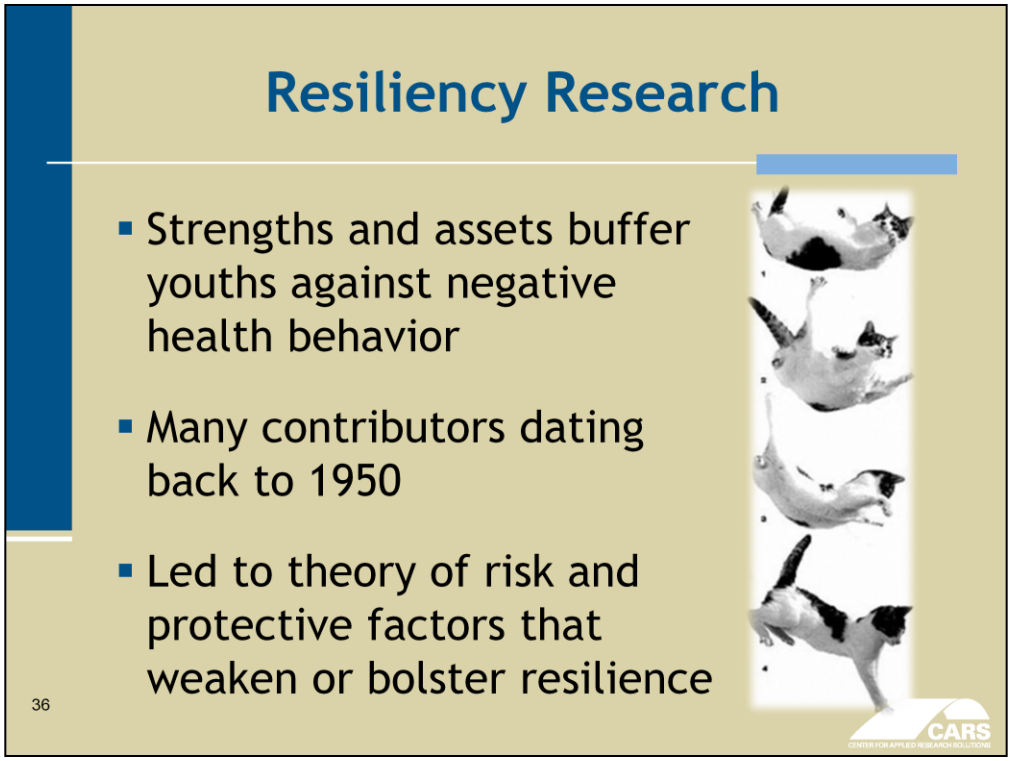
Many prevention programs and interventions address behavior change using this theory of change. Project SUCCESS (schools using coordinated community effort to strengthen students), a widely used and recognized prevention curriculum for adolescents, is based on DiClemente's theory of change model.



Using a disease prevention analogy, the public health model approached an issue by understanding the interrelationship between the host (person) the agent or vector (substance) and the environment (place, situation, circumstances, relationships).



To provide a simple example: The mosquito carries the vector/agent malaria and the environment is standing pool of water….all leading to the spread of disease. In this case the mosquito is a carrier that does not get sick. Taking this one step further, we can see that the host can limit their exposure to the agent by controlling the mosquito itself and controlling the environment that allows them to proliferate. When this model is applied in the prevention field the host is the person who is using or abusing drugs.



The concept of resiliency focuses on the strengths or assets that exist within communities, schools, and families and on individual characteristics that buffer youth against negative health behaviors, such as high-risk sexual behavior and substance abuse. However, what makes a youth resilient to certain negative health behaviors is unique to that particular individual and the environment in which he or she lives.

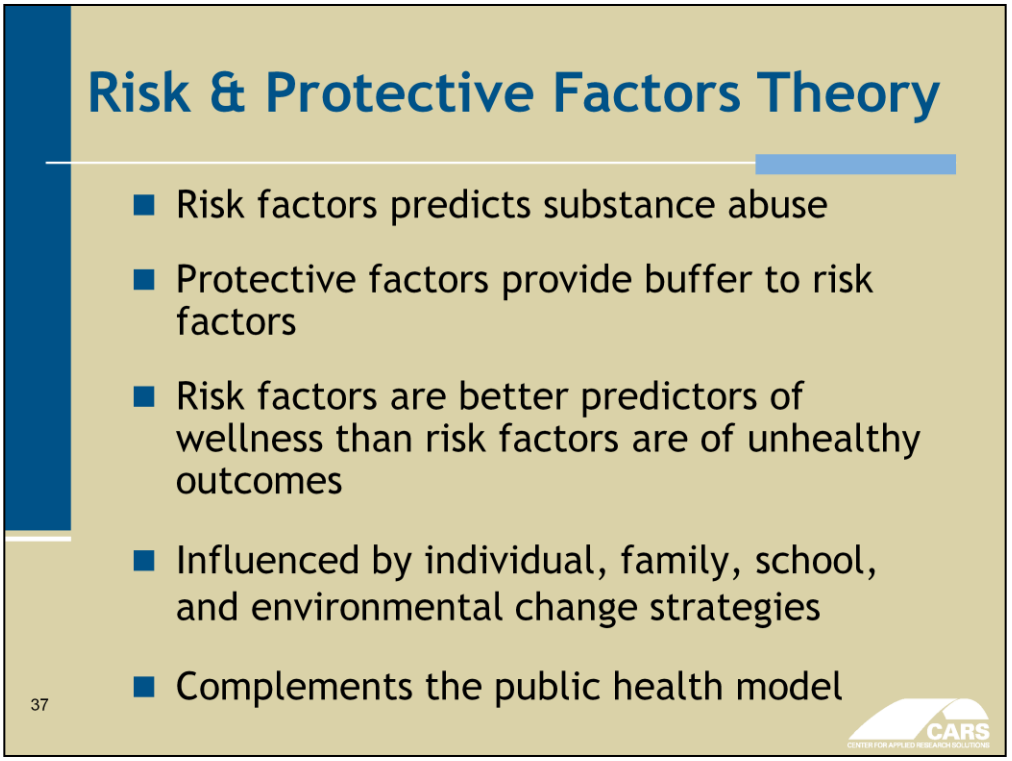
The concept of resiliency was first introduced into the adolescent health literature with a longitudinal research study by Emmy Werner that began in the 1950s and ended in the 1980s.

In 1992, David Hawkins and Richard Catalano developed the Risk and Protective Factor Framework that outlined individual characteristics, family behavior and values, and bonding to school, as well as the values and norms of the community that can protect youth from negative outcomes.

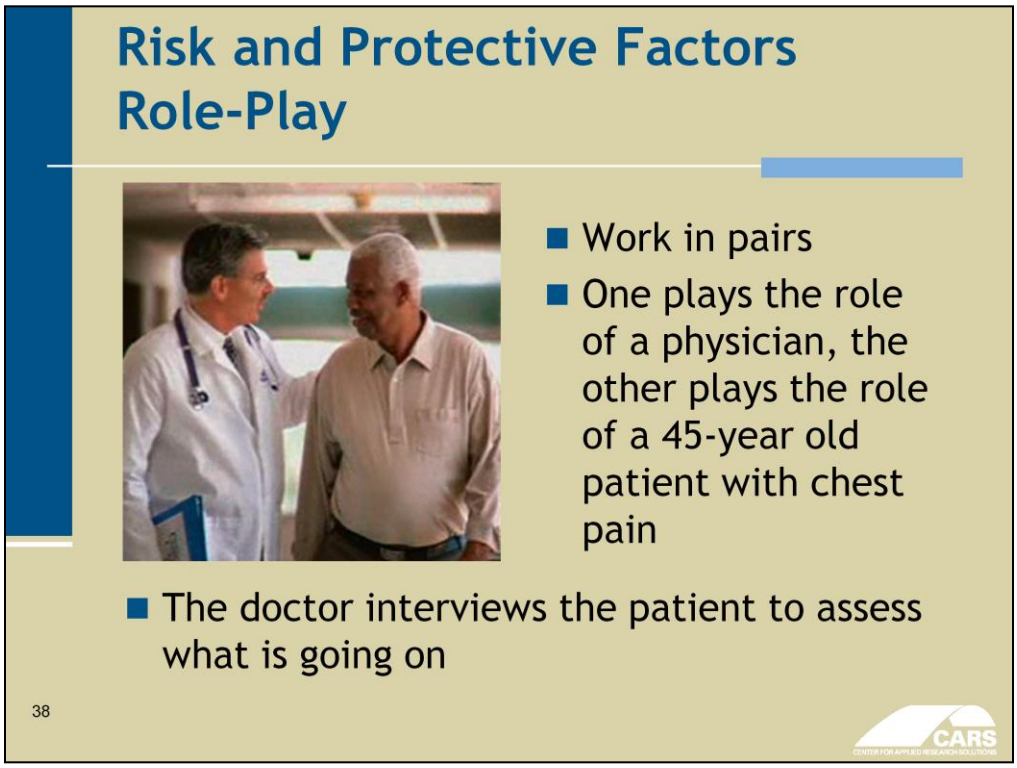
More recent research, such as that by Bonnie Benard, has furthered the concept that positive factors deter youth from engaging in negative behaviors.

Source: "Resiliency-Based Research and Adolescent Health Behaviors", by Elizabeth Rink, L.C.S. and Ray Tricker, Ph.D., C.H.E.S. (February 2003 - Vol. 10,

*No. 1).*Risk and Protective factors become the basis for the IOM model and population focused thinking



- The risk and protect factors theory says that while risk factors do predict substance abuse, protective factors can buffer risk factors.
- Risk factors were once thought to play a stronger role in predicting poor outcomes, but research now shows that protective factors are actually more influential and are better predictors. (Bonnie Benard, 2004).
- Risk and protective factors are influenced by individual, family, school, and environmental change strategies.
- It complements the public health model, with focus on decreasing risk and increasing protection within the environment and the host, while also decreasing access to the agent.



A. Physician-Patient Activity:

Set up: Ask participants to find a partner.

Have them designate one person "A" and the other "B."

A's role-play physicians; B's role-play patients.

Explain that patients are 45 year-olds consulting their physician after experiencing chest pain.

Explain that the physicians are to interview their patient for 5 minutes to assess what they believe is going on and to make some recommendations.

After 5 minutes, reconvene the group.

Debrief: Ask patients what kinds of questions their physicians asked them.

Why were these questions asked? *(Because these are risk factors for heart disease.)*

Did the physicians ask their patients what size shoe they wear? Why not? *(Because this is not a risk factor for heart disease.)*

What recommendations did the physicians make to the patients and why? *(To reduce risk factors and increase protective factors for heart disease.)*

How did non-physicians, role-playing physicians know what questions to ask and recommendations to make? *(Because U. S. Public Health has disseminated this research to the public and provided education which has resulted in behavior changes.)*

Heart disease rates in the U. S. have gone down significantly over the past 20 years due to the behavior and lifestyle changes made as a result of public health education.

David Hawkins and Richard Catalano at the University of Washington followed this public health model in their work on substance abuse prevention. They have organized their research into the Risk and Protective Factor Theory.

Risk and Protective factors become the basis for the IOM model and population-focused thinking.

CARS offer a day-long training on risk and resiliency.

Risk and Protective Factor Activity

This optional activity (20 minutes) is an interactive exercise designed to enhance understanding of how risk and protective factors interact and how they affect the life of a child.

Introduction

We know that some children exposed to high levels of risks do not develop adolescent problems behaviors. Why not? What is different for these children? Some children have a variety of protective factors in place in their lives which protect them from the impact of risk factors on their lives.

To experience how protective factors help protect children from risk, I'd like to involve a number of you in a fun role play. Your tasks in the role play will be simple, and I'll direct you, so no one will have to improvise on their own.

Instructions

May I have a volunteer who would like to play our "adolescent?"

Script: This is (name). (S)he lives with her/his Mom/Dad. (S)he is trying to do well in school, wants to stay out of trouble and have a more successful life than many of the adults (s)he sees around her/him.

May I have a volunteer who would like to play Mom/Dad?

Script: This is (name's) Mom/Dad. (S)he is very supportive and also wants (name) to do well in school, stay out of trouble and do more with her/his life than Mom/ Dad has been able to do. Referring to your SDS diagram, which protective factors do you see Mom/Dad providing? *(Bonding, healthy beliefs and clear standards)*

Now, Mom/Dad is supporting the family alone and works long hours. (Name) is out of school several hours before Mom/Dad gets home from work.

Who would like to play a grandparent?

Script: This is (names) grandparent, and Mom/Dad has arranged for (name) to go to the grandparent's house every day after school until Mom/Dad gets home. They are really working well together to make this time productive for (name). (Name) is to get something to eat, do homework and any assigned chores, and grandparent will be there to supervise and help if needed. Which protective factors do you see grandparent providing for (name)? *(Bonding, healthy beliefs and clear standards)*

Who would like to be (name's) friend?

Script: (Name's) friend is also trying to do well in school and wants to be successful.

The two friends are a great support and encouragement for each other. Which protective factors is the friend providing? *(Bonding, healthy beliefs and clear standards)*

Now can we have a coach?

Script: This is (name's) basketball coach. Recently (name) has become interested in basketball and has made the school basketball team. Coach thinks (s)he has real potential and spends time working to develop her/his skills and confidence. Which protective factors do you see at work here? *(Bonding, healthy beliefs and clear standards, individual characteristics)*

Who would like to be a police officer?

Script: This community police officer works with young people in (name's) neighborhood to help them find ways to contribute to their community. (S)he provides guidance and support for them to be drug free, successful in school, to develop goals for themselves, and create neighborhood revitalization networks. Which protective factors is the community police officer providing? *(Bonding, healthy beliefs and clear standards)*

Have the participants representing protective factors form a circle around the adolescent, joining hands, facing in. This is (names) circle of protection.

Also in the community we have some risk factors at play. Who would like to be a convenience store operator?

Script: This convenience store operator is known to sell alcohol and cigarettes to minors. Which risk factor does this represent? *(Availability of drugs)*

We need another friend.

Script: This friend has recently tried marijuana and wants (name) to try it, too. Which risk factor is this? *(Friends who engage in the problem behavior)*

(Name) has a sister/brother. Who would like to play this role?

Script: Sister/Brother has been involved with a group of friends who are receiving and selling stolen property, and making a good deal of money. Mom/Dad recently found out about it, and there has been a lot of heated arguing about it around home. What risk factor is this? *(Family conflict)*

Who would like to be a school board president?

