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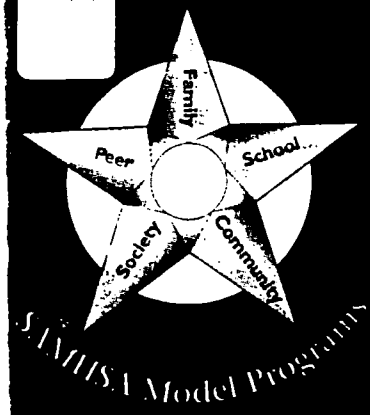
ABSTRACT

The Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Substance Abuse Prevention (CSAP) are committed to bringing effective substance abuse prevention and behavioral health promotion programs to every community in the Nation. As more knowledge is gained about efficacy and effectiveness of prevention and behavioral health promotion, it becomes more important to make that information available to prevention service providers across the country. This report provides the latest information about individual model programs and important syntheses of research and evaluation findings across multiple prevention programs. It describes a comprehensive system that SAMHSA is using to ensure optimal use of these programs in communities across America. It is expected that this report will be of use to officials at all levels of government; to prevention researchers and practitioners; and to parents, educators, community youth workers, and faith leaders. The report specifically updates current knowledge in five areas that are central to SAMHSA's mission of bringing scientific data to practice settings: progress in identifying SAMHSA's model programs; synthesis of research findings; knowledge dissemination; issues, progress, and future directions in various essential topics of science-based prevention programming; and the latest listing of SAMHSA model programs, effective programs, and promising programs. (GCP)



SCIENCE-BASED PREVENTION PROGRAMS AND PRINCIPLES

2002

Effective Substance Abuse and Mental Health Programs for Every Community

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

Science-Based Prevention Programs and Principles, 2002

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Note to the reader: Because the National Registry of Effective Prevention Programs—as described in this report—is an ongoing process of prevention program review, certain programs listed herein will have changed status during the publication process. The matrix beginning on page 51 represents the most current listing of Model Programs as of this writing.

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Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Substance Abuse Prevention (CSAP) are committed to bringing effective substance abuse prevention and behavioral health promotion programs to every community in the Nation. We recognize that evidence-based prevention initiatives rapidly are being called upon to replace programs that provide no evidence of substance abuse effectiveness or solid science. As we gain more knowledge about efficacy and effectiveness of prevention and behavioral health promotion, it becomes more important for us to make that information available to prevention service providers across the country.

But even as we do that, the importance of helping to create and maintain an infrastructure at the Federal, State and local levels to ensure this information and technology can be used wisely and well cannot be understated. Otherwise, the potential impact of this technology is muted, at best.

We are pleased to bring to you *Science-Based Prevention Programs and Principles, 2002,* that provides the latest information about individual model programs and important syntheses of research and evaluation findings across multiple prevention programs. It describes a comprehensive system that SAMHSA is using to ensure optimal use of these programs in communities across America.

We expect this report will be of use to officials at all levels of government; to prevention researchers and practitioners; and to parents, educators, community youth workers, and faith leaders who insist on bringing the most effective prevention practice to those with whom they work and care most about.

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Table of Contents

Purpose of 2002 Report

Recent events give new value to the mission of SAMHSA's Center for Substance Abuse Prevention (CSAP): to bring effective prevention to every community. Now more than ever, American communities require and deserve effective prevention programs, practical knowledge, and dissemination assistance. Today, American youth, adults, and families are encountering greatly elevated risks of substance use, stress, and violence. Trauma and posttraumatic stress bring their own problems. Exposure to trauma puts people at four to five times greater risk of substance abuse.[1] Furthermore, stress is the leading cause of relapse to alcohol and drug abuse, addiction, and cigarette smoking. Surveys find that the emotional strain caused by the September 11, 2001, terrorist attacks on the United States and threats of bioterrorism have led large numbers of Americans to seek treatment for substance abuse problems.[2]

If the aftermath of the Oklahoma City bombing mirrors the future for New York, Washington, and the rest of the Nation affected by the terrible events of September 11, more problems lie ahead. One year after the Oklahoma City bombing, three times as many residents of that city reported increased drinking compared with residents of comparably sized Indianapolis, Indiana. Understandably, rescue workers in Oklahoma City also experienced significant rates of substance abuse, depression, and suicide months and years after the bombing.[3]

Overview

This year's *Science-Based Prevention Programs and Principles* updates current knowledge in five areas that are central to SAMHSA's mission of bringing scientific data to practice settings:

- **Progress in identifying SAMHSA's model programs,** including background information on the scientific development of prevention programs, on risk and protective factors, on how research knowledge is defined and integrated, and on SAMHSA's National Registry of Effective Prevention Programs (NREPP). NREPP is a process to screen and identify intervention programs that because of their scientific support and practical findings warrant national dissemination and replication. NREPP now covers multiple problem topics, going well beyond its original substance abuse and prevention foci.
- **Synthesis of research findings,** covering fidelity, adaptation, findings from the National High-Risk Youth Cross-Site Evaluation, and core components analysis.
- **Knowledge dissemination,** including the National Dissemination System and a new initiative, the Prevention Program Outcome Monitoring System.
- **Issues, progress, and future directions** in various essential topics of science-based prevention programming.
- **The latest listing of SAMHSA model programs, effective programs, and promising programs,** representing the yield of the NREPP methodology from its inception to the date of this report.

I. Identifying SAMHSA Model Programs

Scientific Development of Prevention Programs

Though variations among program developers exist, the construction of nearly every prevention program begins with an understanding of factors that place people at risk for—or protect them from—problem behavior. This understanding comes from theory and a conceptual framework.

Conceptual Framework. Theory and theoretical frameworks in the substance abuse prevention field have been evolving over time, often through induction based on applied empirical research. Among the most important developments in substance abuse prevention theory and programming in recent years has been a focus on risk and protective factors as a unifying descriptive and predictive framework.

Risk Factors. Risk factors include biological, psychological/behavioral, and social/environmental characteristics such as a family history of substance use, depression or antisocial personality disorder, or residence in neighborhoods where substance use is tolerated. Put simply, one often-tested and supported hypothesis derived from this framework is that the more risk factors a child or youth experiences, the more likely it is that she or he will experience substance use and related problems in adolescence or young adulthood.[4,5] Researchers have also found that the more the risks in a child's life can be reduced—for example, by effectively treating mental health disorders, improving parents' family management skills, and stepping up enforcement of laws regarding sales of illicit drugs to minors and drinking and driving—the less vulnerable that child will be to subsequent health and social problems.[6]

Protective Factors and Resilience. Protective factors, such as solid family bonds and the capacity to succeed in school, help safeguard youth from substance use. Research has also demonstrated that exposure to even a substantial number of risk factors in a child's life does not mean that substance abuse or other problem behaviors will inevitably follow. Many children and youth growing up in presumably high-risk families and environments emerge relatively problem-free. The reason, according to many researchers, is the presence of protective factors that reduce the likelihood that a substance abuse disorder will develop.[7,8]

Research on protective factors explores the positive characteristics and circumstances in a person's life and seeks opportunities to strengthen and sustain them as a preventive device. Among these resilient children, protective factors appear to balance and buffer the negative impact of risk factors.[9,10,11,12] From a substance abuse prevention perspective, protective factors function as mediating variables that can be targeted to prevent, postpone, or reduce the impact of use.

The construction of nearly every prevention program begins with an understanding of factors that place people at risk for—or protect them from—problem behavior.

Concepts of risk and resilience enhance understanding of how and why youth initiate or refrain from substance use. Although not all risk and protective factors are susceptible to change—genetic susceptibility to substance use, for example—research demonstrates that their influence can often be assuaged or enhanced.

Domains. Risk and protective factors exist at every level at which an individual interacts with others and the society around him or her. Clearly, the individual brings a set of qualities or characteristics to each interaction, and these factors act as a filter, coloring the nature and tone of these interactions—whether positive or negative. One useful way to look at this interplay is to organize interactions by the six life or activity domains in which they chiefly occur. On the basis of more than 30 years of study, researchers have delineated specific subcategories of risk within each domain. They include:

Risk and protective factors exist at every level at which an individual interacts with others and the society around him or her.

Domain	*Subcategory of Risk*
Individual	biological and psychological dispositions, attitudes, values, knowledge, skills, problem behaviors
Peer	norms, activities, bonding
Family	function, management, bonding
School	bonding, climate, policy, performance
Community	bonding, norms, resources, awareness/mobilization
Society/ Environment	norms, policy/sanctions

Research also has revealed that domains are not static in their impact but interact with each other and change over time. As an individual develops, his or her perceptions and interactions with family, peers, schools, work, and community alter.[13,14,15,16] CSAP depicts this more intricate set of relationships through its Web of Influence model (Figure 1).

The Web of Influence model illustrates the complex series of interactions that occur between the individual and the six external domains that can result in substance use and other problem behaviors.

Current Knowledge on Risk and Protective Factors

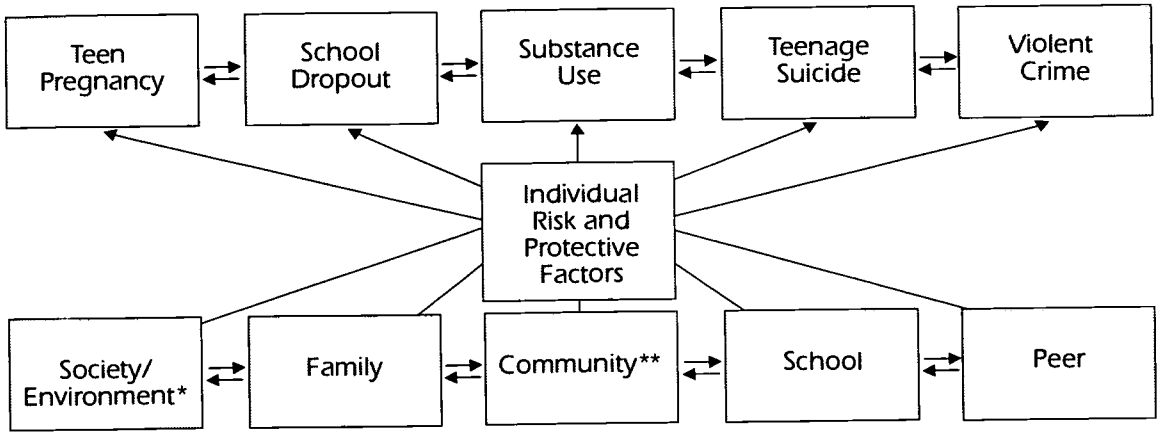
Research findings guide prevention science by identifying risk and protective factors that respectively increase and decrease the likelihood of substance use and abuse. Those research findings are neither fixed nor immutable, but rather change as research studies report new findings. To keep up with this dynamic process, each *Science-Based Prevention Programs and Principles* report, including this one, presents the results of recent research on risk and protective factors. In the following sections, *italicized findings* are those reported in the past year.

New findings on risk and protective factors emerge continuously. Because of the evolving knowledge base, new findings do not always support prior knowledge and may even run contrary to conventional wisdom. What is more, results of a single study, which is the modal instance in the following review, may not represent a trend or offer definitive evidence; such results may be unique to the circumstances and population of the particular research.

Individual

- The prevalence of alcohol and illicit drug use is 7 to 10 times higher in smokers than in nonsmokers.[17]
- *Youth who experiment with, and use, cigarettes at an early age are more likely than nonsmokers to experience a variety of behavior problems by the time they reach 12th grade.*[18]
- Youth who believe that cigarettes or drugs will cause them physical harm are less likely to smoke or use drugs.[19] Young people tend to be more concerned about the immediate effects of substance use than about the long-term effects.[20,21,22]
- *Use of cigarettes, alcohol, and any illicit drug is associated with adolescents' reports of having frequent sleep problems.*[23]

Figure 1. Web of Influence



*Society/Environment: Refers to the total complex of external social, cultural, and economic conditions affecting a community or an individual.

**Community: Refers to the specific geographic location where individuals live and their workplaces.

- Sensation seeking, a personality trait involving preferences for novel, unusual, or risky situations,[24,25,26] is linked with tobacco use[27,28] and drug and alcohol use,[29,30,31,32,33] *and, according to new data, the need for sensation seeking also is linked with substance use.*[34]
- *Recent increases in adolescents' use of marijuana have occurred in the context of lower rates of other drug use among youth. Combined, these findings call into question earlier arguments of a progression from relatively "soft" illicit drugs to "harder" drugs.*[35] *Whether current marijuana use will antecede later, more serious drug use, therefore, is a phenomenon that begs for continued empirical research.*
- Inappropriate expression of anger increases the chances of forming deviant peer associations and of developing deviant norms around substance use and other risks.[36] Conduct disorders, anxiety, and aggression may be precursors of later drug use.[37,38,39,40] Arrests for assault correlate with youthful substance abuse.[41]
- Youth at highest risk often are not only frequent and heavy users of tobacco and alcohol, but also are poly-substance users and have high levels of problems in social functioning, criminal activity, psychological distress, physical health, human immunodeficiency virus (HIV) risk, and substance dependence.[42]

Research findings guide prevention science by identifying risk and protective factors that respectively increase and decrease the likelihood of substance use and abuse.

- Relative to HIV risk, young women are more likely than young men to have shared needles and had sex in exchange for drugs or money, with an HIV-infected partner or with an injection-drug user.[43]
- *Depressive symptoms and substance use are linked among middle school students.*[44] *Among adolescent boys, alcohol and marijuana use appear to mediate depressive symptoms.*[45]
- *Substance use among adolescents is associated with sexual activity and failure to use condoms during sexual intercourse.*[46]

- Comorbid psychiatric and substance abuse diagnoses are attributed to adolescents with more behavior problems[47] and functional impairment.[48] Favorable treatment outcome for drug-abusing adolescents is two to three times more likely if treatment is completed than for those who did not complete treatment or receive treatment at all.[49]
- *Posttraumatic stress disorder appears to predate substance abuse problems, according to a large and growing literature on the topic.*[50]
- *New research indicates that youth who are uncertain about their sexual orientation, express suicidal ideation, or are homeless may place themselves at inordinate risk for substance use and abuse.*[51]
- Aggressive and disruptive classroom behavior predicts substance abuse, particularly among boys.[52]
- *Religiosity, already shown to protect youth against substance use problems, also appears to protect against substance use among children of opiate addicts, who are at high risk for substance use.*[53]
- Differential treatment profiles between genders among adolescent substance abusers reveal that males report lower perceived family support, support from friends, and incidents of residential treatment and truancy; females have high levels of depression, family support, support from friends, history of abuse, self-mutilation, past residential treatment, suicidality, and truancy. In addition, females have lower rates than males of unusual harmful behavior (fire-starting and animal cruelty), all arrests except for sexual offense (prostitution), poor academic performance, and sexual activity.[54]
- *Adolescents who fail to understand the risks of smoking require effective antismoking messages to relate risks to their norms and lifestyles.*[55]
- Youth who have conventional values are less likely to abuse substances,[56] as are youth who value academic achievement more than independence.[57]
- Youth who possess a variety of social competencies, or life skills, resist substance abuse;[58] decisionmaking skills, personal efficacy, and beliefs about the social benefits of smoking are important in preventing cigarette smoking.[59]
- *Youth with low social competence may turn to smoking and drinking because they perceive important social benefits from doing so.*[60]
- Youth who engage in problem behaviors are at risk for using tobacco, alcohol, and illicit drugs.[61,62] Risk behaviors such as rebelliousness are influential for smoking in both males and females.[63,64]
- *Youth identified with substance abuse problems are more likely than youth not so identified to engage in risky sexual behaviors during adolescence and to continue risky sexual behaviors to the extent that substance abuse problems persist.*[65]
- Increased use of alcohol and marijuana at younger ages is related to riskier sexual activity and increased use of alcohol and marijuana as young adults.
- *To be effective, treatment models for adolescent substance abusers cannot be based on adult models and instead must reflect risks particular to young people.*[66]

Family

- Poor parenting practices exacerbate antisocial behavior in childhood and adolescence and can predict adolescent substance abuse.[67,68,69] Children's substance use also is predicted by nonexistent or inconsistent parental discipline,[70,71] whereas disciplinary techniques that include clear limit-setting and consistent rewards for positive behavior are associated with reduced substance use.[72,73]

- *Children exposed to parental substance use are at high risk for becoming substance abusers.*[74] *Maternal illicit drug use is positively associated with children's behavior problems, whereas maternal alcohol use has a less consistent impact.*[75] *More than parents, older siblings appear to influence younger siblings toward substance use and abuse.*[76]
- Fetal alcohol syndrome (FAS) results in lifetime debilitation and affects 5,000 infants born each year in this country. Estimated cost of related disabilities is about $2 million per child. FAS, caused by maternal alcohol use during pregnancy, is entirely preventable.[77]
- Low parent-child bonding is associated with substance use risk.[78] Bonding is of particular consequence for migrant families,[79] as is perceived parent-child communication in these families.[80,81] Prevention programs that acknowledge and address differential family acculturation have produced positive effects.[82]
- Personal problems of drug-dependent mothers may influence their children's problems indirectly by increasing family problems.[83]
- Positive family dynamics are associated with positive bonding among family members,[84] and close and mutually reinforcing parent-child relationships are linked with less substance abuse.[85,86,87]
- *Women who are substance users are more likely to be victims of domestic violence than those who are not.*[88]
- Strong parent-child attachment leads to children's internalization of traditional norms and behavior, that, in turn, leads to less substance use.[89]
- Age,[90] increased family size,[91] parental smoking, sibling smoking, and living with a single parent are associated with regular active smoking in adolescents.[92] Parental substance abuse disorders also predict substance abuse in adolescent children.[93]
- Parental monitoring and supervision of children's activities and relationships protect against substance abuse.[94,95,96]
- Besides such risk factors for substance use as age, mental health status, and use of psychoactive medications, youth also report an unstimulating family atmosphere, living situations that do not include their mother and father, and negative perceptions of health.[97]
- *Skills training for parents of substance-abusing adolescents can increase parental coping skills and improve family functioning, family communication, and youth's abstention from marijuana use.*[98]

School

- Poor school performance, absenteeism, prior dropout status, and referrals from school personnel of youth at risk for dropout predict future truancy, dropout, and drug use.[99,100,101,102,103,104] In contrast, outstanding school performance can reduce the likelihood of frequent drug use;[105] engagement in school activities and sports, less frequency of being drunk, and better family role models reduce the likelihood of future substance use.[106]
- School bonding protects against substance abuse and other problem behaviors.[107]
- Negative, disorderly, and unsafe school climates can contribute to problematic developmental outcomes among students.[108]
- *School conflict, as well as family and personal factors, can contribute to adolescent substance abuse.*[109]
- Teacher and student perceptions of firm and clear rule enforcement are linked with reduced school disorder, an outcome associated with substance nonuse.[110]

- A severe lag between chronological age and school grade places youth at risk for substance abuse.[111] Youth in alternative high schools face elevated risks of substance use.[112] Compared to public school students, those in private schools report higher rates of alcohol use, drunk driving, binge drinking, smoking, marijuana use, and drug-impaired sexual activity.[113]
- Severe substance use is associated with higher likelihood of drinking at school. Alcohol users are more likely to drink at home or at a friend's house. Drug users are more likely to report using substances of abuse outdoors, at a friend's house, at parties, and at school.[114]
- Though many school-based prevention programs employ a social-influences approach based on cognitive-behavioral theory, new data call the efficacy of this approach into question.[115,116]
- *Prevention programs can be effective with multiple populations and in diverse settings. For example, classroom-based prevention programs developed for youth in regular high schools also exert a beneficial effect on youth in alternative high schools.*[117]

Peer

- Peer substance use is among the strongest predictors of substance use,[118,119,120] a finding confirmed across ethnic-racial groups,[121,122,123,124] although peer influences are weaker for black youth than for Latino or white youth.[125,126] Across all groups, young people overestimate peer substance use.[127,128,129,130]
- Peer pressure and peer conformity are stronger predictors of risk behaviors than are measures assessing popularity, general conformity, or dysphoria.[131]
- Sustained involvement in structured peer activities, including extracurricular programs, is linked with low levels of drug use.[132,133,134,135]
- Associating with deviant peers strongly predicts early substance use.[136,137] Low acceptance by peers appears to place youth at risk for school problems and criminality, both risk factors for substance abuse.[138,139] Youth who are strongly peer-oriented or who have a strong external locus of control are vulnerable to substance use and other problem behaviors.[140]
- *Adolescents with higher levels of social support are more likely to abstain from or experiment with alcohol than are consistent users.*[141]
- Peer involvement in both intervention implementation and normative education appears critical to the success of those intervention and education efforts.[142,143,144,145]
- *Gender, social modeling, peer pressure, past experimentation with smoking, smoking among family members and role models, and self-image are associated with smoking among youth.*[146]

Community

- Ready access to tobacco, alcohol, and illicit drugs increases the likelihood that youth will use substances.[147,148,149,150]
- *Immigrant youth in the United States have relatively low rates of alcohol and marijuana use, though these youth report high levels of pressure from immigrant and nonimmigrant peers toward such use and experience less parental support to avoid risk behaviors.*[151]
- Monetary incentives to entice adolescents to participate in smoking-related community surveys increase response rates, but incentives do not adversely affect youth's willingness to participate in smoking cessation interventions.[152]
- *Youth in rural areas are more likely than urban youth to have parent-reported substance use problems.*[153]

- *Homelessness among adolescents is a risk factor for later substance use that must be addressed in intervention programs.*[154]
- Rural community-based HIV/AIDS prevention programs may have a positive impact on adolescent sexual risk taking.[155]
- Communities lacking economic and social resources are vulnerable to high rates of adolescent substance abuse.[156,157,158,159,160]
- *Comprehensive treatment programs assist adolescents with a primary substance use disorder; however, more research is needed to identify programs that achieve clinical success for youth with diffuse or polydrug use problems.*[161]
- Community awareness and media efforts can improve perceptions of the likelihood of apprehension and can reduce noncompliance.[162] Counteradvertising on their hazards reduces sales of cigarettes[163,164] and their consumption;[165,166,167] conspicuous labeling influences awareness and behavior.[168,169,170]
- *Because many young people smoke by the time prevention programs are offered to them, efforts to reduce tobacco use must provide smoking cessation for youth if these services are to be effective.*[171]

Environmental

- The ability to purchase alcohol is related to consumption and problem behavior,[172,173,174,175,176,177,178] whereas minority ethnic status[179] is related to increased ability to purchase cigarettes.
- *Policy analysis indicates that the most effective ways to reduce adolescent drinking are tax or price increases, increased minimum age for drinking, graduated licensing, and/or zero tolerance policies.*[180,181,182,183,184,185,186,187,188,189]
- The likelihood of smoking is increased among adolescents who are willing to use a cigarette promotional item; smoking initiation decreases when such items are lost or youth become unwilling to use them.[190]
- Cigarette brand-specific magazine advertising influences brand market share, brand of initiation among new smokers, brand smoked by current smokers, and attention to the brand advertised.[191] Declines in cigarette promotions and advertising and increases in antismoking message awareness have been reported by some students.[192]
- Neighborhood antidrug strategies (e.g., citizen surveillance, nuisance-abatement programs) can dislocate dealers and reduce the number and density of retail drug markets while also lowering other crimes.[193,194,195,196,197,198]
- *Correlational evidence links increased substance use with certain types of television viewing among youth. These data suggest that parents should limit the quantity and selection of television their children watch, particularly programming that glorifies various substance use.*[199]
- Raising the minimum purchase age for alcohol decreases use among youth,[200,201] particularly beer consumption,[202] and lowers alcohol-related traffic accidents.[203,204]
- *Because active enforcement of youth access laws using unannounced compliance checks has been shown to reduce the rate of illegal tobacco sales to minors and may reduce youth smoking, efforts to increase the level of enforcement should be promoted.*[205]

Workplace

- Adolescents who work more than 15 hours a week may face increased risk for substance abuse.[206]
- Stress in the workplace may modestly elevate alcohol consumption.[207,208,209]
- Alienation from work may increase employees' drinking behavior,[210,211] though such findings have been challenged by other research.[212,213] Employee drug use is linked with job estrangement and alienation.[214]

- Different occupations have widely varied norms about drinking.[215] Frequently, heavy-drinking occupations attract employees prone to this behavior.[216]
- When employers communicate company policy disapproving of substance use or abuse, workplace norms change,[217,218] though lunchtime drinking in the workplace remains fairly common.[219]
- Urine testing can identify job applicants who have used illegal drugs in the recent past.[220] Random drug testing is on the rise[221] and enjoys substantial public support.[222]
- Worker hangovers affect cognitive and motor functions, creating risks of bad judgment, interpersonal conflict, and injuries,[223] but are a neglected contributor to job performance problems.[224,225]

Institute of Medicine Prevention Classifications

Risk and protective factors within the context of the Web of Influence can guide the development of theory-based prevention programs. Further guidance comes from the Institute of Medicine's (IOM) prevention program classification system. As noted in the table below, these classifications clarify the differing objectives of various interventions and match them to the needs of targeted populations.[226]

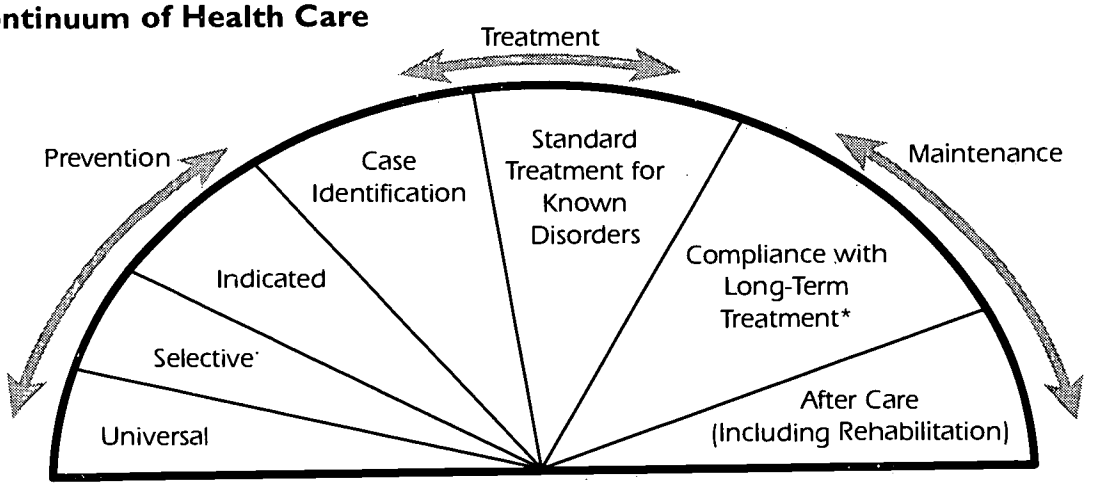
Institute of Medicine Prevention Categories

- **Universal** programs (e.g., mass media, school-based health curricula): Target the general population.
- **Selective** programs (e.g., mentoring programs aimed at children with school performance or behavioral problems): Target those at higher-than-average risk for substance abuse.
- **Indicated** programs (e.g., parenting programs for parents with substance abuse problems): Target those already using or engaging in other high-risk behaviors (such as delinquency) to prevent chronic use.

The IOM system classifies prevention interventions according to the populations they affect.[227] Universal interventions target general population groups without reference to those at particular risk. All members of a community, not just specific individuals or groups within a community, benefit from a universal prevention effort. Selective interventions target those who are at greater-than-average risk for substance use. Targeted individuals are identified on the basis of the nature and number of risk factors for substance use to which they may be exposed. Indicated interventions are aimed at individuals who may already display signs of substance use or abuse and are designed to prevent the onset of regular or heavy substance use. Together, the Web of Influence and the IOM classification system provide both a conceptual and an organizational scheme for identifying risk groups and targeting outcomes.

From its conceptualization of prevention programs, the IOM also has derived a continuum of health care, as depicted in the following graphic. This continuum shows the relationship of prevention, treatment, and maintenance to various stages in the health care process. Though prevention operations are most evident early in the process, prevention has a role in the reduction of relapse, or relapse prevention, even during the maintenance stage.

Continuum of Health Care



*Goal: Reduction in Relapse and Recurrence.

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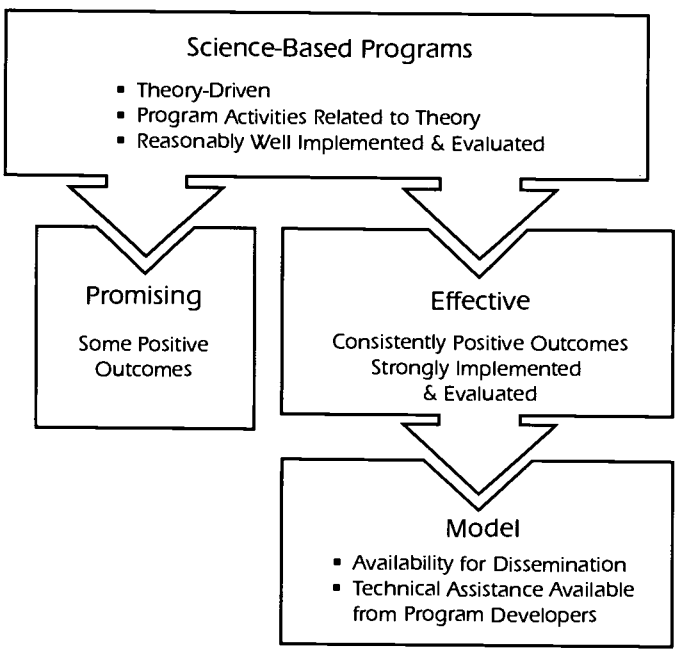
Issues in Defining Scientifically Defensible Knowledge

Scientific inquiry stems from the need to understand the world at large. The strength of science and the scientific method is that it uses strictly defined, standardized procedures to determine how events are causally related. As science improves its methods, levels of certainty about the nature and extent of cause-and-effect relationships increase and more is understood about the resources and effort required to achieve specific changes in existing relationships. Using the scientific method more systematically to identify knowledge also fosters recognition of the diversity of approaches involved in implementing prevention programs and extracting data.



Different Ways of Knowing

Like good medicine, the practice of prevention is art and science. To assess prevention programs as a whole and to understand whether the strategies and interventions have an effect, it is critical to consider both quantitative and qualitative evidence. Quantitative data supply the raw material for the extensive statistical analyses that lend scientific credence to program results. Qualitative data provide the rich, descriptive information needed to explain the effects of program interventions.

Data Types and Research Strategies

Although much discussion of knowledge focuses on the results of quantitative outcome evaluations, qualitative information also can be extremely useful even if it is not always amenable to strict outcome evaluation. Qualitative data may describe program process or identify contextual variables that affect outcome results. Such process information adds depth to findings from programs, enhancing understanding of program results. When researchers and the field in general ignore qualitative data, valuable information can be lost.

Reviews of qualitative information can produce credible findings and recommendations. For example, expert consensus panels convened by many Agencies of the U.S. Department of Health and Human Services (e.g., National Cancer Institute, Center for Substance Abuse Treatment, Food and Drug Administration, and National Institute on Alcohol Abuse and Alcoholism) and private organizations review and use both qualitative and quantitative data to reach conclusions and formulate recommendations affecting the health and well-being of the Nation as a whole.

National Registry of Effective Prevention Programs (NREPP)

To help professionals in the field become better consumers of prevention programs, SAMHSA's CSAP created the National Registry of Effective Prevention Programs. NREPP is a resource to review and identify science-based prevention programs, all of which are theoretically driven by the aforementioned risk and protective factors.

Solicited from academic and community-based organizations, approaches considered by NREPP usually take form as programs and policies developed in response to targeted problems. Though the majority of programs reviewed to date are school and family focused, increasing numbers of community coalitions, community partnerships, and environmental programs are now being considered.

For purposes of NREPP review, evidence of efficacy or effectiveness may encompass data from systematic evaluations that employ experimental and quasi-experimental designs, time-series analysis, and ethnographic research. If the evaluation methodology supports a causal link between the approach or intervention and the designated outcome, any study effort can satisfy the criteria used by NREPP to rate submitted materials.

Sources of NREPP Candidate Programs

Candidate programs for NREPP review come from four primary sources. The first source is the existing scientific literature. Research reports on prevention programs that have been published in scholarly journals provide many candidate programs. Many successful prevention efforts—focused on tobacco, alcohol, and illicit drugs as well as on violence, HIV infection, and other behavioral and health risks—have been the subject of scientific articles in the last few years. NREPP staff continually scan the corpus of scientific journals in which such papers appear and refer relevant ones for NREPP review. Unsurprisingly, scientific reports of prevention programs in the scholarly literature often substantiate outcome effects in a careful, step-wise manner. Consequently, many effective programs that emerge from the NREPP process are supported by documentation in these scholarly papers.

Lists of effective programs as assessed by other rating processes provide a second source of candidate programs for NREPP review. Not only Government agencies (e.g., National Institute on Drug Abuse, Centers for Disease Control and Prevention, Department of Education, Department of Justice) but also nongovernmental bodies publish lists of programs that have passed review through processes similar to those NREPP uses. Though not usually employing the same criteria as NREPP, these organizations nonetheless follow a rigorous process to screen and select prevention programs that have demonstrated positive effects. From such listings, NREPP identifies prevention programs for its own review. The NREPP process occurs independent of other reviews and is not influenced by prior findings—whether reported in scientific journal articles or by parallel review processes.

Program candidates submit published and unpublished program materials to NREPP for review by teams of scientists who rate each program according to 15 criteria of scientific soundness.

The third source of candidate programs for NREPP is SAMHSA's CSAP itself. Using final reports submitted by its grantees, CSAP sends NREPP description and outcome information for the programs developed, tested, and implemented by those grantees. Final reports are written with great attention to detail about all facets of a prevention program and therefore usually contain all the information needed for a thorough NREPP review. When additional documentation is necessary, NREPP contacts the developers directly.

The fourth source of programs for NREPP consideration comprises general solicitations to the field. Responding to invitations from CSAP—posted on the SAMHSA Web site, mailed directly to agencies in the field, and announced at national conferences—program developers send NREPP documentation of their successful prevention efforts. Programs developed in the field by practi-

Call for NREPP Submissions

You are invited to submit prevention programs for NREPP review. If you want to explore whether your program is ready for review, call 866 43NREPP or send an e-mail to NREPP@intercom.com. Send program submissions by mail to:

Steven Schinke
National Center for the Advancement of Prevention*
Intersystems, 30 Wall Street, 4th Floor
New York, NY 10005

*The National Center for the Advancement of Prevention is sponsored by SAMHSA Contract No. 277-99-6023.

tioners who daily confront the challenges of substance abuse problems and myriad prevention issues are apt to reflect everyday realities in a manner not possible in academic settings.

Review Process

Published and unpublished program materials (e.g., grantee reports, manuscripts under development) are submitted to NREPP and distributed to teams of scientists for review. Team members, working independently, read, analyze, and score each program according to 15 criteria, summarized in the box on page 15. Review team members meet regularly to compare their assigned ratings, to clarify areas of disagreement, and to ensure program rating reliability.

NREPP reviewers include a diverse cadre of doctoral-level scientists who are expert in prevention research methodology and programs. They prepare for their task through extensive training plus illustrative program reviews and critiques. Currently, 27 scientists conduct NREPP reviews. Reviewer backgrounds span such fields as psychology, sociology, social work, education, public health, biostatistics, and public affairs. NREPP reviewers are employed largely in academia, but a number are with private research and development firms, think tanks, consulting, health services, and private practice. Approximately half of all reviewers are women, and 15 of the 27 reviewers are black, Hispanic, or Asian.

Definitions

Because of their essential role in the NREPP process, each of the 15 criteria for evaluating candidate programs is discussed in detail.

1. *Theory refers to the principles that underlie a prevention program.* For substance abuse prevention, theory explains antecedents of substance abuse and how they can be changed. Understanding the determinants of substance abuse behavior is the first step in tailoring a successful intervention to reduce or eliminate that behavior. Social learning theory argues that substance abuse is a learned behavior emerging from modeling, influence, and reinforcement. Mindful of that theory, a program developer can build an intervention aimed at positively affecting social influences. Such an intervention might focus on building personal skills, such as assertiveness and problem solving, to counter negative social influences. Equally important is a theoretical understanding of risk and protective factors, that, respectively, raise or lower individual susceptibility to substance use problems. For example, some programs address the risk factor of negative peer pressure by helping young people learn to offset unreasonable requests by friends and dating partners to use tobacco, alcohol, or illicit drugs.
2. *Intervention fidelity is the quality of program delivery.* Fidelity of a program is essential to determining whether the program caused measurable outcome effects. If practitioners differed in the number of program sessions they delivered, in the length of time they provided for each session, or in the number of curriculum objectives addressed, they would not be practicing program fidelity. Some delivery agents may choose to skip certain sessions of a prevention curriculum altogether; others may reorder sessions; still others may deliver the program exactly as written. Not surprisingly, research suggests that, when field agents are faithful to the details of a program, its recipients benefit more.[228,229,230,231]

3. *Process evaluation measures assess qualitative and quantitative parameters of program implementation.* These measures include attendance data, participant feedback, and program-delivery adherence to implementation guidelines. As such, process data can reveal how a program was implemented. These data, in turn, may explain a program's success or failure. If, for example, a program is intended for sequential delivery with peer leaders, yet process data reveal that the program was delivered out of sequence and with different leaders, researchers can better understand why the program may have failed to achieve the desired effect.
4. *Sampling strategy and implementation concern the selection and management of program recipients.* For this criterion category, prevention program reviewers focus on the size and type of test sample, on the adequacy of controls over who received the program and who did not, and on the way program developers tested the program. For example, greatest weight is placed on programs tested with large, representative samples using control or comparison groups to which individuals have been assigned randomly. Any compromises in these standards result in a lower assessment of the rigor of program evaluation procedures.
5. *Attrition refers to the number of participants lost over the course of a program evaluation.* Though some participant loss is inevitable due to transitions among program recipients, extraordinary attrition rates generally lower the degree of confidence reviewers are able to place in outcome findings. Often, loss of participants to attrition is a major element determining the score of programs reviewed by NREPP.
6. *Outcome measures should assess actual behavior change.* It is important to assess

NREPP Rating Criteria

- Theory—the degree to which programs reflect clear, well-articulated principles about substance abuse behavior and how it can be changed.
- Intervention fidelity—how the program ensures consistent delivery.
- Process evaluation—whether program implementation was measured.
- Sampling strategy and implementation—how well the program selected its participants and how well they received it.
- Attrition—whether the program retained participants during its evaluation.
- Outcome measures—the relevance and quality of evaluation measures.
- Missing data—how the developers addressed incomplete measurements.
- Data collection—the manner in which data were gathered.
- Analysis—the appropriateness and technical adequacy of data analyses.
- Other plausible threats to validity—the degree to which the evaluation considers other explanations for program effects.
- Replications—number of times the program has been used in the field.
- Dissemination capability—whether program materials are ready for implementation by others in the field.
- Cultural- and age-appropriateness—the degree to which the program addresses different ethnic-racial and age groups.
- Integrity—overall level of confidence of the scientific rigor of the evaluation.
- Utility—overall pattern of program findings to inform prevention theory and practice.

whether program recipients use substances of abuse as well to as assess various risk and protective factors associated with substance use and nonuse. Outcome measures also should quantify what they purport to assess (i.e., they should be valid) and they must show consistent results (i.e., they must be reliable).

7. *Missing data is not the same as attrition.* The latter refers to the rate at which participants prematurely leave a prevention research study, while the former refers to the absence of or gaps in information from participants who remain involved. A large amount of missing data, implying flawed measurement procedures or faulty assumptions about study participants, can threaten the integrity of an evaluation.
8. *Data collection, as a criterion in rating prevention programs, focuses on the quality of measurement procedures.* Strong prevention studies collect data using unbiased procedures. Participant subject data are anonymous or at least confidential; researchers ensure that data are coded and stored to protect individual identities.
9. *Analysis means the appropriateness of data analytic techniques for determining the success of a prevention program.* Effective substance abuse prevention programs employ state-of-the-art data analysis techniques to assess program effectiveness by participant subgroup. Researchers should use the most suitable current methods to measure outcome change. Subgroup analyses allow researchers to evaluate outcomes by participant gender, age, and ethnicity, for example.
10. *Other plausible threats to validity are factors that permit alternative explanations of prevention program outcomes.* To satisfy this criterion, a study design must establish a causal link between the program and its presumed outcomes. If, for example, researchers claim that their prevention program caused lower substance use rates, the researchers must be able to rule out other factors that could explain these reductions, such as competing programs, concurrent media campaigns, and the effects of maturation among study participants.
11. *Replications are the number of instances in which a program has been evaluated.* Other independent evaluations can prove that study findings were not unique to a single investigation or participant population.
12. *Dissemination capability concerns the readiness of program materials for use by others.* For example, a program with strong dissemination capability would make available a range of services and materials such as training, technical assistance, standardized curricula, manuals, fidelity instrumentation, videos, recruitment forms, and other program resources.
13. *Cultural and age appropriateness is a hallmark of programs that have been tested with diverse groups of participants.* Culturally appropriate substance abuse prevention programs mirror the cultural values of the target group and include intervention strategies and components reflecting cultural characteristics, as well as behavioral preferences and expectations of the target group.[232] Similarly, developmentally appropriate prevention programs are tailored to the cognitive and emotional capacities associated with different age ranges.
14. *Integrity reflects the overall confidence reviewers can place in the findings of a prevention program's evaluation.* Confidence is derived from the sum of the positive assessment of the quality of the intervention's implementation, the evaluation study design, and the actual conduct of the study. This criterion requires reviewers to rate the merits of the science that guided the evaluation.
15. *Utility, paralleling integrity as a summative rating, is an overall assessment of the pattern and value of program findings to guide subsequent prevention programs.* Simply put, utility describes whether, and to what degree, a program produces a consistent pattern of results and is usable and appropriate for widespread application and dissemination.

Rating Process

Individual scores from members of each review team are compiled together with their narrative descriptions of the review program's strengths, weaknesses, major components, and outcome findings. Summary scores from two parameters, "integrity" and "utility," are then used to rank programs respectively on the scientific rigor of their evaluation and on the practicality of their findings for widespread use in substance abuse prevention programming.

If scores across raters are within one point of the same valence, average scores among raters for those two criteria are then used to define programs in one of three categories: effective programs, promising programs, and programs with insufficient current support. If differences are larger than one point, or straddle the midpoint, a consensus conference is convened to reach agreement on program valuation. Programs defined as effective have the option of becoming SAMHSA Model Programs if their developers choose to take part in CSAP dissemination efforts. The conditions for making that choice, together with definitions of the three major criteria, are detailed in the following paragraphs.

SAMHSA Model Programs are effective programs whose developers have the capacity and have coordinated and agreed with SAMHSA's CSAP to provide quality materials, training, and technical assistance to practitioners who wish to adopt their programs. That help is essential to ensure that the program is carefully implemented, and maximizes the probability of repeated effectiveness. Fact sheets on all SAMHSA Model Programs identified to date appear in the section of this report titled "SAMHSA Model Programs."

Effective Programs are prevention programs that produce a consistent positive pattern of results. Only programs that have a positive effect on the majority of intended recipients or targets are considered effective. These programs must score at least 4.0 on a 5-point scale on parameters of "integrity" and "utility." Descriptions of all effective programs that have emerged from NREPP are provided in the "SAMHSA Model Programs" section of this report.

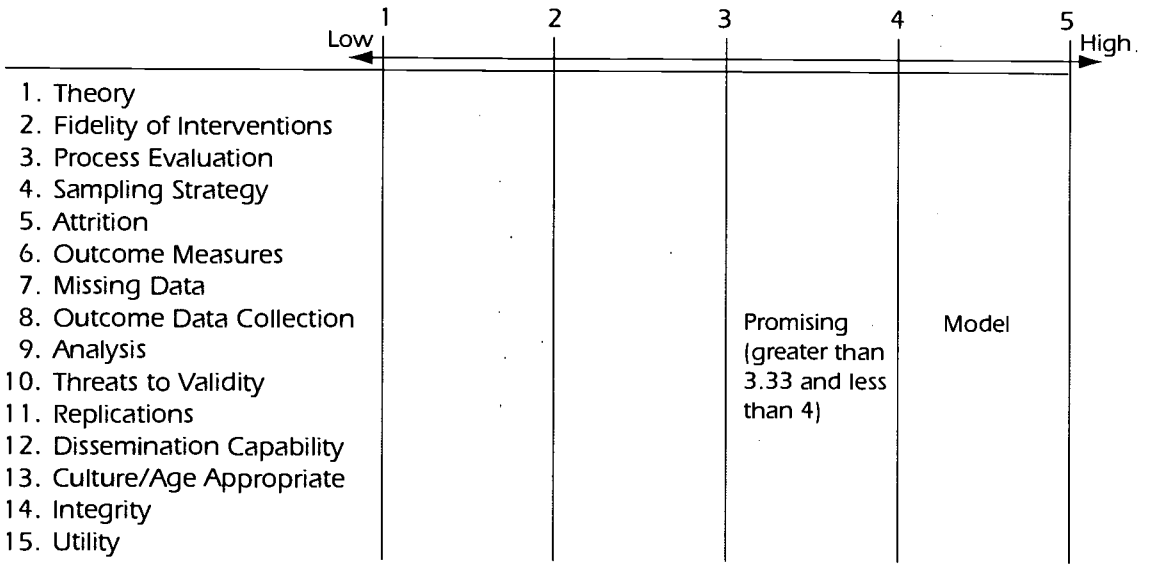
Promising Programs provide useful, scientifically defensible information about what works in prevention, but do not yet have sufficient scientific support to meet standards set by SAMHSA for designation as effective or model programs. Nonetheless, promising programs are eligible to be elevated to effective or model status after review of additional documentation regarding program effectiveness. Promising programs must score at least 3.33 on the 5-point scale on parameters of integrity and utility. Originated from a range of settings and spanning diverse target populations, promising programs are rich sources of guidance for prevention practitioners and designers. Information on all promising programs from NREPP is available online at www.modelprograms.samhsa.gov.

Based on the overall scoring level achieved, programs rated through NREPP are categorized as SAMHSA Model Programs, Effective Programs, Promising Programs, or Programs with Insufficient Current Support.

Insufficient Current Support refers to programs that require additional data or details before they can be considered effective or promising. Programs that score less than 3.33 on integrity or utility parameters may be very worthwhile and have many implications that can inform other prevention efforts. But, in their current form, these programs do not warrant a rating of promising or higher.

Scoring levels for Promising and SAMHSA Model Programs are depicted in schematic form in Figure 2. Though all programs are scored on each of the 15 rating parameters, scores that determine program classification are based on integrity and utility variables, which serve as summaries for the other 13 criteria.

Figure 2. Scoring Levels for Promising and SAMHSA Model Programs



Summary Matrix

Included with this year's report is a SAMHSA Model Program Summary Matrix. The columns in the matrix display various characteristics of the programs that account for their model status and that can guide their consideration and possible selection by practitioners in the field. Characteristics of the programs are described in the following paragraphs, using the first program in the matrix, *Across Ages*, as an exemplar.

Program. The first column in the table lists the name of the program, its developer, and the developer's institutional affiliation. *Across Ages*, the initial entry in the program, for example, was developed by Dr. Andrea Taylor of Temple University in Philadelphia.

Target Population. Divided into two subcolumns, the Target Population column identifies the age and ethnic-racial background of the recipients on whom the program was tested. For a program to claim efficacy with different target populations, it must be separately tested with members of that population. The *Across Ages* program was developed for, and has been tested with, children ranging from ages 9 to 13. The program also is intended to engage the parents of these children, and has involved children and parents from many ethnic-racial groups.

Results. This column graphically presents the length of measurement period used by the research design that showed the program to be effective. To qualify as science-based, any prevention program must include at least pretest and posttest data collection and analysis. In addition, most effective programs include at least 1-year followup data; research designs for many programs require followup measurements of 3 years or longer. *Across Ages* has gathered evaluation followup data in excess of 3 years after the program was administered and, thus, warrants a bar spanning the full range of followup period choices.

Replications. This column graphs how many times a SAMHSA Model Program has been tested. No replications mean that the program was evaluated only once and was shown to be effective and to qualify for model status. One or more replications show that a program was subjected to the indicated number of additional research studies beyond the original test. Because *Across Ages* has been replicated scores of times, it received the highest ranking on the replication parameter.

Cultural Adaptation. Because a number of SAMHSA Model Programs have been adapted for application with populations that differ from the original target population, this column describes the nature and extent of those adaptations. Notably, programs that have not been adapted may have current efforts under way to tailor them to other populations. The table shows only evidence of cultural adaptations as confirmed by the research literature or by program developers. We note that *Across Ages* is adapted not only for application with majority-culture populations, but also for Spanish-speaking and American Indian groups.

Location. This column lists the settings in which a program has been implemented and tested. *Across Ages* has been applied and tested primarily in urban areas.

Domain. Each SAMHSA Model Program is categorized according to the domain through which it reached its target population. All programs penetrated more than one domain because of the nature of their focus and intervention delivery. As a result of multiple foci, *Across Ages* is categorized as appropriate for individual, school, and peer domains.

IOM Category. As described earlier, IOM defines prevention programs according to the manner in which they seek to engage target recipients. *Across Ages* is categorized as a selective program because it seeks to engage children and families who, because of their backgrounds and experiences, are deemed at above-average risk for substance abuse problems.

Program Activities. Entries in this column summarize the major elements of model prevention programs. Though each program includes several elements, the entries encompass only a portion of the total number of components for most programs, given the multicomponent nature of contemporary approaches to prevention. For *Across Ages*, the table details five major sets of program activities. Warranting mention, however, is that *Across Ages* and most other SAMHSA Model Programs include many prevention activities that are part of standard practice and hence are not listed in the matrix. For example, activities such as building rapport, engaging parents, and preparing children for future risky, high-pressure situations, though these are part of *Across Ages*, are not specified in the table as they are relatively standard components in SAMHSA Model Programs.

SAMHSA Model Program Summary Matrix

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1 yr	2 yr	3 yr							
Across Ages Andrea Taylor Temple University	9-13 & Parents	Mixed	■					3+ 2 1	Replicated with Spanish-speaking and American Indian children	Urban	Individual School Peer		◆Older adults mentor youth ◆Perform community service ◆Develop youth coping/life skills ◆Provide academic support ◆Provide parent support	Decreased youth substance use, suspensions, and problem behavior; improved self-esteem, school attendance, and knowledge of dangers of substance use; improved relationships with adults; improved attitudes about older adults.

Findings. Because every program listed in the table is—by definition—effective, findings in this column summarize major program outcomes. Each item in this list was found to be statistically significant according to the research documenting each program. Again, *Across Ages* shows the types of findings most notable for a SAMHSA Model Program. Here, as for all SAMHSA Model Programs, the list contains only findings that could not have occurred by chance alone. Any statistical test aims to rule out chance as a factor in determining outcomes. Thus, findings identified in the matrix are proven to have been caused by the model prevention program.

2. Synthesizing Research Findings

Fidelity and Adaptation

When programs are implemented in the field, practitioners rightly wonder whether they will realize the same outcomes as those reported from the original implementations. To increase that likelihood, program developers recommend that others implement the program consistent with prescribed protocols. In this way, developers seek maximum program fidelity. Realistically, though, field replications often must adapt to local needs and conditions.

Fidelity defines the extent to which the delivery of a prevention program conforms to the curriculum, protocol, or guidelines for implementing that program. A program delivered exactly as intended by its originator has high fidelity. A program delivered quite differently than intended by its originator has low fidelity. Because programs delivered with high fidelity are more likely than those with low fidelity to achieve their original intended results—results that identified them as effective—fidelity is important for prevention practice.[233] A program carried out with absolute fidelity is considered a replication.

Adaptation defines the degree to which a program undergoes change in its implementation to fit needs of a particular delivery situation. The apparent antithesis of fidelity, adaptation could alter program integrity if a program is adapted so drastically that it is not delivered as originally intended. Paradoxically, however, the adaptation process may render a program more responsive to a particular target population. Adaptation could increase a program's cultural sensitivity and its fit within the new implementation setting. The quality of adaptation may represent the *sine qua non* of a prevention program's acceptance by the intended end users.

Indeed, cultural adaptation has been found necessary to engage the interest of prevention program participants. Absent such interest, the program is less likely to result in participants who yield to and internalize program content. Empirical support for the value of this adaptation is provided by CSAP's cross-site evaluation, detailed below.

Despite the clear benefits of adaptation, a prevention program adapted just slightly could lose the very components that made the original program successful. A heavily adapted program, furthermore, could be so unrecognizable from its base model that it does not deliver the qualities sought by those who adapted it for use in the field. How much a program can be adapted without losing fidelity is an issue that requires practical research.

Fidelity defines the extent to which the delivery of a prevention program conforms to the curriculum, protocol, or guidelines for implementing that program.

Adaptation defines the degree to which a program undergoes change in its implementation to fit needs of a particular delivery situation.

Research in other fields suggests that adapting prevention programs is acceptable up to a "zone of drastic mutation," after which further modification will compromise the program integrity and effectiveness.[234] Clearly, the limits of this zone need to be known and shared with the field. In so doing, we can find and disseminate substance abuse prevention programs that are flexible and effective. Programs need to anticipate and allow for modifications that can promote a sense of ownership. In turn, that sense may contribute to the success and durability of a prevention program.

Prior Research. An extensive review of the research literature found that *a priori* attention to fidelity and adaptation are essential for successful

implementation of science-based substance abuse prevention programs.[235] The research indicates that fidelity and adaptation are not opposite poles of a continuum within which each specific implementation of substance abuse prevention program falls. Rather, a balance of fidelity and adaptation should be sought to deal with the complex, dynamic interaction between a program and its environment.

A literature review cannot provide detailed practice guidelines regarding the balance between fidelity and adaptation. However, the research literature points toward six guidelines to help balance fidelity and adaptation:

1. *Identify and understand the theory base behind the program.* Published literature on the program should describe its theoretical underpinnings; if not, a query to the program developer may yield this information. Information about the theory base may or may not include a logic model that describes in linear fashion how the program works. The theory and logic model in themselves are not core components of a program; however, they can help identify the core components and how to measure them. This step also identifies core values or assumptions about the program that can be used to help persuade community stakeholders of the program's fit and importance for their environment.

...Adapting prevention programs is acceptable up to a "zone of drastic mutation," after which further modification will detract from the program's integrity and effectiveness... we need to find the limits of this zone and share that knowledge with the field. In so doing, we can find and disseminate substance abuse prevention programs that are flexible and effective.

2. *Employ core components analytic data.* A core components analysis such as the one provided later in this report can give implementers a roster of the main "program ingredients" and at least some sense of the components essential to success and those more amenable to modification to meet local conditions and needs. Core components analysis represents a bridge between developer and implementer and between fidelity and adaptation. Ideally, the program developer or a third party already will have conducted a core components analysis. If not, with good information about the program, implementers can juxtapose the elements of their programs with those found effective through a core components analysis.
3. *Assess fidelity/adaptation concerns for the particular implementation site.* This step requires a determination of the adaptations necessary to match the target population, community environment, political and funding circumstances, and so on. It also means determining the core components most critical to address fidelity, given these same circumstances.
4. *Consult as needed with program developer to review the above steps and how they shaped their plan to implement the program in a particular setting.* This step also may include actual technical assistance from the developer or referral to peers who have implemented the program in somewhat similar settings.
5. *Consult with the organization and/or community in which the implementation will take place.* This process will allow potential barriers to surface, build support for the program, and generate input on how to acheive successful implementation.
6. *Develop an overall implementation plan based on these inputs.* Include a strategy to achieve and measure fidelity/adaptation balance for the program to be implemented, both at the initial implementation and over time. By addressing all stages of implementation, such a plan can increase the number of opportunities to make choices that shape a program to local needs, while maintaining fidelity.

In sum, these guidelines can inform prevention practice to help program implementations achieve program fidelity and make necessary adaptations to facilitate effective program delivery. Even greater precision in implementing prevention programs is realized when field implementations are guided by careful study of the program replication process.

Prospective Research on Replications. Original research on the replication process comes from a

careful examination of CSAP-sponsored prevention programs.[236] The research began when CSAP established an initiative to determine if a successful program for high-risk youth could be implemented effectively in different locations with similar results. The study focused on 16 replications of 11 distinct program models. For present purposes, the study addressed three questions of interest:

- How similar were the replications to the original models (fidelity)?
- Did the replication sites produce outcomes similar to the original findings? (Was a fidelity/effectiveness connection evident?)
- What findings from the replication initiative should guide future SAMHSA programming or more global Federal efforts in the prevention arena?

To answer these questions, focus groups were convened twice during the replication initiative. Focus groups sought to better understand the evolution of the projects in the field, perceptions of the replication initiative, project staff interactions with staff at the original developer sites, and support available from CSAP staff. An additional paper-and-pencil survey of principal investigators was conducted to assess their sense of the efficiency and effectiveness of the replication initiative.

Fidelity instruments were developed to quantify the degree to which the new projects replicated the original project models. Considerable effort was invested in generating tools that described the original program in great detail. These tools, developed in close collaboration with the original SAMHSA Model Program developers, were then completed by the principal investigators at the replicating sites. The tools were constructed carefully to ensure that the level of specificity was parallel across program models, permitting comparison of the degree of fidelity across program models.

Project directors also were asked about fidelity from several perspectives. First, they were asked to articulate the CSAP prescription with respect to high-fidelity implementation versus adaptation. In general, respondents felt that direct services should be altered only in minor ways from the original model. However, they clearly understood that major modifications were appropriate in doing evaluations, provided they measured the same basic outcomes that the original project sought to affect. This perception matched CSAP's mandate for more rigorous evaluation during the period between the original projects' funding and the funding of replications.

Guidelines can help program implementations achieve program fidelity and make necessary adaptations to facilitate effective program delivery.

Consistent with fidelity instrument findings that program directors felt they had infused in their design, replication project directors consistently reported only minor changes in any area.

Program directors were asked whether changes in program design they implemented reflected no change, minor change, moderate change, or substantial change from developer-defined perspectives across many programmatic dimensions (e.g., community entrée, needs assessment, staff training, participant recruitment). Across program elements, the percentage of program directors who indicated they had made only minor alterations ranged from 81 percent to 100 percent. The domains in which project directors reported moderate or substantial changes were staff recruitment (two programs), program services (two programs), and materials development (two programs).

Finally, respondents felt that, in general, being required to implement the project with considerable fidelity helped improve the quality of their implementation. In particular, services planning, materials development, staff recruitment and training, participant recruitment and incentive plans, and some assessment components of their evaluation plan were considerably strengthened by following the lead of the original program developers.

This sense that fidelity improved the quality of implementation was followed by a sense that it increased the effectiveness of the program. Respondents were asked whether fidelity with

respect to different program dimensions was linked to their positive outcomes. The data showed that most achieved high fidelity to each program element, and that this fidelity contributed to replicating original outcomes.

Adopting organizations felt that locating the ideal balance between fidelity and adaptation was a delicate process. Some felt it was important to maintain the principles but not necessarily the specific procedures, curriculum, or staffing patterns of the original model. This opinion begs the question of what is being replicated, if replication is limited to principles. Nevertheless, these organizations felt a need to adapt to the local community and give staff flexibility.

Outcomes across the 16 replication projects suggest that SAMHSA Model Programs...can be replicated by other grantees in other settings and produce outcomes similar to those identified in the original setting.

Language and culture make fidelity difficult. Some materials, role-plays, and examples were culturally irrelevant, disrespectful, or (at best) confusing. Respondents felt that revising an activity was acceptable if it led to the same end. Others held a firmer ground in support of fidelity. One program director said, "Trust the process." His experience showed that maintaining fidelity is difficult, but that, even when it seemed counterintuitive to follow original program guidelines, it inevitably worked best.

Outcomes across the 16 replication projects suggest that SAMHSA Model Programs developed through Federal demonstration grants can be replicated by other grantees in other settings and produce outcomes similar to those identified in the original setting. A number of factors appear related to the variability in outcomes observed. Among those factors are fidelity and dosage or exposure. Evidence from these assembled case studies supports the literature suggesting that higher-fidelity replications tend to produce outcomes more like those observed in the originals than do lower fidelity implementations.[237,238]

Further, although fidelity and dosage are overlapping constructs, some replication projects did not implement the program model with sufficient intensity. This fact directly affected their fidelity scores, but in some cases, general failure to carefully monitor the project led to sloppy implementation. Although the project director would still rate the project site as having moderate fidelity, considerable followthrough was lacking. In fact, this sort of variation was evident in one replication project where two sites were implemented and staffing problems at one site led to a less intense implementation at that site. Positive findings, apparent at the site with sufficient exposure, were not present at the low-intensity site. Although fidelity varied, differences in fidelity scores were not nearly as pronounced as differences in exposure.

Data from this prospective study provide insights into the changes that occur before, during, and after the adoption process, consistent with observations on the nature of social change.[239] Among study participants, a clear understanding emerged of the value of adopting and replicating evaluated and disseminated programs. This value is consistent with other literature and anecdotal evidence suggesting a need and demand for tested, if not proven, technologies.

Data from the surveys and focus groups highlight the efficiency of this process. Many startup costs associated with developing innovations can be minimized and services can be delivered in a shorter time. No other industry would put so much effort into developing models without mass producing and marketing some of the resulting technologies.

The human and cultural dynamics of adopting existing programs must be recognized and addressed. While this research is generally consistent with other findings confirming the value of fidelity, there are clear limits on how much fidelity is possible and how much is desirable. The conflict between fidelity and adaptation needs to be reframed as a balance. Considerably more research needs to be done to illustrate the contexts that influence the ideal balance points. For instance, this research suggests that, as cultural similarity between the original and adopting sites decreases, the direct bearing of high fidelity, at

least with respect to some aspects of the program and its outcomes, may also decrease.

Human factors also enter into the technical assistance phase of dissemination and replication. Although the written manuals were fairly detailed, there appears to be no substitute for the value of human interaction between the original program developer and the adopting site. This finding supports Fairweather's contention that the written word is a useful but insufficient component of a dissemination effort.[240] Implementers stated that such assistance, and having the opportunity to contact these developers at critical stages of implementation, were essential to the success of their replication.

The evidence regarding the degree to which program replications were implemented with high fidelity suggests that fidelity dissemination can be achieved. Across programs and across program domains, implementers reported that they had remained faithful to the original model. This program is not an example of the more natural and typical processes of dissemination and diffusion, however. Grantees were instructed to, and felt an obligation to, implement with fidelity. Even so, 2 of the 16 programs reported moderate changes in program services, seemingly the heart of the program, even when fidelity was mandated, and even though 15 of the 16 program directors felt that fidelity to program services affected program outcomes positively.

Implementers reported that this obligation was the primary reason they remained faithful at certain points in the implementation process. In fact, one site complained vehemently to CSAP staff about several core program components. Yet, 6 months later, the project team was grateful it had stuck to the plan, because the developer's intended effects materialized in a robust way. These data suggest the potential for faithful program transfer, given adopting sites' motivation and incentives to do so.

Despite the finding that fidelity can be achieved, much remains to be learned. Specifically, greater study is needed to delineate the elements of a program that are "core" and critical to the program's success, and which are more suitable for adaptation. Clearly, the fidelity-adaptation debate was not resolved by this study, nor was it a goal of the study. Nevertheless, insight has been gained and illustration provided of the human and organizational dynamics on each side of the debate.

As this prospective study compellingly demonstrates, fidelity can be achieved in program replications. Beyond this general, though essential, finding, the researchers' analysis suggests conditions under which fidelity can be achieved. They also question whether replication is desirable under strict requirements for program fidelity. In its entirety, this report on replication is the type of research synthesis that can take place only with large data sets and a central coordinating body.

There are clear limits on how much fidelity is possible and how much is desirable. The conflict between fidelity and adaptation needs to be reframed as a balance.

Similarly, findings from a third research synthesis task came from data aggregated across multiple studies analyzed by a central Federal agency. This synthesis was a national cross-site evaluation of SAMHSA-sponsored prevention programs.

National High-Risk Youth Cross-Site Evaluation

Since CSAP's establishment in 1986, it has sponsored nearly 500 demonstration programs to prevent substance use among youth at high risk for alcohol or drug use. Youth were provided with such interventions as behavioral skills training, alternative activities, school-based environmental change programs, peer education and leadership training, mentoring, and efforts aimed at strengthening family bonds. Prevention programs offered through the high-risk youth initiative were implemented in schools, community-based organizations, health and social service agencies, faith-based organizations, and residential facilities.

Aims and Methods. The purpose of the national cross-site evaluation of these programs was to assess the impact of the interventions on prevention or on reducing substance use and to assess

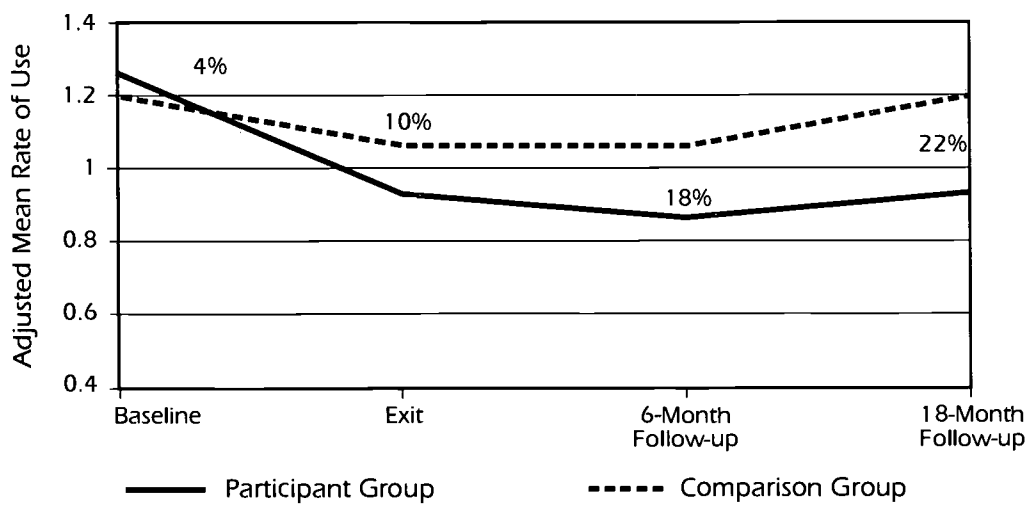
whether the programs reduced risk factors and enhanced protective factors associated with substance use. Involving 48 geographically distinct sites and more than 10,000 youth, the evaluation employed control and comparison groups, common instruments, measurements at four points in time, dosage-response exposures to prevention services, and documentation of program-level characteristics.

Youth Sample. When youth entered the prevention programs, they ranged from 9 to 18 years of age, with 75 percent between 11 and 15 years. About half were African-American or Hispanic. At baseline, rates of substance use among the sample were relatively high. For example, 14- and 15-year-olds reported baseline rates of cigarette, alcohol, and marijuana use, respectively, of 33 percent, 31 percent, and 27 percent. For 16- and 17-year-olds, these rates approached 50 percent across substances.

Findings. Outcome findings for the cross-site evaluation of high-risk youth prevention programs emerged from analyses of data collected at four points: program entry (baseline); program completion (exit); 6 months after program completion; and 18 months following program completion. Study findings can be summarized as follows:

1. *CSAP High-Risk Youth Prevention Programs reduced rates of substance use.* By 18 months postintervention, youth who took part in the prevention programs reported 30-day substance use rates 6 percent lower than their counterparts who were not exposed to the prevention programs.
2. *Youth already using cigarettes, alcohol, or marijuana at the time they began the prevention program lowered their substance use after the program.* At 18-month followup, average 30-day substance use rates for these youth were 22 percent less than rates for youth not involved in the prevention programs (see Figure 3).
3. *Gender plays an important role in risk, protection, and substance use.* Whereas young men initially responded better to the prevention programs, differences at 18-month followup measurements disappeared between males involved in the programs and those who were not. For young women, however, the separation in rates of substance use in favor of those involved in the programs was small at first but grew larger over time, reaching 9 percent at 18-month followup.
4. *Family, peers, and school can help protect youth against substance use.* Path analysis findings from the study showed that such factors as parental attitudes, family supervision

Figure 3. Trends in 30-Day Substance Abuse Among Youth Who Initiated Substance Use Before Program Entry



and bonding, school connectedness, school performance, and peer substance use were associated with rates of substance use among participating youth.

5. *Science-based prevention program components produce consistent and lasting reductions in substance use.* Such intervention components (in order of importance) as focused behavioral skills training, connection building, and coherently delivered programs accounted for significant reductions in 30-day substance use rates for youth who participated in the prevention programs.
6. *Prevention programs implemented consistently and coherently were commensurately more effective in achieving substance use reduction outcomes.* Substance use rates were positively affected by such elements as coherent program implement, strong intervention design, evaluation feedback, and supportive management.
7. *Communities with more opportunity for participation in prevention programs were successful in reducing substance use among youth.* Data on cigarette, alcohol, and marijuana use revealed that higher exposure to prevention programs was associated with reductions as much as 60 percent greater than lower levels of exposure to program content.

Summary. Conclusions from these findings include:

- Prevention is most effective when it focuses on reducing risk and/or strengthening protection in young lives.
- Programs that focus on developing life skills were more effective in reducing substance use than programs that emphasized other content.
- Programs that involved participants interactively were more effective in reducing substance abuse than programs that relied on passive classroom-style teaching.
- Programs that combine life skills, interactive delivery, intensive participation, and strong implementation consistently produced stronger and longer-lasting positive effects on substance use.
- The process of change observed for young women and young men differed. Yet, key components within programs leading to change did not differ. These findings have implications for program design and delivery. Young men's and young women's risk and protective influences differ, pointing to the need for differing gender-specific strategies.

Science-based prevention program components produce consistent and lasting reductions in substance abuse.

- Substance abuse prevention programs designed for specific populations get results and are an effective part of Federal drug control policy.
- Culturally adapted programs proved superior to programs not so adapted. Apparently, culturally adapted programs were better able to capture youths' attention and foster engagement, which are essential to the process of changing attitudes and behavior.

Core Components Analysis of SAMHSA Model Programs

Because prevention programs are constructed from theory, scientifically grounded knowledge of risk and protective factors, and proven strategies, effective programs share many common features. Even a cursory glance at model prevention programs in the appended Model Program Summary Matrix reveals similarities in program emphasis, targeting, and techniques. Increasingly practitioners and researchers alike are interested in ascertaining the active or core ingredients that account for prevention program success. One way to identify these ingredients is a core components analysis.

If we know why a prevention program had an impact, we can emphasize those components that exert the greatest influence in future programs. Likewise, knowing what works can decrease the chances of eliminating a crucial programmatic component for the sake of expediency, time, or economy. Core components analysis thus serves multiple ends in substance abuse prevention

practice and research. Once the active ingredients of a prevention program are specified, practitioners can determine which specific elements must remain intact to achieve fidelity, changing only less essential elements.

Even so, performing a core components analysis offers challenges. Yet the rewards for finding and isolating those parts of a program responsible for improved outcome rates are too significant to ignore. Consequently, the search for common core components continues, with the promise of positive developments for the field and for advancing prevention.

CSAP sponsored a core components analysis that, though it is still under way, already has yielded informative findings for prevention program fidelity and adaptation. Before work began, surprisingly little scientific effort had focused on analyzing intervention programs' core components. The first step of this examination, therefore, was to develop a methodology for identifying the core components of effective prevention programs.

The methodology involved two stages. First, a program model, or template, was created to delineate each of the core components. Second, actual implementation of the program model was compared against this template. Though a detailed description of the analytic method is beyond the scope or purposes of this report, data issuing from it are summarized here.

Two types of data were derived from the preliminary analysis: core components of effective programs, and, for certain components, the "range of permissible adaptation" when implementing the component. If, for example, one of the core intervention components occurred in a 10-session curriculum implemented in 8, 12, or 20 sessions across evaluation studies in which positive effects are attributed to the component, we assume that the total number of sessions offered can be altered within this range without compromising the component's integrity.

Once the active ingredients of a prevention program are specified, practitioners can determine which elements must remain to achieve fidelity, and they can change less essential elements, thus adapting the program with confidence.

The initial core components analysis was performed on 17 programs identified as Model Programs at the time:
Across Ages
Athletes Training and Learning To Avoid Steroids
Child Development Project
Communities Mobilizing for Change on Alcohol
Coping Power Program
Creating Lasting Family Connections
DARE To Be You
Family Advocacy Network
Family Effectiveness Training
Incredible Years
Keep a Clear Mind
Leadership and Resiliency Program
LifeSkills Training
Positive Action
Project ACHIEVE
Project ALERT
Project Northland

Results and Conclusions

From the core components analysis of these 17 SAMHSA Model Programs, several conclusions emerge about the substance and process of prevention program implementation. Detailed below, these conclusions cover prevention program content, community building, delivery, context, relationships, adaptation, strengths focus, continuity, facilitators, and parental involvement. After we detail the results and conclusions, we offer several recommendations on how to use these findings in making program adaptations and achieving implementation fidelity.

Content

- Program content may address generic life skills or knowledge and skills related to alcohol, tobacco, and illicit drugs (ATID), but ATID-related content alone is insufficient.
  - None of the programs reviewed focuses exclusively on ATID-related knowledge and skills. Half of the programs emphasize the acquisition of generic life skills. The remain-

ing half incorporate both generic and ATID-specific content.

- Beside imparting new knowledge and skills, effective prevention programs offer participants opportunities to use this information.
  - Among programs reviewed, opportunities for practice were incorporated into curriculum-based activities or through the addition of intervention components intended to reinforce curriculum content. Commonly employed curriculum-based strategies include:
    - Modeling and behavioral rehearsal (facilitator demonstrates a new skill; participants then perform the skill within session)
    - Assigned out-of-session activities intended to reinforce concepts (journaling, identification of issues to be raised in subsequent sessions, practice of skills at home with parents or others)
    - Cueing (teachers cue students to use new behaviors in specific situations)
    - Placing participants in the role of expert and having them demonstrate new knowledge and skills (e.g., participants create an antidrug advertising campaign that would be effective with their peer group)
    - Use of self-monitoring techniques to enhance awareness and enactment of desired behaviors

Community Building

Effective programs move beyond change at the individual level. Emphasis is placed on creating lasting changes within individual, family, and school domains in an effort to create "caring communities" that share accountability for change.

