ADP

RESOURCE PAPER

The Prevention Recipe: A Skillful Blending of Ingredients

A Guide to Using Research and Theory to Create Effective Programs

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I. Introduction

A key challenge for the tobacco, alcohol and drug prevention field of the 1990's is to turn current research and theory into programs that work. This isn't always easy. Although risk factor and protective factor research provides a breakthrough in our ability to more clearly address the task of prevention, there are still gaps. This paper does not presume to provide all the answers when it comes to risk factor research. Rather, it is intended to clarify and distill major ideas and promising concepts for prevention planners and workers. Given the diversity of Californians, the reader will have to further synthesize much of what is presented in this booklet to his or her particular population or community.

This booklet was written for people who are working on behalf of youth and the communities in which they live and who want to prevent the use and abuse of alcohol and other drugs. While children and youth may be the primary audience of many prevention efforts, much of the information contained here can be applied to a broader cross-section of community organizations and members.

This is not a training manual. Its purpose is to present a clear synthesis of the recent research, blend it with examples of what's working, and provide a method for designing effective prevention programs. The author is indebted to the years of work of researchers and writers including David Hawkins, Denise Lishner, Richard Catalano, Matthew Howard, E.R. Oetting, Fred Beauvais, Joel Moskowitz, Emmy Werner, Cheryl Perry, David Murray, Peter Bell, Stephen Glenn, Bonnie Benard, Karol Kumpfer, Gregory Austin, Michael Prendergast, Harvey Lee and Kenneth Maton. Their work has been woven throughout the booklet, although some specific citations are mentioned.

An underlying assumption of prevention is that young people do not develop alcohol and other drug problems without prior behavioral, emotional, cognitive or physical reasons. We can trace some of these precursors back as early as kindergarten if we consider behavioral problems as possible links to future alcohol and drug use. Many problem behaviors can be altered if we are deliberate in our approaches. In addition, by applying the available research, well planned programs can have an impact on a wide range of problems facing youth—not only alcohol and drug abuse, but teen pregnancy, gang involvement and school drop-out.

Our programs potentially offer a healing "spillover" effect into our communities and society as a whole. One precautionary note: Just as there does not exist a single cause (e.g., peer pressure) of alcohol and other drug abuse, neither is there a magic formula that prevents it. Our frustrations as prevention workers often lie in seeing the magnitude of the problem that faces us, coupled with the ensuing limits of strategies and resources available to us.

If we, as prevention specialists, want our efforts to result in a successful prevention recipe, then we must work from a base of proven ingredients. This base can be flexible enough to adapt to the needs, innovations, and "tastes" of differing communities and populations. Whether a recipe is for chocolate cake, chicken salad, or something brand new, an expert cook will make changes and blend ingredients carefully to ensure a desired outcome. So it goes with designing and running prevention programs. Let's look at all the ingredients of an effective prevention recipe.

II. Trends in Alcohol and Other Drug Use: A Good Beginning

The use of illicit drugs by high school seniors has declined steadily since 1982. Drug use among the nation's youth apparently peaked in 1982 when 64.4 percent of seniors reported they had used an illicit drug. According to the most recent National High School Survey, 47.9 percent of the class of 1990 had used an illicit drug by their senior year.

Some categories of alcohol use also declined significantly. The survey showed that current use of alcohol decreased, from a high of 72.1 percent in 1978 to 57.1 percent in 1990. Daily and binge drinking have also declined substantially from their peaks in the early 1980's, but cigarette smoking has virtually remained at the same level for the past six years.

While it is promising that illicit drug use is decreasing among our youth, their use of alcohol and tobacco continues to remain at high levels.

The National Adolescent School Health Survey conducted in 1987 showed 89 percent of tenth graders reported having tried alcohol, with 53 percent of them having had a drink within the last month. Thirty-eight percent of tenth graders reported having five or more drinks in the previous two week period. Sixty-three percent of tenth graders reported having tried a cigarette, and 26 percent reported having smoked within the last month.

One of the most encouraging findings of both surveys is that disapproval of drug use continues to grow along with a continuing increase in perceived risk of substances. According to Dr. Lloyd Johnston, principal investigator of the High School Survey, the broad trends are due almost entirely to a change in demand, not supply. This reduced demand is attributable largely to important changes in the attitudes, beliefs, and social norms among young people.

The 1990 National Household Survey on Drug Abuse, conducted by the National Institute on Drug Abuse, measured the prevalence of illicit drug use in American households. It found 6.4 percent (12.9 million) of the population age 12 and older were current users, i.e., had used drugs in the past month. This figure represents a 44 percent decline since 1985 and an 11 percent decline from the 1988 findings, again indicating a downward trend in illicit drug use. In 1985, the number of Americans using any illicit drugs in the 30-day period prior to the survey was 23 percent. In 1988 it was 14.5 percent. This trend holds true for the 12–17 age group as well as the adult population.

These surveys have their strengths and limitations. The High School Survey is often criticized for not measuring drug use patterns of those most at risk: school drop-outs. According to Johnston, drug use trends among these youth are similar to the in-school population. Critics of the Household Survey have said the sample of approximately 9,000 is too small to produce an accurate picture of nationwide drug use. Plus, it doesn't measure the use patterns of the homeless, those in prison or in treatment programs, or other subgroups likely to have drug problems. As a result of these criticisms, plans include increasing the sample size for 1991 to nearly 31,000 and expanding it to include hard-to-reach groups in metropolitan areas.

Major surveys give us a general picture of alcohol and drug use trends, but it is apparent that they have limitations. As prevention workers it is essential that we become aware of the tobacco, alcohol and other drug use patterns of the communities we are trying to

impact. Local information may in fact be more useful than national statistics when planning prevention efforts. Smaller studies of specific ethnic[1] subgroups are showing actual increases in the use of specific illicit substances that may be showing as decreases in the general population.

III. A Major Ingredient: Risk Factors

There has been a great deal of discussion about the risk factors that lead to alcohol and other drug use. Risk factor studies are not new to the health field, but have only recently been applied to the substance abuse field. Risk-focused prevention is based on the premise that if you want to prevent a problem from happening, you have to identify those risks that are likely to cause it and address them through programs, activities, and behavioral and societal change. For example, by becoming aware of the risks associated with heart disease (high-fat diet, stress, and lack of exercise), doctors have been able to educate their patients about how to reduce those risks by changing their behavior. The overall goal, of course, is to gain the buy-in of the individual so he or she will make lifestyle changes and reduce their risks.

The awareness of risk factors in the medical field has led to a larger societal shift in our thinking about diet, weight, stress and exercise. Note the numerous products available that contain unsaturated fats and oils; the wide availability of exercise shoes, equipment and gyms; and to a lesser extent the availability of stress-reduction and management classes, books and seminars.

Many studies have found a link between certain risk factors and whether or not a young person experiments with, occasionally uses, or abuses alcohol and other drugs. Risk factor-focused prevention efforts affect individuals differently. In some, it may delay the first use of a substance; in others it may prevent its use altogether. Studies indicate that the longer we can delay experimentation with alcohol and other drugs, the better our chances of preventing serious problems.

While final conclusions are not yet available, it's clear that multiple risk factors must be considered when designing prevention programs. As researcher J. David Hawkins stresses, "If we are going to prevent drug abuse, we can't just do whatever we want. We have to take a risk-focused approach. We have got to address multiple risk factors, we can't just take on one and think we're going to get the job done."

Three major categories of risk factors are widely referred to in the research: demographic, psychosocial/environmental, and biological risk factors. An in-depth discussion of these categories is presented in this section.

1. Demographic Risk Factors

Many demographic factors, such as gender, ethnicity, age, and socioeconomic status are strongly correlated or related to alcohol and other drug use. For instance, many prevalence and use studies show males tend to use alcohol and drugs more often than females, with the exception of nicotine and stimulants (Kumpfer 1989). Young adults (18–29) use alcohol and drugs more than any other age group. The exception to this is African-American youth, who use significantly less alcohol than their parents or grandparents. Overall, white adolescents tend to use alcohol and drugs more than their counterparts in all other ethnic or racial groups. While certain ethnic groups may use substances less, they are affected more by the adverse consequences of alcohol and drug use, which may be further exacerbated by conditions of

1. For purposes of this booklet, "ethnic" refers to those groups of people that are distinguished by their customs, language, culture or race and who comprise or are part of a larger community or society. For further information on drug use studies of specific populations, contact the Western Center for Drug-Free Schools and Communities.

poverty, unemployment, discrimination, poor health and despair.