Script: The school has policies about drug use by students and about weapons and violence at school. The policies are written and kept in some notebook somewhere in somebody's office. The school enforces these policies- unless the student involved is the star quarterback! Which risk factor is this? *(Community laws and norms favorable to the problem behavior)*

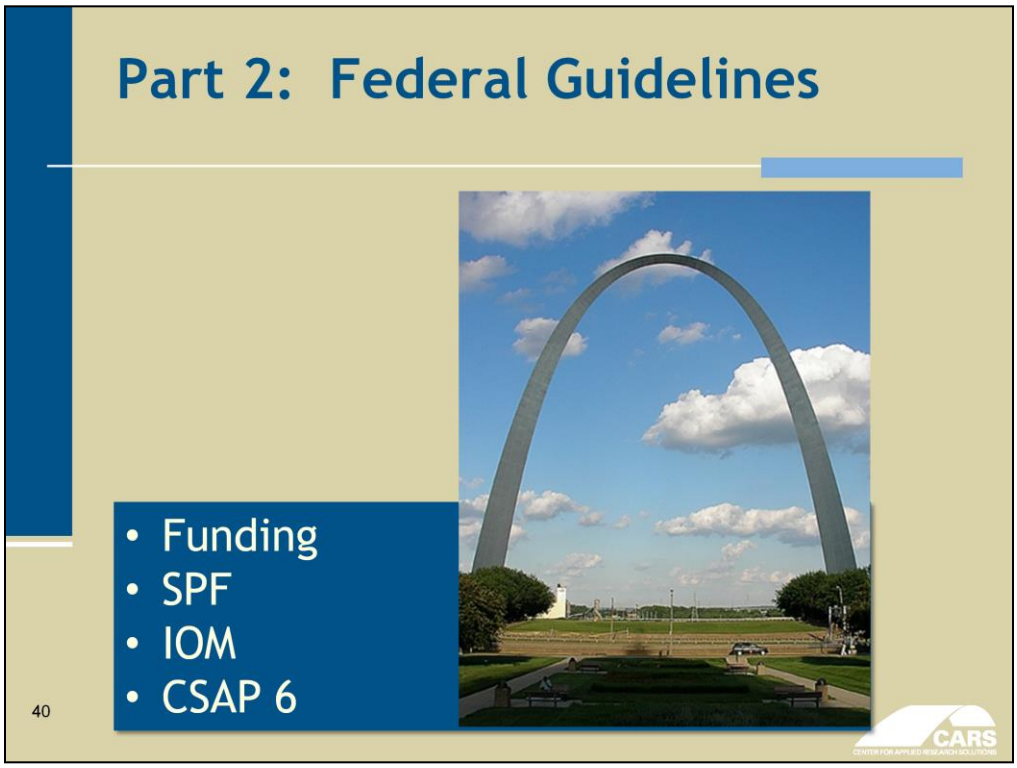
Instruct people representing risk factors to, without causing bodily harm, try to "get to" (name). Instruct protective factors to say or do what they need to in order to protect (name). Instruct participants not directly involved in the role play to observe what happens. After a few minutes, stop the role play and debrief what you saw/heard.

Ask the participant playing the adolescent to report how it felt to be in the middle of the action. Point out that sometimes it gets loud and active and we can almost overwhelm or smother our kids trying to protect them.

What did participants see/hear? *(Connect comments to the interaction of protective factors and risk factors.)* As protective factors, we can support young people by providing them with close bonds, healthy beliefs and clear standards.

But we can also protect them by facing outward and working to reduce the levels of risk factors. For instance, if the parent and grandparent got a group of parents together to picket the convenience store until they stop selling alcohol and tobacco to minors, they could reduce the level of the risk factor, availability of drugs. Or the coach and the police officer could hold the school board president accountable for consistent application of the school drug policies, thereby reducing the level of the risk factor, community laws and norms favorable to the problem behavior.

Close by leading applause to thank participants for helping illustrate how protective factors and risk factors interact in the life of a child.



Much of the prevention profession is guided by the research, tools and funding from the federal government.

First, we'll talk about funding sources and guidelines

Then we'll talk about the three sets of guidelines, and how they fit together:

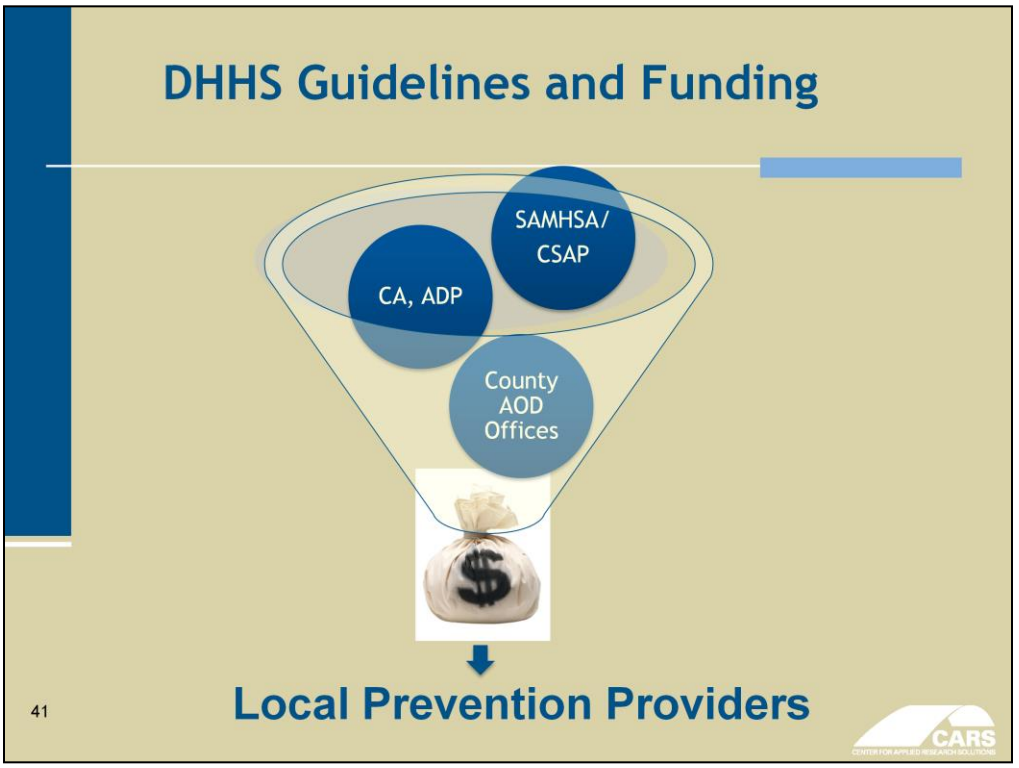
•The Strategic Prevention Framework, or SPF, which provides the framework

•The Institute of Medicine Model, or IOM, which determines the population

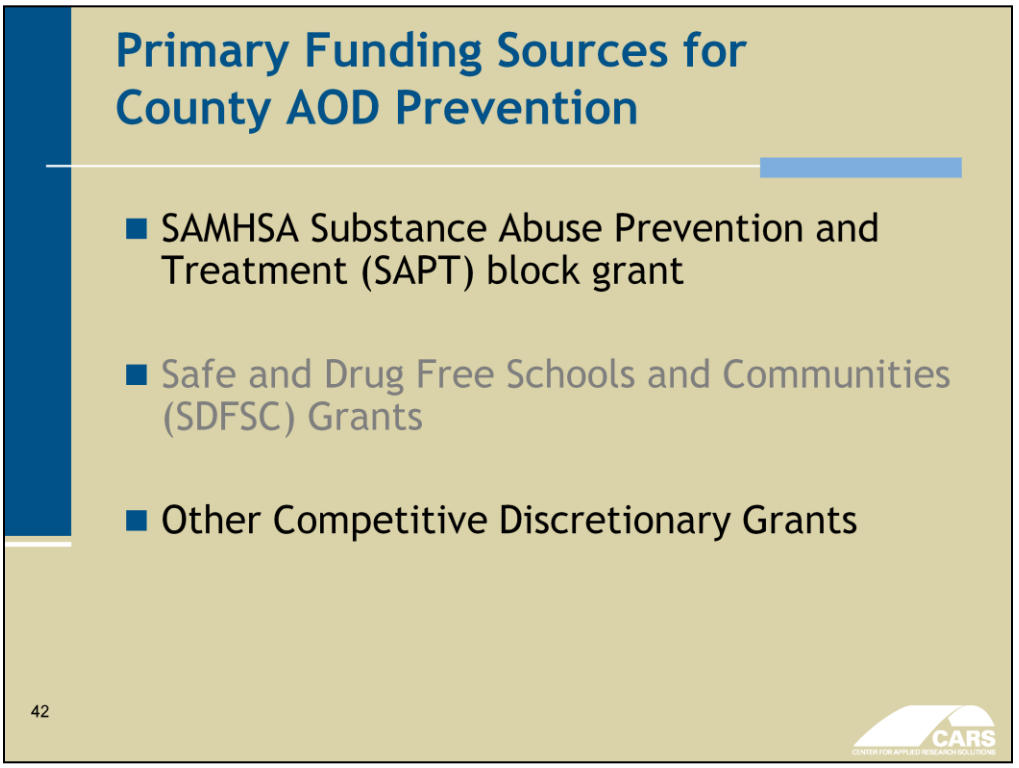
•And the six Center for Substance Abuse Prevention (CSAP) strategies, which tells us what we can do

Even if you don't receive (or think you receive) federal funds, many of your partners likely do. AND these are excellent planning tools and relevant models for the populations with whom you work.

So let's begin by talking about funding.



Let's start with funding. This graphic illustrates how the Department of Health and Human Services begins the funnel of money that starts at the federal level and then to states, passed onto counties and then, often but not always, community based prevention providers. In this way, government supported prevention work is done at all levels.

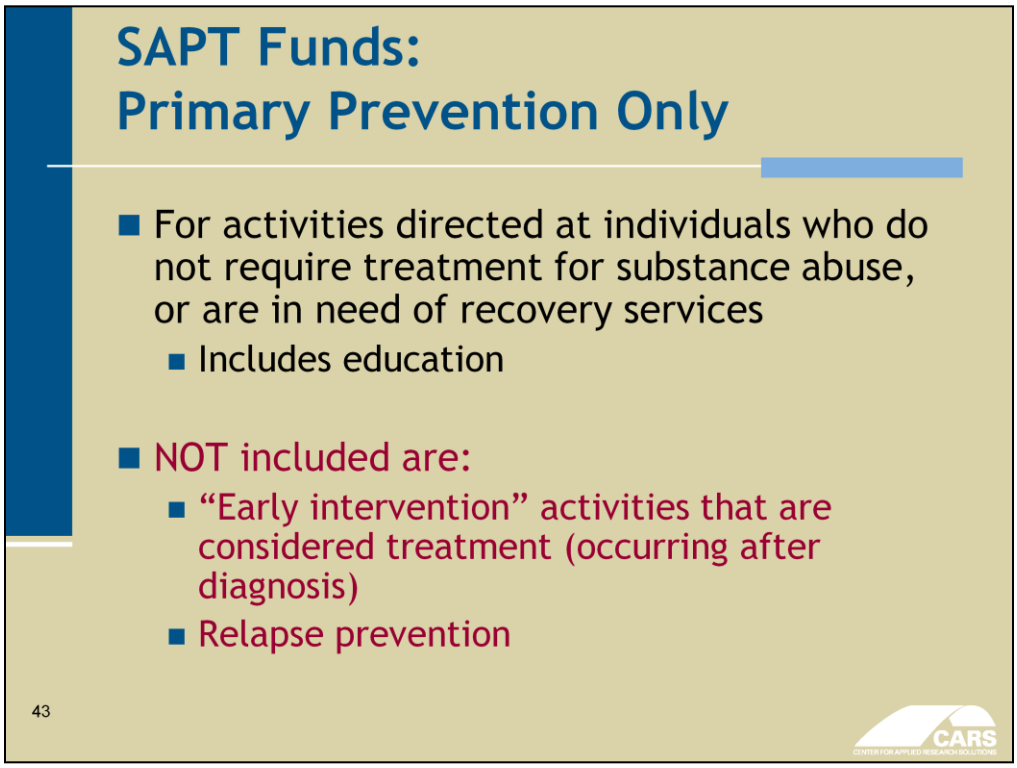


These are the primary funding sources for county AOD prevention:

•The SAMHSA Substance Abuse Prevention and Treatment (SAPT) block grant is a 20% minimum set aside for primary prevention

•Safe and Drug Free Schools and Communities (SDFSC) Grants is a 20% Governor's Program Set Aside. Unfortunately, it is being phased out.

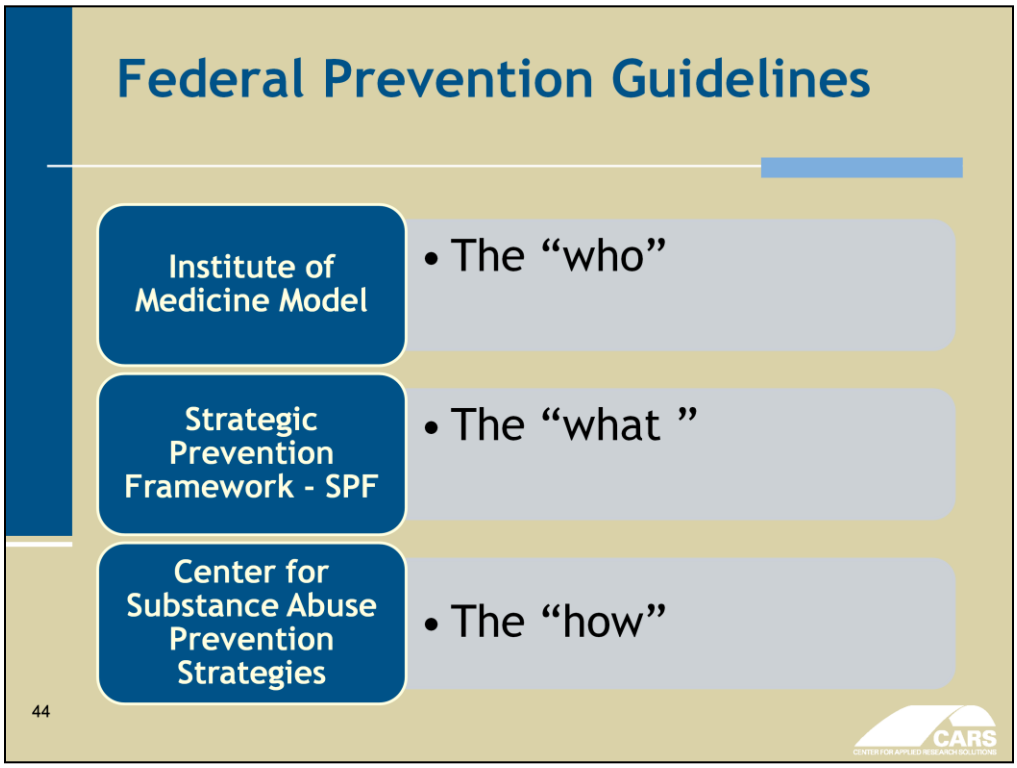
•Other competitive Discretionary Grants, such as the Drug-Free Communities Grants.



SAPT funds can only be used for primary prevention, which is carefully defined. They are for activities directed at individuals who do not require treatment for substance abuse, or in need of recovery services. It includes education.

It does **not** include early intervention activities that are offered after a diagnosis has been made, and relapse prevention is not included.

This can gets confusing, since the term "intervention" is being used in the CA version of the IOM model to describe activities that transcend across prevention, treatment and maintenance on the continuum of care. We'll talk more about these models later.