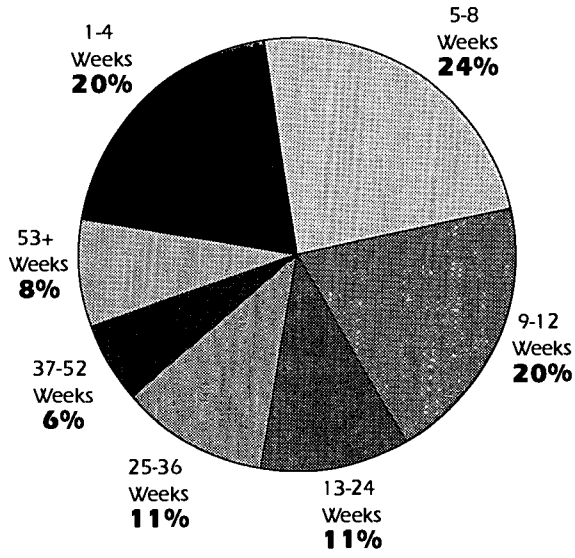
Delivery

- The most commonly used method to deliver program content is through written, session-by-session curricula, largely because many of the programs reviewed for this analysis were school-based. Across programs, curricula were implemented over relatively short intervals (9–12 weeks); the periodicity of sessions was at least weekly in three-fourths of reviewed programs.
- While the degree of structure found in curriculum implementation materials varies (from highly to loosely structured), effective programs use materials that are clear and easy to follow. Persons with minimal or no training can understand and implement curricula with relative ease.

Context

- Successful programs promote a consistent message sent through multiple channels (e.g., parents, teachers, peers).
  - For example, *Incredible Years, Child Development Project,* and *Project ACHIEVE* employ a "whole school reform" approach.

Duration of Intervention
(Across Intervention Components)



A consistent message is sent to parents, teachers, and students, and students consistently hear this message in settings where they spend most of their time—at home and school.

- Effective programs attend to characteristics of the target population that place them at risk for ATID use. Intervention components ancillary to curricula are often used to attend to these characteristics.
  - Mentoring, for example, was an effective strategy to provide youth with social supports absent from their lives and expose them to positive peers and adults who model drug-free behavior.
  - Experientially based activities, such as volunteering, help youth experience self-efficacy, serve others, and share what they have learned. This strategy also lessens the sense that their personal struggles are unique.
  - Recreational, cultural, and social events were used to strengthen family bonds, or, when carried out in the school setting, school bonds.

Relationships

- Successful programs emphasize relationship building as a precursor to the delivery of program content. Although the number of sessions provided and activities that comprise the intervention vary, a common first step is gaining influence.
  - For example, *Family Effectiveness Training, Leadership and Resiliency,* and *Communities Mobilizing for Change on Alcohol* stress the importance of relationship building across individual and agency levels. Effective programs establish relationships with agencies in which services will be offered, and nurture these relationships throughout the life of the program.
  - Teachers, coaches, and other individuals delivering program content receive ongoing support and direction.
  - Initial sessions focus on joining participants together, before introducing program content.
  - Critical to the success of *Project ACHIEVE* was "buy-in" on the school and district levels prior to program implementation.
  - The positive effects of relationship were observed among participants in the *Across Ages* program:
    - The greatest gains were observed among participants in the mentoring component of the program who engaged in consistent and ongoing contact with caring adult mentors.

Integration and Adaptation

- Successful programs work through naturally occurring social networks. Services are delivered via the school, community-based agencies, or other networks already in place (e.g., the sports team setting).
- Effective programs stress the importance of entering into the world of the client and integrating services into it. For example:
  - Programs serving disadvantaged adults provide daycare, meals, transportation, and other services to address barriers that would otherwise prevent them from participating in the program.
  - Programs serving racially and ethnically diverse groups discourage the use of a "one size fits all" approach.
    - Effective programs tailor materials for specific groups and use bicultural facilitators to deliver program content.
  - The use of language-translated materials is discouraged because the content of translated materials may not be culturally meaningful to the targeted group. Yet, materials carefully adapted for a particular population in a language other than the one in which the program was originally developed can be effective. Consequently, translating materials alone may be necessary but insufficient.

Strengths Focus

- Effective prevention programs view individuals and families in relation to their strengths and assets rather than focusing on deficits:
  - The *Incredible Years* program, for example, employs a collaborative group method that seeks to remove the perception that group leaders are experts and relies on the strengths and knowledge of group participants.
  - The *Leadership and Resiliency Program* uses a "whole person" approach that acknowledges individual deficits but does not give priority to those deficits over positive attributes.
  - *Family Effectiveness Training* shifts focus from the "identified patient," instead highlighting functional interactions within the family unit.
  - Didactic instruction and skills-building training for participants in the *Positive Action* program focus on their strengths in relation to their developing self-concepts and self-esteem.
  - The message of the *LifeSkills Training* program is promoted within the context of self-improvement and the acquisition of general life skills.

Continuity

- Process evaluation data reveal that successful programs enjoy high fidelity to the curriculum, dosage adequacy, and dosage consistency.
  - Ongoing support is provided to facilitators implementing program components to ensure uniform delivery.
  - Program activities are structured to create a sense of safety and continuity for participants.
    - The *Leadership and Resiliency Program,* for example, uses a small-group modality to deliver the intervention. Groups are composed of six to nine students, are closed to new members during the year, and continue for the duration of students' high school careers.
  - Outcome evaluation data reveal the efficacy of booster sessions in maintaining gains made over longer periods.

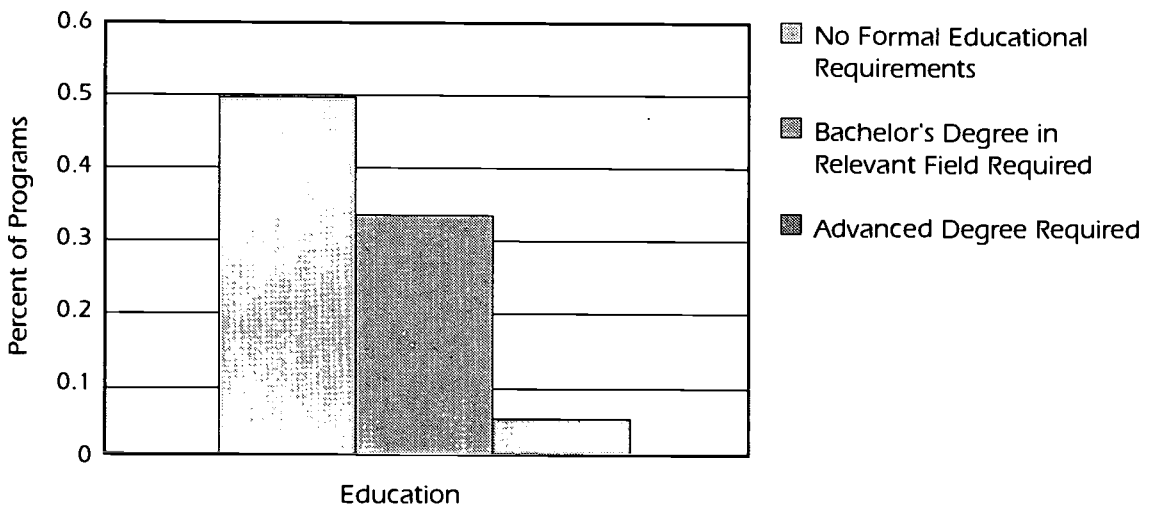
Facilitators

- Educational attainments and experience levels of persons delivering intervention vary widely, yet programs consistently require the training of delivery agents (self-instructional, curriculum-based, or in-person) before program implementation.
  - One-half of reviewed programs do not require delivery agents to have specific educational attainments; two-fifths require agents to hold a bachelor's degree in a relevant field. Two-thirds require facilitators to have prior employment experience in an area relevant to the target population and/or target problems/issues to be addressed.
  - Four-fifths of facilitators received advance training to acclimate them to the goals and philosophy of their respective programs and to standardize practices employed over the duration of intervention.

Remote site training is the most common type of training participants receive prior to implementing the intervention.

- Effective prevention programs use known (versus outside) authorities to deliver program content.
  - Head Start teachers, athletic coaches, parents, and others with whom participants have an ongoing relationship deliver the content.
  - Over three-fourths of known authorities delivering content are teachers.
- Effective programs targeting adolescents acknowledge the developmental importance of the peer group and its influence on adolescent beliefs and perceptions.
  - Programs targeting adolescents rely on peers to deliver some or all of the content.
- Trainer attributes are critical to program success.
  - Process evaluation data reveal that participants perceive effective trainers as having the following characteristics: they are knowledgeable about local resources available to participants, believe in the program and are committed to its success, and share the same ethnic-racial heritage as participants.
  - Training and certification of facilitators are consistently emphasized in program-related documentation as a way of maintaining integrity of process and consistency of results.

Educational Requirements: Program Facilitators



Parental Involvement

- Program developers consider parental involvement to be a critical factor for success. Efforts to include parents focus on two interrelated goals: enhancing parenting skills and self-efficacy, and increasing parents' involvement in the lives of their children.
  - Close to half (48 percent) of reviewed programs incorporate a parenting component.
  - Fully 60 percent of programs with a parenting component use structured activities and experiential activities (social, cultural, recreational events) to foster more interaction between parents and youth.
  - The remaining 40 percent of programs with a parenting component provide one or more forms of parenting skills training.

Recommendations From Analyses of Core Components. On the basis of analyses and conclusions derived from the SAMHSA Model Programs reviewed to date, a number of recommendations surface to guide the planning and implementation of effective substance abuse prevention programming. These recommendations are organized according to major considerations of substance abuse prevention programming: structure—the format and processes of prevention program planning and delivery; content—the substantive material in a program; and channels—the way program recipients are exposed to and learn the content.

Recommendations From Core Components Analytic Findings

Structure	*Content*	*Channels*
Structure intervention activities to focus on relationship building prior to the delivery of program content.	Combine ATID-related content with strategies intended to promote the acquisition of generic life skills.	Incorporate programs into existing networks (e.g., school or community setting, church).
Use written, session-by-session curricula to impart knowledge and skills training. Curricula must be clearly written and easy to follow.	Follow the delivery of content with opportunities to practice behaviors learned.	Eliminate barriers that could prevent participants from taking part in the program (e.g., transportation, child care).
Attend to characteristics of the target population that place them at risk for ATID use, and structure supplemental activities accordingly.	Capitalize on client strengths. Employ a holistic view of clients that acknowledges weaknesses but does not focus exclusively on them.	Employ known authorities to deliver intervention (peers, parents, teachers, guidance counselors, sports team coaches).
Tailor program content to the culture and language of the target population.	Involve parents in programs targeting children and adolescents.	Ensure that persons delivering intervention receive training prior to program implementation.
Tailor services to the developmental needs of the target population.	Attend to parental deficits by providing skills training to enhance parental self-efficacy.	Establish long-term, effective partnerships with collaborating agencies. Nurture these relationships throughout the life of the program.
Plan social, recreational, and cultural events to foster increased interaction among parents and youth.	Promote a consistent message to participants through multiple channels (e.g., parents, peers, and teachers).	Involve the larger community in change efforts; incorporate intervention strategies that promote increased accountability for change across domains.

Mindful of these core components analytic results and recommendations, practitioners can more closely approximate—or may even surpass—outcomes documented during initial SAMHSA Model Program development and testing. Additional guidelines for strategies to enhance fidelity in the field will issue from core components analyses of the remaining SAMHSA Model Programs not included in the foregoing report.

Conclusions From Knowledge Synthesis Activities

Knowledge synthesis tasks completed in the past year—fidelity and adaptation, cross-site evaluation findings, and core components analysis—have yielded greater understanding of the processes, outcomes, and essential ingredients of substance abuse prevention programming. Findings bring us closer to knowing not only the potential of substance abuse prevention, but also the conditions under which optimal prevention can occur and the keys to achieving success. Knowledge synthesis work during the past year considerably advances the science and practice of prevention.

To make plain the value of knowledge synthesis for the field, major lessons from work on fidelity and adaptation, the cross-site evaluation, and the core components analysis are highlighted:

- Program implementers must balance fidelity and adaptation to ensure that programs are executed in a manner true to their original design and evaluation—essential to approximating the original outcomes—and that programs respond to the particular circumstances—demographic characteristics, organization context, logistical constraints, and so on—of the program recipients and delivery setting.
- Knowledge synthesis work on fidelity and adaptation underscores the wisdom of careful preparation and planning before program implementation and the ability to alter those plans once the program is in the field. Instead of simply applying a program in a rote manner, implementers must lay out detailed steps for how they will balance fidelity and adaptation. But the balancing process cannot rest and may need to be readdressed when the program enters the field and is modified because of unique implementation circumstances and challenges. Only then can implementers expect to offer their recipients a prevention program that has a strong likelihood of success.
- Prospective work demonstrates that SAMHSA Model Programs can be replicated and can produce outcomes similar to those identified in the original setting. Apparent elements in program replication are fidelity and dosage or exposure, which contribute to outcomes when held to high standards.
- Although fidelity and dosage are overlapping constructs, some replications may fail because practitioners do not implement the program model with sufficient intensity. High intensity is therefore a necessary condition for successful replication.
- Human factors enter into the technical assistance phase of dissemination and replication. Even though detailed written manuals may be available, no substitute exists for human interaction between the original program developer and the adopting site during program replications.
- Notwithstanding conclusions that program fidelity is possible during replications, questions remain whether fidelity ought to be achieved. In raising these questions, knowledge synthesis on program replications points directly to the importance of learning which elements of a program are core and critical to the program's success, which are more suitable for adaptation, and which circumstances and settings call for various adaptations. Consequently, work on replication links nicely with the final synthesis task of core components analysis, which will be considered at the end of this section.
- Cross-site evaluation data offer the most compelling research to date that prevention works.

- The cross-site study also uncovered interactions in the effects of prevention programs on girls and boys, and on youth who have prior histories of substance abuse.
- Findings from hundreds of program replications in nearly every state in the United States involving thousands of youth also permit strong and unambiguous conclusions about the role of families and communities in helping children avoid programs with ATID.
- Gender differences and conclusions about cultural tailoring have implications for structuring prevention programs to ensure that recipients are prepared for and accept program content.
- Cross-site data further support the increasingly accepted notion that particular program components and combinations of components can exert potent influences on youth.
- Similarly, the core components analysis yielded empirical data on the active ingredients of successful prevention programs. Echoed in other research synthesis work on fidelity and adaptation, program replications, and cross-site analyses, results from the core components analysis point toward the benefits of knowing what works in SAMHSA Model Program delivery.
- Analyses of core components let us distinguish between essential and nonessential elements and among elements that combine to achieve optimal results in SAMHSA Model Program delivery.
- Core components of SAMHSA Model Programs reveal practical conclusions about prevention program structure, content, and channels for content delivery.
- Core components analysis is a tool for attaining program fidelity while adapting a program to fit implementation demands.

Findings...bring us close to knowing not only the potential of substance abuse prevention, but also the conditions under which optimal prevention can occur and the keys to achieving success.

These lessons denote the role of research synthesis to elicit practical, sound knowledge from many kinds of prevention programs. Questions should no longer exist as to whether SAMHSA Model Programs can be implemented with fidelity and concurrently adapted to fit the particular field setting. More important, empirical data support the predictability of positive outcomes from replicated SAMHSA Model Programs. Moreover, with findings on what makes SAMHSA Model Programs work and how they can be improved in the field, we are more ready than ever to ensure the quality implementation and adaptation of SAMHSA Model Programs. Possessing such research synthesis data, policymakers and practitioners can more confidently deliver science-based programs under varying circumstances, knowing that they have a strong likelihood of attaining positive results with no sacrifice of program relevance and responsiveness.

3. Knowledge Dissemination

For SAMHSA's CSAP, dissemination is the process of bringing effective prevention to every community. To ensure that effective programs reach the maximum number of communities and ultimate recipients, CSAP has built a multicomponent dissemination system.

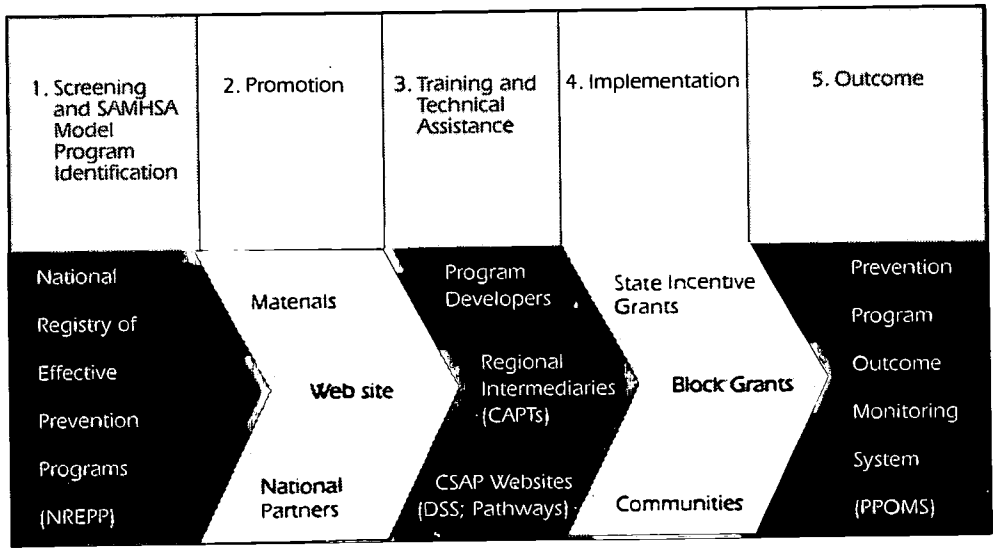
Dissemination System

As shown in Figure 4, SAMHSA's dissemination system begins with prevention projects originating in the field and in academic research centers. Once screened through the NREPP process, programs that emerge as models are marketed through expressly constructed SAMHSA materials, through SAMHSA's Model Programs Web site (www.modelprograms.samhsa.gov), and through the auspices of such national partners as the Child Welfare League of America, the National Association of Elementary School Principals, the National Head Start Association, the National Council on the Aging, the National Mental Health Association, the National Senior Service Corps, the DHHS Office of Minority Health, the U.S. Department of Agriculture Cooperative State Research Education Services, the Community Anti-Drug Coalitions of America, and the National Association of State Alcohol and Drug Abuse Administrators.

Training and technical assistance for disseminating SAMHSA Model Programs are provided by program developers as well as through SAMHSA's Decision Support System (DSS) and its Centers for the Application of Prevention Technologies (CAPT).

Accessible through the Web site www .preventiondss.org, the DSS is an interactive facility that allows practitioners, policymakers, and other interested parties to learn about the available database of model and promising programs and to gain consulting assistance for their own prevention program planning.

Figure 4. SAMHSA Model Programs National Dissemination System



Six CAPTs, currently serving every region of the country, are charged with offering, coordinating, and managing prevention program information, training, and technical assistance within the regions they serve. The CAPT Web site portal, accessible through www.modelprograms.samhsa.gov, has links to the Northeast CAPT, Border CAPT, Southwest CAPT, Southeast CAPT, Central CAPT, and Western CAPT.

Screened through CSAP's National Registry of Effective Prevention Programs (NREPP), programs that emerge as models are marketed through materials and contracts dedicated to these purposes, including the SAMHSA Model Program Web site (www.modelprograms.samhsa.gov).

CSAP awards State Incentive Grants (SIGs) to individual States to facilitate the implementation of model and other science-based programs. Totaling $9 million for 3 years, SIG funding permits States to distribute smaller grants to subrecipients, usually school districts and community-based organizations. Stipulations on SIG funds require States to invest 85 percent of the grants in prevention programming, at least 50 percent of which must go to model and promising programs.

Substance Abuse Treatment and Prevention block grants, also awarded by SAMHSA, are the cornerstone of the States' substance-related programs. These grants account for 40 percent of public funds expended on substance prevention activities and treatment services. This grant program—with funds disbursed to the States, Territories, and the District of Columbia based on a congressionally mandated formula—enables States to provide substance abuse treatment and prevention services through a variety of means. Statutes and regulations place special emphasis on providing treatment and primary prevention services to both injection-drug users and substance-abusing women who are pregnant or have dependent children.

Communities are the ultimate target for disseminating science-based programs. Indeed, prevention programming must reach the community level for the consumers—children, families, schools, faith-based organizations—to benefit. Once implemented in a community, a science-based program becomes available to its members. As such, communities are the best dissemination means for programs and will rightly dominate the planning of CSAP and others interested in disseminating scientific knowledge and products about substance abuse and other target problems.

As shown in Figure 4, the first two stages of the dissemination system encompass the effectiveness portion of the system; the next three steps define capacity. The entire system is marked by accountability, which comes from close monitoring by CSAP.

Prevention Program Outcome Monitoring System (PPOMS)

To help measure the impact of disseminating prevention programs into the field, SAMHSA is attempting to quantify the extent to which programs are disseminated, how they are adapted for the field, and what outcomes they produce. That work will occur under the auspices of the Prevention Program Outcome Monitoring System (PPOMS), which is at the time of this writing awaiting final approval from the Office of Management and Budget (OMB). Data generated by PPOMS will allow SAMHSA to quantify the market penetration, processes, and effectiveness of its science-based program replications. Though the core interest of PPOMS is to document the dissemination of SAMHSA Model Programs, PPOMS will gather data on all substance abuse prevention programs currently in use in the United States.

The national PPOMS assessment will ask prevention practitioners about their use of, modifications to, and satisfaction with science-based and other prevention programs. In particular, PPOMS will

- Gauge practitioner access to SAMHSA science-based materials and programs;
- Estimate the proportion of practitioners replicating these programs;

- Quantify and explain barriers and facilitating mechanisms for program replication;
- Document the degree of fidelity and adaptation of program replications; and
- Measure program replication outcomes.

Knowledge of these areas will allow SAMHSA to better direct its dissemination of NREPP-identified programs and give practitioners access to targeted training and technical assistance. Equally important, PPOMS findings will shed new light from the field on the core components of science-based programs and how fidelity and adaptation contribute, and are related, to programmatic outcomes.

Preliminary Development of PPOMS Assessment. An early, abridged version of the national PPOMS assessment was tested at a CSAP-sponsored conference in spring 2001. The conference, "From Research to Practice," showcased 15 SAMHSA Model Programs. Administrators and practitioners in attendance were given information on the SAMHSA Model Programs and offered in-depth training in the implementation of each program.

At the conference, about 250 participants, representing an 84 percent response rate, agreed to help with PPOMS procedures. Participants were employees of agencies, schools, and organizations interested in learning more about science-based prevention program implementation. They represented many geographical regions and settings, varied levels of expertise in prevention programming, and diverse experience in implementing school- and community-based prevention programs. Consequently, findings from this initial test of PPOMS are somewhat generalizable to the types of organizations and individuals in the field interested in science-based program replications.

From the PPOMS assessments distributed and collected at the conference, the following data emerged:

- 74 percent of respondents had little or only basic background information on science-based programs.
- 69 percent of respondents were familiar with prevention principles formulated by Federal agencies that do drug prevention work.
- Of the respondents who indicated familiarity with prevention principles, 87 percent have used these principles to guide past efforts to implement prevention programs.
- 56 percent said that whenever possible, science-based programs should be implemented.
- 28 percent cited government mandates and funds as the most important reason for interest in science-based programs.
- 15 percent cited less-than-optimal outcomes with current and/or prior drug-prevention programs as their most important reason for interest.
- 82 percent indicated that they were aware of government mandates and funds for implementing science-based programs.
- 86 percent of those who were aware of government mandates and funds felt that those mandates and funds served as a catalyst to adopt such programs.
- Approximately 15 percent reported that government mandates exerted negative effects on their organization's desire to implement these programs.

Model Program developers, in conjunction with CSAP's Decision Support System (DSS) and CSAP's six regional Centers for the Application of Prevention Technologies, provide training and technical assistance for disseminating SAMHSA Model Programs.

- 74 percent planned to implement a science-based program in the next 6 months.
- Of the respondents who indicated plans to implement a science-based program in the next 6 months, 47 percent had little or basic background information on these programs.
- 82 percent of agencies and schools represented by respondents offered drug prevention programming.
- About half of the 18 percent of agencies and schools that do not currently offer drug

prevention programs are State government offices, CAPTs, or organizations that offer technical assistance and training to direct service providers.

- Asked about current substance abuse programs employed by their organizations, respondents listed 360 different programs. Approximately 25 percent of these programs were SAMHSA Model Programs.
- Most organizations offering SAMHSA Model Programs indicated that they are satisfied or very satisfied with the programs.
- 58 percent of respondents indicated that their organization had prior experience with science-based programs.
- 54 percent of respondents identified barriers to the implementation of science-based substance abuse prevention programs. The identified barriers fall into the following categories:
  - Inadequate funding for implementation
  - Lack of community and school buy-in and readiness
  - Staffing issues
  - Limited access to schools
  - Training and technical assistance issues
  - Compromised program fidelity when programmatic changes are made because of high implementation costs
  - Difficulty involving parents in prevention efforts
  - Cultural issues
  - Difficulty finding programs that match an organization's goal or focus
  - Difficulty retaining clients for the duration of the program
- 66 percent of respondents identified structures and mechanisms in their organizations that would facilitate implementation of a science-based program. The facilitating mechanisms or structures were grouped into the following categories:
  - Strong community coalitions
  - Community and school buy-in and support
  - Appropriate staffing
  - Access to technical assistance and training
  - State mandates and funding
  - Prior experience
  - Recruiting participants for programs

Besides providing useful information on the background, expectations, and readiness for implementation of conference participants, data from this early PPOMS experience have led to modifications to the national PPOMS assessment, set to begin in the coming year. Ongoing efforts to follow up with conference participants will yield additional evidence on efforts in the field to replicate and adapt SAMHSA Model Programs and on their outcome findings.

4. Issues, Progress to Date, and Future Directions in Science-Based Prevention

Each year this report describes achievements of the past year and reviews emerging issues that will be addressed in the coming year. Consequently, needs articulated in last year's report will be reiterated and progress in addressing these needs will be noted. Finally, future steps that warrant an investment of resources in the coming year will be previewed. These three phases of our synthesis and dissemination agenda are offered in tabular form below, with each element in the table discussed in the ensuing paragraphs.

Issues and Progress to Date

In last year's report and throughout the course of the year, several issues emerged:

Build NREPP Database. Last year, a major issue requiring greater investment was the identification of additional and more diverse programs by NREPP. Since last year, 15 new SAMHSA Model Programs have issued from NREPP, with an additional 21 promising programs identified by the NREPP process. Those programs increase the range of topics covered by NREPP and extend the age groups and types of populations included. Along with the earlier discovered programs, those added in the past year lay a solid foundation of science-based programs upon which the field can build an ever-larger national dissemination system.

Issues	Progress to Date	Future Directions
Build NREPP database	Built database of NREPP programs and topics	Expand NREPP into substance abuse prevention with new populations, workplace, HIV and AIDS, posttraumatic stress disorder, and gambling
Track dissemination of science-based programs	Began PPOMS initiative	Launch PPOMS following OMB review and approval
Assess State Incentive Grant activities	Incorporate State Incentive Grant assessments into PPOMS	Launch State Prevention System Management Information System features of PPOMS
Strengthen the knowledge base	Develop state-of-the-science papers	Continue to publish state-of-the-science papers
Examine existing data on prevention	Conduct and report cross-site synthesis of prevention programs	Disseminate cross-site findings
Increase awareness of science-based activities in the field	Assess awareness of value of science in the field	Find new ways to infuse science-based practice into the field

Track the Dissemination of Science-Based Programs. In the past year, PPOMS has been developed further. Through PPOMS, questions from the field regarding the extent and impact of science-based programs when implemented under everyday conditions can be addressed.

Assess State Incentive Grant Activities. Responding to the needs of the States, SIGs provide significant resources for the local implementation of science-based prevention programs. Understandably, the States and CSAP are committed to maximizing this investment to ensure that the dollars spent reach and help youth, families, and adults at risk. In the past year, CSAP established the State Prevention System Management Information System (SPSMIS). This system will become operational in the coming year and will incorporate elements of PPOMS.

By far the greatest milestone of the past year...is the remarkably increased awareness of the role and value of scientific contributions to prevention programming in this country.

Strengthen the Knowledge Base. The field demands and deserves the highest quality of knowledge development, synthesis, and dissemination of manuals that present the latest scientific knowledge, written to offer practical guidelines to the field. This year CSAP commissioned a number of papers on the state of the science of substance abuse prevention. These papers cover a range of issues of interest to prevention practitioners, policymakers, and researchers are being published in the *Journal of Primary Prevention*. Topics of papers already published or scheduled for publication in the near future include: family approaches; prevention with minority groups; etiology; prevention in the workplace, school, and community; and issues of comorbidity in substance abuse prevention.

Examine Existing Data on Prevention. As a centralized, coordinating Federal resource, SAMHSA's CSAP is in a position to draw together disparate studies and research to generate coherent, helpful guidelines for the field. During the past year, CSAP has drawn together a large body of that learning from its sponsorship of high-risk youth demonstration grants. Previously detailed in this report, findings from the National Cross-Site Evaluation support the work of the prevention community and justify in manifold ways our collective commitment to, and investment in, substance abuse prevention programs.

Awareness of Value of Science in the Field. By far the greatest milestone of the past year has been the remarkably increased awareness of the role and value of scientific contributions to prevention programming in this country. Across America, practitioners, policymakers, and the myriad dedicated organizations and associations responsible for substance abuse prevention have advanced their collective cause in ways not thought possible just a year ago.

A few observations illustrate that advance. The march of science-based prevention programs into States, communities, and localities is now palpable and apparently unstoppable. That is a major accomplishment that will benefit the field and, most important, America's children and families, for the foreseeable future. A nascent, yet tangible awareness of the need for accountability in substance abuse and other problem behavior prevention is now present. No longer is the value of prevention programs accepted simply because they seem like the right thing to do. Oversight, monitoring, and careful evaluation that mark a sophisticated field are now defining the quality of prevention programs.

Though hardly exhaustive, this list of accomplishments must include the increased capacity of States and communities to implement prevention programs. Training, technical assistance, and guidelines for program fidelity and adaptation, just some of the reasons for that capacity, are much in evidence.

Future Directions

CSAP is responding to feedback from the field to continue current work and to pursue new areas. Areas of work include expanding the substantive content topics covered by NREPP, launching PPOMS, commissioning state-of-the-science papers, disseminating cross-site results, and iden-

tifying new ways to incorporate science-based programs and practice into the field.

Expansion of NREPP Substantive Areas of Focus. In keeping with its current direction, the focus of NREPP reviews is being expanded. This expansion includes prevention targeting new populations, in workplace programs, programs aimed at HIV and AIDS, efforts to treat and prevent sequelae-associated posttraumatic stress disorder, and prevention and treatment programs for gambling disorders.

Substance Abuse Prevention with New Populations. NREPP continues to search for exemplary programs. Grassroots, community-based substance abuse prevention programs are particularly needed, especially those that serve populations underrepresented in the current NREPP database (e.g., programs for the elderly, those tailored expressly for ethnic-racial minority group members, and environmentally oriented programs). NREPP also is seeking new approaches to substance abuse prevention that not only are grounded in theory and science, but also consider the real-world time, budget, and staffing constraints of program delivery in the field.

Workplace. By their nature, when problems of substance use and abuse become exacerbated, they lead to impairments in everyday functioning. Those impairments are particularly costly in the workplace. Individuals who use drugs and alcohol on the job, or who come to work under the influence, are a clear hazard to themselves, their coworkers, and their families. Workers in charge of sensitive operations, dangerous machinery, and various forms of transportation can cause inordinate damage if they are even slightly impaired by substance use. Just as substance use in the workplace requires special consideration, so do programs to address substance use among workers.

Programs to prevent and treat substance use in the workplace enjoy a long history in this country. To bring the best of those programs to the attention of the practice community, NREPP is now inviting and screening interventions, approaches, and curricula that address substance use and abuse in workplace settings. Those efforts take the form of employee assistance programs, referral services, and programs to prevent not only substance use, but also interpersonal, traumatic, and family problems associated with substance use that can lead to impairment. NREPP has reviewed several workplace programs and found them of high quality. When their NREPP criteria scoring permits, these programs will be brought to the attention of the field through CSAP's ongoing dissemination initiatives.

HIV and AIDS. Medical problems of HIV and AIDS have clear antecedents and correlates related to substance use and abuse. Not only are injected drugs a major conduit for HIV transmission, but also persons under the influence of drugs and alcohol are more likely to take sexual risks that are linked with exposure to HIV infection. Equally important, the prevention of HIV and AIDS is an appropriate target for NREPP inclusion, given the threat to public health.

Responding to feedback from the field, CSAP will continue to build and expand the topics covered by NREPP, disseminate findings and inform the field about what works in prevention, and build the capacity of States and communities to implement effective prevention programs and practices.

In 2001, CSAP began submitting HIV prevention programs to NREPP for review. Many of these programs were developed with funding from the Centers for Disease Control and Prevention and have undergone careful testing. The NREPP review of HIV and AIDS prevention programs began with a body of existing research. From that research, one SAMHSA Model Program, two promising programs, and four effective programs have emerged to join the NREPP database. Differing somewhat from prevention programs that heretofore have typified NREPP, the HIV programs target populations characterized by their demonstrated risk of exposure to HIV infection risk factors. Results of efforts to find HIV and AIDS prevention programs will be forthcoming this year.

Posttraumatic Stress Disorder. The terrorist attacks on the United States in September 2001, together with their aftermath, have brought atten-

tion to the manifestations, prevention, and treatment of psychological trauma, or posttraumatic stress. The disorder associated with posttraumatic stress, long documented among scientists and increasingly known among laypersons as posttraumatic stress disorder (PTSD), has clear salience for SAMHSA and its constituents. Not only are elevated rates of substance use linked with PTSD, but adults suffering from PTSD are at risk for associated problems. In addition, spouses and other family members of adults experiencing PTSD show increased rates of substance use, as well as other psychosocial and health problems.

Children who have experienced trauma are of special interest. Young people have less sophisticated coping mechanisms than adults and lack the life experience to place horrific events in any historical context or perspective. Children and adolescents however, are ideal candidates for prevention programs. Unlike adults, youth are denied easy access to harmful substances and are unaccustomed to self-medicating with substances as a way to reduce stress and other posttraumatic effects. PTSD intervention programs with young people currently can address the direct effects and consequences of trauma.

For these reasons, NREPP now is including PTSD intervention programs. To date, several PTSD programs have been subjected to NREPP's 15 rating criteria—modified as appropriate to fit the parameters of PTSD and its manifestations. As further programs are discovered and ranked as promising and model, they will be included in future reports and entered into DSS along with all other NREPP products.

Gambling. Gambling is another disorder that has been reviewed by NREPP over the past year. With clear implications for problems of co-occurring substance use, gambling is also a problem in its own right. Gambling is increasingly recognized not only as a serious threat to the economic well-being of those who frequently engage in it for high stakes, but also as a factor contributing to damaged interpersonal relationships, job loss, and family problems. Though in its nascence, the serious scientific study of gambling has already yielded answers to many questions with salience for prevention programming. Scientists know, for instance, that chronic gambling is linked with many of the same risk and protective factors commonly understood to affect substance use. Indeed, recent data indicate that U.S. adults who have a current dependency on alcohol are 23 times more likely to have a current gambling problem than those who do not drink.[241]

Still, the epidemiology of gambling differs from that of alcohol and drug abuse. For example, gambling is more common among people from lower socioeconomic groups, as well as among African American and Hispanic people, than it is among affluent people and nonminority group members. The incidence of current gambling pathology is seven to eight times as high among black and Hispanic men and women as among white men and women.[242] Data on problem gambling appear to show a disquieting trend. A 1998 nationwide survey conducted for the National Gambling Impact Study Commission found that the national rate of pathological gambling was a little less than 1 percent. Recent data fix the rate of Americans who are currently pathological gamblers at between 1 percent and 2 percent. About 5 percent of Americans are judged to be problem gamblers. The lifetime prevalence of problem gambling is estimated to be from 4.8 percent to 11.5 percent. Overall, more than 80 percent of American adults reported gambling in the past year.[243]

Unsurprisingly, gambling appears to share opportunities for intervention and prevention with substance abuse. The emerging science of gambling, however, is just beginning to focus on the development and testing of programs suitable for field implementation. In its mission to codify science-based prevention programs, NREPP has taken an initial look at research on programs aimed at reducing the risks of habitual gambling. Next year's report on Science-Based Prevention Programs and Principles will include those findings and a list of any exemplary programs that issue from NREPP review.

PPOMS. In the coming year, PPOMS will begin its work in earnest. National telephone interviews

will commence concurrently with data gathering via the Internet and SPSMIS. Essential to the success of PPOMS data collection activities is the support, cooperation, and involvement of professionals in the field. PPOMS will reveal how programs are adopted, what processes adopters employ in their decisions to implement and adapt programs, and the degree to which results from implementations affect substance use prevalence rates in the index communities and institutions.

Particular attention in the next year will be given to measuring SAMHSA Model Program implementation fidelity and adaptation among SIG recipients. Because SIG recipients are required to devote one-half of their prevention program resources to science-based SAMHSA Model Programs, SIG States are ideal field-test sites for assessing the relationship between program delivery parameters and outcomes. The number of State recipients and subrecipients—local entities responsible for program delivery—will ensure a large, representative, and robust sample of field sites to measure issues related to fidelity and adaptation.

Readers of this report represent the very consumers of prevention programs who will determine whether PPOMS meets its objectives to monitor science-based prevention program implementations, adaptations, and outcomes throughout the United States.

Continue to Publish State-of-the-Science Papers. As is clear from the list of state-of-the-science papers appended to this report, articles will continue to appear in print throughout the coming year.

Disseminate National Cross-Site Findings. CSAP has completed detailed findings and reports on its National Cross-Site Evaluation of High-Risk Youth Programs. The following five volumes in this series are all available from CSAP by calling (301) 468-2600 or visiting www.samhsa.gov/csap/preventionpathways

- National Cross-Site Evaluation of High-Risk Youth Programs Overview
- Monograph Series No. 1: Preventing Substance Use: Major Findings From National Cross-Site Evaluation of High-Risk Youth Programs
- Monograph Series No. 2: Understanding Risk, Protection, and Substance Use Among High-Risk Youth
- Monograph Series No. 3: Findings on Designing and Implementing Effective Prevention Programs for Youth at High Risk
- Monograph Series No. 4: Making Prevention Effective for Adolescent Boys and Girls: Gender Differences in Substance Use and Prevention

These five volumes offer sound and rigorous, yet practical and user-friendly information, data, and conclusions from the cross-site evaluation. Results reviewed earlier in this report provide only a small portion of that material. Interested readers are urged to obtain the complete set of volumes for useful guidelines from the National Cross-Site Evaluation of High-Risk Youth Programs.

Find New Ways to Inform the Field About Science-Based Prevention. Doubtless, the most rewarding task—and the greatest challenge—facing CSAP in the coming year is, as always, the provision of helpful information, data, and guidance to the field. If the agency cannot serve our practice and policymaking constituents, little that CSAP does has value. The mission of bringing effective prevention to every community can be fulfilled only if the field is informed by SAMHSA'S knowledge development, synthesis, and dissemination activities.

Only readers and constituencies can determine whether SAMHSA has succeeded or failed in our efforts to disseminate science-based prevention information.

State-of-the-Science Papers

Journal of Primary Prevention, Volume 21, Issue 2, Winter 2000.

James Alexander, Michael Robbins, & Thomas Sexton. Family-based intervention with older, at-risk youth: From promise to proof to practice.

Anthony Biglan & Ted Taylor. Increasing the use of science to improve child rearing.

Donald Gordon. Parent training via CD-ROM: Using technology to disseminate effective prevention practices.

John E. Lochman. Parent and family skills training in targeted prevention programs for at-risk youth.

Richard Spoth & Cleve Redmond. Research on family engagement in preventive interventions: Toward improved use of scientific findings in primary prevention practices.

William L. Turner. Cultural considerations in family-based primary prevention programs in drug abuse.

Journal of Primary Prevention, Volume 22, Issue 2, Winter 2001.

Paul Brounstein & Steven Schinke. Introduction to the beginning of a series of review papers stemming from the Center for Substance Abuse Prevention and the National Center for the Advancement of Prevention State-of-the-Science papers.

Lawrence M. Scheier. Etiologic studies of adolescent drug use: A compendium of data resources and their implications for prevention.

Journal of Primary Prevention, Volume 22, Issue 3, Spring 2002.

Steven Schinke & Paul Brounstein. Introduction to this series of papers on Primary Prevention and Special Populations.

James R. Moran & Julia Archer Reaman. Substance abuse prevention among American Indian Youth.

John M. Wallace, Jr., & Jordana R. Muroff. Preventing substance abuse among African American children and youth: Race differences in risk factor exposure and vulnerability.

Tonda L. Hughes & Michelle Eliason. Substance use and abuse in lesbian, gay, bisexual, and transgender populations.

Judith R. Vicary & Christine M. Karshin. College alcohol abuse: A review of the problems, issues, and prevention approaches.

Journal of Primary Prevention, Volume 22, Issue 4, Summer 2002.

William N. Hanson. Program evaluation strategies for substance abuse prevention.

Journal of Primary Prevention, Volume 23, Issue 1, Fall 2002.

James Emshoff & Paul Brounstein. Introduction to this series of papers on primary prevention and special locations for practice.

John E. Lochman & Antoinette van den Steenhoven. Family-based approaches to substance abuse prevention.

Royer Cook & William Schlenger. Prevention of substance abuse in the workplace: Review of research on the delivery of service.

Journal of Primary Prevention, Volume 23, Issue 3, Spring 2003.

Eric Schaps & Daniel Solomon. The role of the school's social environment in preventing student drug use.

Howard S. Adelman & Linda Taylor. Creating school and community partnerships for substance abuse prevention programs.

John F. Stevenson & Roger E. Mitchell. Community-level collaboration for substance abuse prevention.

Journal of Primary Prevention, Volume 23, Issue 4, Summer 2003.

Mary C. Ruffolo, Mary E. Evans, & Ellen P. Lukens. Primary prevention programs for children in the social service system.

Carol T. Mowbray & Daphna Oyserman. Substance abuse in children of parents with mental illness: Risks, resiliency, and best prevention practices.

Laurie L. Meschke & Joan M. Patterson. Resilience as a theoretical basis for substance abuse prevention.

5. SAMHSA Model Programs

SAMHSA and its CSAP are at the forefront of the Federal Government's sustained efforts to prevent substance abuse and related problems at the local, State, and national levels. Since its establishment SAMHSA's CSAP has sponsored a broad array of demonstration programs and other initiatives in multiple settings that provide strong evidence that prevention works. The search for usable, effective substance abuse prevention models has fostered the development and dissemination of prevention science and growing recognition of the benefits that accrue when substance abuse is stopped before it starts.

In 1987, the High-Risk Youth (HRY) Demonstration Grant Program first began awarding grants to develop innovative programming tailored to the needs of identified subpopulations of youth at high risk for substance abuse. Effective programs are identified after a comprehensive screening process. Programs that agree to be a part of the dissemination process then are listed as SAMHSA Model Programs. Each program is designed to be adopted and adapted to meet the needs of different communities. This approach enhances the likelihood that the program will be successfully replicated.

Model Program Summary Matrix. Already discussed in this report is the SAMHSA Model Program Model Program Summary Matrix. The columns in the matrix display various characteristics of the programs that account for their model status and that serve as a guide for their consideration and possible selection by practitioners in the field. Characteristics of the programs were described early in the report, with illustrations provided by the first program in the matrix, *Across Ages*. (Note: Certain programs will have changed status during the process of publishing this report; the Model Program Summary Matrix represents the most current listing of Model Programs as of this writing.

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1 yr	2 yr	3 yr							
Across Ages Andrea Taylor Temple University	9–13 & Parents	Mixed	■	■	■	■	■	3+ 2 1	Replicated with Spanish-speaking and Native American children	Urban	Individual School Peer		◆ Older adults mentor youth ◆ Perform community service ◆ Develop youth coping/life skills ◆ Provide academic support ◆ Provide parent support	Decreased youth substance use, suspensions, and problem behavior; improved self-esteem, school attendance, and knowledge of dangers of substance use; improved relationships with adults; improved attitudes about older
All Stars William Hansen Tanglewood Research	11–15	Mixed	■	■	■			3+ 2 1	Materials in Spanish	Urban Suburban Rural	Individual Family School Peer		◆ Develop positive peer norms ◆ Increase bonding to school ◆ Provide parent support	Reduced drug use, sexual activity, and reported violence; increased bonding with school and family.
Athletes Training and Learning to Avoid Steroids (ATLAS) Linn Goldberg Diane Elliot Oregon Health Sciences University	14–18 Males	Mixed	■	■	■			3+ 2 1	No	Urban Rural Suburban	Individual School Peer Community		◆ Provide youth leadership training and peer-led sessions ◆ Develop resistance skills ◆ Educate youth on sports nutrition	Reduced drinking/driving occurrences; decreased use of anabolic steroids, athletic supplements, and alcohol/illicit drugs.

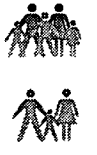
 Universal  Selective  Indicated

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1 yr	2 yr	3 yr							
Border Binge Drinking Reduction Program* Robert Voas James Baker Pacific Institute for Research and Evaluation; Institute for Public Strategies	<25	Mixed	■	■	■	■		3+ 2 1	N/A	Urban Suburban	Community		◆ Enhance alcohol law enforcement on border ◆ Promote responsible beverage service practices ◆ Create binational youth service center ◆ Implement media advocacy programs	Reduced number of young Americans returning to the United States with illegal BACs after night of drinking in Mexico; reduced number of alcohol-related crashes among underage drinkers; increased awareness of new enforcement program.
Brief Strategic Family Therapy (BSFT) Jose Szapocznik University of Miami	8–17 & Families	Hispanic and African American	■	■	■	■		3+ 2 1	Tailored to work with Hispanic and African-American families	Urban Rural	Individual Family School Peer		◆ Provide problem-focused family maladaptive ◆ Restructure therapy behaviors ◆ Facilitate healthy family interactions	Reduced drug use and emotional and behavioral problems; improved family functioning.

 Universal  Selective  Indicated

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1 yr	2 yr	3 yr							
CASASTART* Lawrence Murray National Center on Addiction and Substance Abuse Columbia University	8–13	Mixed	■	■	■	■	■	3+ 2 1	Tailored to work with African American and Latino families	Urban	Individual Family School Community	Selective Indicated	◆ Improve youths' attachment to prosocial individuals and institutions ◆ Increase youths' opportunities to achieve positive goals ◆ Provide parent education/training	Reduced students' reports of using gateway and stronger drugs; reduced association with delinquent peers and violent offenses; increased positive peer influence.
Challenging College Alcohol Abuse (CCAA) Koreen Johannessen University of Arizona	>18 & Parents	Mixed	■	■	■	■	■	3+ 2 1	N/A	Urban	Individual Peer Family School Workplace Community	Universal	◆ Implement SHADE (Student Health Alcohol and Drug Education) ◆ Implement Peer Education Classes (ANGLE, CARE, Frisky Business)	Decreased negative consequences of AOD use; decreased positive perceptions of alcohol; decreased heavy drinking; decreased AOD-related crimes.
Child Development Project (CDP) Eric Schaps Diane Wood Developmental Studies Center	6–12	Mixed	■	■	■	■	■	3+ 2 1	Some materials in Spanish	Urban Rural Suburban	Individual Family School Peer	Universal	◇ Develop youth coping and life skills ◇ Increase bonding to school and peers ◇ Provide parent education/training	Decreased substance use; increased liking for school, enjoyment of class, and motivation to learn; greater conflict resolution skills.

Universal Selective Indicated

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1 yr	2 yr	3 yr							
Communities Mobilizing for Change on Alcohol (CMCA) Alexander Wagenaar University of Minnesota	<21	Mixed	■	■	■	■	■	3+ 2 1	No	Urban Suburban Rural	Peer Community Society		◆ Mobilize and organize communities ◆ Enforce laws concerning alcohol sales to minors	Less likely to buy alcohol or drink in a bar; increased age-identification checking and reduced sales to minors; decreased arrests while driving under the influence.
Community Trials Intervention to Reduce High-Risk Drinking (RHRD) Harold Holder Prevention Research Center	<21	Mixed	■	■	■	■	■	3+ 2 1	Materials in Spanish	Urban Suburban Rural	Community Society		◆ Mobilize and organize communities ◆ Provide responsible beverage service training ◆ Enforce laws concerning alcohol sales to minors	Reduced youth access to alcohol, sales of alcohol to minors, and alcohol-related automobile crashes.
Creating Lasting Family Connections (CLFC) Ted Strader Council on Prevention and Education: Substances, Inc.	11–15 & Parents	Mixed	■	■				3+ 2 1	No	Urban Suburban Rural	Individual Family Community		◆ Develop youth coping and life skills ◆ Provide individual/group counseling ◆ Provide parent education/training	Increased child resiliency; increase in setting family norms on substance use; delayed onset of substance use.

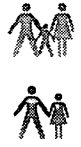
 Universal  Selective  Indicated

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1 yr	2 yr	3 yr							
DARE To Be You (DTBY) Jan Miller-Heyl Colorado State University	2–5 & Families	Mixed	■	■	■	■	■	3+ 2 1	N/A	Urban Suburban Rural	Individual Family School Community		◆ Provide peer mentoring ◆ Develop life skills and coping skills in youth ◆ Provide parent training and education	Increased parent efficacy; increased child development skills.
Early Risers "Skills for Success" Gerald August University of Minnesota	6–9 & Parents	Mixed	■	■	■			3+ 2 1	Tested primarily with African American children and families	Rural	Individual Family School Peer		◆ Develop social skills ◆ Enhance academic performance ◆ Parent education and training	Improved social skills and academic achievement; increased parental involvement; reduced impulsivity.
Families And Schools Together (FAST)* Lynn McDonald University of Wisconsin-Madison	4–13 & Families	Mixed	■	■	■	■	■	3+ 2 1	Implemented in Australia, Austria, Canada, Germany, and France	Urban Suburban Rural	Individual Family School		◆ Enhance family functioning ◆ Prevent child from experiencing school failure ◆ Prevent substance abuse by child and family ◆ Reduce parent and child stress	Improved classroom and at-home behaviors; increased family closeness and communication; reduced family conflict; increased parental involvement in school.

Universal Selective Indicated

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1 yr	2 yr	3 yr							
Family Effectiveness Training (FET) Jose Szapocznik University of Miami Center for Family Studies	6–11 & Families	Hispanic	■	■				3+ 2 1	Tailored to work with Hispanic families	Urban Suburban Rural	Individual Family School Peer		◆ Target intergenerational and intercultural conflict ◆ Restructure maladaptive behaviors ◆ Facilitate healthy family interactions training	Improved school performance; reduced problem behaviors; improved child concept and family functioning.
Family Matters* Karl Bauman University of North Carolina-Chapel Hill	12–14 & Families	Mixed	■	■				3+ 2 1	N/A	Urban Suburban Rural	Individual Family Peer		◆ Provide alcohol and drug information ◆ Develop resistance skills ◆ Provide parent training ◆ Develop family strengths	Reduced prevalence of adolescent cigarette smoking and alcohol use for non-Hispanic white adolescents.
High/Scope Perry Preschool Project* David Weikart High/Scope Educational Research Foundation	3–5	Mixed	■	■	■	■	■	3+ 2 1	N/A	Rural Suburban Urban	Individual Family School Institutional		◆ Implement High/Scope preschool curriculum ◆ Introduce training methodology ◆ Provide specialized two-part assessment system	Intervention children do significantly better throughout childhood and adulthood than comparison group.

Universal Selective Indicated

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1 yr	2 yr	3 yr							
Incredible Years Carolyn Webster-Stratton University of Washington	3–10 & Parents	Mixed	■	■	■	■	■	3+ 2 1	Replicated with African-American, Asian, and Hispanic families	Urban Suburban Rural	Individual Family School Peer		◆ Enhance social and academic competence ◆ Develop youth coping and life skills ◆ Provide parent education and training	Reduced problem behaviors; increased social competence and academic engagement.
Keep A Clear Mind (KACM) Chudley Werch Michael Young University of Arkansas	9–11 & Parents	Mixed	■	■	■	■	■	3+ 2 1	Some groups have translated materials into Vietnamese, Hmong, and Spanish	Urban Suburban Rural	Individual Family Peer		◆ Develop resistance skills ◆ Provide alcohol and drug information ◆ Foster family support	Increased ability to resist pressure to use substances; increased parent discussions with children on substance use.
Leadership and Resiliency Program (LRP) Amrit Daryanani Fairfax-Falls Church Community Services	13–18	Mixed	■	■	■	■	■	3+ 2 1	No	Urban Suburban Rural	Individual School Peer Community		◆ Individual/group counseling ◆ Increase bonding to school and family ◆ Improve social competence	Reduced school absences and school disciplinary reports; increased GPA and graduation rates.

 Universal  Selective  Indicated

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1 yr	2 yr	3 yr							
LifeSkills™ Training (LST) Gilbert Botvin Cornell University Medical College	10–14	Mixed	■	■	■	■	■	3+ 2 1	No	Urban Suburban Rural	Individual Family School Peer		◆ Enhance self-esteem ◆ Teach interpersonal and communication skills ◆ Develop resistance skills	Greater ability to refuse offers of alcohol, marijuana, and cigarettes; decreased rates of substance use; increased ability to find different ways to cope with stress.
Mpowerment* Susan Kegeles University of California, San Francisco	12–30	Mixed	■	■				3+ 2 1	N/A	Rural Suburban Urban	Individual Peer Community		◆ Conduct formal and informal peer outreach programs ◆ Conduct ongoing publicity campaigns	Decreased unprotected anal intercourse; decreased percentage with non-primary partners and boyfriends.
Multisystemic Therapy Scott Henggeler Medical University of South Carolina	12–17 & Families	Mixed	■	■	■	■	■	3+ 2 1	Materials in Norwegian	Urban	Family Community		◆ Conduct family sessions at home ◆ Enhance parenting skills ◆ Improve family and peer relations ◆ Improve school performance	Reduced long-term rates of re-arrest and out-of-home placements; improved family functioning; decreased mental health problems.

 Universal  Selective  Indicated

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1 yr	2 yr	3 yr							
Nurse-Family Partnership (NFP) David Olds National Center for Children, Families, and Communities	>13 & unwed women; families bearing first child	Mixed	■	■	■	■	■	3+ 2 1	Spanish-speaking nurses were assigned to monolingual Spanish-speaking clients	Rural Urban	Individual School Community		◆ Conduct family sessions at home ◆ Provide education on prenatal, infant, and early childhood development ◆ Build supportive relationships	Reduced cigarette smoking during pregnancy; reduced rates of child abuse; fewer subsequent births; fewer maternal behavior problems.
Olweus Bullying Prevention Dan Olweus University of Bergen	9–14	Mixed	■	■	■	■		3+ 2 1	Implemented in Bergen, Norway; Southeastern US; Sheffield, England; and Schleswig-Holstein, Germany	Rural Urban Suburban	Individual School Peer		◆ Restructure school environment ◆ Increase positive involvement and supervision from teachers ◆ Use consistent, nonhostile sanctions	Reduced students' reports of being bullied, bullying others, and general antisocial behavior.
Parenting Wisely* Donald Gordon Ohio University	Parents of delin-quents and at-risk adolesc-ents	Mixed	■	■	■			3+ 2 1	Implemented in Australia, Ireland, England, Belgium, France, Germany, and Switzerland	Urban Suburban Rural	Individual Family		◆ Enhance parent communication skills ◆ Increase parental knowledge and use of appropriate and effective parenting techniques ◆ Promote healthy family interactions	Increased knowledge of parenting principles and skills; reduced child problem behaviors.

 Universal  Selective  Indicated

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1 yr	2 yr	3 yr							
Positive Action (PA) Carol Gerber-Allred Positive Action, Inc.	6–18	Mixed	■	■	■	■	■	3+ 2 1	No	Urban Suburban Rural	Individual Family School Peer Community		◆ Restructure school environment ◆ Enhance self-management and social skills ◆ Improve self-concept	Better achievement scores; fewer incidents of violence; fewer out-of-school suspensions; fewer chronic absentees.
Preparing for the Drug-Free Years (PDFY) J. David Hawkins University of Washington	8–14 & Parents	Mixed	■	■	■	■	■	3+ 2 1	Tested with African American, Latino, and Samoan families	Urban Rural Suburban	Individual Family School Peer		◆ Provide family sessions ◆ Enhance parenting skills ◆ Improve family and peer relations ◆ Develop youth coping and life skills	Reduced children's antisocial behavior; fewer incidents of drug use in school; improved parenting behaviors.
Project ACHIEVE Howard Knoff University of South Florida	5–13	Mixed	■	■	■	■	■	3+ 2 1	Replicated in Native American reservation schools/special education programs	Urban Suburban Rural	Individual Family School Peer		◆ Improve classroom management skills of school personnel ◆ Enhance problem-solving skills ◆ Increase social and academic progress	Decreased referrals to, and placements in, special education; decline in disciplinary referrals to principal's office; improved academic performance.

Universal Selective Indicated

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1 yr	2 yr	3 yr							
Project ALERT Phyllis Ellickson RAND	11–14	Mixed	■	■	■	■	■	3+ 2 1	Replicated in Spanish with special education programs, hearing impaired	Urban Suburban Rural	Individual Family School Peer		◆ Enhance decisionmaking, resistance, and interpersonal skills ◆ Provide alcohol and drug information ◆ Provide parent activities	Decreased marijuana use initiation; decreased current and heavy smoking; reduced prodrug attitudes and beliefs.
Project Northland: An Alcohol Prevention Curriculum Cheryl Perry Carolyn Williams University of Minnesota	11–13	Mixed	■	■	■	■		3+ 2 1	No	Rural	Individual Family School Peer Community Society		◆ Provide alcohol and drug information ◆ Provide peer mentoring ◆ Enhance interpersonal skills ◆ Provide parent education/training	Reduced tobacco and alcohol use; decreased peer influence to use alcohol; improved parent-child communication about consequences of alcohol use.
Project SUCCESS Ellen Morehouse Student Assistance Services	13–18	Mixed	■	■	■	■	■	3+ 2 1	Yes	Urban Rural Suburban	Individual Family School Peer		◆ Provide prevention education and referral services ◆ Enhance youth coping and life skills ◆ Provide parent activities	Reduced alcohol, tobacco, and illicit drug use and problem behaviors.

 Universal  Selective  Indicated

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1 yr	2 yr	3 yr							
Project Toward No Drug Abuse (TND) Steven Sussman University of Southern California	15–18	Mixed	■	■	■	■	■	3+ 2 1	Some materials in Persian	Urban Suburban Rural	Individual Family School Peer Community		◆ Enhance youth coping and life skills ◆ Build resistance to peer pressure ◆ Facilitate attitude change	Reduced higher levels of alcohol use and all levels of hard drug use.
Project Toward No Tobacco Use (TNT) Steven Sussman University of Southern California	10–15	Mixed	■	■	■	■	■	3+ 2 1	Some materials in Spanish	Urban Suburban Rural	Individual Family School Peer Community		◆ Teach interpersonal and decision-making skills ◆ Build resistance to peer and media pressure ◆ Facilitate attitude change	Reduced initiation of cigarettes; reduced initiation of smokeless tobacco; reduced cigarette smoking; eliminated smokeless tobacco use.
Promoting Alternative THinking Strategies (PATHS)* Mark Greenberg Pennsylvania State University	5–11	Mixed	■	■	■	■	■	3+ 2 1	N/A	Rural Suburban Urban	Individual Peer School		◆ Prevent or reduce behavioral and emotional problems ◆ Assist students in identifying/labeling feelings and behaviors ◆ Provide teachers with systematic lessons and materials	Improved self-control, understanding, and recognition of emotions; ability to tolerate frustration; decreased anxiety, conduct problems, and symptoms of sadness and depression.

 Universal  Selective  Indicated

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1 yr	2 yr	3 yr							
Protecting You / Protecting Me* Kappie Bliss Mothers Against Drunk Driving	5–10	Mixed	■					☐ 3+ 2 1	N/A	Suburban Urban	Individual School		◆ Increase students' knowledge about the human brain and development ◆ Increase students' knowledge about refusal and self-protection skills ◆ Enhance parents' knowledge of children's development	Students were less likely to ride with an impaired driver, gained critical life-saving skills to protect themselves, became more strongly opposed to drinking and driving; significant increases in attitudes toward risks of underage alcohol and illicit drug use.
Reconnecting Youth (RY) Leona Eggert University of Washington School of Nursing	14–17	Mixed	■					☐ 3+ 2 1	No	Urban Suburban Rural	Individual Family School Peer		◆ Build youth coping and life skills ◆ Enhance interpersonal and decision-making skills ◆ Provide peer mentoring	Improved school grades and attendance; reduced drug use and emotional distress; increased self-esteem, personal control, prosocial peer bonding, and social support.

 Universal  Selective  Indicated

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1 yr	2 yr	3 yr							
Residential Student Assistance Program (RSAP) Ellen Morehouse Student Assistance Services	14–17	Mixed	■					3+ 2 1	Yes	Urban Suburban Rural	Individual Peer Community		◆ Provide alcohol and drug information ◆ Enhance interpersonal and decisionmaking skills ◆ Provide individual, group, and peer counseling	Decreased alcohol, tobacco, and marijuana use.
Responding in Peaceful and Positive Ways (RIPP)* Aleta Lynn Meyer Virginia Commonwealth University	11–14	Mixed	■	■				3+ 2 1	N/A	Urban	Individual School Peer		◆ Promotion of schoolwide norms ◆ Social cognitive problem-solving model ◆ Implementation of program by adult role model ◆ Opportunities for real-life application of skills	Decreased school disciplinary code violations and peer pressure to use drugs; decreased student-reported frequency of drug use; increased peer support for prosocial behavior.
Second Step Lisa Walls Committee for Children	2–14	Mixed	■	■	■	■	■	3+ 2 1	Taught in Germany, Denmark, Japan, Norway, South Africa, England, Canada, and Australia	Rural Suburban Urban	Individual Peer Family School Workplace Community		◆ Teach empathy, impulse control, and anger management skills ◆ Provide opportunities for modeling, practice, and reinforcement of these skills	Reduced physical and verbal aggression; increased social interactions; greater understanding of emotional skills; less likely to endorse relational aggression.

 Universal  Selective  Indicated

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1 yr	2 yr	3 yr							
Start Taking Alcohol Risks Seriously (STARS) for Families Chudley Werch University of North Florida	11–13	Mixed	■	■	■	■	■	3+ 2 1	Yes	Urban Suburban Rural	Individual Peer Family School		◆ Enhance stress management and problem-solving skills ◆ Provide alcohol and drug information ◆ Promote family involvement	Reduced initiated alcohol use and heavy drinking over time.
Strengthening Families Program (SFP) Karol Kumpfer University of Utah	6–11 & Family	Mixed	■	■				3+ 2 1	Yes	Urban Suburban Rural	Individual Family School Peer		◆ Provide education services ◆ Develop youth coping and life skills ◆ Provide family and alternative drug-free activities	Decreased alcohol, tobacco, and illicit drug use; improved social/life skills; improved parent-child attachment/ family relations; improved parenting skills.
Students Managing Anger and Resolution Together (SMART) Team Kris Bosworth University of Arizona	10–14	Mixed	■	■				3+ 2 1	No	Urban Suburban Rural	Individual Peer		◆ Present activities in form of motivational software ◆ Teach anger management skills ◆ Enhance decision-making skills	Improved knowledge of anger and anger management; greater frequency of self-reported prosocial acts; decreased beliefs of violence.

 Universal  Selective  Indicated

Program	Target Population		Results					Replications	Cultural Adaptation	Location	Domain	IOM Category	Program Activities	Findings
	Age	Ethnicity	Pre	Post	1 yr	2 yr	3 yr							
Too Good For Drugs (TGFD) Cynthia Coney Mendez Foundation	5–13	Mixed	■	■	■	■	■	3+ 2 1	N/A	Rural Suburban	Individual Peer Family School Workplace Community		◆ Prevent ATOD use ◆ Provide education in social and emotional competencies ◆ Teach instructional strategies for improving various skills	Decreased potential or actual tobacco use; decreased potential or actual alcohol use; decreased potential or actual marijuana use.

 Universal  Selective  Indicated

* Fact Sheets are currently under development.

SAMHSA Model Programs Fact Sheets

The SAMHSA Model Program four-page fact sheets that follow this part of our report highlight important programmatic and program implementation information and display dramatically positive effects of the programs. Fact sheets include information on current SAMHSA Model Programs' successes, intervention strategies, evaluation standards, target populations, resources needed to implement the program, and program outcomes. (An asterisk in the program listing found in the Model Program Summary Matrix indicates that a fact sheet for that program was not available at time of publication.) Each fact sheet lists information in the following sections:

- **Program Description:** Briefly describes what the program was designed/proven to do, the behaviors the program addresses, its target audience, and the types of interventions and strategies the program employs.
- **Proven Results:** Summarizes the program's study outcomes, including numerical statistics whenever possible.
- **Intervention:** Notes whether the program is Universal, Indicated, or Selective, or any combination of the three preventive interventions.
- **Benefits:** Lists the changed or new behaviors the program is designed to develop and how they contribute to study outcomes.
- **Target Population:** Describes the population the program was designed for and tested on and discusses the behaviors/symptoms of that population and populations affected by the behavior. This section also provides age and/or grade ranges and geographic, socioeconomic, gender, and ethnic/racial information.
- **How It Works:** Briefly describes the strategic interventions used in the program, such as specific activities and intervention techniques, and discusses the setting(s) where the program will operate.
- **Implementation Essentials:** Discusses elements that are essential to successful program replication, such as training and technical assistance, program resources and materials, and an implementation timeline.
- **Target Areas:** Describes the risk and protective factors affected by the program, by appropriate domains.
- **Program Background:** Summarizes the program's history, development, and usage.
- **Evaluation Design:** Summarizes the methodology and components involved in the program's evaluation.
- **Outcomes:** Summarizes the program's evaluation outcomes with charts and graphs that illustrate the program's significant findings.
- **Program Developer:** Provides information on the program's developer(s), including a brief summary of the developer/organization's general mission, focus, and professional background, with, in some cases, information on other related programs.
- **Contact Information:** Provides information on where to obtain costs, materials, technical assistance, and general program information.
- **Recognition:** Lists awards, academic or research accomplishments, and certifications.

Across Ages

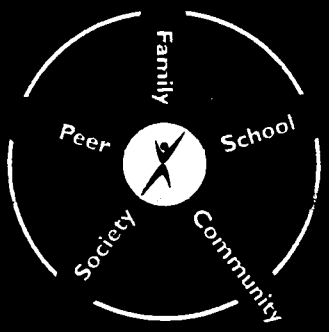
Across Ages is a school- and community-based drug prevention program for youth 9 to 13 years old that seeks to strengthen the bonds between adults and youth and to provide opportunities for positive community involvement. The unique and highly effective feature of Across Ages is the pairing of older adult mentors (age 55 and above) with young adolescents, specifically youth making the transition to middle school. The program employs mentoring, community service, social competence training, and family activities to build youths' sense of personal responsibility for self and community. Specifically, the program aims to—

- Increase knowledge of health and substance abuse and foster healthy attitudes, intentions, and behavior toward drug use among targeted youth
- Improve school bonding, academic performance, school attendance, and behavior and attitudes toward school
- Strengthen relationships with adults and peers
- Enhance problem-solving and decisionmaking skills

The overall goal of the program is to increase the protective factors for high-risk students to prevent, reduce, or delay the use of alcohol, tobacco, and illegal drugs, and the problems associated with such use.

TARGET POPULATION

The original project and two replications were designed and tested on African American, Hispanic/Latino, White, and Asian American middle school students (sixth grade) living in a large urban setting. More than 30 subsequent replications have been adapted for 9- to 13-year-old Native



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Proven Results*

- Increased knowledge about and negative attitude toward drug use
- Decreased alcohol and tobacco use
- Increased school attendance, decreased suspensions from school, and improved grades
- Improved attitudes toward school and the future
- Improved attitudes toward adults in general and older adults in particular

**The level of mentor involvement was positively related to improvement on various outcome measures.*

INTERVENTION

Universal

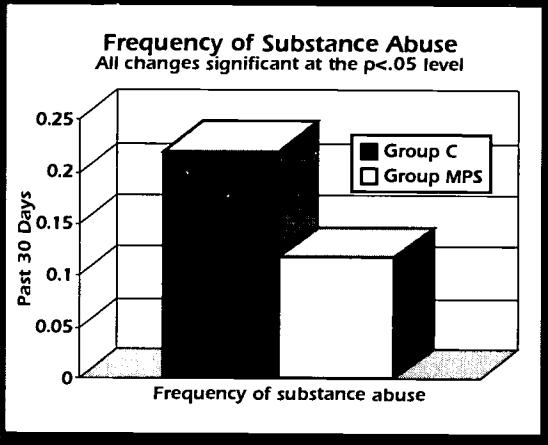
Selective

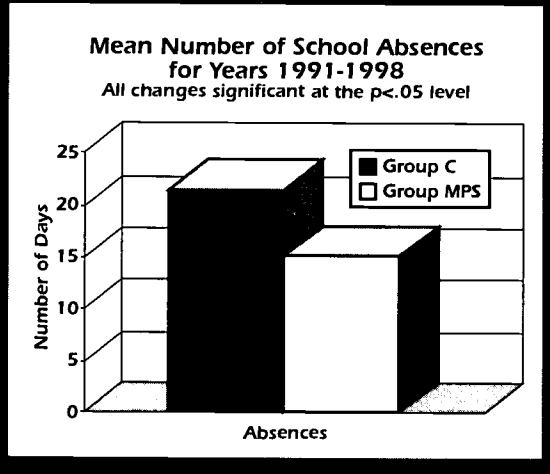
Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

The data demonstrate the efficacy of the intervention for all program youth. In particular, the research showed the effectiveness of matching youth with older adult mentors in improving prosocial values, increasing knowledge of the consequences of substance use, and helping youth avoid later substance use by teaching them appropriate resistance behaviors.





American, White, Hispanic/Latino, and African American youth living in urban, suburban, and rural settings. Testing has shown that Across Ages is not appropriate for extremely rural communities because these communities do not offer the anonymity necessary for the youth-mentor relationship to work effectively. Risk factors for targeted youth include:

- Residence in communities with no opportunities for positive free-time activities
- Few positive adult role models
- Being in kinship care due to inability of one's birth parents to care for one, often due to incarceration or substance use

BENEFITS

Participating youth have an opportunity to form lasting relationships with significant adults who can provide guidance, nurturing, and support. They learn positive coping skills and have an opportunity to be of service to their community. As a result, youth demonstrate improved commitments to school, healthier attitudes and behaviors regarding nonuse of substances, a sense of social responsibility, and the capacity for positive problem solving.

HOW IT WORKS

Across Ages can be implemented as a school-based or after-school program. It has been replicated most successfully in urban/suburban settings where there is access to transportation **and** sufficient numbers of older adults not personally known or related to participating families and youth. If the project is school-based, most of the activities for youth will take place in the classroom; if it is an after-school program, a school, community center, or faith-based institution is an appropriate setting. The activities and interventions include:

- **Mentoring.** Older adults (55 and older) are recruited and trained, and spend a minimum of 2 hours each week in one-on-one contact with the youth.
- **Community Service.** Youth spend 1 to 2 hours per week performing community service.
- **Social Competence Training.** Across Ages uses the Social Problem-Solving Module of the *Social Competence Promotion Program for Young Adolescents* that is composed of 26 weekly lessons, 45 minutes each.
- **Family Activities.** Monthly weekend events are held for youth, their family members, and mentors.

Across Ages materials are available in English and Spanish.

IMPLEMENTATION ESSENTIALS

To replicate with fidelity, programs must:

- Use all program components
- Have mentors who are 55 years or older
- Implement State- or agency-approved screening and training of mentors that includes 8 to 10 hours of preservice training and monthly in-service meetings
- Provide training and orientation for all participants
- Provide stipends or reimbursement to mentors
- Vigilantly monitor the mentor-youth matches
- Prepare written agreements among collaborating organizations
- Staff the program adequately (i.e., a minimum of one full-time and one part-time staff person for 30 youth and 15 to 20 mentors)

Resources

In addition to part-time clerical support, the program needs:

- **Program Coordinator:** One full-time college graduate with a minimum of 3 years of experience in education, social work, counseling, or related field
- **Outreach Coordinator:** One individual familiar with the community to recruit mentors and oversee community service, preferably working full time, but a part-time employee is acceptable

Across Ages requires family consent for youth participation as well as cooperation from the school and/or referring agencies. A classroom and one or more central meeting locations are needed for youth-mentor training and meetings, participation in social competence curriculum, training and in-service meetings for mentors, and family activities.

Timeline

Program planning and startup take about 6 months, including mentor recruitment and 2 days of preservice staff training. Two days of technical assistance (TA) during the first year and 1 day of TA in subsequent years are recommended. Across Ages requires 12 months of youth-mentor collaboration for successful implementation.