Noted author and lecturer Peter Bell cites a bi-polar or unequal distribution of drug abuse consequences based on socioeconomic class: the lower the class, the more obvious the problems, at least initially. For example, the death rate for liver cirrhosis is nearly twice as high for African-Americans as for whites, and in the 25–34 age group, it is ten times as high in some cities (Williams 1982).

Because of cultural and societal practices and barriers, ethnic populations tend to access treatment services much later than do whites. Problems tend to go unrecognized until there is an involvement with the criminal justice system (Mosley et al. 1988). There are many discussions about why this is so, such as a lack of culturally relevant services in ethnic communities or an insensitivity to the issues of racism. However, it has been difficult to prove these through research studies.

If we look at economic deprivation as a risk factor, while studies show a link between this and delinquent behavior, it is much more difficult to link this risk factor specifically with drug abuse (Hawkins 1989). We know that all people, regardless of economic status, use and abuse alcohol and other drugs. In general, low socioeconomic and other demographic factors tend to combine with early behavioral and environmental problems to lead to alcohol and other drug problems.

Lack of quality education is more closely linked to drug abuse than other demographic factors. Poor academic motivation and low school success often result from a lack of meaningful, quality education and are strong indicators of subsequent drug use by youth. Young people in communities where schools are overcrowded, lack qualified teachers, or have other cultural or institutional barriers to learning, may be at greater risk for alcohol and other drug use. These and related risk factors will be presented in the sections on school and community influences. Further study is necessary to determine the impact of demographic risk factors on alcohol and other drug use.

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2. Psychosocial/Environmental Risk Factors

This larger category of psychological, social and environmental risk factors provides important clues for addressing the risks with carefully designed programs. In addition, this category allows us to begin to see another key ingredient of the prevention recipe emerging, that of protective factors. Protective factors are those elements that guard or defend someone from harm or danger, in this case, substance abuse. An overall protective goal of prevention efforts is to promote bonding or attachment to the prosocial or positive values and norms of the family, school and community. (Protective factor research is presented in Section IV.)

Psychosocial/environmental risk factors can be clustered into three sub-groupings that have the most influence on young people: family, school/peer and community.

Family Influences/Risk Factors

The early influences of the family, whether nuclear, blended or extended, are considered of primary importance in developing an individual's attitudes, values, and abilities to cope with the stresses and decisions of life, including alcohol or other drug use. The major family influences include:

Parental and sibling alcohol and other drug use and attitudes about drugs: Numerous studies show parental and sibling use of alcohol and other drugs is an important risk factor. This

may be due to the early development of values and attitudes that say drug use is "OK."

Negative parent-child interactions/poor family management: This includes several key components: a) inconsistent or excessively severe or lenient discipline practices; b) lack of caring and family attachment; c) lack of positive adult role models. The quality of family relationships and closeness have been found to prevent involvement in drug use by children, even in those families where some drug use is present. This is particularly true for ethnic families, where studies show that parental influences are more important for these youth than peer influences.

There are no indications that single-parent or blended families are at greater risk for alcohol and drug problems as long as these and other risks are addressed. Family structure is less important than attachment and closeness of the family (Hawkins et al. 1986). While the disruption of the intact family can be an underlying factor in drug use, it can be addressed by maintaining communication and family closeness and by providing other protective factors.

Low educational expectancies: The family promotes early values which can determine whether or not the child will have a commitment and positive attitude toward school. If parental expectations for academic success are low, then the child will most likely be less motivated to do well in school. Academic failure has been found to lead to a variety of antisocial behaviors, including drug use, delinquency, truancy and school drop-out. The family is particularly key in ethnic communities when addressing this influence.

Lack of clear rules, norms and culture: A lack of clear rules and norms about drug use leaves young people not knowing what their families expect of them. Without defined expectations, children often rely on information from other sources, such as peers and the media, when deciding whether or not to use drugs. According to Peter Bell, a cultural context—i.e., a pre-set and clearly defined way of life based on customs or beliefs, within the family as well as community—helps define what is, and is not, acceptable. When the cultural context is unclear, the behavioral expectations are fuzzy.

Lack of family rituals/low religiosity: Researchers have argued that adolescent drug use may be considered a standard form of initiation into adulthood in our society. However, if given opportunities for healthy initiation and rites of passage, this need not be the case. Families that follow religious practices tend to have lower rates of alcohol and other drug problems. Because of the prominence of the church/synagogue in many ethnic communities, its importance in prevention efforts should always be considered. Family rituals need not be in a religious context, but that of providing consistency and a means for attachment and bonding to the family, e.g., nightly family meals or weekly family outings.

Family history of chemical dependency: This influence may be linked to an increase in the child's genetic vulnerability towards chemical dependency. This type of family history may also contribute to a "fatalistic" attitude or sense of hopelessness on the part of the parents, school and community members toward drug problems. However, prevention workers can do much to address this risk factor by keeping protective and effective strategies in mind.

School and Peer Influences/Risk Factors

The influence categories of school and peers have been combined for this publication since the majority of peer interactions in a young person's life takes place in the school setting. Of course, peer influences seen in school can also be transferred to the neighborhood, community center or church. The major school and peer influences/risk factors include:

Association with drug-using peers: Peers who use drugs and approve of their use are one of the strongest predictors of later drug use, partic-

ularly for initiation into gateway drugs. This holds especially true for white youth, although peer attitudes and behaviors also affect youth of color. When discussing the influence of peers, studies often refer to "peer pressure" as a driving force behind drug use. The image conjured up by this term is that of a helpless, passive youth being forced to try drugs by other youth or a drug pusher.

New studies present peer influence as it relates to a dynamic, active "peer cluster" whose members are actively involved in defining and making drug use a normal part of their activities (Oetting et al. 1987). Peer clusters in general are smaller, tighter, and more homogeneous groupings of peers who closely share attitudes, values and beliefs. These are the closest friends, the "soul mates" who share intimate time together. Members of these clusters may not be experiencing peer pressure as it is commonly defined. They, in fact, are shaping what behaviors are acceptable, what drugs are used, and when, where, and how they are used.

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Our challenge when considering such influence is to gain an understanding of the psychosocial/environmental risk factors that may lead a young person to join a certain peer cluster. We also must determine how to prevent a young person from accepting the undesirable behaviors of the peer cluster. This is a more complex issue than that of peer pressure and further supports the need for comprehensive prevention programs involving the family, the school, peers and the community.

Greater reliance on peers than parents: Young people who rely more on their peers for support, information and behavioral cues tend to follow the behavior of the peer group. While it is part of healthy childhood development to transfer some reliance from parents to peers, parental influence should remain strong throughout childhood and adolescence.

Lack of clear school policies regarding substance use: As in the family setting, the school must establish clear rules and norms regarding alcohol and other drug use. Without clear policies for the students, administration and teachers, the messages given to students may be ambiguous and confusing. They may even imply that the school accepts as harmless or expects some drug use (e.g., smoking in the bathrooms).

Poor academic performance: Young people who enter school with low family or personal expectations to succeed in school, in combination with other risk factors, may end up with low academic performance. A whole variety of antisocial and problem behaviors, such as aggression, rebelliousness, truancy and delinquency, can lead to or are related to this one risk factor.

Lack of life skills instruction: If the school is not providing some instruction in basic problem-solving, coping, and refusal skills, young people may not learn these skills anywhere else. The school is the most likely setting for providing structured lessons in life skills.

Community Influences/Risk Factors

The community and its cultural context reinforce and provide many of the values, norms and standards of behavior and the messages young people receive about alcohol and other drugs. Those who live in communities where alcohol and other drugs are readily available, promoted, or used are more likely to use them. Within the community, the influences of family, religion, culture and

media further define expected behaviors. The key influences/risk factors found in communities include:

Lack of positive community norms and values, general community disorganization: These can include: a) pro-drug attitudes and practices, and b) conflicting or lack of cultural messages. The complexity of our society and the great diversity of its people have in some cases led to a breakdown of clear and consistent boundaries. When boundaries break down, the cultural context is lost. As a result, positive values and norms may not be applied to everyday life. Formal, imposed regulations may need to take over as a system of control. However, laws and regulations have not been shown to produce long-lasting decreases in alcohol or other drug abuse.

High availability, advertising, and low cost of tobacco, alcohol and other drugs: This risk factor can be disastrous for young people. Large numbers of liquor stores and bars, particularly in ethnic communities, provide easy access to alcohol. They also teach young people about drinking by exposing them daily to the presence of alcohol and the adults who use it. Heavy advertising of alcohol and tobacco products in the community can send favorable images regarding their use to impressionable young minds.