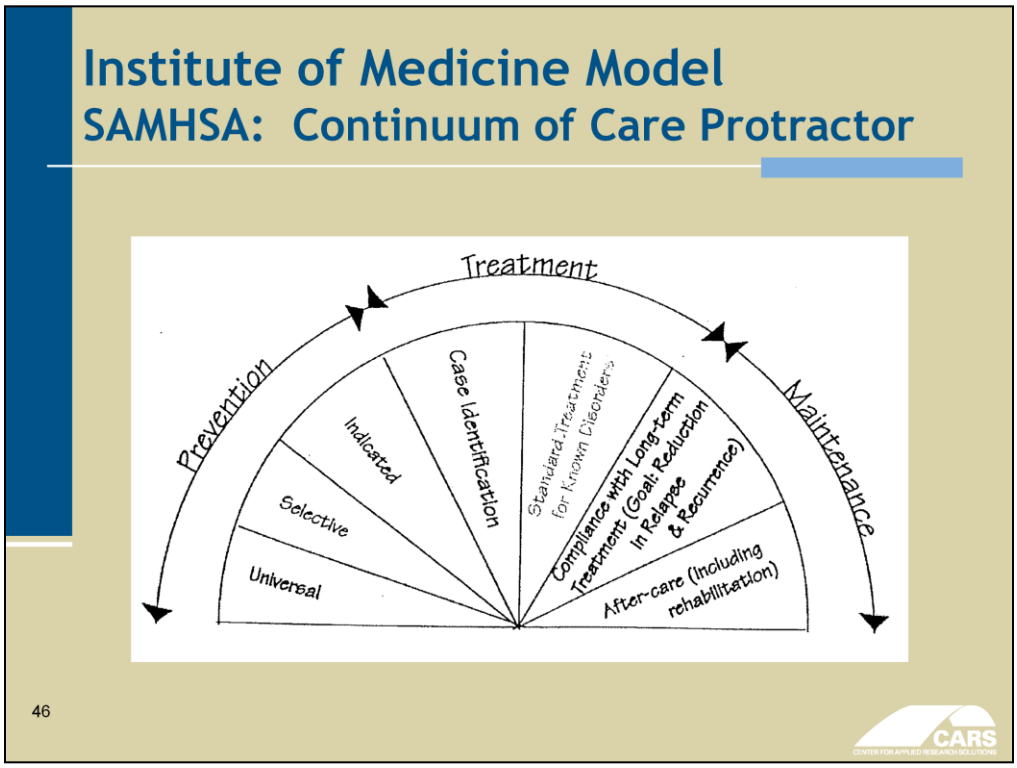
Now let's review the three types of federal prevention guidelines, and how they fit together:

•IOM is a risk-based categorization of prevention by population within a Continuum of Services. It provides the "who" of prevention services.

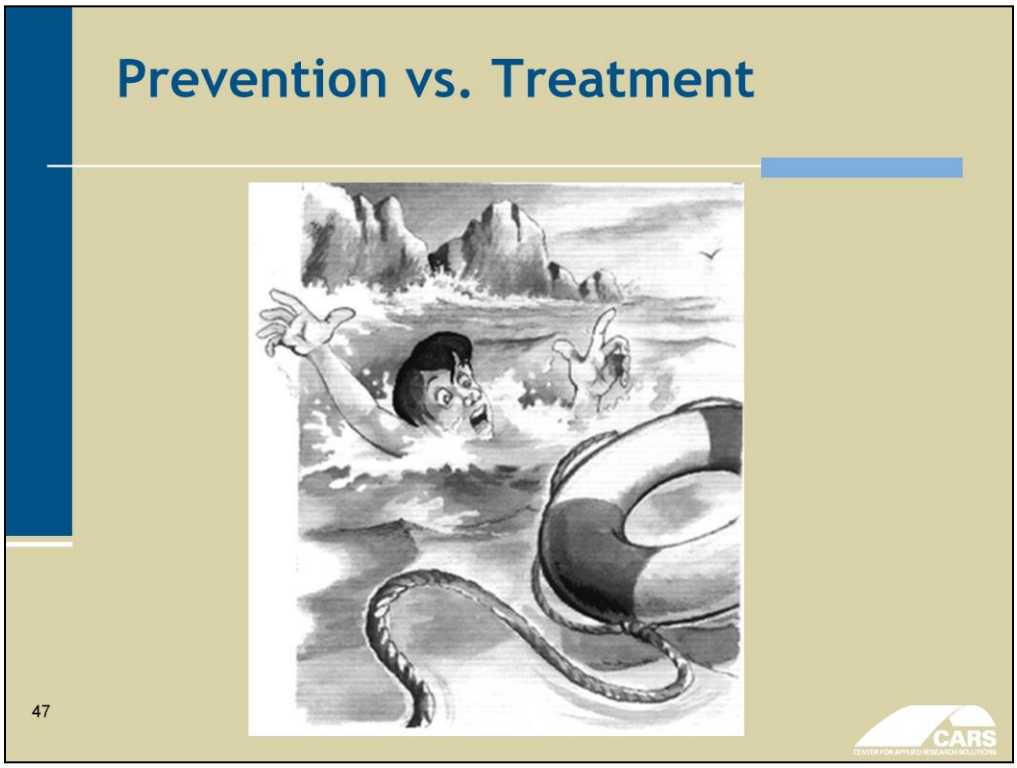
•SPF provides the "what." It is the framework that drives the work (strategies and activities) with the risk populations.

•CSAP Strategies are the "how" of prevention: six basic strategies by which prevention efforts are categorized.

Next, for the "who" of prevention.



The "who" is determined by using the IOM Continuum of Care Protractor. Note that prevention is only focused on the first 1/3 of the protractor. Prevention can be concretely defined as all services provided prior to a specific diagnosis of abuse or dependence. Treatment comes after.



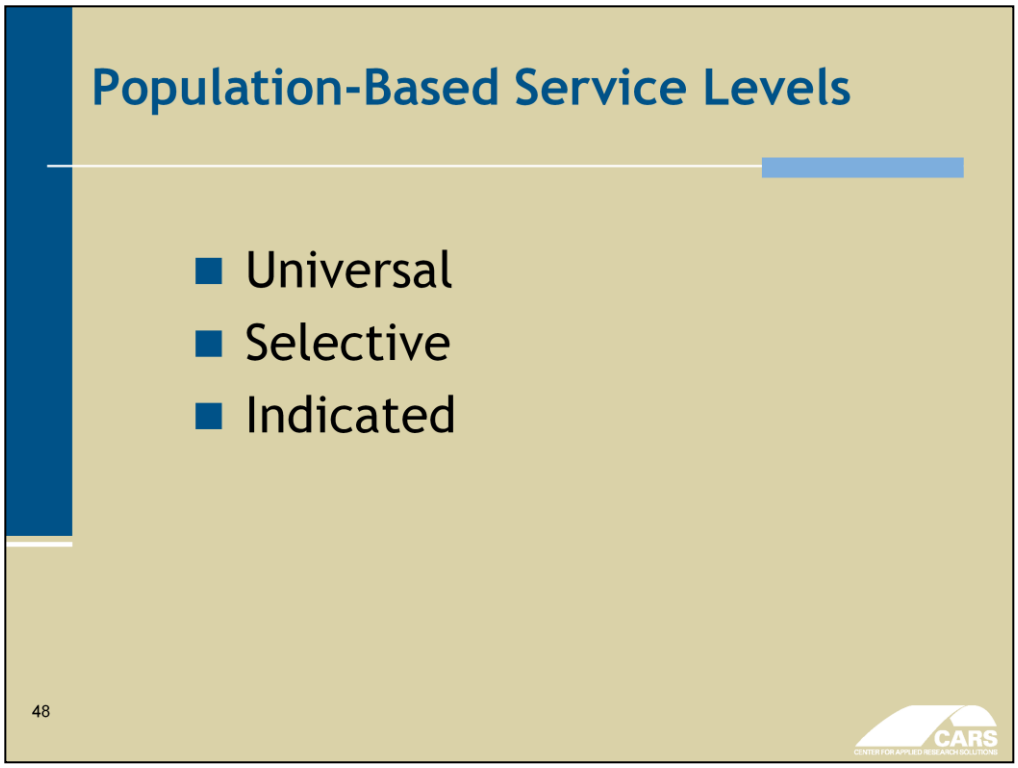
Let's pause now and elaborate on the difference between prevention and treatment, because it is a very important distinction to funders.

I'll tell a story that may illustrate the difference. Two friends, Susan and Fernando, are fishing on a river when Fernando looks up river and sees a man in the water! He is struggling to stay afloat, so Fernando drops his fishing pole and pulls the man out of the water. The man is sputtering and cold, and Susan calls an ambulance on her cell phone to take the person to a hospital. Susan and Fernando go back to fishing. Pretty soon they look up river again and see a woman in the water! She is struggling, too, so Fernando drops his fishing pole again and pulls the woman out of the water. She is not in very good shape, so Susan calls another ambulance to take her to a hospital. The friends return to fishing when they look up river and see a whole group of people in the water! They are struggling to stay afloat, but look like they are dragging each other down. Fernando drops his fishing pole and starts hauling people out of the water. He looks up and sees Susan walking away, up river. He calls to her to come help pull these people out of the river, and Susan responds that she is going up river to find out why all the people are ending up in the water.

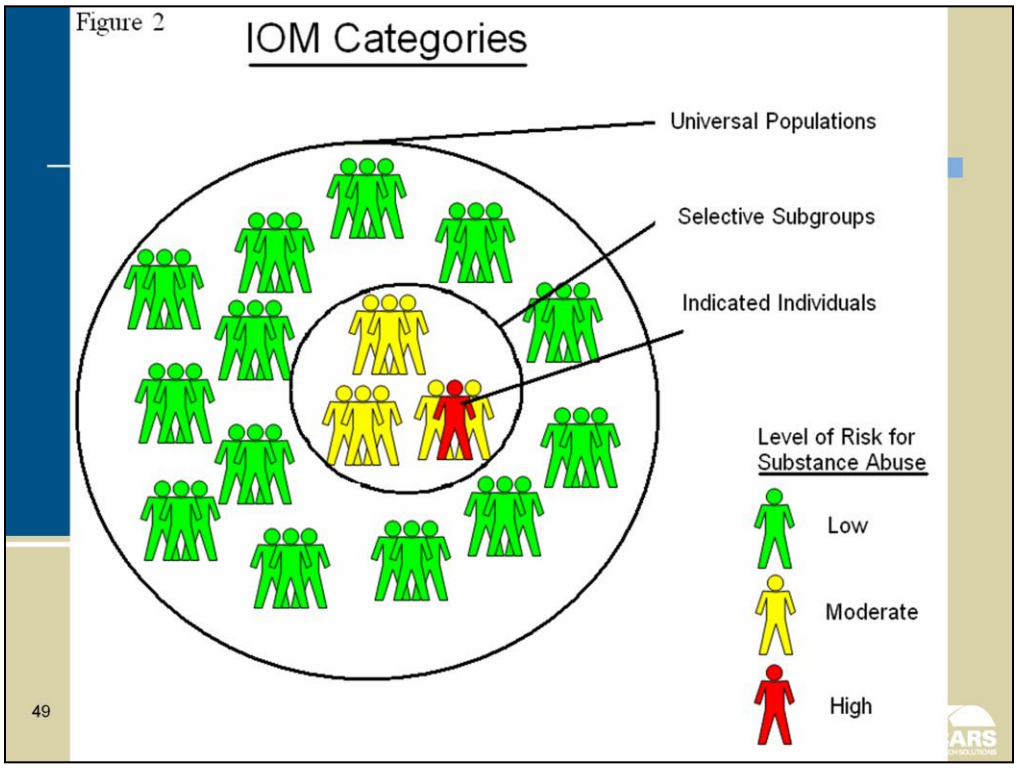
The people in the water represent individuals who are already in trouble with alcohol, tobacco or other drugs. Do you think we will always have some people in the water, or that we will ever completely eradicate substance abuse? We know we will always need ambulances, representing treatment providers, to provide treatment services for those already harmfully involved with substances. We in prevention, however, work up river. We go up river to find out what contributes to people ending up abusing substances and needing treatment services. We want to know exactly what is causing people to fall into *this* river, which may be different from river to river. Perhaps we go upstream and find a fence, built to keep people away from the river, has fallen and needs to be rebuilt. Maybe we find a slippery slope running into the river and can plant vegetation on the slope to prevent people from falling down the slope. Maybe we find a big sign announcing, "The water's great, jump in!" and we can take the sign down and replace it with a warning sign.

So, in prevention, we work to find out what is causing kids to abuse substances in *our* community, and then we work to reduce those risks and to build protection against substance abuse. In this curriculum we will offer a research-based process communities can use to assess their community's unique needs in relation to substance abuse and its contributing factors, find where gaps exist in their current prevention plan, use proven prevention strategies to design programs and services that will enhance their particular community's efforts to prevent substance abuse, and evaluate the effectiveness of their efforts.

Ask participants if this story helps clarify what prevention is and how it differs from treatment. Solicit comments and questions toward this end.



IOM uses three population-based levels of service: Universal, Selective, and Indicated.



Universal Prevention :

Addresses the **entire** population.

Aim is to prevent/delay use of ATOD. Deter onset through a variety of broad level approaches

Selective Prevention :

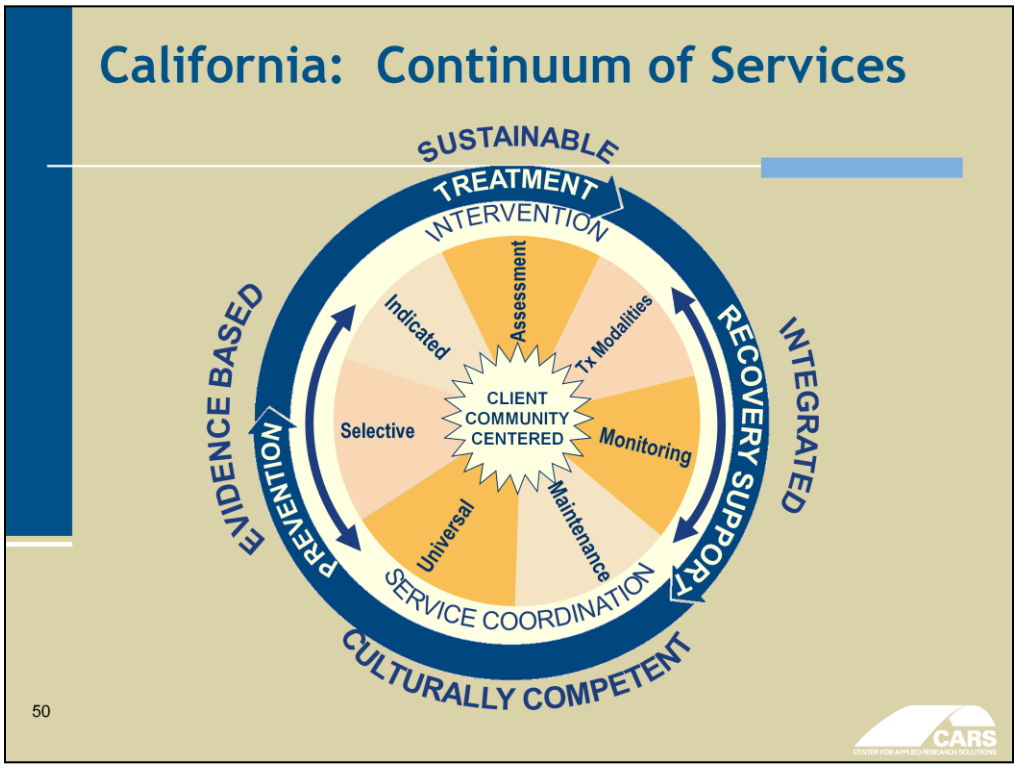
Addresses needs of **subsets** of population considered at risk by virtue of their membership in a particular subgroup.