PROGRAM BACKGROUND

Across Ages was developed at Temple University's Center for Intergenerational Learning in Philadelphia, PA. The Center is dedicated to strengthening communities and meeting the needs of individuals and families by bringing generations together. The project was originally funded in 1991 by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP) as a school-

Target Areas

Protective Factors To Increase

Individual

- Relationship with significant adult
- Engagement in positive free-time activities
- Problem-solving/conflict resolution skills
- Bonding to school

Peer

- Association with peers engaged in positive behavior and activities

Family

- Engagement in positive family activities
- Improved communication between parents and children

School

- Improved school attendance, behavior, and performance

Community

- Youth given useful role in the community and viewed positively by community members

Risk Factors To Decrease

Individual

- School failure
- Identified behavior problems in school
- Lack of adult role models
- Poor decisionmaking and problem-solving skills

Peer

- Engagement in risky behavior

School

- Lack of bonding to school

Family

- Substance-abusing parents and siblings
- Incarcerated family members
- Little positive interaction between parents and children

Community

- Residence in communities lacking opportunities for positive recreational activities, and with high incidence of drug-related crime and pro-use norms

and community-based demonstration research project and was replicated in Philadelphia and West Springfield, MA, from 1995 to 1998. Today, more than 30 replication sites span 17 States.

EVALUATION DESIGN

The outcome research design was quasi-experimental rather than experimental since it was not possible to select schools on a completely random basis. A classic randomized pretest–posttest with a control group design was used for the evaluation. The three groups evaluated were:

- **Group C:** The control group did not receive the intervention.
- **Group PS:** This group participated in the Positive Youth Development Curriculum (PYDC) and performed community service activities 2 hours per week. Caregivers and family members were invited to attend family workshops and activities.
- **Group MPS:** This group participated in the PYDC, community service activities, and family workshops and activities 4 hours per week. Participants in this group also were matched with older mentors with whom they met regularly for 2 to 3 hours per week. (For details, see *Outcomes* section.)

The main hypotheses of the Across Ages replication were that the multifaceted intervention provided by this project would result in significant positive outcomes for all students participating in the experimental groups. More specifically, it was predicted that sixth-grade participants in both the PS and MPS groups would demonstrate significant improvement between pre- and posttest scores in a number of areas when compared to students in the control group.

PROGRAM DEVELOPER

Andrea Taylor, Ph.D.

Dr. Andrea Taylor is assistant director of the Temple University Center for Intergenerational Learning, an organization with a 21-year history of implementing innovative cross-age programs. She is the principal investigator and project director of *Across Ages* and *Project Youth Connect*, two projects funded by SAMHSA/CSAP. In conjunction with the Philadelphia Family Planning Council and Congreso de Latinos Unidos, Inc., she is a co-investigator on the Abuelas Y Jovenes Project, a SAMHSA-funded initiative for pregnant and parenting teens. All of these projects involve intergenerational mentoring as an approach to positive youth development, the prevention of failure in school, substance abuse, and early or repeated teen pregnancies.

CONTACT INFORMATION

For information on program design, implementation, costs, and training, contact:

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Fax: (215) 204-3195
E-mail: ataylor@temple.edu
Web site: www.temple.edu/cil/acrossageshome.htm

To order materials, contact:

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RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Best Practice Model in Youth Violence Prevention—Centers for Disease Control and Prevention, U.S. Department of Health and Human Services

Top 25, Positive Youth Development Program—U.S. Department of Health and Human Services

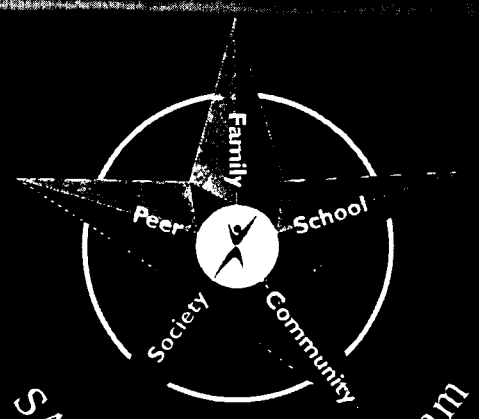
All Stars™

All Stars™ is a school- or community-based program designed to delay the onset of or prevent high-risk behaviors in middle school-age adolescents, 11 to 14 years old. It affects youth substance use, violence, and premature sexual activity by fostering development of positive personal characteristics. A highly interactive program, All Stars involves 9 to 13 lessons during its first year and 7 to 8 booster lessons in its second year.

All Stars is based on strong research that has identified the critical factors that lead young people to begin experimenting with substances and participating in other high-risk behaviors. The program is designed to reinforce positive qualities typical of youth at this age; it works to strengthen five specific qualities vital to achieving preventive effects:

- Developing positive ideals and future aspirations
- Establishing positive norms
- Building strong personal commitments
- Promoting bonding with school and community organizations
- Promoting positive parental attentiveness

All Stars is available in formats for delivery in schools as part of regular classroom instruction and in after-school and community-based organizations and programs.



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Proven Results

- Increased commitment to avoid substance use and other high-risk behaviors
- Increased adoption of a belief in positive peer group norms that make substance use, violence, and premature sexual activity unacceptable
- Reduced substance abuse by 40% to 60%*
- Reduced sexual activity 80%*
- Increased belief that substance use and high-risk behaviors would interfere with one's desired lifestyle
- Increased bonding to school

*At immediate posttest.

INTERVENTION

Universal

Selective

Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

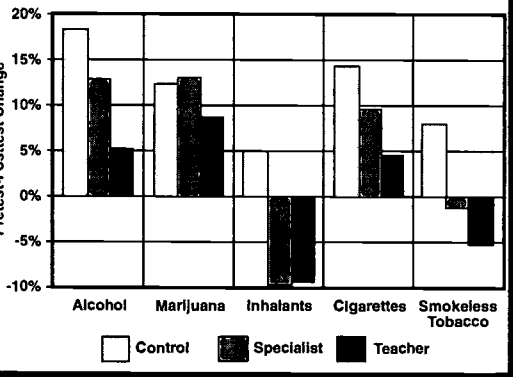
OUTCOMES

Short-term results for All Stars indicated:

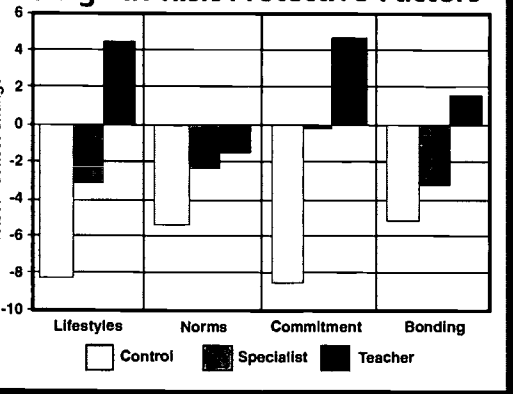
- Improvements in each of the risk and protective factors targeted by the program
- Reductions in substance use
- Delays in the onset of sexual activity
- Better results with the teacher format than the specialist format

An analysis of how the program achieved its effects indicates that the most important factor was whether or not teachers were successful in changing targeted risk and protective factors. The conclusion drawn is that program implementers must be sure to address the specific factors targeted by the program.

Effects of All Stars on Specific Substances



Change in Risk/Protective Factors



TARGET POPULATION

The All Stars core program targets young adolescents before they have begun to participate in the targeted risky behavior, typically sixth and seventh graders; however, program initiation depends on the school system's structure. The booster program is designed for implementation 1 year after the core sessions. All Stars has been tested in rural, suburban, and urban settings with children from diverse ethnic and socioeconomic backgrounds, at sites in Arizona, Colorado, Florida, Georgia, Illinois, Kentucky, Massachusetts, Montana, Nebraska, North Carolina, Oregon, Texas, and Washington.

All Stars Junior (currently under evaluation) is designed as a preparatory intervention for fourth and fifth grade students, and is taught as part of science, math, and language arts classes. All Stars Senior (also currently under evaluation) is designed as a high school followup taught in health classes.

BENEFITS

- Emphasizes the development of positive character and positive environments
- Promotes positive norms that support the choice to avoid high-risk behaviors
- Promotes perceptions that high-risk behaviors will interfere with desired and valued lifestyles
- Strengthens bonds to positive social groups and institutions that promote positive values
- Increases the amount of positive attention young adolescents receive from parents and other respected adults

HOW IT WORKS

All Stars is a guided multiyear program that is delivered to all students or group members on a weekly basis. The program is packaged in three different formats (described below), each designed to meet a specific need. In each format, students are engaged through:

- Small group activities
- Group discussions
- Enjoyable and meaningful worksheet tasks
- Videotaping
- Games
- Art activities

Students receive a personalized certificate documenting voluntary commitments. Commitment rings—symbolic reminders of commitments made—are optional. The booster program uses similar methods with an additional community service component.

Parents and important adults participate through homework assignments. Parents also participate in a separate training meeting and receive an audio CD that presents seven strategies for positive parenting.

The **teacher format** is designed for use by classroom teachers. It is recommended that delivery be augmented with the assistance of school guidance counselors. This format involves:

- Thirteen 45-minute classroom lessons for the core program
- Eight 45-minute classroom lessons for the booster program
- Optional one-on-one meetings with individual students
- A celebration ceremony to conclude the program

The **specialist format** is designed for use by prevention professionals from community prevention agencies who visit schools or organizations as outside experts. It has the same classroom lessons and activities as the teacher format.

The **community format** is designed for use in non-classroom settings including after-school programs, faith community and community programs, recreation programs, and day camps. The program includes the same activities as the other two formats, but the lessons change to:

- Nine 60-minute group meeting lesson plans in the core program
- Seven 60-minute group meeting lesson plans in the booster program

IMPLEMENTATION ESSENTIALS

Training

A 2-day training session, provided by Tanglewood Research staff and authorized trainers, is highly recommended for teachers and anyone who plans to deliver the program. Teachers who have run the program report (as preliminary research also suggests) that continued training significantly boosts program effectiveness. Training includes:

- A thorough explanation of key concepts that underlie the program
- An introduction to methods, including strategies for addressing unanticipated events
- Continuing toll-free telephone technical assistance

Materials

Materials are purchased directly from Tanglewood Research. Order forms are available online at www.tanglewood.net/products/allstars/All_Stars_Order_Form.pdf. All costs are documented on the order form.

Reusable materials include teacher manuals, a movie slate (for use with videotaping sessions), and an All Stars banner. Consumable materials include student worksheets, special forms for certificates, software for producing certificates, parent CDs, and a $20 gift certificate for purchasing office supplies and student prizes.

Target Areas

Protective Factors To Increase

Individual

- Idealism and an orientation toward the future
- Belief in conventional norms
- Commitment to avoid high-risk behaviors

Family

- Communication with parents
- Parental monitoring and supervision
- Establishment of clear rules and standards
- Expressions of love and affection
- Discipline at times when it is appropriate
- Motivation to provide a good example

School

- Bonding to school
- Student-teacher communication
- Parental support for school prevention activities

Community

- Commitment to be a productive citizen
- Participation in community-focused service projects

Peer

- Visibility of positive peer opinion leaders
- Establishment of conventional norms about behavior

Risk Factors To Decrease

Individual

- Perceived pressure to participate in substance use

Family

- Parental tolerance of deviance

Peer

- Offers and pressure from peers to use substances
- Identification and exclusion of negative peer role models

PROGRAM BACKGROUND

All Stars began in 1993 with the goal of creating the single most effective programmatic intervention for early adolescents possible, given what was known about modifiable risk and protective factors associated with substance use onset and experimentation. All Stars is the accumulation of nearly 25 years of research by Dr. William B. Hansen, the program developer.

EVALUATION DESIGN

All Stars was pilot tested from 1994 to 1995. The program was also field tested with an independent evaluation conducted by Dr. Nancy Harrington of the University of Kentucky, from 1995 to 1998. That study involved the assignment of schools to one of three conditions: 1) Control (no All Stars), 2) Teacher (delivered by classroom teachers), or 3) Specialist (delivered by trained outside specialists).

All evaluations have assessed targeted risk and protective factors. Independently evaluated field trials include an assessment of substance use, fighting, and sexual activity. All measures are currently available free of charge online at www.tanglewood.net/products/allstars/survey.htm.

Two national longitudinal studies of All Stars' school classroom and community versions are currently being conducted by Colorado State University and University of Kentucky. Results are expected in 2002.

PROGRAM DEVELOPER

William B. Hansen, Ph.D.

Dr. William B. Hansen, president of Tanglewood Research, is a widely recognized expert in substance abuse prevention. Besides All Stars, Dr. Hansen has written numerous curricula for school- and community-based prevention, including Project SMART and Project STAR. The goal of his research has been to identify and evaluate evidence-based prevention programs that reduce the onset of substance use and that can be applied in everyday settings. Groups that have relied upon Dr. Hansen for advice include the U.S. Congress' Office of Technology Assessment; the U.S. Department of Education; the National Institute on Drug Abuse; numerous State agencies and private foundations; the United Nations; the Swiss, Spanish, Mexican, and Portuguese Departments of Health; and the U.S. Information Agency.

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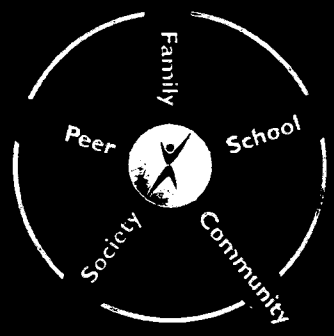
RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Promising Program—U.S. Department of Education



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

ATLAS (Athletes Training and Learning to Avoid Steroids)

ATLAS—Athletes Training and Learning to Avoid Steroids—is a multicomponent school-based program for male high school athletes, 13 to 19 years old. It capitalizes on team-centered dynamics and uses positive peer pressure and role modeling to reduce the use of—

- Anabolic steroids
- Alcohol and other drugs
- Performance-enhancing supplements

Delivered to a school sports team, with instruction led by student athlete peers and facilitated by coaches, ATLAS promotes healthy nutrition and exercise behaviors as alternatives to substance use. The 10-session curriculum is highly scripted and contains interactive and entertaining activities that make it easy and desirable to deliver, enhancing the fidelity of the intervention. The product of 10 years of research and field testing, ATLAS focuses specifically on adolescent male athletes' risk and protective factors.

TARGET POPULATION

ATLAS is designed for male student athletes in grades 9 through 12, although it has been used with younger athletes. The program has been successfully implemented in urban and rural schools with participants from diverse racial, ethnic, and socioeconomic backgrounds.

Proven Results

- New substance use decreased 50%
- New anabolic steroid use decreased 50%
- Occurrences of drinking and driving declined 24%
- Lower index of alcohol and drug use
- Reduced use of performance-enhancing supplements
- Improved nutrition and exercise behaviors

INTERVENTION

Universal

Selective

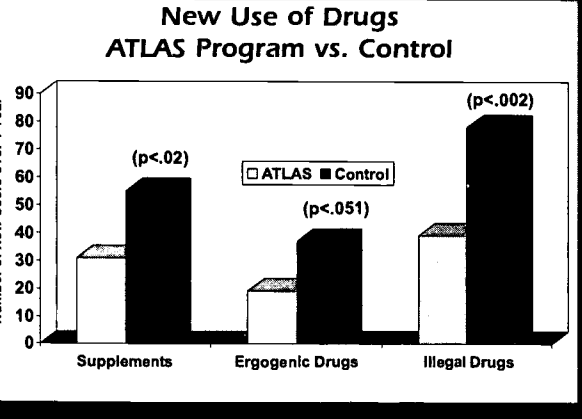
Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

One year after the intervention, compared to the control groups, students who participated in ATLAS showed:

- Reduced intent to use anabolic steroids
- Greater substance use resistance skills
- Reduced substance abuse risk factors (e.g., less belief in media advertisements)
- Improved substance abuse protective factors (e.g., better nutrition behaviors, improved perception of athletic competence)
- Increased number of reasons not to use anabolic steroids
- Greater perception of the team and peers as an information source
- Improved knowledge of alcohol, marijuana, and anabolic steroids



BENEFITS

ATLAS-trained students demonstrate:

- Improved substance use resistance skills
- Higher perceived personal susceptibility to the harmful effects of drugs
- Increased belief that their coach will not tolerate steroid use
- Improved perception of their personal athletic competence
- Reduced drinking and driving occurrences

HOW IT WORKS

ATLAS is delivered in a classroom to an entire sports team. Students are divided into small social learning groups with a peer (squad) leader for each group. ATLAS' team-centered approach works to exert positive peer pressure and promote positive role modeling. It is easy to implement, because it is highly scripted with explicit instructions.

Each of the program's ten 45-minute sessions consists of interactive activities including:

- Educational games
- Role-playing exercises
- The creation of mock public service campaigns
- Friendly competition between squads

Because of their significance for adolescents, the program focuses on potential *immediate consequences,* rather than the future adverse effect of substance use. Athletes learn how to achieve their athletic goals using state-of-the-art sports nutrition and strength training and to avoid harmful substance use that will impair their physical and athletic abilities. Team workbooks, sports menus, and training guides complement the instructional materials.

IMPLEMENTATION ESSENTIALS

A 1-day training program, offered by the program developer, is not required but is recommended for school districts with multiple teams and coaches. Training will enhance the fidelity of the curriculum delivery. Successful replication of ATLAS also requires:

- A highly committed coach-facilitator

- A coach "Instructor Package" which includes:
  - Program background information
  - *Squad Leader Training Guide* (explains how to train effective squad leaders)
  - *Ten-Session Curriculum Guide*
  - Overhead slides
- Use of student materials (workbook, sports menu, and *Training Guide* booklets)
- Team-based presentation of the program with one peer leader in each small group (i.e., squad) of six to eight students
- *Ten-Session Curriculum Guide* for each peer leader (this may be photocopied)

PROGRAM BACKGROUND

ATLAS was initiated in 1993 with funding from the National Institute on Drug Abuse (NIDA). NIDA wanted a program designed to reduce or stop adolescent male athletes' use of anabolic steroids, sport supplements, alcohol, and illegal drugs, while improving healthy nutrition and exercise practices. The program was tested in randomized controlled settings at 31 schools, in 12 cities and 2 States (Oregon and Washington) with more than 3,200 participants. The NIDA randomized study was based on 4 years of prior research among more than 1,500 male athletes in 16 high schools in smaller, yearly randomized controlled trials.

EVALUATION DESIGN

In a randomized control design, three sequential cohorts were assessed before and after each athletic season (1994, 1995, 1996) and were combined for analysis. At followup, 1 year later, program effects were available for the 1994 and 1995 cohorts and combined. Fifteen high schools used the ATLAS program; 16 schools served as controls. In addition to confidential survey results, objective measures (i.e., body composition, body weight, muscle strength) were evaluated to assess the health promotion aspects of the trial.

Target Areas

Protective Factors To Increase

Individual

- Decisionmaking skills
- Sports nutrition knowledge
- Perception of personal athletic competence
- Athletic self-efficacy
- Exercise skills
- Reasons for not using drugs
- Proper nutrition and eating behaviors
- Perception of drug risks
- Knowledge about steroids, alcohol, and other substances of abuse

Peer

- Peers as source of correct information

School

- Team as a source of information
- Exercise and use of school gym
- Coaching staff intolerance to substance use

Risk Factors To Decrease

Individual

- Negative peer pressure

Community

- Belief in media advertisements promoting performance-enhancing products

PROGRAM DEVELOPERS

Linn Goldberg, M.D.

Diane Elliot, M.D.

Dr. Linn Goldberg and Dr. Diane Elliot, professors of Medicine at the Oregon Health & Science University, have collaborated on clinical and scientific studies that have resulted in more than 150 publications and 3 books. They direct the University's Division of Health Promotion & Sports Medicine and the Human Performance Laboratory. For more than 12 years, they have focused on substance abuse prevention among adolescents. In addition, Drs. Goldberg and Elliot have been crew chiefs for the United States Olympic Committee, physicians for professional sports teams, and are principal and co-principal investigators on other National Institutes of Health research studies. They also have designed ATHENA (Athletes Targeting Healthy Exercise and Nutrition Alternatives), with a format similar to ATLAS. It is a NIDA-funded eating disorder and substance abuse prevention program for adolescent female athletes.

CONTACT INFORMATION

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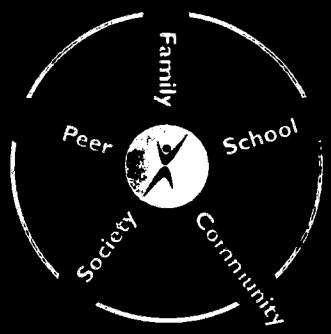
To order materials, contact:
Sunburst Technology
Phone: (800) 431-1934
Web site: www.sunburst.com

RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Exemplary Program—U.S. Department of Education

Effective Program—National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Brief Strategic Family Therapy

Brief Strategic Family Therapy (BSFT) is an effective, problem-focused, and practical approach to the elimination of substance abuse risk factors. It successfully reduces problem behaviors in children and adolescents 6 to 17 years old and strengthens their families. BSFT provides families with tools to decrease individual and family risk factors through focused interventions that improve problematic family relations and skill-building strategies that strengthen families. It targets:

- Acting-out behavioral problems
- Associations with antisocial peers
- Early substance use
- Problematic family relations

The program fosters parental leadership, appropriate parental involvement, mutual support among parenting figures, family communication, problem solving, clear rules and consequences, nurturing, and shared responsibility for family problems. In addition, the program provides specialized outreach strategies to bring families into therapy.

TARGET POPULATION

BSFT helps children and adolescents 6 to 17 years old who exhibit rebelliousness, truancy, delinquency, early substance use, and association with problem peers. BSFT also benefits families that are affected by poor behavior management, parental discord, anger, blaming interactions, and other problematic relations. This program was tested and proven in Hispanic/Latino families and adapted and tested with African American families.

Proven Results*

- 42% improvement in acting-out behavioral problems
- 75% reduction in marijuana use
- 58% reduction in association with antisocial peers
- Retained over 75% of youth in program

*Relative to comparisons. Different tests focu on changes over time between treatment and comparison groups.

INTERVENTION

Universal

Selective

Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

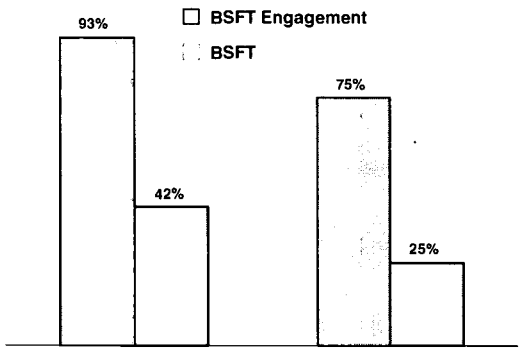
In children and families:

- Reductions in acting-out behavioral problems
- Improvements in self-concept
- Improvements in family functioning

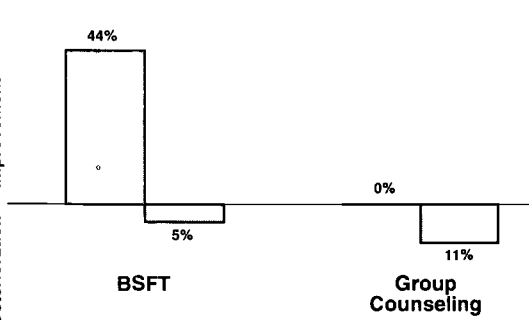
In adolescents and families:

- Reductions in acting-out behavioral problems
- Reductions in association with antisocial peers
- Reductions in substance use
- Improvements in family functioning
- Increased family participation in therapy

Retention Rates: BSFT and BSFT Engagement



BSFT Statistically Reliable Change on Acting-Out Behavioral Problems



BENEFITS

- Improves youth's self-concept and self-control
- Reduces youth behavior problems, substance use, and association with antisocial peers
- Increases parental involvement and develops more positive and effective parenting
- Makes parental management of children's behavior more effective
- Improves family cohesiveness, collaboration, and child bonding to the family
- Improves family communication, conflict resolution, and problem-solving skills

HOW IT WORKS

BSFT can be implemented in a variety of settings, including community social services agencies, mental health clinics, health agencies, and family clinics. BSFT is delivered in 8 to 12 weekly 1- to 1.5-hour sessions. The family and BSFT counselor meet either in the program office or the family's home. Sessions may occur more frequently around crises because these are opportunities for change. There are four important BSFT steps:

Step 1: Organize a counselor-family work team. Development of a therapeutic alliance with each family member and with the family as a whole is essential for BSFT. This requires counselors to accept and demonstrate respect for each individual family member and the family as a whole.

Step 2: Diagnose family strengths and problem relations. Emphasis is on family relations that are supportive and problem relations that affect youths' behaviors or interfere with parental figures' ability to correct those behaviors.

Step 3: Develop a change strategy to capitalize on strengths and correct problematic family relations, thereby increasing family competence. In BSFT, the counselor is plan- and problem-focused, direction-oriented (i.e., moving from problematic to competent interactions), and practical.

Step 4: Implement change strategies and reinforce family behaviors that sustain new levels of family competence. Important change strategies include reframing to change the meaning of interactions; changing alliances and shifting interpersonal boundaries; building conflict resolution skills; and providing parenting guidance and coaching.

IMPLEMENTATION ESSENTIALS

Trained counselors who can implement the program as tested are required for successful replication. The ideal counselor has a master's degree in social work or marriage and family therapy. However, individuals with a bachelor's degree and experience working with families may qualify. One full-time counselor can provide BSFT to 15 to 20 families for in-office sessions and 10 to 12 families for in-home sessions.

Administrative support is key to successful BSFT replication. BSFT requires an agency that is open at times that are convenient for participating families, provides transportation and, if needed, provides childcare when sessions are conducted in the office.

Training and technical assistance are available through the Center for Family Studies' Training Institute. The Institute provides a broad range of training programs in Miami or will train onsite at agencies around the country. Training is tailored to agency needs and populations and offered in Spanish and English.

Startup takes about 1 year, including hiring and training of counselors, developing community referral resources, and recruitment and screening of referred families.

PROGRAM BACKGROUND

BSFT was developed at the Spanish Family Guidance Center in the Center for Family Studies, University of Miami. BSFT has been conducted at these centers since 1975. The Center for Family Studies is the Nation's oldest and most prominent center for development and testing of minority family therapy interventions for prevention and treatment of adolescent substance abuse and related behavior problems. It is also the Nation's leading trainer of research-proven, family therapy for Hispanic/Latino families.

EVALUATION DESIGN

Three studies tested the efficacy of BSFT in increasing family participation in therapy. A study funded by the National Institute on Drug Abuse (NIDA) randomized 108 Hispanic/Latino substance-using adolescents and their families to BSFT or BSFT Engagement. BSFT Engagement included components developed specifically to overcome the family dynamics that prevent families from coming into treatment. The BSFT condition was modeled after methods typically used in this community. This study was replicated with funding from NIDA by randomizing 79 Hispanic/Latino adolescents with conduct problems to BSFT and BSFT Engagement. A third replication, with 104 African American and Hispanic/Latino adolescents with conduct and/or emotional problems, was funded by the Subsance Abuse and Mental Health Services Administration's Center for

Target Areas

Protective Factors To Increase

Individual

- Bonding to family and school
- Positive self-concept
- Positive transition into adolescence
- Problem-solving skills
- Good school attendance, conduct, and achievement

Family

- Appropriate levels of parental involvement with youth, their schools, and their peers
- Effective parental leadership and behavior management
- Effective parent-child communication
- Effective family conflict resolution, problem-solving, and decisionmaking skills
- Appropriate parental support and family cohesiveness
- Effective parenting skills in managing youths' peer relations

Risk Factors To Decrease

Individual

- Lack of self-discipline
- Poor tolerance for frustration
- Early antisocial behavior
- Association with antisocial peers
- Unconventional beliefs or attitudes

Family

- Parent-child conflict
- Angry and blaming family interactions
- Conflict among parent figures
- Family isolation
- Ineffective parental behavior control
- Parental or older sibling involvement with drugs

Substance Abuse Prevention. In this study, adolescents and their families were randomized to either BSFT Engagement or a community clinic. The NIDA-funded study also randomized the 108 adolescents to BSFT or group counseling. In addition, a study funded by the National Institute of Mental Health randomized 69 troubled children and their families to BSFT, individual therapy, or a control. (Study results are presented in the *Outcomes* section.)

PROGRAM DEVELOPER

José Szapocznik, Ph.D.

Dr. Szapocznik is an internationally known expert on families and family-based interventions. A professor of Psychiatry and Behavioral Sciences, Psychology, and Educational Research and Counseling Psychology, he is also director of the Spanish Family Guidance Center and the Center for Family Studies, all at the University of Miami. Dr. Szapocznik received the 2000 Presidential Award for "Contributions to the Development of Family-Based Interventions" from the Society for Prevention Research, and, in 1999, received the first ever Research Award from the Center for Substance Abuse Prevention.

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Information on costs, materials, and ongoing technical assistance can be obtained from:

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RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Presidential Award—Society for Prevention Research

Research Award—Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Challenging College Alcohol Abuse

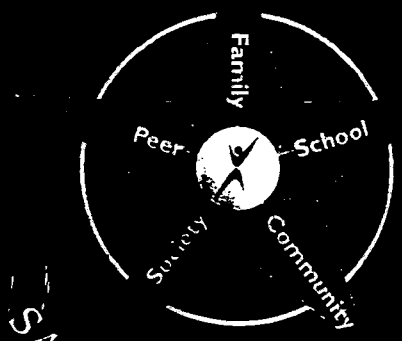
Challenging College Alcohol Abuse (CCAA) is a social norms and environmental management program that reduces high-risk drinking and related negative consequences in college students (18 to 24 years old). Under CCAA, the campus health service uses new and innovative methods to communicate public health information to students, the campus community, and the surrounding community to—

- Correct misperceptions, increase knowledge, and change attitudes about alcohol and drug use behaviors among undergraduate students
- Change policies and practices related to alcohol and drug use and abuse among campus fraternity and sorority chapters
- Change faculty, administration, parental, community, and policymaker perceptions to prevent perpetuation of alcohol and drug myths
- Increase restrictions on alcohol availability and monitor on- and off-campus distribution and consumption

CCAA fosters development of policies that establish and maintain a healthy and safe environment for all students. It also seeks to develop community and civic partnerships and collaborations in support of campus alcohol and drug policies, and State and local laws.

TARGET POPULATION

The CCAA trial targeted both male and female undergraduate students 18 to 24 years old, attending The University of Arizona, a large, urban, land grant university with both residential and commuter students. Special emphasis was given to the heaviest drinking subpopulations—fraternity and sorority



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Proven Results*

- 29% reduction in heavy drinking
- 48% reduction in driving after drinking
- 49% reduction in heavy drinking among frequent heavy drinkers*
- Significantly fewer students used alcohol in the past 30 days
- Significantly more students reported their alcohol use decreased in the last year
- Significant decreases in alcohol-related fights and arguments, trouble with campus police or school authorities

**Heavy drinking means having five or more drinks at a sitting three or more times in the last 2 weeks.*

INTERVENTION

Universal

Selective

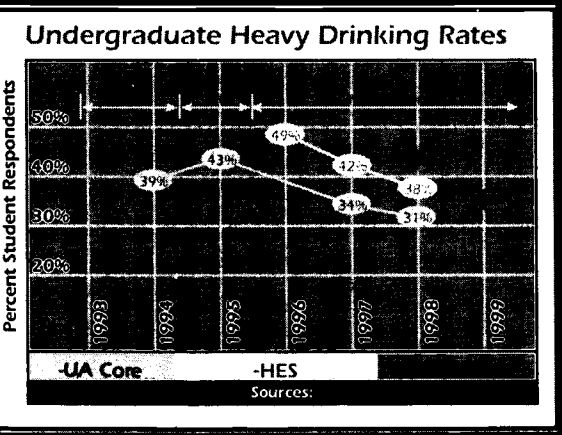
Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

Data showed significant changes in alcohol use and related behaviors between 1995 and 1998, including:

- A 29% decrease in the rate of heavy drinking (five or more drinks on one occasion within the last 2 weeks) among undergraduate students (Core 1995-98).
- Decreases in negative consequences, including
  - fights or arguments
  - trouble with campus police or school authorities
  - "did something I later regretted"
  - was taken advantage of sexually
  - did poorly on a test or important project and missed class
- Police statistics for Homecoming, the largest campus/community annual celebration, showed an overall decrease in community calls, arrests of minors in possession of alcohol, and verbal warnings for alcohol



members, freshmen, and students referred to a diversion program. (Diversion program students were primarily underage White males who had on- or off-campus alcohol-related violations.) Social norms and environmental management strategies can be adapted to K-12 populations from any socioeconomic or ethnic group where the norm for alcohol and drug use is less than perceived use (and in many instances is non-use).

BENEFITS

- Students drink more moderately and experience fewer negative consequences
- Identifies and corrects student misperceptions about campus heavy drinking
- Increases awareness by students that the majority are moderate or non-drinkers
- Eliminates mixed messages about drinking and drug use
- Eliminates ineffective and confusing alcohol and drug policies and enforcement practices
- Positively affects the overall health and well-being of the campus and greater community

HOW IT WORKS

CCAA delivers messages/information about drinking and drug use norms through posters, newspaper inserts, flyers, newsletters, and other mass media, as well as in-person reports to key campus committees, campus leadership, and community partners. The interventions supplant the misperceived norm that "everybody drinks a lot, smokes, and uses drugs," which helps protect incoming students from the pressure to "drink up" or use drugs in order to fit in with perceived peer norms.

Frequent and consistent exposure to accurate information helps to change the public conversation about alcohol and drug use, and informs and reminds students of campus alcohol and illegal drug policy changes.

CCAA's environmental management component helps senior administrators and other key stakeholders to develop a consistent alcohol policy for all campus activities, including use of sports facilities and campus grounds.

IMPLEMENTATION ESSENTIALS

To successfully implement CCAA on a college campus, organizers must focus on the environment, not the individual. Implementation also requires a team of people who have evaluation, program, materials design, and target market analysis expertise, in order to—

- Survey student behaviors, attitudes, and perceptions about alcohol and drug use, including protective factors before and throughout the program implementation
- Identify misperceptions that influence alcohol and drug use/abuse
- Produce media and saturate the campus with correct alcohol and drug information
- Incorporate social norms information in diversion classes, freshman orientations, and presentations to high-risk and other groups
- Further change the public conversation about alcohol and drug use through faculty, advisors, senior administrators, and campus leadership
- Eliminate mixed messages, policies, and practices for campus sporting and celebration events

PROGRAM BACKGROUND

In 1994, The University of Arizona (UA) Campus Health Service received a 5-year grant from the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention to implement and test strategies to prevent student heavy drinking and illegal drug use. Additional grants were awarded through the U.S. Department of Education's Fund for the Improvement of Post-Secondary Education, and the Safe and Drug Free Schools Act.

Since 1995, the UA substance abuse prevention program has developed a two-pronged approach: social norms and environmental management. (Moderation skills training is also provided for students in the university diversion program.) The goal of the program is to create campus-wide impact on student alcohol and drug perceptions and use patterns, campus and community perceptions, and policies and procedures that support safer drinking practices.

EVALUATION DESIGN

Both quantitative and qualitative data were collected from 1994 through 1998. A nationally recognized survey instrument, the Core Alcohol and Drug Survey (Core), and a program-specific instrument, the Health Enhancement Survey (HES), were utilized to provide baseline data. The Core was mailed to a random sample of undergraduates. HES, first administered in 1996, was mailed to all students in the identified high-risk population—those living in residence halls and fraternity/sorority residences.

The Core and HES gathered information on students' alcohol, tobacco, and drug knowledge, attitudes and perceptions, and their frequency of exposure to activities related to campus alcohol, tobacco, and drug and

Target Areas

Protective Factors To Increase

Individual

- Openness to ability for change and growth
- Value systems open to change and growth
- Correct information about alcohol and drug use

Peer

- Strong "family" support system within Greek chapters
- Leadership development within campus Greek chapters
- Help friends control their actions while drinking
- Express and promote majority norm of moderate use, including non-use
- Express and promote protective behaviors endorsed by the majority

School

- Support for student wellness in residence halls
- Faculty and administration support of students' education and wellness
- Quality and credibility of campus health care services
- Policies and enforcement aimed at a drug-free environment
- Policies and enforcement that support correct alcohol and drug use information
- Policies and enforcement aimed at eliminating high-risk alcohol and drug-related behavior

Risk Factors To Decrease

Individual

- Freshman year student experimentation with alcohol and drugs
- High-risk drinking and drug use behavior prior to college
- Misperception of high levels of alcohol and drug use and sexual activity in college
- Combining alcohol and drug use and sexual activities
- Social anxiety

Peer

- Increased alcohol and drug use associated with membership in fraternity/sorority chapters and residence housing
- Increased availability of alcohol and drugs in fraternity/sorority culture, especially during membership initiation, and at sports and celebration events

School

- Permissive faculty and administration attitudes toward alcohol and drug abuse
- Inconsistent and ineffective alcohol and drug policies and enforcement
- High tolerance of alcohol effects and consequences
- Easy access to and high visibility and illegal use of alcohol and drugs at campus/community celebration events
- Perceived lack of drug- and alcohol-free social and recreational activities

Community

- Easy access to alcohol and drugs
- Proximity to accessible and inexpensive alcohol and underage drinking (e.g., Mexico border) and drugs
- Alcohol industry advertising targeting college youth
- Local establishments' alcohol advertising targeting college youth
- Lax local ordinances and policing of underage drinking parties

related issues. These issues included sexual health, violence, and behaviors students engaged in that could lower their risk of harm when drinking—protective factors. A third survey, the 1998 Annual Campus Health and Wellness Survey (a random sample of undergraduate students administered in classrooms), was developed to pilot new items for potential incorporation into the HES.

In addition, multiple qualitative evaluation methods used included: 1) one-on-one interviews with key informants; 2) focus group interviews with students; 3) observation of key alcohol- and drug-related events like Homecoming, Fraternity Bid Night, and sports events; 4) interviews with staff and students in the target population; and 5) analysis of secondary data sources, e.g., newspaper articles, newsletters, memos, student records and reports, critical incidents, and anecdotes.

PROGRAM DEVELOPER

The University of Arizona
Health Promotion and Preventive Services

Staff of the Health Promotion and Preventive Services department of The University of Arizona Campus Health Service developed this model collegiate substance abuse prevention program under the direction of Koreen Johannessen, M.S.W., and Carolyn Collins, M.S. Additional funding from the U.S. Department of Education Safe and Drug Free Schools program, and training and support from its contractor, the Higher Education Center for Alcohol and Other Drug Prevention, have allowed refinements and new target audiences for social norms and other environmental management strategies. Ms. Johannessen, Ms. Collins, and Peggy Glider, Ph.D., the project's chief evaluator, consult nationally on the implementation and evaluation of the program.

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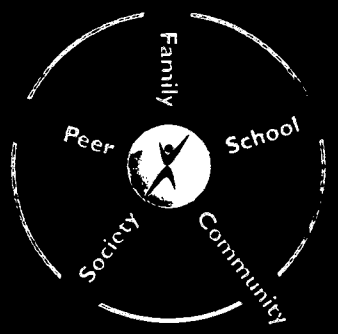
www.SocialNorms.CampusHealth.net

RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Alcohol and Other Drug Prevention Model Program Award—U.S. Department of Education

so available in Spanish



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Child Development Project

The Child Development Project (CDP) is a multifaceted, schoolwide improvement program that helps elementary schools become "caring communities of learners" for their students (5 to 12 years old). CDP significantly reduces children's early use of alcohol and marijuana and their involvement in violence-related behavior. CDP is designed to strengthen connections among peers and between students of different ages, teachers and students, and home and school, in order to promote:

- School bonding—students' commitment to, and engagement in, their school
- Students' interpersonal skills and commitment to positive values
- Classroom and schoolwide climate of safety, respect, caring, and helpfulness

The program, which involves students in all grade levels, their families, teachers, and school administrators, prepares children to play responsible roles in their classrooms and schools so that later they can contribute to the wider society. The program has recently been streamlined and strengthened to make it more feasible and affordable to implement and more effective at boosting literacy skills.

TARGET POPULATION

The original CDP student population varied widely: 2 percent to 95 percent of children were receiving free or reduced-price lunch (a measure of socioeconomic status), and 26 percent to 100 percent were minority group members. The program can be implemented in any rural, suburban, or urban elementary school.

Proven Results*

- Alcohol use declined from 48% to 37% of students
- Cigarette use declined from 25% to 17% of students
- Marijuana use declined from 7% to 5% of students
- Other risky behavior declined, including carrying weapons, threats of violence, and involvement in "gang fights"

*Among fifth and sixth grade students in school that fully implemented CDP.

INTERVENTION

Universal

Selective

Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

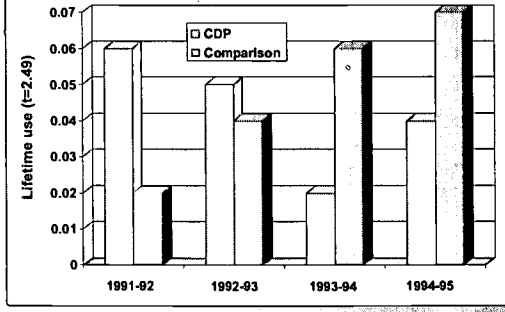
Although issues of substance abuse are not directly addressed in the CDP program, a comprehensive evaluation of the program shows that when well implemented, it produces significant preventive effects on students' use of alcohol and marijuana, and marginal effects on use of tobacco.

In schools where the program led to widespread change in teaching practices, the following effects were shown:

- Prevalence of alcohol use declined by an average 11% over 4 years in CDP schools, compared with an increase of 2% in matched comparison schools.
- Prevalence of marijuana use by CDP students declined by 2% compared with a 2% increase by comparison school students.
- Prevalence of cigarette use by CDP students declined by 8% compared with a 3% decline by comparison school students.

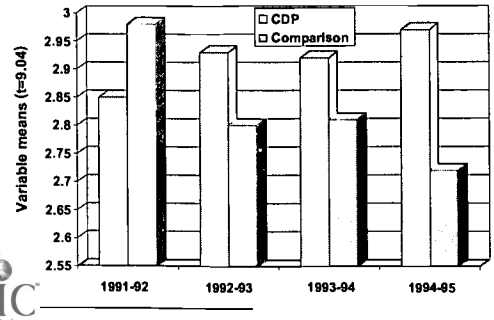
Involvement with Marijuana

Adjusted mean frequency among CDP and Comparison students



Sense of School as a Community

Student questionnaire among CDP and Comparison students



BENEFITS

- Creates an atmosphere of trust and respect between students and teachers
- Nurtures responsibility, fairness, honesty, and helpfulness in students
- Enhances students' conflict resolution skills
- Increases students' academic motivation
- Strengthens family-school-community connections

HOW IT WORKS

CDP is implemented in two phases. Phase I focuses on building a strong sense of the school and classroom community, while Phase II focuses on building students' literacy skills and interpersonal skills.

Phase I

Phase I activities include:

- ***That's My Buddy*** partners older and younger students for academic activities, promotes cooperative learning and relationship building, reduces teasing/bullying behavior, and contributes to a schoolwide atmosphere of trust. Requires 1 hour of class time per week or month and an additional 15 minutes of teacher preparation time.
- ***Homeside Activities*** are short conversational activities (printed in English and Spanish) that students do at home with their parents or caregivers. One or two activities, introduced monthly, provide opportunities for students and parents to share ideas and experiences while offering families a window on what their child is learning in school. These require 15 minutes of class time to introduce to students and 20 to 40 minutes to share in class afterward.
- ***At Home in Our Schools*** details noncompetitive activities that involve students, parents, and school staff, such as Grandparent Gatherings and Family Read-Alouds, which emphasize helping others and creating an inclusive school environment.
- ***Ways We Want Our Class To Be*** details class meetings that provide a forum for students and teachers to reflect, discuss issues, plan, and make decisions that affect the classroom climate, including establishing norms for classroom behavior and finding solutions to common social problems. Class meetings are held as needed to establish a cohesive classroom community.

Phase I components do not have to be implemented concurrently and may be introduced one at a time. A full school year may be needed to establish the program when the components are implemented concurrently.

Phase II

Phase II consists of two major modules:

- **SIPPS (Systematic Instruction in Phoneme Awareness, Phonics, and Sight Words):** A stand-alone instructional module in decoding that develops word recognition strategies and skills that enable students to become independent, confident, and fluent readers. A "decodable text" program, SIPPS is designed to be flexible and wide-ranging both across and within grades. There are three levels of SIPPS that can be used, as needed, in grades one through six.
- **Making Meaning: Strategies That Build Comprehension and Character:** A K-6 module that teaches eight pivotal reading comprehension strategies (e.g., retelling, summarizing, inference, synthesis) and integrates academic, ethical, and social development throughout. This program provides a clearly defined scope and sequence of specific comprehension lessons for each grade level. It also provides ongoing opportunities for students to work together in pairs, small groups, and larger groupings, and in the process to learn important values and interpersonal skills. Full implementation of Phase II usually takes 2 additional years.

IMPLEMENTATION ESSENTIALS

Training for Phase I

There are a range of options for professional development to introduce a school's staff to Phase I. These include: 1) a 1-day introductory workshop to introduce all four components of Phase I; 2) a 2-day introductory workshop, the second day of which focuses on the class meeting component; 3) a 1-day class meeting workshop; and 4) a 2-day class meeting workshop. (The class meeting-specific workshops are offered because this is typically the most challenging component for teachers to implement.) For districts or small groups of schools located in one region, a cost-saving, 3-day training-of-trainers workshop is offered. Followup visits by Developmental Studies Center (DSC) staff developers also are available to provide coaching and consultation. Fees for workshops and followup visits are $1,200 per day, plus travel expenses.

Materials for Phase I

- *That's My Buddy:* one book for each teacher
- *Homeside Activities:* one grade-level book for each teacher
- *At Home in Our Schools:* one book for each member of a coordinating team of staff and parents
- *Ways We Want Our Class To Be:* one book for each teacher

Materials cost approximately $50 per teacher.

Please contact DSC for more information about training and costs for Phase II components.

Target Areas

Protective Factors To Increase

Individual

- Healthy ethical, social, and emotional development
- Commitment to prosocial values

School

- Attachment (bonding/connection) to school
- Strong sense of community among students in school
- Academic engagement and success
- Caring relationships with teachers

Peer

- Caring relationships with peers

Risk Factors To Decrease

Individual

- Early antisocial behavior
- Lack of self-control, assertiveness, and other social/emotional skills
- Lack of commitment to core societal values

School

- School failure
- Lack of school bonding
- Low sense of community in school
- Lack of family involvement in schooling

PROGRAM BACKGROUND

The Child Development Project has been developed over the past 20 years through a series of demonstration studies and revisions. It has been rigorously implemented and evaluated in such diverse settings as Dade County, FL; White Plains, NY; Louisville, KY; and San Francisco, Salinas, and Cupertino, CA. Copies of various evaluation studies, assessment instruments, program descriptions, and program materials are available from its developer, the nonprofit Developmental Studies Center in Oakland, CA.

EVALUATION DESIGN

In the 1990s, CDP was evaluated using a quasi-experimental design involving two demonstration schools and two comparison schools in each of the six school districts nationally. Beginning baseline assessments were followed by annual assessments for 3 years, using a structured classroom observation system and student and teacher questionnaires. Assessments included standardized multiple-choice achievement tests and performance assessments, and review of school records. (Note: Since this evaluation, the CDP program, specifically the literacy component, has been revised and strengthened.)

PROGRAM DEVELOPER

Eric Schaps, Ph.D.

Dr. Schaps is founder and president of the Developmental Studies Center in Oakland, CA. Established in 1980, DSC specializes in designing educational programs and evaluating their effects on children's ethical, social, and intellectual development. The Center has a full-time staff of 50 whose work has been supported by 40 philanthropic foundations and governmental agencies. Dr. Schaps is the author of 3 books and 60 book chapters and articles on character education, preventing problem behaviors, and school change.

CONTACT INFORMATION

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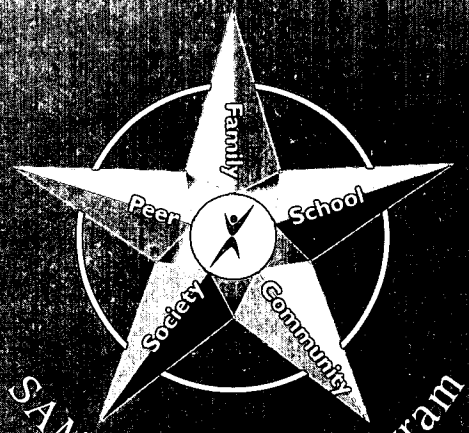
E-mail: info@devstu.org
Web site: www.devstu.org

RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Promising Safe and Drug Free Schools Program—U.S. Department of Education

Educational Programs That Work—U.S. Department of Education



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Communities Mobilizing for Change on Alcohol

Communities Mobilizing for Change on Alcohol (CMCA) is a community-organizing program designed to reduce adolescent (13 to 20 years old) access to alcohol by changing community policies and practices. Initiated in 1991, CMCA has proven that effectively limiting the access to alcohol of people under the legal drinking age not only directly reduces teen drinking, but also communicates a clear message to the community that underage drinking is inappropriate and unacceptable.

CMCA employs a range of social organizing techniques to address legal, institutional, social, and health issues in order to reduce youth alcohol use by eliminating illegal alcohol sales to youth by retailers and obstructing the provision of alcohol to youth by adults.

TARGET POPULATION

CMCA can be implemented in virtually any rural, suburban, or urban community. The program targets interventions at all members of a community. Communities from Minnesota and Wisconsin participated in the initial program evaluation.

BENEFITS

The CMCA project—

- Mobilizes communities to make institutional and policy changes
- Limits youth access to alcohol
- Improves the health of the community

Proven Results

- Alcohol merchants increased age checks and reduced alcohol sales to minors
- Youths 18 to 20 years old reduced the practice of providing alcohol to younger teenagers
- Youths 18 to 20 years old were less likely to try to buy alcohol, drink in a bar, or consume alcohol
- Arrests for driving under the influence of alcohol declined significantly among 18- to 20-year-olds

INTERVENTION

Universal

Selective

Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

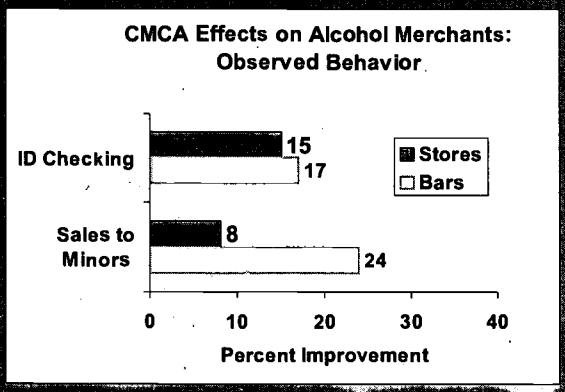
OUTCOMES

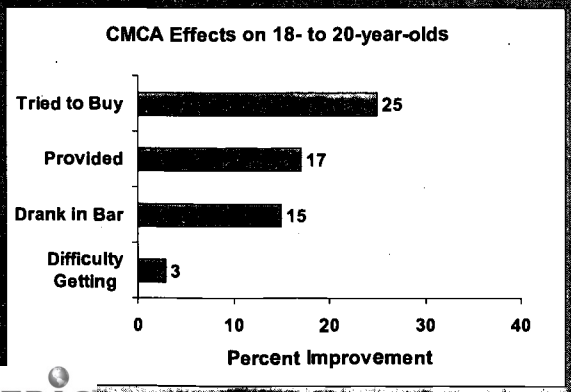
Results show that the CMCA intervention:

- Significantly and favorably affected the drinking behavior of 18- to 20-year-olds
- Significantly and favorably affected the practices of establishments serving alcohol
- May have favorably affected the practices of alcohol package sales establishments

Other outcomes include:

- Alcohol merchants increased age-identification checking and reduced propensity to sell to minors
- Older teenagers (18 to 20 years old) reduced provision of alcohol to other teens and the likelihood to try to buy alcohol or drink in a bar
- Significant decline in arrests for driving under the influence of alcohol among 18- to 20-year-olds





HOW IT WORKS

CMCA involves motivating community members to seek and achieve changes in local public policies and in the practices of community institutions that can affect youth's access to alcohol. CMCA offers resource materials to help communities organize these efforts, for example:

- **Civic Groups** can adopt policies to prevent underage drinking at organization-sponsored events and initiate and participate in community-wide efforts to prevent underage alcohol use.
- **Faith Organizations** can provide a link between prevention organizations, youth, parents, and the community. They can also offer education, develop internal policies to prevent teens from accessing alcohol at their events, and participate in efforts to keep alcohol away from youth.
- **Schools** can teach alcohol refusal skills and create and enforce policies restricting alcohol use and access, both on school property and in the surrounding community.
- **Community Groups** can voluntarily control the availability and use of alcohol at public events such as music concerts, street fairs, and sporting events.
- **Law Enforcement** can mandate compliance checks or encourage voluntary compliance checks by law enforcement or licensing authorities. Police can also encourage and support the use of administrative penalties for failure to comply with State or local laws relating to the sale of alcohol to minors.
- **Liquor Licensing Agencies** can offer and promote mandatory or voluntary programs that train managers, owners, servers, and sellers at alcohol outlets how to avoid selling to underage youth and intoxicated patrons.
- **Advertising Outlets** can be influenced to remove alcohol advertising from public places or wherever youth are exposed to these messages. Communities can also restrict alcohol companies' sponsorship of community events.

IMPLEMENTATION ESSENTIALS

CMCA is a community-based program that can be implemented by a range of groups, from all-volunteer grassroots activists to nonprofit organizations or public agencies of any size. In order to successfully replicate CMCA, organizations need to be able to—

- Assess community norms, public and institutional policies, and resources
- Identify, from inception, a small group of passionate and committed citizens to lead efforts to advocate for change
- Create a core leadership group that can build a broad citizen movement to support policy change

- Develop and implement an action plan
- Build a mass support base
- Maintain an organization and institutionalize changes
- Evaluate changes on an ongoing basis
- Manage widely variable program costs

PROGRAM MATERIALS

Free materials on reducing youth access to alcohol are available to assist in the implementation of CMCA, including a series of papers written by alcohol epidemiology experts. These include:

- **Alcohol Compliance Checks:** *A Procedures Manual for Enforcing Alcohol Age-of-Sale Laws*—This user-friendly manual is designed for public officials, law enforcement officers, and community groups; it is a practical guide for developing and implementing a compliance check system for establishments that sell or serve alcohol.
- **Model Ordinances:** This material provides information on and samples of specific local laws that regulate alcohol use in the community, designed to reduce the supply of alcohol to youth under age 21.
- **Model Public Policies:** These are sample alcohol control policies aimed at limiting social and commercial access to alcohol, including beer keg registration; restricting alcohol use in public places and at community events; restricting alcohol advertising; developing social host liability laws; initiating responsible beverage sales, service training, and compliance checks; banning alcohol home delivery; and restricting alcohol companies' sponsorship of community events.
- **Model Institutional Policies:** Sample policies are available that describe actions that can reduce youth access to alcohol and can be used by community institutions, including civic groups, colleges and universities, faith organizations, hotels, police, schools, employers, and parents.
- **Reprints of Papers:** Papers published in scientific journals on subjects related to CMCA are also available. Citations are listed on the program's Web site and copies of the papers are available by request.

The above-listed materials can be downloaded and reproduced, free of charge, from the University of Minnesota's Alcohol Epidemiology Program Web site at www.epi.umn.edu/alcohol. The University requests:

- **Source citation** in any publications where the information is used
- **Notification** if the program or any portion of it is implemented, sent to NREPP@intercom.com

Target Areas

Protective Factors To Increase

Community

- Institutional policies that discourage youth alcohol use
- Public and institutional policies that reduce alcohol sales to youth
- Civic action against illegal sale and provision of alcohol to youth
- Increased interaction among diverse community sectors

Risk Factors To Decrease

Peer

- Peers providing alcohol
- Peers using alcohol

Community

- Easy availability of alcohol
- Normative support of alcohol sales to underage youth
- Normative support of alcohol consumption by underage youth
- Poor enforcement of alcohol laws and regulations
- Lack of laws or institutional policies that limit alcohol availability

PROGRAM BACKGROUND

The CMCA intervention was based on established research that showed the importance of the social and policy environment in facilitating or impeding drinking among youth. CMCA community organizing methods drew on a range of traditions in organizing efforts to deal with the social and health consequences of alcohol consumption.

EVALUATION DESIGN

CMCA was evaluated in a fully randomized 5-year research trial across 15 communities. Data were collected at baseline before random assignment of communities to the intervention or control condition and again at followup after a 2.5-year intervention period. Data collection included in-school surveys of 9th and 12th graders, telephone surveys of 18- to 20-year-olds and alcohol merchants, direct testing (using underage youth to attempt purchases) of the likelihood of alcohol sales to youth, and monitoring changes in relevant practices of community institutions. Analyses were based on mixed-model regression, used the community as the unit of assignment, took into account the nesting of individual respondents or alcohol outlets within each community, and controlled for relevant covariates.

PROGRAM DEVELOPER

Alexander C. Wagenaar, Ph.D.

Dr. Alexander C. Wagenaar, professor of Epidemiology and director of the Alcohol Epidemiology Program at the University of Minnesota, developed the CMCA project. The Alcohol Epidemiology Program (AEP) is a research program within the School of Public Health, University of Minnesota in Minneapolis. The AEP conducts policy-evaluation research on specific initiatives to prevent alcohol-related problems and studies community coalitions and other efforts to change the social and policy environment around alcohol. In recent years, AEP has studied adolescent drinking, community organizing efforts, randomized community trials, alcohol-involved traffic crashes, effects of macroeconomic conditions on drinking rates, training for alcohol outlet managers and servers, natural experiments with changes in alcohol policies, and public opinion surveys.

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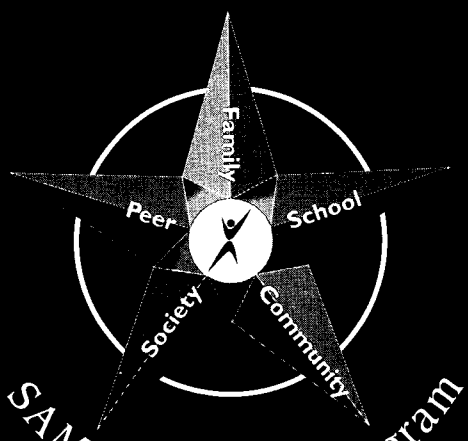
RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services



Effective Substance Abuse and Mental Health Programs for Every Community

Community Trials Intervention To Reduce High-Risk Drinking

Community Trials Intervention To Reduce High-Risk Drinking (RHRD) is a multicomponent, community-based program developed to alter alcohol use patterns of people of all ages [e.g., drinking and driving, underage drinking, acute (binge) drinking] and related problems. The program uses a set of environmental interventions including:

- Community awareness
- Responsible beverage service (RBS)
- Preventing underage alcohol access
- Enforcement
- Community mobilization

The program's aim is to help communities reduce various types of alcohol-related accidents, violence, and resulting injuries.

TARGET POPULATION

Each of the six intervention and comparison communities located in northern and southern California and South Carolina had approximately 100,000 residents. The communities were racially and ethnically diverse and included a mix of urban, suburban, and rural settings.

Proven Results

- Decreased alcohol sales to youth
- Increased enforcement of DUI laws
- Implementation and enforcement of RBS policies
- Adoption of policies limiting the dense placement of alcohol-selling establishments
- Increased coverage of alcohol-related issues in local news media

INTERVENTION

Universal

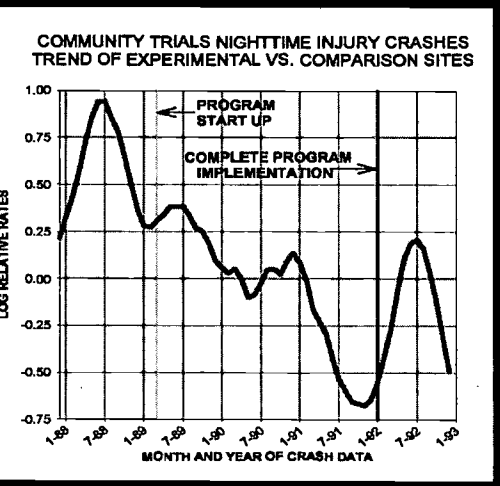
Selective

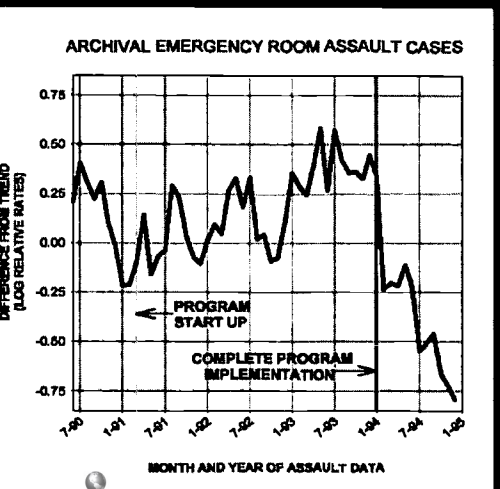
Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

- 51% decline in self-reported driving when "over the legal limit" in the intervention communities relative to the comparison communities
- 6% decline in self-reported amounts consumed per drinking occasion
- 49% decline in self-reported "having had too much to drink"
- 10% reduction in nighttime injury crashes
- 6% reduction in crashes in which the driver had been drinking
- 43% reduction in assault injuries observed in emergency rooms
- 2% reduction in hospitalized assault injuries





BENEFITS

The program brings about:

- Reductions in intentional and unintentional alcohol-related injuries (i.e., car and household accidents, assaults)
- Mobilization of community members and key policy makers
- Increased enforcement of drinking and driving laws
- Decreased formal and informal youth access to alcohol
- Responsible alcohol beverage service and sales policies

HOW IT WORKS

For the RHRD program to be successful, the implementing organization must first determine which program components will best produce the desired results for its community. The RHRD program uses five prevention components, including:

Alcohol Access. Assists communities in using zoning and municipal regulations to restrict alcohol access through alcohol outlet (bars, liquor stores, etc.) density control.

Responsible Beverage Service. Through training and testing, RBS assists alcohol beverage servers and retailers in the development of policies and procedures to reduce intoxication and driving after drinking.

Risk of Drinking and Driving. Increases actual and perceived risk of arrest for driving after drinking through increased law enforcement and sobriety checkpoints.

Underage Alcohol Access. Reduces youth access to alcohol by training alcohol retailers to avoid selling to minors and those who provide alcohol to minors, and through increased enforcement of underage alcohol sales laws.

Community Mobilization. Provides communities with the tools to form the coalitions needed to implement and support the interventions that will address the previous four prevention components.

IMPLEMENTATION ESSENTIALS

Understanding the community's alcohol environment (e.g., norms, attitudes, usage locations, cultural and socioeconomic dynamics, etc.) and alcohol distribution systems (e.g., alcohol sales licensing, alcohol outlet zoning, and alcohol use restrictions) is key to the startup of RHRD. This requires gathering the data needed to determine which interventions to use and adapting them to the individual community.

Project staff are key to this information gathering and for working with a wide array of community components, including local community organizations, key opinion leaders, police, zoning and planning com-

missions, policy makers, and the general public. Though dependent on local conditions, staff generally includes the following:

Director—responsible for developing the initiative and its strategy, seeking funding, building coalitions with key community groups and leaders, and hiring project staff

Assistant director—responsible for day-to-day management of office operations and staff, recruiting and organizing volunteers, and implementing interventions/tactics

Data managers—collect information to track program trends

Administrative—assist with managing volunteers and processing information; the first line of information for public and other stakeholders

Volunteers—provide general support for program interventions; elicit support from the broader community and participation by key community leaders (e.g., police); assist in the "synergistic" application of program components, such as media coverage of program efforts; attend community meetings and hearings to speak or gather information on targeted topics; and assist with public education projects and other interventions as needed

Program Task Force—composed of key community leaders (e.g., police captains, zoning, public safety and youth commissioners); they can provide and further build coalitions to support program interventions

Staff can be employees of the lead agency endeavoring to implement the program or may be hired and separate from existing entities.

Training and Materials

Training and consultation target the specific needs and problems of the individual community. Consultation is available and is tailored to the individual site. Training manuals for RBS are available at a minimal cost.

Brochures are also available that offer strategies and tactics for reducing alcohol use within various areas of the community, such as on college campuses, in neighborhoods, within the high school population, etc.

PROGRAM BACKGROUND

The Community Trials Project was originally inspired by the success of community-wide programs to address chronic health problems such as cardiovascular disease, results from natural experiments (e.g., reductions in the minimum drinking age), and earlier community-wide programs designed to reduce drinking and drinking-related problems. Additionally, it involved a careful collection of baseline data during the pre-intervention period, adopted well-defined community-level alcohol-related problems as targets, had a long-term implementation and monitoring period,

Target Areas

Protective Factors To Increase

Individual

- Perceived high risk of arrest for drinking and driving

Family

- Parental supervision of alcohol access to youth within the home

Community

- RBS training of alcohol establishments and related sales and service policies
- Enforcement of drinking and driving laws
- Publicity surrounding changes in youth alcohol access and drinking and driving enforcement
- Media advocacy in support of alcohol policy change
- Decreased alcohol outlet density
- Decreased formal and informal youth access to alcohol

Risk Factors To Decrease

Individual

- Low perceived risk of arrest for drinking and driving

Family

- In-home alcohol access to minors

Community

- Proliferation of alcohol outlets
- Alcohol sales and service to minors at on- and off-premise alcohol outlets
- Alcohol service to intoxicated patrons at bars and restaurants
- Lax enforcement of drinking and driving laws
- Little media coverage of community efforts to combat problematic drinking and associated outcomes

was followed by a final evaluation of changes in target problems, and involved an empirically documented successful result in the target attributable to the intervention.

EVALUATION DESIGN

The project evaluation used a longitudinal, multiple-time series design across three intervention communities. The matched comparison communities served as no-treatment controls. Within this design, the effects of project interventions can be determined by comparing outcomes to those from matched comparison communities.

Data collected as a part of the evaluation included:

- A community telephone survey including self-reported measures of drinking and drinking and driving
- Traffic crash records
- Emergency room surveys
- Intoxicated patron and underage decoy surveys
- Local news coverage of alcohol-related topics
- Roadside surveys conducted on weekend evenings

PROGRAM DEVELOPER

Harold D. Holder, Ph.D.

Harold D. Holder, Ph.D., is the principal investigator for the Community Trials Project, which was developed and implemented by the Prevention Research Center (PRC), Berkeley, CA, under a grant from the National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health, U.S. Department of Health and Human Services. The PRC is 1 of 14 alcohol research centers and specializes in the development of and advocacy for prevention science and related research and is a project of the Pacific Institute for Research and Evaluation.

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RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

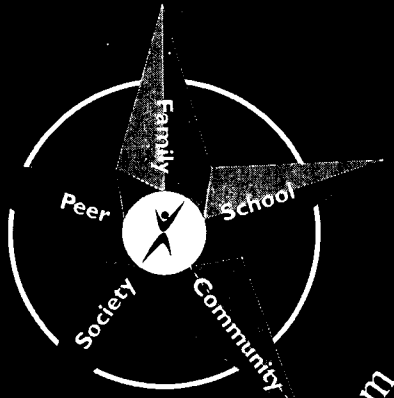
Creating Lasting Family Connections

Creating Lasting Family Connections (CLFC) is a comprehensive family strengthening, substance abuse, and violence prevention curriculum. CLFC has demonstrated that youth and families in high-risk environments can be assisted to become strong, healthy, and supportive people. Program results, documented with children 11 to 15 years old, have shown significant increases in children's resistance to the onset of substance use and reduction in use of alcohol and drugs.

CLFC provides parents and children with strong defenses against environmental risk factors by teaching appropriate skills for personal growth, family enhancement, and interpersonal communication, including refusal skills for both parents and youth.

TARGET POPULATION

CLFC is designed for youth 9 to 17 years old and their families. The populations that participated in the evaluations were primarily African American, White, or of mixed ethnicity; were 11 to 15 years of age; and lived in rural, suburban, or urban settings. The program has been implemented in 40 States with a variety of populations, including Hispanics/Latinos, Asian Americans, and Native Americans. CLFC has been successfully implemented in schools, faith communities, recreation centers, community settings, juvenile justice facilities, and other settings.



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Proven Results*

- Delayed onset of substance use for participating youth
- Decreased use of substances among participating youth
- Increased parents' knowledge and appropriate beliefs about substance use
- Increased parental involvement in setting rules about substance use

*Compared to nonparticipants.

INTERVENTION

Universal

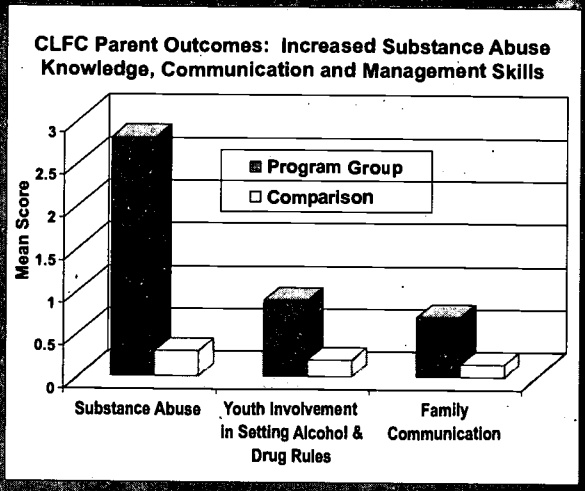
Selective

Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

The CLFC program evaluation found positive effects on family and youth resiliency and on substance use among youth 11 through 15 years of age. The program also increased community resiliency by empowering community volunteers to identify, recruit, and retain families.



Statistically significant overall program effects on family resiliency included:

- Improved parental knowledge of and beliefs about substance use
- Increased youth involvement in setting rules related to substance use
- Increased use of community services

Positive effects on youth resiliency included:

- Increased use of community services when personal or family problems arose
- Increased bonding with mother, father, and siblings
- Increased community involvement under specific conditions

In addition, the program improved family modeling of alcohol use in African-American communities and moderated overall family alcohol use. Most important, the evaluation found that reductions in substance use among youth who participated in the program were conditionally related to changes in family-level and youth-level resiliency factors targeted by the program.

BENEFITS

CLFC is designed to—

- Improve refusal skills, resulting in both delayed onset and reduced use of substances by youth
- Increase communication and bonding between parents and children
- Foster greater use of community services in resolving family and personal problems
- Decrease uncontrolled behavior (i.e., reduce violence)

HOW IT WORKS

Implementing the CLFC model involves—

- Identifying, recruiting, assessing, and selecting the community system(s) that will serve as the focal point of the program.
- Creating, orienting, and training a small cadre of community volunteers to advocate for youth and their families in high-risk environments, and recruiting and helping retain those families in the program.
- Recruiting youth and families in high-risk environments who are willing to participate in the program.
- Administering six highly interactive training modules, three each to both parents and youth, separately (i.e., one module on substance use issues, a second on personal and family responsibilities, and a third on communication and refusal skills).
- Providing early intervention services and followup case management services to connect families to community resources and appropriate alternative activities when necessary.

IMPLEMENTATION ESSENTIALS

For a high-fidelity replication of CLFC, at least two part-time facilitators are needed for each of the parent and youth modules. After the recruitment phase, these four part-time facilitators can work with up to 30 families, 1 day per week, 4 hours a day, for the duration of the 20-week program. A minimum of two facilitators for each group is strongly recommended because a team approach significantly enhances the group learning experience and is likely to increase the participants' positive response to the program.

Program startup takes 1 to 3 months, and includes:

- 5 to 10 days of training by the developer
- Community mobilization activities
- Identification and recruitment of parents and youth

Facilitators should provide weekly 2.5-hour parent and youth training sessions for a 20-week period. However, the modules may be offered in 5-week increments throughout the year if families are unable to commit to a 20-week program. Facilitators also are responsible for case management or referrals to community services (an optional element when used with universal populations).

PROGRAM BACKGROUND

CLFC is the national dissemination model based on the results of Creating Lasting Connections (CLC), a 5-year Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention research demonstration project. The project was designed as an ecumenical, community-based program focused on increasing community, family, and individual youth protective factors that would delay the onset and reduce the frequency of substance use. The program was delivered to at-risk 11- to 15-year-old youth through the implementation of a preexisting and privately developed prototype version of CLFC. The external evaluation of the CLC program showed that the program increased key resiliency factors and (through moderating effects) delayed the onset of substance use and reduced the amount of use.

EVALUATION DESIGN

The CLFC program was evaluated rigorously using random assignment procedures, valid and reliable outcome measures, and multivariate analysis methods to uncover direct and conditional relationships between the program and outcomes.

PROGRAM DEVELOPER

Ted N. Strader, M.S.