Widespread drug trafficking also tends to teach young children that such behavior is acceptable. One study of inner-city youth found that 91 percent witnessed drug trafficking daily. Throughout the community it caused a sense of fear, hopelessness and powerlessness. Adults were deeply concerned that children were internalizing the values, rules and attitudes of the "drug culture" rather than their own culture (Nobles et al. 1987).

Economic and social deprivation and oppression: This risk factor, while not clearly linked to drug use, has been found to combine with other problem behaviors, including delinquency, low self-esteem, alienation and isolation, that may lead to future involvement with drugs.

Lack of meaningful life roles and role models: Many researchers have said it is important for young people to learn life skills and have opportunities to be responsible and serve others in the community. In many cases, positive adult role models can provide the guidance many youth may not receive at home.

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3. Biological Risk Factors

Certain biological factors such as genetics, drug and alcohol use by the pregnant woman, and chemical and learning disorders, interact with the other risk factors to further cause vulnerability to alcohol and other drug problems. A growing body of knowledge suggests there may be genetic links to criminality, alcoholism, delinquency and drug addiction.

Studies of adopted twins and children of alcoholics have found higher susceptibility to chemical dependency in these children. In some cases, sons of alcoholic fathers may have up to nine times greater probability of becoming alcoholic than sons of non-alcoholic fathers. This is important to consider when developing prevention programs, particularly when presenting general information about the effects and consequences of alcohol and other drug use. Participants in prevention workshops should be informed that biological vulnerabilities, which may not be obvious or known to the individual, make it difficult to know if experimentation with drugs or alcohol will lead to early or immediate addiction.

The Impact of Influences/Risk Factors on the Individual

The impact of risk factors can be seen as the result of the many demographic, family, school, peer, community and biological influences. These influences and risk factors can be looked upon as a progression. They begin with biological vulnerabilities and family influences at the earliest stages of development, then move into the influence of school and peers, and finally to those demographic and external community conditions that affect the young person.

In an effort not to "blame the victim," risk factors linked to the individual are presented as those behaviors a young person exhibits if multiple family, school, peer and community risk factors are present and have had an influence on the developing person. These can include:

- Early anti-social behavior
- Rebelliousness and isolation
- Unwillingness or inability to bond to family, school, or community
- Rejection of cultural, social and religious values and practices
- Poor academic performance
- Alcohol and other drug use
- Inability to cope with life stresses, problem-solve and resist peer and other pressures

Cognitive Motivations

By learning more about the risk factors it is easier to understand how they can predispose someone to problem behaviors such as alcohol and other drug use. However, an important question still unanswered is: What is the critical link that leads a young person, whether faced with several risk factors or not, to use drugs? Some researchers believe there exists a mediating process between risk factors and drug use. These "cognitive motivations," or internal reasons for use or non-use, may be the result of how the risk factors affect the individual and the resulting coping behaviors. While cognitive motivations are not actually considered risk factors, they are closely related.

In a study of tenth, eleventh and twelfth graders in Los Angeles, motivations most commonly cited for using alcohol and marijuana among boys were social cohesion ("feel good around people, friends pressure me into using it, everyone else uses it, get along better with friends") and to enhance positive affect and creativity ("know myself better, enjoy what I am doing more, be more creative and original, understand things differently, feel better about myself") (Newcomb et al. 1988). Girls tended to use alcohol and marijuana for similar reasons but also selected reduced negative affect ("stop boredom, get rid of anxiety or tension, feeling sad, blue or depressed") more than boys. The last reason seemed to increase with grade level for both boys and girls. These cognitive motivations can provide more clues to an understanding of how risk factors and influences can impact the behaviors of young people.

IV. A Second Major Ingredient: Protective Factors

There still exists one remaining question: Why is it that some young people, faced with horrendous life circumstances and a majority of the risk factors, can still develop into healthy and well-functioning adults? It is important to examine another major ingredient of the recipe: protective factors contributing to resilient individuals.

A 30-year study of 698 children on the island of Kauai found that one in three identified high-risk children (defined as high-risk if they encountered four or more specifically designated risk factors) grew into "competent young adults who loved well, worked well and played well. They succeeded in school, managed home and social life well, and set realis-

tic educational and vocational goals and expectations for themselves..." (Werner 1989).

Norman Garmezy, who studied the ability of children of schizophrenics to positively adapt to life, found that most of the children did not become maladaptive as adults. Many, in fact, developed unique coping abilities and grew up to be warm, competent people (1983). Children who grew up with a number of protective factors at work seemed to develop a resiliency that led to competency and mastery over their environment. According to Garmezy, children develop personality disposition factors (known to us as individual protective factors) that help children cope. These include:

Effectiveness in work, play and love: These resilient children work well, play well and love well. They make positive friendships and do well in school.

Healthy expectancies and a positive outlook: They tend to have an orientation toward success rather than failure and are able to set realistic goals for themselves.

Self-esteem and internal sense of control: They experience feelings of self-worth and self-competence and feel a sense of control over their own lives.

Self-discipline: They are able to delay gratification, control impulses and maintain a future orientation.

Problem-solving/critical thinking skills: They can think more abstractly, can reflect on ideas, are flexible in their thinking and can propose alternate solutions to cognitive and social problems.

Humor: They can laugh and be amused about themselves, others and the world around them.

Broader, external protective factors currently being explored by Werner, Garmezy and others include:

Supportive family environment; family, cultural and racial pride: These provide children with attention and support, a sense of stability, and an awareness and appreciation of family, racial and cultural heritage.

External sources of support and role-models: These include positive substitute child care including the intergenerational kinship of grandparents, aunts and uncles, positive role models and positive social groups. The children receive support and acknowledgement. Resilient children in the studies were all able to establish a close bond with at least one caretaker outside the immediate family who could give them support and attention. They tended to find a great deal of emotional support from community sources such as a church group, YMCA, 4-H or other extracurricular activity.

Fewer chronic stressful life events: Stressors include illness, family discord or abuse, community disorganization or economic deprivation, or external events such as war.

It makes sense to assume that for every risk factor there exists a corresponding protective factor, and that the protective factor should be considered when developing prevention programs. This has not yet been clearly articulated in the research, but a balance of risk-focused and protection-focused approaches are what we can strive for in our efforts. If at-risk children are showing an inherent ability to "bounce back," apparently against all odds and without formal interventions, then perhaps by providing a deliberate, well-balanced approach to prevention, we can impact on the lives of those children who may not be naturally resilient.

David Hawkins has identified two key principles that are essential for prevention and that contain important links to protective factors:

1. Any prevention strategy has to be designed

to increase bonds between young people and positive social units (family, school/peers, community). Ways to promote bonding include providing opportunities to:

- actively contribute to the social unit;
- develop the life skills necessary to be successful in one's contribution to the unit;
- receive consistent rewards and recognition for being a positive member and contributor of the social unit.

2. There need to exist clear norms and expectations within the social unit about drug use and other behaviors. This can be accomplished by:

- developing family policies on drug use and other behaviors;
- developing clear school policies;
- enforcing policies and upholding known consequences of not following them.

In addition, various research by authors[2] studying prevention strategies for specific ethnic groups concludes that:

1. Culture, values, customs, language, social status, drug use patterns as well as broader problems of poverty, school drop-out, discrimination, crime, and cultural adjustment for each ethnic group should be considered when designing prevention programs.

2. Differences in the relevance of specific risk factors and protective factors for each ethnic group must be taken into account when developing programs using a risk-focused approach. For example, "poor academic achievement" has little importance, relative to other ethnic groups, for most Asian youth whereas "family disorganization" rates high for Latino youth as a risk factor.

3. Further prevention research on risk factors, influences and protective factors needs to be done for all ethnic groups. This type of research should include members of the specific community in both an advisory and research capacity.

2. J. Butler, P. Bell, E. Maddahian, Z. Wong, P. Akutsu, M. Dawkins, F. Galen, R. Zambrana, M. Aguirre-Molina, M. Gilmore

V. Model Programs Addressing Risk Factors

The quality of a final prevention "product" depends largely on our ability to skillfully use or alter the recipe. The following examples were selected because they mixed the key ingredients into a successful program.