Targets the **entire** subgroup regardless of the degree of risk in the group.

Examples: children in foster care, children who live in homes where alcohol and/or drugs are abused.

Indicated Prevention :

Focuses on **individuals** who are exhibiting early signs or consequences of AOD use or problem behavior associated with substance use.



Before we move on, let's examine California's Continuum of Services model, which is circular. Study the diagrams on page X and X of your Participant Guide. How are the IOM and California models the same?

With regard to Prevention, same population groups

How are they different?

•*Uses the terms "intervention" and "service coordination"*

•*Adds the values "evidence based," "sustainable," "integrated," "culturally competent," and "client community centered"*

•*Appears circular, but funding does not support a circular approach: there is no funding for prevention of relapse, for example, after diagnosis and treatment of drug abuse.*

The "What"

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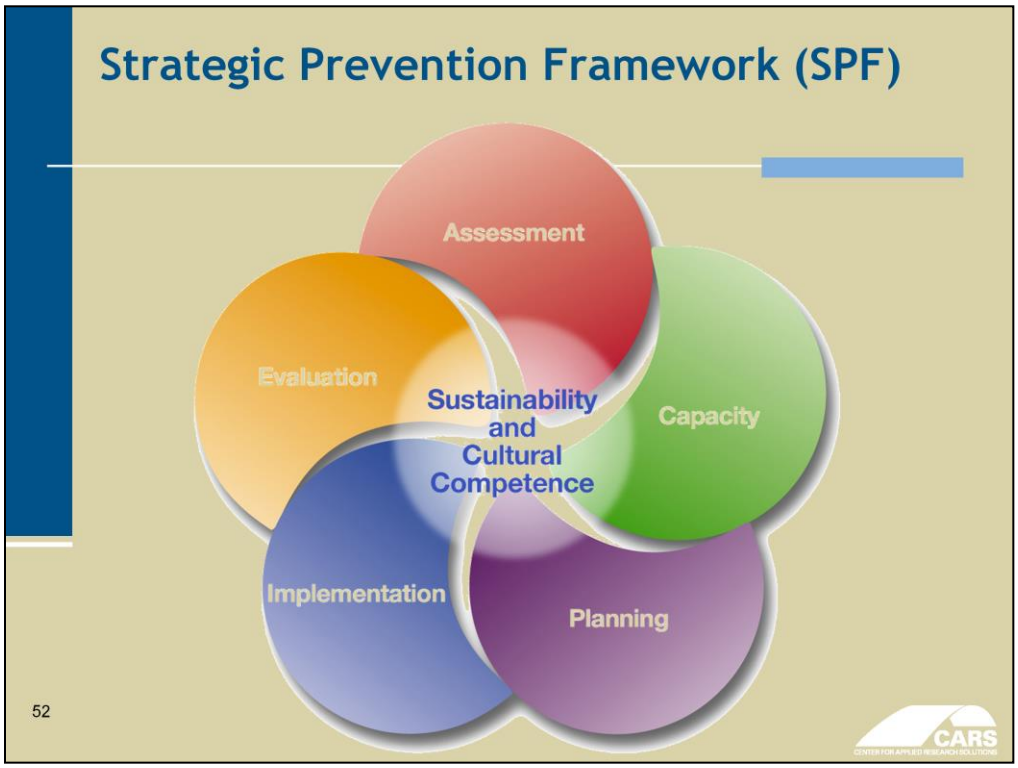
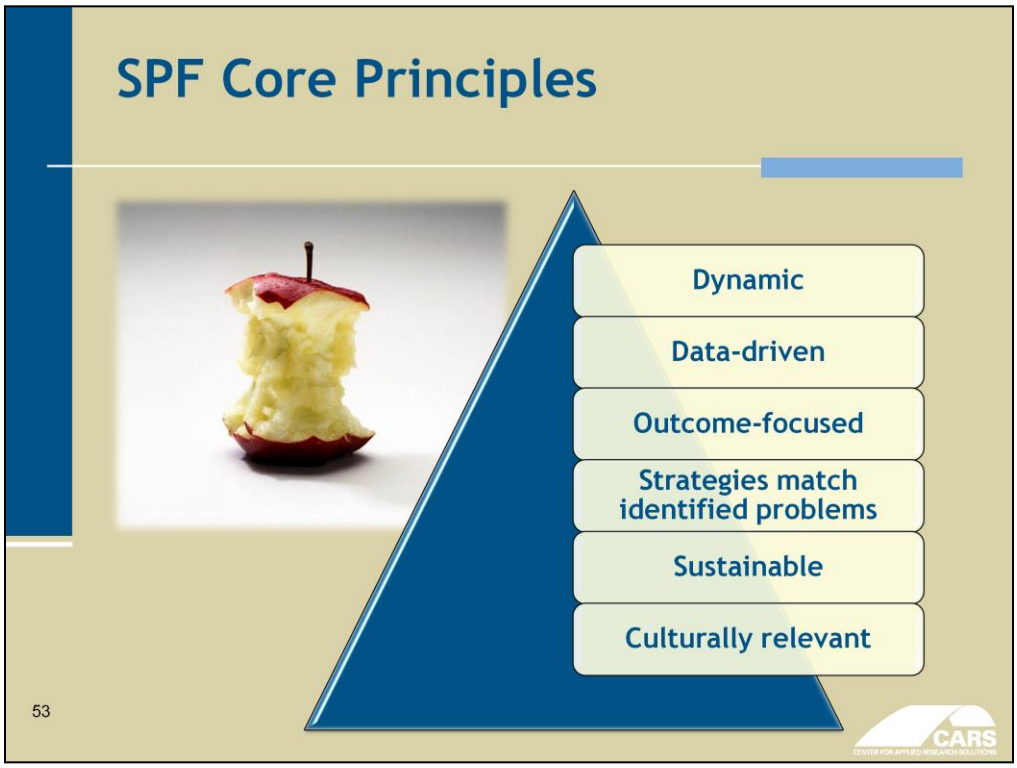


Let's start with SPF, which forms the framework for prevention activities. This is the SPF daisy. It is an excellent planning tool, used broadly by government and federally-funded agencies.

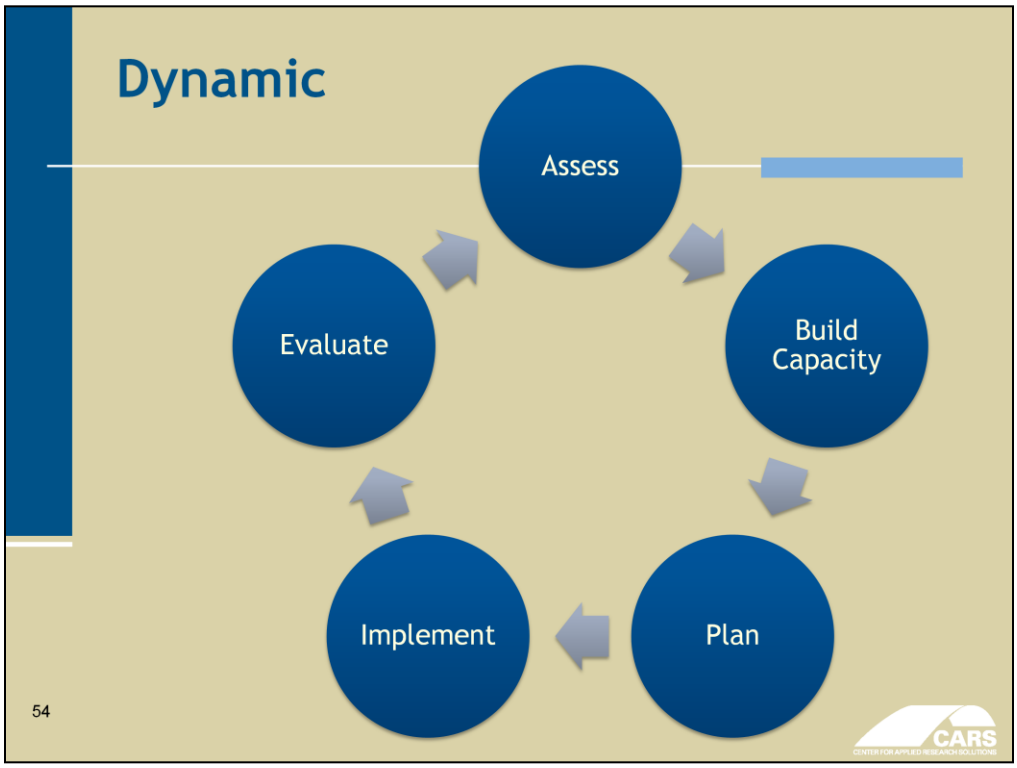
Cultural competence and sustainability central to SPF, so they are in the center.

The six petals are the stages of a prevention program: assessment, capacity, planning, implementation, and evaluation.

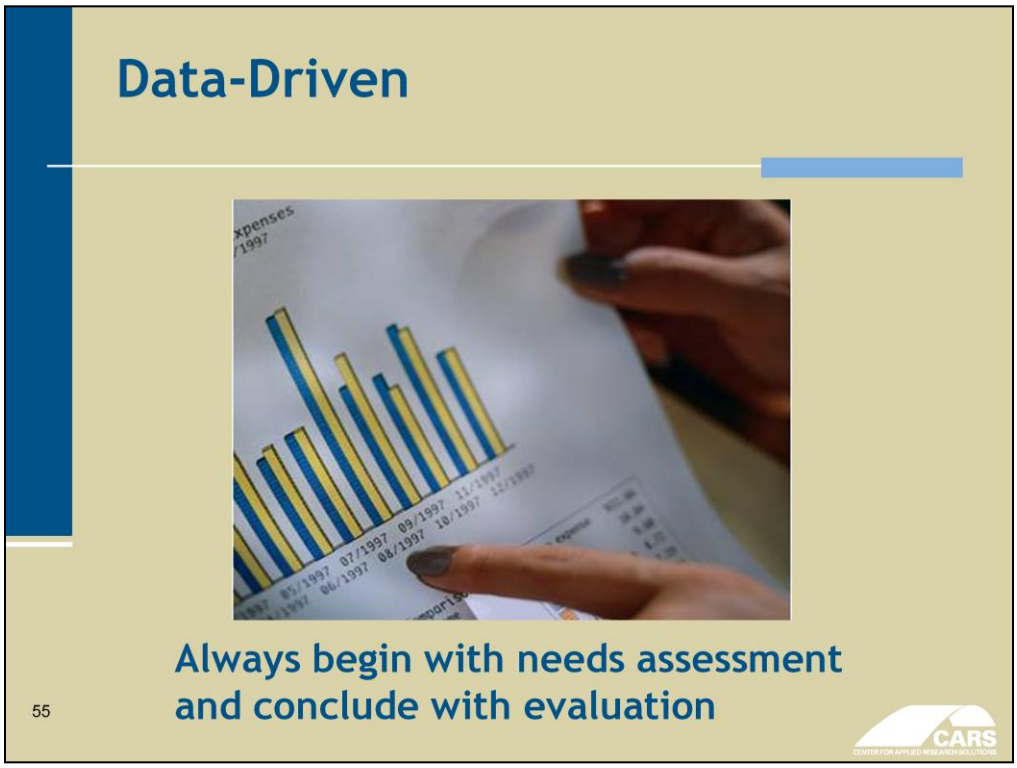
They are depicted in a circular design because they are meant to be dynamic, not linear.



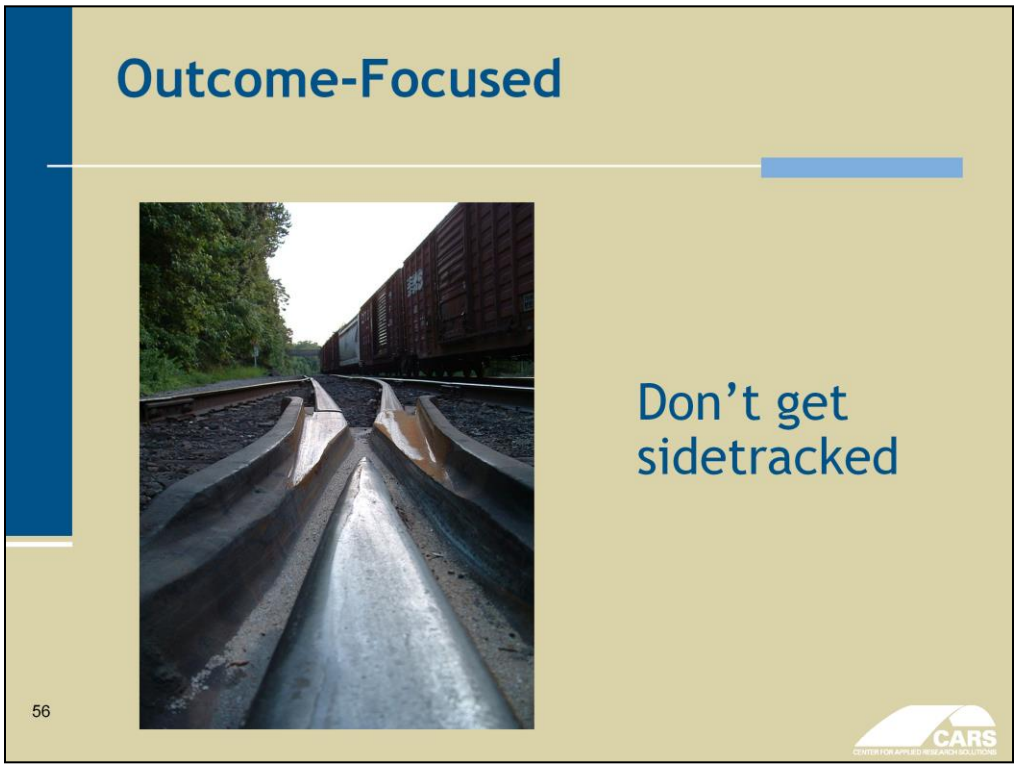
These are the core principles of SPF. They should be applied to every process in the daisy, everything we do in prevention. Let's examine them briefly.



By dynamic, we mean that strategic planning is ongoing and cyclic, not linear.



Data-driven means that the SPF process, from needs assessment to evaluation, uses data to inform decisions, select outcomes and gauge progress. It is important that data be reliable and replicable.



If you are clear on the outcomes you are working towards, all decisions become simplified and you are able to focus your time and energy where it will be the most productive. Don’t let yourself get sidetracked with activities that don’t lead in the direction of your stated outcomes.

This core principle relates back to your needs assessment. Make sure that your strategies match your community's needs and capacities, and that they address identified problems.