Ted N. Strader is founder and executive director of the Council on Prevention and Education: Substances, Inc. (COPES). Under his leadership, COPES has implemented projects on substance abuse and violence prevention, solvent inhalation prevention, research, parent education, and voluntarism. In addition, Mr. Strader has published several articles, produced films, and presented papers and workshops at many local, State, and national conferences on drug abuse. He has recently written a book, *Building Healthy Individuals, Families and Communities: Creating Lasting Connections.*

Target Areas

Protective Factors To Increase

Individual

- Appropriate substance use knowledge and beliefs
- Attitudes unfavorable to substance use
- Refusal skills
- Bonding with mother and father
- Honest communication
- Participation in family rule setting
- Bonding with community
- Social skills

Family

- Appropriate parental substance use knowledge and beliefs
- Appropriate parental substance-using behavior
- Family management skills (including family meetings)
- Bonding with youth
- Involvement of youth in family rule setting (both substance related and not)
- Help-seeking for family and personal problems
- Appropriate expectations and consequences
- Family stability, harmony, cohesiveness, and positive communication
- Family recreational and community activities

Community

- Youth and parent perceptions of community support
- Access to health and social services
- Community empowerment
- Responsiveness and flexibility of social service provision
- Community service

School

- School bonding by youth
- School attendance
- Positive school climate

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RECOGNITION

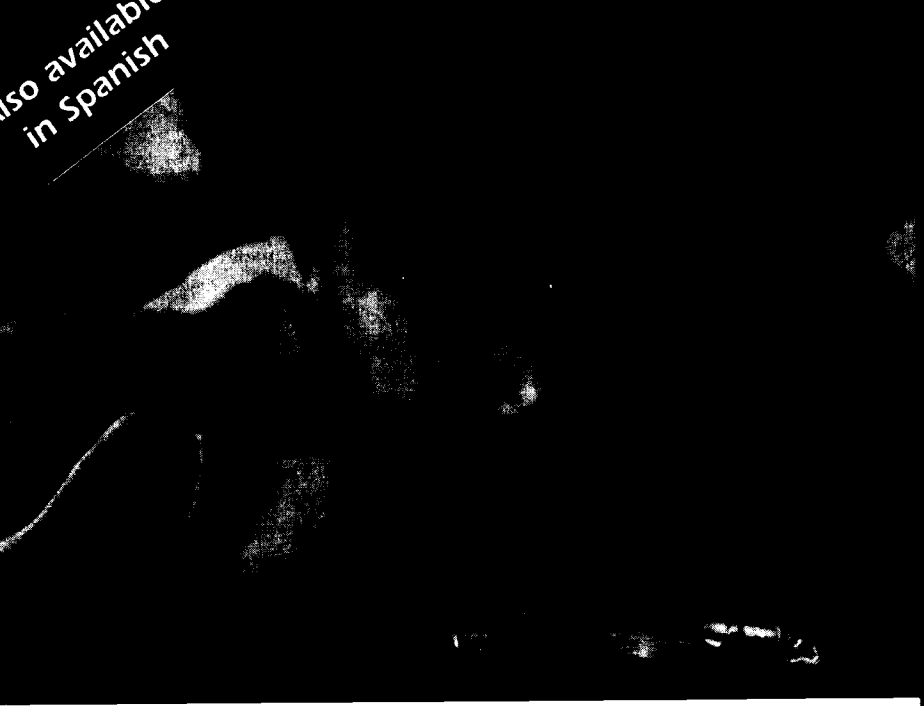
Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

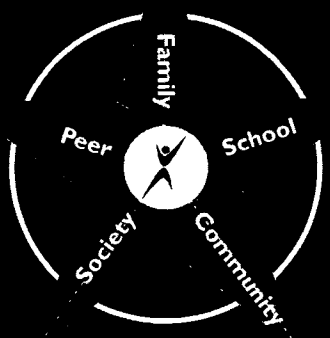
Model Program—Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice

Promising Program—U.S. Department of Education

Special Recognition Award—White House Office of National Drug Control Policy

Selected for worldwide replication by the International Youth Foundation—YouthNet Model Program





SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

DARE To Be You

DARE To Be You (DTBY) is a multilevel, primary prevention program for children 2 to 5 years old and their families. It significantly lowers the risk of future substance abuse and other high-risk activities by dramatically improving parent and child protective factors in the areas of communication, problem solving, self-esteem, and family skills. Program interventions are designed to—

- Improve parents' sense of competence and satisfaction with being a parent
- Provide parents with knowledge and understanding of appropriate child management strategies
- Improve parents' and children's relationships with families and peers
- Boost children's developmental levels

DARE To Be You program materials are available in English and Spanish.

TARGET POPULATION

The original participants were Native American, Hispanic/Latino, African American, and White parents and their preschool children at locations across Colorado. Additional participants included siblings, Head Start teachers, day care personnel, and other supportive community members who worked with the families. Positive results held true for all sites and ethnic groups.

Proven Results

- Increased parental effectiveness and satisfaction, maintained over 2 years*
- Increased appropriate parental limit setting, maintained for 2 years
- Decreased parental child blaming and harsh punishment
- Increased child developmental level, maintained for at least 2 years*

**Compared to control group.*

INTERVENTION

Universal

Selective

Indicated

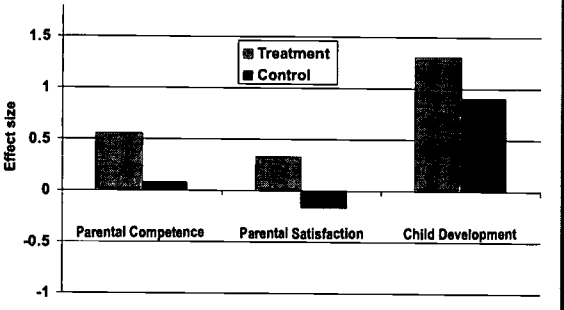
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

- Significantly increased satisfaction with support systems and self-sufficiency
- Better child self-management and family communication reported by families
- 45% of the families had a male father figure participate and complete the intervention

Effect sizes for DARE To Be You

(Changes between baseline and 1-year followup; effect size of .20 is small, .50 is medium, .80 is large)



Effect sizes for DARE To Be You

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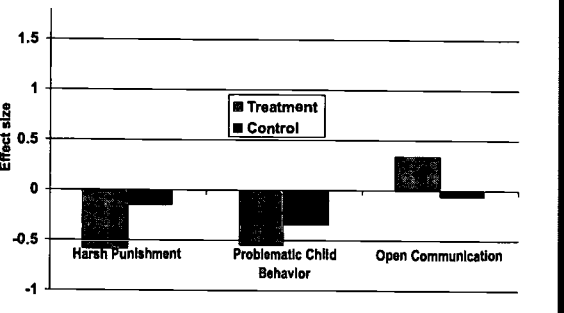

BENEFITS

- Improved parental competence
- Increased satisfaction with and positive attitude about being a parent
- Adoption and use of nurturing family management strategies
- Increased and appropriate use of limit setting
- Substantial decreases in parental use of harsh punishment
- Significant increases in child developmental levels

HOW IT WORKS

The DARE To Be You program should have a site sponsor—a key agency that works with families. While the site sponsor may vary with the needs of the community, it must be respected by the community. Sponsors may be Head Start or other preschool educational programs, schools, family centers, or coalition groups. The program is delivered to families at a site convenient to the families in a location comfortable for families to attend. The program consists of three components:

- **Family Component,** which offers parent, youth, and family training and activities for teaching self-responsibility, personal and parenting efficacy, communication and social skills, and problem-solving and decisionmaking skills. It consists of an initial 12-week family workshop series (30 hours) and semiannual 12-hour reinforcing family workshops. (Post-DTBY support groups are also recommended.)
- **School Component,** which trains and supports teachers and child-care providers who work with the target youth.
- **Community Component,** which trains community members who interact with target families, local health departments, social services agencies, family center personnel, probation officers, and counselors.

Both **School** and **Community Component** participants have the same 15-hour training requirement. Training for childcare providers and involved community members will also be held at a place deemed appropriate by the site sponsor.

IMPLEMENTATION ESSENTIALS

For the Family Component, DTBY activities require a room large enough to handle up to 45 family members and staff, 2 or more breakout rooms for 20 to 30 children, and space for the family meal. One medium-size room is needed for teacher and community member training.

A positive and nurturing staff of 3 part-time professionals is required to effectively deliver DTBY to 20 adult family members and their children (per session), including:

A **Site Coordinator** who works with referral sources; recruits, screens, hires, and supervises staff; and contracts for initial training and assists with program logistics. This 10-hour per week position requires a bachelor's degree.

The **Parent Trainer/Facilitator** conducts weekly family workshops, monthly post-DTBY, and bimonthly reinforcing workshops. This 10-hour per week position, which also requires an undergraduate degree, coordinates its parent activities with the child program staff and may provide teacher and community training. Trainers should budget 80 hours to prepare, promote, and implement the Teacher and Community Components.

A **Child Program Coordinator/Teen Trainer-Supervisor** prepares and implements the children's program; trains, monitors, and mentors teen teachers; and assists with workshop logistics. A bachelor's degree is preferred for this position that requires 10 to 12 hours a week.

Teen Teachers are recruited to work with the program children 3 hours a week. Two to 5 hours of clerical/administrative support will be needed.

Evaluation Staff is required by research design.

Training and Materials

Three days (20 hours) of onsite implementation training for up to 35 site team members, plus 2 hours of technical assistance (TA) by telephone, is available from DTBY staff. Followup implementation/site visits (1-day minimum) and other TA packages are also available. Printed program materials available from the Colorado State University Cooperative Extension include:

- *DARE To Be You Parent and Preschool Training Guides* (English or Spanish/English)
- *DARE To Be You K-12 Substance Abuse Prevention Curriculum*
- Promotional video
- Puppet patterns or a set of all four ready-made puppets
- *DARE To Be You Community Training Manual*
- Parent and child activity booklets
- Optional program brochures, awards, and buttons
- Preschool activity kit

Target Areas

Protective Factors To Increase

Individual

- Positive personal characteristics (e.g., social and communication skills)
- Positive sense of self (e.g., competence and efficacy)
- Problem-solving skills
- Internal locus of control
- Empathy
- Autonomy
- Future orientation
- Appropriate developmental attainments and school readiness
- Enhanced socioeconomic status (through increased self-efficacy and motivation)

Family

- Nurturing and well-managed home environment
- Attachment to parents and extended family
- Parental satisfaction with parental role
- Positive parent-child interactions

Risk Factors To Decrease

Individual

- Low parental effectiveness and satisfaction
- Poor school readiness for children entering school (low developmental level)
- Poor self-management skills
- Economically disadvantaged
- Individual mental health problems

Family

- Disorganized or unstable family environment
- Poor communication
- Child or self-blame attributions leading to potential abuse
- Family mental health problems

Community

- High levels of alcohol and drug abuse
- Pro alcohol and drug use norms

PROGRAM BACKGROUND

The DARE To Be You program began in 1979 with a research grant from the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, to establish a community-based system to help decrease alcohol and tobacco use by youth 8 to 12 years old. In 1985, the U.S. Department of Education funded development of a K-12 curriculum and corresponding teacher training. In 1989, the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention funded the development and evaluation of the component for families and their preschool youth described in this fact sheet. A 2-year project ensued, and the DTBY principles were tested with these youth as they became 10 to 14 years of age. Because of the positive results of this research, for 14 years the Colorado Department of Health included DTBY in its community team prevention efforts. Requests from both researchers and community teams led to development of the teacher training/school component and the family component.

EVALUATION DESIGN

Families with children 2 to 5 years old were randomly selected into control and experimental groups. The parents in each group completed a battery of pretests and 1-year and 2-year followup surveys. The experimental group also completed a posttest immediately after completing a 12-week, 20-plus-hour intervention. Child program staff completed pre- and postprogram surveys on the participating youth. The survey instruments are described by our evaluation protocol (see *Outcomes*). In addition to the outcome variables measured, process measures included workshop environment scales, workshop log sheets that documented activities, staff, participants, and the environment of each workshop. Community agencies completed surveys on the program. Results included statistically significant decreases and/or delays in onset of alcohol and tobacco use in the experimental over the control peers.

PROGRAM DEVELOPER

Jan Miller-Heyl, M.S.

Jan Miller-Heyl began the DARE To Be You program in 1979. With a background in physiological, biomedical, and ecological systems research, Ms. Miller-Heyl's commitment to conduct prevention/intervention of problem behaviors with an ecological or systems approach evolved naturally. Her belief that involving entire families in the prevention/intervention process led to the commitment use incentives to increase family dosage. Over time, Ms. Miller-Heyl found that the addition of school and community components also is necessary for a successful systems approach. Following the theoretical base of Bandura, the DTBY program builds on strengths to establish efficacy.

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Program information, including ordering forms for training and materials, will be faxed or mailed on request.

Free information that can be e-mailed as attachments or downloaded from the SAMHSA Model Programs Web site includes:

- Replication Manual
- Evaluation Protocol (Instruments are not owned by the DTBY program)
- Fidelity Instruments

RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

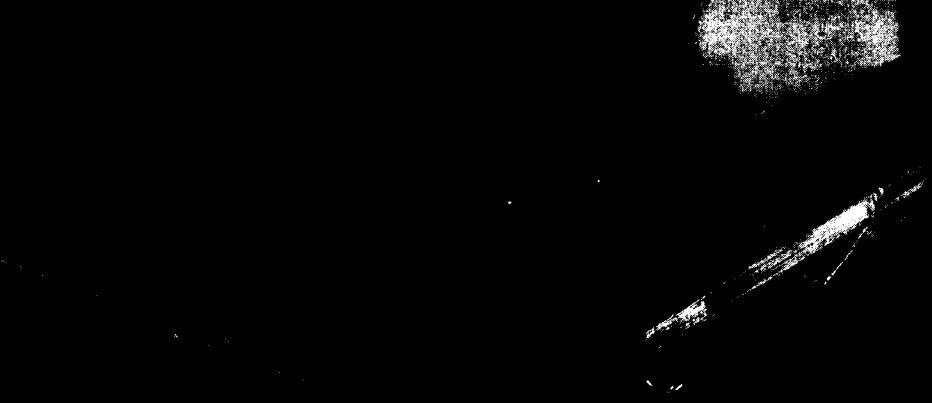
Exemplary Program—National Association of State Alcohol and Drug Abuse Directors and the National Prevention Network

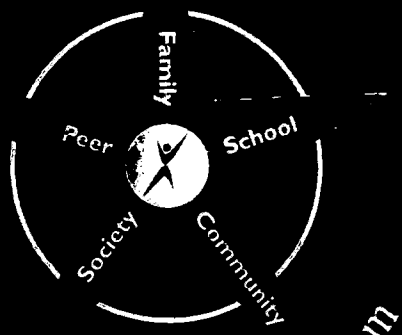
Building Human Capital Award—U.S. Department of Agriculture

Distinguished Service Award—Cooperative Extension Service

Excellence in Prevention—Colorado Governor's Award

Champion for Children and Families, Individual Award—Colorado Mothers, Inc.





SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Early Risers: *Skills for Success*

Early Risers is a multicomponent, high-intensity, competency-enhancement program that targets elementary school children 6 to 10 years old at high risk for early development of conduct problems, including substance use. Early Risers is based on the premise that early, comprehensive, and sustained intervention is necessary to target multiple risk and protective factors. The program uses a full-strength intervention model with two complementary components to move high-risk children onto a more adaptive developmental pathway. Interventions include:

- Child social skills training and strategic peer involvement
- Reading and math instruction and educational enrichment activities
- Family support, consultation, and brief interventions to cope with stress
- Proactive parent-school consultation
- Contingency management of aggressive, disruptive, and noncompliant child behavior

The enhanced competence gained through Early Risers leads to the development of positive self-image, independent decisionmaking, healthy problem solving, assertive communication, and constructive coping. Once acquired, these attributes and skills collectively enable youth to resist personal and social forces that encourage early substance use and potential abuse and dependency.

TARGET POPULATION

Early Risers is a prevention program for children 6 to 10 years old and their families. Original participants were primarily Whites residing in semi-rural communities. Subsequent replications of the program have

Proven Results*

- Significant gains in social competence including improved social skills and social adaptability
- Significant gains in academic achievement
- Children with the most severe aggressive behavior showed significant reductions in self-regulation problems
- Children whose parents achieved recommended levels of participation reported less parental distress and improved methods for disciplining children

** Relative to comparisons. Different tests focus on changes over time between program and control.*

INTERVENTION

Universal

Selective

Indicated

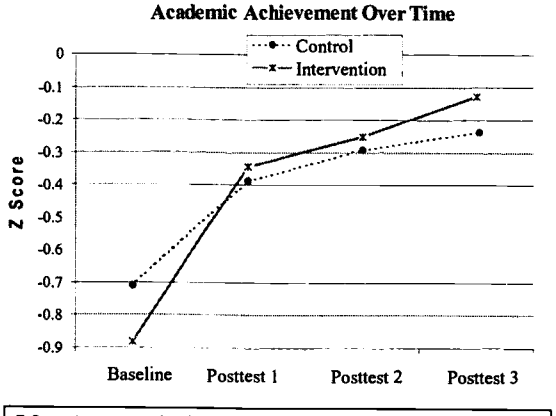
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

High-risk children whose parents received 50 percent or more of recommended FLEX home visiting contact time showed improvement on academic achievement, reduced attention/concentration problems, and improvement in social skills and overall social competence. Compared to high-risk control participants, high-risk program participants made significant improvements in a number of areas, including:

- Academic achievement: High-risk children receiving the program showed significant improvement in rate of academic achievement with this effect primarily accounted for by gains in basic reading skills. This effect held true for boys and girls.
- Self-regulation: Both program and control children showed reductions in self-regulation problems. However, those program children with the highest level of aggressive behavior showed significant reductions in behavioral problems as compared to their high aggressive control counterparts.
- Social competence: High-risk children receiving the program made significant gains in social skills, social adaptability, and leadership following 3 years of intervention.

Parents of children with the highest level of aggressive behavior, who received 50 percent or more of recommended FLEX contact time, reported improved investment in their child and less personal distress.



Z-Score is a standardized score with a mean of 0 and a standard deviation of 1. It expresses how far a subject's score lies from the mean distribution of the score of a normative group representing the general population.

involved African American children and their families living in economically disadvantaged urban communities. The program is specifically aimed at children who display early aggressive, disruptive, and/or nonconformist behaviors.

BENEFITS

- Positive self-image
- Self-regulation and constructive coping
- Healthy problem-solving and assertive communication skills
- Positive peer affiliations
- Positive attitudes toward learning
- Parental competence and capacity to support and nurture children's development

HOW IT WORKS

A family advocate is responsible for running Early Risers. This individual coordinates and provides services for the CORE (child-focused) and FLEX (parent/family-focused) components. The family advocate is responsible for delivering Early Risers' manualized program to children and their parents, year-round, at school and at home.

For the CORE component, the family advocate is responsible for:

- Regularly visiting the child's school
- Consultation with teachers
- Individual mentoring of the student
- Facilitating improved communication between home and school
- Teaching children the skills necessary to make and sustain friendships
- Providing recognition for children's efforts and accomplishments
- Administration and coordination of summer school program

In the role of FLEX home visitor, the family advocate:

- Schedules regular home visits
- Develops supportive relationships with parents
- Assesses family strengths and needs
- Assists in family goal-setting and strategic planning
- Brokers community services

Early Risers is best implemented in schools or local community centers. A Summer Program component is ideally delivered in community school settings, but also can be run in community centers, faith-based centers, or similar locations. The Summer Program also requires a larger staff.

IMPLEMENTATION ESSENTIALS

Staffing

Cost-effective operation of Early Risers requires one family advocate for every 25 to 30 child/family participants. A qualified family advocate must have a minimum of 2 years of field experience in human services and a bachelor's degree in social work or related field. A supervisor, responsible for staff recruitment, education, training, oversight, and evaluation, also is needed.

Program Training and Materials

A 5-day training program can be held at the host site for up to 20 family advocates and program supervisors. Further technical assistance via site visits or phone contact is recommended. Early Risers also offers a *Skills for Success Training Manual,* "Skills for Success" program video, and other program resources.

Timeline

- Startup activities will require 3 to 6 months. They include screening and recruiting children and their families, recruiting and training program family advocates, developing referral sources and relationships with community service providers, and obtaining school support.
- Program implementation starts with a 6-week **Summer Program** that runs 4 days per week. Program components include academic instruction, social skills training, cultural education, and creative arts and sports skills instruction.
- The **Check and Connect Program** begins shortly after the start of the school year and runs concurrently until the end of each school year for 2 to 3 years. Family advocates visit each child's classroom on a weekly basis to consult with teachers and provide one-on-one mentoring to the child when indicated.
- The **Family Program** also begins shortly after the start of the school year. Parent and child groups are assembled and meet for biweekly evening sessions (12 sessions in years 1 and 2 and 6 sessions in year 3). Sessions begin with a communal family dinner followed by concurrent parent and child groups that last approximately 90 minutes and conclude with a 30-minute parent-child interactive activity.
- **FLEX Family Support Program** begins approximately 3 months into the school year and runs continuously thereafter. The amount of FLEX contact time will vary for each family based on need. A minimum of six home visits per year is recommended.

Target Areas

Protective Factors To Increase

Individual

- Emotional regulation and behavior control skills
- Prosocial behavior
- Interpersonal communication skills
- Social problem-solving skills
- Conflict resolution and anger management skills
- Positive attitudes toward school
- Reading, written expression, and math skills
- Affiliation with prosocial peers

Family

- Parenting self-efficacy
- Empowerment
- Personal well-being
- Involvement in community alliances
- Access to community systems of care
- Supportive and nurturing parental behavior

School

- Supportive and competent teachers
- Supportive schools

Risk Factors To Decrease

Individual

- Early aggressive and disruptive behavior
- Poor academic achievement
- Damaged peer relationships
- High emotional reactivity or impaired emotional regulation

Family

- Limited community support systems
- Inconsistent or ineffective discipline methods
- Low monitoring and supervision
- Harsh and disapproving communication
- Low support and involvement
- Limited educational stimulation and support for mastery
- Parent mental illness and substance abuse
- Social insularity and marital discord
- Poverty and unemployment

PROGRAM BACKGROUND

Over a 10-year period, Early Risers evolved from a school-based intervention delivered by teachers and expert consultants to a community-based intervention delivered by community providers. Its home visitation delivery system provides for interventions and services that are tailored to each family's strengths, needs, and barriers to participation. Several variations of the program now exist, each contextualized to accommodate both urban and rural implementation.

EVALUATION DESIGN

The intervention was tested using a multiple time-series design involving a baseline assessment and three annual assessments thereafter. Children were screened for risk (i.e., aggressive behavior) during kindergarten and randomly assigned (nested within schools) to either the program or no-program (i.e., control) conditions. Eighty-two percent of the participants completed the 3-year prevention trial. Rate of attrition and characteristics of those who failed to complete the trial did not differ for program and control groups. Outcome variables were specified that corresponded to four global competence domains (i.e., academic competence, social competence, self-regulation, and parent investment), each of which included several specific skill domains.

PROGRAM DEVELOPERS

Gerald J. August, Ph.D.
George M. Realmuto, Ph.D.
Michael L. Bloomquist, Ph.D.

Early Risers "Skills for Success" was developed by Drs. Gerald J. August, George M. Realmuto, and Michael L. Bloomquist at the Center for Prevention and Children's Mental Health at the University of Minnesota. This group of prevention specialists is involved in the design and evaluation of community-based prevention programs that address serious conduct problems experienced by youth such as drug abuse, violence, and delinquency.

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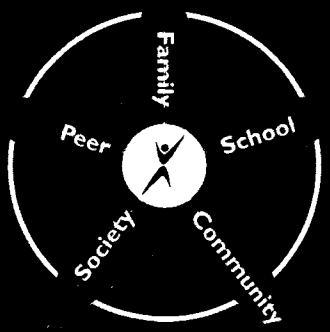
RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Family Effectiveness Training

Family Effectiveness Training (FET) is a family-based program developed for and targeted to Hispanics/Latinos. It is effective in reducing risk factors and increasing protective factors for adolescent substance abuse and related disruptive behaviors. FET, applied in the preadolescent years (6 to 12), targets three family factors that place children at risk as they make the transition to adolescence: 1) problems in family functioning, 2) parent-child conflicts, and 3) cultural conflicts between children and parents. FET uses two primary strategies:

1) Didactic lessons and participatory activities that help parents master effective family management skills
2) Planned family discussions in which the therapist/facilitator intervenes to correct dysfunctional communications between or among family members

Interventions employed by FET cover:

- Normal family changes during the transition to adolescence and related conflict resolution
- Substance use and adolescent alternatives to using
- Parent and family supervision of children and their peer relationships
- Family communication and parenting skills

TARGET POPULATION

FET helps Hispanic/Latino immigrant families with 6- to 12-year-old children, particularly in cases where the child is exhibiting behavior problems, associating with deviant peers, or experiencing parent-child communication problems. Program evaluation has only been conducted with Hispanic/Latino families.

Proven Results

- 35% reduction in children's disruptive behaviors
- 66% reduction in children's associations with antisocial peer
- 34% reduction in children's irresponsible behaviors
- 14% improvement in children's self-concept
- 75% improvement in family functioning

INTERVENTION

Universal

Selective

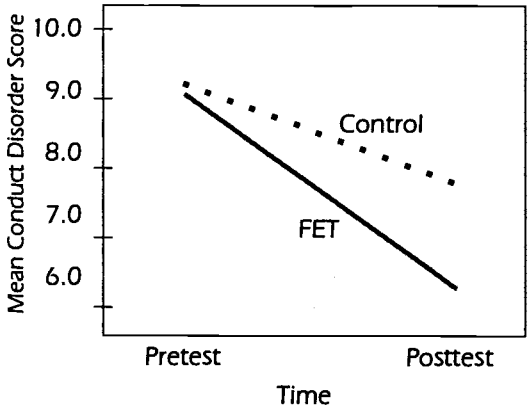
Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

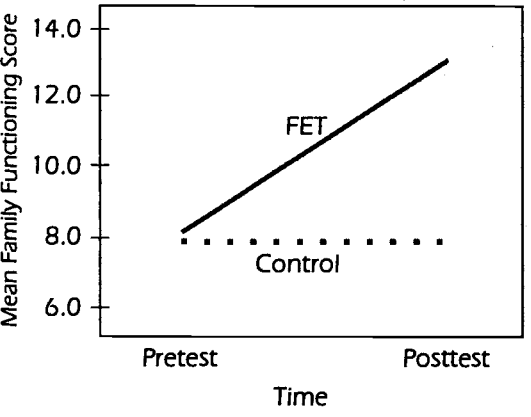
OUTCOMES

FET reduced children's disruptive behaviors, promoted maturity and reduced personality problems, and improved children's self-concept. FET was also shown to improve family functioning.

Reduction in Disruptive Behaviors for FET and Comparison Group



Improvement in Family Functioning for FET and Comparison Group



BENEFITS

- Improves parental understanding of their children's cultural assimilation, and children's understanding of their parents' Hispanic/Latino culture, bridging the culture gap between parents and children
- Improves family cohesiveness and child bonding to the family
- Improves parental knowledge, understanding, competence, and skills to effectively manage children's behavior
- Increases parental and child knowledge about and negative attitudes toward substance use
- Increases substance use resistance skills in children
- Improves child self-discipline and self-concept
- Reduces child antisocial and immature behavior

HOW IT WORKS

FET is designed to engage and retain a family in the program by focusing on how the entire family functions and viewing the child's problems as a symptom of cultural differences within the family.

During the course of 13 family sessions, FET uses the following strategic interventions:

- Teaching bicultural skills to promote bicultural effectiveness
- Providing Brief Strategic Family Therapy (BSFT), a problem-focused, direction-oriented, and practical approach to the elimination of substance abuse risk factors
- Educating parents on normal adolescent development
- Promoting effective parenting skills
- Promoting family communication, conflict resolution, and problem-solving skills
- Disseminating substance abuse information to parents

FET can be implemented in a variety of settings, including community social services agencies, schools, mental health clinics, faith communities, and community youth centers. Because FET works with the entire family, the program is usually limited to afternoons, evenings, and Saturdays.

IMPLEMENTATION ESSENTIALS

FET requires committed, enthusiastic, sympathetic counselors who are familiar with and respectful toward Hispanic/Latino and American cultures, languages, and values. Minimum professional qualifications include basic knowledge of how family systems operate and 3 years of clinical experience with children and families. The ideal candidate has a master's

degree in social work or marriage or family therapy. However, individuals with a bachelor's degree and experience working with families may also qualify. Counselors must be able to—

- Present didactic material in an understandable way
- Elicit family participation in structured exercises
- Intervene in family discussions to improve dysfunctional family interactions
- Be flexible enough to adapt the intervention to the specific needs of each family

Each family participates in the program for 13 weeks, with one 1.5- to 2-hour session per week. One full-time counselor can provide FET to 15 to 20 families per week, depending on the experience and maturity of the counselor.

Agencies should allow 6 months to hire and train counselors, develop referral resources from the community, and recruit and screen participant families. The provider agency must be open at times convenient to families, and provide transportation and childcare when needed.

Videotaping equipment, a monitor, and a VCR are needed for supervision and review of work. Midsize offices with a blackboard or easel are adequate for administering FET and videotaping sessions. Finally, visual teaching aids and handouts for families are required.

PROGRAM BACKGROUND

FET grew out of a long-standing tradition of work with Hispanic/Latino immigrant families at the Spanish Family Guidance Center in the University of Miami Center for Family Studies. In the process of implementing BSFT, Center researchers observed that, in many cases, families of problematic and drug-abusing adolescents were characterized by acculturation differences between parents and adolescents. This resulted in the parents' inability to communicate effectively with their adolescents. To address this risk factor, a preventive intervention was developed to correct cultural gaps between parents and children.

The theory behind this early work was that increasing parents' familiarity with American culture and the values and attitudes to which their children were acculturating, and increasing children's familiarity with their parents' Hispanic/Latino culture, would help to close the family cultural gap, improve family relationships, and prevent problem adolescent behavior.

The current version of FET was developed to work with families of preadolescents to foster parenting skills needed in American society before children had grown old enough to manifest the cultural gaps associated with problem behavior and drug abuse in Hispanic/Latino immigrant families.

Target Areas

Protective Factors To Increase

Individual

- Bicultural adjustment
- Acceptance of culture of origin
- Self-discipline
- Positive transition into adolescence
- Alternatives to drug use
- Good self-concept
- Conventional beliefs and attitudes
- Good school attendance, conduct, and achievement

Family

- Family bicultural adjustment
- Understanding of family development
- Effective parent-child communication
- Family conflict resolution skills
- Effective parental nurturance and behavior control
- Increased family cohesiveness
- Effective parenting skills in managing child's peer relations

Risk Factors To Decrease

Individual

- Cultural identity confusion
- Rejection of culture of origin
- Behavior problems in school or at home
- Early antisocial behavior
- Association with antisocial peers
- Feelings of inadequacy and immaturity
- Poor self-discipline
- Poor frustration tolerance
- Poor self-concept
- Unconventional beliefs or attitudes

Family

- Poor parent-child communication
- Parent-child conflict
- Parent-child-cultural conflict
- Negative effect in family interactions
- Marital problems
- Family isolation
- Ineffective parental behavior control
- Parent uninvolved with child, child's school, and child's peers

EVALUATION DESIGN

A randomized pretest, posttest, and followup group design was employed. Seventy-nine Hispanic/Latino families were randomized either to receive FET or to a minimum contact control condition. Pretest assessments were conducted prior to assignment to condition. Posttest assessments were conducted at approximately 13 weeks for both the experimental/FET and control families (around the time the FET condition was completed). A followup was conducted 6 months after the posttest. Families assigned to FET received 13 lessons, at a rate of one lesson per week. Families assigned to the control group had only minimal contact with program staff. (See *Outcomes* section.)

PROGRAM DEVELOPER

José Szapocznik, Ph.D.

Dr. Szapocznik directs the Spanish Family Guidance Center at the University of Miami's Center for Family Studies, the Nation's oldest and most prominent research center focusing on the development and testing of Hispanic/Latino family-oriented interventions in the prevention and treatment of adolescent substance abuse and related behavior problems. Dr. Szapocznik has received a number of awards and honors for his work, including the 2000 Presidential Award for "Contributions to the Development of Family-Based Interventions" from the Society for Prevention Research and, in 1999, the first ever Research Award from the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention.

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Information on costs, materials, technical assistance, and other aspects of the program can be obtained from:

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RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department Health and Human Services

Presidential Award—Society for Prevention Research

Research Award—Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, U.S. Department Health and Human Services

The Incredible Years Training Series

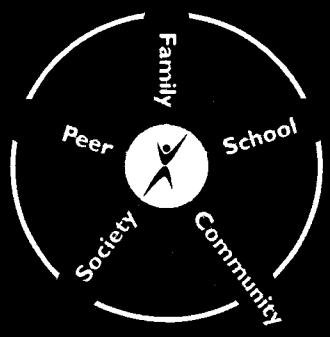
The Incredible Years Training Series features three comprehensive, multifaceted, developmentally based curricula for parents, teachers, and children. The program is designed to promote emotional and social competence and to prevent, reduce, and treat aggressive, defiant, oppositional, and impulsive behaviors in young children 2 to 8 years old.

Young children with high rates of aggressive behavioral problems have been shown to be at great risk for developing substance abuse problems, becoming involved with deviant peer groups, dropping out of school, and engaging in delinquency and violence. Ultimately, the aim of the teacher, parent, and child training programs is to prevent and reduce the occurrence of aggressive and oppositional behavior, thus reducing the chance of developing later delinquent behaviors.

Incredible Years addresses multiple risk factors known to be related to the development of conduct disorders in children in both school and home. In all three training programs, trained facilitators use videotaped scenes to structure the content and stimulate group discussion and problem solving.

TARGET POPULATION

Incredible Years has been tested with 2- to 8-year-old children presenting with conduct problems (i.e., having high rates of aggression, defiance, oppositional, and impulsive behaviors). It has also been evaluated with children 2 to 6 years old, who are at high risk by virtue of living in poverty. These programs have been evaluated and found successful with children of both genders from



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Proven Results

- According to standardized reports by teachers and parents, at least 66% of children previously diagnosed with Oppositional Defiant Disorder/Conduct Disorder (ODD/CD) whose parents received the parenting program were in the normal range at both the 1-year and 3-year followup assessments.

- The addition of the teacher and/or child training programs significantly enhanced the effects of parent training, resulting in significant improvements in peer interactions and behavior at school.

INTERVENTION

Universal

Selective

Indicated

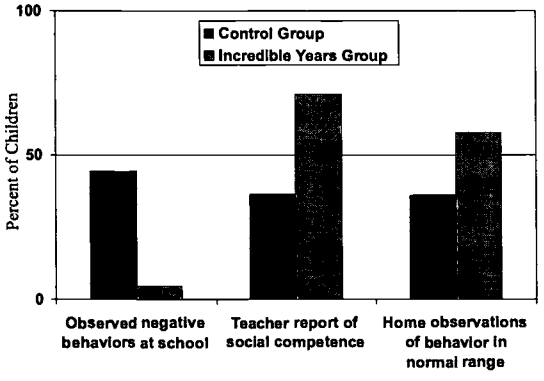
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

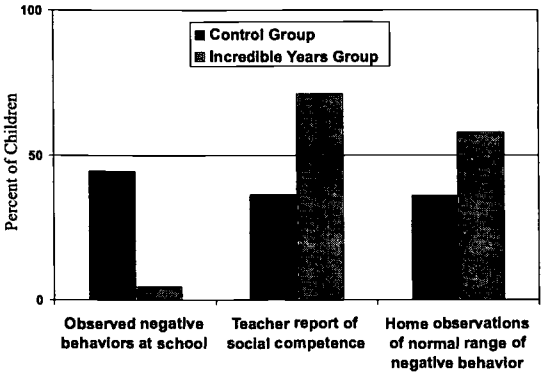
Two randomized control group evaluations indicated that the child training series significantly:

- Increased children's appropriate cognitive problem-solving strategies
- Increased children's use of prosocial conflict management strategies with peers
- Increased children's social competence and appropriate play skills
- Reduced conduct problems at home and school

Clinically significant improvements in social competence and negative behaviors among high-risk Head Start children



Clinically significant post-intervention changes in behavior among Head Start children who were in high-risk range at baseline



various ethnic groups, including Hispanic/Latino, Asian American, and African American, and diverse socioeconomic backgrounds in parts of the United States, Canada, and Great Britain.

The Incredible Years curricula may be implemented by schools, school districts, and related programs (including Head Start, day care, and kindergarten) as early prevention programs. Additionally, the child and parent curriculum may be used in mental health centers as a treatment for families with children who are diagnosed with Oppositional Defiant Disorder/Conduct Disorder (ODD/CD) and Attention Deficit Hyperactivity Disorder.

BENEFITS

- The child program promotes children's social competence and reduces conduct problems
- The parent program helps parents strengthen parenting skills and become more involved in their children's school activities
- The teacher program strengthens classroom management skills, reduces classroom aggression, and improves teachers' ability to focus on students' social, emotional, and academic competence

HOW IT WORKS

The program uses interventions delivered through three curricula: BASIC (basic parenting skills), ADVANCE (parental communication and anger management), and SCHOOL (parents promoting children's academic skills), which are presented in four distinct formats:

Dina Dinosaur Small Group Therapy—18 to 22 weekly 2-hour sessions for children

Dina Dinosaur Classroom—includes 60 lesson plans that can be delivered 1 to 3 times a week in 45-minute class periods (preschool and early school-age lesson plans available)

Parenting Groups—12 to 14 weekly 2-hour sessions for the BASIC series and 10 to 12 weekly 2-hour sessions for the ADVANCE and SCHOOL series

Teacher Classroom Management Series—fourteen 2-hour sessions or 4-day intensive

Some of the strategic interventions used in these programs include:

- Group parenting skills training
- Group teacher classroom management training
- Group support for parents, teachers, and children
- Self-management skills training

- Peer support
- Decisionmaking skills training
- Training of group leaders/facilitators
- Interpersonal skills for training parents, teachers, and children

IMPLEMENTATION ESSENTIALS

To successfully implement Incredible Years, the organization or school must be committed to excellence, evident in good administrative support and support for facilitator certification by certified trainers, as well as ongoing technical support and consultant workshops.

Each of the three curricula consists of videotapes, comprehensive facilitator manuals, books, take-home assignments, and refrigerator notes. It is recommended that all group participants (parents, teachers, children) have their own individual books and that facilitators have their own manuals. Videotape equipment is necessary.

Each group should have two group leaders. Group leaders complete a certification process that involves attendance at a certified training workshop, peer review, videotape feedback, and consultation.

Training and Materials

Certified trainers are available to train therapists, counselors, teachers, and others to run parent, teacher, and child groups. Training sessions can accommodate 25 people, and run 3 days for group leaders of the Parenting Program, 2 days for leaders of the Dinosaur Child Program, and 4 days for the Teacher Classroom Management Program.

PROGRAM BACKGROUND

The Incredible Years series was developed to promote positive, effective, research-proven parenting and teaching practices that strengthen young children's social competence and problem-solving abilities, and reduce aggression at home and school. In the 1980s, the BASIC parenting program was evaluated and found to be successful in promoting lasting improvements in parent-child interactions and reducing children's behavior problems at home for at least two-thirds of the children. However, a followup evaluation 3 years later indicated that approximately one-third of the children were still having considerable difficulties at school and with their peer group. As a result of these findings, two new components—one focusing on parental communication, anger management, and problem-solving skills (ADVANCE) and another that developed child social skills and promoted problem-solving strategies and emotional language (Dinosaur School)—were added. Evaluation indicated these program components enhanced peer relationships, social problem-solving, and marital collaboration. For the past 6

Target Areas

Protective Factors To Increase

Individual

- Child social competence
- Positive interactions with peers
- Social skills

Family

- Nurturing family atmosphere
- Strong parent-child bonds
- Family support
- Parenting skills

School

- Cooperation with teachers and peers
- Problem-solving abilities
- Academic success
- Teacher classroom management

Peer

- Positive peer play

Community

- Community support
- Positive networks with other families
- Increased community involvement with school

Risk Factors To Decrease

Individual

- Problems with aggressive behavior
- Harsh, critical parenting behaviors
- Corporal punishment

Family

- Rejecting, unsupportive family atmosphere
- Poor parent-child bonds

School

- Negative classroom atmosphere
- Poor classroom management
- Child aggression at school
- Overly critical teacher behaviors

Peer

- Peer rejection
- Aggression toward peers

years, a teacher-training curriculum, designed to teach positive classroom management skills, also has been under evaluation and found to significantly enhance the effectiveness of parent training.

EVALUATION DESIGN

All three program components have been extensively evaluated in randomized control group studies with children diagnosed with ODD/CD. Program evaluations have included home and school observations by unbiased evaluators and teacher and parent reports on standardized measures. These findings have been replicated in four randomized studies by independent investigators with different ethnic populations and age groups in the United States, Canada, and the United Kingdom.

In the past decade, these programs have been adapted for use as prevention programs and have been evaluated with Head Start families with preschoolers and with toddlers and teachers in day care facilities. Two randomized control group studies have proven the effectiveness of the parent and teacher interventions in Head Start programs. Currently, the classroom-based Dinosaur Curriculum is being evaluated in kindergarten and first grade.

PROGRAM DEVELOPER

Carolyn Webster-Stratton, Ph.D.

Dr. Webster-Stratton, professor and director of the Parenting Clinic at the University of Washington, developed and produced The Incredible Years. Her mission is to develop cost-effective interventions to prevent and treat conduct problems in young children that can be widely disseminated. Dr. Webster-Stratton's programs have been extensively researched over the past 20 years in a series of studies funded by the National Institute for Nursing Research, Head Start Partnerships Grants, and various agencies of the U.S. Department of Health and Human Services, including the National Institute of Mental Health, the National Institute on Drug Abuse, and the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention.

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RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Model Program—Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice

U.S. Leila Rowland National Mental Health Award

Keep A Clear Mind

Keep A Clear Mind (KACM) is a take-home drug education program for upper-elementary-school students (8 to 12 years old) and their parents. The take-home material consists of four weekly sets of activities to be completed by parents and their children together. The program also uses parent newsletters and incentives.

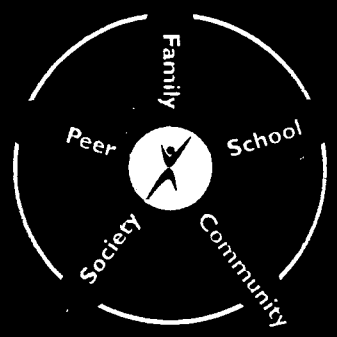
KACM lessons are based on a social skills training model and designed to help children develop specific skills to refuse and avoid the use of "gateway" drugs. This unique, early intervention program has been shown to positively influence known risk factors for later substance use.

TARGET POPULATION

KACM is designed for upper-elementary-school students and their families. The program has been rigorously evaluated in field tests involving students in grades four through six and their parents.

BENEFITS

- Increases student ability to resist peer pressure to use tobacco, alcohol, and marijuana
- Increases student recognition of the harmful effects of tobacco, alcohol, and marijuana
- Helps students identify and choose positive alternatives to substance use
- Decreases students' actual use of tobacco, alcohol, and marijuana
- Helps parents become effective drug educators
- Increases parent-child communication about substance use



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Proven Results*

As a result of participation, students were:

- Less likely to expect to use cigarettes or snuff
- More likely to indicate an increased confidence in their ability to resist pressure to use tobacco
- More likely to have changed their view of peer use of tobacco, alcohol, and marijuana (i.e., they viewed use as less common)
- More likely to realize the harmful effects of tobacco

*Compared to students not in the program.

INTERVENTION

Universal

Selective

Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

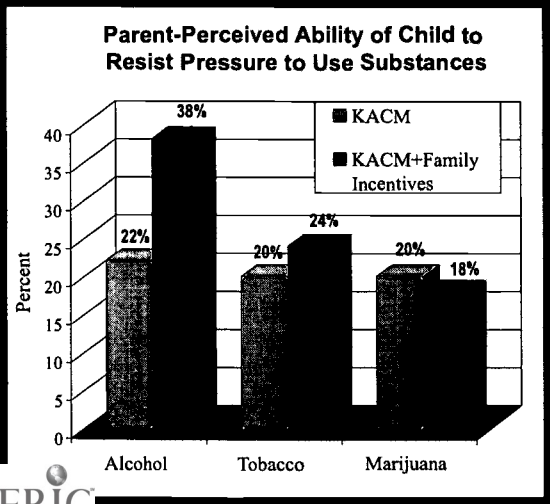
OUTCOMES

Findings generated from the evaluation of KACM activities have considerable scientific and programmatic significance for substance use prevention in youth. Outcomes reported by parents who participated in the program (compared to those in the control group) include:

- 20% more parents indicated that their children had an increased ability to resist peer pressure to use alcohol, tobacco, and marijuana
- 29% more parents indicated a decreased expectation that their children would try substances
- 14% more parents expressed a more realistic view of drug use among young people and a greater realization of its effects

Outcomes reported by children who participated show a:

- 9% decrease in the KACM students' perceptions of extensive substance use among peers compared to an 18% increase in the control group's perception
- 15% decrease in KACM participants' expectations that they would use tobacco, compared to more than a 100% increase in the control group
- 59% increase in the number of children who indicated that their parents did not approve of the use of marijuana



HOW IT WORKS

KACM consists of:

- Four take-home lessons on tobacco, alcohol, marijuana, and drug refusal
- Five parent newsletters
- Student incentives

Four weekly lessons are sent home with the student, preferably on Monday. Lessons include a feedback sheet for parents to indicate that the lesson for that week has been completed, which is to be returned at the end of each week. Students returning the parent-signed sheet receive a small incentive, such as a KACM bookmark, bumper sticker, or pencil. Students receive these incentives for completing the lesson, not for how well they score. Some schools use additional incentives for scoring well on the lessons. Biweekly parent newsletters are sent home with students for 10 weeks, beginning immediately after completion of the four take-home lessons.

KACM requires a minimal commitment of organizational time, yet it is a cost-effective way to reach parents and enhance parent-child communication about substance use. The program can be easily facilitated by schools, youth organizations, religious groups, and health centers.

IMPLEMENTATION ESSENTIALS

KACM is easy to implement. The program is usually conducted over the course of one semester during a school year or during a similar time period. Successful replication of KACM involves:

- Recruiting fourth, fifth, and/or sixth grade students to participate in the program
- Recruiting a program facilitator (e.g., classroom teacher, counselor, etc.)
- Delivering lessons and newsletters, and monitoring the implementation of take-home lessons
- Conducting pre- and postprogram outcome data collection to measure program effects

Program facilitator training is helpful but is not essential to the delivery of the program. Many schools find that KACM T-shirts are a useful incentive, but they are also not essential. Assistance in analyzing outcome data and developing evaluation reports is available.

PROGRAM BACKGROUND

KACM was developed to provide schools with a program that did not require extensive classroom interventions, created parental involvement, was easy and inexpensive to implement, and addressed known risk factors for substance use. The program is based largely on social-cognitive theory and behavioral self-control theory. Program development was initially funded by the U.S. Department of Education with additional funds coming from the Nancy Reagan Foundation and the Community Care Foundation.

EVALUATION DESIGN

Two published studies have evaluated the effectiveness of the KACM program. The initial study involved 511 fourth, fifth, and sixth grade students and their parents from six schools in northwest Arkansas. Students were blocked according to school and grade level, then assigned randomly by class to either the KACM program or a control group that was placed on a waiting list for the program. Data were collected from students and their parents approximately 2 weeks before and after program implementation.

The second study involved 1,447 fourth, fifth, and sixth grade students and their parents from 18 schools across the State of Arkansas. Six schools were assigned to the basic KACM program. Six additional schools were to receive KACM plus a family incentives program. The remaining six schools were assigned to a control group that was on a waiting list. Pre- and postprogram data were collected from students and parents at all 18 schools. Additional evaluation of the program's results is currently under way.

PROGRAM DEVELOPERS

Chudley Werch, Ph.D., FAAHB
Michael Young, Ph.D., FAAHB

KACM was initially developed at the Health Education Projects Office at the University of Arkansas. Dr. Chudley Werch was the initial developer of the program. Dr. Michael Young has served as the principal investigator on all grants resulting in the development and testing of the KACM intervention.

Target Areas

Protective Factors To Increase

Individual

- Problem-solving skills
- Communication and social skills
- Belief in society's values
- Motivation to pursue positive goals
- Accurate perception of social norms

Family

- High parental expectations
- Clear and consistent parental expectations
- Parental involvement

Society

- Media literacy and resistance to pro-use messages

Risk Factors To Decrease

Individual

- Lack of self-control and peer refusal skills
- Favorable attitudes toward use
- Low self-confidence in ability to refuse alcohol offers

Peer

- Susceptibility to negative peer pressure

Family

- Family attitudes that favor substance use
- Ambiguous, lax, or inconsistent rules regarding use

CONTACT INFORMATION

To obtain KACM materials, training, or research and evaluation information, or for technical assistance, contact:

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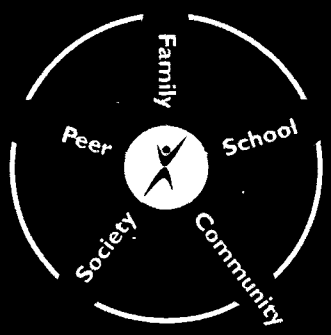
Web site: www.uark.edu/depts/hepoinfo/clear.html

RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Leadership and Resiliency Program

The Leadership and Resiliency Program (LRP) is a school- and community-based program for high school students (14 to 19 years of age) that works to enhance youths' internal strengths and resiliency, while preventing involvement in substance use and violence. Program components include:

- **Resiliency Groups** held at least weekly during the school day
- **Alternative Adventure Activities** that include ropes courses, white water kayaking, camping, and hiking trips
- **Community Service** in which participants are active in a number of community- and school-focused projects

These alternative activities, offered after school, on weekends, and during the summer, focus on community service, altruism, learning about managed risk, social skills improvement, and conflict resolution.

TARGET POPULATION

LRP is a year-round, comprehensive program aimed at youth ages 14 to 19, who have a combination of behavioral issues manifested in high absenteeism and high levels of disciplinary actions, low grades, substance use, and/or violence. School administrators and guidance staff, in cooperation with prevention staff from the collaborating community agency, identify participants; however, some students self-nominate. Students are interviewed to assess their risk and protective factors and the highest risk students are enrolled in the program. Study participants have been from diverse cultural and ethnic backgrounds, and the program is designed for both mainstream and alternative high school populations.

Proven Results

- Significant reduction in school absences over previous years
- Grade point averages increased 0.8 (on a 4.0 point scale)
- Increased sense of school bondin
- Extremely high percentage of participants either become employed or pursue post-secon ary education; 100% graduated

INTERVENTION

Universal

Selective

Indicated

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Substance Abuse and Mental Health Services Administration
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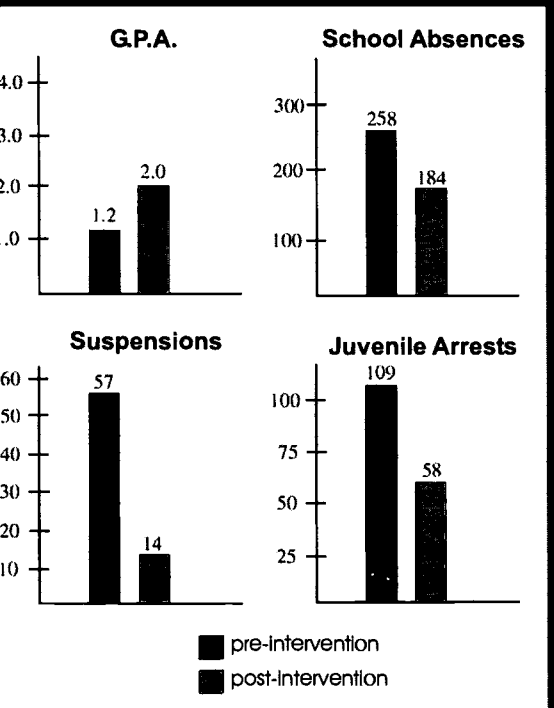
OUTCOMES

Program participants realized:

- An increase of 0.8 in GPA (based on a 4.0 scale)
- A 60% to 70% increase in school attendance
- A 65% to 70% reduction in school behavioral incidents
- 100% graduation rates



BENEFITS

The program is designed to—

- Increase students' perceptions of competence and self-worth
- Improve participant identification with positive roles
- Reduce disciplinary actions in school
- Improve participants' communication and refusal skills
- Increase knowledge of and negative attitudes about substance abuse and violence
- Increase community involvement in promoting the healthy development of youth and the valuing of adolescents

HOW IT WORKS

LRP requires a partnership between a high school and a substance abuse or health service agency. Schools work with agency personnel to identify program candidates and provide different types of support, as needed.

For best results, students should enter the program early in their high school career and participate until graduation. However, students may enter the program in any grade during high school. Participants attend weekly in-school resiliency groups led by a facilitator (i.e., program leader) for the duration of the program. Additional individual or small group followup discussions between the facilitator and students may be held at other times during the week.

LRP students are expected to participate at least weekly in community service activities, which take place after school or on weekends. Core activities include:

- **Animal Rehabilitation**—LRP youth volunteer at a local rescue shelter for abused and neglected animals
- **Community Beautification**—participants clean area streams and plant trees to improve the environment
- **Puppet Project**—participants learn skits on relevant issues, such as family substance abuse and social skills development, and present them to elementary school students

LRP students are required to participate in animal rehabilitation activities at least once a month. Outdoor and adventure activities are also scheduled regularly, and each participant is expected to attend at least five of these trips over the several years they are involved in the program. Longtime LRP students who exhibit increased maturity gain the opportunity to participate in the Puppet Project. Each group is

expected to perform a puppet skit for elementary students at least once during their high school career (and preferably three times or more). The LRP students help to write the skits as well as perform them. All community service and adventure activities are conducted as a group and monitored or supervised by an LRP facilitator.

IMPLEMENTATION ESSENTIALS

Cooperative agreements must be set up between the school where the program will be implemented and the substance abuse treatment or health service provider, as well as with humane foundations (i.e., animal shelters), contractors for outdoor activities, volunteer groups or businesses that can provide space for summer activities, and the elementary schools where the students will deliver their puppet projects. Ongoing communication to coordinate these activities also is needed. In terms of logistics and personnel, the school should commit:

- Dedicated space within the school for group activities
- Access to school records
- A guidance counselor or similar staff member to cofacilitate in-school groups
- Transportation for participants to out-of-school activities

In order to staff the program, schools will need to hire:

- **Program Leaders** who work directly with students and are able to effectively manage a caseload of 50 youth. They also will establish and maintain school partnerships, facilitate group meetings, conduct screenings, and provide crisis interventions.
- **A Program Supervisor/Manager** who will handle project management, data collection, and outcomes analysis. This individual must be an experienced, graduate-level clinician, who has clinical supervision skills; proposal writing and fundraising skills; and the ability to build relationships with youth, systems, and bureaucracies.

Program startup, which includes hiring and training staff—as well as identifying and establishing agreements and partnerships with schools, businesses, and off-site programming—can take up to 4 months. Implementation requires that youth participate in all three program components over the course of 5 months to 1 year for each of the 2 to 4 years they are in the program. (Four years of programming is possible for participants who enter LRP in their freshman year.)

Target Areas

Protective Factors To Increase

Individual

- Empathy
- Optimism
- Social and emotional competence
- Bonding to societal institutions and values
- Positive personal characteristics
- Future orientation

Family

- Identification of values

School

- School bonding and involvement
- High expectations from school personnel

Peer

- Association with healthy, positive peer group
- Peer-refusal skills
- Healthy peer boundaries

Risk Factors To Decrease

Individual

- Favorable attitudes toward substance use
- Conduct problems
- Strong, external locus of control
- High sensation-seeking behaviors
- Emergent mental health concerns

School

- Academic failure
- Poor student morale

Peer

- Substance use in peer group
- Association with delinquent peers
- Negative peer pressure

Training

An initial half-hour phone or E-mail consultation is free. Trainers are available to conduct initial training and can provide additional consultation and technical assistance. Fees are based on current county (Fairfax, VA) consulting rates. Curriculum and instruments will be available at the training. In addition, each locality will need to work with LRP staff to coordinate an alternative activity training site and equipment.

PROGRAM BACKGROUND

LRP is the result of grassroots advocacy for vital youth substance abuse prevention and youth development services. Local faith and community groups believed collaborative, cost-effective, and innovative programming was the best way to engage youth in positive activities and thus prevent substance use. These groups turned to Fairfax County (VA) Alcohol and Drug Services (ADS) with their ideas. ADS prepared a successful grant proposal that funded the development of LRP.

The Washington-Baltimore HIDTA (High Intensity Drug Trafficking Area) of the White House Office of National Drug Control Policy funded ADS to run LRP as a 3-year regional demonstration project. The University of Maryland provided research oversight. LRP continues to be funded and operated by the Fairfax-Falls Church Community Services Board, a Fairfax County, Virginia agency, in cooperation with Fairfax County Public Schools.

EVALUATION DESIGN

Pretest and posttest data were collected during the school year using the Gang Resistance and Education Training instrument developed for LRP. School records were used to track attendance, behavioral reports, and grade point averages. Anecdotal data were collected from youth, school personnel, parents, and press reports. (For details, see *Outcomes* section.)

PROGRAM DEVELOPER

The Leadership and Resiliency Program was developed by Amrit Daryanani with support from Alcohol and Drug Services in collaboration with the Fairfax County Public Schools. Alcohol and Drug Services of the Fairfax-Falls Church Community Services Board is an agency of the Fairfax County Government, serving the county of Fairfax (VA) and the cities of Fairfax and Falls Church with comprehensive mental health, substance abuse, and mental retardation services.

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RECOGNITION

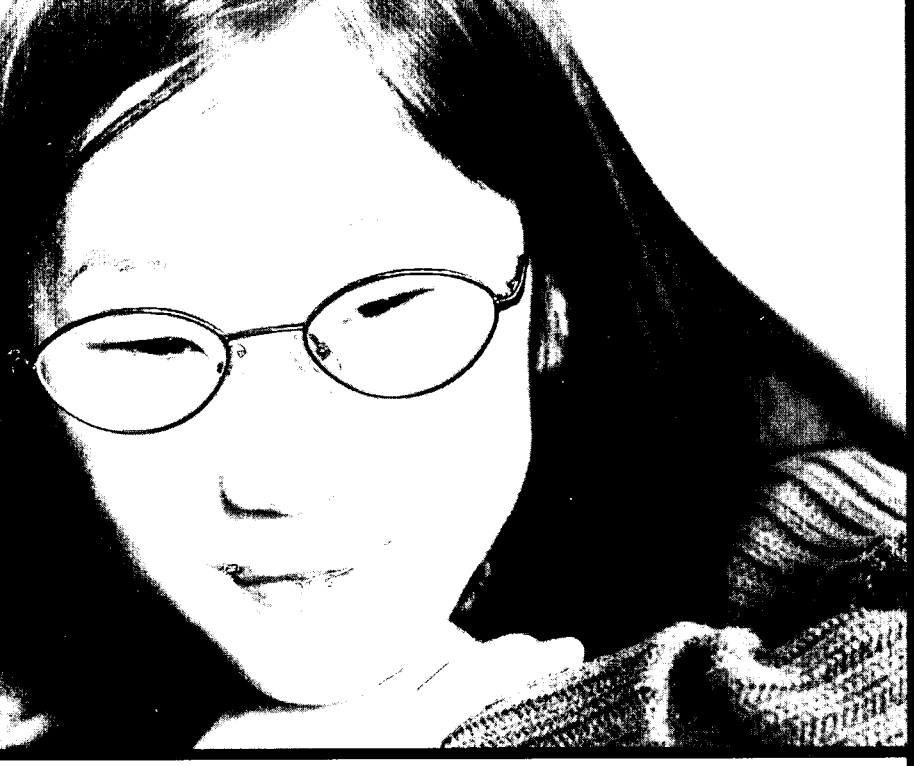
Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Best Practices in Science-Based Programming—Washington Metropolitan Council of Governments

Achievement Award—National Association of Counties

Governor's Recognition—Commonwealth of Virginia

Certificate of Recognition—Fairfax County (VA) Board of Supervisors



LifeSkills™ Training

LifeSkills Training is a program that seeks to influence major social and psychological factors that promote the initiation and early use of substances. *LifeSkills* has distinct elementary (8 to 11 years old) and middle school (11 to 14 years old) curricula that are delivered in a series of classroom sessions over 3 years. The sessions use lecture, discussion, coaching, and practice to enhance students' self-esteem, feelings of self-efficacy, ability to make decisions, and ability to resist peer and media pressure.

LifeSkills consists of three major components that address critical domains found to promote substance use. Research has shown that students who develop skills in these three domains are far less likely to engage in a wide range of high-risk behaviors. The three components each focus on a different set of skills:

- **Drug Resistance Skills** enable young people to recognize and challenge common misconceptions about substance use, as well as deal with peer and media pressure to engage in substance use.
- **Personal Self-Management Skills** help students to examine their self-image and its effects on behavior, set goals and keep track of personal progress, identify everyday decisions and how they may be influenced by others, analyze problem situations, and consider the consequences of alternative solutions before making decisions.
- **General Social Skills** give students the necessary skills to overcome shyness, communicate effectively and avoid misunderstandings, use

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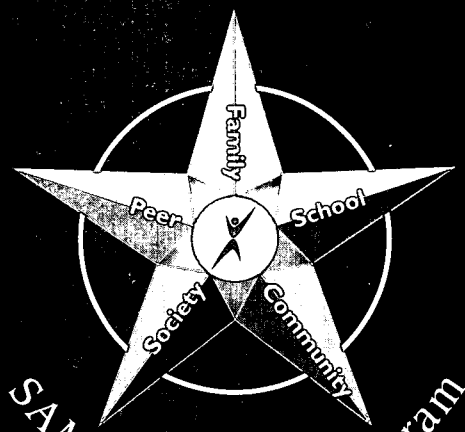


Effective Substance Abuse and Mental Health Programs for Every Community

Proven Results*

These effects have been observed up to 6 years after the intervention:

- Alcohol, tobacco, and marijuana use cut 50% to 75%
- Multiple drug use decreased up to 66%
- Pack-a-day smoking reduced by 25%
- Decreased use of inhalants, narcotics, and hallucinogens

*Outcomes relative to controls.

INTERVENTION

Universal

Selective

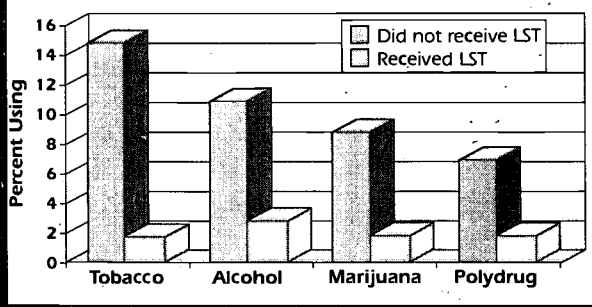
Indicated

OUTCOMES

The outcomes relative to controls included the following:

- Reduced initiation of cigarette smoking by 75% and 3 months after program completion by 67%
- Reduced alcohol use by 54%, heavy drinking by 73%, and drinking to intoxication one or more times a week by 79%
- Reduced marijuana use by 71% and weekly or more frequent use by 83%
- Reduced multiple drug use by 66%
- Reduced both long-term and short-term substance abuse
- Reduced pack-a-day smoking by 25%
- Decreased use of inhalants, narcotics, and hallucinogens by up to 50%

Followup Results from 4 Published Studies
(8th grade drug use and 12th grade polydrug use)



both verbal and nonverbal assertiveness skills to make or refuse requests, and recognize that they have choices other than aggression or passivity when faced with tough situations.

TARGET POPULATION

LifeSkills targets individuals who have not yet initiated substance use. It is designed to prevent the early stages of substance use by influencing risk factors associated with substance abuse, particularly occasional or experimental use. The program has been tested in urban and suburban schools with White, African American, Hispanic/Latino, and Asian American students in grades 7 through 12 (11 to 18 years old). An elementary school version of *LifeSkills* has been tested with students in grades three to five (8 to 11 years old).

BENEFITS

- Develops resistance to peer and media pressure to use substances
- Develops a positive self-image
- Develops decisionmaking and problem-solving skills
- Helps youth manage anxiety
- Fosters effective communication
- Builds healthy relationships
- Increases youths' self-confidence in social situations

HOW IT WORKS

The *LifeSkills Training* curriculum for middle (or junior high) schools is intended to run for fifteen 45-minute class periods. A booster intervention has been developed that is taught over 10 class periods in the second year and 5 in the third year. This means the initial program should be implemented with sixth or seventh grade students, followed by booster sessions during the next 2 years. Optional violence prevention units can be implemented for each year of the program, extending the overall number of class sessions.

The *LifeSkills Training* elementary school curriculum runs for 24 class sessions, each 30 to 45 minutes long, to be conducted over 3 years. The first year (i.e., Level 1) is composed of eight class sessions and covers all skill areas. The remaining booster sessions are divided into eight class sessions for Level 2 and eight for Level 3. The booster sessions provide additional skill development and opportunities to practice in key areas. Level 1 is designed for either grade three or four, depending on when the transition from elementary to middle school begins.

Both the elementary and middle school programs can either be taught intensively (consecutively every day or two to three times a week) until the program is complete, or they can be taught on a more extended schedule (once a week). Both formats have proven to be equally effective.

IMPLEMENTATION ESSENTIALS

LifeSkills is a completely self-contained prevention curriculum. To implement the program, in addition to a *LifeSkills*-trained provider (teacher, counselor, or health professional), all that is required is a curriculum set consisting of a *Teacher's Manual, Student Guide,* and relaxation tape.

Provider training is available for individuals interested in conducting the *LifeSkills* program. All training is conducted by qualified trainers who are certified by National Health Promotion Associates, Inc. The provider training workshop is designed to—

- Teach the background, theory, and rationale for *LifeSkills*
- Familiarize participants with the program
- Teach participants the skills needed to conduct *LifeSkills*
- Provide an opportunity to practice teaching selected portions of the program
- Discuss practical implementation issues

PROGRAM BACKGROUND

Beginning in the 1980s, a series of evaluation studies have been conducted to test the effectiveness of substance abuse prevention approaches based on the *LifeSkills* model. These studies have helped facilitate the development of a prevention approach that is effective with different problem behaviors when implemented by different types of providers, and with different populations.

The focus of the early research was on cigarette smoking and involved predominantly White, middle-class populations. More recent research extended this work to other problem behaviors including substance use. In addition, this research has increasingly focused on the utility of this approach when used with inner-city, minority populations. Finally, this research has assessed the long-term durability of the *LifeSkills Training* prevention model, its impact on hypothesized mediating variables, and the importance of high-fidelity implementation.

Target Areas

Protective Factors To Increase

Individual

- Social development, self-esteem, self-discipline
- Communication skills
- Decisionmaking skills
- Problem-solving skills
- Social skills
- Assertiveness and refusal skills
- Stress and anxiety management
- Goal setting, self-monitoring, self-reinforcement

Family

- Effective communication with parents and other family members

Peer

- Resistance to negative peer pressure
- Social skills

School

- Academic success
- Goal setting

Risk Factors To Decrease

Individual

- First confrontation with illegal substances, tobacco, and alcohol
- Lack of self-control and assertiveness

Peer

- Prodrug influences

EVALUATION DESIGN

Over the past 20 years, a dozen evaluation studies of *LifeSkills Training* have been conducted. Among these are:

- A randomized study that tested the effectiveness of peer leaders as providers of *LifeSkills Training*. The number of new smokers in the group that received training with the peer leader was compared with a control group. Results were corroborated by a saliva thiocyanate (SCN) analysis, where an increase in SCN levels is indicative of increased smoking.
- A randomized study that compared alcohol use over the past month and degree of use by students who received *LifeSkills Training* with use rates reported by a control group.
- The National Institute on Drug Abuse (NIDA), National Institutes of Health, U.S. Department of Health and Human Services funded a study of approximately 1,200 seventh grade students (from predominantly White, middle-class families) in 10 suburban New York junior high schools. The study compared the proportion of students reporting marijuana use in the peer-led *LifeSkills* group and a group of students who received *LifeSkills* booster sessions with the rates reported in the control group.
- NIDA also funded a randomized study involving nearly 6,000 students from 56 middle schools. Students received the program in the seventh through ninth grades and followup data were collected at the end of the twelfth grade.

PROGRAM DEVELOPER

Gilbert J. Botvin, Ph.D.

Dr. Gilbert J. Botvin, an internationally known expert on drug abuse prevention, developed the *LifeSkills* program. For the past 20 years, Dr. Botvin has been a full-time faculty member of Weill Medical College at Cornell University, and he currently serves as a professor in both the Department of Public Health and the Department of Psychiatry. Dr. Botvin is also director of Cornell's Institute for Prevention Research. His groundbreaking work in the area of substance abuse prevention has received national and international attention. Most recently (1998), he received the Society of Prevention Research's Presidential Award for prevention research excellence. Dr. Botvin is founding editor of the scientific journal *Prevention Science*, and president of the Society for Prevention Research.

CONTACT INFORMATION

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RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Programs That Work—Centers for Disease Control and Prevention, U.S. Department of Health and Human Services

Model Program—Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice

Model Program—White House Office of National Drug Control Policy

Exemplary Program—U.S. Department of Education

Programs That Work—National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services

Grade "A"—Drug Strategies, Inc.

Multisystemic Therapy

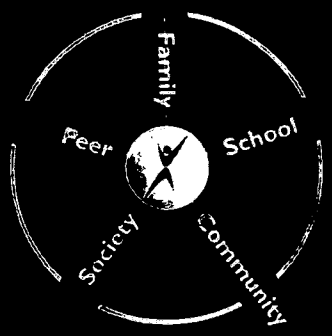
Multisystemic Therapy (MST) is a family-oriented, home-based program that targets chronically violent, substance-abusing juvenile offenders 12 to 17 years old. It uses methods that promote positive social behavior and decrease antisocial behavior—including substance use—to change how youth function in their natural settings (i.e., home, school, and neighborhood). The primary goals of MST are to—

- Reduce youth criminal activity
- Reduce antisocial behavior, including substance abuse
- Achieve these outcomes at a cost savings by decreasing incarceration and out-of-home placement rates

Based on the philosophy that the most effective and ethical route to help youth is through helping their families, MST views parents or guardians as valuable resources, even when they have serious and multiple needs of their own. A "multisystemic" approach, however, views these youth as involved in a network of interconnected systems that encompass individual, family, and extrafamilial (e.g., peer, school, neighborhood) factors, and recognizes that it is often necessary to intervene in more than one of these systems. MST addresses these factors in an individualized, comprehensive, and integrated manner.

TARGET POPULATION

MST targets chronic, violent, or substance-abusing male and female juvenile offenders at risk of out-of-home placement. The "typical" MST youth is 12 to 17 years old, has multiple arrests or an arrest for a violent offense,



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Proven Results*

- Decreased adolescent substance use
- Decreased adolescent psychiatric symptoms
- Reduced long-term rearrest rates 25% to 70%
- Reduced long-term out-of-home placement 47% to 64%
- Improved family relations and functioning
- Increased mainstream school attendance
- Considerable cost savings over other social services (up to $131,000 per youth)

**In comparison with control groups in eight randomized research projects.*

INTERVENTION

Universal

Selective

Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
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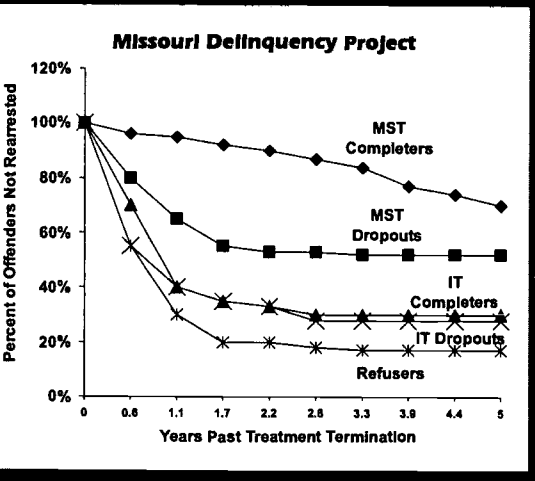
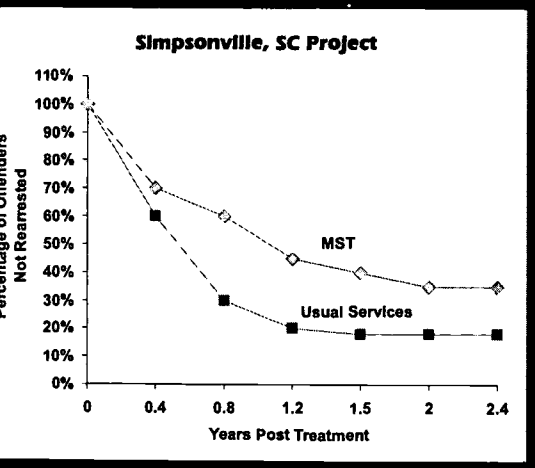
OUTCOMES

MST has proven effective in reducing substance use and antisocial behavior among diverse populations of serious and chronic juvenile offenders. Follow-up studies with youth and families 2 and 4 years after completing the program supported the long-term effectiveness of MST. In addition, despite its intensity, MST was a relatively inexpensive intervention. With a small client-to-therapist ratio (4:1) and a course of treatment lasting 3 to 5 months, the cost per client for treatment in the MST group was about one-fifth the average cost of an institutional placement. A recent study by the Washington State Institute for Public Policy estimated savings of $31,000 to $131,000 for each youth served in MST (based on MST preventing a subsequent incident requiring social or judicial services).





is deeply involved with delinquent peers, has problems at school or does not attend, abuses multiple drugs (e.g., marijuana, alcohol, and cocaine), and lives in a single-parent household that has multiple needs and problems. MST is equally effective with families who have different strengths and weaknesses and who come from a range of socioeconomic and ethnic backgrounds.

BENEFITS

MST youth:

- Were significantly less likely to use substances
- Had fewer arrests for all types of offenses
- Spent less time in out-of-home placements
- Engaged in less aggression with peers
- Were less likely to be involved in criminal activity

HOW IT WORKS

MST typically uses a home-based model of service delivery to reduce barriers that keep families from accessing services. Therapists have small caseloads of four to six families; work as a team; are available 24 hours a day, 7 days a week; and provide services at times convenient to the family. The average treatment involves about 60 hours of contact during a 4-month period.

MST therapists focus on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g., extended family, neighbors, friends, faith community members) and removing barriers (e.g., parental substance abuse, high stress, poor relationships between partners). This family-therapist collaboration allows the family to take the lead in setting treatment goals while the therapist helps them to accomplish their goals.

Once engaged, the parents or guardians collaborate with the therapist on the best strategies to set and enforce curfews and rules; decrease the adolescent's involvement with deviant peers and promote friendships with prosocial peers; improve the adolescent's academic and/or vocational performance; and cope with any criminal subculture that may exist in the neighborhood.