A Police-School-Community Partnership: The San Francisco Story

In the fall of 1986 the Mayor's Narcotic Task Force of the City and County of San Francisco realized that traditional law enforcement and drug education efforts were not controlling or preventing the city's drug problems. They directed the school district and police department to work cooperatively to identify a comprehensive approach to prevention.

The police community services division and the school administrator for health education researched curriculum based on criteria published by the U.S. Department of Education and the Rand Corporation. They selected "Here's Looking at You, 2000." This curriculum focuses largely on developing positive peer relationships, understanding and resisting peer pressure and building individual life skills. Its greatest impact is on peer and school risk factors.

San Francisco faces unique problems. A multicultural and multiethnic city of 800,000 packed into 49 square miles, it contains large African American, Latino (from Central and

South America and Mexico), and Asian (from China, Japan, Korea, Philippines, Laos, Vietnam, Samoa and Cambodia) pockets. Much of the population lives in public and subsidized housing, close to the poverty line. The initial effort, funded through drug assets/seizures and some school money, trained police officers to work in ten public elementary schools with the help of about thirty classroom teachers. The model consisted of eight sessions taught in grades three, four, and five, with police officers and classroom teachers alternating as instructors.

In late 1987 funding was secured from the state Office of Criminal Justice Planning and an all-out effort was launched. The police department took the lead on training teachers. By 1990 over 300 teachers representing all 72 public elementary schools were trained. Teachers were trained to deliver the full K–5 curriculum, with the help of police officers for the fourth and fifth grades because of their effectiveness with that age. By the end of the 1991 school year, each Catholic and a number of private schools will also have a complete set of K–5 materials and a trained teacher on site.

The police department saw its involvement as a way to improve its community relations and image while being role models for the kids. "Many of these kids have known police officers in a negative way, arresting a family member or being involved in a neighborhood drug-bust," says Dan Lawson, coordinator of the program with the police department. "Now they have the opportunity to get to know us as people, as someone they can talk to."

The police serve as personal and community resources for the kids. "We talk to them about their problems, and where they can go for help. We also want them to know that family problems with alcohol or drug use are not their fault. Kids now relate to us more positively.

"It's probably the most comprehensive thing the department has ever done in regards to crime prevention," says Dan. "The potential is there to reach 25,000 kids each year. The school-based program has been successful and impressive. We have been able to work cooperatively with the school district and community-based organizations to reduce duplication of effort, set common goals in the city, and reduce the peer and school risks that students face. We no longer have a grab-bag of programs delivering one-shot deals to a few schools. We now have a handle on what every child in the San Francisco schools receives." But it's not enough to work only with the children, according to Dan. "We knew there was more to do. When these kids go home, they face a new set of risks that we couldn't impact."

In 1988 the police department contacted the San Francisco office of the Center for Human Development, a prevention agency training parents as classroom presenters of prevention information. "Our program model was difficult to implement in San Francisco," says Maryann Fleming, parent program coordinator. "It was hard getting the parent volunteers we needed. They just wouldn't come out in the city. When Officer Lawson contacted us we saw how we could change our focus slightly and enhance what the police and schools were doing with the Here's Looking at You, 2000 (HLAY) curriculum. Thus, Strengthening Family Ties was born."

Developed as a multicultural parenting workshop, the six hours of instruction (presented in from two to six sessions) familiarizes parents with the risk factors and refusal skills their children are learning in school. It also trains them in skills for improving family management through positive communications, reducing conflicts, creating a family policy about drug use, methods of discipline, and increasing family connectedness. Carefully designed to meet the needs of the diversity of San Francisco while addressing family risk factors, the program trains parents and community workers to serve as workshop facilitators. The sessions are offered in English, Spanish, Mandarin, Cantonese and Tagolog.

The parent workshops have been well-

received. Over 1,400 parents attended sessions last school year. "We're pleased with the growth of the program," says Maryann. "As a result, parents are more willing to talk about their problems and seek help. This is so important in those cultural groups that may not admit to a problem until it's very severe."

Both Dan and Maryann envision this program continuing for a number of years. Now it is considered as part of the school district's overall drug, alcohol and tobacco prevention plan, and a recognized prevention effort of the county's alcohol and drug department. "It's the first time so many people are actually working together in the city to deal with this problem and that feels good," reports Dan, "but I'm particularly concerned about the very high-risk and dysfunctional families. Our approach is reaching those kids and families who have great potential for having problems, but I'm afraid we're missing many of those who need us most."

In an effort to make the program even more comprehensive, the school district has funded Strengthening Family Ties support groups to begin next year. In addition, new culturally specific modules are being designed with money from a local foundation. The police department has been working with the local chapter of the National Council on Alcoholism and Drug Dependence to provide support groups for the children. The pupil services department of the school district has also been working to improve their school drug policies. Evaluations are showing that students, parents and administrators are all pleased with the program, but that further parent involvement and teacher training is needed.

"Things are happening," Dan says. "This type of program is the answer. The grassroots involvement, the basic foundation of information, the children, it's our only chance...even if we get frustrated at times, we've got to continue!"

A Drug-Free Club for Hispanic Youth and Their Siblings: Hermanos Club

In 1982 the California Hispanic Commission on Alcohol and Drug Abuse recognized the need for a prevention approach designed specifically for Latino children and youth. Because of the large concentration of Latinos in the East Los Angeles area and the lack of prevention services at the time, this site was selected. A program was designed based on four major assumptions:

1. Younger Latino siblings aspire to be like their older brothers, sisters or cousins.
2. The family and community must believe in and support the program.
3. Teens must be given meaningful and rewarding opportunities for influencing their younger siblings.
4. Young people can be taught the difference between acceptable and non-acceptable behavior.

The program operating in 1991 is similar to that designed in 1982 but is being continuously updated to reflect new findings in the prevention field. Teenagers ages 13–17 are recruited to join the Hermanos (brothers/sisters) Club. Very little recruiting is needed because teens usually join on a friend's recommendation. They must have a younger sibling, cousin, or friend (ages 7–12) to bring along as part of the Club. The teens then go through a rigorous six-month training program with twice-weekly sessions. They learn about respect of self and others; protocol in the family; communication skills; peer pressure; prioritizing and decision-making; friendly, family, and intimate relationships; role modeling; self-esteem; culture; and values. These sessions are attended once a week by the younger sibling as well. "The program emphasizes acceptance and connection to the hispanic family and culture," reports Sarah Vergara, project director. "It does not pertain to non-hispanic communities in,

say...West Los Angeles. It was primarily developed to reach a ten-block radius of the poor barrio where these kids live, although it can be adapted to hispanic communities in other areas."

The teens put their skills into action at twice-monthly recreational, social or community service activities with the younger members. Activities include dances and family parties, baseball games, trips to the park or beach, cultural events, outings to amusement parks, Christmas caroling at nursing homes, a graffiti "paint out" or neighborhood clean-up.

The staff of Hermanos Club are all bilingual and bicultural. They reach out to the community and plan and lead activities with community and youth input. The Hermanos Club also has an advanced leadership component for teens to take on the actual planning and carrying out of activities. The teen leaders serve as liaisons between the younger kids and the teens, and the teens and the staff. Many of the teens involved in the leadership program receive salaries through summer job training programs of the City of Los Angeles and the local archdiocese.

'We no longer have a grab-bag of programs delivering one-shot deals to a few schools.'

Other family members are included in many of these events. Mothers and grandmothers often do the cooking and baking for holiday parties; fathers and grandfathers serve as chaperones for dances and outings. "We feel it's essential to have the whole family involved in improving themselves," says Sarah. "The parents like that their children are involved. We don't have scouts or service clubs here. This is the only program that provides meaningful life roles for teens, positive role models for younger kids, all in the context of a drug-free club." Sarah believes the program addresses risk factors pertaining to peer pressure, role modeling, and creating a healthy, drug-free environment for the kids. "But we'd like to do more. Our future plans include offering a culturally relevant parenting course with a tutoring component for the kids. Hispanic families are less likely to call a babysitter, so we want to provide an academically based program for the children while their parents are in the class."

The parenting program will offer a variety of skills to help parents better understand and effectively deal with what their children are going through. It will also serve as a problem-solving and support group.

Sarah would like to expand the community service portion of the program. "These young people have a lot to give to the community, and the community needs them." She also has plans to work more closely with the church, an important part of the Latino community.