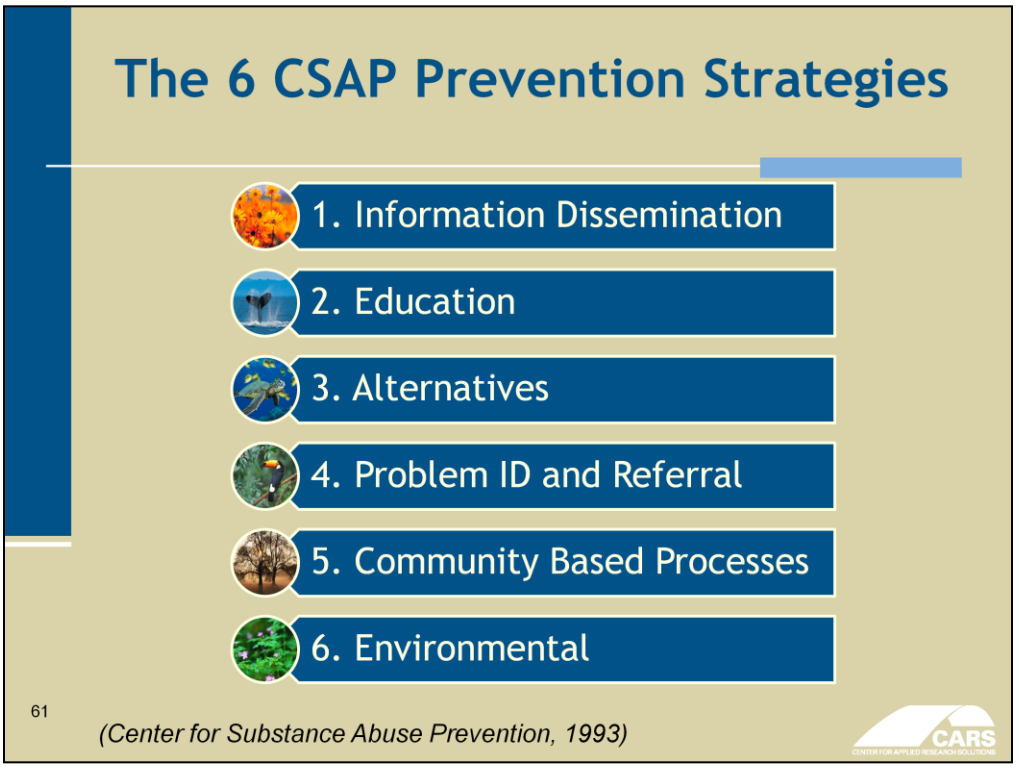
Sustainability will always be a consideration. You need a plan for how you will sustain your activities until your goals have been reached.

Finally, all your prevention activities need to be relevant culturally to the community in which you are working.

To be culturally relevant, your activities need to be community-based, community-driven, and inclusive. To get the community involved, you need to address real problems that they can perceive, and create real change.

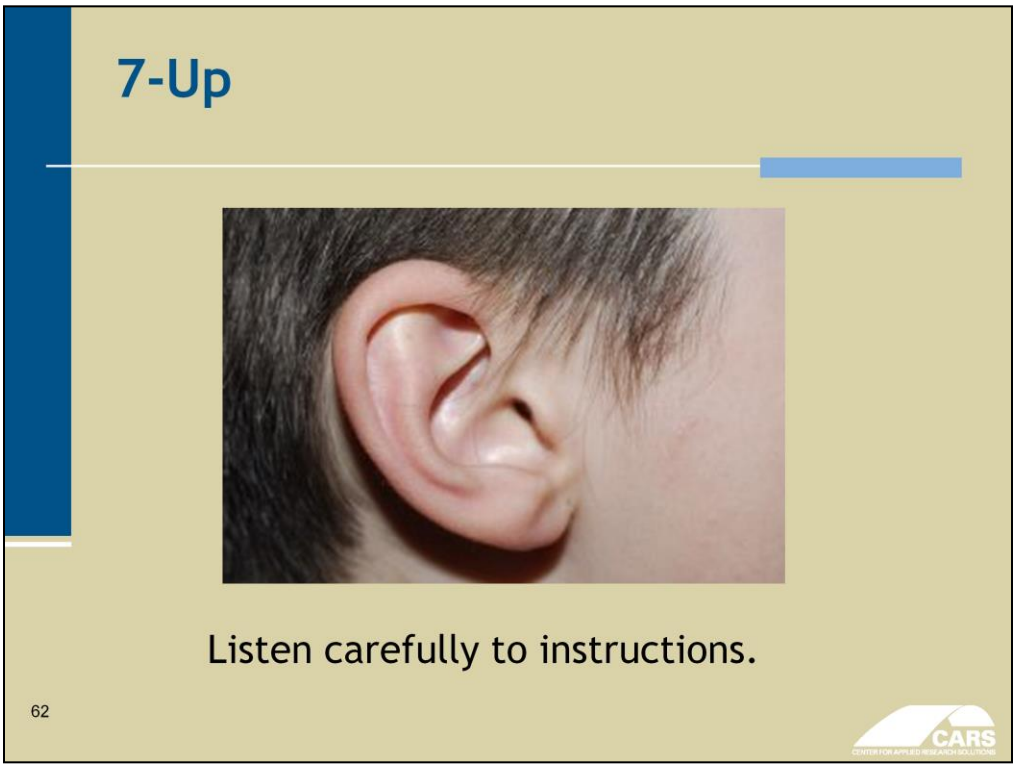
Cultural relevance is fundamental to sustainability. If it's not culturally relevant, it won't be sustained.

Next, the "how" of prevention. This leads us to the CSAP strategies.



These are the 6 categories of prevention activities, according to CSAP.

Again, these are federal guidelines and musts for those receiving this type of funding, but for others doing prevention, they still serve as an excellent resource and guide.



Activity: 7-Up*. The following is an optional activity to increase participants' understanding of the need for planning. (5 minutes)*

Tell participants you want them to join you in an activity called "7-UP." Then give them the following instructions:

It is very important that you perform well in this activity, so listen carefully.

There are two instructions for this activity:

There are to be 7 people standing in the room at all times

No one person is to stand for more than 5 seconds at a time

Do not respond to any questions, but quickly follow these instructions with:

"GO!"

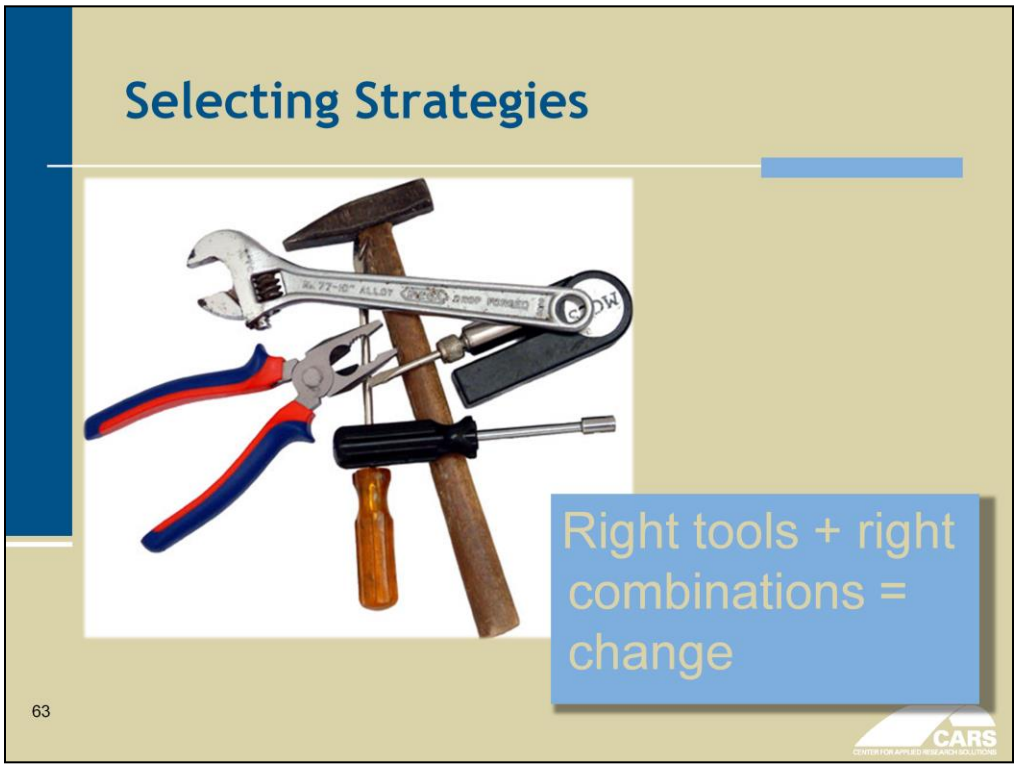
Observe, but do not speak with participants. After about a minute, call "time" and debrief the activity around the following questions:

What happened? *(Point out that most people just assumed they couldn't talk to each other, that some people tried really hard to participate and make it work, others exhibited frustration and gave up trying, others refused to play at all, and still others may have tried to organize the group at some point, with varying degrees of success.)*

Did the instructions sound clear and specific at first? Did the fact that you were told that it was very important that you perform well create stress?

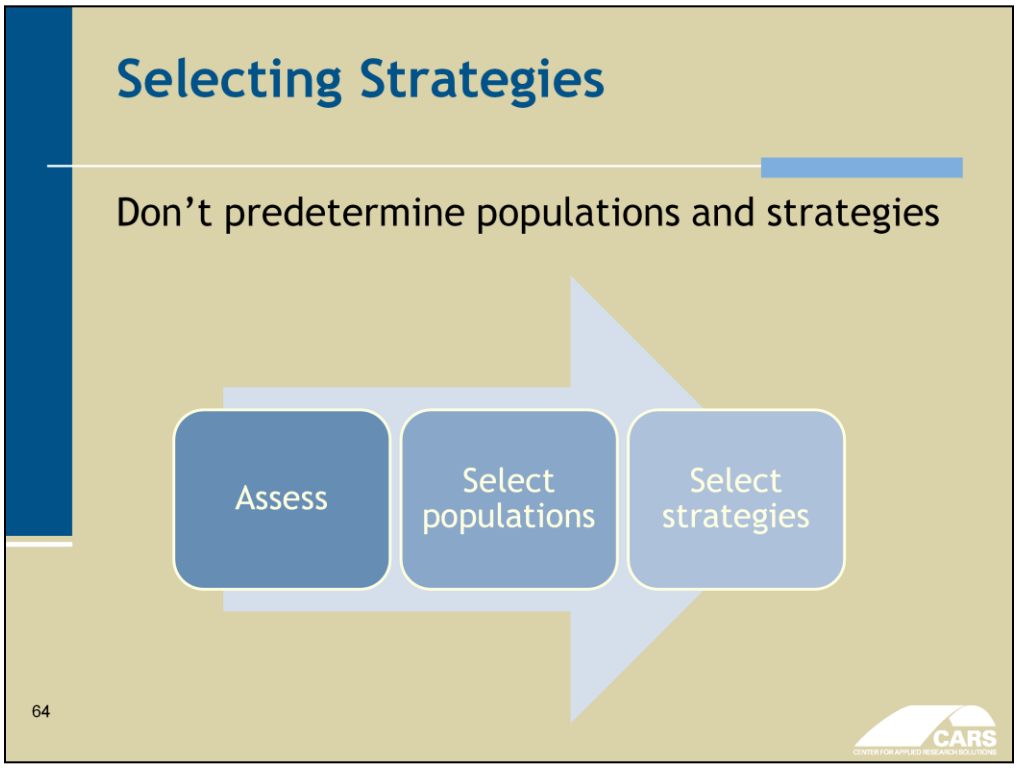
What would have made it easier for you to be successful? *(Communication, an articulated reason for doing the activity, a mutually agreed-upon plan, cooperation, encouragement, celebration of success, etc.)*

What does this activity have to do with planning? *(Compare this experience with the way many of us do prevention in our communities. We know it is very important that we are successful in helping young people avoid the use of drugs. There are many people, programs, agencies and organizations working hard to prevent adolescent substance abuse, and we can get frustrated when our desired outcomes are not achieved. A few of us might try working together, but there is rarely any overall community plan for prevention that informs each of us how our piece "fits" into the bigger picture of prevention in our community, why we are doing what we're doing, how we know it is likely to work.)*

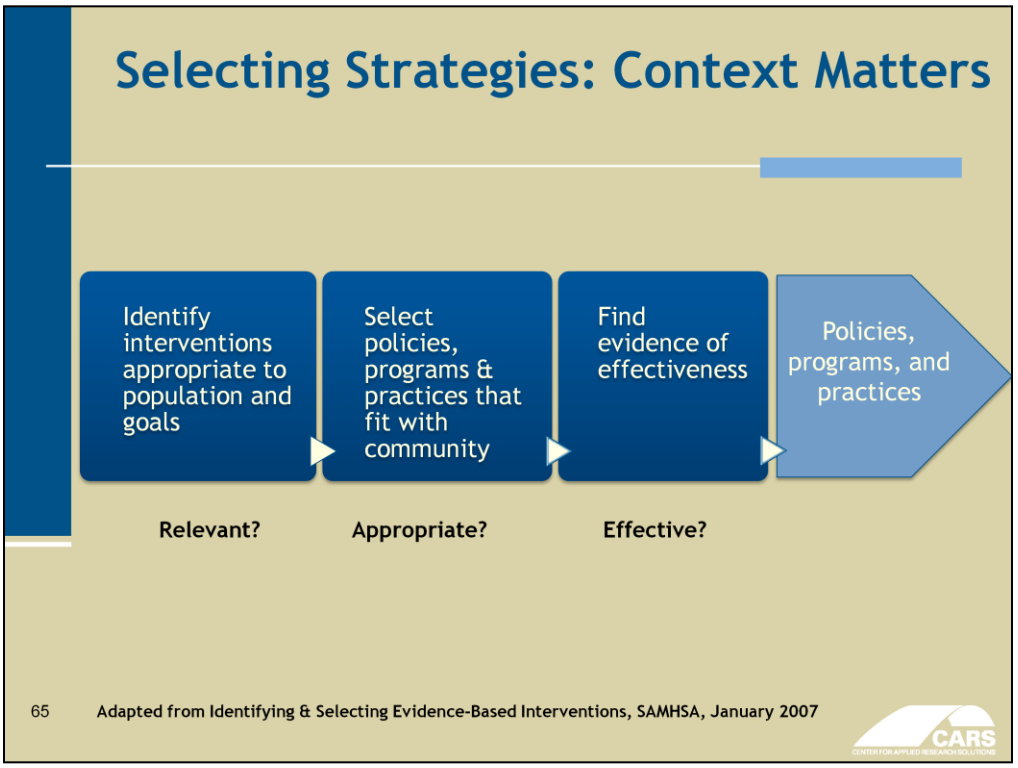


Let's consider the process of selecting strategies for your program.

It is likely that you will need to employ multiple strategies to achieve your goals. You will need to use right tools, in the right combinations, to make the desired change.



Populations to be served and service strategies should not be predetermined. They should be selected based on the findings of your assessment and refined during the planning process.



When selecting strategies, context matters.

First, identify types of interventions, such as policies, programs, practices, educational, environmental, that address your population and fit your data-based problems, goals, and objectives. In other words, make sure your interventions are relevant.

Next, select policies, programs & practices that fit with community. Make sure the community has the resources, capacity, and readiness to support the intervention, and that it complements existing efforts. In other words, make sure it is appropriate.