IMPLEMENTATION ESSENTIALS

MST requires:

- Dedicated full-time clinical staff of three to five people, including a supervisor, who work as a clinical "team"
- Staff availability 24 hours a day, 7 days a week
- Small caseloads of four to six families per therapist
- Buy-in from community members and social service agencies (e.g., child welfare, probation, etc.) to allow the MST therapist to take the lead in clinical decisionmaking and treatment planning for the youth and family (and not be kept from achieving positive outcomes because of existing policies and procedures)
- Commitment to MST supervision and training protocols
- Outcome-based discharge criteria (i.e., observable youth behavior change)
- Treatment cycles of 3 to 5 months on average
- Emphasis on knowledgeable, experienced staff (e.g., M.A. in counseling, M.S.W., etc.)

PROGRAM BACKGROUND

The current form of MST is the result of extensive scientific evaluation. To date, eight randomized clinical research trials have been published and, in 2001, more than a dozen additional randomized trials evaluating MST were under way. The strength of these results has led to the program's dissemination throughout the United States and around the world. MST is currently used in over 25 States, Canada, England, Ireland, New Zealand, Norway, and Sweden.

The Family Services Research Center, the MST-focused research group at the Medical University of South Carolina, has supported the dissemination of MST since the early 1990s. In 1996, a university-affiliated organization, MST Services, was formed to help communities establish MST programs.

EVALUATION DESIGN

The effectiveness of MST has been supported by several controlled, random-assignment evaluations. In these studies, youth were randomly assigned to either MST or a control group receiving other services. (For details, see *Outcomes* section.)

Target Areas

Protective Factors To Increase

Individual

- Youth coping strategies (e.g., social skills, personal hygiene skills, impulse control, etc.)

Peer

- Association with positive peers
- Involvement in prosocial activities

Family

- Positive family relations and functioning
- Parental monitoring
- Rule setting and positive rewards in the home
- Family engagement with neighbors and access to community resources
- Planned between-family monitoring of youth group activities

School

- Mainstream school attendance and performance
- Youth involvement in school and after-school activities
- Relationship between parental figures and school

Community

- Family awareness of and access to existing community resources

Risk Factors To Decrease

Individual

- Antisocial and criminal behaviors
- Psychiatric symptoms in youth

Peer

- Association with negative peers

Family

- Conflict in the home
- Psychiatric symptoms in caregivers

School

- School failure

PROGRAM DEVELOPER

Scott Henggeler, Ph.D.

MST has been under development for over 25 years under the leadership of Dr. Scott Henggeler, director of the Family Services Research Center (FSRC) at the Medical University of South Carolina. The mission of the FSRC is to develop clinically effective and cost-effective treatments for youth with serious behavioral problems. The center has approximately 50 staff and over $15 million of committed Federal research funding over the next 5 years.

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RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Model Program—Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice

Effective Program—U.S. Surgeon General's Report on Mental Health and Youth Violence

Families Count Award—Annie E. Casey Foundation

SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Nurse-Family Partnership Program

The Nurse-Family Partnership (NFP) program provides first-time, low-income mothers of any age with home visitation services from public health nurses. NFP nurses work intensively with these mothers to improve maternal, prenatal, and early childhood health and well-being, with the expectation that this intervention will help achieve long-term improvements in the lives of these at-risk families. The intervention process is effective because it focuses on developing therapeutic relationships with the family and is designed to improve five broad domains of family functioning:

- Health (physical and mental)
- Home and neighborhood environment
- Family and friend support
- Parental roles
- Major life events (e.g., pregnancy planning, education, employment)

Starting with expectant mothers, the program addresses substance abuse and other behaviors that contribute to family poverty, subsequent pregnancies, poor maternal and infant outcomes, suboptimal childcare, and a lack of opportunities for the children.

TARGET POPULATION

NFP serves first-time mothers with little or no income. Ultimately, their babies and everyone in their supportive environment (e.g., friends, boyfriends, fathers, parents, etc.) are involved in the program, but the primary clients are first-time mothers. Some program sites choose to focus exclusively on teen mothers.

Proven Results

- Improved birth outcomes
- Reduced rates of subsequent pregnancy
- Reduced rates of childhood injury, abuse, and neglect
- Decreased smoking and alcohol use, especially among teenage mothers

INTERVENTION

Universal

Selective

Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

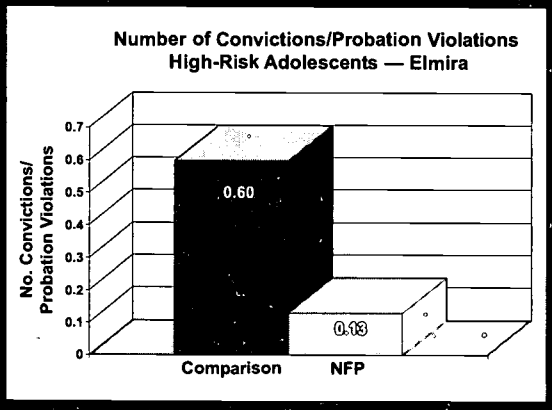
OUTCOMES

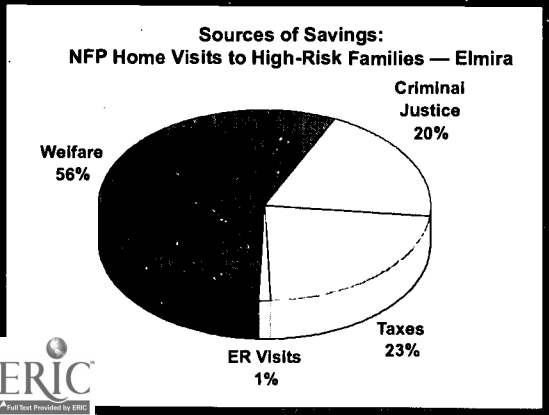
NFP produced consistent benefits for low-income mothers and their children through the child's fourth year in the areas of:

- Mothers' prenatal health (especially in relation to their use of cigarettes)
- Injuries to children
- Rates of subsequent pregnancy
- Use of the social welfare system

A 15-year followup study of the Elmira sample found that the program:

- Reduced child abuse and neglect 79%
- Reduced maternal behavioral problems due to substance use 44%
- Reduced arrests among the mothers 69%
- Resulted in 54% fewer arrests and 69% fewer convictions among the 15-year-old adolescents
- Resulted in 58% fewer sexual partners among the 15-year-old adolescents
- Reduced cigarette smoking by the 15-year-old adolescents 28%





BENEFITS

- Improved birth outcomes through the reduction of preterm and low-birth-weight babies
- Improved parenting and the home environment
- Reduced quickly recurring and unintended pregnancies
- Increased participation in the workforce
- Reduced the incidence of conduct disorders, involvement in crime, and delinquency
- Saved $4 for every dollar invested, due to reduced welfare, fewer arrests, and lower health care (especially emergency room) costs

HOW IT WORKS

NFP represents a refined version of the long-established service strategy of home visitation; it achieves results by providing visits from highly trained public health nurses. These visits usually take place in the client's home but can occur at other locations when necessary.

The *Nurse-Family Partnership Home Visit Guidelines* are the primary resource for nurse home visitors working in the program. The guidelines provide the nurse with a consistent structure for each visit and tools to use in working with clients. The guidelines are designed so that the topics and resources are matched to the specific developmental needs of the family and infant/child. The guidelines also instruct and encourage nurses to adapt interventions to each family's unique interests, strengths, and needs.

NFP uses solution-focused tools to help the nurse assess current client attitudes, skills, knowledge, and situational support. These tools also assist the client in achieving personal goals, attaining behavioral changes, and addressing challenges. The tools include activities for the client and her family, which can be done with or without the nurse, designed to help them apply new knowledge and skills.

IMPLEMENTATION ESSENTIALS

The program meets its objectives by addressing several key components that research and experience have shown to be important:

- The program focuses on first-time mothers with little or no income.
- The home visitors are registered nurses.
- Nurses follow program guidelines that focus on the mother's personal health, quality of caregiving for the child, and parents' own development.

- Nurses begin making home visits while the mother is still pregnant (before the 28th week, ideally between the 12th and 20th week) and continue through the first 2 years of the child's life.
- Nurse home visitors employ a visit schedule that follows the developmental stages of pregnancy and early childhood.
- Nurses work with the mother's existing support system, including family members, fathers when appropriate, and friends, to help families access other health and human services they may need.
- Each nurse home visitor carries a caseload of no more than 25 families.
- The organization implementing the program provides a well-prepared half-time nursing supervisor for every four nurse visitors.
- The program is located in and run by an organization known in the community for providing quality services to low-income families.
- Program staff uses the Clinical Information System that has been designed for the model to keep track of family characteristics, needs, services provided, and progress toward accomplishing objectives.

Program Development and Assistance

An application to become a demonstration site is the basis of initial planning for implementation of the NFP model at the local level. Through telephone consultation and one or more site visits, representatives of the National Center for Children, Families and Communities (NCCFC) and the local agency or organization develop a joint assessment of readiness to implement the program. The application ultimately becomes a work plan for the new program sites. New sites are developed to start serving 100 families using 4 nurse home visitors, a half-time nurse supervisor, and a half-time administrative support person.

Program Fidelity

Program demonstration sites must agree in writing to implement the program with fidelity to its essential components. In return, they receive training, technical assistance, and support for the assessment-focused Clinical Information System from NCCFC.

PROGRAM BACKGROUND

NFP was originally started as a research study in Elmira, NY, in the late 1970s. Because of the encouraging findings, the Office of Juvenile Justice and Delinquency Prevention of the U.S. Department of Justice made NFP part of their "Weed and Seed" initiative, funding the program in six demonstration cities. In 1999, NCCFC was established to disseminate the program nationwide. Currently, NFP programs operate in 22 States.

Target Areas

Protective Factors To Increase

Individual

- Good parenting skills
- Knowledge of substance use effects on pregnancy
- Knowledge of proper prenatal care
- Knowledge of child development

Family

- Support for using needed services
- Involvement of father and/or other family members

Risk Factors To Decrease

Individual

- Unemployment or low levels of income
- Conduct disorders
- Criminal involvement or delinquency
- Positive attitude toward substance use
- Lack of parenting skills
- Early onset of sexual activity and multiple sexual partners
- Single and/or teenage mothers

Family

- Abuse or violence

EVALUATION DESIGN

A major evaluation of NFP was conducted in three large scientifically controlled studies—first in Elmira, NY, then in Memphis, TN, and most recently in Denver, CO. In the studies, pregnant women were randomly assigned either to the NFP program or a control group that received other services, then their children's progress toward the program's goals was assessed over time (i.e., through adolescence). The studies were designed to determine whether the provision of prenatal and infancy home visits improves maternal, child, and family health and well-being as children mature.

PROGRAM DEVELOPER

David Olds, Ph.D.

The Nurse-Family Partnership was originally developed and tested by Dr. David Olds and his colleagues from Rochester, NY. Currently, Dr. Olds is a member of the faculty at the University of Colorado Department of Pediatrics and works closely with the national dissemination effort, conducted through NCCFC, an interdisciplinary program based at the University of Colorado Health Sciences Center. Bridging the university's School of Medicine and School of Nursing, NCCFC is devoted to research, development, and replication of programs in local communities that improve the lives of children and families who live there.

NCCFC is currently directed by Dr. Patricia Moritz, associate professor of Nursing and associate dean for Research in the University of Colorado Health Sciences Center's School of Nursing, and has a staff of nearly 40 full- and part-time employees.

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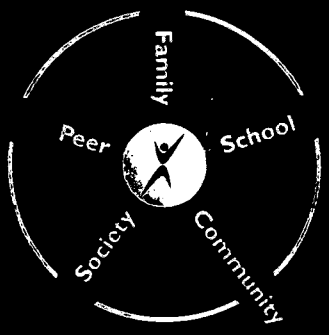
RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Model Program—Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

The Olweus Bullying Prevention Program

The Olweus Bullying Prevention Program is a multilevel, multicomponent school-based program designed to prevent or reduce bullying in elementary, middle, and junior high schools (students 6 to 15 years old). The program attempts to restructure the existing school environment to reduce opportunities and rewards for bullying. School staff is largely responsible for introducing and implementing the program. Their efforts are directed toward improving peer relations and making the school a safe and positive place for students to learn and develop.

While intervention against bullying is particularly important to reduce the suffering of the victims, it is also highly desirable to counteract these tendencies for the sake of the aggressive student, as bullies are much more likely than other students to expand their antisocial behaviors. Research shows that reducing aggressive, antisocial behavior may also reduce substance use and abuse.

TARGET POPULATION

The Olweus Bullying Prevention Program targets students in elementary, middle, and junior high schools. All students participate in most aspects of the program, while students identified as bullying others or as targets of bullying receive additional individual interventions.

BENEFITS

- Reduces existing bullying/victim problems
- Prevents development of new cases of bullying
- Improves peer relations at the school

Proven Results

- A 30% to 70% reduction in student reports of being bullied and bullying others; results are largely parallel with peer ratings and teacher ratings
- Significant reductions in student reports of general antisocial behavior (e.g., vandalism, fighting, theft, and truancy)
- Significant improvements in classroom order and discipline
- More positive attitude toward schoolwork and school

INTERVENTION

Universal

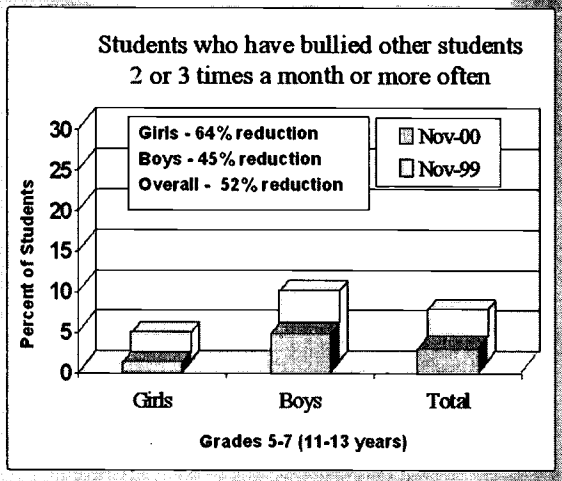
Selective

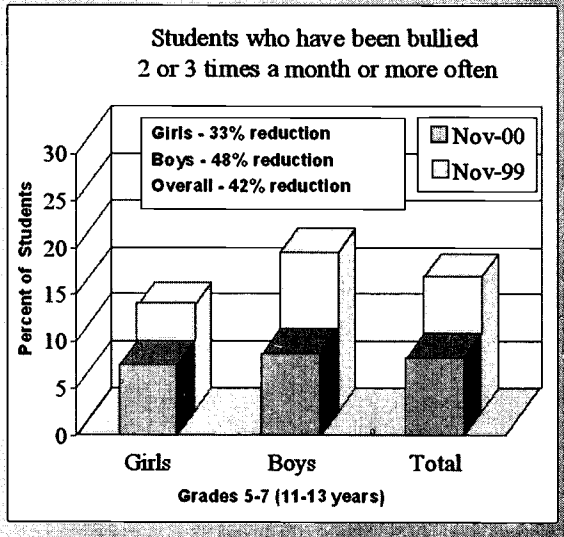
Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

Some key results are reported under the heading Proven Results. Two graphs from the last evaluation of 10 schools in Oslo, Norway, are presented below. The reductions in bully/victim problems varied between 33 and 64 percent for the various subgroups (girls and boys 11 to 13 years old in grades five to seven).





HOW IT WORKS

The Olweus Bullying Prevention Program works with interventions at three levels:

Schoolwide Interventions

- Administration of the Olweus Bully/Victim Questionnaire about bullying (filled out anonymously by the students)
- Formation of a Bullying Prevention Coordinating Committee
- Staff training
- Development of schoolwide rules against bullying
- Development of a coordinated system of supervision during break periods

Classroom-level Interventions

- Regular classroom meetings about bullying and peer relations
- Class parent meetings

Individual-level Interventions

- Individual meetings with children who bully
- Individual meetings with children who are targets of bullying
- Meetings with parents of children involved

IMPLEMENTATION ESSENTIALS

Implementation of the Olweus Bullying Prevention Program requires significant and ongoing commitment from school administrators, teachers, and other staff. A first step is to establish a Bullying Prevention Coordinating Committee composed of administrators, teachers, students, parents, and the program's onsite coordinator.

Training

All school staff participate in a half- to 1-day training session. In addition, teachers are expected to—

- Thoroughly read the *Teacher Handbook: Olweus' Core Program Against Bullying and Antisocial Behavior* and the book *Bullying at School: What We Know and What We Can Do.*
- Hold weekly 20- to 40-minute classroom meetings.
- Participate in regular Teacher Discussion Groups during the first year of the program.

Additionally, school personnel on the Bullying Prevention Coordinating Committee—

- Participate in a 1.5-day training with a certified trainer.
- Attend 1- to 2-hour monthly meetings.

Program Management and Timing

Depending on the school's size, a program will require a part- or full-time onsite coordinator. The optimal approach to program implementation involves selecting the onsite coordinator and administering the questionnaire survey in the spring; training staff in August, before school opens; and holding a schoolwide kickoff at the beginning of the fall semester.

Technical Assistance

Technical assistance is available for interested schools, including followup telephone consultation provided to the onsite coordinator every 3 to 4 weeks during the first year of implementation.

Program Resources

It is required that each teacher have a copy of the *Teacher Handbook* and *Bullying at School.* Other required materials include the Olweus Bully/Victim Questionnaire and accompanying PC software for processing and evaluating student responses. One videotape and accompanying guidebook, appropriate for grades three through eight, should be purchased for every six classrooms. Supplemental lesson plans may also be purchased.

PROGRAM BACKGROUND

In 1983, after three adolescent boys in northern Norway committed suicide, most likely as a consequence of severe bullying by peers, the country's Ministry of Education commissioned Professor Dan Olweus to conduct a large-scale research and intervention project on bully/victim problems. The resulting Olweus Bullying Prevention Program, developed at the University of Bergen in Norway, has been refined, expanded, and evaluated with positive results in two new large-scale projects in Norway. As part of the Norwegian Government's plans for the prevention of delinquency and violence among children and youth, the Olweus Program is now being implemented on a large-scale basis all over Norway. The program has also been successfully implemented in other countries, including the United States, the United Kingdom, and Germany. During the 1990s, Professor Olweus worked closely with a number of colleagues in the United States, notably Dr. Sue Limber and Dr. Gary Melton at Clemson University in South Carolina, to implement and evaluate the program in the United States.

EVALUATION DESIGN

Two different types of evaluation designs have been used to assess the program. In several evaluations, what is often called an "age-cohort design" with time-lagged contrasts between adjacent but age-equivalent cohorts was used. One of the strengths of this quasi-experimental design is that several of the cohorts serve both as intervention and control/baseline groups (in different comparisons). Also, in one evaluation project, a traditional control group design was used.

Target Areas

Risk Factors To Decrease

Individual

- Impulsive, hot-headed, dominant personality
- Lack of empathy
- Difficulty conforming to rules
- Low frustration for tolerance
- Positive attitudes toward violence
- Physical strength (boys)
- Gradually decreasing interest in school

Peer

- Friends/peers with positive attitudes toward violence

Family

- Lack of parental warmth and involvement
- Overly permissive parenting
- Harsh discipline/physical punishment
- Lack of parental supervision

School

- Indifferent or accepting teacher attitudes toward bullying
- Indifferent or accepting student attitudes toward bullying

PROGRAM DEVELOPER

Dan Olweus, Ph.D.

For almost 30 years, Professor Dan Olweus has been involved in research and intervention in the area of bullying among school children and youth. In 1970, he started a large-scale research project, now generally regarded as the world's first scientific study of bully/victim problems. In the 1980s, he began the first systematic study of bullying intervention and documented the positive effects of this program. During the late 1990s, Professor Olweus and his research and intervention group at the University of Bergen conducted several new large-scale intervention projects using a somewhat different study design, again gaining good results. Professor Olweus has been named "the world's leading authority" on bully/victim problems by *The Times* newspaper of London. His book, *Bullying at School: What We Know and What We Can Do*, has been published in 15 languages.

CONTACT INFORMATION

To locate and order program resources, visit:
http://virtual.clemson.edu/groups/ncrj/pdfs/bullying_fact_sheet2.pdf

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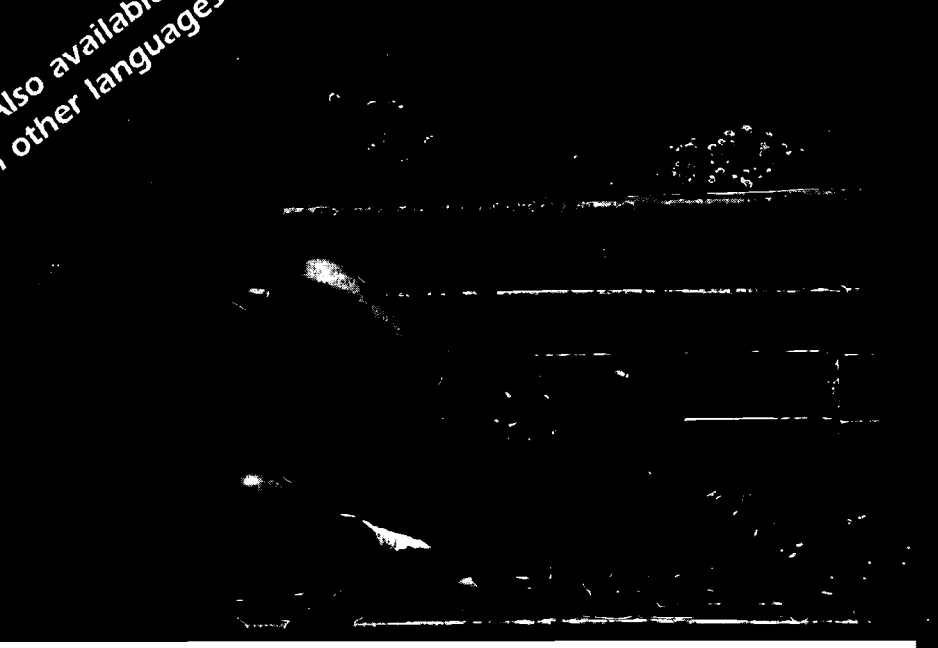
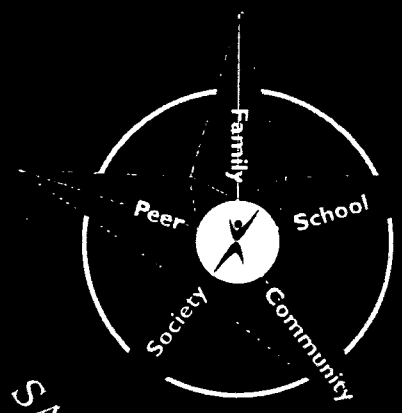
RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Model Program—Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice





SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Positive Action

The Positive Action (PA) program is an integrated, comprehensive, and coherent program that has been shown to improve the academic achievement and multiple behaviors of children and adolescents (5 to 18 years old) and their parents and teachers. It is intensive, with lessons at each grade level (kindergarten to 12th) that are reinforced all day by including school, family, and community components, which work together or can stand alone.

For **students**, Positive Action improves:

- Individual self-concept
- Academic achievement and learning skills
- Decisionmaking, problem-solving, and social/interpersonal skills
- Physical and mental health
- Behavior, character, and responsibility

PA improves **school climate**, attendance, achievement scores, disciplinary referrals/suspensions, parent and community involvement, services for special-need and high-risk students, efficiency, and effectiveness. PA positively affects instruction and classroom/school management skills of **school personnel** through improved self-concept, professionalism, and interpersonal/social skills and, in turn, has a positive impact on their personal lives.

Finally, PA helps **families** by improving parent-child relations and overall family attitudes toward and involvement in school and the community.

Proven Results

- Violence and substance use reduced 26% to 56%
- Academic achievement improved 12% to 65%
- General discipline improved by 23% to 90%
- Absenteeism decreased between 6% and 45%
- Truancy decreased by 14% to 20%
- Suspensions reduced 8% to 81%
- Self-concept improved up to 43%

INTERVENTION

Universal

Selective

Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

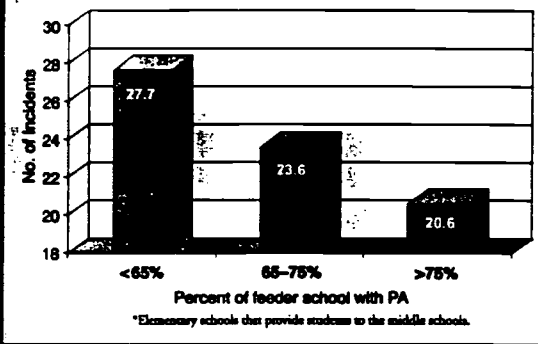
Data from a study that used a matched case-control design found that, compared to the control group, a large Nevada school district that used PA:

- Reported 85% fewer violent incidents per 1,000 students
- Scored 16% higher in their fourth grade achievement scores

Similar matched case-control data from Hawaii found that, compared to a control group, PA schools reported:

- 52% better SAT scores
- 76% fewer disciplinary problems
- 7.5% lower daily absenteeism

Effects of Positive Action feeder* schools on middle school substance-related incidents



*Elementary schools that provide students to the middle schools.

In a large Florida school district, middle schools with a high percentage of students coming from PA elementary schools reported:

- 15% fewer incidents of substance abuse (see figure)
- 20% more students scoring above the median on standardized eighth grade reading and math tests
- 21% fewer violence-related incidents
- 8% fewer suspensions from school, with the effects being larger for high-minority schools

Overall, there was a strong dose-response relationship, with stronger effects occurring in middle schools that had greater numbers graduate from PA grade schools.

TARGET POPULATION

PA involves all members of a school community: students, faculty, support staff, administrators, student family members, and people who live in the community surrounding the school. It is effective in urban, suburban, and rural areas and with all ethnic and cultural groups as well as with special-needs students.

PA is primarily implemented in grades K to 12, in before- and after-school programs, within Evenstart and Head Start programs, and during extracurricular, family, and community activities. It may be implemented in whatever environment best suits the intervention including social service agencies, businesses, criminal justice agencies, faith institutions, and mental health service agencies.

BENEFITS

- Develops healthy, self-motivated children who avoid harmful behaviors and substances
- Develops educators who are professional, caring, and competent
- Develops parents who are involved with their children's education and school, and who teach and reinforce program goals at home
- Offers students a quality after-school program
- Motivates community activists to link their community groups to local schools

HOW IT WORKS

Ideally, a PA school implements the program schoolwide and reinforces positive actions throughout the day. The principal, a PA Coordinator, and PA Committee guide the program. Classroom teachers teach the curriculum, using a grade-appropriate kit containing prepared materials and a manual with lesson plans. Counselor and special education materials are included.

Parents receive a *Family Kit* that contains lessons and materials that correlate to the school program and supports parenting classes. The *Community Kit* is used to organize a steering committee that guides community partners to develop and coordinate positive community initiatives and activities.

PA offers an implementation plan, with an interactive Web site, to achieve implementation fidelity, and a program evaluation plan that schools are strongly encouraged to use.

IMPLEMENTATION ESSENTIALS

First and foremost, the PA program requires willing faculty, administrative staff, parents, community members, and, most important, a principal who will provide primary leadership. Key staff includes:

- **Positive Action Committee**—This group is composed of a teacher from every grade level, the principal or designee, a support staff representative, several parents, community members, and students. They oversee program implementation.
- **Positive Action Coordinator**—This person may be the principal or designee and is responsible for coordinating the Positive Action Committee and monitors day-to-day program activities.
- **Parent Coordinator**—A member of the Positive Action Committee, this individual provides information to parents and assists with parenting classes.
- **Community Coordinator**—Coordinates the community steering committee and plans activities.

Training and Materials

Schools implementing the PA program will need a *Principal's Kit* for the school-climate program; a grade-level *Teacher's Kit* for each classroom, special education class, and after-school program; a *Counselor's Kit; Family Kits* for parents; a *Community Kit*; and an implementation plan. The Parent and Positive Action Coordinators, adult members of the Coordinating Committee, and all teachers should participate in .5 to 2 days of training. One trainer can train 50 people. Schools need not implement all program components, as each can stand alone.

PROGRAM BACKGROUND

PA was developed in Twin Falls, ID, between 1974 and 1982, at which time the Positive Action Company was founded. The program has been used in more than 7,000 schools nationally and internationally. Development and refinement of the program are ongoing.

PA is based on the intuitive philosophy that "you feel good about yourself when you do positive things." The program aligns schools, parents, and communities in promoting specific positive actions for youth that affect them physically, intellectually, socially, and emotionally.

Target Areas

Protective Factors To Increase

Individual
- Positive personal characteristics (e.g., cooperation, self-concept, self-discipline, motivation to succeed)
- Healthy ethical, social, and emotional development
- Social skills (e.g., communication, problem solving, conflict resolution, positive empathy)
- Positive bonding to social institutions and values, including school
- Commitment to prosocial values

Family
- Bonding and attachment with parents and siblings
- Positive parenting (e.g., avoiding use of criticism, modeling and reinforcing positive behavior and accomplishment)
- Emotionally supportive family (e.g., knowledge of child's friends and their parents, involvement in homework and school activities)
- Frequent positive communication

Peer
- Association with peers who are involved in school
- Association with peers who engage in positive behaviors

School
- Caring and supportive teachers, staff, and school climate
- Environment reinforces positive behavior
- Teacher warmth and positive role modeling

Community
- Student, parent, and school involvement with community

Risk Factors To Decrease

Individual
- Inadequate self-concept, confidence, or social skills
- Problem or unhealthy behaviors
- Susceptibility to peer pressure

Family
- Family disorganization and conflict
- Lack of involvement

Peer
- Delinquent peers

School
- Disorganized, chaotic, lax, or inconsistent rules
- Lack of teacher warmth, positive role modeling, and reinforcement

Community
- Community disorganization
- Easy availability of drugs

EVALUATION DESIGN

From the 1970s through 2001, PA has been researched and evaluated in a wide variety of schools (with high and low minority representation, mobility rates, and/or levels of poverty) by the program's developer, various school districts, and independent evaluators.

Evaluations have used experimental-control group, national comparison group (e.g., evaluating changes in percentile rankings), matched control, pre- and post-case studies, and comparison group study designs.

Data from various comparison group designs involving more than 100 elementary schools that used PA demonstrate the program's consistent positive effects on student behavior (i.e., discipline, suspensions, crime, violence, drug use), performance (i.e., attendance, achievement), and self-concept. Results were often better in more disadvantaged schools.

PROGRAM DEVELOPER

Carol Gerber Allred, Ph.D.

Dr. Carol Gerber Allred was an English and Psychology teacher at Twin Falls High School (Idaho) when she developed the first version of the Positive Action Program. In 1977, she moved to an elementary school to develop the elementary component. The Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice, and the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, provided 5 years of funding for the development and multiple independent evaluations of the program. In 1982, Dr. Allred founded the Positive Action Company (now Positive Action, Inc.) and has continued to develop and expand the program.

CONTACT INFORMATION

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RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Promising Program—U.S. Department of Education

Model Program—U.S. Department of Education, Title I Comprehensive School Reform

Promising Practices—Education Commission of the States for Comprehensive School Reform

Governor's Award—Idaho Exemplary Substance Abuse Programs

Preparing for the Drug Free Years®

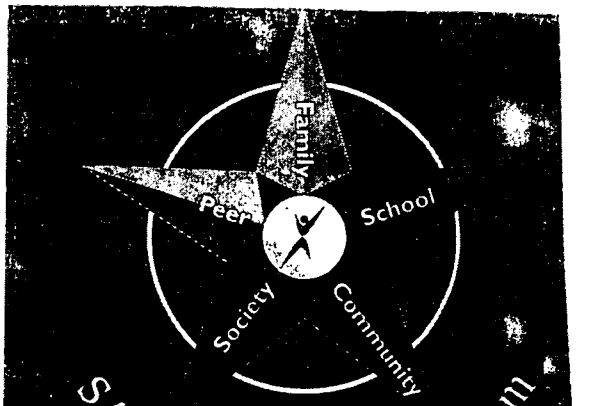
Preparing for the Drug Free Years® (PDFY) is a multimedia program that gives parents of children in grades four through eight (8 to 13 years old) the knowledge and skills needed to guide their children through early adolescence. Over the last 20 years, research has shown that positive parental involvement is an important protective factor that increases school success and buffers children against later problems such as substance abuse, violence, and risky sexual behaviors.

This program aims to—

- Strengthen and clarify family expectations for behavior
- Enhance the conditions that promote bonding in the family
- Teach skills to parents and children that allow children to successfully meet the expectations of their family to resist drug use

TARGET POPULATION

PDFY, which targets families with children aged 8 to 13, works with parents and children from various ethnic and socioeconomic backgrounds. It has been tested with Hispanic/Latino, African American, Samoan, Native American, and White families. It has been implemented in diverse urban and rural communities across the United States.



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Proven Results

- Reduced substance use 2 years after the intervention was completed
- Among those not using substances at 1-year followup, more remained substance-free at 2-year followup (relative risk reduction of 26%)
- Among those using substances at 1-year followup, fewer had progressed to more serious substances at the 2-year followup
- Significantly lower rates of increase in initiation of drinking to drunkenness and marijuana use over a 4-year period
- Less drinking in the past month (relative reduction of 40.6%)
- Increased parent communication of substance abuse rules and consequences
- Greater involvement in family activities and decisions and better ability to manage anger and conflict

INTERVENTION

Universal

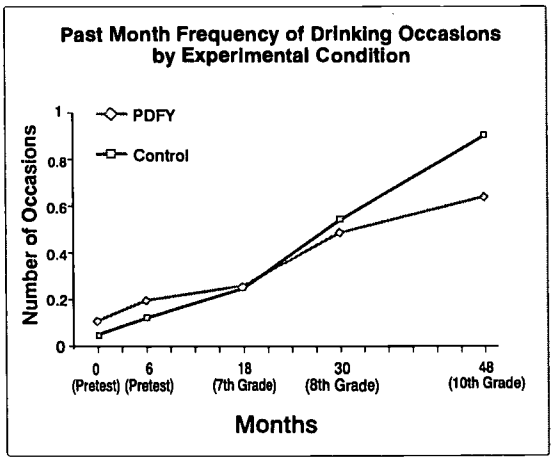
Selective

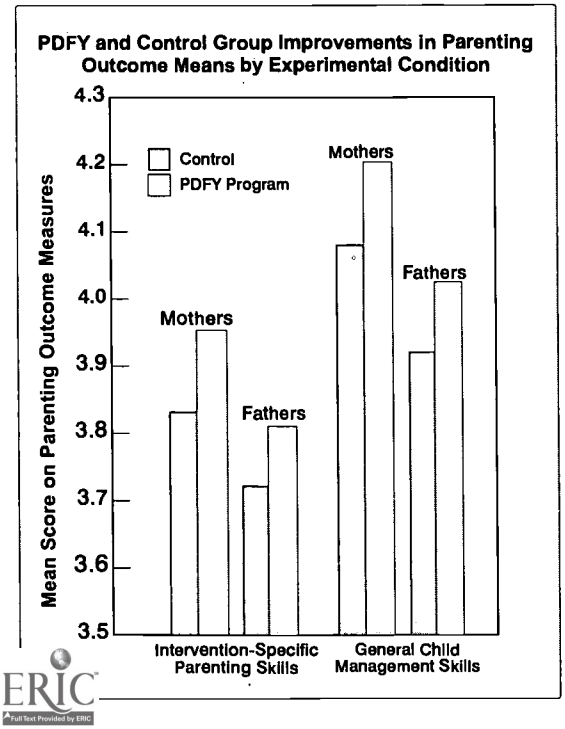
Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

- Significant effects on targeted parenting behaviors were found at posttest and maintained 1 year later.
- At the 2-year followup, youth in the PDFY group who had not initiated substance use at the 1-year followup were significantly more likely to have remained nonusers than their counterparts in the control group. Youth in the PDFY group who had initiated substance use at the 1-year followup were significantly less likely to have progressed to more frequent or varied substance use than youth in the control group.
- At the 3.5-year followup, the increase in rates of initiation for drunkenness and marijuana use was significantly lower in the PDFY group than for youth in the control group. The PDFY group also had a significantly lower proportion of youth who reported using alcohol during the previous month, lower frequencies of alcohol use, and lower growth of alcohol use frequency.





BENEFITS

PDFY increases parents' ability to—

- Provide teenagers with appropriate opportunities for involvement in the family
- Recognize competencies and skills
- Teach children how to keep their friends and popularity while using drug-refusal skills
- Set and communicate healthy beliefs and clear standards for children's behavior

HOW IT WORKS

PDFY comprises five 2-hour sessions usually held over 5 consecutive weeks. Curriculum can also be presented in ten 1-hour sessions. Session topics include:

- Preventing substance abuse in your family
- Setting clear family expectations regarding drugs and alcohol
- Avoiding trouble
- Managing family conflict
- Strengthening family bonds

The sessions are interactive and skill-based, with opportunities for parents to practice new skills and receive feedback from workshop leaders and other parents. Video-based vignettes demonstrate parenting skills through the portrayal of a variety of family situations. Families also receive a *Family Guide* containing family activities, discussion topics, skill-building exercises, and information on positive parenting. The program has been offered to parents in schools, worksites, faith communities, community centers, homes, hospitals, and prisons.

IMPLEMENTATION ESSENTIALS

The workshop leaders who conduct PDFY should be skilled in providing parenting workshops, understand the principles of adult learning, and be knowledgeable about risk and protective factors as they relate to prevention. It is highly recommended that workshop leaders attend a 3-day workshop leader's training event.

The PDFY workshop site should be in an accessible, safe, and familiar part of the neighborhood. The site should have enough meeting space to comfortably accommodate parents and their children and should be equipped with video equipment, an easel or chalkboard, and an overhead projector (or computer-based LCD projector). All other materials for the workshop come with the purchase of the PDFY Workshop Kit or are provided when attending a PDFY workshop leader's training event.

PROGRAM BACKGROUND

PDFY grew from research that showed that positive parental involvement is an important factor in helping children resist substance use and other antisocial behaviors. PDFY's curriculum was developed to teach parents the skills they need to reduce the risk factors and enhance the protective factors that can help prevent substance abuse in their families.

The PDFY curriculum was field-tested for 2 years in 10 Seattle public schools before being made into a video-assisted program for wider distribution in 1987. Since 1987, PDFY has been implemented in more than 30 States and in Canada. The program has trained more than 120,000 families.

EVALUATION DESIGN

In addition to the initial field tests, the curriculum has been tested in a controlled trial in a rural setting, as part of a regional broadcast media program, in different statewide implementations, within a health maintenance organization, and in a project focusing on families of color.

The most comprehensive test of this program was a randomized clinical trial led by Dr. Richard Spoth at Iowa State University. Families of sixth graders enrolled in 33 rural schools in 19 contiguous counties in a midwestern State participated in this test. Schools were selected based on school free-lunch-program eligibility and community size (8,500 or fewer). Schools were assigned using a randomized block design, wherein blocks were formed on the basis of school size and the proportion of students residing in low-income neighborhoods. Within blocks, schools were assigned to PDFY (n = 221 families) or a minimal contact control group (n = 208). The sample completing both pre- and posttests was primarily composed of dual-parent families (85 percent) and Whites (98.6 percent). In 51 percent of the families, the target child for the intervention was female.

Target Areas

Protective Factors To Increase

Individual

- Healthy beliefs and clear standards for behavior

Family

- Opportunities for children to be involved in and contribute to the family
- Skills for family communication and problem solving
- Recognition of new skills and family involvement
- Family bonding

Risk Factors To Decrease

Individual

- Early initiation of substance abuse
- Favorable attitudes toward substance abuse

Family

- Poor family management
- Family conflict
- Parental involvement in problem behaviors and attitudes favorable to problem behaviors

Peer

- Friends who engage in problem behaviors

PROGRAM DEVELOPERS

Richard Catalano, Ph.D.
J. David Hawkins, Ph.D.

Dr. Richard Catalano is a professor and the associate director of the Social Development Research Group, School of Social Work, University of Washington, Seattle. For more than 20 years, he has led research and program development to promote positive youth development and prevent problem behavior.

Dr. J. David Hawkins is the Kozmetsky Professor of Prevention at the School of Social Work and the director of the Social Development Research Group, both at the University of Washington, Seattle. His research focuses on understanding and preventing child and adolescent health and behavior problems.

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RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Programs That Work—National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services

Promising Program—Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice

Promising Program—U.S. Department of Education

Effective Substance Abuse and Mental Health Programs for Every Community

Project ACHIEVE

Project ACHIEVE is an innovative school reform and school effectiveness program developed for use in preschool, elementary, and middle schools (students 3 to 14 years old). It is designed to help schools, communities, and families develop, strengthen, and solidify their youths' resilience, protective factors, and self-management skills. Project ACHIEVE works to improve school and staff effectiveness and places particular emphasis on increasing student performance in the areas of:

- Social skills and social-emotional development
- Conflict resolution and self-management
- Achievement and academic progress
- Positive school climate and safe school practices

Project ACHIEVE implements schoolwide positive behavioral and academic prevention programs that focus on the needs of all students. It also develops and implements strategic intervention programs for at-risk and underachieving students, and it coordinates comprehensive and multifaceted "wrap-around" programs for students with intensive needs.

TARGET POPULATION

Project ACHIEVE has been replicated at more than 25 sites across the United States. Its target audience is predominantly elementary and middle school children; however, program components also have been used in high schools, alternative schools, psychiatric and juvenile justice facilities, Head Start and after-school programs, and a number of specialized charter schools.

Proven Results*

- Overall discipline referrals to the principal decreased 16%
- Out-of-school suspensions decreased 29%
- Grade retentions decreased 47%
- Special education referrals decreased 61%
- School bus discipline referrals to the office decreased 26%

** Comparison of prior-year data from one of many studied schools with the data averaged after 8 years of program implementation at the same school.*

INTERVENTION

Universal

Selective

Indicated

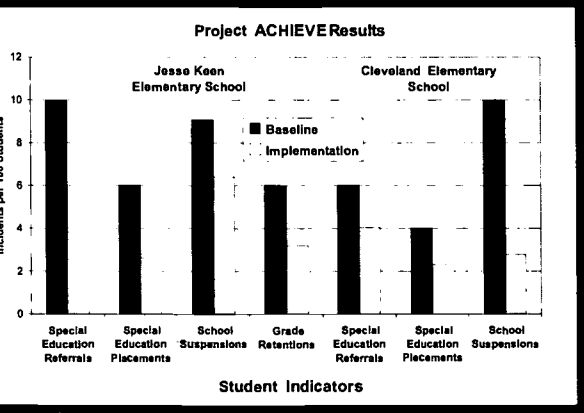
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

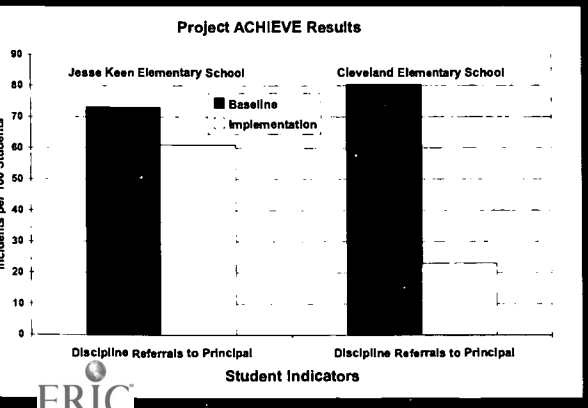
OUTCOMES

In addition to reduced behavioral problems, a comparison of prior-year data with the averages from 8 years of Project ACHIEVE implementation at one of the studied schools showed academic gains on the California Test of Basic Skills (CTBS), including:

- Reading CTBS: 33% of the Full Project Cohort students scored at or above the 50th percentile compared to 29% of the Partial Project Cohort
- Math CTBS: 40% of the Full Project Cohort students scored at or above the 50th percentile compared to 36% of the Partial Project Cohort students
- Language CTBS: 41% of the Full Project Cohort students scored at or above the 50th percentile compared to 36% of the Partial Project Cohort students

Longitudinal outcomes from three schools that have implemented Project ACHIEVE can be reviewed in greater detail at: www.coedu.usf.edu/projectachieve.





Schools included in the program study had students from a wide range of ethnic and cultural backgrounds. Project ACHIEVE also has been implemented in diverse geographic locations throughout the country and in school districts ranging in size from very small to large.

BENEFITS

This program helps to—

- Maximize student academic achievement
- Create safe and positive school climates
- Increase and sustain effective classroom instruction
- Increase and sustain strong parent-school involvement
- Teach students social skills and self-management behavior

HOW IT WORKS

Project ACHIEVE is implemented by following a series of carefully sequenced steps that generally occur over a 3-year period. The program uses professional development, inservice, and technical assistance to train school personnel at each facility. Successful replication of the Project ACHIEVE model involves seven interdependent components:

1) **Strategic Planning and Organizational Analysis and Development** analyzes the facility's operations and recommends specific program objectives and action plans and coordinates meaningful evaluation procedures.

2) **Referral Question Consultation Problem-Solving Process (RQC)** uses a systematic, functional, problem-solving process to explain why student problems are occurring and link assessment to interventions that help students progress.

3) **Effective Classroom and School Processes/Staff Development** focuses on developing and reinforcing teachers' classroom behaviors and school processes that maximize students' academic engagement and learning.

4) **Instructional Consultation and Curriculum-Based Assessment and Intervention** involves the functional assessment of referred students' learning problems. It evaluates their response to and success with the curriculum and coordinates the instruction and interventions needed to teach them to master necessary academic skills.

5) **Social Skills, Behavioral Consultation, and Behavioral Interventions** facilitate implementation of effective interventions that address students' curricular and behavioral problems, including "special situation" analyses, crisis prevention and intervention procedures, and team development.

6) **Parent Training, Tutoring, and Support** develop ongoing home-school collaboration, including the assessment, coordination, and use of community resources.

7) **Research, Data Management, and Accountability** reinforce the collection of formative and summative outcome data (including consumer satisfaction and time- and cost-effectiveness data) to validate various aspects of a schoolwide improvement process.

IMPLEMENTATION ESSENTIALS

The **Stop & Think Social Skills Program** is Project ACHIEVE's curriculum for teaching students appropriate behavior and self-management skills. It includes the *Social Skills* book and support materials that allow teachers to organize and implement a social skills program. The *RQC Workbook*, which describes the problem-solving and strategic intervention approach and provides step-by-step training and examples of how to use it with individually referred students, is also available. Using these materials, Project ACHIEVE is best installed in this sequence:

- **Year 1** activities involve Social Skills training; RQC problem-solving training; and providing teachers with release time for planning, meetings, and technical assistance.
- **Year 2** activities include Social Skills/RQC training and booster sessions, Behavioral Observation and Instructional Environment Assessment training; Curriculum-Based Assessment and Measurement (CBA/CBM) training; and release time for planning, meetings, and technical assistance.
- **Year 3** implementation requires booster sessions in all prior components; parent involvement planning, training, and facilitation; grade-level intervention planning and implementation; and release time for planning, meetings, and technical assistance.

Beyond Year 3, Project ACHIEVE schools provide approximately 1 day per month of release time for teachers to plan and implement the activities identified in their action plans.

Other Project ACHIEVE materials are provided during professional development workshops as different components of the project are implemented. Training and technical assistance are available and supported through public and private funding.

Project ACHIEVE can be implemented with the staff and resources available in most schools, especially when there are a large number of special or Title I students referred to and/or already in an existing program. In addition to current staff, it is recommended that school districts identify one project coordinator for every three to five project buildings during the first 3 years of implementation and for every five to eight buildings thereafter.

Target Areas

Protective Factors To Increase

Individual

- Positive sense of self
- Belief in society's values
- Prosocial behavior and conflict resolution skills
- Communication and problem-solving skills
- Responsiveness, empathy, and caring
- Goal-directedness and self-discipline
- Cooperation and flexibility
- Strengthened commitment to school

Family

- Avoidance of severe criticism
- High but realistic parental expectations
- Clear and consistent expectations
- Emotionally supportive family environment
- Orderly and structured parent-child relationships
- Parent involvement in homework and school-related activities

School

- Caring and supportive environment
- Sense of community in classroom and school
- Reinforced high expectations from school personnel
- Clear standards and rules for appropriate behavior

Risk Factors To Decrease

Individual

- Lack of self-control, assertiveness, and other social and emotional skills
- Low self-esteem and self-confidence
- Emotional and psychological problems
- School failure
- Conduct problems and early antisocial behavior (e.g., lying, stealing, aggression)
- Economic disadvantage

Family

- Poor child supervision and discipline
- Unrealistic expectations for development

Peer

- Susceptibility to negative peer pressure

School

- Poor school performance and high absenteeism
- Ambiguous, lax, or inconsistent rules and sanctions for student behavior
- Harsh, arbitrary, or disproportionate student management practices
- Poor sense of community in school
- Lack of parental involvement in schooling

PROGRAM BACKGROUND

Project ACHIEVE, developed by Dr. Howard Knoff at the University of South Florida, began as a district-wide training program for school psychologists, guidance counselors, social workers, and elementary-level instructional consultants. It is now a school-based improvement, professional development, and technical consultation program that targets and reinforces critical staff skills and intervention approaches for an entire school. Since 1990, Project ACHIEVE has been implemented in schools and school districts across the country. To date, almost 1,500 schools in more than 40 States have been trained in one or more of its components.

EVALUATION DESIGN

While validated at numerous individual sites, Project ACHIEVE has undergone one published, referred evaluation with a quasi-experimental design at the elementary school level. This 1990 to 1998 evaluation used a matched-comparison design, with one treatment and one control school. In choosing a comparison school, researchers used school demographics, giving the most weight to the percentage of students on the Federal free-lunch program. Project ACHIEVE was implemented over a 3-year period. Data were collected in the treatment school during 4 academic years and during 1 academic year in the comparison school. Additional longitudinal analyses, at three school sites, were completed using a multiple baseline design across numerous variables, with each school used as its own internal control.

The American Institutes for Research also performed an independent analysis of Project ACHIEVE for the U.S. Department of Education using a team of national experts who conducted a 2-day onsite evaluation of two school sites. The predominant methodology for this evaluation entailed a structured interview-based qualitative analysis that collected data from students, parents, staff, school and district administrators, community members, and agency representatives.

PROGRAM DEVELOPER

Howard M. Knoff, Ph.D.

Dr. Knoff is a professor of School Psychology at the University of South Florida (Tampa, FL), and was director of the School Psychology Program there for 12 years. He is currently director of the Institute for School Reform, Integrated Services, and Child Mental Health and Educational Policy. He received his Ph.D. from Syracuse University in 1980, and has worked as a practitioner, consultant, licensed private psychologist, and university professor since 1978. Known for his research and writing on organizational change and school reform, consultation and intervention processes, social skills and behavior management training, personality assessment, and various professional issues, Dr. Knoff has published more than 75 articles and book chapters and delivered over 300 papers and workshops. He was the 21st president of the National Association of School Psychologists.

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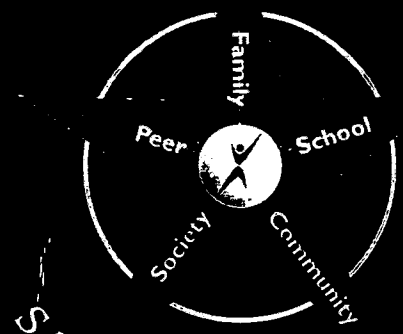
RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Exemplary Program—White House Conference on School Safety

Effective School Reform Program—Center for Effective Collaboration and Practice, American Institutes for Research



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Project ALERT

Project ALERT is a drug prevention curriculum for middle school students 11 to 14 years old, which dramatically reduces both the onset of substance abuse and their regular use. The 2-year, 14-lesson program focuses on the substances that adolescents are most likely to use: alcohol, tobacco, marijuana, and inhalants. Project ALERT uses participatory activities and videos to help:

- Motivate adolescents against drug use
- Teach adolescents the skills and strategies needed to resist prodrug pressures
- Establish nondrug-using norms

Guided classroom discussions and small group activities stimulate peer interaction and challenge student beliefs and perceptions, while intensive role-playing activities help students learn and master resistance skills. Homework assignments that also involve parents extend the learning process by facilitating parent-child discussions of drugs and how to resist using them. These lessons are reinforced through videos that model appropriate behavior.

TARGET POPULATION

Project ALERT is highly effective with adolescents, 11 to 14 years old, from widely diverse backgrounds and communities. The program has proved successful with high- and low-risk White, African American, Hispanic/Latino, Asian American, and Native American youth from urban, rural, and suburban communities and a variety of socioeconomic backgrounds. The original program was tested in schools in different geographic areas with different population densities, and among students with a range of racial/ethnic and economic backgrounds.

Proven Results*

Students receiving Project ALERT:

- Reduced initiation of marijuana use by 30%
- Decreased current marijuana use by 60%
- Reduced past-month cigarette use by 20% to 25%
- Decreased regular and heavy smoking by 33% to 55%
- Substantially reduced students' prodrug attitudes and beliefs

*Compared with control groups.

INTERVENTION

Universal

Selective

Indicated

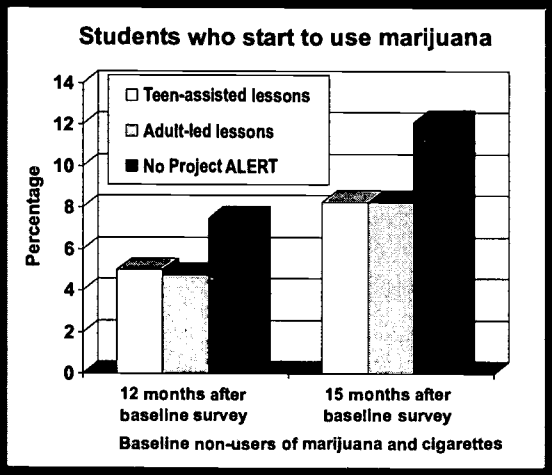
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

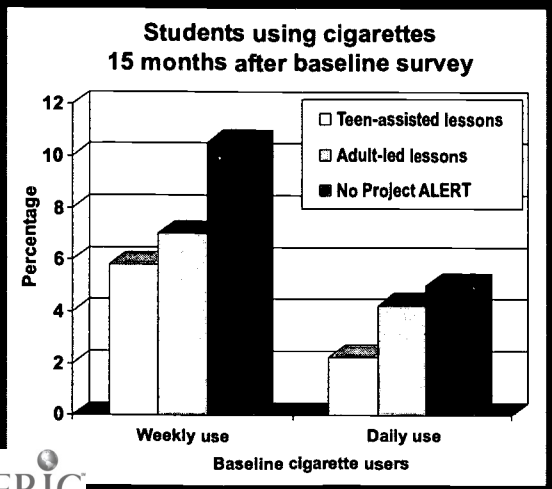
OUTCOMES

Project ALERT was effective in schools with both large and small minority populations from a variety of socioeconomic backgrounds, with youth experimenting with drugs and at risk for becoming regular users, as well as those who had not tried drugs before the program began. It substantially decreased prodrug attitudes and beliefs, including intentions to use drugs, beliefs that drug use is not harmful, and perceptions that many peers use drugs. It also increased beliefs that one can successfully resist both internal and external pressures to use drugs. The program markedly reduced the use of marijuana and cigarettes and the initiation of marijuana use.

With this program, 15 months after baseline, relative to controls:

- Marijuana initiation rates were 30% lower for ALERT students
- Current marijuana use was 60% lower in adult-led programs
- Current and occasional cigarette use was 20% to 25% lower among baseline experimenters
- Regular and heavy cigarette use was one-third to 55% lower among baseline experimenters
- Antidrug beliefs were significantly enhanced, with many effects persisting into 10th grade





BENEFITS

Project ALERT helps adolescents—

- Understand the consequences of using drugs
- Develop reasons not to use
- Understand the benefits of being drug free
- Recognize that most people do not use drugs
- Identify and counter prodrug pressures
- Resist advertising appeals
- Support others in their decisions not to use
- Learn how to quit
- Communicate with parents
- Recognize alternatives to substance use

HOW IT WORKS

Trained teachers typically deliver Project ALERT in a classroom setting, but some districts have adapted it for use in after-school settings where trained personnel are available.

Implementing Project ALERT involves staff in the following activities:

- Participating in a 1-day training workshop
- Teaching 11 core lessons during the first year and 3 booster lessons the following year
- Promoting parent involvement through home learning opportunities

To deliver lessons effectively, teachers need to establish an open, supportive classroom environment, facilitate student participation, reinforce good performance, help students acquire the confidence that they really can resist prodrug pressures, and respond appropriately to student questions about drugs.

IMPLEMENTATION ESSENTIALS

Project ALERT lessons should be taught 1 week apart over the course of 11 weeks for Year 1 and over 3 weeks for Year 2.

Teachers need to participate in a 1-day training workshop where they learn the rationale and theory underlying Project ALERT, the skills needed to deliver the lessons, and implementation guidelines for achieving program fidelity. The location and dates of upcoming training workshops are listed on the program's Web site, www.projectalert.best.org.

Teachers leave the training workshop with the following resources:

- A manual with 11 lessons for Year 1 and 3 booster lessons for Year 2
- Eight interactive student videos
- Twelve full-color classroom posters
- Demonstration videos of key activities and teaching strategies
- An overview video for colleagues and community members

Project ALERT periodically updates and distributes curricula, videos, posters, and other information to trained teachers free of charge.

Technical assistance is provided through an online faculty advisor, toll-free telephone support, and newsletters. A fidelity instrument is available to monitor implementation quality.

PROGRAM BACKGROUND

In the early 1980s, the RAND Corporation, an internationally recognized nonprofit institution established to improve policy and decisionmaking through research and analysis, assessed the effectiveness of three major strategies for curtailing adolescent drug use: prevention, law enforcement, and treatment. Based on that study's conclusions, the Conrad N. Hilton Foundation funded RAND to develop and test Project ALERT between 1983 and 1993.

National dissemination of the program, underwritten by the Hilton Foundation, began in 1991. Project ALERT has a presence in all 50 States. More than 18,000 teachers in approximately 3,500 school districts use Project ALERT in their classrooms. RAND is now developing and testing an enhanced version of Project ALERT that is designed for high schools.

EVALUATION DESIGN

Project ALERT used a rigorous pre-post design with random assignment of 30 schools to one control and two treatment conditions (i.e., an adult teacher group and an adult teacher plus teen leader group). The participating schools had diverse student bodies. Nine schools had a minority population of 50 percent or more.

Trained data collectors administered student surveys in all schools before and after program lessons. Self-reported drug use was validated by testing saliva samples collected from students and by consistency analyses over time. Logistic regression was used to analyze substance use outcomes as a function of treatment and baseline covariates. Multiple controls helped rule out alternative explanations of treatment effects. All analyses were adjusted for attrition and clustering of students within schools.

Target Areas

Protective Factors To Increase

Individual

- Reasons not to use drugs
- Perceptions that few peers use, most disapprove
- Belief that one can resist prodrug pressures
- Intentions not to use
- Belief that friends respect nonusers
- Ability to identify and counter advertising appeals
- Multiple strategies for resisting drugs
- Ability to identify and resist internal pressures to use

Peer

- Motivation and skills to help friends avoid drug use
- Responsible behavior modeled by peers

Family

- Communication with parents and other adults

School

- Establishment of norms against drug use
- Cooperative learning
- Respect for others

Risk Factors To Decrease

Individual

- Current use of alcohol, tobacco, or illegal drugs
- Intention to use in the future
- Belief that drug use is not harmful or has positive effects
- Belief that drug use is normal
- Low self-esteem
- Inadequate resistance skills

Peer

- Peer drug use
- Peer approval of drugs

School

- High levels of drug use
- Low norms against use

Family

- Lack of clear norms against use
- Poor communication

PROGRAM DEVELOPER

Phyllis Ellickson, Ph.D.

Dr. Phyllis Ellickson and colleagues at RAND developed and evaluated Project ALERT. This program has its own dissemination organization, established by the Hilton Foundation, to train teachers in effective implementation of the program, provide technical assistance, and periodically update classroom materials. Project ALERT is subsidized by ongoing funding from the Hilton Foundation.

CONTACT INFORMATION

For information on teacher training, curriculum materials, technical assistance, and cost, contact:

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E-mail: info@projectalert.best.org
Web site: www.projectalert.best.org

RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Exemplary Program—U.S. Department of Education

Exemplary Program—White House Office of National Drug Control Policy

Exemplary Program—National Prevention Network

Exemplary Program—National Association of State Alcohol and Drug Abuse Directors

Exemplary Program—Community Anti-Drug Coalitions of America

Endorsed by the National Middle School Association

Project Northland

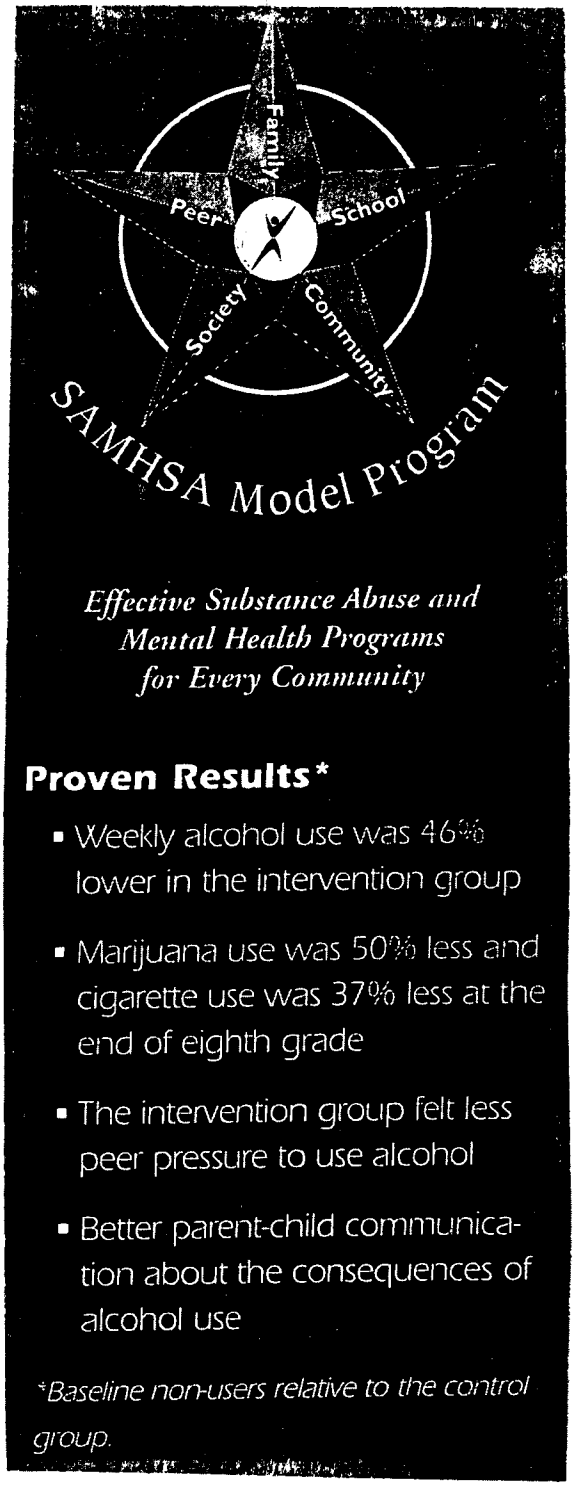
Project Northland is a multilevel, multiyear program proven to delay the age at which young people begin drinking, to reduce alcohol use among those who have already tried drinking, and to limit the number of alcohol-related problems of young drinkers. Designed for sixth, seventh, and eighth grade students (10 to 14 years old), Project Northland addresses both individual behavioral change and environmental change. Project Northland also strives to change how parents communicate with their children, how peers influence each other, and how communities respond to young adolescent alcohol use. Components include:

- Parent involvement
- Behavioral curricula
- Peer-led small group activities
- Community mobilization
- Strategies to reduce access to alcohol

Each intervention year has an overall theme and is tailored to the developmental level of the young adolescent. Alcohol is the focus of the Project Northland program because it is American teenagers' drug of choice and inflicts the greatest harm among youth.

TARGET POPULATION

Project Northland is designed to provide state-of-the-art alcohol use prevention materials for students in grades six through eight. The original evaluation involved approximately 2,400 students from 24 school districts in northeastern Minnesota. This largely rural area is one of the U.S. communities rated highest for alcohol-related problems. A replication of the Project Northland study is currently under way in a major city.



INTERVENTION

Universal

Selective

Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

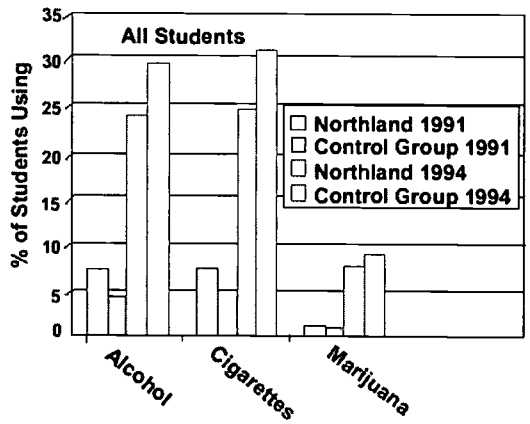
OUTCOMES

Project Northland sustained widespread participation in the program, including 3 years of curricula implementation in all intervention schools, parent participation in alcohol education activities, and participation by nearly half of the students in peer-planned alcohol-free activities outside of school. Relative to controls, Northland participants:

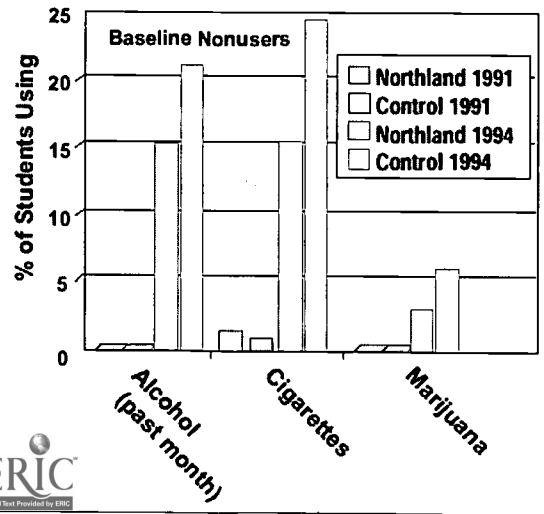
- Drank significantly less at the end of eighth grade
- Were significantly less likely to be users of both alcohol and cigarettes at the end of the eighth grade

Project Northland was effective in changing peer influence to use alcohol, normative expectations about how many young people drink, and parent-child communication about the consequences of alcohol use and the reasons for not using alcohol.

Project Northland Alcohol and Other Drug Use Outcomes
(Fall 1991 6th graders to followup Spring 1994, 8th graders)



Project Northland Alcohol and Other Drug Use Outcomes
(Fall 1991 6th graders to followup Spring 1994, 8th graders)



BENEFITS

- Teaches youth decisionmaking and interpersonal skills
- Enhances parenting skills
- Strengthens peer, parent, and community no-use norms
- Has a positive effect on other substance use
- Reduces youth access to alcohol

HOW IT WORKS

Project Northland consists of four components:

- **Slick Tracy Home Team Program** has sixth grade students and their parents complete fun and educational activities at home. This "home team" approach provides a forum for the students and their families to discuss alcohol-related issues using the Slick Tracy comic book series during the eight 45-minute classroom sessions. Students create posters and exhibits about alcohol and explain them to the parents attending Slick Tracy Poster Fair.
- **Amazing Alternatives!** provides curriculum for eight 45-minute teacher- and peer-led classroom sessions. It is designed to teach seventh graders the skills to identify and resist influences to use alcohol and to encourage alcohol-free alternatives.
- **PowerLines** features eight 45-minute sessions that are part of a 4-week program for eighth grade students. It teaches students how communities influence behavior and how they can create changes in communities.
- **Supercharged!** includes strategies that worked in Project Northland communities and provides schools with materials and a framework that can help them get parents and communities involved to reduce youth access to alcohol. Youth are placed in a leadership role to support healthy activities and initiatives.

IMPLEMENTATION ESSENTIALS

Successful replication of the Project Northland model requires:

- Student involvement from sixth through eighth grades
- Teacher and peer training (recommended to maintain implementation fidelity)
- Incorporation of student-selected peer leaders at all three grade levels
- A community member task force
- Program coordinator

Training and Technical Assistance

Project Northland, through Hazelden Information and Educational Services, can provide training of teachers and community coordinators based on local needs. Training can be conducted for one grade level each year or for all three grade levels at once. Hazelden also offers evaluation services.

Program Materials and Resources

The following materials are available from Hazelden:

- **Slick Tracy Home Team Program** (Sixth Grade)—includes 1 teacher's manual, 30 sets of 4 comic books, 30 envelopes, and 1 poster
- **Amazing Alternatives!** (Seventh Grade)—includes one teacher's manual, four cassette tapes, one blackboard game, and two posters
- **PowerLines** (Eighth Grade)—includes one teacher's manual and one cassette tape
- **Supercharged!**—a manual that presents successful strategies for getting parents and communities involved in youth alcohol use prevention (includes the Community Night Game Pack)
- **Project Northland Complete Set**—includes one each of the three grade-level programs, as well as the ancillary products

Timeline

One day of training is strongly suggested for each year's curriculum. This training can equip those providing direct services to youth or persons who will then train additional staff to use the program. It is suggested the program be implemented beginning with Slick Tracy in year one, Amazing Alternatives! in year two, and PowerLines in year three. The community mobilization training is designed to build coalitions and can be scheduled anytime during the 3-year implementation cycle.

PROGRAM BACKGROUND

Project Northland was developed at the University of Minnesota School of Public Health, Division of Epidemiology, and evaluated with a grant from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) of the National Institutes of Health, U.S. Department of Health and Human Services. The evaluation was the largest and most rigorous alcohol use prevention trial ever funded by NIAAA, and Project Northland was shown to be effective in delaying and reducing alcohol use among young adolescents. After the initial evaluation, the program underwent extensive pilot testing in a comparable Minnesota community, and revisions were made prior to implementation.

Target Areas

Protective Factors To Increase

Individual
- Problem-solving skills
- Social competence and cooperation
- Attachment to parents and other caring adults
- Belief in society's values

Family
- Frequent and consistent communication with parents
- Presence of a significant adult
- Strong parental guidance
- Parent involvement in homework and school-related activities

Peer
- Responsible behavior modeled by peer group or peer leader
- Association with peers involved in school, recreation, service, religion, or other organized activities

School
- Sense of community in classroom
- Clear standards and rules for appropriate behavior
- Youth participation, involvement, and responsibility in school tasks
- School bonding

Community
- Caring and support from community
- Opportunities for youth to participate in community activities

Society
- Media literacy

Risk Factors To Decrease

Individual
- Inadequate life skills
- Weak peer-refusal skills
- Favorable attitudes toward alcohol use
- Lack of school bonding

Family
- Family attitudes favor alcohol use
- Poor child supervision and discipline
- Inconsistent rules and consequences related to alcohol use

School
- Inconsistent rules and consequences related to alcohol use
- Lack of school bonding
- Favorable staff and student attitudes toward alcohol use

Peer
- Association with delinquent peers and peers who reject mainstream activities
- Susceptibility to negative peer pressure

Community
- Community disorganization
- Lack of community bonding
- Community attitudes favorable to alcohol use
- Inadequate youth services and opportunity for youth involvement in community

Society
- Pro-alcohol use messages in the media

EVALUATION DESIGN

The Project Northland evaluation involved approximately 2,400 students from 24 school districts in northeastern Minnesota during their sixth, seventh, and eighth grade years (1991 to 1994), and included children from seven area American Indian reservations. This area has the highest rate of alcohol-related problems in the State.

Twenty-four school districts were recruited systematically and four smaller school districts were combined with nearby districts to ensure an adequate sample size in each unit to be randomized. These combined districts were blocked by size and randomized to an intervention condition (n=10) or a reference condition (n=10). The population of the six participating counties was 235,000; 94 percent of the students were White, while American Indian students constituted about 5.5 percent of the study's cohort. Because of their small number, analyses of intervention effects within this subgroup were not possible. This area is predominantly rural and lower-middle class to middle class. (See *Outcomes* for details.)

PROGRAM DEVELOPER

The University of Minnesota, School of Public Health, Division of Epidemiology, in 1991, was awarded a grant from NIAAA, National Institutes of Health, U.S. Department of Health and Human Services to develop Project Northland. Through the research and development of this program, developers were able to successfully link and study behavioral curricula in schools, parental involvement, extracurricular peer leadership, and community-wide efforts for the prevention of adolescent alcohol use.

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RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Exemplary Program—U.S. Department of Education

Rated "A"—Drug Strategies, Making the Grade

Promising Program—Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice

Project SUCCESS

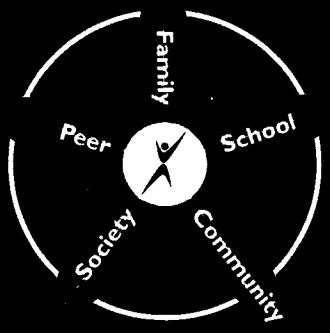
Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) prevents and reduces substance use among high-risk, multiproblem high school adolescents. Developed and tested with alternative school youth 14 to 18 years old, the program places highly trained professionals in schools to provide a full range of substance use prevention and early intervention services. Counselors use a variety of intervention strategies, including:

- Information dissemination
- Normative and preventive education
- Counseling and skills training
- Problem identification and referral
- Community-based processes
- Environmental approaches

In addition, Project SUCCESS links the school to the community's continuum of care when necessary, referring both students and families to human services organizations, including substance abuse treatment agencies.