Is the program working? All participants are tested when they begin the program and when they leave. Those results have always shown improvement in skills, knowledge and self-esteem. However, longitudinal studies are yet to be done. Sarah relates a favorite success story about two extremely poor children who joined the Hermanos Club, one as a teen and the other as the younger sibling. These children had a father in prison and a mother who could barely make ends meet. "They were doing poorly in school and appeared very hopeless when they came to us," recalls Sarah. "But they stuck it out, with the older one eventually getting involved in our leadership program. Now they are both attending UCLA (University of California at Los Angeles) and doing well. We hear from them often because they believe it was Hermanos that showed them they were special and could change their lives. It's this type of impact that I think would show up in a long-term study."

A Community Teams Up to Prevent Youth Alcohol Problems

Marsha Burgess, superintendent of the Community Services Department of the City of Irvine, realizes that community input and buy-in is invaluable when designing prevention strategies. She believes, "You can't expect to make significant or lasting changes when the solutions aren't developed by citizen groups."

In an effort to fight growing alcohol problems among youth in this Southern California community, the City of Irvine's Substance Abuse Task Force joined with Orange County's Alcohol and Drug Education Prevention Team and the Drug Free Schools and Communities program to develop a comprehensive prevention effort. Utilizing information contained in the *Manual for Community Planning to Prevent Alcohol Availability* by Fried Wittman and Patricia Shane, this upper-middle class, mostly white community developed a planning process best suited to their needs.

A Youth Alcohol Access Committee was formed in January 1989 to direct an assessment phase of the project. The committee represented a broad cross-section of the community from parents and youth to law enforcement and business. A thorough assessment of the situation was accomplished through surveys, interviews, public forums, and the analysis of medical, arrest and related statistics. Community participation on many levels was key throughout the assessment. This included ongoing promotion and education about the project to the public.

The assessment revealed that, even though it is illegal for high school and middle school students to purchase alcohol, it is the most widely used drug among Irvine youth. Nearly half of all students surveyed reported experiencing intoxication before they turned 15 years old. The findings also showed alcohol is easily accessible to youth of all ages and consumed most often at unsupervised private home parties, special events and public celebrations. (Irvine hosts concerts and sports events at a large privately-owned amphitheater and at the campus of the University of California, Irvine.) Youth reported access to alcohol through bars, restaurants, grocery stores and other retail outlets, where they purchase it themselves or through an older friend.

Several community and peer risk factors were found to be operating. Some of these were:

- Easy access to alcohol in a variety of public, social and retail sources;
- Difficulty in enforcing illegal alcohol purchases by underage buyers;
- Similar pricing between beer and soda;
- A widespread perception among the youth that most or all of their peers drank alcohol;
- Considerable promotion of alcohol products in the community at major sporting events, concerts and other community events in and near Irvine.

As a result of these findings the Committee and Task Force determined that "Irvine citizens must decide what community norms they wish to adopt to govern alcohol availability and must begin to implement those strategies that will impact the maintenance of these norms." Recommendations were drafted and the City Council unanimously approved the recommendations on March 27, 1990. These include:

- The City should require responsible beverage service training be given to applicants for licenses to sell alcohol at city events and facilities. The use of these facilities should prohibit alcohol use by groups whose members are mostly under-age. The City should prohibit alcoholic beverage promotions at city-sponsored youth or sports events.
- The City should make it a misdemeanor for a property owner to allow premises to be used for consumption of alcohol by minors.
- The City should prohibit the consumption of alcohol in public parking lots.
- The City should consider Conditional Use

Permit policies which would control proliferation of alcohol outlets (such as stores and bars), especially in high-risk settings, including proximity to schools and residences.

The process of putting these recommendations into place has been long and tedious, but according to Marsha, that's okay. "I'm glad we're moving somewhat slowly on these. It's allowing for a smoother transition."

The majority of the recommendations needed to go before the city attorney for legal review before they could be acted upon. The attorney found when there was an existing state law (e.g., penalties for underage purchasing of alcohol), the local city could not make those penalties any more severe.

Progress has been made on an ordinance that prohibits drinking in public and semi-private parking lots. Passage was expected early in 1991. "This will virtually eliminate tailgate parties in those places where problems associated with alcohol have been well-documented," reports Marsha. Another soon-to-be-drafted ordinance will require new businesses applying for alcohol sales and service permits within the city to have employees serving alcohol who are under the age of 21 supervised by older employees. They must also inform all employees of the legalities of alcohol sales and service and post these requirements.

Several ordinances affecting the use of city-run or -owned facilities are also being drafted. One states that if the contracting group has members predominantly under the legal drinking age, such as fraternities from the university, they will no longer get a permit to serve alcohol at the event. An informal, voluntary policy approved by the city council discourages the involvement of alcohol beverage companies in the promotion of events on city property. It also discourages groups wishing to use city facilities from seeking sponsorship from alcohol beverage companies. Marsha hopes to make this policy more publicly known and supported within the coming months. This can have major implications on how special events look in Irvine.

Currently a city staff person is active on a countywide server training council and will be trained to provide instruction to employees of bars, restaurants and other locations where alcohol is served. Server training would inform them of safe-serving practices and liabilities, including ways to protect a patron from overdrinking and to prevent underage use. "The next step in this process would be to provide instruction to those owners and employees of places where alcohol products are sold, but not served, such as liquor stores and markets," according to Marsha.

Citizens must decide what community norms they wish to adopt.

While there is a great deal more to do, everyone involved agrees that much has been accomplished. "It's a sign of the times, as well as a reflection on the process we used, which has enabled us to get so much done," says Marsha. "The community has been involved and informed from the beginning. But there also seems to be a growing consensus within the community that we have to do all we can to eliminate alcohol problems among our young people." Marsha points to the recent alcohol-related deaths of two young partygoers in a nearby community. "This unfortunate event not only alarms and saddens the citizenry, but mobilizes them to action. The time is right."

Citizens Making It Work—Together

The staff of the Palavra Tree Prevention

Center in San Diego believes all citizens must share the responsibility for a community's health and well-being. "The programs of the Palavra Tree are designed to create environments that encourage members of the community to get involved in activities that will reduce, postpone, or totally eliminate the use of alcohol and prescription drugs, and any use of illegal drugs," explains Dr. Cleo Malone, executive director. "We serve as a launching pad for their concerns and plans. Once the community is empowered to take action, we assist them in any way we can."

A key to the success of the many community efforts undertaken by Palavra Tree is the belief that all program efforts must be sensitive and specific to cultural needs. "We have always taken into account the cultural and ethnic differences that exist in the population we serve," reports Cleo. This low-income, central and southeast section of San Diego is composed primarily of African Americans (70%), followed by Latinos (20%), then small pockets of Asians, Native Americans, and whites. Instead of holding a community Christmas celebration, Palavra Tree hosted a Kawanzaa celebration, a newly adopted holiday of many African Americans that recognizes the contributions and principles of early African teachings. The holiday is celebrated between Christmas and the new year. "While we offer AA and other 12-Step meetings, we do them in a way that I believe is culturally sensitive and gets to the root of the problem. This may mean, for instance, dealing with the illiteracy, that led to the frustration, that led to the inability to get a job, that resulted in drinking, and so on." Quoting W. E. B. DuBois, Cleo believes, "'A man without a knowledge of himself is like a tree without roots.' We want our people to know where they've been so they can understand where we are now, and where we need to go."

Planning for community empowerment must be done with great care and sensitivity. Because of the enormous impact the African church can have on the community, many efforts have been targeted at black clergy. A 15-week clergy training program was developed to teach clergy about addiction, alcoholism, and its related problems. "It was very difficult to change the mindset of the clergy from one of believing alcoholism is a sin to one that understands it as a disease," explains Cleo. "We had to work with the clergy and the community to ensure congregations wouldn't all of a sudden lose faith in their religious leaders for admitting they had made a mistake about alcoholism. Congregants might then ask, 'What else have they been mistaken about?' We didn't want the clergy to lose credibility. We wanted them to gain even more!"

The clergy has been instrumental in keeping liquor stores out of the area. "There have been 24 applications for alcohol sales in the community in the last few years," says Cleo, "but because of a combined effort of the clergy and their support groups we got them all turned down." The Palavra Tree assisted the clergy to understand and access the channels that could impact decisions made about the community. Clergy spoke at city council meetings and in front of the Alcohol Beverage Control Board. A women's clergy group was instrumental in forcing the merchants in the area to stop selling drug paraphernalia.