Finally, make sure there is evidence of effectiveness, based in recognized practice, scientific reports, documented experience, and judgment

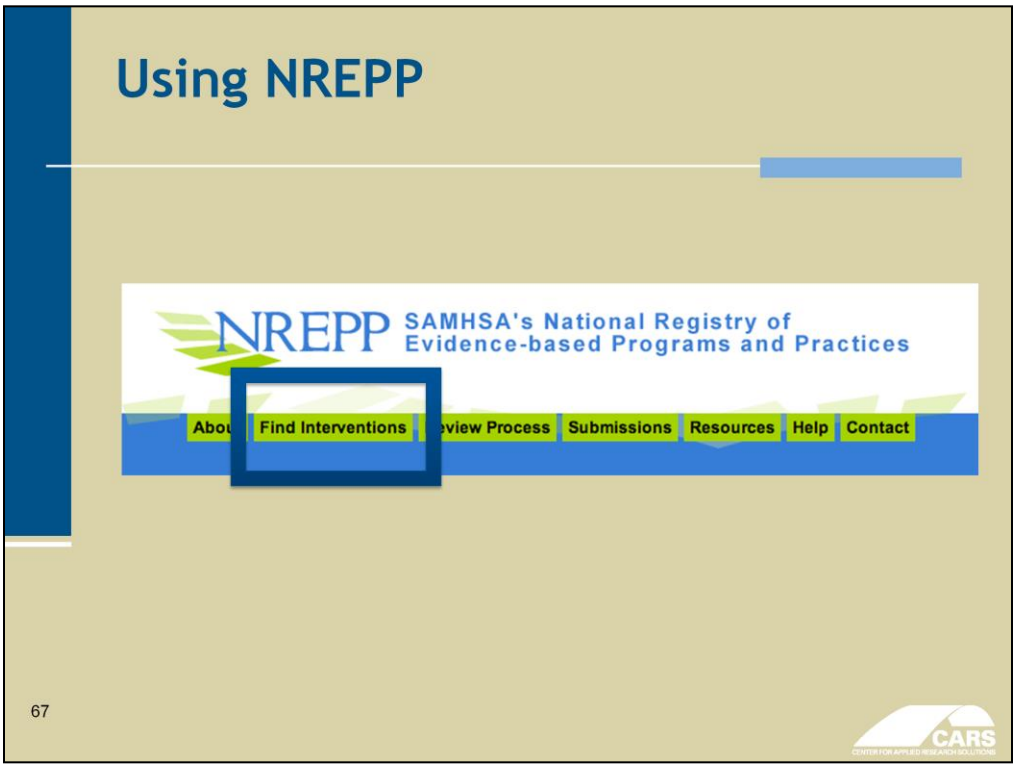
A source of prevention tools is the National Registry of Evidenced-Based Programs and Practices, or NREPP. It is a database of substance abuse prevention, treatment, and mental health "interventions."

It has evolved to a "continuum" of evidence approach:

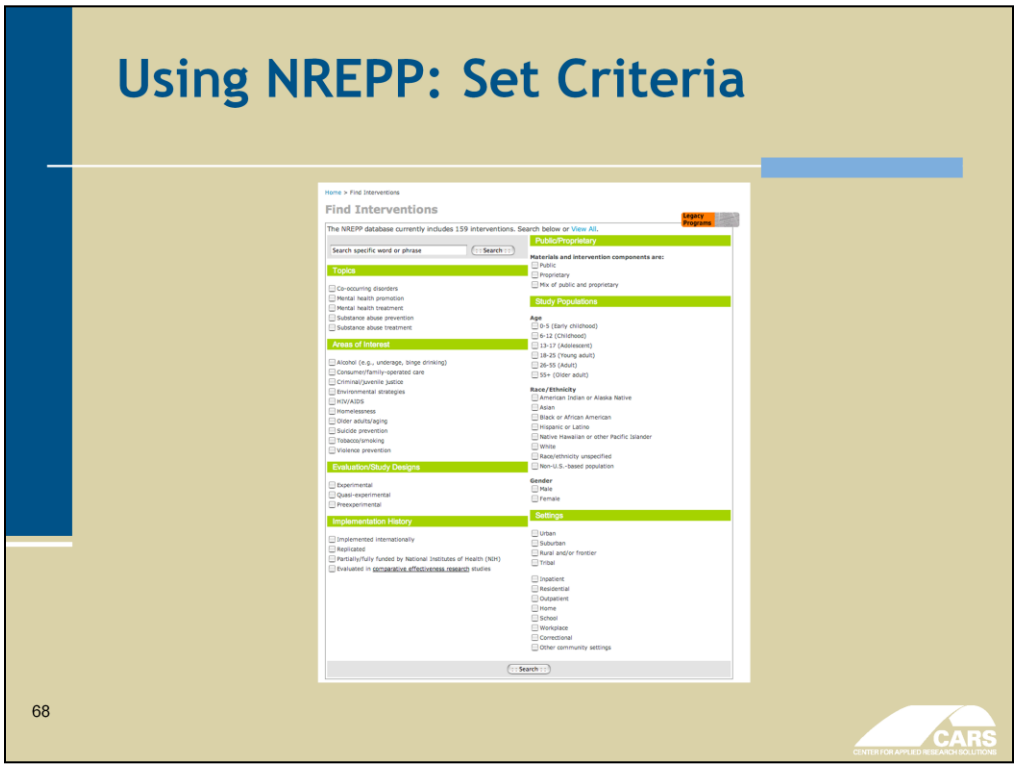
- Moved away from categories
- Model and Promising programs became "Legacy Programs"

- Seen as a “selection tool”
- States are able to create their own definitions/standards
- CA ADP acknowledges “Legacy Programs” as being evidence-based

NOTE: If Internet access is available, go to the NREPP site now and replace the next three slides with a live demonstration.



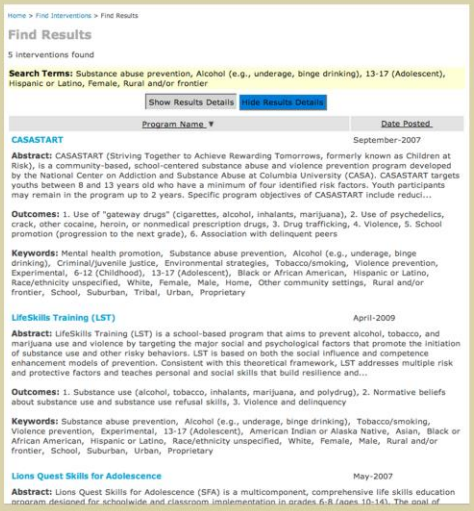
To use the NREPP site to find interventions, click on the Find Interventions tab of the home page.



This will open a form where you set the criteria for the type of interventions you are looking for. This includes topics, areas of interest, study designs, study populations, settings, and more.

For my search, I chose alcohol use by Latina teens in a rural setting. I checked off the boxes and clicked on “search” at the bottom of the page.

Using NREPP: Search Results


Home > Find Interventions > Find Results

Find Results

5 interventions found

Search Terms: Substance abuse prevention, Alcohol (e.g., underage, binge drinking), 13-17 (Adolescent), Hispanic or Latino, Female, Rural and/or frontier

Show Results Details | Hide Results Details

Program Name ▼	Date Posted
CASASTART	September-2007

Abstract: CASASTART (Striving Together to Achieve Rewarding Tomorrows, formerly known as Children at Risk), is a community-based, school-centered substance abuse and violence prevention program developed by the National Center on Addiction and Substance Abuse at Columbia University (CASA). CASASTART targets youths between 8 and 13 years old who have a minimum of four identified risk factors. Youth participants may remain in the program up to 2 years. Specific program objectives of CASASTART include reduci...

Outcomes: 1. Use of "gateway drugs" (cigarettes, alcohol, inhalants, marijuana), 2. Use of psychedelics, crack, other cocaine, heroin, or nonmedical prescription drugs, 3. Drug trafficking, 4. Violence, 5. School promotion (progression to the next grade), 6. Association with delinquent peers

Keywords: Mental health promotion, Substance abuse prevention, Alcohol (e.g., underage, binge drinking), Criminal/juvenile justice, Environmental strategies, Tobacco/smoking, Violence prevention, Experimental, 6-12 (Childhood), 13-17 (Adolescent), Black or African American, Hispanic or Latino, Race/ethnicity unspecified, White, Female, Male, Home, Other community settings, Rural and/or frontier, School, Suburban, Tribal, Urban, Proprietary

LifeSkills Training (LST)	April-2009

Abstract: LifeSkills Training (LST) is a school-based program that aims to prevent alcohol, tobacco, and marijuana use and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. LST is based on both the social influence and competence enhancement models of prevention. Consistent with this theoretical framework, LST addresses multiple risk and protective factors and teaches personal and social skills that build resilience and...

Outcomes: 1. Substance use (alcohol, tobacco, inhalants, marijuana, and polydrug), 2. Normative beliefs about substance use and substance use refusal skills, 3. Violence and delinquency

Keywords: Substance abuse prevention, Alcohol (e.g., underage, binge drinking), Tobacco/smoking, Violence prevention, Experimental, 13-17 (Adolescent), American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Race/ethnicity unspecified, White, Female, Male, Rural and/or frontier, School, Suburban, Urban, Proprietary

Lions Quest Skills for Adolescence	May-2007

Abstract: Lions Quest Skills for Adolescence (SFA) is a multicomponent, comprehensive life skills education program designed for schoolwide and classroom implementation in grades 6-8 (ages 10-14). The goal of

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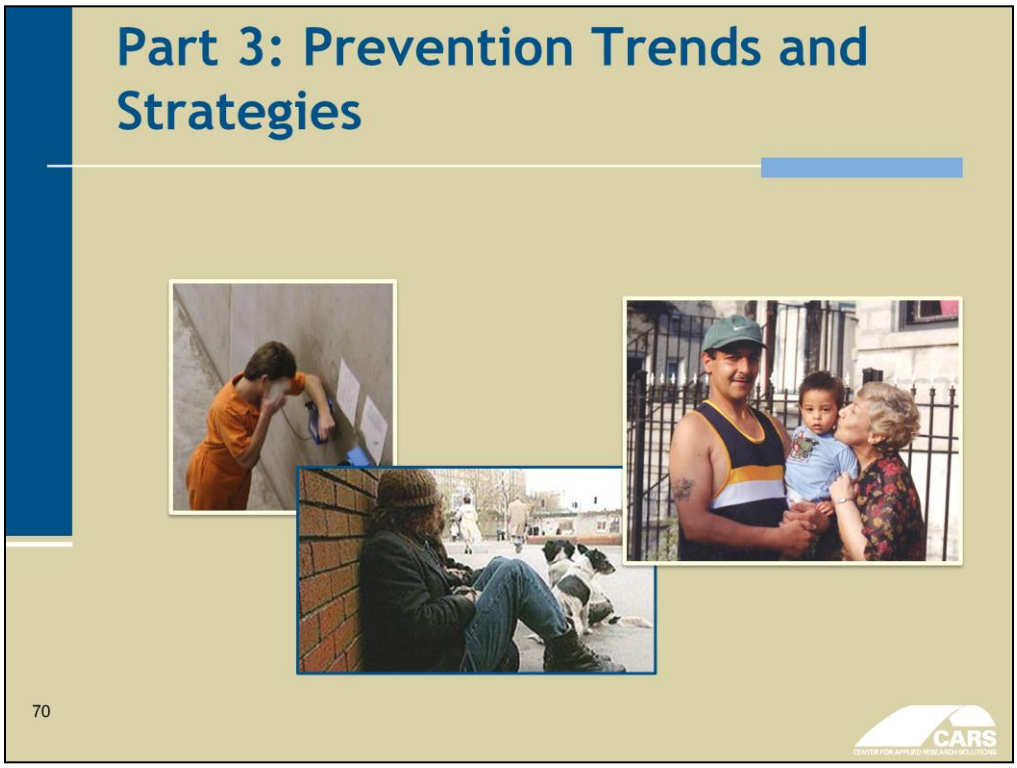
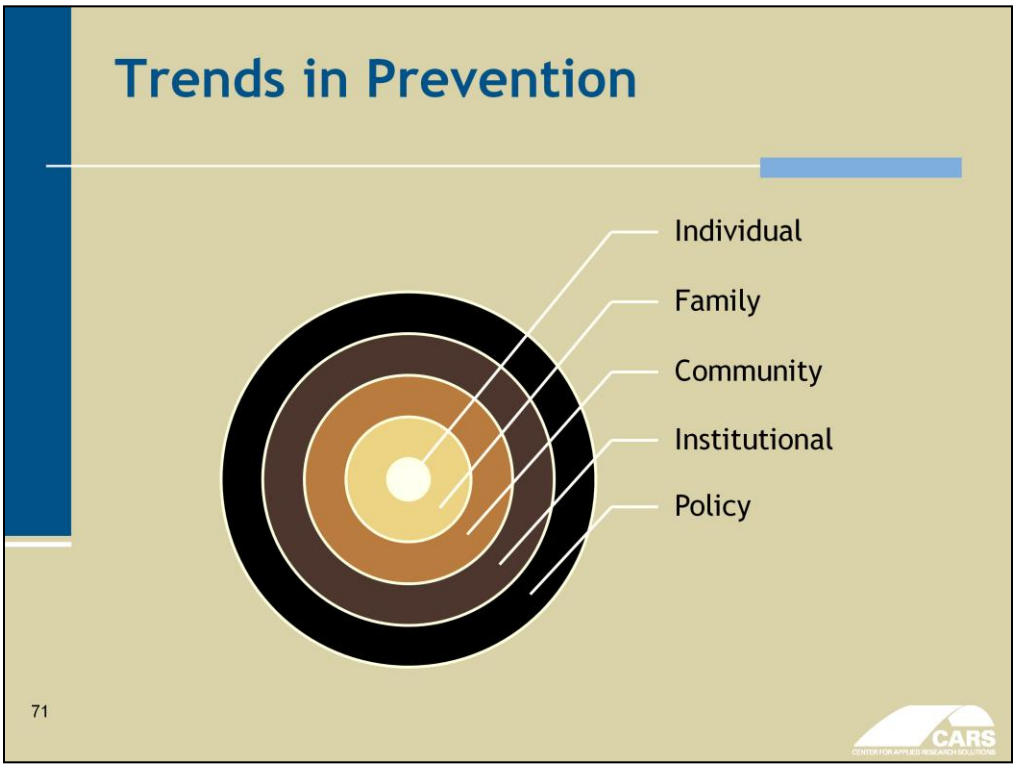
CARS
CENTER FOR APPLIED RESEARCH SOLUTIONS

My search turned up a list of 5 interventions that met my criteria. Clicking on any of them will open the abstract that describes the intervention and results.



In our next topic, we will discuss trends in prevention and prevention strategies.



Some current trends are based on sound research and have evidence practices associated with them. Others are more experimental, with studies and research still occurring.