TARGET POPULATION

Project SUCCESS was tested with 14- to 18-year-old adolescents who attended an alternative school that separated them from the general school population. Participants typically came from low- to middle-income families, and 30 percent had parents who abused substances. The program is effective with African American, Asian American, White, and Hispanic/Latino youth of both genders. These adolescents have been placed in an alternative school setting for a variety of reasons, including:



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Proven Results*

- 23% reported ending substance use
- 37% decrease in overall substance use
- Decreased problem behavior
- Decreased associations with peers who use substances
- 45% reported ending marijuana use
- 23% reported ending tobacco use
- 33% reported ending alcohol use

**Relative to adolescents in comparison group who did not participate in Project SUCCESS. For those who did not quit drug use, there was a significant reduction in mean alcohol and drug use.*

INTERVENTION

Universal

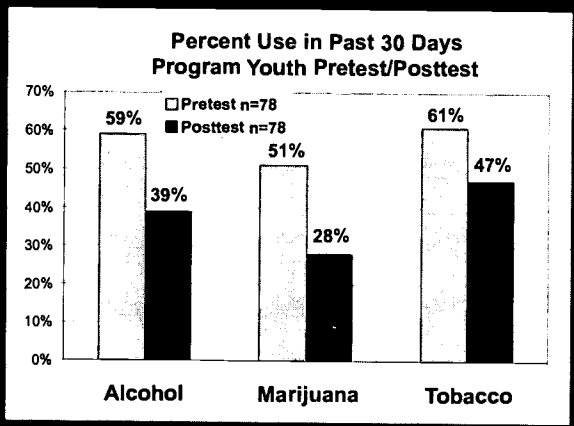
Selective

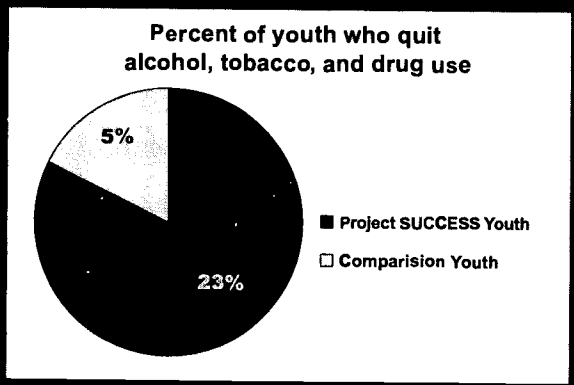
Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

Adolescents participating in Project SUCCESS showed a significant 37% overall decrease in substance use as compared to adolescents in the comparison group who did not participate in Project SUCCESS. Of the adolescents using substances, 23% of those in the Project SUCCESS program quit using, whereas only 5% in the comparison condition quit. For those adolescents who did not quit using substances, there was still a significant reduction in mean substance use ranging between 17% and 26.6% among Project SUCCESS participants.





Posttest data regarding use during the previous 30 days revealed that of students in the second year of Project SUCCESS (*n*=78) who reported using at pretest:

- 33% (15 of 46) reported no longer using alcohol
- 45% (18 of 40) reported no longer using marijuana
- 23% (11 of 48) reported no longer using tobacco

Project SUCCESS was found to be effective with both genders, students from various ethnic groups, and across grade levels from the 9th to 12th grades. Project SUCCESS benefited not only students who participated directly in the program but also those students (the control group) who participated in [illegible]oy associating with Project S[illegible]students.

- Poor academic performance
- Emotional problems
- School discipline problems
- Truancy
- Negative attitude toward school
- Criminal activity

BENEFITS

Project SUCCESS helps adolescents with emotional, learning, and behavioral problems expressed in behaviors such as fighting, cutting class, and talking back to teachers. The program teaches resistance and social competency skills for:

- Communication
- Decisionmaking
- Stress and anger management
- Problem solving
- Resisting peer pressure

HOW IT WORKS

A partnership is established between a prevention agency and alternative school. An individual with a graduate degree in social work, counseling, or psychology, who is experienced in providing substance abuse prevention counseling to adolescents, is recruited to work in the alternative school as a Project SUCCESS Counselor (PSC). This individual will provide the school with a full range of substance abuse prevention and early intervention services to help decrease risk factors and enhance protective factors related to substance abuse. Program components include:

- **Prevention Education Series**—An eight-session substance abuse prevention education program conducted by the PSC.
- **Individual Assessment**—Following the Prevention Education Series, students are seen individually by the PSC to determine their level of substance use, family substance abuse, and the need for additional services.
- **Individual and Group Counseling**—Following assessment, a series of 8 to 12 time-limited individual or group sessions are conducted in the school. Students attend one of seven different groups based on their developmental differences, substance use, and family history of substance abuse. Individual sessions are scheduled as needed.
- **Parent Programs**—Parents attend an evening dinner meeting with a speaker who discusses what they can do to prevent and reduce substance use.

- **Referral**—Counselors refer students and parents who require treatment, more intensive counseling, or other services to appropriate agencies or practitioners in the community.

IMPLEMENTATION ESSENTIALS

Project SUCCESS requires formation of a partnership between a substance abuse prevention organization that will administer the program and an alternative school where it will operate. Specific staff participants include:

- **School Principal** who establishes the initial implementation agreement, selects the counselor, oversees the program, and supervises the counselor onsite
- **Executive Director/Project Director** who initiates and manages the program, develops procedures, and hires staff
- **Project SUCCESS Counselor** (PSC) who implements the program at the school, consults with the principal and teachers, engages in informal outreach activities with students and their parents, and provides all prevention and early intervention services to students
- **Project Supervisor** who supervises the PSC and helps coordinate activities with school staff

Program staff and administrators need to address the following steps:

1) Define program goals and objectives
2) Define target population
3) Provide training and consultation for school staff
4) Establish a school staff substance abuse task force
5) Obtain technical assistance and training

A 75-page implementation manual is available for $150. The manual includes resource material for professionals and worksheets for students. Onsite and offsite training of varying lengths up to 5 days also is available.

PROGRAM BACKGROUND

Project SUCCESS began in September 1995 in three alternative secondary schools in Westchester County, NY, funded with a 3-year Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention High-Risk Youth Grant. The program is based on the effective Residential Student Assistance Program (RSAP) model, which had been used in residential facilities for troubled adolescents beginning in 1987 and which, in turn, was adapted from the Westchester Student Assistance Program. This latter program used interventions based on those developed for employee assistance programs.

Target Areas

Protective Factors To Increase

Individual

- Self-efficacy and sense of mastery
- Social competence

Family

- Family protection

School

- Participation in school activities

Risk Factors To Decrease

Individual

- Favorable attitudes toward substances of abuse
- Depression
- Violence

Family

- Substance-abusing parents

School

- Poor school performance
- School dropout, failure, or high absenteeism

Project SUCCESS was designed to determine if the RSAP model could be adapted with adolescents at very high risk for substance abuse who were attending public alternative schools and living at home.

EVALUATION DESIGN

A pretest and posttest comparison group design was used with a total sample of 425 adolescents. Participants in two of the schools were randomly assigned to Project SUCCESS or to a non-program control condition. In the third school, classrooms were randomly assigned to participate in Project SUCCESS or a non-program control condition. Students assigned to the non-program condition in these three schools were used as a school control group. Additionally, two schools that did not have a Project SUCCESS program were used as a second comparison condition. (In the *Outcomes* section, the in-school control group is referred to as the "control condition" and the two schools that did not receive Project SUCCESS are referred to as the "comparison group.")

PROGRAM DEVELOPER

Student Assistance Services (SAS) Corporation of Tarrytown, NY, developed Project SUCCESS. SAS is a private, nonprofit, community-based substance abuse prevention organization. SAS was formed in 1985 when its core program, the Student Assistance Program, spun off from the Westchester County Department of Community Mental Health, which had operated it since 1979.

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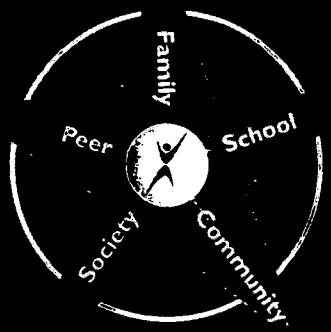
RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Project Toward No Drug Abuse

Project Toward No Drug Abuse (TND) is a highly interactive program designed to help high school youth (14 to 19 years old) resist substance use. A school-based program, TND consists of twelve 40- to 50-minute lessons that include motivational activities, social skills training, and decisionmaking components that are delivered through group discussions, games, role-playing exercise, videos, and student worksheets. Project TND teaches participants increased coping and self-control skills that allow them to—

- Grasp the cognitive misperceptions that may lead to substance use and express a desire not to abuse substances
- Understand the sequence of substance abuse and the consequences of using substances
- Correct myths concerning substance use
- Demonstrate effective communication, coping, and self-control skills
- State a commitment to discuss substance abuse with others

TARGET POPULATION

Project TND was tested with White, African American, Hispanic/Latino, and Asian American adolescents, 14 to 19 years old, attending both regular and alternative schools.

BENEFITS

This program enables students to understand and express the cognitive misperceptions that may lead to substance use. Participants also state a commitment to discuss substance abuse with peers and not to abuse substances.

Proven Results*

- Cigarette use reduced 27%
- Marijuana use reduced 22%
- Alcohol use reduced 9%
- Other drug use decreased 26%
- Weapon carrying among males reduced 25%

**Relative to randomly assigned comparison, participants showed decreased substance use in the last 30 days and in any weapon carrying during the last year.*

INTERVENTION

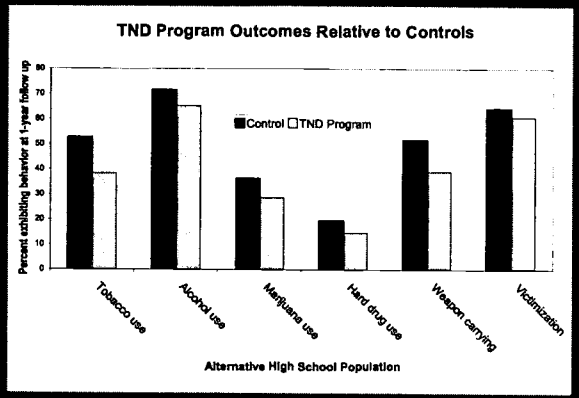
Universal

Selective

Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES



Project TND-II participants in alternative high schools (schools for high-risk students) experienced:

- A reduction in cigarette use of 27%
- A reduction in marijuana use of 22%
- A reduction in higher levels of alcohol use of 9%
- A reduction in "hard" drug use of 26%
- Among males, a reduction in weapons carrying of 25%

Project TND-I participants in regular high schools experienced:

- A reduction in "hard" drug use of 25%
- A reduction in higher levels of alcohol use of 12%
- Among males, a reduction in weapons carrying of 19%

HOW IT WORKS

Project TND's 12 lessons are designed for presentation during a 4-week period, although they may be spread over 6 weeks if all lessons are taught. Project TND involves teacher-led student participation in interactive program components including:

- Education on the progression of substance use to substance abuse
- Exercises to motivate against substance abuse (e.g., exercises include a mock "Talk Show" that provides empathy lessons, discussions on stereotyping, and the effects of being labeled a substance abuser)
- Interpersonal skills development (e.g., communication, active listening)
- Coping skills development (e.g., learning the value of personal health in daily living and life goals)
- Self-control training (e.g., social self-control skills, understanding positive and negative thought and behavior loops, violence prevention)
- Cognitive misperception correction (e.g., substance use myths, denial)
- Tobacco cessation strategies
- Decisionmaking skills development and commitment building
- The "TND Game" (a classroom competition on substance use and effects knowledge)
- The "Drugs and Life Dreams" program video
- The use of longitudinal assessment materials

IMPLEMENTATION ESSENTIALS

Virtually any school or school district can implement Project TND. A single, trained classroom teacher delivers Project TND in a classroom setting to class sizes varying from 8 to 40 students. One to 2 days of teacher training prior to curriculum implementation is highly recommended.

Project TND offers an implementation manual providing step-by-step instructions for completing each of the 12 lessons. Program materials also include:

- A video on the need to eliminate substance abuse in order to achieve life goals
- A student workbook
- An optional kit containing other instructional materials (evaluation materials, the book *The Social Psychology of Drug Abuse,* and Project TND outcome articles)

PROGRAM BACKGROUND

Project TND was developed specifically to fill a gap in substance abuse prevention programming for senior high school youth. It is the result of an ongoing research project that has been funded by the National Institute on Drug Abuse since 1992. The theory underlying Project TND is that young people at risk for substance abuse will not use substances if they 1) are aware of misleading information that facilitates substance use (e.g., myths about substance use, stereotyping), 2) have skills that help them lower their risk for use (e.g., coping skills, self-control), 3) appreciate the consequences that substance use may have on their own and others' lives (e.g., chemical dependency), 4) are aware of cessation strategies, and 5) have decisionmaking skills to make a commitment not to use substances.

EVALUATION DESIGN

Two versions of Project TND (TND-I and TND-II) have been tested in three experimental field trials to date, involving two or three conditions in each design. TND-I is the original 9-lesson program, and TND-II is a 12-lesson program that added lessons on marijuana and cigarette use. Only TND-II is now disseminated.

A 1997-98 trial of TND-II involved 18 alternative high schools. A randomized block design was used to assign six schools to one of three conditions: 1) standard care (i.e., the control group), 2) a 12-lesson classroom program, or 3) a 12-lesson self-instructional version of the classroom program. An earlier trial of TND-I in three regular high schools had a two-group randomized block design where 26 classrooms were assigned to one of two conditions: 1) the nine-lesson classroom program or 2) a standard care control group. Approximately 1,000 youth participated in each trial.

PROGRAM DEVELOPER

Steve Sussman, Ph.D., FAAHB

Steve Sussman is a professor in the University of Southern California's Departments of Preventive Medicine and Psychology and holds a position at the Institute for Health Promotion and Disease Prevention Research. He has published over 170 articles, chapters, or books in the area of substance abuse prevention and cessation. Recent projects include Project Toward No Tobacco Use (TNT), a tobacco-use prevention program that has also been recognized as a Model Program by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention (see other fact sheet), as a "Program That Works" by the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, and as an exemplary program by the U.S. Department of Education. He also helped develop Project EX, which is among the largest and most successful teen tobacco-use cessation trials to date.

Target Areas

Protective Factors To Increase

Individual

- Accurate knowledge of the course of substance abuse, its consequences, and its prevalence
- Effective communication, listening skills, and behavioral and cognitive coping skills
- Empathetic understanding of the effects of substance abuse on others
- Knowledge of tobacco cessation strategies
- Understanding the importance of health in achieving life goals
- Self-control, assertiveness, and conflict resolution skills
- Self-awareness to moderate specific behaviors
- Decisionmaking skills
- Commitment to not use substances

Family

- Understanding of effects of substance abuse on the family and how to get help

School

- School commitment to not allowing substance use

Community

- Resistance to negative stereotyping

Risk Factors To Decrease

Individual

- Low self-esteem
- Self-defeating perceptions regarding substance use consequences
- Belief in substance use myths

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RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Exemplary Program—Health Canada

Model Program—Sociometrics, Inc.

Project Toward No Tobacco Use

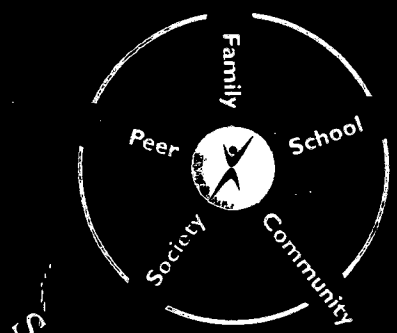
Project Toward No Tobacco Use (TNT) is a comprehensive, classroom-based curriculum designed to prevent or reduce tobacco use in youth 10 to 15 years old in grades five through ten. Upon completion of this program, students will be able to describe the course of tobacco addiction, the consequences of using tobacco, and the prevalence of tobacco use among peers. Delivered in 10 core and 2 booster lessons, TNT is proven effective at helping youth to—

- Resist tobacco use and advocate no tobacco use
- Demonstrate effective communication, refusal, and cognitive coping skills
- Identify how the media and advertisers influence youth to use tobacco products
- Identify methods for building their own self-esteem
- Describe strategies for advocating no tobacco use

Project TNT is designed to counteract several different causes of tobacco use simultaneously because the behavior is determined by multiple causes. This comprehensive approach works well for a wide variety of youth who may have different risk factors influencing their tobacco use.

TARGET POPULATION

Project TNT was completed originally with seventh grade students. It has been successfully implemented with White, African American, Hispanic/Latino, and Asian American adolescents, 10 to 15 years old.



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Proven Results*

- Reduced initiation of cigarette use by approximately 26% when 1- and 2-year outcomes were averaged together
- Reduced initiation of smokeless tobacco use by approximately 30%
- Reduced weekly or more frequent cigarette smoking by approximately 60%
- Eliminated weekly or more frequent smokeless tobacco use

*Relative to control group in a large randomized field experiment.

INTERVENTION

Universal

Selective

Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

The original experimental trial found that students in Project TNT reduced initiation of cigarette smoking by approximately 26 percent over the control group, when 1-year and 2-year followup outcomes were averaged together. Further, initiation of smokeless tobacco use was reduced by approximately 60 percent. Weekly or more frequent cigarette smoking by students in the Project TNT group was reduced by approximately 30 percent. For students in the Project TNT group, weekly or more frequent smokeless tobacco use was eliminated.

BENEFITS

At the completion of this program, students will be able to—

- Describe the course of tobacco addiction and related diseases
- Demonstrate effective communication, refusal, and cognitive coping skills
- Identify how the media and advertisers influence youth to use tobacco products
- Identify methods for building their own self-esteem

HOW IT WORKS

Implementing Project TNT involves the following activities:

- A comprehensive, 10-day, classroom-based social influences program that examines media, celebrity, and peer portrayal of tobacco use
- Training in active listening, effective communication, and general assertiveness development along with methods for building self-esteem
- Education on the course of tobacco-related addiction and diseases; correction of inflated tobacco-use prevalence estimates
- Learning tobacco-specific cognitive coping skills and assertive refusal techniques
- Practicing ways to counteract media portrayals of tobacco use, including social activism letter writing to make a public commitment to not using tobacco products
- Use of homework assignments, a classroom competition (i.e., the "TNT Game"), and a two-lesson booster program
- Longitudinal assessment material

Virtually any school or school district can implement Project TNT. Trained teachers in a classroom setting deliver it to standard class sizes.

IMPLEMENTATION ESSENTIALS

Successful replication of Project TNT involves delivering 10 core lessons and 2 booster lessons, each 40 to 50 minutes in length. The 10 core lessons are designed to occur during a 2-week period, although they may be spread over 4 weeks as long as all lessons are taught. The two-lesson booster is delivered 1 year after the core lessons in a 2-day sequence. However, the booster sessions may be taught one per week.

Project TNT offers an implementation manual that provides step-by-step instructions for completing each of the lessons, along with introductory and background materials. Other program materials include:

- Two videos, one on assertive refusal and the other on combating tobacco use-specific social images
- A student workbook
- An optional kit that includes posters and other instructional materials (e.g., evaluation materials, Project TNT outcomes papers)

Project TNT can provide a 1- to 2-day teacher training session prior to implementation. This training is highly recommended.

PROGRAM BACKGROUND

Project TNT was initially funded, from 1987 to 1993, with a grant from the National Cancer Institute, National Institutes of Health, U.S. Department of Health and Human Services. The theory underlying Project TNT is that young people will best be able to resist using tobacco products if they 1) are aware of misleading social information that facilitates tobacco use (e.g., advertising, inflated prevalence estimates), 2) have skills that counteract the social pressures to achieve approval by using tobacco, and 3) appreciate the physical consequences that tobacco use may have on their own lives (e.g., the beginnings of addiction).

EVALUATION DESIGN

Five conditions (four programs and the "usual school health education" control) were contrasted using a randomized experiment involving 6,716 seventh-grade students from 48 junior high schools. Four curricula were developed. Three of these curricula were designed to counteract the effects of separate (single) program components (normative social influence, informational social influence, and physical consequences), whereas a fourth, comprehensive curriculum, Project TNT, was designed to counteract all three effects. To determine outcomes, 1- and 2-year followups were conducted after the initial intervention was delivered.

PROGRAM DEVELOPER

Steve Sussman, Ph.D., FAAHB

Dr. Steve Sussman is a professor in the Departments of Preventive Medicine and Psychology and the Institute for Health Promotion and Disease Prevention Research at the University of Southern California. He has published more than 170 articles, chapters, and books in the area of drug abuse prevention and cessation. Recent projects include Project Toward No Drug Abuse and Project EX, one of the largest and most successful teen tobacco-use cessation trials to date.

Target Areas

Protective Factors To Increase

Individual

- Accurate knowledge concerning tobacco addiction and related diseases, the consequences of using tobacco, and the prevalence of tobacco use among peers
- Effective communication, refusal, and cognitive coping skills
- Awareness of how the media and advertisers influence teens to use tobacco products
- Self-esteem
- Active use of strategies for advocating no tobacco use
- Knowledge how to quit tobacco use

Family

- Understanding of tobacco addiction among adults

Peer

- Responsible classroom behavior

School

- Enforcement of no tobacco use at the school

Community

- Letter writing to discourage mass media promotion of tobacco use or products

Risk Factors To Decrease

Individual

- Incorrect information concerning tobacco-use myths, tobacco-use prevalence, and tobacco-use social images
- Poor social skills
- Susceptibility to negative peer social influence

Family

- Family modeling of tobacco use
- Accessibility to tobacco products

Peer

- Peer modeling of tobacco use and other risky behavior
- Peer influence to use tobacco

School

- Evidence of tobacco use among school personnel or visitors to the school

Community

- Mass media promotion of tobacco use or products

CONTACT INFORMATION

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To order teacher's manual and student workbooks:

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Web site: www.etr.org

RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Programs That Work—National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services

Exemplary Program—U.S. Department of Education

Programs That Work—Centers for Disease Control and Prevention, U.S. Department of Health and Human Services

Reconnecting Youth

Reconnecting Youth (RY) is a school-based prevention program for youth in grades 9 through 12 (14 to 18 years old) at risk for school dropout. These youth also may exhibit multiple behavior problems, such as substance abuse, aggression, depression, or suicide risk behaviors. Reconnecting Youth uses a partnership model involving peers, school personnel, and parents to deliver interventions that address the three central program goals:

- Decreased drug involvement
- Increased school performance
- Decreased emotional distress

Students work toward these goals by participating in a semester-long high school class that involves skills training in the context of a positive peer culture. RY students learn, practice, and apply self-esteem enhancement strategies, decisionmaking skills, personal control strategies, and interpersonal communication techniques.

TARGET POPULATION

RY is highly effective with high school youth at risk for school dropout—defined as having fewer than the average number of credits earned for their grade level, high absenteeism, a significant drop in grades, or a history of dropping out of school. The program was developed and tested in the greater Seattle area and has been successfully implemented according to design in California, Colorado, Maine, Texas,

SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Proven Results*

- 18% improvement in grades in all classes
- 7.5% increase in credits earned per semester
- 54% decrease in hard drug use
- 48% decrease in anger and aggression problems
- 32% decline in perceived stress
- 23% increase in self-efficacy

*Compared to students not participating in Reconnecting Youth.

INTERVENTION

Universal

Selective

Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

Relative to controls, high-risk youth participating in RY evidenced:

Increased School Performance

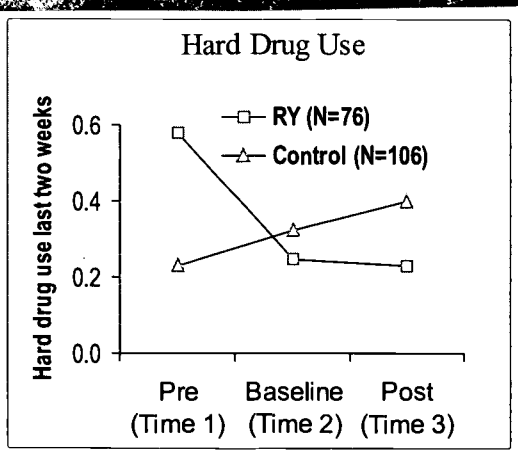
- Increased grades (GPA) in all classes
- Curbed increasing trend in daily class absences
- Increased credits earned per semester
- Decreased high school dropout

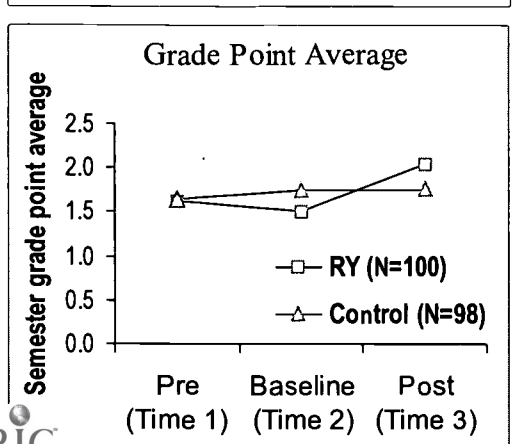
Decreased Drug Involvement

- Curbed progression of alcohol and other drug use
- Decreased drug-use control problems
- Decreased hard drug use
- Decreased adverse drug-use consequences

Decreased Emotional Distress

- Decreased suicidal behaviors (threats, thoughts, and attempts)
- Decreased anxiety and perceived stress
- Decreased depression and hopelessness
- Decreased anger control problems and aggression





and Washington. Students from a variety of racial and ethnic backgrounds, living in suburban and urban settings, have benefited from the program.

BENEFITS

- Improved grades and school attendance
- Reduced drug involvement
- Decreased emotional distress
- Increased self-esteem, personal control, prosocial peer bonding, and social support

HOW IT WORKS

Four key RY components are integrated into the school environment. They include:

- **RY Class**, a core element, is offered for 50 minutes daily during regular school hours for 1 semester (80 sessions) in a class with a student-teacher ratio of 10 or 12 to 1. After a 10-day orientation to the program, approximately 1 month is spent on each of these topics:
  - Self-esteem
  - Decisionmaking
  - Personal control
  - Interpersonal communication
- **School bonding activities** consisting of social, recreational, school, and weekend activities that are designed to reconnect students to school and health-promoting activities as alternatives to drug involvement, loneliness, and depression.
- **Parental involvement**, required for student participation, is essential for at-home support of the skills students learn in RY class. School contact is maintained through notes and calls from teachers who also enlist parental support for activities and provide progress reports.
- **School Crisis Response** planning provides teachers and school personnel with guidelines for recognizing warning signs of suicidal behaviors and suicide prevention approaches.

IMPLEMENTATION ESSENTIALS

From planning through implementation of the RY curriculum, partnerships with school officials are vital. Typical partners include the RY teacher, RY coordinator, parents, designated district representative, the principal, vice principal, student support services, staff, and administrative support staff—especially attendance and registrar. Regular meetings to ensure readiness, commitment, and financial resources will help set a strong foundation for successful replication.

Personnel

- One full-time RY coordinator per every five to six classes is needed to provide teacher support, encouragement, and consultation. The role typically includes bimonthly meetings as well as weekly classroom observation. The RY coordinator is hired and paid by the RY teacher funding source (e.g., school, independent agency). Ideally, the RY coordinator is a skilled RY teacher with supervisory and training expertise.
- RY teachers are selected, not assigned, using preestablished criteria to ensure the program has teachers who are committed to working with high-risk youth and show special aptitude based on student, other teacher, and administrative recommendations.

RY offers recommended selection criteria to identify potential participants. From this group, students should be invited rather than assigned to RY, and their parents must sign an agreement for them to participate. Students' expressed willingness to work toward program goals is essential.

Reconnecting Youth operates best in an environment with active supports. School administrators should secure links with community groups for involvement such as funding, "adoption" of a school to provide mentoring or in-kind donations, or help with providing drug-free activities.

Room, Equipment, and Supplies

A classroom large enough to accommodate the RY teacher and 10 to 12 students is necessary. Teachers will need a copy of the *Reconnecting Youth: A Peer Group Approach to Building Life Skills* curriculum and will need to prepare student notebooks from handouts contained therein. The curriculum can be obtained from the publisher. Please note that the curriculum cost is not included in training costs. Recreational and school-bonding activities, including transportation, will also need to be budgeted.

Training and Technical Assistance

To ensure best-results implementation fidelity, all RY teachers and coordinators should receive implementation training. Onsite implementation training for potential RY teachers and coordinators is available from RY personnel. Initial implementation training lasts 5 days. Followup implementation consultation of 1 day every 6 months during the first year of implementation plus phone consultation is recommended. At least one yearly followup consultation, to manage implementation challenges and to assess implementation fidelity in subsequent years, is also recommended.

Target Areas

Protective Factors To Increase

Individual

- Communicate using self-esteem-enhancing talk
- Personal control, stress, and mood management skills
- Decisionmaking and the ability to apply it to drug use, school, and mood management
- Interpersonal communication and negotiation skills

Family

- Practicing interpersonal communication skills at home
- Enlisting parent support for program goals

School

- Setting norms for and monitoring attendance, achievement, mood, and drug-use control
- School network support
- Facilitating prosocial activities

Peer

- Daily reinforcement of the positive peer group culture norms
- Replacing deviant peer/group belonging with prosocial group belonging

Risk Factors To Decrease

Individual

- Impulsiveness
- Poor decisionmaking and coping skills
- Uncontrolled emotions
- Learned helplessness
- Low self-worth; deviant self-image
- Poor social/interpersonal skills

Family

- Family distress and serious conflicts
- Poor family-school connections
- Unclear/unfair rules

School

- Negative view of school experience
- Norms of skipping school
- Substance use at school
- Poor teacher-student relationships
- Low access to help
- Nonparticipation in school activities

Peer

- Deviant friends in peer group network
- Peers who skip school and use drugs
- Peers lacking personal goals related to school achievement and attendance
- Susceptibility to negative peer influences

PROGRAM BACKGROUND

The development and framework for RY were largely informed by early descriptive work of Dr. Leona Eggert and her colleagues. Early work identified the vulnerabilities among youth at risk for high school dropout, "skippers," and the co-occurring problem behaviors of school deviance, drug involvement, and depression/suicidal behaviors. Reconnecting Youth was specifically designed to meet the participants' needs for inclusion and excitement while teaching them how to be "winners," stay in control, make wise decisions, and evaluate potential consequences of their choices. The program has been funded for testing by the National Institute on Drug Abuse (NIDA) and the National Institute of Mental Health (NIMH), National Institutes of Health, U.S. Department of Health and Human Services, and the U.S. Department of Education in suburban and urban areas of the Pacific Northwest. A two-semester version of the program, with a parent component, is currently being evaluated with funding from NIDA. RY has been adopted by Texas and Maine as an integral part of statewide prevention programming.

EVALUATION DESIGN

A quasi-experimental design with repeated measures was used to test the efficacy of the RY indicated preventive intervention. Trend analyses served to compare the pattern of change for experimental and control groups across pre- and posttests (5 months) and followup tests (5 to 7 months).

PROGRAM DEVELOPER

Leona Eggert, Ph.D., RN, FAAN

Over the past 15 years, Dr. Leona Eggert has led a team of prevention scientists in the Reconnecting Youth Prevention Research Program. They have designed and tested numerous programs to help high-risk youth increase their school performance, drug-use control, and mood management. Reconnecting Youth: A Peer Group Approach to Building Life Skills (RY) is an indicated school-based prevention program targeting potential high school dropouts. The program has received extensive funding from both NIDA and NIMH for testing the RY prevention model. Developers and authors Dr. Eggert and Ms. Liela Nicholas consult nationally and internationally on the implementation and evaluation of the program.

CONTACT INFORMATION

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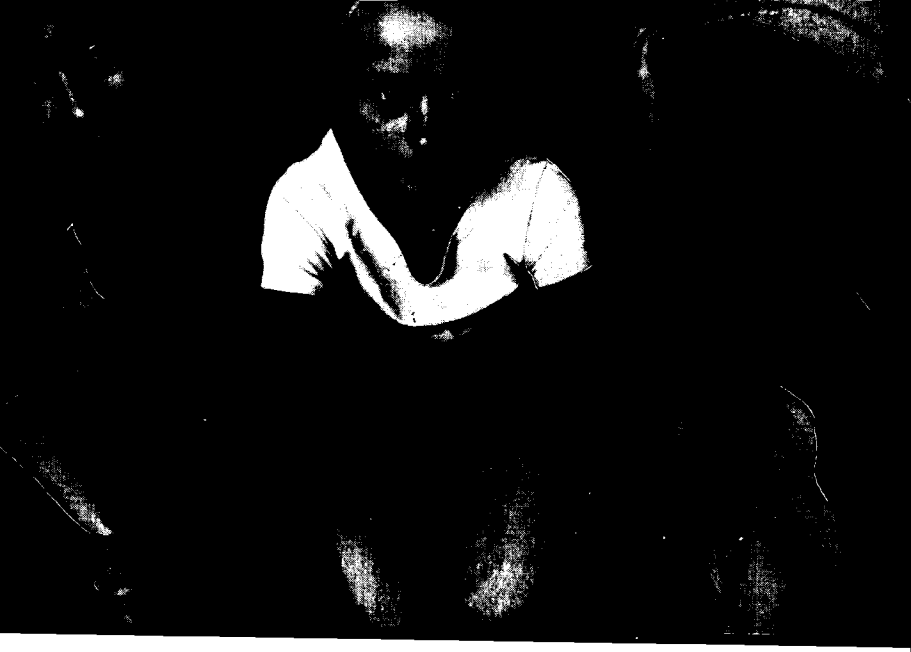
RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Programs That Work—National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services

Grade "A" & "A+"—Drug Strategies, Inc.



Residential Student Assistance Program

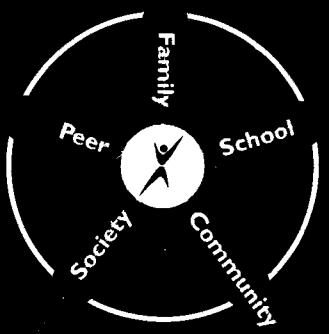
The Residential Student Assistance Program (RSAP) is a substance abuse prevention program developed for high-risk adolescents, 14 to 17 years old, living in residential facilities. The program is based on the Westchester Student Assistance Model and works by placing highly trained professionals in residential facilities to provide residents with a full range of substance abuse prevention and early intervention services. The program uses proven prevention strategies that include:

- Information dissemination
- Normative and preventive education
- Problem identification and referral
- Community-based interventions
- Environmental approaches

RSAP counselors work with adolescents individually and in small groups. Intervention services are fully integrated into the adolescent's overall experience at the residential facility and have an impact on both their school and residential environments.

TARGET POPULATION

RSAP was tested with 14- to 17-year-old adolescents, primarily African American and Hispanic/Latino, living in various residential facilities. Whether voluntarily or involuntarily placed in such facilities, these youth typically present with multiple risk factors and problems, including early substance use; parents who abuse substances; participation in violent or delinquent acts; histories of physical, sexual, or psychological abuse; chronic failure in school; and mental health problems, including attempted suicide.



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Proven Results*

- 68% decrease in overall substance use
- 72% reported ending alcohol use
- 59% reported ending marijuana use
- 27% reported ending tobacco use
- 82% of alcohol nonusers remained nonusers
- 83% of marijuana nonusers remained nonusers
- 79% of tobacco nonusers remained nonusers

* *Relative to adolescents in comparison groups who did not participate in the RSAP.*

INTERVENTION

Universal

Selective

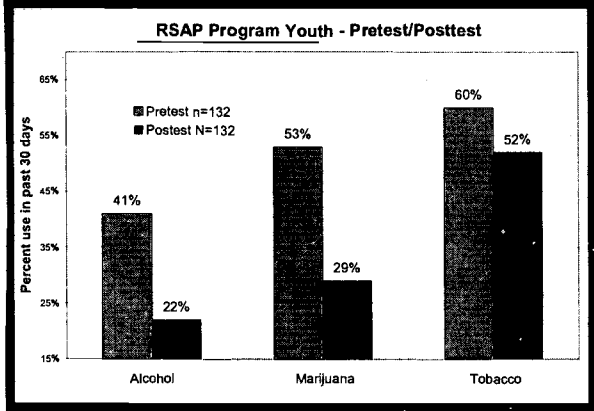
Indicated

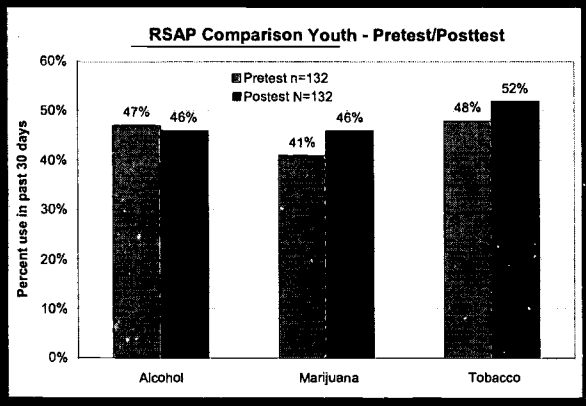
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

Adolescents participating in RSAP showed dramatic reductions in their use of alcohol, marijuana, and tobacco from pretest to posttest measures. For youth not reporting use at pretest, data regarding 30-day use at posttest revealed that:

- 82% remained nonusers of alcohol
- 83% remained nonusers of marijuana
- 78% remained nonusers of tobacco





For youth who reported using substances at the pretest, their posttest reports of use in the past 30 days showed:

- 72% reported no longer using alcohol
- 59% reported no longer using marijuana
- 27% reported no longer using tobacco

BENEFITS

Teaches adolescents important resistance and social competency skills, including:

- Communication
- Decisionmaking
- Stress and anger management
- Problem solving
- Resisting peer pressure

HOW IT WORKS

A partnership is established between a prevention agency and residential facility. An individual with a master's degree in social work, counseling, or psychology, who is experienced in adolescent substance abuse prevention counseling, is recruited to work in the facility as a Student Assistance Counselor (SAC). The SAC provides the facility with a full range of substance abuse prevention and early intervention services that will help residents decrease their risk factors for substance abuse and increase their overall resiliency. Program components include:

- **The Prevention Education Series**—The SAC conducts this eight-session substance use prevention education program.
- **Assessment**—Following the Prevention Education Series, residents are seen individually by the SAC to determine their level of substance use, family substance abuse, and need for additional services.
- **Individual and Group Counseling**—After assessment, the SAC conducts a series of 8 to 12 group-counseling sessions. Residents are placed in one of five different groups based on their developmental differences, substance use patterns, and family history of substance abuse. Individual sessions are scheduled as needed.
- **Referral & Consultation**—The SAC refers residents who require assistance to treatment, more intensive counseling, or 12-step groups. Additionally, the SAC trains and consults with residential facility staff and coordinates the substance abuse services and policies of the facility.

IMPLEMENTATION ESSENTIALS

RSAP requires the formation of a partnership between a prevention agency that will administer the program and a residential facility where it will operate. Specific staff involved in the partnership include:

- **Residential Facility Senior Executive**—This person establishes the initial implementation agreement, oversees the program, and appoints an RSAP liaison who will supervise the SAC and day-to-day program operations.
- **Executive Director/Project Director**—This person initiates and manages the program, sets up procedures, hires staff, and is responsible for direct program oversight.
- **Student Assistance Counselor (SAC)**—This person implements the program at the facility and provides all prevention and early intervention services to residents.
- **Project Supervisor**—This individual supervises the SAC.

These staff members must complete the following administrative steps to ensure successful program implementation:

- Define program goals and objectives
- Define target population
- Provide training and consultation for school staff
- Establish a school staff substance abuse task force
- Establish a school substance abuse task force
- Obtain technical assistance and training

A 75-page implementation manual, which includes resource material for professionals and worksheets for students, and a video are available. Onsite and offsite training of varying lengths, up to 5 days, also is available.

PROGRAM BACKGROUND

RSAP began in 1987 as a 5-year demonstration program in Westchester County, NY, funded through a Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention High-Risk Youth Grant. The program model was based on employee assistance programs successfully used by industry to identify and aid employees whose work performance and lives had been adversely affected by substance abuse. Other experiences contributing to this program's design came from the county's successful implementation of the Westchester Student Assistance Programs within its high schools. This program intended to adapt that model for institutionalized adolescents at a very high risk for substance abuse. The residential facilities participating in the demonstration project included a locked county correctional facility, a residential treatment center for emotionally disturbed adolescents, a nonsecure residential facility, and three foster care facilities.

Target Areas

Protective Factors To Increase

Individual

- Self-efficacy and sense of mastery
- Social competence

Family

- Distancing from chemically dependent parents

Risk Factors To Decrease

Individual

- Juvenile justice and criminal involvement
- Severe emotional problems or mental disabilities
- Suicidal ideation

Family

- Parental substance abuse
- Abuse and neglect

EVALUATION DESIGN

A pretest and posttest nonequivalent comparison group design was used with a total sample of 326 adolescents. Approximately 125 residents participated in RSAP, while the others served as internal and external comparison groups. The internal comparison group was composed of youth from the residential facility that chose not to participate in RSAP. The external comparison group was made up of youth from another residential facility that did not have RSAP. All participants were required to participate in a pretest and posttest assessment. Assessment instruments included a shortened version of the *Monitoring the Future Questionnaire*, the *Rosenberg Self-Esteem Test*, and the *Global Assessment of Functioning*. In addition, the *Community Oriented Program Environment Scales* were used to measure the residents' and staffs' perception of the site environment.

PROGRAM DEVELOPER

Student Assistance Services (SAS) Corporation of Tarrytown, NY, developed RSAP. SAS is a private, nonprofit, community-based substance abuse prevention organization. It was formed in 1985 when its core program, the Student Assistance Program, spun off from the Westchester County Department of Community Mental Health, which had operated it since 1979.

CONTACT INFORMATION

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RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Second Step:
A Violence Prevention Curriculum

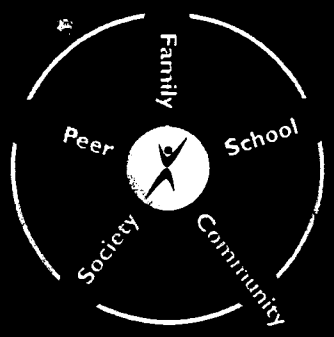
Second Step is a classroom-based social skills program for preschool through junior high students (4 to 14 years old). It is designed to reduce impulsive, high-risk, and aggressive behaviors and increase children's social-emotional competence and other protective factors.

Group discussion, modeling, coaching, and practice are used to increase students' social competence, risk assessment, decisionmaking ability, self-regulation, and positive goal-setting. The program's lesson content varies by grade level and is organized into three skill-building units covering:

- Empathy—teaches young people to identify and understand their own emotions and those of others;
- Impulse control and problem solving—helps young people choose positive goals; reduce impulsivity; and evaluate consequences of their behavior in terms of safety, fairness, and impact on others; and
- Anger management—enables young people to manage emotional reactions and engage in decisionmaking when they are highly aroused.

TARGET POPULATION

Developed for preschool through ninth-grade students (4 to 14 years old), the program's curriculum is intended for use with a broad population of students. Second Step has been proven effective in geographically diverse U.S. and Canadian cities, in classrooms varying in ethnic/racial makeup (predominantly African American, predominantly White, or highly racially mixed), and in schools with students of varied socioeconomic status.



SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Proven Results*

- 20% reduction in physical aggression during lunchtime and recess, compared to control group which increased 41%
- 10% increase in positive social behavior during lunchtime and recess
- 36% less aggressive behavior during conflict/arousing situations
- 41% reduction in the need for adult intervention during conflicts
- 37% more likely to choose positive social goals

*Compared to control group

INTERVENTION

Universal

Selective

Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

Significant outcomes in preschool-kindergarten included:

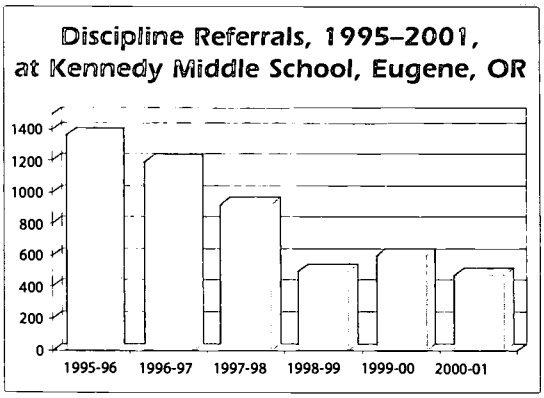
- Decreased verbal aggression, disruptive behavior, and physical aggression
- Improved empathy skills and consequential thinking skills

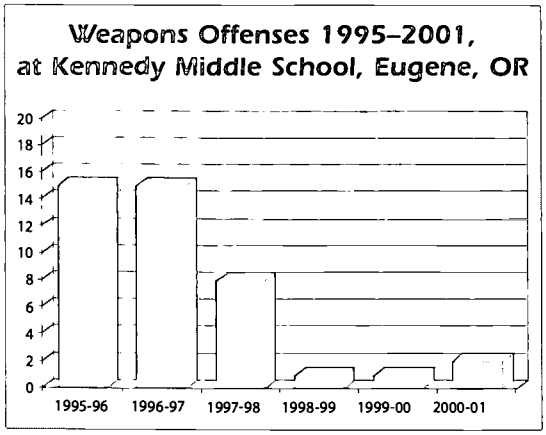
At the elementary level, Second Step has led to:

- Decreased aggression on the playground and in conflict situations
- Decreased need for adult intervention
- More prosocial goal-setting
- Increased social competence and positive social behavior
- Higher levels of empathic behavior in conflict situations (girls)

Middle and junior high school students showed:

- Less approval for physical, verbal, and relational aggression
- Increased confidence in their ability to regulate emotions and problem-solve
- Improved ability to perform social-emotional skills





Second Step is widely used in the United States and Canada, and has been adapted for use in several other countries. Spanish-language supplements are available.

BENEFITS

- Decreases disciplinary referrals
- Increases positive goal-setting
- Increases social competence and positive social interaction
- Decreases approval of physical aggression, verbal hostility, and social exclusion
- Provides practice in peer pressure resistance skills
- Increases risk-assessment and decisionmaking ability

HOW IT WORKS

Second Step lessons are based on interpersonal situations depicted in 11-by 17-inch black-and-white photos and/or videos. The accompanying scripted lesson guides the class discussion and skill practice. Teachers model the skills and children practice them. The pre-K level curriculum includes puppet scripts and sing-along tapes. The middle/junior high school curriculum includes homework assignments.

All lessons recommend ways to transfer skills to the classroom and practice and reinforce them during regular school activities. To promote transfer of learning, posters listing anger management and problem-solving steps are provided. In addition, the curricula for preschool through fifth grade contain a parent education video designed to orient families to the Second Step program.

IMPLEMENTATION ESSENTIALS

Second Step program kits contain everything teachers need to present the program to students. Guides and resources that support a schoolwide implementation are provided to administrators. Between 20 and 25 lessons per year are provided for elementary grades. The middle/junior high school curriculum includes 15 lessons in year 1 and 8 lessons in years 2 and 3. The developmentally appropriate lessons build sequentially within and between each grade level, and should be taught in order.

Materials

Basic program materials include:

- Administrator's and Teacher's Guides
- Photo cards with scripted lesson on reverse side (preschool to fifth grade)
- Classroom videotape

- Posters
- Parent education videotape and reproducible letters
- Sing-along tape (preschool)
- Puppets (preschool)
- Overhead transparencies and reproducible homework sheets (secondary grades)

Training and Technical Assistance

To obtain the best possible outcomes, it is strongly recommended that all school staff be trained in the program. The options are a 1-day staff and teacher training and a 3-day training of trainers. Ongoing program implementation support is available free of charge by phone. The developer also provides free printed materials to help with program selection, implementation, and onsite evaluation, and a quarterly client newsletter.

Resources

Other materials available include:

- Family Guide materials for presenting six workshops to parents
- Segundo Paso, a Spanish-language version used in conjunction with the Second Step student materials.

PROGRAM BACKGROUND

Second Step was developed in the mid-1980s by Committee for Children, a not-for-profit organization of educators and mental health professionals. Previous work provided training for teachers and parents regarding sexual abuse prevention and reporting. CFC program *Talking About Touching* taught personal safety skills to children. In 1985, the organization's mission broadened to include children's aggressive and high-risk behaviors. A development team led by Kathy Beland, M.A., worked to translate scientific research into a school-friendly program with a positive focus—Second Step.

Phillip Kendall's work on cognitive-behavioral interventions formed the backbone of the new program. This was integrated with techniques derived from social learning theory (Bandura), empathy research (Feshbach; Eisenberg), social information-processing models (Dodge), and Spivak and Shure's work on problem solving. Educators appreciated the easy-to-use format and scientific base. In 2002, Second Step was revised with updated lessons and materials, and more videotapes were added.

Target Areas

Protective Factors To Increase

Individual

- Social competence
- Empathy
- Social problem-solving skills
- Emotion regulation
- Risk assessment and decisionmaking
- Goal-setting

Peer

- Quality peer relations

School

- Positive classroom and school climate
- School engagement

Family

- Increased parental support of social/personal skills development

Risk Factors To Decrease

Individual

- Aggression
- Lack of impulse control

Peer

- Peer rejection
- Peer support for antisocial behavior

School

- Disrupted learning environment

EVALUATION DESIGN

At least a dozen evaluations have been conducted on Second Step, by itself or in conjunction with complementary programs (e.g., literacy programs, B.E.S.T.). Among those focusing on only Second Step are:

A randomized pre- and posttest comparison of 790 elementary school children in experimental and control schools. Observers, blind to school condition, made systematic observations of aggressive and positive social behaviors in class and on school playgrounds. Teachers rated student social competence and anti-social behavior.

A study of more than 800 second- and fourth-grade students for 2 years compared experimental and control students on measures of social competence, antisocial behavior, and social beliefs. Observers, blind to school condition, counted aggressive and collaborative behaviors in conflict situations.

A pre- and posttest comparison of behavior and knowledge was conducted with a sample of inner-city African American preschool and kindergarten children. Observers, blind to condition, measured disruptive and aggressive behaviors. Interviewers assessed children's social skills knowledge.

Middle school and junior high school students in intervention and non-intervention classrooms were compared for pre- to posttest changes in social skills knowledge, approval of aggression, and perceived ability to manage emotions and perform social skills.

PROGRAM DEVELOPER

Committee for Children

Committee for Children is a not-for-profit organization whose mission is to promote the safety, well-being, and social development of children, by creating quality educational programs for educators, families, and communities. The organization develops social-emotional learning curricula for children—programs include *Second Step: A Violence Prevention Curriculum* (teaches social-emotional skills), *Talking About Touching: A Personal Safety Curriculum* (teaches sexual abuse prevention skills), and *Steps to Respect: A Bullying Prevention Program.* Committee for Children provides program implementation training and support for these programs.

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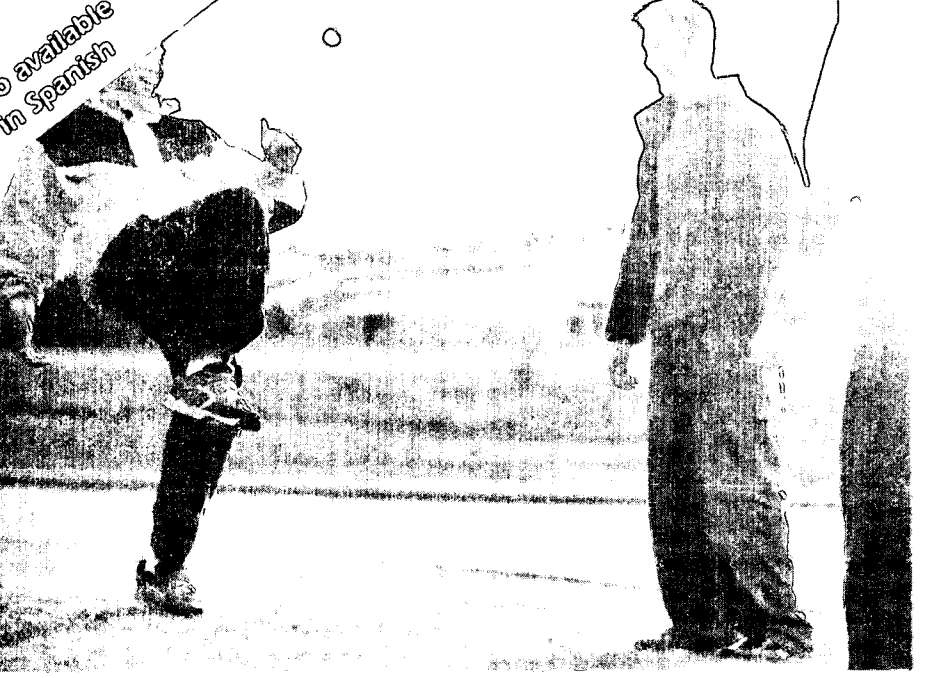
RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Exemplary Program—U.S. Department of Education

Rated "A" Program—Drug Strategies



Start Taking Alcohol Risks Seriously (STARS) for Families

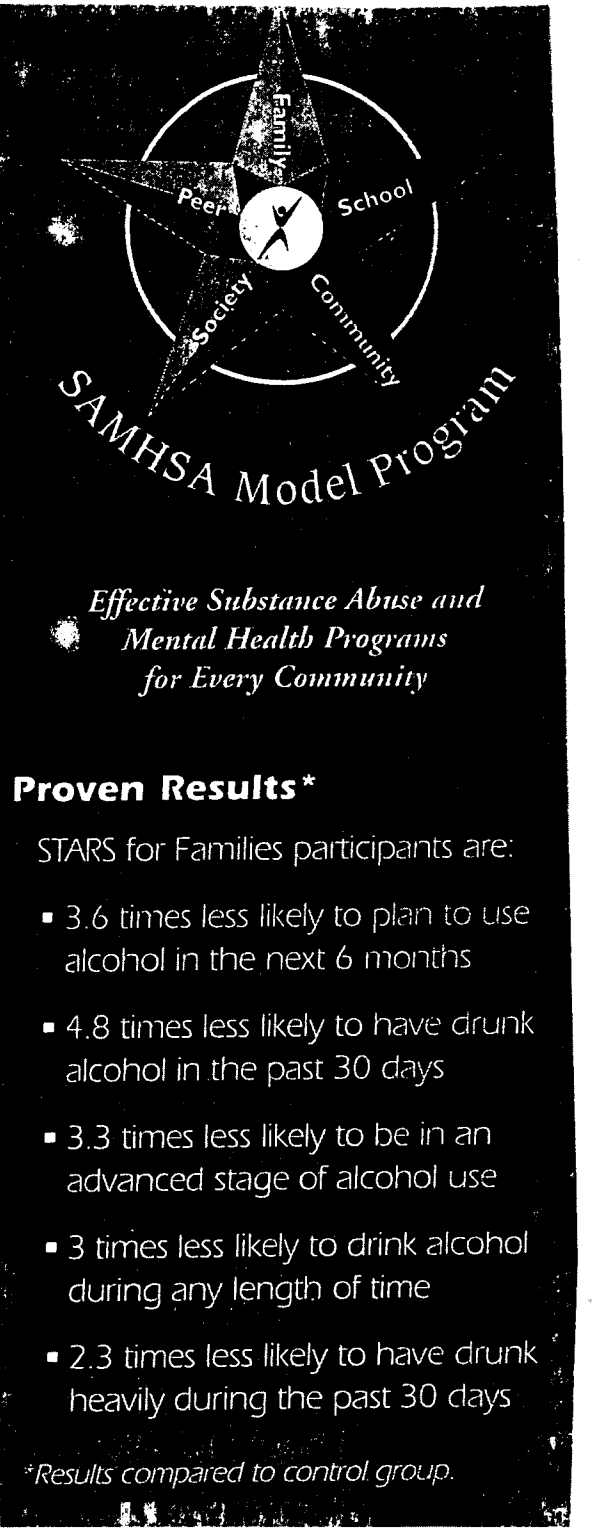
Start Taking Alcohol Risks Seriously (STARS) for Families is a health promotion program for preventing alcohol use among at-risk middle and junior high school youth (11 to 15 years old). The goal of STARS for Families is to have all youth postpone alcohol use until adulthood. The STARS for Families program matches media-related, interpersonal, and environmental prevention strategies to each child's specific stages of alcohol initiation, stages of readiness for change, and specific risk and protective factors. This innovative program has been shown to result in avoidance of, or reductions in, alcohol use among participants.

TARGET POPULATION

STARS for Families is designed for middle and junior high school youth and their families. The program has been tested and shown useful for 11- to 15-year-old youth in both urban and rural schools and for youth attending physical exams for sports teams.

BENEFITS

- Delays the onset of alcohol use among youth
- Reduces quantity and frequency of any alcohol use and heavy alcohol use among those already drinking
- Increases motivation to avoid alcohol use
- Reduces alcohol use risk factors and beliefs that support the use of alcohol
- Increases protective factors and resistance skills
- Increases parent-child communication about alcohol use prevention



INTERVENTION

Universal

Selective

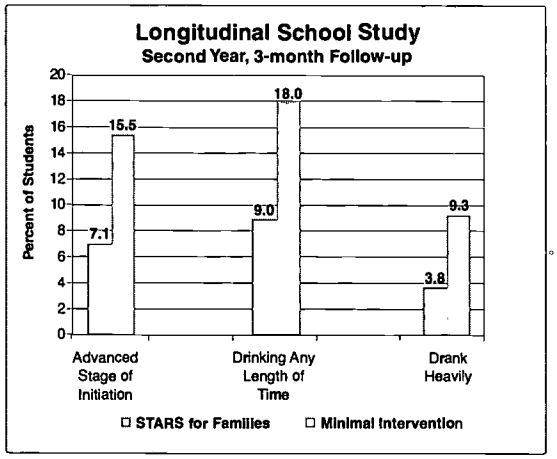
Indicated

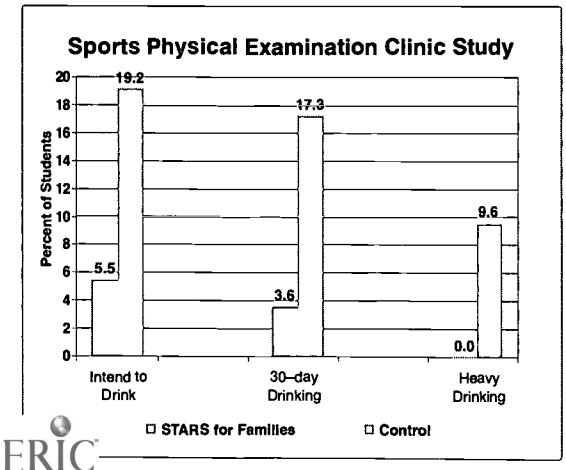
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

A longitudinal study of STARS for Families found that, relative to the controls, participants:

- Were less likely to be in more advanced stages of alcohol initiation 3 months after completing the program
- Were less likely to have drunk alcohol in both the past 7 days and past 30 days, 3 months after program completion
- Were less likely to have drunk heavily during the past 30 days, 3 months after program completion
- Were less likely to be planning to drink in the next 6 months, 1 year after the program ended
- Decreased their intention to drink in the future, 1 year after the program ended
- Had greater motivation to avoid alcohol use, 1 year after the program ended
- Experienced fewer total alcohol-use risk factors, 1 year after the program ended





HOW IT WORKS

STARS for Families consists of three primary strategies:

- **Health Care Consultation**—A nurse or other health care provider delivers a brief (20-minute) annual health consultation concerning how to avoid alcohol use. The intervention is designed to reach youth at specific stages of alcohol initiation and readiness for change and provides a range of prevention messages.
- ***Key Facts* Postcards**—Ten *Key Facts* postcards are mailed to parents or guardians in sets of 1 or 2 per week for 5 to 10 weeks. The cards tell parents what they can say to their children to help them avoid alcohol. Parents can return a detachable postage-paid portion of the card to provide information about their interaction with their children and its usefulness.
- **Family Take-Home Lessons**—Parents and guardians are provided with four weekly take-home prevention activities they can complete with their children and return. The lessons include an alcohol avoidance contract for the child to sign and a feedback sheet to collect satisfaction and usage data from parents.

Unlike most existing programs that consist of several weeks of classroom lessons, the STARS for Families program uses very brief, potentially cost-effective strategies. These strategies can be implemented within schools, health clinics, youth organizations, work sites, families, religious organizations, and communities, using little time and causing minimal organizational disruption.

IMPLEMENTATION ESSENTIALS

Successful replication of STARS for Families involves:

- Recruiting participating youth of middle or junior high school age
- Training nurses or health care providers to administer the program
- Delivering and monitoring annual one-on-one nurse-youth consultations
- Delivering and monitoring implementation of *Key Facts* postcards
- Delivering and monitoring implementation of family take-home lessons
- Conducting pre- and post-program outcome data collections to measure program effects

STARS for Families can be implemented anytime. A sample implementation timeline is provided in the STARS for Families Complete Manual, which also includes all intervention protocols, forms, process measures, program evaluation materials, and training materials. Intervention components are typically administered over the course of 1 to 3 years.

STARS for Families requires participation of trained nurses or other health care providers and a program coordinator. These professionals receive 1 to 2 days of training, and the program can be implemented immediately after training. Even though STARS for Families' consultation protocols are highly scripted, training is recommended to ensure the implementation of accurate and effective consultations.

PROGRAM BACKGROUND

STARS for Families was developed at the Center for Drug Prevention Research, University of North Florida, College of Health, with grants from the National Institute on Alcohol Abuse and Alcoholism. STARS for Families is a health promotion program that uses health care providers and parent prevention materials to prevent alcohol use among at-risk youth.

The program is founded on the Multi-Component Motivational Stages (McMOS) prevention model, which posits stages of habit initiation in health-damaging behavior, such as substance use, that parallel and exist in conjunction with the stages of change described in the Transtheoretical Model. The McMOS prevention model hypothesizes that progression through the stages of initiation and change is influenced by risk and protective factors such as those described as constructs within contemporary psychosocial health theories. Finally, McMOS proposes the use of a range of communication channels for matching prevention content and strategies to specific stage status, including a media and media-related materials channel, an interpersonal channel, and an environmental channel.

EVALUATION DESIGN

The Center for Drug Prevention Research, University of North Florida, has conducted research studies of brief alcohol preventive interventions, including STARS for Families, for more than 8 years. The Center recently studied a modified version of STARS for Families using a randomized controlled trial that tested the program's feasibility and efficacy in physical examinations for school sports teams. The evaluation involved 178 seventh through ninth grade students from one urban, one suburban, and one rural school located in a northeast Florida county. Participating youth were recruited by project staff and introduced to participating nurses during physicals for school sports programs. Most subjects were male (52 percent), and either White (75 percent) or African American (13 percent), with a mean age of 13.1 years (SD=1.00). Subjects were randomly assigned to the intervention or a control group with a 6-month posttest.

Target Areas

Protective Factors To Increase

Individual

- Problem-solving skills
- Communication and social skills
- Belief in society's values
- Motivation to pursue positive goals

Peer

- Association with peers involved in activities not involving alcohol

Family

- High parental expectations
- Clear and consistent parental expectations
- Parental involvement

Society

- Media literacy and resistance to pro-use messages

Risk Factors To Decrease

Individual

- Lack of self-control and peer-refusal skills
- Favorable attitudes toward alcohol use
- Low self-confidence in ability to refuse alcohol offers

Peer

- Association with peers who use alcohol
- Susceptibility to negative peer pressure

Family

- Family attitudes that favor alcohol use
- Ambiguous, lax, or inconsistent rules regarding alcohol use

PROGRAM DEVELOPER

Chudley E. Werch, Ph.D., CHES, FAAHB

Dr. Werch has served as principal investigator on all grants resulting in the development and testing of the STARS for Families preventive intervention. He is research and distinguished professor, Department of Health Science, and director of the Center for Drug Prevention Research at the University of North Florida. Dr. Werch has participated as a consultant or principal investigator for numerous substance abuse prevention and health promotion projects, and is co-developer of another SAMHSA Model Program, Keep A Clear Mind.

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RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Promising Prevention Program—The Urban Institute

Strengthening Families Program

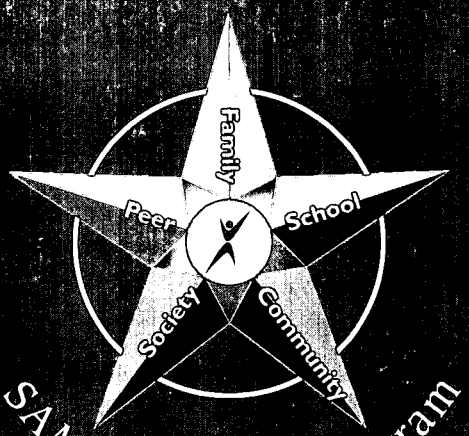
The Strengthening Families Program (SFP) involves elementary school-aged children (6 to 12 years old) and their families in family skills training sessions. SFP uses family systems and cognitive-behavioral approaches to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems. It builds on protective factors by:

- Improving family relationships
- Improving parenting skills
- Increasing the youth's social and life skills

SFP offers incentives for attendance, good behavior in children, and homework completion to increase program recruitment and participation.

TARGET POPULATION

SFP was originally developed and tested in 1983 with 6- to 12-year-old children of parents in substance abuse treatment. Since then, culturally modified versions with new manuals have been evaluated and found effective for families with diverse backgrounds: African American, Asian/Pacific Islander, Hispanic/Latino, Native American, Canadian, and Australian. SFP is also now widely used with non-substance-abusing parents in elementary schools, faith communities, housing communities, mental health centers, jails, homeless shelters, protective services agencies, and social and family services agencies.



Effective Substance Abuse and Mental Health Programs for Every Community

Proven Results*

- Improves resilience, assets, and protective factors in children and parents
- Decreases risk factors in parents and children
- Decreases children's behavioral problems and conduct disorders
- Improves family cohesion, communication, and organization
- Decreases family conflict and stress

*Reductions in aggression and found conduct problems averaged 10 times larger than school-based, child-only prevention interventions.

INTERVENTION

Universal

Selective

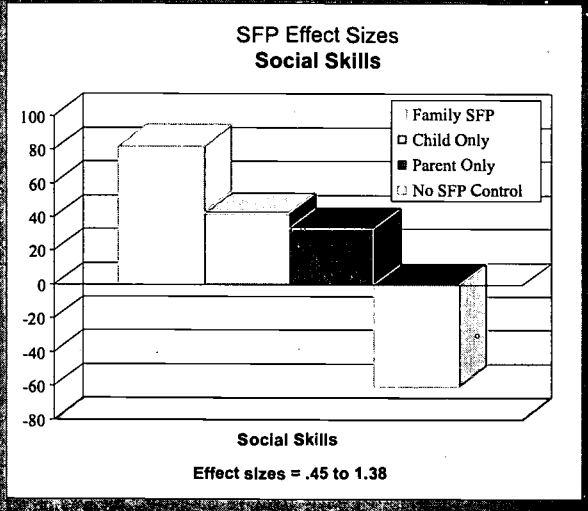
Indicated

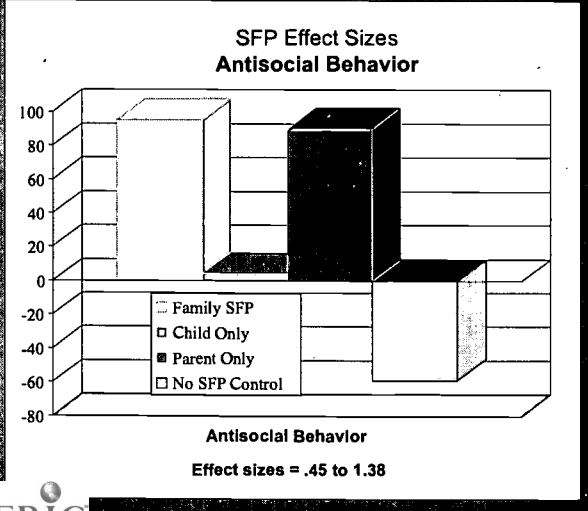
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

OUTCOMES

Using randomized experimental designs and pre- and posttest data collection, research has found consistent positive results for diverse families, and up to 5-year followup measures including:

- Parent Training improves parenting skills and children's behaviors and decreases conduct disorders.
- Children's Skills Training improves children's social competencies (i.e., communication, problem solving, peer resistance, and anger control).
- Family Skills Training improves family attachment, harmony, communication, and organization.
- Full SFP improves more risk and protective factors predictive of later problem behaviors than other studied interventions.





BENEFITS

Immediate results include:

- Improvements in family environment and parenting skills
- Increased prosocial behaviors in children
- Decreased child depression and aggression
- Decreased substance use among parents and children

At 5-year followup:

- 92% of families still used parenting skills, and 68% still held family meetings

HOW IT WORKS

The SFP curriculum is a 14-session behavioral skills training program of 2 hours each. Parents meet separately with two group leaders for an hour to learn to increase desired behaviors in children by increasing attention and rewards for positive behaviors. They also learn about clear communication, effective discipline, substance use, problem solving, and limit setting.

Children meet separately with two children's trainers for an hour, to learn how to understand feelings, control their anger, resist peer pressure, comply with parental rules, solve problems, and communicate effectively. Children also develop their social skills and learn about the consequences of substance abuse.

During the second hour of the session, families engage in structured family activities, practice therapeutic child play, conduct family meetings, learn communication skills, practice effective discipline, reinforce positive behaviors in each other, and plan family activities.

Booster sessions and ongoing family support groups for SFP graduates increase generalization and the use of skills learned.

IMPLEMENTATION ESSENTIALS

Successful replication of SFP requires:

- Implementation of all 14 Parent, Child, and Family Skills Training sessions using SFP manuals and meeting once or twice per week. (Program manuals and other materials may be copied from an SFP CD-ROM.)
- An optimal family load of 4 to 14 families per group.
- Committed and experienced staff, including a part-time site coordinator and four group leaders (working 5 hours per week) who receive 2 to 3 days of training from SFP master trainers. (Warm, empathetic, genuine, and creative leaders are most effective.)

- Reunions or booster sessions of approximately 3 hours each every 6 months.
- Two large training rooms equipped with flip charts and extra space and tables for meals and childcare.
- Family meals, transportation, and childcare should be provided (reduces barriers to attendance).

PROGRAM BACKGROUND

SFP was originally developed by Dr. Karol Kumpfer and associates with a grant from the National Institute on Drug Abuse (NIDA), National Institutes of Health, U.S. Department of Health and Human Services, from 1982 to 1986. It developed out of multiple existing science-based prevention programs. The Parent Training component includes basic behavioral parent training techniques developed by Dr. Gerald Patterson and used in many behavioral parent training programs. The Children's Social Skills component took elements from Dr. Myrna Shure's *I Can Problem Solve*, which also is used in the Seattle Social Development Project and Second Step Program. The Family Skills Training component uses family communication exercises based on Dr. Bernard Guerney's *Family Relationship Enhancement Program*, family meetings used in many effective programs, and child and parent game techniques developed by Dr. Robert McMahon and Dr. Rex Forehand for the *Helping the Non-compliant Child Program*. A new 2001 version of SFP, available on CD-ROM, was modified based on practitioner feedback.

EVALUATION DESIGN

SFP has been evaluated more than 17 times on Federal grants and 150 times on State grants by independent evaluators. The original study involved a true pretest, posttest, and followup experimental design with random assignment of families to one of four experimental groups: 1) parent training only; 2) parent training plus children's skills training; 3) the complete SFP including the family component; and 4) no treatment besides substance abuse treatment for parents. SFP was then culturally adapted and evaluated with five Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention (CSAP) High Risk Youth Program grants by independent evaluators using statistical control group designs that involved quasi-experimental, pre-, post- and 6-, 12-, 18-, and 24-month followup. Recently, SFP was compared to a popular school-based aggression prevention program (*I Can Problem Solve*) and found highly effective (effect sizes = .45 to 1.38) employing a true experimental pre-, post-, 12-, and 24-month followup design in two Utah school districts. A NIDA effectiveness research study of 195 African American and White families in Washington, DC, randomly assigned to parent training only, children's skills training only,

Target Areas

Protective Factors To Increase

Individual
- Self-esteem
- Social and life skills
- Resistance to negative peer influences

Family
- Parenting efficacy
- Family organization
- Effective communication
- Parent–child attachment
- Parental mental health

Peer
- Prosocial friends
- Effective communication

School
- Grades
- School bonding

Risk Factors To Decrease

Individual
- Depression
- Conduct disorders
- Aggression
- Shyness and loneliness

Family
- Family conflict
- Excessive punishment
- Child abuse and/or neglect
- Ineffective discipline
- Modeling of substance use by family members
- Differential acculturation

Peer
- Substance-using friends
- Negative peer influence

School
- Tardiness
- Absenteeism

the full SFP, or minimal contact control, suggests very positive results in reducing children's behavior problems (e.g., aggression and conduct disorders) and improving children's social skills. (See *Outcomes* section.)

PROGRAM DEVELOPERS

Karol Kumpfer, Ph.D.
Henry Whiteside, Ph.D.

Program developer Dr. Karol Kumpfer is a child psychologist, substance abuse prevention researcher, and associate professor of Health Promotion and Education at the University of Utah. From 1998 to 2000, she was director of CSAP in Washington, DC. Other State and local research practitioners have worked with Dr. Kumpfer to develop and evaluate cultural adaptations of SFP for diverse families. Dr. Henry Whiteside, managing partner of Lutra Group, rewrote the 2001 SFP version on CD-ROM and runs the training system.