"Our focus is the community," explains Cleo, "and the community is the family, the neighborhood and the citizens." A key risk factor addressed through programs of Palavra Tree is that of community norms, values and community disorganization. "We are currently organizing three community coalitions to select one or more items from the county's alcohol- and other drug-free 'bill of rights.' These include the right to have streets and highways free from alcohol and other drugs, the right of neighborhoods to be alcohol- and other drug-free, etc. Each coalition will identify the topic that's suited for them and then plan activities and systems to accomplish this. The Palavra Tree will support their efforts in any way we can."

The Palavra Tree believes in the strength of the community and has become an inte-

gral and important part of it. On any given day a young person or adult can come to the center for recreation, a support group, or free bread and milk for the family (over 1,500 loaves are passed out daily). A staff member is always available to provide information and education to a community, church or classroom group. "Each day is a new day for our community." says Cleo, "and we will seek traditional and untraditional channels for promoting its health, well-being and recovery by involving all the people in the process."

Mentoring: A Humbling and Humanizing Experience

Mentors For Achievement matches volunteers from the business community as mentors for students from the local continuation/alternative high schools. Begun in early 1989 as a pilot project of the Sacramento-based People Reaching Out, a community organization offering prevention and intervention services, this joint effort involves the cooperation of the Grant Unified School District and the Rotary Club of Sacramento. "The project has become an exciting alternative for service organizations wanting to donate more than their money to a cause" explains Mary Ellen Rivera, program coordinator. "These Rotarians want to give of themselves by getting personally involved." The project is run with Rotarian financial contributions and volunteerism, both of which are important in this initial start-up phase.

Businesspeople and students in grades nine through twelve are carefully matched through an extensive screening and application process, which includes fingerprinting for the adults. "We receive mutual consent from both parties before the first meeting," says Mary Ellen. "We realize the mentor-student relationship may not always click, but we make every effort to validate it as a positive experience, even if the match doesn't work out."

Mary Ellen provides orientation to everyone involved in the project. "We want them to know what they are getting into and the extent of the commitment," she says. The first meeting between mentor and student includes Mary Ellen as the facilitator to ease the transition. The students represent the varied ethnic backgrounds of the area: African American, Latino, Asian, and white. They also bring a variety of behavioral and social problems to the program, including poor academic performance, family problems such as parental substance abuse, and past drug or crime involvement. Some of the students are considered "emancipated minors," or youth living on their own. "Many of these young people are shouldering tremendous burdens and responsibilities for their families, such as caring for younger siblings or raising babies born to them," says Mary Ellen.

Significant efforts are made to involve the parent or guardian, an important feature of the program's success.

All participating students must be alcohol- and drug-free, have parent or guardian consent, agree to keep appointments and meetings, and understand the protocol of the mentor-student relationship. Significant efforts are made to involve the parent or guardian, an important feature of the program's success. "We are very respectful of the often fragile relationship that exists between the parent or guardian and the student. We don't want them to feel displaced by the mentor relationship with their child. We keep the lines of communication as open as we can."

The mentor is asked to meet the youth initially in the young person's environment, so the first few meetings are held at the school.

"We have found that the staff of the continuation schools are very concerned and caring, and willing to cooperate with an effort that will provide more positive role models for the students," explains Mary Ellen. The youth acquaint the mentors to their world by touring them around the school and introducing them to teachers, friends and other aspects of their life. Eventually relationships of trust and helpfulness develop over shared lunches and visits to the mentors' workplace (many of the students have never ventured beyond their immediate neighborhood). These and other experiences serve to cement the friendships.

The program's founders are well aware of the risk factor regarding lack of positive role models. They based much of the program on the premise that one-on-one role modeling will complement the efforts of the school and improve students' academic performance. Role modeling is used as a strategy to foster more positive self-perceptions by the youth, while promoting positive interaction with their community, and the larger world. Mentors assist the students with their individual needs, such as legal or relationship problems, while exposing them to the life skills necessary to have a worklife and cope with the adult responsibilities awaiting them.

"A major goal of our program is to have an impact on the risk factor of school drop-out and poor academic performance," according to Mary Ellen. "We want them to finish high school and begin thinking about a career, college, or earning an income." Students learn about successful behavior and goal-setting from their mentors. Mentors have helped students enroll in the local junior college, clarify career pursuits and obtain jobs. "The experience has been a bit surprising for the mentors," explains Mary Ellen. "They go into it thinking it is strictly to help the youth, but then begin to learn a great deal about themselves. They also develop an understanding of the many problems facing youth today, problems they may not have had as teens."

"The experience is both humbling and humanizing," according to former project coordinator Allen Smith. "Instead of a charity project, most mentors end up with a friend."

Mary Ellen hopes to see the program offered to other high schools and at-risk teen populations. She would like to involve more service organizations, businesses and community organizations in the effort. "We need more women to get involved. Some of our teens are unwed mothers who need to learn life skills and family skills. Juggling all of this can be extremely difficult. A working mother could be a great role model and mentor for these girls."

Linking Hands in the Asian Community: A Consortium of Agencies Tackle Substance Abuse

The San Francisco Asian community represents a multicultural mix. Major pockets of Chinese, Japanese, Korean, Pilipino and Vietnamese reside here, each very different from the other. "We had to understand each community as a unique entity, plus how they relate to each other before we could develop an effective prevention program," explains Beatrice Lee, program director of the Asian Youth Substance Abuse Project. The project, funded in 1987 through the federal Office for Substance Abuse Prevention (OSAP) as a program of the Asian American Residential Recovery Services, began as a social competency model for Asian youth. "We realized very early that we couldn't impose a mainstream model on the communities involved. We had to be sensitive to cultural needs of each group," reports Beatrice. "In addition, we had seven diverse organizations involved in the consortium, each with different capabilities and ways of doing things. Linkages and confidences needed to first be established."

The project unites seven key human service agencies in the effort to prevent and reduce youthful alcohol and other drug use: Bill Pone Memorial Unit-Haight Ashbury Medical Clinic, Chinatown Youth Center, Japanese Community Youth Council, Korean

Community Services Center, Vietnamese Youth Development Center, West Bay Pilipino Multi-Service Center and Asian American Residential Recovery Services. The first three years of the grant were challenging as the agencies defined their relationships, documented services that were being delivered, and identified service gaps. "We tried to provide a central training and coordination point for all the agencies," explains Beatrice. "They had a long history of coordinated efforts and linkages that needed to be renewed. We trained 25–30 bilingual/bicultural health education staff in the basics of prevention, drug education, the problem in the Asian community and other related topics. Our next step was to go to each community and talk to parents, teachers, clergy, voluntary groups, etc. A strong denial exists among Asians and non-Asians alike about the extent of the alcohol and drug problems we have. We have been slowly breaking through. Now the community is coming to us and asking us to provide services for them."

Once coordination and connection were re-established, the services being offered to the Asian community were examined and categorized. "We found four major components of service: those impacting individuals, families, the community and institutions. Each agency was approaching the components differently, based on their individual target group needs, wants and risk factors," says Beatrice.

In the three years since the grant began individual activities vary from after-school tutoring programs to summer day camps, from elders as mentors to on-site recreational activities and a Chinese expressive arts and music program. High school students participate in cross-age counseling programs, and a youth scholarship program pays teens for community service. The emphasis at all the agencies is on self-esteem, family bonding, positive peer relationships, and support for youth and their families. Many culture- and language-specific publications were also developed.

Family programs vary from parenting classes to intervention-type support groups. "We find the Japanese community is more comfortable letting their needs be known, such as wanting a parent support group. This is not a surprise, since most of the Japanese are third- or fourth- generation Americans. Whereas the Vietnamese community, which is overall still an immigrant group, won't come forward with their problems and concerns. But since denial exists in all the groups, even the Japanese, we often have to approach our public drug education efforts from a broader perspective. For example, we get a better response to a workshop titled 'Learn how to effectively deal with your teenager' than 'How to prevent teen alcohol or drug use,'" Beatrice explains. Most of the activities accomplished over the first three years of the grant have been primarily individual, family and community oriented.

Beatrice believes that since the seven agencies are cooperative among themselves and the city in which they are located, "[I]t wasn't difficult to introduce this new concept of the consortium. Many of these agencies have been operating for years and have worked together on projects. The agency directors were very willing to send their staff to the trainings. At the same time each needed to feel that their unique history, needs, and approaches would be respected and incorporated into any comprehensive effort that developed."