One current trend is the focus on community prevention:

- Brings the power of individual citizens and institutions together
- Creates a comprehensive plan that everyone in the community has a stake in and owns
- Holds community institutions accountable
- Across the lifespan (not just youth)
- Outcomes measured at the population level, not just program level

Prevention Trends: Youth

Common components include:

- In school and after school curricula
- Experiential activities
- Service learning activities
- Peer leadership
- Family outreach
- Screening and referral
- Brief Intervention
- Teaching social skills

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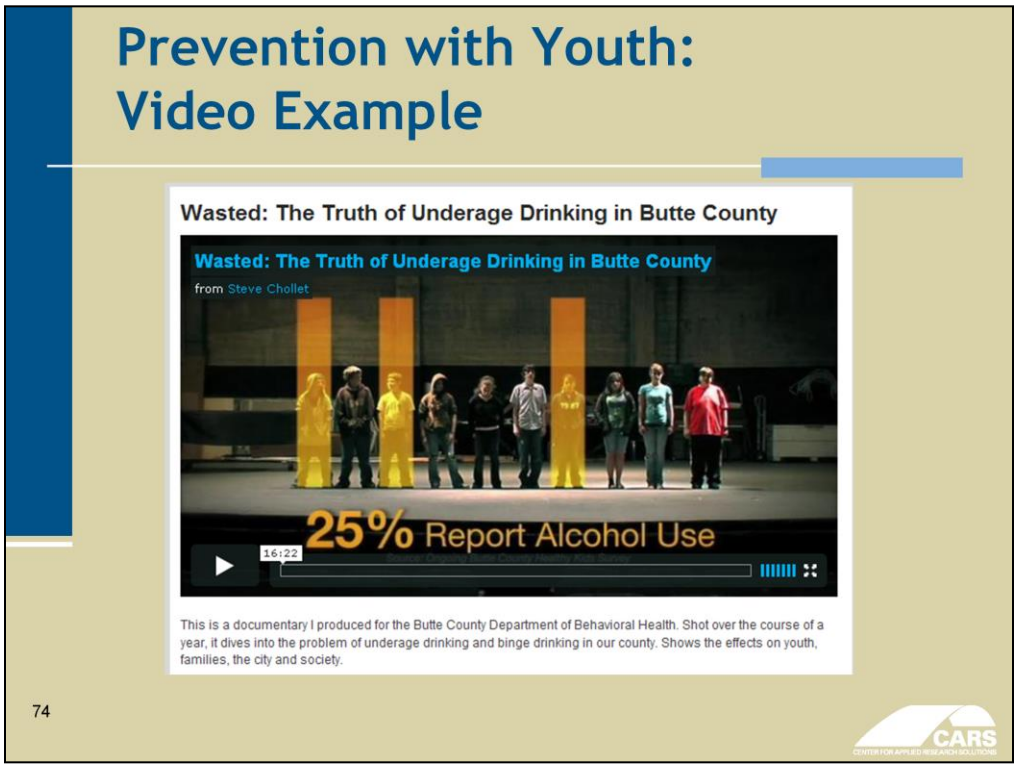
Many evidence base program include several of these components and have, for example, curricula that have been evaluated for effectiveness for certain populations in particular settings. (Projects SUCCESS, Botvine Life Skills, etc.)

Discuss meta-analytic study (2003) of characteristics of effective school-based substance abuse prevention:

•Targeted middle-school age, designing programs that have a peer delivery component

•Programs don't need to be long in duration

•For programs teaching social competency skills, targeting higher-risk youths yields stronger effects



Play video. Click on picture, wait a moment while browser opens. Click on the Full Screen option on the far right of toolbar.

www.synergypost.com/portfolio/wasted-the-truth-of-underage-drinking-in-butte-county

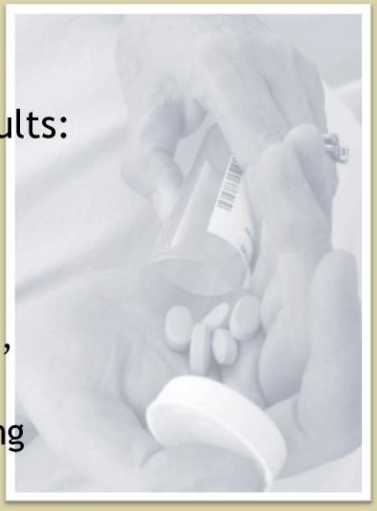
With adults, the trend is toward training primary care and other health specialist about substance abuse and it's likelihood to co-occur with a mental health disorder, and with domestic violence and other violent behaviors. Also, use of more sophisticated screening tools in a healthcare settings (emergency departments, primary care visits, etc.)….moving beyond CAGE. Use of M.I. for any behavioral change. Kaiser doctors, for example, are being trained in this technique using readiness to change models that they can apply to a variety of prevention situations, such as diet, smoking, exercise, etc.

With regard to brief Interventions (provided to heavy alcohol users admitted to hospital) a meta-analytic study published July, 2009 found that results are still inconclusive. From data extracted from two studies it appears that alcohol consumption could be reduced at one year follow up, though further research is recommended. Few studies have been retrieved and the results were difficult to combine because of the different measures used to assess alcohol consumption.

SBIRT – Screening, Brief Intervention, Referral and Treatment – is a federally funded, evidence-based program implemented in community or medical settings (physician offices, educations institutions, mental and health centers). It screens for and indentifies individuals with or at-risk for substance abuse related problems.

Prevention Trends: Older Adults

- Information and support for those who interact with and provide services to older adults:
  - Medical providers
  - Adult children
  - Caregivers
  - Community Based Providers, senior programs
  - Adult daycare, assisted living and senior housing



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Another trend is growing awareness of the use and misuse of prescription drugs by the elderly population.

American Society on Aging provides free training and technical assistance on the abuse and misuse of AOD for non-profit providers and government agencies in CA who serve seniors. They also created the "meducation" website to improve medication adherence in older adults.

Research shows higher risk for AOD abuse in some populations, resulting in specialized intervention strategies:

•Evidence-based programming for Native American youth, for example, includes components that involve elders, ceremony and tribal cohesiveness.

•COSAP – Strengthening Families, for example

•Delinquent minors – wrap around services, parent involvement

For youth in foster care the emphasis is on permanency – keep as many things stable as possible in their lives. Caregivers need to understand the reasons and susceptibility to substance abuse for foster youth.

Another trend is to providing continued services to youth transition out of foster care. Instead of just dropping them as the age out of the system, continue to provide mentoring support, health care, education access etc. Unfortunately, this is an unfunded mandate so counties finding it hard to provide comprehensive services).

This is a target area for MHSA Prevention and Intervention funds. [NOTE: this sounds contradictory]

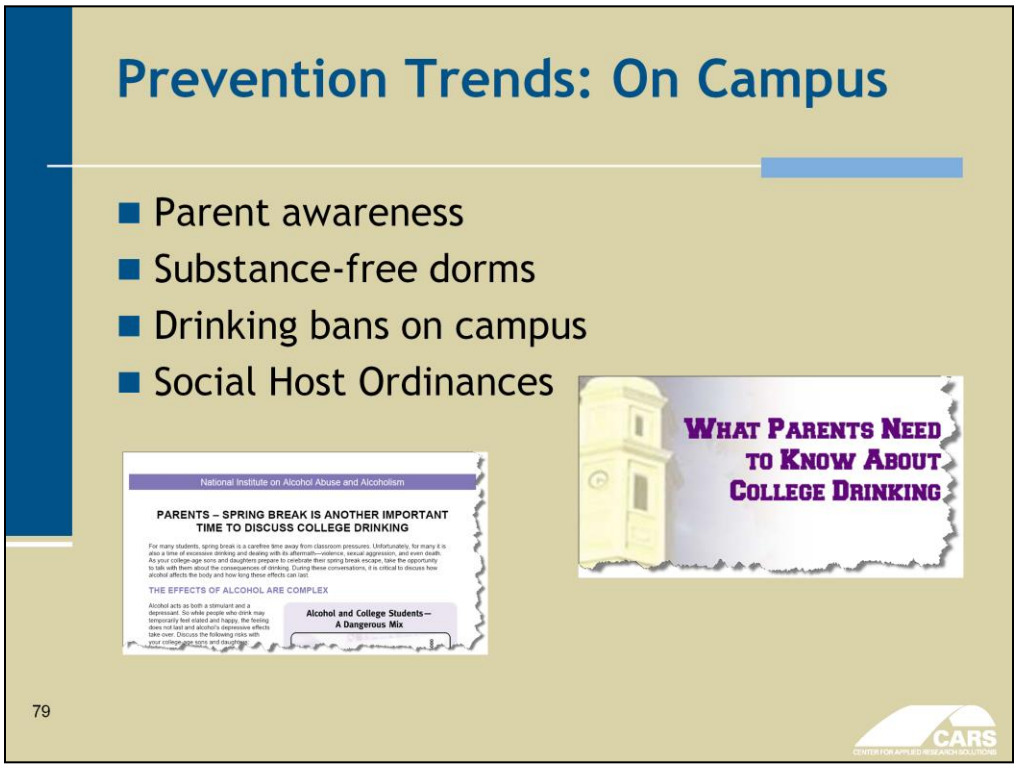
Another trend is in the area or workplace prevention. OSHA, Occupational Safety and Health Administration, recognizes that impairment by drug or alcohol use can constitute an avoidable workplace hazard and that drug-free workplace programs can help improve worker safety and health and add value to American businesses. OSHA strongly supports comprehensive drug-free workforce programs, especially within certain workplace environments, such as those involving safety-sensitive duties like operating machinery.

A comprehensive drug-free workforce approach includes five components—a policy, supervisor training, employee education, employee assistance, and drug testing. Such programs, especially when drug testing is included, must be reasonable and take into consideration employee rights to privacy.

Employee Assistance Programs – often provide cost-free professional consultation and referral services for employees who are experiencing work and personal-related difficulties. Spouses/partners and immediate family members may also eligible for EAP services.

Drug Screening, Cochran Review meta analysis, 2009 findings: There is limited evidence that in the long term mandatory drug-testing interventions can be more effective than no intervention in reducing injuries in occupational drivers. For mandatory alcohol testing there was evidence of an immediate effect only.

Source: **Alcohol and drug screening of occupational drivers for preventing injury,** Cashman CM, Ruotsalainen JH, Greiner BA, Beirne PV, Verbeek JH, April 200).



Parent awareness: Several publications oriented toward parents and the issue is often addressed with parents at freshman orientation. Brochure produced by National Institute on Alcohol Abuse and Alcoholism and National Institutes of Health is to highlight practical information from *A Call to Action* that parents can use in choosing a college for their son or daughter, and to help parents better understand campus culture.

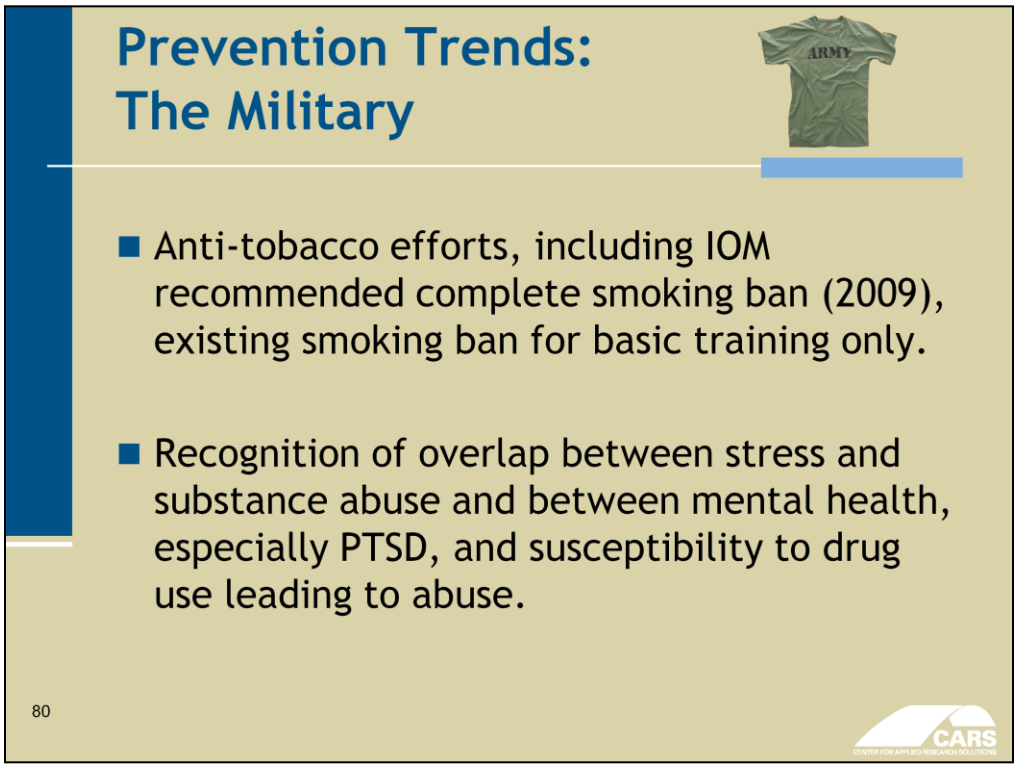
Substance-free dorms: The Harvard School of Public Health College Alcohol Study (2001) has released a new study that shows that substance-free college residence halls are making an impact in reducing heavy drinking.

Drinking bans on campus - The nation's preeminent study of college drinking finds that 21 percent fewer students at colleges that ban alcohol are heavy episodic drinkers. Journal of Studies on Alcohol and Drugs, 2008.

Students who live in substance-free college residences were three-fifths less likely to engage in heavy episodic drinking, compared with students living in unrestricted residences. They also experienced fewer alcohol-related problems. But there is a difference between "substance-free" and "alcohol-free" residences.

Social Host Ordinances – Give local police the authority to issue citations to property owners and/or adults in charge when there is found to be underage drinking on the premises.

MADD has a website that tells which communities have SHO:
http://www3.madd.org/socialhost/index.aspx



In June, 2009, The Institute of Medicine and the American Lung Association both back a phased-in elimination of tobacco across the Department of Defense, beginning with a ban on all use among those entering the military.

From 2007 study published in Addiction Journal "emphasis should be placed on understanding recent increases in substance use and on planning effective interventions and prevention programs to reduce use in this high-risk population."

Environmental prevention is an approach that recognizes the environment as a major factor in behavior when it comes to substance abuse. For example, we have already noted that the commercial world constantly sends out a strong message to youth that alcohol is cool, fun, sexy, and glamorous. These messages directly conflict with community goals to prevent underage drinking. It makes sense to counterbalance influences in the environment that encourage alcohol consumption by changing the environment. We change the environment by reducing negative elements and adding positive elements.

While the emergence of environmental prevention is fairly recent, we are not suggesting here that it is the best approach for practicing prevention. Different approaches can be complementary, and each approach has its strengths for certain objectives.

Link: http://www.youtube.com/watch?v=8dRSFRXIHeI

The Environmental Prevention Model (EPM) is multi-faceted and addresses the problem of alcohol and drug abuse from the larger context of the community, including: Changing the legal, political, economic, and social processes of communities in ways that are associated with reducing substance use; and

Using public policies, laws, rules, regulations and community-level interventions that can affect whole or targeted populations.

The Environmental Prevention Model takes a public health systems approach to substance abuse prevention.

Prevention Trends: Environmental Strategies

- Youth:
  - Provisional ("graduated") driver's license
  - Shoulder tap operations
  - Social Host Ordinances

- Youth and Adults
  - Responsible Beverage Service
  - 911 Report Drunk Drivers Media Campaign
  - Increased regulation of medical marijuana dispensaries.

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These are some current environmental strategies that are being applied.

Remember, these are trends. some have not been evaluated. Other trends have evidence based programs that address them. We are not endorsing one over the other by mentioning here.

Questions?