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RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Programs That Work—National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services

Promising Program—Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice

Exemplary Program—U.S. Department of Education

SMART Team

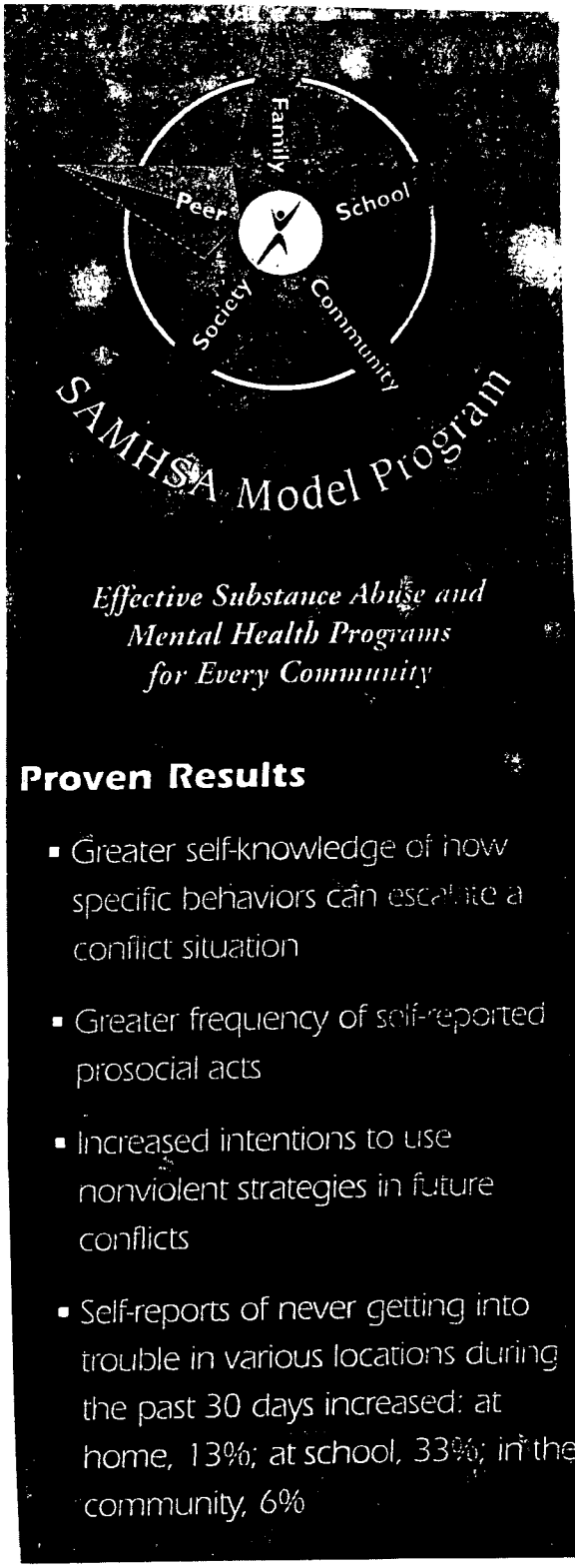
SMART Team is an eight-module, multimedia software program designed to teach violence prevention messages and methods to students in grades six through nine (11 to 15 years old). The program's content fits well with commonly used conflict-mediation curricula and other violence prevention strategies schools may implement. Operation is straightforward, so students can access the modules independently for information, skill-building practice, or to resolve a conflict. This independence eliminates the need for trained adult implementers.

TARGET POPULATION

SMART Team is designed for use with middle and high school students, typically 11 to 15 years old. Evaluations conducted in a large middle school 10 miles from a major midwestern city found the program motivating and effective for a broad range of students. In this school's population, which was socioeconomically and racially diverse (84 percent were White), evaluation results revealed no differences in use rates based on gender, ethnicity, or among students eligible for free or reduced-price lunches (which was used as a measure of socioeconomic status).

BENEFITS

- Gain better understanding of others' perspectives
- Increased conflict resolution and anger management skills
- Decreased beliefs that support the use of violence
- Experience behavior modeling and decisionmaking in realistic contexts



INTERVENTION

Universal

Selective

Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
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OUTCOMES

In the pilot study, SMART Team students demonstrated the following, relative to control groups:

- Correct responses on two of the four items increased significantly
- Significant increases in self-knowledge of how their behaviors can contribute to escalation of a conflict
- Significant increases in self-reported frequency of prosocial behavior and intention to use nonviolent strategies
- Self-reports of never getting into trouble increased whether at home (13% to 32%), school (33% to 44%), or in the community (6% to 54%)
- Students reacted positively to the software: 89% found it easy to use, 91% agreed it was enjoyable to use, 68% reported learning a lot, and 79% would recommend it to a friend
- Both males and females used the program and accessed a range of modules

In the formal evaluation, the intervention group, relative to no-treatment controls:

- Showed greater intentions to use nonviolent strategies ($p = .01$)
- Showed a reduction in beliefs supporting the use of violence ($p = .05$)

The self-awareness measure approached significance at $p = .10$, and self-efficacy and aggressive behavior remained essentially unchanged between pretest and posttest in the intervention group while increasing slightly in the control group.

HOW IT WORKS

SMART Team is designed so that the same basic content is present in every module, which allows modules to stand alone or be used in sequence. Thus, students can acquire a basic set of declarative knowledge through any of the modules. The theoretical underpinnings of the instructional design are twofold:

- **A skill acquisition model** that postulates five stages of learning a new skill, from novice to expert, with learners having different needs at each stage.
- **Social learning theory** that contributes an understanding of how children observe the verbal and nonverbal behavior of role models.

Students acquire three categories of skills:

- **Anger replacement skills** are taught using a skill-building program that combines a psycho-educational intervention with anger-control training and moral education.
- **Dispute resolution skills** help students use negotiation and compromise to resolve disputes.
- **Perspective taking skills** help students to accurately identify other people's feelings and recognize that they may be different from the student's own feelings and perceptions.

All program software modules focus on one of these skills. The modules, which use various interactive interview and game formats, are for each set of skills as follows:

Anger Management

- **What's Anger?** A didactic presentation of the anger replacement therapy model.
- **Triggers and Fuses.** An interactive interview that helps students to identify the situations that trigger their anger.
- **Anger Busters.** General guidelines for dealing with an angry person or an anger-producing situation, specific strategies for de-escalating anger-producing situations, and opportunities for practice.
- **Channel Surfin'.** A game that addresses all the anger-management skills learned elsewhere in authentic situations.

Dispute Resolution

- **Talking It Out.** An interactive mediation process that two students can work through in order to resolve a dispute. This module also provides a written contract that can be printed out.

- **Teen Talk.** The experiences of four high-school student mediators, described in their own words.

Perspective Taking

- **Celebrity Interviews.** Suggestions for resolving conflict and managing the stresses of interpersonal relationships given by four celebrities.
- **What's on THEIR Mind?** A "game-show" scenario format in which users identify different reasons underlying other people's actions to help them better understand others' perspectives.

IMPLEMENTATION ESSENTIALS

SMART Team software has been used primarily in schools, where it was loaded on computers located in classrooms, computer labs, and counselors' offices. However, SMART Team may be used in other settings such as community agencies. The sole constraint on where it can be used is the need for the necessary computer hardware.

SMART Team software is designed to operate on a Macintosh computer with a 68020 CPU or greater, 1.5 MB of RAM, 7.5. MB of hard drive space, and a System 7.0 operating system or newer CD-ROM drive. Less than a half-hour is required to load the program prior to initial use. Thereafter, the program has proved simple enough to be accessed independently by students with rudimentary computer skills. In fact, the program is so easy to use, no requests for instructor or teacher training have ever been made. Teachers may wish to conduct a followup discussion to ascertain students' reactions and reinforce the content of the modules, but direct teaching is optional.

PROGRAM BACKGROUND

SMART Team is one of a series of health, education, and prevention multimedia products developed since the early 1980s at the Center for Health Systems Research and Analysis at the University of Wisconsin-Madison. David H. Gustafson, Ph.D.; Kris Bosworth, Ph.D.; Robert Hawkins, Ph.D.; and Betty Chewning, Ph.D., directed the development of the Body Awareness Resource Network (BARN) software that was the basis for SMART Team. The BARN software includes information and skill-building activities relating to six topics: 1) alcohol and other drugs, 2) body management, 3) human sexuality, 4) stress management, 5) smoking, and 6) HIV/AIDS. SMART Team originally was conceived as an additional module for the BARN system but later became a separate entity. The development of SMART Team began in 1993 with a contractual agreement with the Centers for Disease Control and Prevention and was completed in 1996.

Target Areas

Protective Factors To Increase

Individual

- Social and emotional competence
- Communication skills
- Responsiveness, empathy, and inclination toward prosocial behavior
- Self-discipline

Risk Factors To Decrease

Individual

- Inadequate life skills
- Lack of self-control and assertiveness
- Poor peer-refusal skills

Peer

- Susceptibility to negative peer pressure
- Strong external locus of control

EVALUATION DESIGN

A pilot study was conducted to field-test the SMART Team software. Seventh-grade students in a small-city middle school had access to the program for 4 weeks in their computer lab. After each use, students completed a short questionnaire about their satisfaction with the software and suggestions for improvement.

Formal evaluation used a pretest-posttest design with matched intervention and control groups. This evaluation took place in a large middle school 10 miles from a major midwestern city. Two groups within the school were randomly assigned to the intervention condition (n = 321), and the third to the control condition (n = 195). SMART Team was available for 13 weeks, during which time data were unobtrusively collected by computer. The impact of intervention was assessed with repeated measures multivariate analyses of covariance. The pretest-posttest data were assessed for five outcome measures: 1) self-awareness, 2) beliefs supportive of violence, 3) self-efficacy, or confidence in using nonviolent strategies, 4) intentions to use nonviolent strategies in a future conflict, and 5) self-reported acts of aggression. For all items, the students rated their level of agreement or disagreement with various statements on a five-point scale. (See *Outcomes* for details.)

PROGRAM DEVELOPER

Kris Bosworth, Ph.D.

Dr. Kris Bosworth and colleagues at the University of Indiana's Center for Adolescent Studies developed SMART Team. Its development was supported by a 3-year cooperative agreement with the Centers for Disease Control and Prevention, National Center for Injury Prevention. Currently, Dr. Bosworth is working on a series of videos to demonstrate to teachers how to manage major and minor incidents in the classroom entitled "Peaceful Classrooms."

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RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Promising Program—U.S. Department of Education

Too Good For Drugs

Too Good For Drugs (TGFD) is a school-based prevention program proven to reduce the intention to use alcohol, tobacco, and illegal drugs in middle and high school students. Developed by the Mendez Foundation for use with students in kindergarten through 12th grades (5 to 18 years old), TGFD has a separate, developmentally appropriate curriculum for each grade level, and is designed to develop:

- Personal and interpersonal skills relating to alcohol, tobacco, and illegal drug use
- Appropriate attitudes toward alcohol, tobacco, and illegal drug use
- Knowledge of the negative consequences of alcohol, tobacco, and illegal drug use and benefits of a drug-free lifestyle
- Positive peer norms

The program's highly interactive teaching methods encourage students to bond with prosocial peers, and engage students through role-play, cooperative learning, games, small group activities, and class discussions. Students have many opportunities to participate and receive recognition for involvement. TGFD also impacts students through a family component used in each grade level: "Home Workouts" in kindergarten through 8th grade, and "Home Pages" in high school.

TARGET POPULATION

TGFD targets kindergarten through 12th grade students, 5 to 18 years old. It was developed in Hillsborough County (Tampa), FL, the Nation's 12th largest school district, and tested there in six middle schools. The program was later tested in three Hillsborough County high schools and

SAMHSA Model Program

Effective Substance Abuse and Mental Health Programs for Every Community

Proven Results*

TGFD* reduced students' intentions to:

- Smoke cigarettes: middle school 33%; high school 58%
- Drink alcohol: middle school 38%; high school 50%
- Smoke marijuana: middle school 25%; high school 45%
- Fight: high school 45%

* Compared to students in control groups.

INTERVENTION

Universal

Selective

Indicated

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
www.samhsa.gov

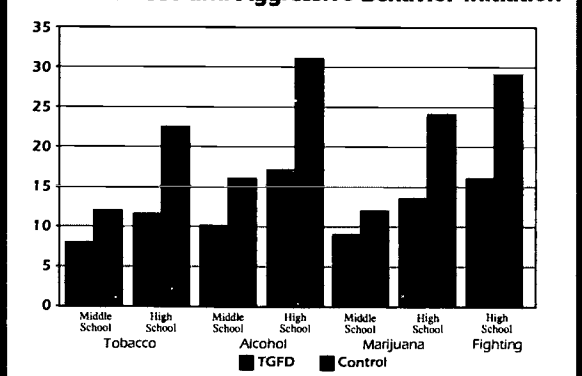
OUTCOMES

Each of the five studies showed positive effects on other risk and protective factors relating to student alcohol, tobacco, and illegal drug use and violence, including significant increases ($p \leq .001$) in:

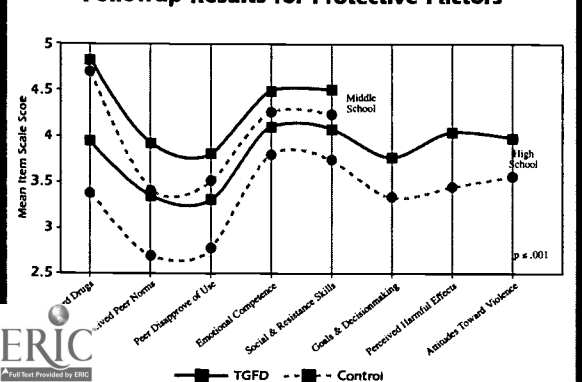
- Attitudes toward drugs
- Attitudes toward violence
- Perceived peer norms
- Peer disapproval of use
- Emotional competence
- Social and resistance skills
- Goals and decisionmaking
- Perceived harmful effects

Positive effects on substance use and protective factors continued to be seen both short- and long-term. Outcomes in comparison to controls include significant increases in students' protective factors ($p \leq .001$).

Followup Results for Middle and High School Substance Use and Aggressive Behavior Initiation



Followup Results for Protective Factors



all Lake County, FL, high schools. Through this testing, TGFD was proven effective with African American, Asian American, Hispanic/Latino, and White students in rural, urban, and suburban areas.

BENEFITS

- Reduces risk and enhances protective factors that affect alcohol, tobacco, and illegal drug use
- Reduces intentions to use alcohol, tobacco, and illegal drugs
- Develops more appropriate attitudes toward alcohol, tobacco, and illegal drugs
- Improves decisionmaking, goal setting, and peer resistance
- Increases friendships with peers less likely to use alcohol, tobacco, and illegal drugs

HOW IT WORKS

TGFD consists of sequential curricula, developmentally appropriate to each grade level, which builds on skills learned in the previous years. While one year of TGFD has produced measurable positive effects, multiyear programming prevents or reduces degradation of these effects. For maximum effectiveness, TGFD should be implemented each school year. TGFD uses proven, research-based strategies, including:

- **Multilesson, Multigrade-Level Programming:** 10 lessons per grade level, kindergarten through 8th grade; 26 high school lessons, with 14 core lessons delivered in the same class and 12 infusion lessons included in other academic classes, all over the course of a single grade level.
- **Normative Education:** provides accurate information about the percentage of youth that use drugs and the percentage that would disapprove if their friends used drugs.
- **Information on Harmful Effects of Drug Use:** raises students' perception of risk.
- **Prosocial Skills Development:** features goal setting, decisionmaking, coping, communication, and peer refusal skills.
- **Diverse Role-Play Situations:** relating to alcohol, tobacco, and illegal drug use and associated problem behaviors provide many opportunities for practice.
- **Cooperative Learning:** promotes prosocial skills and academic development.
- **Parental Involvement:** promotes discussion and reinforces concepts and skills students learn in TGFD.

IMPLEMENTATION ESSENTIALS

For successful implementation, TGFD requires skilled, committed, enthusiastic teachers who personally exhibit the attributes encouraged by TGFD, e.g., non-smokers and non-substance abusers, possessing positive social skills, showing empathy and kindness.

For maximum effectiveness, teachers should deliver:

- One lesson per week for 10 weeks (K-8th grade) and "Home Workouts" for parents
- One lesson per week for 14 weeks (in one high school grade level) or twice a week, if needed, and "Home Pages" for parents
- Twelve high school infusion lessons within subject areas

To attain the best result, each school should:

- Conduct a needs assessment
- Set measurable goals and objectives
- Appoint a schoolwide TGFD coordinator and grade-level coordinators, if desired
- Plan program implementation
- Conduct "TGFD & Violence—Educators" staff development workshop or present overview of TGFD for faculty, and teacher training
- Observe lessons; provide feedback; conduct process evaluations
- Conduct pre- and posttests
- Write evaluation report; recommend implementation changes, if needed

Staff and Administrative Support

Ideally, implementation begins with "Too Good for Drugs & Violence—Educators," a 10-hour staff development program attended by all school personnel—from teachers and secretaries to janitors and food service workers. This course is designed to evaluate and improve school and classroom climate, establish positive norms, and increase students' bonding with the teacher and school. At minimum, begin with an overview of TGFD for the entire school staff.

Training/Technical Assistance

One- or two-day teacher/staff training on how to use each grade-specific curriculum is strongly recommended. Training and technical support are provided by The Mendez Foundation.

Resources/Materials

TGFD includes 10 lessons (kindergarten–8th grade), a 14-lesson core curriculum plus 12 infusion lessons in high school, and 10 staff development sessions. Each grade-level kit includes a scripted curriculum, participant

Target Areas

Protective Factors To Increase

Individual

- Decisionmaking and goal-setting skills
- Stress management skills
- Peer resistance and assertiveness skills
- Internal locus of control
- Positive sense of self-efficacy
- Unfavorable attitudes toward alcohol, tobacco, and illegal drug use
- Accurate perception of peer norms
- Intentions to avoid alcohol, tobacco, and illegal drug use

Family

- Unfavorable parental attitudes toward alcohol, tobacco, and illegal drug use

School

- Bonding with the teachers/school

Risk Factors To Decrease

Individual

- Poor decisionmaking and goal-setting skills
- Poor stress management skills
- Weak assertiveness and peer resistance skills
- Inadequate social skills
- Poor sense of self-efficacy
- External locus of control
- Favorable attitudes toward alcohol, tobacco, and illegal drug use
- Inaccurate perception of peer norms
- Intentions to use alcohol, tobacco, and illegal drugs

Family

- Favorable parental attitudes toward alcohol, tobacco, and illegal drug use

School

- Lack of bonding with teachers/school

workbooks, and teaching materials. Each lesson includes rationale, objectives, materials list, recommended resources, lesson extenders, and a "Home Workout" or "Home Pages" for parents.

Space, Equipment, and Resource Requirements

TGFD is designed for a classroom with a cassette player and overhead projector. Staff-to-program participant ratio is 1 teacher for 30 to 35 students.

PROGRAM BACKGROUND

The Mendez Foundation began providing drug prevention education in Hillsborough County, FL, in 1978. TGFD began as a sixth-grade program taught in a single school. Since then, it has become a comprehensive K-12 program.

After a national television documentary featured TGFD and other promising programs in 1983, the Foundation received calls from leaders around the country who wanted to replicate the program in their own communities. In response, the Foundation began to publish manuals and offer curriculum training and training of trainers. Revised in 1998, to incorporate leading-edge research, TGFD has been implemented in more than 2,500 districts nationwide.

EVALUATION DESIGN

Five studies conducted by independent evaluator Tina Bacon have examined TGFD's effectiveness in reducing adolescents' intention to use tobacco, alcohol, and marijuana, reducing fighting, and strengthening protective and resiliency factors. All of the studies examined pretest equivalence between treatment and control groups; potential bias of loss of student data over time; quality of program implementation; and estimates of reliability and validity of assessment tools.

Middle school studies used a repeated measures treatment-control group design. Middle schools from the Hillsborough County school district were stratified based on location, size, academic performance, and socioeconomic status. Sixth-grade students (n =1,318) were pre- and posttested following the delivery of the TGFD program, 20 weeks, and 1 year later.

High school studies used a pretest/posttest randomized design. Sample populations included students from one large high school from the Nation's 12th largest school district (n = 201) and students from six high schools in a small, rural Florida school district (n = 303).

PROGRAM DEVELOPER

The Mendez Foundation is a not-for-profit organization nationally recognized as an innovative leader in prevention education. Since 1978, the Foundation has been dedicated to helping adults and children develop the skills to live safe, healthy, balanced lives. The staff includes 25 teachers/prevention specialists, trainers, a researcher, and a curriculum development team. Administrators have master of education degrees and certified addiction prevention professional certification. Hundreds of thousands of students nationwide have successfully completed Mendez Foundation prevention programs.

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RECOGNITION

Model Program—Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Excellence in Prevention—American Medical Association

Shining Star Award—Southeastern Drug-Free Schools

First Place in Prevention—Florida Alcohol and Drug Abuse Association/Department of Children and Families Best Practices Conference

SAMHSA Effective Programs

As noted earlier in this report, effective programs are prevention programs that produce a consistent positive pattern of results. Only programs that positively affect the majority of intended recipients or targets are considered effective. These programs must score at least 4.0 on a 5-point scale on parameters of Integrity and Utility. Descriptions of all effective programs that have emerged from NREPP are summarized below.

AIDS Community Demonstration Projects (ACDP)

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The AIDS Community Demonstration Projects (ACDP) evaluated the effectiveness of using community volunteers to deliver a theory-based intervention designed to increase consistent condom and bleach use in a number of populations. The ACDP was a multisite study of five U.S. cities: Dallas, Denver, Long Beach, New York City, and Seattle. Researchers from the project sites and the US DHHS Centers for Disease Control and Prevention collaborated with expert consultants to design a common protocol that was adapted to develop site-specific and population-specific community-level interventions. The target population consisted of ethnically diverse, traditionally hard-to-reach, populations at high risk: men who have sex with men but who do not gay-identify, injection-drug users who are not recruited from treatment programs, female sex partners of male injection drug users, female prostitutes or sex traders, and youth in high-risk situations. Each project intervened with one to three of these groups.

The behavioral intervention materials, in the form of small media such as newsletters, brochures, flyers, or baseball cards, contained role-model stories. Each site produced unique materials with stories tailored to the local populations, based on the experience of local residents and highlighting specific stages of change and theoretical factors based on local data. The media also contained basic AIDS information; instructions on the use of condoms or bleach; biographies of community members participating in the project; and information on other health and social services, such as locations of homeless shelters or needle exchanges, free meals, mammogram screening, or drug and alcohol treatment services. At the community level, movement toward consistent condom use with main and nonmain partners, as well as increased condom carrying, was greater in intervention than in comparison communities. At the individual level, respondents recently exposed to the intervention were more likely to carry condoms and have higher stage-of-change scores for condom and bleach use.

Be Proud! Be Responsible!

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Be Proud! Be Responsible! encourages low-income African-American adolescents in middle and high schools to be proud of themselves and their community, to behave responsibly for the sake of themselves and their community, and to consider their goals for the future and how unhealthful behavior might thwart reaching those goals. The program aims to reduce HIV risk behaviors and increase condom use among African-American adolescents.

Participants attend a 5-hour program designed to increase their knowledge of AIDS and sexually transmitted diseases and to weaken problematic attitudes toward risky sexual behaviors. Designed to be educational but also entertaining and culturally sensitive, the program involves group discussions, videos, games, brainstorming, experiential exercises, and skill-building activities. It also includes information about risks associated with injection-drug use and specific sexual activities. The intervention is based on the social cognitive theory, theory of reasoned action, and theory of planned behavior. The abstinence portion of the intervention is designed to (1) increase knowledge of HIV and sexually transmitted diseases (STDs); (2) strengthen behavioral

beliefs supporting abstinence; and (3) increase self-efficacy and skills regarding peer pressure and negotiation. The safer-sex portion of the intervention is designed to (1) increase HIV/STD knowledge and the belief that using condoms could prevent pregnancy and HIV/STD; (2) allay fears regarding adverse effects of condoms; and (3) increase skills and self-efficacy regarding their ability to use condoms.

One study reported that adolescents who received the intervention had greater AIDS knowledge, less favorable attitudes toward risky sexual behavior, and lower intentions to engage in such behavior than did those in the control group. Three-month followup data revealed that intervention adolescents reported fewer occasions of coitus, fewer coital partners, and greater use of condoms than did the other adolescents. Another study reported that the abstinence participants were less likely to report having sexual intercourse in the 3 months after intervention than were control group participants. Safer-sex participants reported significantly more consistent condom use than did control group participants at 3 months.

Brief Alcohol Screening and Intervention for College Students (BASICS)

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BASICS (Brief Alcohol Screening and Intervention for College Students) is an intervention model under the general umbrella of Alcohol Skills Training Program, a skills-based curriculum that aims to reduce harmful consumption and associated problems in students who drink alcohol. BASICS targets heavy-drinking college undergraduates who either have experienced problems because of heavy consumption or are at high risk of doing so. The primary goal of BASICS is to move a student in the direction of reducing risky behaviors and harmful effects from drinking, as opposed to focusing explicitly on a specific drinking goal, such as abstinence or reductions in drinking. BASICS is nonlabeling, nonconfrontational, nonauthoritarian, and nonjudgmental.

BASICS is conducted over the course of two 50-minute interview sessions. In the first interview, the therapist assesses the student's consumption pattern. In the second interview, the therapist apprises the student of negative behavioral consequences from use of alcohol and other behaviors that may contribute to the student's health risks. Personalized feedback based on the assessment and specific advice about ways to reduce future health risks associated with alcohol use are reviewed. Additional services can range from a single booster session of BASICS to more traditional outpatient or inpatient treatment.

A single-session, individualized preventive intervention was evaluated annually over 4 years, within a randomized control trial with college freshmen who reported drinking heavily while in high school. A randomly selected group from the entire screening pool provided a normative comparison. High-risk controls showed secular trends for reduced drinking quantity and negative consequences without changes in drinking frequency. The intervention group reported significant additional reductions, particularly with respect to negative consequences. Followup assessments in another 2-year randomized control trial showed significant reductions in both drinking rates and harmful consequences, favoring students who received the intervention.

CASASTART

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CASASTART (Center on Addiction and Substance Abuse—Striving Together to Achieve Rewarding Tomorrows) is a community-based, school-centered program designed to keep youth at high risk free of drug and crime involvement through a coordinated effort of preventive services and law enforcement activities. It operates on three levels: building resiliency in the child, strengthening families, and making neighborhoods safer for children and their families. The program targets youth between 8 and 13 years old who attend a partner school and display risk factors known to be strong indi-

cators of later involvement with substance abuse, delinquency, and academic failure. Every CASASTART child and family receive the following service components over their 2-year participation: (1) social support/intensive case management, (2) family services, (3) education services, (4) after-school and summer activities, (5) mentoring, (6) incentives, (7) community policing/enhanced enforcement, and (8) juvenile justice intervention. Participants receive all of the services through an individually tailored plan of service. The specific plans are based on the needs and strengths of the youths and families identified during the initial assessment phase.

Rigorous impact analyses found that children in the program, when compared to the matched control group at the 1-year followup, were significantly less likely to use gateway and stronger drugs, less likely to report involvement in drug trafficking, and more likely to be promoted to the next grade in school. They also reported significantly lower levels of violent offenses, higher levels of positive peer influence, lower levels of association with delinquent peers, and less peer pressure.

Cognitive Behavioral Therapy for Child Sexual Abuse

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Cognitive Behavioral Therapy (CBT) for Child Sexual Abuse is an empirically based treatment approach for children and adolescents ages 3 to 18 that addresses a wide range of trauma-related psychiatric symptoms in children who have been sexually abused. This program of individual and group therapy models for treating posttraumatic stress disorder (PTSD) and related difficulties in children emphasizes enlisting the support of parents or primary caretakers; encouraging children to therapeutically process traumatic memories; changing children's dysfunctional cognitions and behaviors; teaching personal safety skills; and enhancing communication between children and their caregivers. The CBT approach is suitable for all clinical- and community-based mental health settings.

The treatment program consists of parallel individual sessions with the child and his/her nonoffending parent(s), as well as joint parent-child sessions. The treatment approach can be effectively implemented in 12 sessions. Specific components of treatment include (1) psychoeducation about child sexual abuse and healthy sexuality; (2) coping skills training including relaxation, emotional expression, and cognitive coping; (3) gradual exposure and processing of traumatic memories and reminders; and (4) personal safety skills training. Parents also receive behavioral management training to strengthen children's positive behaviors while minimizing behavioral difficulties. Joint parent-child sessions are designed to help parents and children practice and use the skills learned while also fostering communication about the abuse and related issues. This treatment approach has been modified for use with children who have experienced other forms of abuse, such as physical abuse and exposure to domestic violence.

In a series of randomized control trials, the CBT approach led to significantly greater reductions in PTSD, depression, problem behaviors, and parental emotional distress, and resulted in greater improvements in personal safety skills in children. Research examining the impact of this treatment demonstrated the significant value of parental participation in treating acting-out behaviors and depression, but the direct CBT work with the child seemed to be most critical in effectively treating PTSD in this population.

Cognitive Behavioral Therapy for Child Traumatic Stress

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Cognitive Behavioral Therapy (CBT) for Child Traumatic Stress is a research-based treatment model for children and adolescents ages 3 to 18 that addresses a wide range of trauma-related psychiatric symptoms seen in children suffering from traumatic bereavement following September 11, 2001. Individual and group therapy models for treating posttraumatic stress disorder (PTSD) in children place emphasis on enlisting the support of parents or primary caretakers, encouraging children to therapeutically process traumatic memories, changing children's dysfunctional cognitions and behaviors, teaching safety skills, and building communication between adults and youth. This CBT approach is suitable for all clinical settings and most community-based mental health situations.

The 12 to 16 parallel individual sessions for parent and child address the following issues: (1) feeling identification; (2) cognitive coping/processing; (3) gradual exposure; (4) stress management; and (5) psychoeducation. Parents receive a behavioral management program to strengthen children's positive behaviors while minimizing behavioral difficulties. In the aftermath of September 11, 2001, the manual for individual and group CBT was revised specifically for use by therapists treating children who lost loved ones as a result of the terrorist attacks. The revision was undertaken with support of the SAMHSA-funded National Child Traumatic Stress Initiative and its Traumatic Bereavement Task Force. The CBT protocol was modified to focus on traumatic bereavement, with the intent to deal with the child's trauma and grief symptoms.

In a series of randomized control trials, this CBT approach led to significantly greater reductions in PTSD, depression, parental emotional distress, anxiety, problem behaviors, and sexually inappropriate behaviors. Research examining the impact of parent and child components of this treatment demonstrated the significant value of parental participation in treating acting-out behaviors and depression. However, direct CBT work with the child seemed to be of critical importance in effectively treating PTSD in this population.

Coping Power

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Coping Power is delivered to children at moderate to high risk in the late elementary school and early middle school years. The program lasts from 15 to 18 months and includes an integrated set of child and parent components. Coping Power is based on an empirical model of risk factors for substance use and addresses these children's deficits in social competence, self-regulation, school bonding, and positive parental involvement. The Coping Power child component consists of 33 group sessions and periodic individual sessions and is delivered in school-based settings. The Coping Power parent component consists of 16 group sessions and periodic home visits and individual contacts. Postintervention results indicate that the program has had effects on reducing children's aggressive behavior and preventing their substance use.

East Texas Experiential Learning Center

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The goal of the East Texas Experiential Learning Center is to reduce multiple risk factors for alcohol, tobacco, drugs, and inhalants (ATDI) use and abuse among economically disadvantaged seventh graders in Nacogdoches, a rural East Texas community. The project consists of school-based intervention, afterschool trips, weekend day trips at local wilderness facilities and forestlands, Wilderness Challenge Ropes adventure camp for five-day sessions, and community-based programming.

Objectives of the project are to increase the perception of harm of ATDI use by youth and peers at high risk; increase negative attitudes toward ATDI use among youth, peers, family, school, and community; improve social competence; increase both cognitive and social problem-solving skills; increase feelings of autonomy among targeted youth; increase sense of purpose and future; increase involvement of youth at high risk in alternative activities that do not include ATDI use; decrease level of conflict/violence at home, school, and community; enhance the climate at home, school, and community; increase the involvement of family, school, neighborhood, and community in dealing with ATDI problems; increase perception of harm of ATDI use; and increase parenting and teaching skills. The interventions used are adventure-based education; sharing and caring for the environment; development of community spirit and sense of responsibility; cognitive learning, including problem solving, negotiation, anger management and values enhancement; community training, including experiential learning, responsibility, consequences, and multicultural sensitivity; and a give-back program, including environmental community service projects and incentives that promote an investment by the youth in their community.

The program demonstrated the effectiveness of the social learning model within a risk factor approach in reducing risk factors for ATDI use and strengthening resiliency and protective factors, thereby reducing the incidence of ATDI use and related negative consequences.

Family Development Research Project (FDRP)

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The Family Development Research Project (FDRP) began as an omnibus effort to serve low-income, low-education families by providing education, nutrition, health, safety, and human service resources for 108 families. The goal is to support child and familial behaviors that sustain growth and development after the intervention ceases. Home visitors, or CDT's (Child Development Trainers), visited each family weekly from before the birth of the baby until the child was 5 years old and graduated from the FDRP. FDRP targeted very deprived families (low in both income and education) early in the last trimester of pregnancy. Program curriculum theory was based on Erik Erikson and Jean Piaget's work, language development theory, and Saul Alinsky's ideas of empowering families in poverty.

Program service delivery was divided into home visitation, infant-fold, and family-style delivery. Home visitation: CDT's visited 15 families each week demonstrating ways to nurture child development. Family problems—financial, emotional, social, and nutritional—were dealt with as they arose. Infant-fold: Infants were assigned to a caregiver for attention, cognitive and social games, sensorimotor activities, and language stimulation. Family-style: Preschoolers attended a multi-age program that conceptualized the environment as supporting child-chosen opportunities for learning and peer interaction in a spatial—rather than time-oriented—framework.

When the children were teenagers, about 10 years after their graduation from the FDRP program, they were assessed again. More of the FDRP youth expressed a liking for their own physical and personal attributes than did the contrast group. Only 6 percent of the program youth in the followup sample were processed as probation cases by the County Probation Department,

as compared to 22 percent of the control youth. Estimated juvenile court costs were also lower for program youth than for control youth. Education outcomes were not as remarkable for males as for females.

Family Matters

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Family Matters targets families with 12- through 14-year-old adolescents and helps families prevent teen alcohol and tobacco use. Family Matters is a universal prevention program because, in addition to including families with adolescents who do not use tobacco or alcohol, it includes adolescents who smoke or drink and those who are at high risk for other reasons. The program involves successive mailings of four booklets to families and subsequent telephone contacts by a health educator. The materials used for implementing Family Matters are (1) four booklets mailed in succession to families, (2) the Health Educator Guidebook, distributed to all health educators before training, and (3) pictures of small gifts, which were included in the mailings. Each booklet begins with an overview and then proceeds with a question-and-answer section, a description of suggested activities, a summary of the main considerations, and a preview of the next part of the program. The guidebook covers all aspects of program implementation and includes all materials relevant to the program. The health educators receive 2 days of formal training, including monitored practice sessions. Training continues as the program is implemented.

Findings from the main evaluation study reported significant reductions in the prevalence of adolescent smoking and alcohol drinking in the intervention group at 3-month and 12-month followups. Another study suggested that smoking onset was significantly reduced at 1-year followup for non-Hispanic whites. A published article reported that Family Matters was successful in changing several substance-specific aspects of family environment. Parents exposed to the program were more likely to set rules about tobacco and alcohol use, provide encouragement not to smoke, and talk about peer and media influences on alcohol use.

FAN (Family Advocacy Network) Club

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The FAN (Family Advocacy Network) Club is designed for parents of participants in Boys & Girls Clubs of America's SMART Moves program, including Start SMART (ages 10 to 12), Stay SMART (ages 13 to 15), and SMART Leaders (for 14- to 17-year-olds who have completed the Stay SMART program). Combined with these other SMART Moves components, the FAN Club program can be implemented in community-based youth organizations, recreation centers, and schools, in collaboration with a local Boys & Girls Club.

This parent involvement program is offered in combination with a 3-year sequential drug-prevention program for early adolescents at high risk for substance abuse in Boys & Girls Clubs. FAN Club activities fall into four general categories: basic support, parent support, educational program, and leadership activities. The program strengthens families by creating a bond between youth and their parents, providing opportunities for families to have fun together, and helping parents influence their children to lead drug-free lives.

Friendly PEERsuasion

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Friendly PEERsuasion is a leadership and substance abuse prevention program based on the social influence and life skills models of prevention. It is designed to help girls ages 11 through 14 acquire knowledge, skills, and support systems to avoid substance abuse. Underlying Friendly PEERsuasion is the theory that girls who are prepared to teach other children not to use sub-

stances would be less at risk of using those substances themselves. Through a process of "anticipatory socialization" (seeing themselves as future leaders), the girls trained to become PEERsuaders would be more likely to identify with the values and norms expressed by the staff than girls who had not undergone the training. The fundamental purpose is to build girls' capacity to become adults who are responsible, confident, economically independent, and personally fulfilled.

In the first phase, middle school girls participate in 14 biweekly, hour-long sessions facilitated by a trained adult leader. Through hands-on, interactive activities, they learn about the short- and long-term effects of substance abuse, experience healthy ways to manage stress, practice skills for making responsible decisions about drug use, and prepare to become peer leaders. After completing this phase, girls are certified as "PEERsuaders." In the second phase of the program, small teams of PEERsuaders working with adult leaders plan and implement 8 to 10 half-hour sessions of substance abuse prevention activities for children ages 6 through 10.

The program significantly reduced the incidence of drinking among participants and lowered the onset of drinking among participants who had not previously drunk alcohol. The treatment group participants significantly increased leadership skills, stress-reducing skills, and communication skills. Treatment group participants also showed a significantly lower incidence of favorable attitudes toward drinking. The program led participants to disengage from peers who smoked or used drugs.

Get Real About AIDS 1992

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The primary aim of this school-based, skills-based HIV prevention intervention was to postpone the onset of sexual intercourse and reduce the percentage of students engaging in sexual and drug use behaviors that place them at risk for HIV infection. The intervention aimed to positively affect the students' knowledge, attitudes, and behavior related to HIV infection.

The intervention consisted of a 15-session, skills-based curriculum; a set of instructional materials reinforced the themes of the HIV curriculum. The curriculum was organized around two primary theoretical formulations: social cognitive theory and theory of reasoned action. Three of the lessons focused on HIV-related functional knowledge, one on teen vulnerability to HIV, two on the normative determinants of risky behavior, one on condom use, and eight on the development skills designed to help students identify, manage, avoid, and leave risky situations.

Intervention students exhibited greater knowledge about HIV and greater intent to engage in safer sexual practices than the comparison students. Among sexually active students at the 6-month followup, intervention students reported fewer sexual partners within the past 2 months, greater frequency of condom use, and greater intentions to engage in sex less frequently and to use a condom when having sex. Intervention students were also more likely to believe that teens their age who engage in HIV risk behaviors are vulnerable to infection.

Good Behavior Game

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The Baltimore Mastery Learning (ML) and Good Behavior Game (GBG) interventions seek to improve children's psychological well-being and social task performance. Both are implemented when children are in early elementary grades in order to give students the skills they need for responding to later, possibly negative, life experiences and societal influences. The Baltimore ML intervention improves reading skills in order to combat learning problems and subsequent risk for depression. Like the GBG, it uses a group-based approach in which students are assigned reading units and cannot advance until a majority of the class has mastered the previous set of learning objectives. The GBG is primarily a behavior modification program that involves students and teachers. It aims to decrease early aggression and shy behaviors to prevent later criminality. GBG improves teachers' ability to define tasks, set

rules, and discipline students, and allows students to work in teams in which each individual is accountable to the rest of the group.

Evaluations of both programs have demonstrated beneficial effects for children at the end of first grade. At the end of first grade, ML students, compared to a control group, showed increases in reading achievement. At the end of first grade, GBG students, compared to a control group, had fewer aggressive and shy behaviors, according to teachers, and better peer nominations of aggressive behavior. At the end of sixth grade, GBG students, compared to a control group, demonstrated decreased levels of aggression for males who were rated highest for aggression in first grade.

High/Scope Perry Preschool Project

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The High/Scope Educational Research Foundation's principal goals are to promote the learning and development of children from infancy through adolescence and to support teachers, parents, and other adults who work with and care for children. The Foundation's continuing Perry Preschool Project is a longitudinal study of the effectiveness of preschool education for disadvantaged children. It has been influential in the continuation of Head Start and the expansion of other early childhood programs serving children at risk. The curriculum is implemented in State-funded prekindergarten programs, public and private half- and full-day preschools, child-care centers, and family childcare homes. Originally designed for low-income and children at risk, the High/Scope approach is now used for the full range of preschool children.

The High/Scope Preschool curriculum, developed in the early 1960s as an open-framework instructional model, is based on Jean Piaget's constructivist theory of child development, along with traditional teacher experience. This approach includes (1) a curriculum for use with children of all backgrounds, (2) a training method to prepare staff to work effectively with children and families, and (3) a two-part assessment system that combines observational procedures to judge the quality of the program and document the progress of child growth. Children in High/Scope settings are encouraged to make choices about materials and activities throughout the day. As they pursue their choices and plans, children explore, ask and answer questions, solve problems, and interact with classmates and adults. The teachers do not directly teach academic skills through sequenced activities or "school-like" activities; rather, they provide experiences and materials that help children develop broad language and logical abilities.

Longitudinal research, documented in a series of High/Scope Perry Preschool study reports, continues to demonstrate that children at risk who attended the program do significantly better throughout childhood and adulthood than a comparable group of children who did not receive the High/Scope preschool experience.

Home-Based Behavioral Systems Family Therapy

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This family therapy approach is used with families of juvenile offenders, between 6 and 18 years old, and those at risk for juvenile offending and substance abuse. It is a brief structured model delivered in five phases by paraprofessionals and professionals in the homes of families at risk. The orientation is psychoeducational and relies on reducing family defensiveness, assessing needs coincident with healthy family relationships, and training parents and teens. Technical aids, such as the Parenting Wisely CD-ROM program and videotapes, are used at the beginning of treatment to increase commitment to the therapy, as well as decrease time in treatment.

The five phases of the program include (1) Introduction/Credibility, (2) Assessment, (3) Therapy, (4) Education, and (5) Generalization/Termination. In the early phases, therapists are less directive, more supportive, and more empathic than in the later phases. This adapted model has been applied to multiple offending and institutionalized delinquents, targeting families with lower educational levels and higher levels of pathology

than the original Functional Family Therapy model. Modifications were made for families in Appalachia and for inner-city African-American families.

Long-range objectives include reduced child involvement in the juvenile justice system, reduced self-reported delinquency, less teen pregnancy, reduced special class placement, higher graduation rates, and increased employment. Intermediate objectives include less family conflict; more cohesion; improved communication; more effective parental monitoring, discipline, and support of appropriate child behavior; improved problem-solving abilities; better parent-school communication; improved school attendance and grades; and improved child adjustment.

Houston Parent-Child Development Program

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The Houston Parent-Child Development Program assists low-income, Mexican-American families with 1- to 3-year-old children to help their children do well in school and foster intellectual and social competence. The program provides a wide range of educational and support services, delivering these services in ways that are responsive to the families' poverty and culturally sensitive. Program guidelines call for (1) working with children from birth to 3 years of age, (2) training mothers to be effective teachers of their children, and (3) providing comprehensive services to counter the effects of poverty. The program is structured in two stages. The first, beginning when the index child is 1 year old, includes biweekly home visits to the mother and child, several weekend sessions for the entire family, English language classes for the mother, medical examination of the child, and assistance with accessing other community resources. In the second stage, mother and child participate in the program's activities four mornings a week. Activities include homemaker lessons in sewing, buying strategies, health and safety in the home, and group discussions on childcare and management. The entire program requires about 500 hours of participant time over a 2-year period.

The Houston Parent-Child Development Program was effective in training mothers, as demonstrated through comparing the program and a randomly assigned control group on several evaluation procedures. Compared to mothers in the control group, program mothers were found to provide more appropriate play materials, be more emotionally and verbally responsive, and avoid restriction and punishment. For the children, significant differences were found on the Stanford-Binet Intelligence Scale when compared to the control group. A 4-year followup study indicated that program children were less destructive, overactive, and negative-attention-seeking, and were more emotionally sensitive compared to control children. Various other studies showed similar significant results.

Multi-dimensional Treatment Foster Care

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The Multi-dimensional Treatment Foster Care (TFC) program is a team approach based on a theoretical model of the development and maintenance of child behavior problems. TFC is an alternative to group or residential treatment, incarceration, or hospitalization for adolescents who have problems with chronic antisocial behavior, emotional disturbance, and delinquency. Community families are recruited to provide TFC-placed adolescents with treatment and intensive supervision at home, in school, and in the community. TFC emphasizes clear and consistent limits with follow-through on consequences, positive reinforcement for appropriate behavior, a relationship with a mentoring adult, and separation from delinquent peers. The program targets teenagers with histories of chronic and severe criminal behavior at risk of incarceration. In TFC, adolescents are placed, singly or in twos, in a family setting for 6 to 9 months. Community families are recruited, trained, and supported to provide well-supervised placements and treatment. TFC parents are paid a monthly salary and a small stipend to cover expenses. The Core Components for Youth include daily structure and support, an individualized point system, weekly individual treatment, consistent teaching-oriented nonphysical discipline, and psychiatric consultation and medication management as needed. The Core

Components for Families include weekly family treatment with a strong skills focus, instruction in behavior management methods, frequent home visits with on-call and crisis backup, an aftercare parent group, and round-the-clock access to staff. The Core Components for Foster Parents include daily telephone calls, support and training, and round-the-clock staff availability and crisis intervention.

Evaluations of TFC have demonstrated that program youth compared to control group youth spent 60 percent fewer days incarcerated at 12-month followup, had significantly fewer subsequent arrests, ran away from their program three times less often, had significantly less hard drug use, and had quicker community placement from more restrictive settings. Results showed that youth spent significantly fewer days in lockup during another 1- and 2-year followup study, and significantly fewer youth were ever incarcerated following treatment. There was a significant relationship between the number of days in treatment and the number of days of subsequent incarceration for youth in the TFC group.

Parenting Wisely

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Parenting Wisely (PW) is an interactive CD-ROM program designed to teach parents of delinquents and adolescents at risk effective methods for improving family relationships by using adaptive, effective parenting skills. It addresses communication skills, positive reinforcement, contingency management, and problem-solving skills. The program instructs parents in effective parenting skills through the use of demonstration, quizzing, repetition, recognition, and rehearsal. This program is now being used in juvenile and divorce courts, mental health centers, community colleges and health centers, and Head Start centers. PW has been implemented in Australia, Ireland, England, Belgium, France, Germany, and Switzerland, as well as in the United States.

The PW program package contains a CD-ROM, a service provider's manual for maximizing community impact, parent workbooks and certificates, referral cards, and brochures. The program teaches (1) communication, (2) assertive discipline, and (3) supervision. Each of nine case studies opens with a video of a common family problem. The problem is followed by positive and negative responses. Parents choose a response, see a video of how their choice would work, and get feedback on their choice. After choosing the best response, parents answer questions about the ideas and skills presented in the case.

One study not only reported significant improvements on three types of evaluative criteria (reaction, learning, and behavior), but also showed a substantial cost-benefit compared to other parenting interventions. Another study reported that the PW intervention group, at 6-week and 6-month followups, demonstrated significant improvement on measures of child problem behavior, parental depression, and general family functioning. A third study reported that mothers in the PW program showed increased knowledge of adaptive parenting practices and significantly lower frequency of child problem behaviors at 1- and 4-month followups. A study to investigate the effectiveness of the PW program for teenage parents found that the intervention group scored significantly higher on measures of parenting knowledge, belief in the effectiveness of adaptive parenting practices over coercive practices, and application of adaptive parenting skills to hypothetical problem situations. Other published studies also have reported significant improvements.

Popular Opinion Leader (POL)

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Popular Opinion Leader (POL) is an intervention based on a program that identifies, trains, and enlists the help of key opinion leaders to change risky sexual norms and behaviors in the gay community. The program's target population includes gay men who frequent gay clubs/bars. POL is based on diffusion of innovation/social influence principles, suggesting that trends and innovations are often initiated by a relatively small segment of opinion leaders in the population. Once innova-

tions are visibly modeled and accepted, they then diffuse throughout a population, influencing others. On the basis of population-wide surveys of all men patronizing gay clubs, a small cadre of popular "trendsetters" was identified, given training in approaches for peer education, and then contracted to communicate risk reduction recommendations and endorsements to their friends. The training consisted of four weekly sessions. Session one reviewed basic epidemiology of HIV infection, high-risk behavior, and precautionary changes to reduce risk. Session two described characteristics of effective health promotion messages, such as sensitizing others to the potential threat of AIDS. In session three, leaders modeled conversational examples which incorporated characteristics discussed in session two, such as role-playing. Session four reviewed the outcomes of the real-life conversations.

One study reported that the intervention consistently produced systematic reductions in the population's high-risk behavior (unprotected anal intercourse) from baseline levels, with the same pattern of effects sequentially replicated in three other cities. Another study reported a reduction in the number of men who engaged in unprotected anal intercourse (36.9 percent to 27.5 percent) and unprotected receptive anal intercourse (27.1 percent to 19 percent).

Project STAR: Students Taught Awareness and Resistance

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Project STAR, also known as the Midwestern Prevention Project (MPP), is a comprehensive, community-based drug abuse intervention program that uses school, mass media, parent education, community organization, and health policy programming to prevent and reduce tobacco, alcohol, marijuana, and other drug use by adolescents. Developed by the University of Southern California, the project first offers a series of classroom-based sessions for the school program during middle school and continues with the parent, media, community, and policy components. Project successes include a net reduction of 40 to 70 percent in drug use, including up to 40 percent in daily smoking among participants in the program thus far through early adulthood.

Prolonged Exposure (PE) Therapy

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Prolonged Exposure (PE) Therapy for PTSD is a research-based treatment program that addresses a wide range of trauma-related psychiatric symptoms using focused, time-limited cognitive-behavioral therapies to give adults direct ways of coping with PTSD. The program targets female sexual/nonsexual assault victims with chronic PTSD and also other PTSD sufferers. The PE comprehensive theoretical model is suitable for all clinical settings and most community-based mental health situations. Exposure therapy is the most studied of the cognitive-behavioral therapies and has the most methodologically controlled studies revealing the strongest evidence of efficacy in the treatment of trauma. Foa's studies on PE have set the benchmark for all other trauma investigations. PE has been used in Australia, England, Holland, Norway, and other countries. This program of manualized individual therapy for treating PTSD with adults emphasizes preventing and treating PTSD, breathing retraining and psychoeducation, prolonged exposure therapy, *in vivo* exposure, imaginal exposure, and special issues. A PE manual for therapists chronicles the treatment sessions, homework assignments, audiotaping requirements, and scripted instructions to facilitate this standardized cognitive-behavioral treatment protocol. The Center for the Treatment and Study of Anxiety instituted research and treatment programs for PTSD in rape victims in 1984. It offers cutting-edge cognitive-behavioral therapy programs that involve discussions about fearful thoughts, images, and beliefs; stress management training; and relaxation training.

In the initial study, PE was found to be more effective than supportive counseling. At 3-month followup, PE revealed superior improvement in comparison to another treatment: stress inoculation training (SIT). PE, SIT,

and a combination of the two were compared to a control group. PE showed superiority over SIT and PE-SIT on anxiety and depression (posttreatment) and global social adjustment (followup), and had larger effect sizes for PTSD severity, depression, and anxiety. The study also revealed that combined treatment did not perform better than PE or SIT alone. At followup, PE had significantly greater improvements in PTSD, depression, anxiety, and anger over other treatments. Several authors have continued to show positive results with exposure therapy for Vietnam veterans, sexual assault victims, and persons exposed to a variety of other traumas.

Responding in Peaceful and Positive Ways (RIPP)

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Funded by the Centers for Disease Control and Prevention, USDHHS, the Responding in Peaceful and Positive Ways (RIPP) program is a primary prevention program for violence to be implemented for the entire student population at a middle or junior high school. The goal of RIPP is to implement strategies that reduce risk factors (i.e., health-compromising factors) and increase protective factors (i.e., health-promoting factors), which will then lead to less violent, more positive behavior. RIPP employs a valued adult role model to teach students knowledge, attitudes, and skills designed to promote schoolwide norms for nonviolence and positive risk-taking. Methods include the use of team-building activities, a social cognitive problem-solving model, repetition and mental rehearsal, relaxation techniques, role-plays, and a peer mediation program.

This program includes a 25-session curriculum, RIPP-6, designed to be implemented in the sixth grade at middle schools (or seventh grade at junior high schools); 12-session booster programs, RIPP-7 and RIPP-8, designed to be implemented with seventh and eighth graders at middle schools (or with eighth and ninth graders at junior high schools); and a peer mediation program. A prevention facilitator is responsible for teaching the curriculum and supervising the peer mediation program. The RIPP curriculum is typically taught in 50-minute weekly sessions throughout the school year during academic periods devoted to social studies, health, and science.

In a within-school evaluation of RIPP, compared to control students, RIPP-6 students at posttest were significantly less likely to have disciplinary code violations for carrying weapons, were less likely to have in-school suspensions, had lower reported rates of fight-related injuries, and were more likely to participate in their school's peer-mediation program. RIPP-7 participants showed a significant increase in their knowledge of curriculum material and a trend of greater decreases in anxiety. At 6-month followup, RIPP-7 students reported lower rates of peer pressure to use drugs and showed a significant increase in prosocial responses to hypothetical problem situations. In another study, compared to students at control schools, students at intervention schools reported more favorable attitudes toward nonviolence, less favorable attitudes toward violence, and greater knowledge of the material covered in the intervention. Significant differences in the frequency of aggression were found at posttest. An evaluation of RIPP-8 is currently under way.

Rural Educational Achievement Project (REAP)

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The Rural Educational Achievement Project (REAP) is a comprehensive, multilevel approach to prevention involving a universal prevention program (All Stars, Jr.), a selective program delivered in the summer (Camp GUTS: Gearing Up To Success), and a family program (Duke Family Coping Power). The program targets fourth-grade students enrolled in elementary schools. The All Stars, Jr., program is based on the character education and problem behavior prevention curriculum designed for middle school students. The focus draws from an individual's lifestyle, aspirations, social background, and other existing ideals that are likely to be

incongruent with high-risk behaviors and builds or strengthens that perception in the student. The summer Camp GUTS program is a selected 6-week, protocol-driven, school-based program designed to strengthen academic and social competencies and self-esteem. The Duke Family Coping Power program is delivered to parents of students at high risk. The content, derived from social cognitive theory, gives parents skills to deal with various aspects of child aggression. The program also includes sessions on stress management.

Program efficacy was designed around CSAP's four predictor variables: (1) academic achievement, (2) self-regulation, (3) social competence, and (4) parental investment. Findings for academic achievement indicated that this group showed greater gains in scores on a test of mathematics compared to two other groups. Subjects in the family and summer programs showed significantly higher levels of school bonding than the All Stars, Jr.-only and control conditions. Findings for self-regulation indicated that the summer and All Stars, Jr., programs had significant effects in decreasing externalizing behaviors. However, the results for social competence indicated that the family condition had lower baseline levels of social competence compared to the other conditions. The results for the parenting program suggested that the family condition had significant increases in the number of activities between parents and children.

Schools and Families Educating Children (SAFE Children)

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The SAFE Children program is a partnership between the Institute for Juvenile Research at the University of Illinois at Chicago and eight Chicago public schools. The program emphasizes helping families manage child development in risky environments. It is based on the "developmental-ecological model," which focuses on how characteristics of neighborhoods and schools affect children and family and determine how well a child does in school and in later life. The program aims to help with the transition to elementary school, make that first year successful, and set a firm base for the future. Families with children entering first grade and living in inner-city, high-crime neighborhoods are enrolled in a 22-week family program that emphasizes developing support networks among parents, improving parenting skills, and understanding schools and related child development issues. In addition, children receive tutoring in reading to ensure mastery of basic reading skills in the first year of school.

School Violence Prevention Demonstration Program

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The School Violence Prevention Demonstration Program teaches middle and upper elementary school students civic knowledge and skills that affect attitudes that serve as early warning signs of violence. The program has important implications for the way schools use alternate teaching strategies as well as education for democracy content, which may prevent violence while helping students develop into informed, effective, responsible citizens.

Phase I, the first pilot year of the program, was conducted in seven U.S. school districts: Los Angeles Unified, Denver Public Schools, Jefferson County (Colorado) Public Schools, Wake County (North Carolina) Public Schools, Philadelphia Public Schools, and Community School Districts 30 (Queens, New York) and 23 (Brooklyn, New York) public schools. The School Violence Prevention Demonstration Program includes three sets of materials: (1) "We the People...the Citizen and the Constitution" is a program that teaches essential concepts and fundamental values of the U.S. Constitution and the Bill of Rights. Critical-thinking exercises, problem-solving activities, and cooperative-learning techniques help develop the participatory skills necessary for students to become active responsible citizens. (2) "Foundations of Democracy: Authority, Privacy, Responsibility, and Justice" is a multidisciplinary curriculum that focuses on four concepts fundamental to an understanding of politics and government. (3) "We

the People...Project Citizen" promotes competent and responsible participation in State and local government. Youth are actively engaged in learning how to monitor and influence public policy.

Statistically significant gains in knowledge of the Constitution and the Bill of Rights were found in all seven sites and significant positive shifts in attitudes toward police and authority figures in six districts. Significant gains were made among the experimental over control groups in students' sense of civic responsibility in Queens and Denver. In Queens and Denver, statistically significant gains were made in tolerance for the ideas of others and for including all people in the political and social process. Queens also had a positive shift in relation to authority and the law. Qualitative data suggested that teachers appreciated receiving high-quality social studies textbooks, receiving quality teacher training in an important area of their responsibility, meeting with teachers from other schools and districts, and learning new teaching strategies.

Skills for Adolescence (SFA)

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Lions-Quest's Skills for Adolescence (SFA) is a comprehensive school-based program that brings together parents, educators, young people, and other members of the community to support the development of life and citizenship skills in young adolescents within a caring, consistent environment. The program is specifically designed to address the developmental needs of young adolescents, ages 10 to 15, in public and private school settings. Funded by the Centers for Disease Control and Prevention, the National Institute on Drug Abuse, and the Kellogg Foundation, SFA is based upon the rationale that identifies two major outcomes as critical for the promotion of social behaviors and reduction of health-compromising behaviors: (1) to develop positive social behaviors, such as self-discipline, responsibility, and good judgment; and (2) to develop positive commitments to families, schools, peers, and communities, including a commitment to lead healthy, drug-free lives.

Translated into 20 languages and in wide use in the United States, Canada, and 23 other countries, SFA has demonstrated its usefulness in diverse cultures and student populations.

SFA contains five key components that provide schools with a structure for establishing a network aimed at addressing risk and protective factors related to reducing substance use, violence, and other health-compromising behaviors. These components are (1) classroom curriculum (103 45-minute skills-building sessions that are offered in 12 formats, from a minimum 9-week minicourse to a maximum multi-year program); (2) parent involvement (parents participate in SFA through shared homework assignments, parent meetings, and school involvement); (3) positive school climate (staff, students, and parents establish a school climate committee to reinforce program goals and themes); (4) community involvement (staff, parents, and representatives from service organizations, business, and law enforcement take part in workshops, panel discussions, and projects); and (5) training (2- or 3-day workshop models offer an overview of program components and hands-on experience to SFA implementers).

One-year postintervention data indicated that lifetime and recent (past 30 days) marijuana use was significantly lower in SFA than in control schools. Posttest experimental students, when compared to comparison students, showed significantly improved knowledge about the risks of alcohol and illicit drugs; significantly higher perceptions of the harm drinking beer could have on their health; significantly higher school attendance; significantly lower levels of current beer, liquor, and tobacco use; and significantly reduced intentions to use beer and liquor in the future (next 30 days). Two-year results from another study indicated that experimental students had half the rates of misconduct and truancy events shown by control students.

Skills, Opportunities, and Recognition (SOAR)

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Skills, Opportunities, and Recognition (SOAR) is a scientifically tested comprehensive, school-based program designed to promote positive youth development and academic success. It is a schoolwide, school climate program for elementary schools that promotes the healthy development of young people by increasing skills for successful participation in the family, school, peer group, and community, and providing consistent recognition for effort and improvement. A SOAR school provides social skills training for elementary students, training for their teachers to improve methods of classroom management, and instruction on developmentally sequenced parenting workshops for parents. The long-term results indicate that students in SOAR classrooms are more committed to school and have better academic achievement and less misbehavior in the school and the community. SOAR was tested as the Seattle Social Development Program (SSDP), developed by Dr. J. David Hawkins and Dr. Richard Catalano of the University of Washington's Social Development Research Group, and is based on their social development theory. SOAR is focused on the positive development of children in elementary grades. The objective is to make a significant impact on known risk and protective factors for substance abuse, violence and aggressive behavior, and academic success before the critical middle school years when children typically begin to engage in the range of risk behaviors. By increasing protection for children, SOAR can help reduce the overall number of youth at risk entering the middle school years.

Successful replication of SOAR involves installing SOAR over the course of two school years; hiring a program facilitator (a master classroom teacher) to assist teachers in implementation; hiring a family support coordinator; and coordinating the three basic components: school, peer, and family.

SMART Leaders

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SMART Leaders is a curriculum-based program that uses role-playing, group activities, and discussion to promote social and decisionmaking skills in racially diverse 14- to 17-year-olds. It was designed as a 2-year booster program for youth who have completed Stay SMART, a component of Boys & Girls Clubs of America's SMART Moves program. It reinforces the substance abuse prevention skills and knowledge of the first program, with sessions on self-concept, coping with stress, and resisting media pressures. As participants advance in the program, they are involved in educational discussions on alcohol, tobacco, and illicit drugs, and have the opportunity to recruit other youth for the program and assist with sessions offered to younger boys and girls. Evaluation results show the effectiveness of this multiyear approach in promoting refusal skills and creating drug-free peer leaders. The SMART Leaders program, with other SMART Moves components, can be implemented in community-based youth organizations, recreation centers, and schools, in collaboration with all local Boys & Girls Clubs. All the demonstration projects were implemented in Boys & Girls Clubs, a number of which are in or adjacent to public housing projects.

Social Competence Promotion Program for Young Adolescents (SCPP-YA)

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The 45-session Social Competence Promotion Program for Young Adolescents (SCPP-YA) is a social and emotional learning program that has three modules. The first module includes twenty-seven 40-minute lessons of intensive instruction in self-control, stress management, social problem solving, and communication skills. The other modules include two nine-session programs that teach students to apply these personal and social competencies to the prevention of substance use and high-risk sexual behavior. This 1-year program has produced benefits with diverse fifth- through seventh-grade populations. It is most effective when offered in the context of coordinated, multiyear social development and health-promotion programming.

Stop Teenage Addiction to Tobacco (STAT)

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The Stop Teenage Addiction to Tobacco (STAT) initiative is an environmental campaign to enforce laws against tobacco use by minors and to stimulate communities to implement other strategies, such as banning vending machines or installing lockout devices on vending machines to curtail youth access to tobacco. While traditional youth smoking prevention initiatives have focused on reducing the demand or desire for tobacco among youth, the STAT effort focuses on cutting off the supply of tobacco to minors. The STAT effort targets law enforcement, vendors, and other community groups concerned with reducing the ability of minors to purchase tobacco. The aim of the program is to convince merchants to obey the law by refusing to sell tobacco to minors.

The town of Woodridge, IL, was the first in the Nation to put a tough enforcement program in place. As a result of this enforcement program, Woodridge's rate of tobacco use among teenagers was reduced by half.

Support for At-Risk Children

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The goal of the University of Oregon project on Substance Abuse Prevention in Preschool: Support for At-Risk Children (Project STAR) is to develop and investigate the effectiveness of a series of ecological, multidimensional interventions for affecting variables in the preschool years that are predictors of substance abuse. Project STAR developed and investigated the effectiveness of interventions designed to facilitate social competence, self-regulation, cognitive development and school bonding, and caregiver involvement. The program targets 4-year-old children enrolled in Head Start classrooms. There were three components of the Project STAR intervention: (1) classroom-based intervention implemented by Head Start classroom teachers with training and coaching by Project STAR teacher consultants; (2) parent education and support groups conducted jointly by Project STAR staff and Head Start family advocates; and (3) individualized home visiting conducted by Project STAR home visitors. In the classroom-based intervention curriculum, Head Start classroom teachers were trained in promoting children's social competence, self-regulation, language, and early literacy skills. Also included were group activities for directly teaching critical skills within classroom-circle times. The parent education and support component provided training and support on parenting and caregiver involvement to families of Head Start children. The individualized home visiting curriculum provided followup support to families on each of the risk factors the project targeted.

Significant intervention effects were evident at the end of preschool on caregiver involvement and school bonding. Caregiver involvement effects were maintained a year later, after the kindergarten year. In addition, significant effects were found for social competence. No significant intervention effects were found for self-regulation.

Team Awareness

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Team Awareness for Workplace Substance Abuse Prevention is a team-based training program developed to increase the awareness of substance abuse as a group problem rather than an individual event. The training seeks to decrease tolerance and enabling of problem behaviors, enhance group responsiveness to problems, improve attitudes toward policy, and increase help-seeking and peer referral to the employee assistance program (EAP) or other resources. Funded by the National Institute on Drug Abuse, NIH, US DHHS, the major objectives of this worksite prevention training program are to examine and address the role that work group culture and social dynamics play in enabling substance use and how use by any member of the work group can negatively affect every other member. The training addresses five areas of workplace culture associated with substance use: occupational subcultures, drinking climates, tolerance/enabling, group cohesion, and the social context of policy.

The team-oriented awareness training is an 8-hour program, administered across two 4-hour sessions, 2 weeks apart. Interviews and focus groups help customize training. The training is suitable for 9 to 15 employees, to allow for group discussion. There are five training components: (1) relevance, which seeks to increase understanding of the importance of substance abuse prevention; (2) team ownership of policy, which explains that policy is most effective when seen as a useful tool for enhancing safety; (3) understanding stress, in which employees self-assess their coping styles, identify stressors, and review methods for coping; (4) understanding tolerance, which teaches how tolerance can become a risk factor; and (5) support and encourage help, which encourages help-seeking and help-giving behavior.

A randomized control trial reported that group privacy regulation, EAP trust, help-seeking, and peer encouragement increased for the experimental group participants, while the control group showed no change. Stigma of substance users decreased only for the experimental group. A randomized field experiment that assessed the team-oriented training reported that experimental group supervisors were more likely than control group supervisors to improve on several dimensions of responsiveness. Another study determined that the need for this team-oriented approach is greater among employees who experience psychosocial risks, such as workplace drinking climates, social alienation, and policies that emphasize deterrence (drug testing) over educational prevention.

SAMHSA Promising Programs

Promising programs provide useful and scientifically defensible information about what works in prevention, but do not yet have sufficient scientific support to meet the standards for effective/model programs. Promising programs are eligible to be elevated to effective/model status subsequent to review of additional documentation regarding program effectiveness. Promising programs must score at least 3.33 on the 5-point scale on parameters of Integrity and Utility. Originated from a range of settings and spanning many and diverse target populations, promising programs are rich sources of guidance for prevention practitioners and designers. Promising programs identified by NREPP to date are listed below. Detailed information on promising programs is available at www.modelprograms.samhsa.gov.

Adolescent Alcohol Prevention Trial (AAPT)*

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The Adolescent Alcohol Prevention Trial (AAPT) is a classroom-based drug prevention program administered in the fifth grade with booster sessions conducted in the seventh grade. AAPT uses two social psychology-based strategies for preventing the onset of adolescent drug use. The first strategy, Resistance Training, is designed to give adolescents the behavioral skills necessary to refuse explicit drug offers. The second strategy, Normative Education (NORM), is designed to correct erroneous perceptions about the prevalence and acceptability of adolescent substance use and to establish conservative group norms. In addition, the program includes instruction about the social and health consequences of adolescent drug use. In research testing, the combination of resistance skills training and normative education prevented drug use, but resistance skills training alone did not.

*Adolescent Alcohol Prevention Trial was a research project. The resulting curriculum is the SAMHSA Model Program All Stars™.

AIDS/Drug Injection Prevention Program

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This prevention program is based on social learning principles. The intervention is delivered in four 1- to 2-hour sessions over a 2-week period, led by two trainers who encourage a therapeutic atmosphere in which participants feel free to discuss personal problem situations and seek help from the trainers and from their peers. Avoiding injection of illicit drugs is the program's primary goal; reduction in noninjected use of illicit drugs is a secondary goal. Emphasis is placed on recognizing and admitting problems with illicit drug use and not making those problems worse by injecting drugs. This is a community-based intervention for adults who are illicit drug injectors and intranasal ("sniffer") heroin users who are at high risk of injecting drugs. Four sessions cover understanding AIDS, risks of drug use and drug injection, sexual behavior and AIDS, and seeking entry into drug abuse treatment programs. Men and women who participated in the intervention were significantly less likely to inject drugs than those in the comparison condition.

Asian Youth Alliance (AYA)

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The Asian Youth Alliance (AYA) program is a multilevel, ethnic-specific prevention program developed by Asian American Recovery Services in Daly City, California. The long-term goals of decreasing high-risk behaviors and substance use among Filipino and Chinese youth, ages 15 to 20 and 15 to 18 respectively, living in Daly City are accomplished by successfully altering intermediary knowledge, attitudinal, and skill deficits.

AYA achieves these goals by building a consortium of Asian-focused, youth-serving agencies to better meet the needs of targeted ethnic groups, particularly in specific Asian communities, through curriculum-based prevention interventions. The program can be implemented in urban and suburban settings. Collaboration among community-based agencies is the cornerstone of program success. While the program was successful in decreasing intermediary risk (tolerance for drugs, social anxiety) and increasing intermediary protective (cultural pride) factors, further evaluations of the program are needed to determine if changes in these variables will produce anticipated changes in related high-risk behaviors and substance abuse outcomes.

Baby SAFE (Substance Abuse Free Environment) Hawaii

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The Baby SAFE (Substance Abuse Free Environment) Hawaii Program was established by the Hawaii State Department of Health in 1990, creating a State Council on Chemical Dependency and Pregnancy and five specialized committees. The goals of the program are to (a) increase the availability and accessibility of prevention, early intervention, and treatment services for pregnant and postpartum women in Hawaii; (b) decrease the incidence and prevalence of drug and alcohol use among pregnant and postpartum women in Hawaii; and (c) improve birth outcomes for women who use alcohol, tobacco, and illicit drugs during pregnancy, and decrease the number of infants affected by maternal substance use. The service intensive program can be implemented at drug treatment sites, health clinics, and other agencies.

Be a Star

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Be a Star was developed to serve African-American children between the ages of 5 and 12 living in St. Louis, and to build on the afterschool activities already in place at the United Church Neighborhood Houses (UCNH). The neighborhoods served by the UCNH include areas where gang activity is high, where children experience high rates of abuse and neglect, where proportionately large numbers of families receive Aid to Families with Dependent Children; and where the high school dropout rate is 52 percent. The agency has responded to community needs by developing afterschool programs for neighborhood youths and providing a day camp during the summer. In addition, the agency works closely with community residents to place greater emphasis on a safe environment for children and works with other community agencies to coordinate the minimal services available to neighborhood residents. The program can be administered in neighborhood community centers.

Behavioral Monitoring and Reinforcement Program (BMRP)

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The Behavioral Monitoring and Reinforcement Program (BMRP) is a school-based early intervention program that focuses on behavior modification and reinforcement of academic performance and obeying school rules. The BMRP aims to improve student attendance, promptness, and grades and to decrease discipline referrals. BMRP focuses on seventh-grade students who have exhibited at least two of the following predictive characteristics: (a) low academic motivation, (b) a feeling of distance from the family, and/or (c) discipline referrals.

It is designed to be implemented over a 2-year period and includes weekly teacher consultations, weekly student group meetings, and periodic contact with the parents. A third year of less frequent booster sessions is recommended. The program can be implemented in both urban and suburban school systems. Program outcomes at 1-year and 5-year followup showed significant differences between the intervention and control groups in the extent of serious school-based problems, reported abuse of drugs, reported criminal behavior, and numbers of arrests.

Big Brothers-Big Sisters of America

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Big Brothers-Big Sisters of America (BBBSA) is a mentoring program that matches an adult volunteer to a child, with the expectation that a caring and supportive relationship will develop. Equally important is the ongoing supervision and monitoring by a professional staff member who selects, matches, monitors, and closes the relationship with the volunteer and child. The foremost goal is to develop a mutually satisfying relationship through community- and site-based activities. More specific goals might relate to school attendance, academic performance, relationships with other children and siblings, general hygiene, learning new skills, or developing a hobby. BBBSA typically focuses on youth ages 6 to 18. BBBSA agencies operate in a variety of settings, ranging from urban to rural. Evaluation reveals that treatment youth were better than control youth in academic behavior, attitudes, and performance; had higher quality relationships with their peers and with their parents or guardians than control youth; and were less likely to initiate drug or alcohol use.

Bilingual/Bicultural Counseling and Support Services (formerly Proyecto CHAC)

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Bilingual/Bicultural Counseling and Support Services works with the large Hispanic/Latino population of Mountain View, many of whom have few opportunities to assimilate into the mainstream community, leading to alienation and isolation. Strategies include counseling and education programs; information and referral services to low-income families; individual and group activities for youth at risk; child abuse, domestic violence, and rape intervention and prevention services; Latino women's support group; parent education groups; and more. There are also a number of program strategies based in the schools and in the afterschool Tween-Time Mountain View Recreation program, gang prevention groups, and parent education and support groups. Some 75 percent of all Latino youth who received the services were better acculturated, had greater confidence, and appeared to feel more part of their school community.

Club Hero

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Club Hero is an after-school prevention program sponsored by National Families in Action of Atlanta, Georgia. It features a drug education curriculum that teaches children how the brain works and how drugs change the brain, change behavior, and produce addiction. Parental involvement is also an integral part of the program. Club Hero is conceptually grounded in literature demonstrating the link between the family environment and an adolescent's decision to use alcohol, tobacco,

and illicit drugs as well as in evidence supporting the efficacy of prevention programs employing social influence and generic skills-training models. The program focuses on African-American sixth-grade students attending public middle school who qualify for free or partially subsidized breakfasts and lunches. Club Hero can be implemented in any middle school setting. The program has been successfully replicated in 17 mostly rural and suburban communities. Evaluations reveal significant increases in students' knowledge of alcohol, tobacco, and illicit drug use and its impact on African-American families and communities and increased family bonding.