Much of the conflict associated with these issues have been resolved during the last year. The consortium decided that the Asian Youth Substance Abuse Project should serve as a fiscal and monitoring agent. "We handle the budget, the OSAP reporting, and the planning and coordination," explains Beatrice. "The consortium meets twice monthly and discusses policy and implementation issues." This seems to be working. The agencies are more willing to work with the central staff to discuss program strategies and goals. They came together last spring to sponsor a citywide conference, "Meeting the Challenge of High Risk Asian Youth in the 1990s." Over 200 people attended the conference, includ-

ing heads of city and county departments of public health, social services, mental health, police, recreation and parks, and community development. "It was the first time that the city, county and community-based organizations came together to discuss issues concerning Asian youth," explains Beatrice. "It was very exciting."

Several risk factors are at play in the Asian community of San Francisco. Some are associated with family management and intergenerational conflicts, particularly among immigrants. In addition, parents are working long hours, leaving children home alone. Beatrice believes there are also cultural risk factors affecting the youth. "Parents and children are having to adjust to American ways, which may be different from their culture. This can cause confusion in the family. We have to help the families, especially the children who tend to look more towards American customs, learn to appreciate their cultural heritage, even if it may be different from certain American ways." However, there are some cultural differences that may need to be faced and possibly changed. For instance, Beatrice reports that some groups feel it is acceptable for youth to drink in social settings. "We believe youth shouldn't be drinking, and we have to address this through our programs."

'Parents and children are having to adjust to American ways, which may be different from their culture.'

Over the next two years of the grant, Beatrice feels confident they can look seriously at the risk factors facing the Asian community and continue implementing strategies to address them. "The next two years will be spent creating a cohesive, community-wide effort to impact institutions and produce positive and strategic outcomes. We've laid the organizational and planning groundwork and we're ready to move ahead."

VI. A Note About High-Risk Programs

The introduction of risk factors into the prevention field has enabled us to develop broad-based, comprehensive approaches. However, if we look closer at the risk factors we find they often apply to high-risk behaviors or groups. This can serve to further focus our efforts.

Researchers Kumpfer (1989) and Moskowitz (1989) have found the most effective prevention programs are generally the most intensive and tailored to the needs of specific high-risk populations. Hansen (1988) and Kumpfer believe involving children and families from the general population in programs they may not need could have negative effects that are costly, ineffective, and even unethical. Hansen is concerned that some individuals involved in broad-based approaches would have matured out of the problem anyway or would never have had the problem to begin with. Other researchers have cautioned against prevention efforts becoming too interventive by concentrating on a few specific behaviors or populations, for example: "weekend binge drinking of Latino high school males." Jessor's (1984) longitudinal work established adolescence as a high-risk period for all youth and supports the notion of programs that reach broader target groups.

Many prevention practitioners are concerned that children will be labeled high risk and will become high risk as a result of that label. Researchers agree, however, that if we don't identify populations at greater risk for developing problems, vulnerable children and youth may not receive the services they

greatly need. David Hawkins and his colleagues believe that prevention efforts should target high-risk neighborhoods, schools, or communities rather than high-risk individuals. This is one way to address specific risk factors without the possible stigma caused by labeling.

The federal Office for Substance Abuse Prevention has followed this principle by providing funding for programs that target high-risk groups, such as children of alcoholics or those living in public housing and displaying a variety of risk factor–related behaviors. These programs are advertised to the community as services to help young people within these groups live happier and healthier lives, not as those specifically for youth or communities with serious problems.

Many prevention practitioners agree the current need is for more intensive programs, targeted towards specific high-risk behaviors and groups and sensitive to the potential effects labeling may cause.

VII. A Third Major Ingredient: Prevention Planning

The preceding sections presented background information on the current research in prevention, and examples of community models throughout California. This section will provide an overview of a planning process that can serve as a tool for developing and maintaining up-to-date, effective prevention programs. We can never be contented when it comes to prevention program design and implementation. New findings and experiences must be considered with every planning and evaluation cycle.

The planning process described here is neither new nor exhaustive. It may contain some new tasks within each planning step or exclude steps identified by other prevention planning guides. You may need to add (or subtract) certain tasks within the list that are important (or unimportant) for your community.

Program planning should be flexible enough to accommodate and involve the community while maintaining integrity. It should rely on established principles of community organizing, which have been used successfully in various popular movements over the years. Solid planning can transcend differences in ethnic or socioeconomic settings, although an awareness of these differences must always be considered. Two key principles to keep in mind throughout planning are:

1. Maintain sensitivity and responsiveness to the culture, values, social status, language, drug use patterns and problems, and concerns of the community being addressed;

2. Realize that the same risk factors and protective factors may not apply to each ethnic or cultural group; certain ones must be emphasized or de-emphasized to reflect the uniqueness of the group.

The major steps in effective planning are:

1. ASSESS NEEDS
   a. Talk to and/or survey community, organize key individuals and groups for input
   b. Look at risk factor and other research, drug use patterns and key indicators of community problems and situations
   c. Assess group(s) and community for knowledge, attitudes, and practices

2. IDENTIFY THE PROBLEM
   a. Focus on specific problems based on needs assessment
   b. Determine who your possible target audience(s) will be
   c. Discuss possible prevention strategies based on assessment and risk/protective factors to be addressed

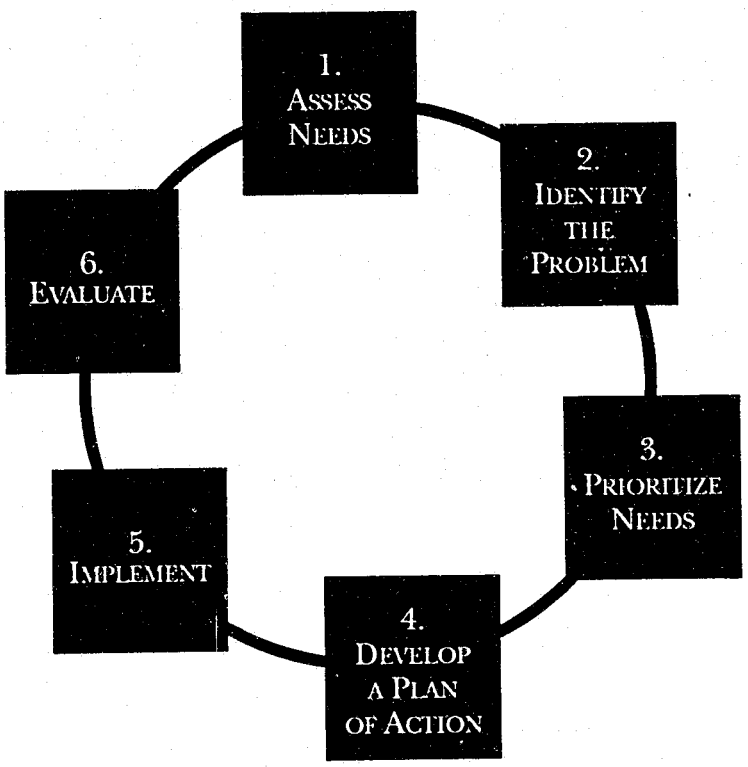
3. PRIORITIZE NEEDS
   a. Collaborate with key members of the community
   b. Get to the bottom line: What do people want? What looks promising? What approach will the program take?
   c. Determine possible setting for the program
   d. Identify who the primary target audience will be
   e. Determine who secondary target audience(s) will be

4. DEVELOP A PLAN OF ACTION
   a. Set program goals and objectives, management policies and procedures
   b. Decide on strategies to address multiple risk factors and develop protective factors
   c. Identify and secure support and resources
   d. Assign key tasks
   e. Train core group of program staff and volunteers

5. IMPLEMENT
   a. Train wider group of community leaders/liaisons
   b. Implement strategies
   c. Collaboratively assess and re-assess

6. EVALUATE
   a. Assess and measure strategies, resources, efficiency
   b. Make changes to steps 1 to 5 based on findings

PREVENTION PLANNING WHEEL



Each step in this process is a complex one in which decisions should be carefully made.

1. Assess Needs

Assessment of needs is closely related to the overall tasks of organizing a community to begin to identify and address alcohol and other drug problems. The process of assessing needs can bring the program and community closer together, giving planners the chance to become intimately acquainted with the uniqueness and character of the community.

In order to effectively assess needs, a broad cross-section of key community members must be gathered together as a working coalition or task force. These "stakeholders" provide input on the knowledge, attitudes, belief, values, culture, practices and behaviors of the community. The task force should include young and old; various ethnic groups; interest groups from business, religion, schools, law enforcement, health services and politics; and others who play an important role in the community.