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Resources

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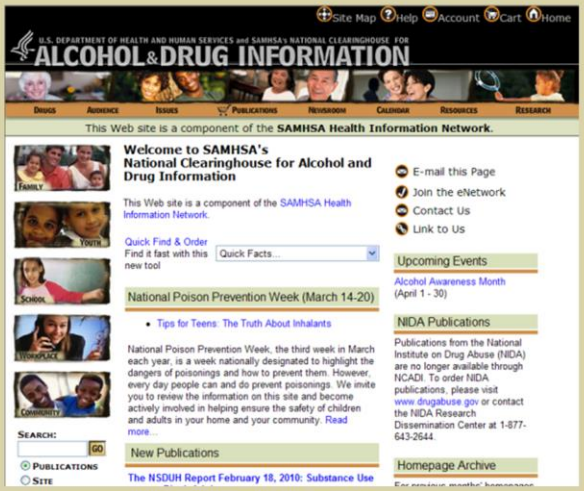
AOD Information



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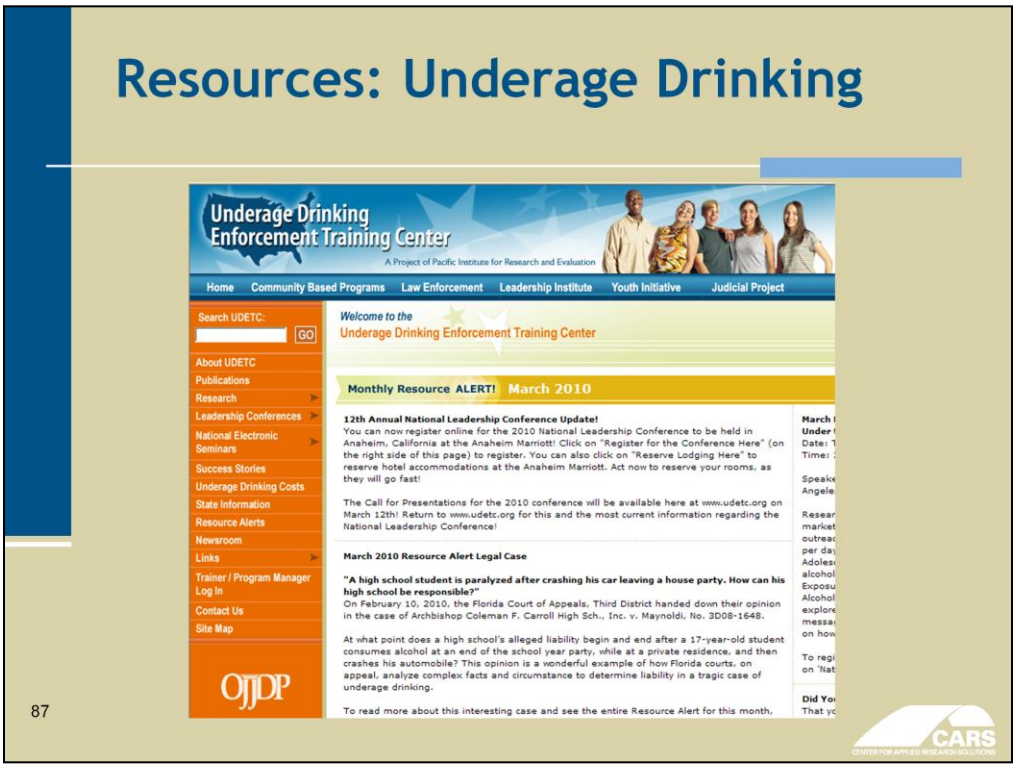
SAMHSA operates the National Clearinghouse for Alcohol and Drug Information. You can search and research the drug classifications we just discussed. This site is very useful, it has a "Quick Facts" for each drug.

National Clearinghouse site at http://ncadi.samhsa.gov.



There are a number of government, non-profit organizations that support the substance abuse field, some that specifically address prevention.

For example,

The Federal Office of Juvenile Justice funds the Underage Drinking Enforcement Training Center

Society for Prevention Research

Resources: SAMHSA

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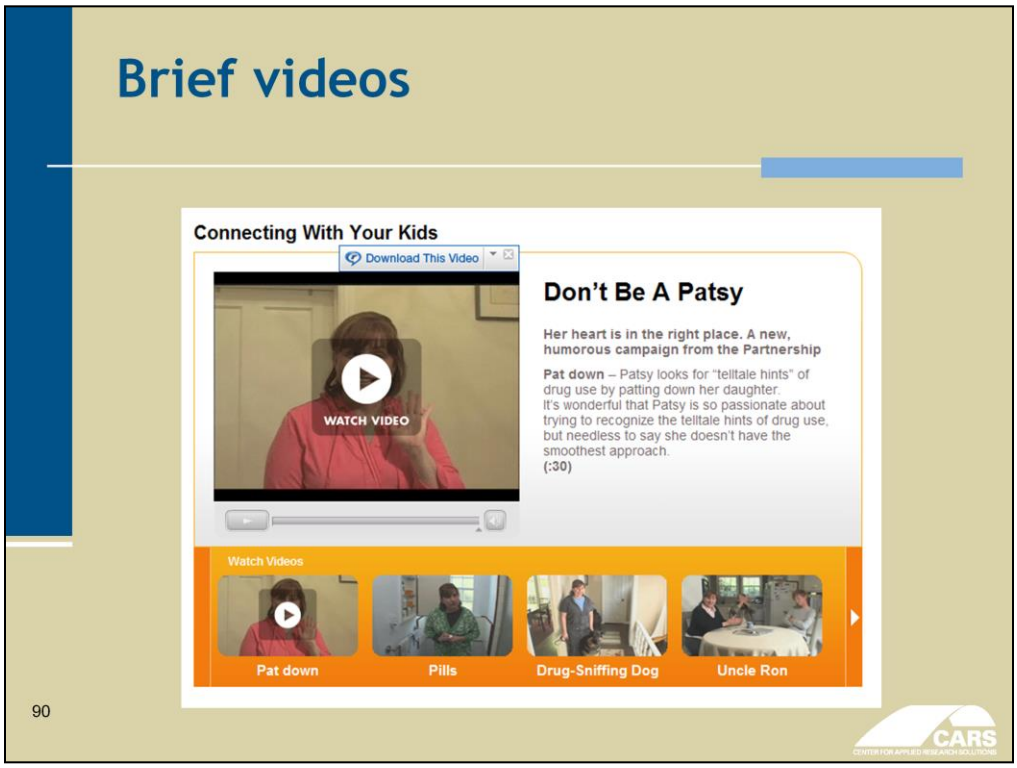
The Partnership for a Drug Free America has a very interactive and up-to-date website with TONS of resources.



Play the videos, they are funny and entertaining.

link: http://www.drugfree.org/parent/connectingwithyourkids/#

Resources cont.

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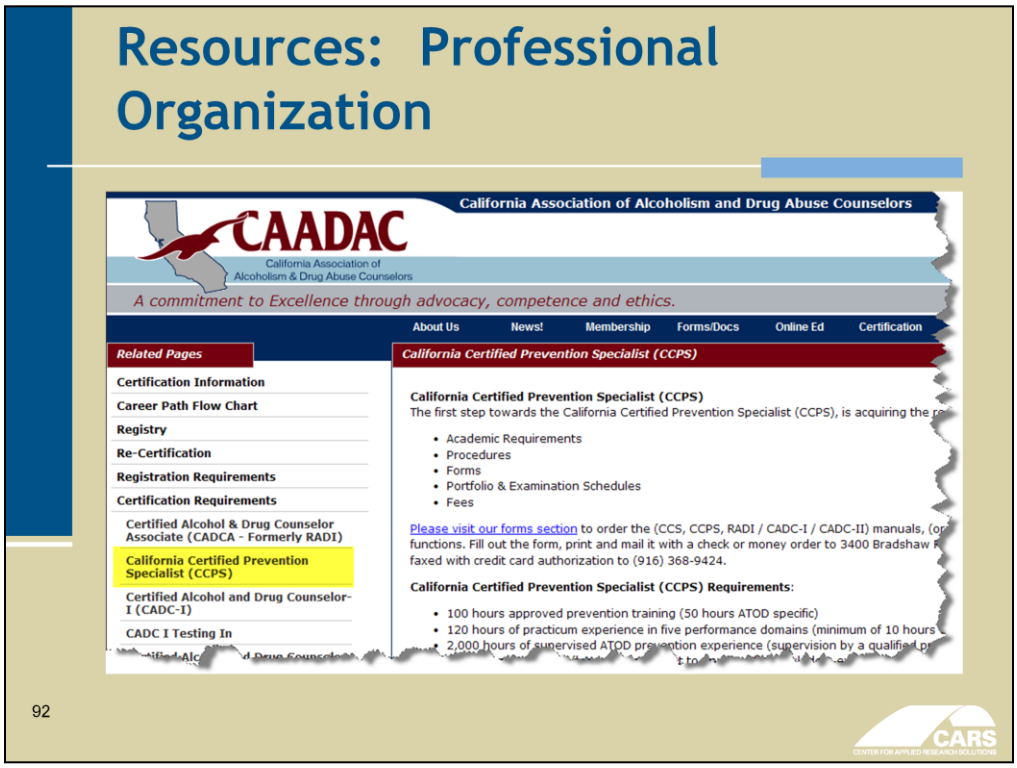
The National Institute on Drug Abuse also provides a wealth of information and resources.



California Association of Alcoholism and Drug Abuse Counselors - CAADAC

Here you can get information on becoming a certified prevention specialist.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WHAT'S NEW
Hydrogen Peroxide Named as Cancer Agent in Cigarette Smoke
The hydrogen peroxide in cigarette smoke causes cells in the lungs to become cancerous, according to new research from the University of California at Davis.
Drinking Doesn't Make You Forget Your Troubles, Researchers Say
Not only can't you drink your troubles away, but ethanol actually reinforces memories, according to Japanese scientists.
New ASH Ad Compares Tobacco Firms to 9/11 Terrorists
The Sept. 11, 2001 terrorists who destroyed the World Trade Center and attacked the Pentagon were pikers compared to the tobacco industry, which is responsible for the deaths of 30 million people since 2001, according to the antismoking group ASH.
Annual Report Identifies Allies, Enemies in Drug War
The U.S. State Department's annual International Narcotics Control Strategy Report slams Venezuela for failing to cooperate in fighting drug smuggling and says that the Taliban are using revenues from opium poppy crops to fund their insurgency in Afghanistan.
CARS mission is to improve the lives of youth, families and communities by facilitating the exchange of knowledge and experience among the prevention research community, practitioners, policy makers and the public.
HIGHLIGHTED PROJECTS AND WEBSITES
View All Projects >
The Community Prevention Initiative (CPI) provides training and technical assistance supportive to California agencies and organizations involved in community-based prevention.
Visit Project Website
The Safe and Drug Free Schools and Communities Technical Assistance Project (SDFSC) TA supports grantees of the SDFSC Governor's Program in implementing their alcohol, drug and violence prevention programming efforts.
Visit Project Website
Preventing Adolescent Binge Drinking is an initiative to reduce binge drinking among youth ages 9 to 20. The initiative is a product of the California Governor's Prevention Advisory Council (GPAC).
Visit Project Website
The CARS Mentoring Technical Assistance Project provides no-cost assistance to California school and community-based mentoring programs that serve youth ages 5 to 18.
Visit Project Website
The California State Incentive Grant is a technical assistance and training project of CPI, supporting grantee efforts in binge drinking, community coalition and environmental prevention programming.
Visit Project Website
The purpose of Students Assistance Programs (SAP) is to emphasize the importance and need for SAPs in CA school environments and to provide resources for school officials interested in promoting and implementing the use of SAPs to "support student achievement."
Visit Project Website
METH
California Meth Action has been established to provide a forum to take action against the problems associated with methamphetamine production, distribution and addiction.
Visit Project Website
My Prevention Community
My Prevention Community (MPC) is a free social utility network that connects prevention-focused professionals, consultants and adult students locally and throughout the country.
Visit Project Website


MyPrevention
Online Networking Community for Prevention Professionals
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RESOURCES
NEWS & OPINION
PROFESSIONAL DEVELOPMENT
SPECIAL PROJECTS
MARKETPLACE
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National Job Listings: Post, Find & Apply
MyPrevention is a free social network that connects prevention-focused professionals, consultants and adult students locally and throughout the country. MyPrevention members can interact with other participants, stay up-to-date with prevention news, find out about upcoming events, collaborate on group sites, submit resources, maintain a personal profile page, and much more, all within a private network. more...
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Join the DISCUSSIONS
Explore RESOURCES
Professional DEVELOPMENT
Stay Current with NEWS
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Free employment listing for employers!
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Call for Presenters for the ADP 2010 Conference
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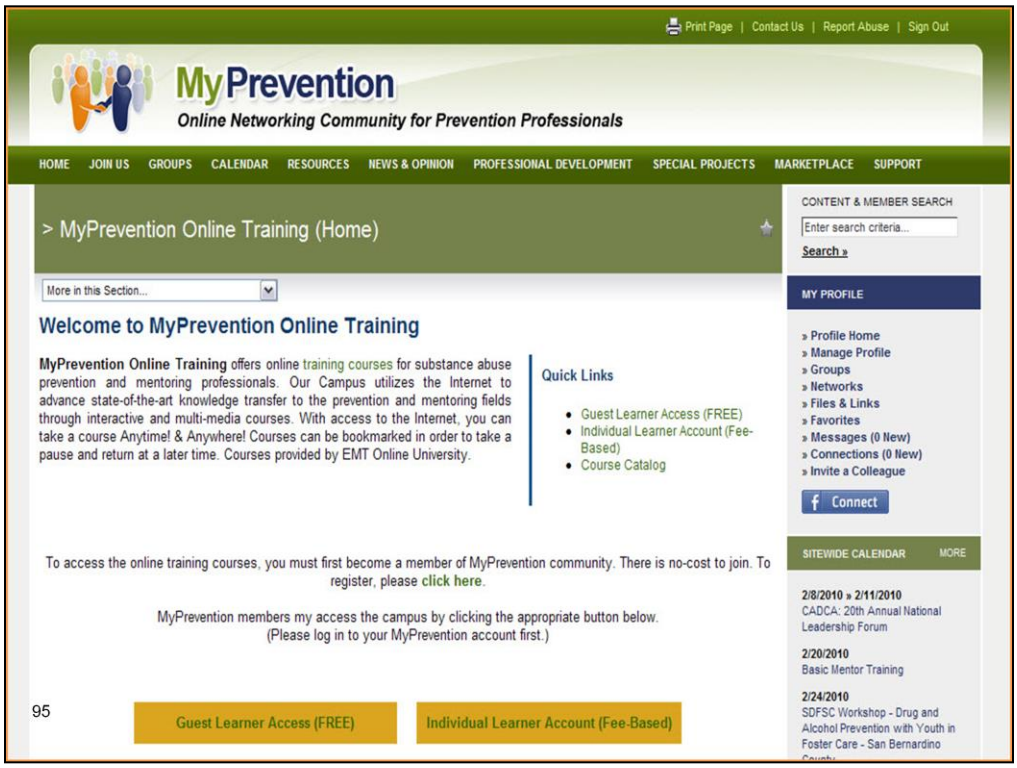
CADCA: 20th Annual National Leadership Forum
2/20/2010
Basic Mentor Training
2/24/2010
SDFSC Workshop - Drug and Alcohol Prevention with Youth in Foster Care - San Bernardino County
2/24/2010
CPI PX:Prevention 101: Foundations of Substance Abuse Prevention (Ventura County)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