Colorado Youth Leadership Project (CYLP)

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The Colorado Youth Leadership Project (CYLP) was developed to address identifiable drug risk factors through school-based program components for seventh graders at risk. The project was designed to (1) reduce factors in the individual, peer group, and school that place students at high risk for using alcohol, tobacco, and illicit drugs, and (2) increase the resiliency/protective factors within students and peer groups so there is a reduction in the likelihood that students will use alcohol, tobacco, and illicit drugs. The intervention includes six major components that are designed to help youth at high risk become more resilient and avoid using alcohol, tobacco, and illicit drugs. There is also a summer leadership program. Project ALERT Curriculum and the Second Step Violence Prevention Curriculum, both nationally validated curricula, are used in the Life Skills component of CYLP.

Faith-Based Prevention

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The Health Advisory Council developed the Jackson County Alcohol and Other Drug Prevention Partnership Concept. The group consists of six African-American churches that successfully implemented health promotion projects funded by the Department of Health and Human Services, Office of Minority Health, American Heart Association, and the Florida Department of Health and Rehabilitative Services. The founding group then recruited other minority organizations and majority providers of drug, health, and educational services to participate. The partnership has existed for several years and is ongoing. Evaluations reveal significant accomplishments that include a coordinated approach to prevention planning in a rural area with organizations using the locality development approach; behavioral lifestyle changes via the church prevention programs, stressing the target populations' culture and value systems that reinforced school activities; and "Old South" cultural practices that allowed the African-American community to improve the quality of life for all Jackson County residents.

Family Health Promotion Program (FHPP)

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CODAC developed the Family Health Promotion Program (FHPP) to begin addressing the many needs of the people living in the targeted area. FHPP is a primary prevention program for a traditionally hard-to-reach and underserved population of predominantly Hispanic/Latino origin. Most family members are monolingual Spanish speakers. The program focuses on children ages 3 to 8 and their families. Through home visitation, the resiliency skills and protective factor curriculum being taught in the Connie Chambers Early Childhood Education Center is explained and adapted for home use. Families are provided with opportunities to participate

in enjoyable school activities, thus promoting school bonding. Children are involved in developmentally appropriate activities in childcare, school, and recreational activities to develop resiliency skills. Parents are involved in activities that empower them and increase protective factors. FHPP can be implemented in school and community settings. It uses the Building Me activities manual. A quasi-experimental pretest/posttest showed that as a rule the Latino children in the CODAC programs improved dramatically from pretest to posttest. On many measures they improved substantially more than did the comparison group children.

Focus on Families (FOF)

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Focus on Families (FOF) combines parent skills training and home-based case management services to reduce parent's risk for relapse and children's risk for substance use while enhancing protection. The intervention aims to improve opiate-addicted parenting and relapse skills through systematic group training that follows a structured curriculum format. Focus on Families includes a parenting curriculum, taught by a professional team, where parents are taught different skills and provided with home practice activities during each session. The program also includes home-based case management to help parents and children generalize and maintain skills learned in the group sessions and assess clients' appropriate use of skills. The intervention is suitable for a clinic-based setting. Following the FOF intervention of 9 months, experimental parents received higher scores on the problem-solving skills and drug-related situations, used significantly less heroin at the end of parent training and at the 12-month followup, and used significantly less cocaine at the 12-month followup.

Gatekeeper Case Finding and Response System

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Gatekeeper, developed by Raymond Raschko, M.S.W., at Elder Services, Spokane Mental Health, Spokane, Washington, in 1978, was designed to identify older adults at risk who do not typically come to the attention of the mental health and aging service delivery systems. With this technique, nontraditional community referral sources, such as employees of community businesses, and other community organizations, are organized and trained to identify elders at high risk who may be experiencing problems that threaten their ability to live independently and safely in the community. Gatekeepers may include meter readers, utility workers, property appraisers, bank personnel, postal carriers, police, sheriff and fire department personnel, and others who, through their normal daily routine, come into contact with the most isolated community-dwelling older adults. Gatekeepers refer the older person in need to a designated agency for a comprehensive assessment and subsequent linkage to mental health, aging, medical, or other social services. The model has been adapted successfully in urban, rural, and suburban communities and coordinated by single service systems or in collaboration with multiple systems.

Get Real About Violence

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Get Real About Violence (GRAV) is a K–12, research-based prevention program that addresses a wide range of violent behavior in students—from bullying and verbal aggression at early grades, through fighting and social exclusion at middle grades, to relationship abuse

and assaults in later grades. GRAV emphasizes enlisting the support of bystanders, changing violent norms, teaching social skills, and building communication and partnerships between adults and youth to stop violence. It is suitable for all school-based settings and most community-based learning situations. The curriculum, for students in grades K–3, 4–6, and 6–9, and for school staff in K–12 schools, teaches students special skills to stay safe and healthy by showing them how to maintain self-control when tempted by violence, resolve conflicts without violence, and prevent or avoid violent situations.

I Can Problem Solve (ICPS)

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I Can Problem Solve (ICPS) is a training program that is both preventive and rehabilitative. ICPS helps children to resolve interpersonal problems and prevent antisocial behaviors by teaching them how to think, not what to think. The ICPS training teaches the problem-solving skills of perspective-taking, recognition of people's potential motivations for behavior, sensitivity to the existence and causes of an interpersonal problem, and listening and awareness skills. These skills enrich children's ability to generate alternative solutions to real-life problems, anticipate potential consequences to an act, and plan sequenced steps to a stated interpersonal goal. ICPS also trains teachers to engage in a problem-solving style of communication (called ICPS dialoguing) when actual problems arise. Instead of telling, suggesting, or even explaining why a child should or should not do something, teachers ask questions to define the problem and guide consequential thinking and thinking about the child's own and others' feelings. This approach gives children the skills and freedom to think and solve problems for themselves. On the basis of measures of the intervention with kindergarten children in the fall and the following spring, 83 percent of the trained kindergarten children were rated as adjusted, compared with 30 percent of the controls in the spring.

Kids Intervention with Kids in School (KIKS)

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Kids Intervention with Kids in School (KIKS) is a school-based youth development and primary prevention program for children in grades 6 to 12, administered by the Children's Home Society of New Jersey (CHS), a private, not-for-profit, statewide agency. The goal of the KIKS program is to help pre-adolescent and young adolescent students avoid self-destructive behaviors and cope in positive ways with personal and social problems they encounter in their everyday lives. The KIKS program has five major components: youth development groups, after-school activities, tutorial program, parent involvement, and summer peer leader training. Children in grades 6 to 8 meet weekly during the school year in groups of up to 15, led by teenage peer leaders from grades 8 to 12 who are supervised by adult group workers. The teen and adult leaders use experiential activities to motivate the younger children to adopt, and value, self-preserving behaviors and to stay in school and learn. The children participate in group discussions, role-playing, and other hands-on activities to learn and practice how best to cope with problems at home, in school, or in their social interactions with peers.

Linking the Interests of Families and Teachers (LIFT)

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Linking the Interests of Families and Teachers (LIFT) is a research-based intervention program designed to prevent the development of aggressive and antisocial behavior in children within the elementary school setting. LIFT has three main components: (1) child social

skills training, (2) the playground Good Behavior Game, and (3) parent management training. Child social skills training sessions, held during the regular school day, include 20 one-hour sessions over a 10-week period in two distinct segments. Session content focuses on positive reinforcement, discipline, monitoring, problem solving, and parent involvement in the school. LIFT has been found to decrease child physical aggression toward classmates on the playground, to increase teachers' positive impressions of children's social skills with classmates, and to decrease parent aversive behavior during family problem-solving discussions.

Massachusetts Tobacco Control Program (MTCP)

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The Massachusetts Tobacco Control Program (MTCP) is one of the Nation's most comprehensive programs to combat tobacco use. MTCP fosters youth prevention efforts in three broad categories: (1) community efforts to increase enforcement of youth-access provisions, including banning free samples, requiring permits for tobacco retailers, restricting access to vending machines or banning them entirely, staging buy attempts by minors, and funding community-based tobacco prevention programs; (2) school efforts to inform youth of the harmful effects of smoking and to involve them in positive efforts to prevent smoking; and (3) media efforts, including enlisting celebrities in antismoking public relations efforts and implementing statewide media campaigns aimed at reducing smoking and smokeless tobacco use. The program is suitable for implementation in urban school systems.

Multimodel Substance Abuse Prevention

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The Multimodel Substance Abuse Prevention project was implemented at a residential treatment center for court-adjudicated males ages 13 to 18. All of the youth were subject to multiple risk factors in the individual, school, peer, and neighborhood domains. The main purposes of the project were (1) to determine the effectiveness of each of two intervention programs for reducing substance use and illegal behavior: (a) a triple module skills-training classroom program, consisting of Botvin's Life Skills Training, Prothrow-Stith's Anti Violence Program, and Raths Values Clarification procedure; and (b) a program consisting of a group role-play procedure and family therapy sessions; and (2) to compare the degree of effectiveness in Group A participants, who were provided with the multimodel classroom training, with the effectiveness in Group B participants, who were provided with the classroom program plus the group role-play and family therapy components. The participants in Groups A and B combined reported significantly greater reduction at followup than the controls (Group C) in drug use, in the perpetration of illegal offenses, and in the selling of drugs.

New Connections: Infant Intervention Program

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New Connections is a family-focused intervention that serves substance-exposed children from birth to age 6 and their parents. By enhancing protective factors and reducing known risk factors, the program aims to decrease levels of developmental delay and impairment in children; increase levels of child and caregiver attachment and bonding; decrease maternal depression;

improve parenting and family management skills; and increase access to and use of health and community support services. New Connections maintains positive working relationships with many community partners to provide integrated services for substance-exposed infants and children; parent education classes; and parent recovery support services. In evaluating New Connections, significant results were reported in knowledge regarding child health and development and in decreased maternal depression and parenting stress.

Parent-Child Assistance Program (P-CAP)

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The Parent-Child Assistance Program (P-CAP) is a paraprofessional home visitation model for substance-abusing women at extremely high risk. The program uses a case-management approach to achieve four goals: (1) to assist mothers in obtaining treatment, maintaining recovery, and resolving the complex problems associated with their substance abuse; (2) to guarantee that the children are in a safe environment and receiving appropriate health care; (3) to link families with community resources; and (4) to demonstrate successful strategies for working with this population to prevent the risk of future drug- and alcohol-affected children. Paraprofessional advocates have a maximum caseload of 15 families. They visit client homes, transport clients and their children to important appointments, link clients with appropriate service providers, work actively within the context of the extended family, trace clients who are missing, and provide advocacy services for the target child, regardless of who has custody of the child. Clinical supervisors meet individually with advocates on a weekly basis to review cases. The intervention lasts 36 months. Advocates visit client homes weekly for the first 6 weeks, then biweekly or more frequently, depending on client needs.

Parenting Partnership

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Parenting Partnership is a collaborative initiative between corporate worksites and human service providers that focuses on enhancing parenting skills, knowledge, and attitudes while facilitating the creation of support networks within the worksite. To address systemic barriers to program participation by working parents, the Parenting Partnership delivers training sessions in partnership with corporations at the worksite. Parent training courses are led by a trained facilitator and held in the worksite during the employee's lunch/meal time. Each complete Parenting Partnership course provides 24 one-hour sessions, twice a week, for 12 weeks. Program dosage is significantly related to impact: parents in the program who received high dosage levels (i.e., more than 80 percent of sessions) showed better short-term and longer-term impacts across 18-month followups on child behavior problems and strengths, knowledge and attitudes related to substance abuse resistance, reduced parental stress, depression and irritability, and increased utilization of social support.

Peer Assistance and Leadership (PAL®)

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The Peer Assistance and Leadership (PAL®) program is a nationally recognized program operating in 350 Texas school districts and in five other States. Long-term objectives are reduction of use and abuse of alcohol, tobacco, and illicit drugs. Short-term objectives include improvements in school attendance and grades,

reduction of discipline referrals, increased performance on standardized tests, improved attitude toward school, and improved behavior at home. The PAL curriculum was initially developed for high school students, but now includes middle school and elementary school students. An independent evaluation during the 1996–97 school year showed increases in grade point averages and percentage of students passing Texas Assessment of Academic Skills and decreases in student absences and student disciplinary referrals following program participation.

Perinatal Care Program

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The Perinatal Care Program was designed to facilitate intervention and prevention strategies for drug- and alcohol-abusing women who had prematurely delivered cocaine-exposed babies. Most of these mothers were single, on public assistance, and had not completed high school. They lived in inner-city neighborhoods characterized by disproportionate rates of violence, poverty, poor health care access, and organized drug activity. The Perinatal Care Program offers the following assistance: ambulatory pediatric care; child developmental assessments and referrals; family case management; physical therapy for hospitalized premature infants and caregiver education on the use of therapeutic techniques; parent education classes; caregiver-infant development interventions; caregiver support groups; transportation to all scheduled program activities; and linkage referral services for substance abuse treatment, daycare, vocational training, and other social services.

Plan A Safe Strategy (PASS) Program

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The Plan A Safe Strategy (PASS) Program is a 12-lesson education program designed to weaken students' intentions to drink and drive or to be the passenger of a driver who has been drinking. PASS is also designed to strengthen the participant's intentions to use alternative strategies and to preplan in order to avoid these situations. The program proceeds on the assumption that the intention to perform or not perform an act is the strongest predictor of future action. The outcome goal for the target population of 10th-grade students in rural and urban areas of Queensland, Australia, is to reduce students' later involvement in drinking-and-driving situations. Results of the short-term evaluation (1988) revealed strong trends in the desired direction in reduced drinking and driving and passenger behaviors. Attitudes toward drinking and driving and being a passenger in drinking-and-driving situations and myths about safety in these situations changed significantly in the desired direction. Students from the intervention group were also significantly more likely to be prepared to use alternatives in target situations and to avoid these situations.

Project BASIS

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Project BASIS is a school-based program designed to address the following components: (1) increasing the clarity of school rules and consistency of rule enforcement, (2) improving classroom organization and management, (3) increasing the frequency of school/parent

communications regarding student behavior, and (4) replacing punitive disciplinary strategies with positive reinforcement of appropriate behavior. The BASIS program advocates the adoption of a schoolwide computerized behavior tracking system. The computer system also facilitates improved school/parent communication by generating letters regarding both positive and negative student behavior. Positive reinforcement strategies replace punitive disciplinary strategies schoolwide. Teachers are trained in this new system and also classroom organization and management.

Project Break Away

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Several studies have demonstrated the effectiveness of long-term afterschool programs that combine remedial/compensatory education programs, recreational opportunities, and nutritional supplementation, along with social and life skills training and education about substance use and other health issues. Project Break Away provided an afterschool and summer educational and recreational substance use prevention program for adolescents who were exclusively on supervised probation through the Monroe Circuit Court. Specifically, the target population was middle-school-age youth between the ages of 12 and 14 on probation who were determined to have a history of early involvement or be at high risk of involvement with substance use, in need of adult supervision after school hours, and at risk of dropping out of school or not attending school. Participation in the project was one of several options the adolescents could choose as part of their probation order. The intervention is suitable for other school- and community-based settings. The programming was provided for each participant, 3 days a week during the school year and for 8 weeks during the summer. Resources included the "Making Decisions" curriculum. Major program outcomes showed that a comparison group indicated a greater increase in cigarette use than both low-dosage and high-dosage intervention groups. Project Break Away participants who received low dosage reported significantly less heroin/opium use compared to comparison group members and participants who received high dosage.

Project Link

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Project Link is a hospital-based program sponsored by Women and Infants Hospital of Providence, Rhode Island. It features clinical and case management services, individualized to the needs of enrolled clients, that focus on substance abuse treatment, crisis intervention, and counseling. Project Link's mission is to integrate specialized substance abuse services into the maternal-child health system at Women and Infants Hospital. The program serves pregnant and postpartum women with substance abuse problems who deliver at Women and Infants Hospital. The women reside in an economically disadvantaged, urban community with high drug trafficking. Project Link can be implemented in other hospital-based settings. Project Link is a multicomponent program. Clinical services include substance abuse assessment, crisis intervention, comprehensive psychosocial assessment, individual therapy, group therapy, child and family therapy, toxicology screening, and referral to ancillary services. Case-management services include home visiting, parenting assessment, parenting education, monitoring of pediatric visits, HIV education, and GED (general equivalency diploma)/literacy tutoring.

Project PACE

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The objective of Project PACE (Participation and Cooperation in Education), a primarily school-based, high-impact prevention/education program, was to enable the Town of Huntington Youth Bureau to replicate a model high-risk youth program for the prevention of alcohol,

tobacco, and illicit drug use. Project PACE focused on the prevention of substance use by providing a series of intensive interventions to fourth-grade students (determined to be at risk) and their families in Huntington Intermediate and Southdown Intermediate schools. These interventions were meant to strengthen protective factors and reduce risk factors in three domains: the individual youth at risk, the family, and the school. The intervention is suitable for other school-based settings. The program had a positive impact on reducing school absences. The low-risk participants showed increased self-esteem while the high-risk participants and the control group showed a reduction in self-esteem. There was a general decrease in negative problem behaviors for the participant group and the high-risk control group in the pre- and posttest period, while the low-risk control group experienced an increase in negative behaviors.

Sembrando Salud

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Sembrando Salud is a culturally sensitive tobacco and alcohol use prevention program specifically adapted for migrant Hispanic youth and their families. The program is designed to improve parent-child communication skills as a way of improving and maintaining healthy youth decisionmaking. Sembrando Salud contains a school and family curriculum delivered by bilingual/bicultural college students. Through presentation of information, modeling, and behavioral rehearsal, adolescents are exposed to how problems can be identified and analyzed, solutions generated, and decisions made, implemented, and evaluated. Another component of this program is the specific focus on developing parental support for the healthy decisions and behaviors of the adolescents through enhanced parent-child communication. The program targeted adolescents between the ages of 11 and 16 and their families, identified through the Migrant Education Program in San Diego County. The intervention is suitable for other school-based settings.

SISTERS

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SISTERS Intervention Services is a comprehensive paraprofessional case-management program for substance-abusing pregnant and postpartum women receiving detoxification treatment services. The program provides peer support and case management to ensure the coordination of drug treatment, prenatal, postpartum, pediatric, and family support services for pregnant and postpartum women. The SISTERS program was specifically designed to add peer-oriented outreach and case management to the existing Maternal Substance Abuse Services Program. The SISTERS program served pregnant women, of which the majority were either African American or Hispanic/Latino. The intervention is appropriate for service provider environments that address women's health issues, particularly pregnancy, substance abuse, and trauma. The project demonstrates the effectiveness of peer counseling. A repeated-measures (intake, 2 months, 6 months) evaluation design with a comparison group of non-SISTERS clients from the clinic reported significant positive outcomes.

Storytelling for Empowerment

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The Storytelling for Empowerment Project is a school-based secondary prevention program designed for club and classroom settings, serving Native American and Latino-Latina middle school youth. The specific target populations are Native American middle-school-age youth living on a rural Indian Nation and Latino-Latina middle-school-age youth living in urban settings. The intervention is suitable for club formats and other school-based settings. The project addresses the risk fac-

tors of confusion of cultural identity, the lack of congruence of multicultural learning styles and instruction, and the lack of consistent, positive parental role models. The goal of this program is to decrease the incidence of alcohol, tobacco, and illicit drug use among youth at high risk by identifying and reducing factors in the individual, family, school, peer group, neighborhood/community, and society/media that place youth at high risk for substance use. In addition, it attempts to enhance factors that may strengthen youth resiliency and protect them from substance use. The major components of the Storytelling for Empowerment Project are the Storytelling PowerBook, which is a 27-lesson activity book, accompanied by a detailed Facilitator's Guide. The intervention can be implemented within 3 months during the school year.

Strengthening the Bonds of Chicano Youth and Families

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Strengthening the Bonds of Chicano Youth and Families (El Proyecto de Nuestra Juventud) is a community-based, culturally appropriate intervention model for rural Hispanic youth in Central Arizona. The project recruited youth from the target areas of the City of Eloy and the neighboring community of Picacho, both rural agricultural areas. Participants had certain risk factors, including siblings of substance users, children of substance users, juvenile delinquents, children at risk of becoming teen parents, children at risk of dropping out of school, and children residing in public housing. The project was conceived and implemented by the Pinal Hispanic Council, a minority, nonprofit organization based in the City of Eloy. The intervention is suitable for a community-based setting. The comprehensive, multilevel program is rooted in a family-oriented approach that is based on Mexican-American culture, values, and principles.

Strengthening Hawaii Families (SHF)

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Strengthening Hawaii Families (SHF) is a culturally relevant, family-focused prevention program designed by the Coalition for a Drug-Free Hawaii (CDFH). The program targets Pacific Island and Asian youth, specifically children in grades three to five enrolled in elementary schools on the island of Oahu, Hawaii, and their parents. SHF can be implemented in other urban, suburban, and rural school and community-based settings. SHF prevents substance abuse and related problems by improving family relationships and functioning, parenting skills, and children's social skills, and by reducing behavioral problems among children. The prevention intervention is based on evidence demonstrating the link between poor family functioning and alcohol, tobacco, and illicit drug use, as well as literature delineating risk and protective factors unique to Pacific Island and Asian families with elementary-school-age children. The SHF model provides the tools and process to build on existing strengths through clarification of family and cultural values, family skills building, and nurturing connections among families, schools, and their communities. A standardized curriculum delivers program content (through guided discussions, hands-on activities, and group sharing) to groups of six to ten families attending weekly 2-hour meetings.

Teams-Games-Tournaments Alcohol Prevention

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The Teams-Games-Tournaments (TGT) Alcohol Prevention program combines peer support with group reward structures in its approach to preventing alcohol use. TGT focuses on group, rather than individual, achievement to learn about alcohol and its effects, including biological, psychological, sociocultural, and physiologic determinants and attributes of alcohol; self-management skills for responsible drinking; drinking and driving; recognizing and treating drinking problems; and assertiveness training to respond to peer pressure regarding alcohol. The program served high school sophomores, juniors, and seniors and included metropolitan, semi-metropolitan, and rural areas. In all participating schools, students received instruction by one of three methods: the experimental TGT method, traditional instruction (1-week course material developed by the State Department of Education and taught by regular school teachers or the highway patrol), or no instruction (the control group).

Teenage Health Teaching Modules

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Teenage Health Teaching Modules (THTM) is a comprehensive, secondary school health education curriculum developed by Education Development Center of Newton, Massachusetts, for middle and senior high school students in grades 6 through 12. The program is intended to positively affect student health knowledge, attitudes, practices, and self-reported behaviors. Unlike traditional health instruction, THTM materials are organized according to developmentally based tasks of concern to adolescents, rather than by content areas. All modules are intended to build the following seven skills: self-assessment, risk assessment, communication, decisionmaking, goal setting, health advocacy, and healthy self-management. THTM can be implemented in virtually any rural, urban, or suburban secondary school. THTM includes a series of instructional modules grouped by grade level. Approximately ninety 45-minute THTM sessions are available at each of the following grade levels: 6–8, 9 and 10, and 11 and 12. The developers of THTM recommend a "minimal dose" of 45 class sessions at each grade level.

Tinkham Alternative High School

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The Tinkham Alternative High School is a substance abuse prevention alternative high school program that serves students at risk referred by local high schools. The Tinkham method employs broad-based and multifaceted social learning strategies. The heart of the program, service learning, is designed to provide students with opportunities to "give back" to the community by caring for others. Along with this experiential component, counseling, coaching, mentoring, tutoring, and referral are provided to offer comprehensive assistance to students in their service endeavors. In addition, students with substance abuse problems are referred for ancillary services, and family counseling is available through the school's family resource center.

Urban Women Against Substance Abuse (UWASA)

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Urban Women Against Substance Abuse (UWASA) is a school-based program that focuses on Puerto Rican, Latina, and African- and Caribbean-American girls and their female caregivers. UWASA is theoretically grounded in social learning theory demonstrating the connection between identified risk indicators—juvenile drug abuse violations, high school dropouts, teen birthrate, sexual abuse referrals—and the primary protective factors identified as cultural and community leadership by female adults. UWASA features a self-development curriculum that teaches girls about building cultural and gender identity; knowledge of alcohol, tobacco, and illicit drugs; HIV awareness; and career options. Evaluations of UWASA revealed the success of this program in achieving a positive and significant effect on HIV/AIDS knowledge. Furthermore, girls who received treatment appeared to maintain substance use attitudes as healthy as those observed at baseline after the intervention.

Woodrock Youth Development Program (YDP)

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The Woodrock Youth Development Program (YDP) is a school-based substance abuse prevention program designed to prevent or reduce alcohol, tobacco, and illicit drug use; raise awareness about the dangers of use; improve self-esteem, school attendance, and attitudes toward racial and ethnic diversity; and reduce aggressive attitudes and behaviors among elementary and middle school minority youth at risk. YDP serves African-American, Latino, Asian, and White youth ages 6 through 14. Program youth attend public schools located in North Philadelphia, Pennsylvania. YDP schools are in economically depressed communities characterized by a high incidence of hate crimes, ethnic conflict, and drug trafficking. YDP can be implemented in other urban elementary and middle school settings. Despite strengths in the design and implementation of the evaluation, statistically significant improvements were evidenced for only half of the outcomes targeted. The absence of additional effects was attributed to insufficient intervention.

ENDNOTES

1. Vlahov, D., & Galea, S. (2002). Impact of September 11th events on residents of Manhattan. *New England Journal of Medicine*, March 28, 2002.

2. National Center of Addiction and Substance Abuse at Columbia University. (2001). Results of post-September 11th survey of substance use in America. Posted on Yahoo.com Web site, December 5, 2001. www.yahoo.com.

3. Ibid.

4. Bry, B., & Krinsley, K. (1990). Adolescent substance abuse. In E. Feindler & G. Kalfus (Eds.), *Adolescent behavior therapy handbook*. New York: Springer.

5. Newcomb, M. D., & Felix-Ortiz, M. (1992). Multiple protective and risk factors for drug use and abuse: Cross-sectional and prospective findings. *Journal of Personality and Social Psychology, 63*(2), 280–296.

6. Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin 112*(1), 64–105.

7. Ibid.

8. Mrazek, P. J., & Haggerty, R. J. (Eds.). (1994). *Reducing the risk for mental disorders: Frontiers for preventive intervention research*. Washington, DC: National Academy.

9. Anthony, E. J., & Cohler, B. J. (1987). *The invulnerable child*. New York: Guilford Press.

10. Hawkins, et al., 1992., op. cit.

11. Mrazek & Haggerty, 1994, op. cit.

12. Wolin, S., & Wolin, S. (1995). Resilience among youth growing up in substance abusing families. *Pediatric Clinics of North America 42*(2), 415–429.

13. Botvin, G. J., Baker, E., Dusenbury, L. D., Botvin, E. M., & Diaz, T. (1995). Long-term follow-up results of a randomized drug abuse prevention trial in a white middle-class population. *Journal of the American Medical Association 273*(14), 1106–1112.

14. Donaldson, S. I., Graham, J. W., & Hansen, W. B. (1994). Testing the generalizability of intervening mechanism theories: Understanding the effects of a school-based prevention program for potential high school dropouts and drug abusers. *International Journal of Addictions 25*(7), 773–801.

15. Hawkins, et al., 1992., op cit.

16. Kumpfer, K. L., Molgaard, V., & Spoth, R. (1996). The Strengthening Families Program for the prevention of delinquency and drug use. In R. Peters & R. McMahon (Eds.), *Preventing childhood problems, substance abuse, and delinquency* (pp. 241–267). Thousand Oaks, CA: Sage Publications.

17. Challier, B., Chau, N., Predine, R., Choquet, M., & Legras, B. (2000). Associations of family environment and individual factors with tobacco, alcohol and illicit drug use in adolescents. *European Journal of Epidemiology, 16,* 33–42.

18. Ellickson, P. L., Tucker, J. S., & Klein, D. J. (2001). High-risk behaviors associated with early smoking: Results from a 5-year follow-up. *Journal of Adolescent Health, 28,* 465–473.

19. Johnston, L., O'Malley, P., & Bachman, J. (1991). *Drug use among American high school seniors, college students, and young adults,*

1975–1990: Vol. 1 (DHHS Publication No. ADM 91-1813). Rockville, MD: National Institute on Drug Abuse.

20. Flay, B. R., & Sobel, J. L. (1983). The role of mass media in preventing adolescent drug abuse. In T. J. Glynn, C. G. Leukefeld, & J. P. Lundford (Eds.), *Preventing adolescent drug abuse: Intervention strategies* (NIDA Research Monograph 47, DHHS Pub No. ADM 83-1280, pp. 5–35). Rockville, MD: National Institute on Drug Abuse.

21. Flynn, B. S., Worden, J. K., Secker-Walker, R. H., Pirie, P. L., Badger, G. J., & Carpenter, J. H. (1997). Long-term responses of higher and lower risk youths to smoking prevention interventions. *Preventive Medicine, 26,* 389–394.

22. Paglia, A., & Room, R. (1998). *Preventing substance use problems among youth: A literature review and recommendations* (ARF Document No. 142). Toronto, Ontario, Canada: Addiction Research Foundation.

23. Johnson, E. O, & Breslau, N. (2001). Sleep problems and substance use in adolescence. *Drug and Alcohol Dependence, 64,* 1–7.

24. Arnett, J. (1996). Sensation seeking, aggressiveness, and adolescent reckless behavior. *Personality and Individual Differences, 20,* 693–702.

25. Stephenson, M., Palmgreen, P., Hoyle, R., & Donohew, L. (1999). Short-term effects of an anti-marijuana media campaign targeting high sensation seeking adolescents. *Journal of Applied Communication Research, 27*(3), 175–195.

26. Zuckerman, M. (1994). *Behavioral expressions and biosocial bases of sensation seeking.* New York: Cambridge University Press.

27. Coogan, P. F., Geller, A., & Adams, M. (2000). Prevalence and correlates of smokeless tobacco use in a sample of Connecticut students. *Journal of Adolescence, 23,* 129–135.

28. Burt, R. D., Dinh, K. T., Peterson, A. V. Jr., & Sarason, I. G. (2000). Predicting adolescent smoking: A prospective study of personality variables. *Preventive Medicine, 30,* 115–125.

29. Bates, M. E., White, H. R., & Labouvie, E. (1994). Changes in sensation seeking needs and drug use. In P. J. Venturelli (Ed.), *Drug use in America: Social, cultural, and political perspectives* (pp. 67–75). Sudbury, MA: Jones & Bartlett Publishers.

30. Donohew, R. L., Hoyle, R. H., Clayton, R. R., & Skinner, W. F. (1999). Sensation seeking and drug use by adolescents and their friends: Models for marijuana and alcohol. *Journal of Studies on Alcohol, 60*(5), 622–631.

31. Earleywine, M., & Finn, R. (1991). Sensation seeking explains the relation between behavioral disinhibition and alcohol consumption. *Addictive Behaviors, 16,* 123–128.

32. Everett, M., & Palmgreen, P. (1995). Influences of sensation seeking, message sensation value, and program context on effectiveness of anticocaine public service announcements. *Health Communication, 7*(3), 225–248.

33. Wislar, J. S., & Fendrich, M. (2000). Can self-reported drug use be used to assess sex risk behaviors in adolescents? *Archives of Sexual Behavior, 29,* 77–89.

34. Kopstein, A. N., Crum, R. M., Celentano, D. D., & Martin, S. S. (2001). Sensation seeking needs among 8th and 11th graders: Characteristics associated with cigarette and marijuana use. *Drug and Alcohol Dependence, 62,* 195–203.

35. Golub, A., & Johnson, B. D. (2001). Variation in youthful risks of progression from alcohol tobacco to marijuana and to hard drugs across generations. *American Journal of Public Health, 91,* 225–232.

36. Oetting, E. R., & Lynch, R. S. (in press). Peers and the prevention of adolescent alcohol use. In W. J. Bukoski & Z. Sloboda (Eds.), *Handbook for drug abuse prevention, theory, science, and practice.* Westport, CT: Greenwood Publishing Group.

37. Hinshaw, S. P., Lahey, B. B., & Hart, E. L. (1993). Issues of taxonomy and comorbidity in the development of conduct disorder. *Development and Psychopathology, 5,* 31–49.

38. Loeber, R. (1990). Development and risk factors of juvenile antisocial behavior and delinquency. *Clinical Psychological Review, 10,* 1–42.

39. Farrington, D. P. (1991). Childhood aggression and adult violence: Early precursors and later life outcomes. In D. J. Pepler & K. H. Rubin (Eds.), *The development and treatment of childhood aggression* (pp. 5–29). Hillsdale, NJ: Erlbaum.

40. Pliszka, S. R., Sheman, J. O., Barrow, M. V., & Irick, S. (2000). Affective disorder in juvenile offenders: A preliminary study. *The American Journal of Psychiatry, 157,* 130–133.

41. Weisz, J., Martin, S., Walter, B., & Fernandez, G. (1991). Differential prediction of young adult arrests for property and personal crimes: Findings of a cohort follow-up study of violent boys from North Carolina's Willie M. program. *Journal of Child Psychology and Psychiatry, 32,* 783–792.

42. Spooner, C., Mattick, R. P., & Noffs, W. (2000). A study of patterns and correlates of substance use among adolescents applying for drug treatment. *Australian and New Zealand Journal of Public Health, 24,* 492–503.

43. Pugatch, D., Ranratban, M., Strong, L., Feller, A., Levesque, B., & Dickinson, B.P. (2000). Gender differences in HIV risk behaviors among young adults and adolescents entering a Massachusetts detoxification center. *Substance Abuse, 21,* 79–86.

44. Kelder, S. K., Murray, N. G., Orpinas, P., Prokhorov, A. McReynolds, L., Zhang, Q., & Roberts, R. (2001). Depression and substance use in minority middle-school students. *American Journal of Public Health, 9,* 761–766.

45. Shrier, L. A., Harris, S. K., Sternberg, M., & Beardsless, W. R. (2001). Associations of depression, self-esteem, and substance use with sexual risk among adolescents. *Preventive Medicine, 33,* 179–189.

46. Santelli, J. S., Robin, L., Brener, N. D., & Lowry, R. (2001). Timing of alcohol and other drug use and sexual risk behaviors among unmarried adolescents and young adults. *Family Planning Perspectives, 33,* 200–205.

47. Pliszka, S.R., et al., 2000, op. cit.

48. King, R. D., Gaines, L. S., Lambert, E. W., Summerfelt, W. T., & Bickman, L. (2000). The co-occurrence of psychiatric and substance use diagnosis in adolescents in different service systems: Frequency, recognition, cost and outcomes. *The Journal of Behavioral Health Services & Research, 27,* 417–431.

49. Winters, K. C., Stinchfiled, R. C., Opland, E., Weller, C., & Latimer, W. W. (2000). The effectiveness of the Minnesota model approach in the treatment of adolescent drug abusers. *Addiction, 95,* 601–613.

50. Jacobsen, L. K., Southwick, S. M., & Kosten, T. R. (2001). Substance use disorders in patients with posttraumatic stress disorder: A review of the literature. *American Journal of Psychiatry, 158,* 1184–1190.

51. Noell, J. W., & Ochs, L. M. (2001). Relationship of sexual orientation to substance use, suicidal ideation, suicide attempts, and other factors in a population of homeless adolescents. *Journal of Adolescent Health, 29,* 31–36.

52. Kellam, S. G., & Anthony, J. C. (1998). Targeting early antecedents to prevent tobacco smoking: Findings from an epidemiologically-based randomized field trial. *American Journal of Public Health, 88*(10), 1490–1495.

53. Miller, L., Weissman, M., Gur, M., & Adams, P. (2001). Religiousness and substance use in children of opiate addicts. *Journal of Substance Abuse, 13,* 323–336.

54. Ellis, R. A., O'Hara, M., & Sowers, K. M. (2000). Profile-based intervention: Developing gender-sensitive treatment for adolescent substance abusers. *Research on Social Work Practice, 10,* 327–348.

55. Romer, D., & Jamieson, P. (2001). Do adolescents appreciate the risks of smoking? Evidence from a national survey. *Journal of Adolescent Health, 29,* 12–21.

[56] Newcomb, M. D., & Felix-Ortiz, M. (1992). Multiple protective and risk factors for drug use and abuse: Cross-sectional and prospective findings. *Journal of Personality and Social Psychology, 63*(2), 280–296.

[57] Wynn, S. R., Schulenberg, J., Kloska, D. D., & Laetz, V. B. (1997). The mediating influence of refusal skills in preventing adolescent alcohol misuse. *The Journal of School Health, 67*(9), 390–395.

[58] Botvin, G. J., Schinke, S. P., Epstein, J. A., Diaz, T., & Botvin, E. M. (1995). Effectiveness of culturally-focused and generic skills training approaches to alcohol and drug abuse prevention among minority adolescents: Two-year follow-up results. *Psychology of Addictive Behaviors, 9*(3), 183–194.

[59] Epstein, J. A., Griffin, K. W., & Botvin, G. J. (2000). A model of smoking among inner-city adolescents: The role of personal competence and perceived social benefits of smoking. *Preventive Medicine, 31,* 107–114.

[60] Griffin, K. W., Epstein, J. A., Botvin, G. J., & Spoth, R. L. (2001). Social competence and substance use among rural youth: Mediating role of social benefit expectancies of use. *Journal of Youth and Adolescence, 30,* 485–498.

[61] Baron, S. (1999). Street youths and substance use. *Youth and Society, 31*(1), 3–26.

[62] Burt, et al., 2000, op. cit.

[63] Koval, J. J., Pederson, L. L., Mills, C. A., McGrady, G. A., & Caravajal, S. C. (2000). Models of the relationship of stress, depression, and other psychosocial factors to smoking behavior: A comparison of a cohort of students in grades 6 and 8. *Preventive Medicine, 30,* 463–477.

[64] Burt, et al., 2000, op. cit.

[65] Tapert, S. F., Aarons, G. A., Sedlar, G. R., & Brown, S. A. (2001). Adolescent substance use and sexual risk-taking behavior. *Journal of Adolescent Health, 28,* 181–189.

[66] Muck, R., Zempolich, K. A., & Titus, J. C. (2001). An overview of the effectiveness of adolescent substance abuse treatment models. *Youth & Society, 33,* 143–168.

[67] Dishion, T. J., Capaldi, D., Spracklen, K. M., & Li, F. (1995). Peer ecology of male adolescent drug use. *Development and Psychopathology, 7,* 803–824.

[68] Jones, D. C., & Houts, R. (1992). Parental drinking, parent-child communication, and social skills in young adults. *Journal of Studies on Alcohol, 53*(1), 48–56.

[69] Jackson, C., Henriksen, L., Dickinson, D., & Levine, D. (1997). The early use of alcohol and tobacco: Its relation to children's competence and parents' behavior. *American Journal of Public Health, 87*(3), 359–364.

[70] Kumpfer, K., & Alvarado, R. (1995). Strengthening families to prevent drug use in multi-ethnic youth. Salt Lake City: University of Utah, Health Education Department.

[71] Yoshikawa, H. (1994). Prevention as cumulative protection: Effects of early family support and education on chronic delinquency and its risks. *Psychological Bulletin, 115,* 28–54.

[72] Brook, J. S., Brook, D. W., Gordon, A. S., Whiteman, M., & Cohen, P. (1990). The psychological etiology of adolescent drug use: A family interactional approach. *Genetic, Social, and General Psychology Monographs, 116* (Whole No. 2).

[73] Fletcher, A. C., & Jefferies, B. C. (1999). Parental mediators of associations between perceived authoritative parenting and early adolescent substance use. *The Journal of Early Adolescence, 19*(4), 465–487.

[74] Biederman, J., Faraone, S. V., Monuteaux, M. C., & Feighner, J. A. (2001). Patterns of alcohol and drug use in adolescents can be predicted by parental substance use disorders. *Pediatrics, 106,* 792–797.

[75] Chatterji, P., & Markowitz, S. (2001). The impact of maternal alcohol and illicit drug use on children's behavior problems: Evidence from the children of the national longitudinal survey of youth. *Journal of Health Economics, 20,* 703–731.

76. Boyle, M., Sanford, M., Szatmari, P., Merikangas, K., & Offer, D. (2001). Familial influences on substance use by adolescents and young adults. *Canadian Journal of Public Health, 92,* 206–209.

77. National Institute on Alcohol Abuse and Alcoholism. (1997). *Alcohol and health: Ninth special report to the U.S. Congress.* Rockville, MD: Author.

78. Brook, J., Whiteman, M., Finch, S., & Cohen, P. (2000). Longitudinally foretelling drug use in the late twenties: Adolescent personality and social-environmental antecedents. *The Journal of Genetic Psychology, 161*(1), 37–51.

79. Szapocznik, J., Santisteban, D., Rio, A., Perez-Vidal, A., & Santisteban, D. (1989). Family effectiveness training: An intervention to prevent drug abuse and problem behaviors in Hispanic adolescents. *Hispanic Journal of Behavioral Sciences, 11*(1), 4–27.

80. Litrownik, A. J., Elder, J. P., Campbell, N. R., Ayala, G. X., Slymen, D. J., Parra-Medina, D., Zavala, F. B., & Lovato, C.Y. (2000). Evaluation of a tobacco and an alcohol use prevention program for Hispanic migrant adolescents: Promoting the protective factor of parent-child communication. *Preventive Medicine, 31,* 124–133.

81. Elder, J. P., Campbell, N. R., Litrownik, A. J., Ayala, G. X., Slymen, D. J., Parra-Medina, D., & Lovato, C. Y. (2000). Predictors of cigarette and alcohol susceptibility and use among Hispanic migrant adolescents. *Preventive Medicine, 31,* 115–123.

82. Kumpfer, K. L., & Alvarado, R. (1995). Strengthening families to prevent drug use in multiethnic youth. In G. Botvin, S. Schinke, & M. Orlandi (Eds.), *Drug abuse prevention with multiethnic youth* (pp. 255–294). Thousand Oaks, CA: Sage.

83. Stanger, C., Kamon, J., Dumenci, L., Higgins, S. T., Bickel, W. K., Grabowski, J., & Amass, L. (in press). Predictors of internalizing and externalizing problems among children of cocaine and opiate dependent parents. *Drug and Alcohol Dependence.*

84. Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin, 112*(1), 64–105.

85. Brook, J. S., Brook, D. W., Gordon, A. S., Whiteman, M., & Cohen, P. (1990). The psychosocial etiology of adolescent drug use: A family interactional approach. *Genetic, Social, and General Psychology Monographs, 116* (Whole No. 2).

86. Catalano, R. F., Hawkins, J. D., Krenz, C., Gillmore, M., Morrison, D., Wells, E., & Abbott, R. (1993). Using research to guide culturally appropriate drug abuse prevention. *Journal of Consulting and Clinical Psychology, 61,* 804–811.

87. Werner, E. E., & Smith, R. S. (1992). *Overcoming the odds: High-risk children from birth to adulthood.* Ithaca, NY: Cornell University Press.

88. Scheller, T. F., & Berens, P. (2001). Domestic violence and substance use. *Obstetrics & Gynecology, 97,* S53.

89. Brook, J. S., et al., 1990, op. cit.

90. Everett, S. A., Warren, C. W., Sharp, D., Kann, L., Husten, C. G., & Crossett, L. S. (1999). Initiation of cigarette smoking and subsequent smoking behavior among high school students. *Preventive Medicine, 29,* 321–326.

91. Litrownik, et al., 2000, op. cit.

92. Withers, N. J., Low, J. L., Holgate, S. T., & Clough, J. B. (2000). Smoking habits in a cohort of U.K. adolescents. *Preventive Medicine, 94,* 391–396.

93. Biederman, J., Faraone, S. V., Monteaux, M. C., & Feighner, J. A. (2000). Patterns of alcohol and drug use in adolescents can be predicted by parental substance use disorders. *Pediatrics, 106,* 792–798.

94. Catalano, R. F., Morrison, D., Wells, E. A., Gillmore, M. R., Iritani, B., & Hawkins, J. D. (1992). Ethnic differences in family factors

related to early drug initiation. *Journal of Studies on Alcohol, 53,* 208–217.

95. Chilcoat, H. D., Dishion, T. J., & Anthony, J. C. (1995). Parent monitoring and the incidence of drug sampling in urban elementary school children. *American Journal of Epidemiology, 141,* 25–31.

96. Fletcher, A. C., Darling, N., & Steinberg, L. (1995). Parental monitoring and peer influences on adolescent substance abuse. In J. McCord (Ed.), *Coercion and punishment in long-term perspectives* (pp. 259–271). New York: Cambridge University Press.

97. Challier, et al., 2000, op. cit.

98. McGillicuddy, N. B., Rychtarik, R. G., Duquette, J. A., & Morsheimer, E. T. (2001). Development of a skill training program for parents of substance-abusing adolescents. *Journal of Substance Abuse Treatment, 20,* 59–68.

99. Herting, J. R. (1990). Predicting at-risk youth: Evaluation of a sample selection model. *Communicating Nursing Research, 23,* 178.

100. Eggert, L. L., Thompson, E. A., Herting, J. R., Nicholas, L. J., & Dicker, B. G. (1994). Preventing adolescent drug abuse and high school dropout through an intensive school-based social network development program. *American Journal of Health Promotion, 8*(3), 202–215.

101. Maguin, E., & Loeber, R. (1996). Academic performance and delinquency. In M. Tonry (Ed.), *Crime and justice: A review of research. Vol. 20* (pp. 145–264). Chicago: University of Chicago Press.

102. Reiff, M. (1998). Adolescent school failure: Failure to thrive in adolescence. *Pediatrics in Review, 19*(6), 199–207.

103. Shannon, D. M., James, F. R., & Gansneder, B. M. (1993). The identification of adolescent substance misuse using school-reported factors. *The High School Journal, Dec/Jan,* 118–128.

104. Gottfredson, G. D. (1988). Issues in adolescent drug use. Unpublished final report to the U.S. Department of Justice. Baltimore: Johns Hopkins University, Center for Research on Elementary and Middle Schools.

105. Hundleby, J. D., & Mercer, G. W. (1987). Family and friends as social environments and their relationship to young adolescents' use of alcohol, tobacco, and marijuana. *Journal of Clinical Psychology, 44,* 125–134.

106. Holmen, T. L., Barrett-Conner, E., Holmen, J., & Bjermer, L. (2000). Adolescent occasional smokers, a target group for smoking cessation? The Nord-Trondelag health study, Norway, 1995-1997. *Preventive Medicine, 31,* 682–690.

107. Resnick, M. D., Bearman, P. S., Blum, R. W., Bauman, K. E., Harris, K. M., Jones, J., Tabor, J., Beuhring, T., Sieving, R. E., Shew, M., Ireland, M., Bearinger, L. H., & Udry, J. R. (1997). Protecting adolescents from harm: Findings from the national longitudinal study on adolescent health. *Journal of the American Medical Association, 278,* 823–832.

108. Hawkins, J. D., Catalano, R. F., Morrison, D. M., O'Donnell, J., Abbott, R. D., & Day, L. E. (1992). The Seattle Social Development Project: Effects of the first four years on protective factors and problem behaviors. In J. McCord & R. E. Tremblay (Eds.), *Preventing antisocial behavior: Interventions from birth through adolescence* (pp. 139–161). New York: Guilford Press.

109. Victorio, A. (2001). The relation between intake patterns and substance abuse in a student sample. *Addictive Behaviors, 26,* 439–445.

110. Gottfredson, G. D., & Gottfredson, D. C. (1985). Victimization in schools. New York: Plenum Press.

111. Dembo, R., Schmeidler, J., Nini-Gough, B., & Manning, D. (1998). Sociodemographic, delinquency-abuse history, and psychosocial functioning differences among juvenile offenders of various ages. *Journal of Child & Adolescent Substance Abuse, 8*(2), 63–78.

112. Grunbaum, J. A., Kann, L., Kinchen, S. A., Ross, J. G., Gowda, V. R., Collins, J. L., & Kolbe, L. J. (1999). Youth Risk Behavior Surveillance—National Alternative High School

Youth Risk Behavior Survey, United States, 1998. In *CDC Surveillance Summaries,* October 29, 1999. MMWR 1999; 48 (No. SS07); 1–44.

113. Valois, R. F., Thatcher, W. G., Drane, J. W., & Reininger, B. M. (1997). Comparison of selected health risk behaviors between adolescents in public and private high schools in South Carolina. *Journal of School Health, 67*(10), 434–440.

114. Hussong, A. (2000). The setting of adolescent alcohol and drug use. *Journal of Youth and Adolescence, 29,* 107–119.

115. Peterson, A. V., Kealey, K. A., Mann, S. L., Marek, P. M., & Sarason, I. G. (2000). Hutchinson smoking prevention project: Long-term randomized trial in school-based tobacco use prevention—results on smoking. *Journal of the National Cancer Institute, 92,* 1979–1991.

116. Clayton, R. R., Scutchfield, F. D. & Wyatt, S. W. (2000). Hutchinson smoking prevention project: A new gold standard in prevention science requires new transdisciplinary thinking. *Journal of the National Cancer Institute, 92,* 1964–1965.

117. Dent, C. W., Sussman, S., & Stacy, A. W. (2001). Project towards no drug abuse generalizability to a general high school sample. *Preventive Medicine, 32,* 514–520.

118. Barnes, G. M., & Welte, J. W. (1986). Patterns and predictors of alcohol use among 7–12th grade students in New York State. *Journal of Studies on Alcohol, 47,* 53–62.

119. Brook, J. S., Brook, D. W., Gordon, A. S., Whiteman, M., & Cohen, P. (1990). The psychosocial etiology of adolescent drug use: A family interactional approach. *Genetic, Social, and General Psychology Monographs, 116* (Whole No. 2).

120. Butcher, J. N., Williams, C. L., Graham, J. R., Tellegen, A., & Ben-Porah, Y. S. (1992). *Manual for the administration, scoring, and interpretation of the adolescent version of the MMPI.* Minneapolis, MN: University of Minnesota Press.

121. Brook, J., Whiteman, M., Balka, E., Win, P., & Gursen, M. (1998). Similar and different precursors to drug use and delinquency among African Americans and Puerto Ricans. *The Journal of Genetic Psychology, 159*(1), 13–29.

122. Byram, O. W., & Fly, J. W. (1984). Family structure, race, and adolescent's alcohol use: A research note. *American Journal of Drug and Alcohol Abuse, 10,* 467–478.

123. Morehouse, E. & Tobler, N. S. (2000). Preventing and reducing substance use among institutionalized adolescents. *Adolescence, 35,* 1–29.

124. Harford, T. C. (1985). Drinking patterns among Black and non-Black adolescents: Results of a national survey. In R. Wright & T. D. Watts (Eds.), *Prevention of Black alcoholism: Issues and strategies.* Springfield, IL: Charles C. Thomas.

125. Brannock, J. C., Schandler, S. L., & Oncley, P. R. (1990). Cross-cultural and cognitive factors examined in groups of adolescent drinkers. *Journal of Drug Issues, 20,* 427–442.

126. Newcomb, M. D., & Bentler, P. M. (1986). Substance use and ethnicity: Differential impact of peer and adult models. *Journal of Psychology, 120,* 83–95.

127. Hansen, W. B. (1989). *Theory and implementation of the social influence model of primary prevention. Prevention research findings: 1988* (pp. 93–107). OSAP Prevention Monograph 3. Rockville, MD: USDHHS, PHS, ADAMHA.

128. Chassin, L., Presson, C. C., Sherman, S. J., Corty, E., & Olshavsky, R. (1984). Predicting the onset of cigarette smoking in adolescents: A longitudinal study. *Journal of Applied Social Psychology, 14,* 224–243.

129. Graham, J. W., Marks, G., & Hansen, W. B. (1991). Social influence processes affecting adolescent substance use. *Journal of Applied Psychology, 76*(2), 291–298.

130. Sussman, S., Dent, C. W., Mestel-Rauch, J. S., Johnson, C. A., Hansen, W. B., &Flay, B. R. (1988). Adolescent nonsmokers, triers, and regular smokers' estimates of cigarette smoking prevalence: When do overestimates occur and

by whom? *Journal of Applied Social Psychology, 18*(7), 537–551.

131. Santor, D. A., Messervery, D., & Kusumakar, V. (2000). Measuring peer pressure, popularity, and conformity in adolescent boys and girls: Predicting school performance, sexual attitudes, and substance abuse. *Journal of Youth and Adolescence, 29,* 163–183.

132. Buckhalt, J. A., Halpin, G., Noel, R., & Meadows, M. E. (1992). Relationship of drug use to involvement in school, home, and community activities: Results of a large survey of adolescents. *Psychological Reports, 70*(1), 139–146.

133. Voydanoff, P., & Donnelly, B. (1999). Risk and protective factors for psychological adjustment and grades among adolescents. *Journal of Family Issues, 20*(3), 328–349.

134. Selnow, G. W., & Crano, W. D. (1986). Formal vs. informal group affiliations: Implications for alcohol and drug use among adolescents. *Journal of Studies on Alcohol, 47*(1), 48–52.

135. Richardson, J. L., Dwyer, K., McGuigan, K., Hansen, W. B., Dent, C., Johnson, C. A., Sussman, S. Y., & Flay, B. (1989). Substance use among eighth-grade students who take care of themselves after school. *Pediatrics, 84*(3), 556–566.

136. Dishion et al., 1995, op. cit.

137. Swisher, J. B. (1992). *Peer influence and peer involvement in prevention.* Rockville, MD: Center for Substance Abuse Prevention, Division of High Risk Youth.

138. Coie, J. D. (1990). Towards a theory of peer rejection. In S. R. Asher & J. D. Coie (Eds.), *Peer rejection in childhood* (pp. 365–398). New York: Cambridge University Press.

139. Kupersmidt, J. B., Coie, J. D., & Dodge, K. A. (1990). The role of poor peer relationships in the development of disorder. In S. A. Asher & J. D. Coie (Eds.), *Peer rejection in childhood* (pp. 274–305). Cambridge, England: Cambridge University Press.

140. Swisher, J. B. (1992). Peer influence and peer involvement in prevention. Rockville, MD: Center for Substance Abuse Prevention, Division of High Risk Youth.

141. Sneed, C. D., Morisky, D. E., Rotheram-Borus, M. J., Ebin, V. J, & Malotte, C. K. (2001). Patterns of adolescent alcohol, cigarette, and marijuana use over a 6-month period. *Addictive Behaviors, 26,* 415–423.

142. Botvin, G. J., Baker, E., Filazzola, D., & Botvin, E. (1990). A cognitive-behavioral approach to substance abuse prevention: One year follow-up. *Addictive Behaviors, 15,* 47–63.

143. Bell, R. M., Ellickson, P. L., & Harrison, E. R. (1993). Do drug prevention effects persist into high school? How Project ALERT did with ninth graders. *Preventive Medicine, 22,* 463–483.

144. Dielman, T. E., Kloska, D. D., Leech, S. L., Schulenberg, J. E., & Shope, J. T. (1992). Susceptibility to peer pressure as an explanatory variable for the differential effectiveness of an alcohol misuse prevention program in elementary schools. *Journal of School Health, 62,* 233–237.

145. Dryfoos, J. (1993). Preventing substance use: Rethinking strategies. *American Journal of Public Health, 83,* 793–795.

146. Sperber, A. D., Peleg, A., Friger, M., & Shvartzman, P. (2001). Factors associated with daily smoking among Israeli adolescents: A prospective cohort study with a 3-year follow-up. *Preventive Medicine, 33,* 73–81.

147. Altman, D. G., Foster, V., Rasenick-Douss, L., & Tye, J. B. (1989). Reducing the illegal sale of cigarettes to minors. *Journal of the American Medical Association, 261,* 80–83.

148. Forster, J. L., Hourigan, M., & McGovern, P. (1992). Availability of cigarettes to underage youths in three communities. *Preventive Medicine, 21,* 320–328.

149. Radecki, T. E., & Zdunich, C. D. (1993). Tobacco sales to minors in 97 U.S. and Canadian communities. *Tobacco Control, 2,* 300–305.

150. Preusser, D. F., & Williams, A. F. (1992). Sales of alcohol to underage purchasers in three New York counties and Washington, D.C. *Journal of Public Health Policy, 13*(3), 306–317.

151. Blake, S. M., Ledsky, R., Goodenow, C., & O'Donnell, L. (2001). Recency of immigration, substance use, and sexual behavior among Massachusetts adolescents. *American Journal of Public Health, 91,* 794–798.

152. Martinson, B. C., Lazovich, D., Lando, H. A., Perry, C. L., McGovern, P. G., & Boyle, R. G. (2000). Effectiveness of monetary incentives for recruiting adolescents to an intervention trial to reduce smoking. *Preventive Medicine, 31,* 706–713.

153. Spoth, R., Goldberg, C., Neppl, T., Trudeau, L., & Ramisetty-Mikler, S. (2001). Rural-urban differences in the distribution of parent-reported risk factors for substance use among young adolescents. *Journal of Substance Abuse, 13,* 609–623.

154. Slesnick, N., & Meade, M. (2001). System youth; A subgroup of substance-abusing homeless adolescents. *Journal of Substance Abuse, 13,* 367–384.

155. Smith, M. U., & DiClemente, R. J. (2000). STAND: A peer educator training curriculum for sexual risk reduction in the rural south. *Preventive Medicine, 30,* 441–449.

156. Johnston, L. D., O'Malley, P. M., & Bachman, J. G. (1999). *National survey results on drug use for the Monitoring the Future Study, 1975-1998: Vol. 1* (NIH Publication No. 99-4660). Washington, DC: U.S. Government Printing Office.

157. Oetting, E. R., & Beauvais, F. (1990). Adolescent alcohol use: Findings of national and local surveys. *Journal of Consulting and Clinical Psychology, 58,* 365–394.

158. Hechinger, F. M. (1992). *Fateful choices: Healthy youth for the 21st century.* New York: Carnegie Corporation.

159. Dusenbury, L., Kerner, J. F., Baker, E., Botvin, G., James-Ortiz, S., & Zauber, A. (1992). Predictors of smoking prevalence among New York Latino youth. *American Journal of Public Health, 82,* 55–58.

160. Schinke, S., Orlandi, M., & Cole, K. (1992). Boys & girls clubs in public housing developments: Prevention services for youth at risk. *Journal of Community Psychology,* (OSAP Special Issue), 118–128.

161. Spooner, C., Mattick, R. P., & Noffs, W. (2001). Outcomes of a comprehensive treatment program for adolescents with a substance-use disorder. *Journal of Substance Abuse Treatment, 20,* 205–213.

162. Forster, et al., 1992, op. cit.

163. Calfee, J. (1997). *Fear of persuasion: A new perspective on advertising and regulation.* Washington, DC: AEI Press.

164. Schneider, L., Klein, B., & Murphy, K. (1981). Governmental regulation of cigarette health information. *Journal of Law and Economics, 24,* 575–612.

165. Chaloupka, F. J., & Grossman, M. (1996). *Price, tobacco control policies, and youth smoking.* Unpublished Working Paper No. 5740. Cambridge, MA: National Bureau of Economic Research.

166. Ho, R. (1998). The intention to give up smoking: Disease versus social dimensions. *The Journal of Social Psychology, 138*(3), 368–380.

167. Wallack, L., & DeJong, W. (1995). Mass media and public health: Moving the focus from the individual to the environment. In S. Martin & P. Mail (Eds.), *The effects of the mass media on the use and abuse of alcohol* (NIAAA Research Monograph No. 28, pp. 253–268). Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism.

168. Barlow, T., & Wogalter, M. S. (1993). Alcoholic beverage warnings in magazine and television advertisements. *Journal of Consumer Research, 20*(1), 147–156.

169. Laughery, K., Young, S., Vaubel, K., & Brelsford, J. (1993). Noticeability of warnings on alcohol beverage containers. *Journal of Public Policy and Marketing, 12*(1), 38–56.

170. Malouff, J., Schutte, N., Wiener, K., Brancazio, C., & Fish, D. (1993). Important characteristics of warning displays on alcohol containers. *Journal of Studies on Alcohol, 54,* 457–461.

171. Matei, M-E., & McFee, R. B. (2001). Youth tobacco use: A multifactorial problem. *Preventive Medicine, 33,* 514–515.

172. Adrian, M., & Ferguson, B. S. (1987). Demand for domestic and imported alcohol in Canada. *Applied Economics, 19,* 531–540.

173. Clements, K. W., & Johnson, L. W. (1983). The demand for beer, wine and spirits: A system-wide analysis. *Journal of Business, 56,* 273–304.

174. Gruenewald, P. J., Ponicki, W. R., & Holder, H. D. (1993). The relationship of outlet densities to alcohol consumption: A time series cross-sectional analysis. *Alcoholism: Clinical and Experimental Research, 17*(1), 38–47.

175. Levy, D., & Sheflin, N. (1985). The demand for alcoholic beverages: An aggregate time-series analysis. *Journal of Public Policy and Marketing, 4,* 47–54.

176. Selvanathan, A. E. (1988). Alcohol consumption in the UK, 1955-85: A system-wide analysis. *Applied Economics, 20,* 1071–1086.

177. Coate, D., & Grossman, M. (1988). Effects of alcoholic beverage prices and legal drinking ages on youth alcohol use. *Journal of Law and Economics, 31,* 145–171.

178. Saffer, H., & Grossman, M. (1987). Beer taxes, the legal drinking age, and youth motor vehicle fatalities. *Journal of Legal Studies, 16,* 351–374.

179. Landrine, H., Klonoff, E. A., Campbell, R., & Reina-Patton, A. (2000). Sociocultural variables in youth access to tobacco: Replication 5 years later. *Preventive Medicine, 30,* 433–437.

180. Grube, J. W., & Nygaard, P. (2001). Adolescent drinking and alcohol policy. *Contemporary Drug Problems, 28,* 87–131.

181. DiFranza, J., Savageau, J., & Aisquith, B. (1996). Youth access to tobacco: The effects of age, gender, vending machine locks and "It's the Law" programs. *American Journal of Public Health, 86,* 221–224.

182. Radecki, T. E. (1994). 16 cities: Merchant responsibility, 3–4/year Checks better. *Drug Free Youth News, 7,* 1–2.

183. Chaloupka, F. J., & Grossman, M. (1996). *Price, tobacco control policies, and youth smoking.* Unpublished Working Paper No. 5740, National Bureau of Economic Research, Cambridge, MA.

184. Edwards, G., Anderson, P., Babor, T., Casswell, S., Ferrence, R., Giesbrecht, N., Godfrey, C., Holder, H., Lemmens, P., Makela, K., Midanik, L., Norstrom, T., Osterberg, E., Romelsjo, A., Room, R., Simpura, J., & Skog, O. J. (1994). *Alcohol policy and the public good.* New York: Oxford University Press.

185. Evans, W. N., & Farrelly, M. C. (1997). *The compensating behavior of smokers: Taxes, tar, and nicotine.* Unpublished Working Paper, University of Maryland, Department of Economics, College Park, MD.

186. National Cancer Institute. (1993, May). *The impact of cigarette excise taxes on smoking among children and adults: Summary report of a National Cancer Institute expert panel.* Paper presented at the annual information exchange conference of ASSIST (America Stop Smoking Intervention Study), San Francisco, CA.

187. U.S. Department of Health and Human Services. (1992). *Youth access to tobacco.* Washington, DC: Office of Evaluation and Inspectors, Office of Inspector General.

188. Levy, D. T., Cummings, K. M., Hyland, A. (2000). Increasing taxes as a strategy to reduce cigarette use and deaths: Results of a simulation model. *Preventive Medicine, 31,* 91–99.

189. Siegel, M., Biener, L., & Rigotti, N. A. (1999). The effect of local tobacco sales laws on adolescent smoking initiation. *Preventive Medicine, 29,* 334–342.

190. Sargent, J. D., Dalton, M., Beach, M., Bernhardt, A., Heatherton, T., & Stevens, M. (2000). Effect of cigarette promotions on smok-

ing uptake among adolescents. *Preventive Medicine, 30,* 320–327.

191. Pucci, L. G., & Siegel, M. (1999). Exposure to brand-specific cigarette advertising in magazines and its impact on youth smoking. *Preventive Medicine, 29,* 313–320.

192. Soldz, S., Kreiner, P., Clark, T. W., & Krakow, A. (2000). Tobacco use among Massachusetts youth: Is tobacco control working? *Preventive Medicine, 31,* 287–295.

193. Davis, R. C., Smith, B. E., Lurigio, A. J., & Skogan, W. G. (1991). Community response to crack: Grassroots anti-drug programs. Report of the Victim Services Agency, New York, to the National Institute of Justice.

194. Eck, J., & Wartell, J. (in press). Improving the management of rental properties with drug problems: A randomized experiment. In L. Green-Mazarolle & J. Roehl (Eds.), *Civil remedies.* Monsey, NY: Criminal Justice Press.

195. Green-Mazarolle, L., Roehl, J., & Kadleck, C. (1997). Controlling social disorder using civil remedies: Results from a randomized field experiment in Oakland, California. In L. Green-Mazarolle & J. Roehl (Eds.), *Civil remedies.* Monsey, NY: Criminal Justice Press.

196. Lurigio, A., Davis, R., Regulus, T., Gwisada, V., Popkin, S., Dantzker, M., Smith, B., & Ouellet, A. (1993). *An evaluation of the Cook County State's Attorney's Office Narcotics Nuisance Abatement Program.* Chicago: Loyola University Department of Criminal Justice.

197. Rosenbaum, D. P., & Lavrakas, P. J. (1993, November). *The impact of voluntary community organizations on communities: A test of the implant hypothesis.* Paper presented at the annual meeting of the American Society of Criminology, Phoenix, AZ.

198. Smith, B. E., Davis, R. C., Hillenbrand, S. W., & Goretsky, S. R. (1992). *Ridding neighborhoods of drug houses in the private sector.* Washington, DC: American Bar Association.

199. Committee on Public Education. (2001). Children, adolescents and television. *Pediatrics, 107,* 423–426.

200. O'Malley, P. M., & Wagenaar, A. C. (1991). Effects of minimum drinking age laws on alcohol use, related behaviors and traffic crash involvement among American youth: 1976–1987. *Journal of Studies on Alcohol, 52,* 478–491.

201. Wagenaar, A. C. (1993). Minimum drinking age and alcohol availability to youth: Issues and research needs. In M. E. Hilton & G. Bloss (Eds.), *Economics and the prevention of alcohol-related problems: Proceedings of a workshop on economic and socioeconomic issues in the prevention of alcohol-related problems, October 10–11, 1991.* (NIAAA Research Monograph No. 25, pp. 17–200). Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

202. Berger, D. E., & Snortum, J. R. (1985). Alcoholic beverage preferences of drinking-driving violators. *Journal of Studies on Alcohol, 46,* 232–239.

203. National Highway Traffic Safety Administration. (1995). *Traffic safety facts 1994: A compilation of motor vehicle crash data from the Fatal Accident Reporting System and the General Estimates System.* Washington, DC: National Center for Statistics and Analysis, National Highway Traffic Safety Administration, U.S. Department of Transportation.

204. Toomey, T. L., Rosenfeld, C., & Waggoner, A. C. (1996). The minimum legal drinking age: History, effectiveness, and ongoing debate. *Alcohol, Health & Research World, 20*(4), 213–218.

205. Howard, K. A., Ribisl, K. M., Howard-Pitney, B., Norman, G. J., & Rohrbach, L. A. (2001). What factors are associated with local enforcement of laws banning illegal tobacco sales to minors? A study of 182 law enforcement agencies in California. *Preventive Medicine, 33,* 63–70.

206. Valois, R. F., Dunham, A. C., Jackson, K. L., & Waller, J. (1999). Association between employment and substance abuse behaviors among public high school adolescents. *Journal of Adolescent Health, 25*(4), 256–263.

207. Bennett, I., & Lehman, W. E. K. (1998). Workplace drinking climate, stress, and problem indicators: Assessing the influence of teamwork (group cohesion). *Journal of Studies on Alcohol, 59*(5), 608–618.

208. Martin, J. K., & Roman, P. (1996). Job satisfaction and drinking among employed persons. *Work and Occupations, 23,* 115–142.

209. Lehman, W. E., Farabee, D., Holcom, M., & Simpson, D. D. (1995). Prediction of substance abuse in the workplace: Unique contributions of personal background and work environment variables. *Journal of Drug Issues, 25,* 253–274.

210. Rosenbaum, A. L., Lehman, W. E. K., Olson, K. E., & Holcom, M. L. (1992). *Prevalence of substance use and its association with performance among municipal workers in a southwestern city.* Unpublished manuscript. Institute of Behavioral Research, Texas Christian University, Fort Worth.

211. Lehman, W., & Simpson, D. (1992). Employee substance use and on-the-job behaviors. *Journal of Applied Psychology, 77,* 309–321.

212. Rosenberg, R. (1999). The workplace on the verge of the 21st century. *Journal of Business Ethics, 22*(1), 3–14.

213. Parker, D. A., & Farmer, G. C. (1990.) Employed adults at risk for diminished self-control over alcohol use: The alienated, the burned out, and the unchallenged. In Roman, P. M. (Ed.), *Alcohol problem intervention in the workplace: Employee assistance programs and strategic strategies.* New York: Quorum Books.

214. Lehman, W. E., Farabee, D., Holcom, M., & Simpson, D. D. (1995). Prediction of substance abuse in the workplace: Unique contributions of personal background and work environment variables. *Journal of Drug Issues, 25,* 253–274.

215. National Opinion Research Center, Substance Abuse and Mental Health Services Administration. (1996). *Drug use among US workers: Prevalence and trends by occupation and industry categories.* DHHS Pub. No. (SMA)96-3089. Rockville, MD: SAMHSA.

216. Hoffman, J., Larison, C., & Sanderson, A. (1997). An analysis of worker drug use and workplace policies and programs. Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

217. Ames, G. M., & Janes, C. A. (1992). A cultural approach to conceptualizing alcohol and the workplace. *Alcohol, Health & Research World, 16,* 112–119.

218. Cook, R., Back, A., & Trudeau, J. (1996). Substance abuse prevention in the workplace: Recent findings and an expanded conceptual model. *Journal of Primary Prevention, 16,* 319–339.

219. Mangione, T. W., Howland, J., Amick, B., Cote, J., Lee, M., Bell, N., & Levine, S. (1999). Employee drinking practices and workplace performance. *Journal of Studies on Alcohol, 60,* 261–270.

220. Macdonald, S., & Roman, P. (Eds.) (1995). *Drug testing in the workplace: Research findings and perspectives.* New York: Plenum Press.

221. Zhang, Z., Huang, L., & Brittingham, A. M. (1999). *Worker drug use and workplace policies and programs: Results from the 1994 and 1997 NHSDA.* Washington, DC: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services.

222. Roman, P. M., & Blum, T. C. (1999). Employee Assistance Programs and other workplace interventions. In Galanter, M., & Kleber, H. D. (Eds.), *Textbook of substance abuse treatment.* Washington, DC: American Psychiatric Press, Inc.

223. Moore, R. S. (1998). Hangover: An ambiguous concept in workplace alcohol policy. *Contemporary Drug Problems, 25,* 49–64.

224. Ames, G. M., Grube, J. W., & Moore, R. S. (1997). Relationship of drinking and hangovers to workplace problems: An empirical study. *Journal of Studies on Alcohol, 58,* 37–47.

225. Mangione, et al., 1999, op. cit.

226. Kumpfer et al., 1997, op. cit.

227. Gordon, 1987, op. cit.

228. National Institute of Drug Abuse. (1997). *Preventing drug use among children and adolescents: A research-based guide* (NIH Publication No. 97-4212). Rockville, MD: National Institute on Drug Abuse.

229. Battistich, V., Schaps, E., Watson, M., & Solomon, D. (1996). Prevention effects of the Child Development Project: Early findings from an ongoing multi-site demonstration trial. Special Issue: Preventing adolescent substance abuse. *Journal of Adolescent Research, 11,* 12–35.

230. Ialongo, N. S., Werthamer, L., Kellam, S. G., Brown, C. H., Wang, S., & Lin, Y. (1999). Proximal impact of two first-grade preventive interventions on the early risk behaviors for later substance abuse, depression, and antisocial behavior. *American Journal of Community Psychology, 27*(5), 599–641.

231. Rohrbach, L. A., Graham, J. W., & Hansen, W. B. (1993). Diffusion of a school-based substance abuse prevention program: Predictors of program implementation. *Preventive Medicine, 22,* 237–260.

232. Marin, G. (1993). Defining culturally appropriate community interventions: Hispanics as a case study. *Journal of Community Psychology, 21*(2), 149–161.

233. Blakely, et al., 1987, op.cit.

234. Hall, G. E., & Loucks, S. F. (1978, March). *Innovation configurations: Analyzing the adaptation of innovations.* Paper presented at the annual meeting of the American Educational Research Association, Toronto, Ontario, Canada.

235. Backer, T. (2001). *Finding the balance: Program fidelity and adaptation in substance abuse prevention.* Rockville, MD: National Center for Advancement of Prevention (NCAP). Copies available from NCAP: (301) 984-8470; 11400 Rockville Pike, Suite 209, Rockville, MD 20852.

236. Emshoff, J., Blakely, C., Gray, D., Jakes, S., Brounstein, P., & Coulter, J. (2001). *An ESID case study at the federal level.* Unpublished manuscript. Georgia State University, Atlanta.

237. Blakely, et al., 1987, op. cit.

238. Emshoff, J. G., & Blakely, C. H. (1987). Innovation in education and criminal justice: Measuring fidelity of implementation and program effectiveness. *Educational Evaluation and Policy Analysis, 9,* 300–311.

239. Fairweather, G. W. (1967). Methods for experimental social innovation. New York: Wiley.

240. Fairweather, 1967, op. cit.

241. Welte, J. W., Barnes, G., Wieczorek, W., Tidwell, M-C., & Parker, J. (2001). Alcohol and gambling pathology among U.S. adults: Prevalence, demographic patterns and comorbidity. *Journal of Studies of Alcohol, 62,* 706–712.

242. Ibid.

243. Ibid.

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