A part of assessing needs involves looking at: 1) current population and demographic trends and drug-use information; 2) police reports containing key indicators of community crime, accidents and arrests related to use patterns; 3) other available research about the community. In addition, surveying the community through informal and formal questionnaires, focus groups and interviews can provide good information. As much as possible, members of the community should be included throughout the process, assisting with tasks and promoting the overall project. The findings from the assessment will help identify those risk factors and protective factors at play in the community.

2. Identify the Problem

This step allows planners and/or the task force to focus even more on the specific groups, organizations, risk factors, practices and possible strategies, etc., that a prevention effort might address. As with any of the planning steps, the identification of the problem must be done in collaboration with key community members.

3. Prioritize Needs

Prioritizing the identified needs is a pivotal step requiring the input and synthesis of many community members. This is when people within the community determine their "bottom line." They identify what they believe is needed based on the needs assessment and problem identification, who the primary recipients of the services will be, where the services or effort will occur, who the secondary recipients of the services will be and possible steps to be taken to address the needs.

4. Set a Plan of Action

At this point program planners and/or the task force gather a team of key program staff and community volunteers to determine which priorities can best be addressed. Given the current circumstances and resources, the team and the task force determine which of the risk factors and protective factors can and should be included. They develop measurable, realistic goals and objectives, and program/management policies and procedures for addressing them. A program plan or document of recommendations should result.

This step also includes the identification and gathering of resources and support, both monetary and non-monetary. In some cases a source of funding may have already been identified and even secured. While this can be a relief to some it may be a hindrance for others, particularly if major planning occurred without gaining consensus of the community. In either case, it is important to determine the type of support the community can offer from within (materials, business endorsements, volunteers, legal assistance, etc.) and what can be secured externally (grants, media coverage, supplies, corporate or business donations, etc.). There may be obstacles to overcome if major funding and preliminary planning are viewed as having been imposed upon a community.

A final task of this step is training of hired staff and volunteers in program philosophy and strategies as well as management proce-

dures. Training can be accomplished in a variety of ways based on the availability, values, and learning styles of the staff and volunteers. Be sure to explore a number of options including seminars, reading materials, and classes, as well as experiential and on-the-job techniques. If implementation is to be carried out in a consistent manner, training is critical.

5. IMPLEMENT

Implementation consists of the actual running of the program or accomplishment of set strategies. Throughout this step the model and strategies are promoted and diffused into the community through publicity, educational forums, training, and involvement of additional community members and liaisons. It is always important to "take a step back" and collaboratively assess and re-assess what has taken place, making changes as necessary.

6. EVALUATE

Evaluation is an important tool for planning a program. If time was allowed in the early stages of planning to develop clear goals and measurable objectives, then one of the most critical parts of evaluation has already been completed. When evaluation is integrated in program planning, design and implementation, many problems can be avoided. Usually evaluation is divided into three components:

Process Evaluation: To determine what activities the program has conducted in quantifiable terms, such as the number of participants on a community task force, the number of media spots that aired in a given period of time, or if newly written ordinances prohibiting public drinking were adopted.

Outcome Evaluation: To determine whether or not broader objectives are being accomplished, such as whether a young person learned the skills needed to resist peer pressure, if families report improved communication as a result of a parenting workshop, or whether newly adopted anti-drug policies in the workplace are being enforced.

Impact Evaluation: To determine whether key indicators of the problem are changing as a result of the program, such as declining drug use rates reported by high school students or reduction in drunk driving arrests. Impact evaluations can also measure larger changes in overall community norms, such as a decreased acceptance within the community for alcohol beverage companies being allowed to sponsor public celebrations or sporting events.

Evaluation need not be a tedious and forboding process. Try to make it an integral and relevant part of program efforts.

VIII. A Sample Prevention Recipe

As with any successful recipe, the ingredients must be skillfully blended together. Just as a recipe is more than a mere listing of ingredients, a prevention program is more than just planning or risk and protective factors. But how do we use the information available to us to develop effective programs? Who should be involved? What do they each have to do? What strategies should be selected? Why? How can the pieces all work together?

Prevention efforts will look different in each community and for each target group. It would be impossible to include a model that is inclusive for everybody. We do know if each of the necessary elements of a prevention effort are clearly described and understood by all, then their purpose and interdependence will be evident. One important point to remember when developing a prevention program: All strategies should evolve out of the planning process and be consistent with the risk factors present in the community. There is no longer any reason to "pull strategies out of a hat" merely because it is popular or suits some-

one's idea of what prevention should look like. If the approach is deliberate, then we can track its success by identifying which risk factors or protective factors we are addressing.

More specifically, a prevention program should:

- Impact on multiple risk factors within the categories of family, school/peer, and community, keeping aware of the cognitive motivations that may be important driving forces. One key goal is to provide as many protective factors as possible.
- Address several settings within the community. One setting, such as community recreation centers, can be the primary focus while other settings, such as school or family, receive supportive services.
- Be geared towards a primary target group, such as youth in middle school, with a secondary focus, such as teachers or siblings, receiving supportive services.
- Have a community focus on the broader norms, values, and practices impacting the target group, such as availability of alcohol or other drugs and their promotion in the community. Strategies for addressing these norms or practices, such as passing ordinances that limit alcohol consumption at concerts, can be addressed simultaneously with other strategies.

One suggested method for bringing it together includes using the following prevention planning grid (see pages 28–29). The Hermanos Club, described in Section V: Model Programs Addressing Risk Factors, is given as the example.

The planning grid can be used as a visual tool for mapping prevention planning efforts by illustrating the interrelated components most needed for effective and comprehensive programs.

IX. Summary and Conclusions

Prevention program developers and specialists must be vigilant about assessing community needs to determine which influences, risk factors, cognitive motivations and protective factors are at work. Once this initial scanning is complete, program design, recommendations and development can begin. Providing intensive prevention programs that are developmentally and culturally appropriate and relevant for individuals and communities is our ultimate challenge. Given the amount of information available about the major ingredients of alcohol and other drug prevention programs, we are in a better position than ever before to provide comprehensive, well-grounded programs.

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Sample programs included in this booklet:

Crime Prevention and Drug Education Unit
San Francisco Police Department
850 Bryant Street
San Francisco, CA 94103
(415) 553-9582
-OR-
Center for Human Development
111 New Montgomery Street, Suite 209
San Francisco, CA 94105
(415) 979-0366

Hermanos
California Hispanic Commission on Alcohol and Drug Abuse
5838 East Beverly Blvd.
Los Angeles, CA 90022
(213) 722-4529

City of Irvine, Community Services Department
PO Box 19575
Irvine, CA 93713
(714) 724-6000
-OR-
Alcohol and Drug Education Prevention Team (ADEPT)
County of Orange
1200 N. Main Street, Suite 730
Santa Ana, CA 92701
(714) 568-4189

Palavra Tree Prevention Center
4252 Boston Ave.
San Diego, CA 92113
(619) 263-7768

Mentors For Achievement
People Reaching Out
5433 El Camino Ave., Suite 700
Carmichael, CA 95608
(916) 971-3300

Asian Youth Substance Abuse Project
Asian American Residential Recovery Services
300 Fourth Street, 2nd Floor
San Francisco, CA 94107
(415) 541-9285

PREVENTION PLANNING GRID

Risk Factors	Protective Factors	Activities to Address Risks	Expected Outcomes
Family			
Low educational expectancies	*Promote bonding to school*	*Provide tutoring and cross-age support*	*Improved grades; kids stay in school*
Lack of clear rules and norms about drug use and other behaviors	*Provide family drug policy; clarify family rules*	*Parenting classes that teach importance of rules and norms; develop a family policy about drug use; teach protocol in the Latino family*	*Less arguments about expectations; improved communication*
School/Peer			
Association with drug-using peers	*Drug-free club*	*Positive educational, social, cultural and recreational activities*	*Youngsters select friends that are involved in healthy non-drug related activities*
Lack of life skills instruction	*Teach problem-solving and refusal skills*	*Educational activities that allow for practice of new skills; opportunities to teach younger siblings the skills*	*Teens and their siblings are better able to solve problems and deal with peer pressure*
Community			
Lack of meaningful roles and role models	*Provide positive real-life experiences and role models*	*Teens and children provide a variety of community service activities that help others, teach responsibility; teens act as positive role models to younger kids*	*Teens will gain an attachment to community and positive values/norms; children will bond to positive teen role models*

WORKSHEET

PREVENTION PLANNING GRID

Risk Factors	Protective Factors	Activities to Address Risks	Expected Outcomes
Family			
School/Peer			
Community			