WHAT ARE WE TRYING TO PREVENT?

As the California AOD prevention community moves toward science-based prevention, we want more than ever to understand “what works” for useful outcomes. The focus for action remains at the local (county, city, community) level, where county alcohol and drug programs (county ADPs) continue to enjoy broad discretion under federal funding guidelines from CSAP and SDFSC (DOE). However, new accountability and reporting requirements are emerging. Local agencies are under increasing pressure to be clear what they are trying to prevent, and how they are going about it. Credible methods and measurable results are becoming a necessity.

Help is available through training and TA offered by the Community Prevention Institute and by CSAP and other federal agencies that offer demonstrated prevention methods and approaches such as WestCAPT. However, county ADP agencies and other local organizations still must decide which methods and approaches they will use. What are the critical AOD issues from local perspectives? How can effective local responses be developed that will meet stringent state requirements and federal guidelines?

The following perspective is offered to help county ADP programs find answers to these questions, and to engage other local agencies and community based organizations (CBOs) that provide AOD prevention services. A second article in the next edition of this newsletter will address ways that county ADPs and local communities can take effective action on long-standing practical difficulties and policy challenges that stand in the way of realizing the perspective outlined below. A third article will report on state-level and local efforts to help overcome these difficulties and challenges.

**Problem-oriented prevention.** What are we trying to prevent? While there is no one right answer, the field needs to clarify what approach(es) we want to pursue as a matter of common interest, so our joint efforts can be mutually supportive. Currently, most approaches to community level AOD prevention follow a “problem-prevention” perspective to reduce illness, harm, and loss. This perspective is pursued through several disciplines – Public health, education, social welfare, public safety, community planning, advocacy, and health service delivery – and operates through corresponding local agencies, community organizations, and unofficial groups. In practice, these community-level entities are usually involved in some form of problem-reduction (harm reduction), and in efforts to delay or reduce AOD use. These efforts often mesh with other community initiatives and policies that serve related objectives.

This “problem reduction” approach makes sense for AOD-related community issues that drain community resources and that involve a number of groups, including innocent bystanders, and community organizations. Four AOD problem-areas of great concern to local communities are: driving under the influence, disruptive public behavior related to drinking and drug use, young people’s AOD experiences, and AOD-related crime and violence, among other concerns.

Continued on Page 2
This problem-oriented perspective has great potential for improvement and broad application if (a) the scope, or theory of problem-oriented prevention is clear, and (b) the scale, or level, of application is specified. This article summarizes prevailing thoughts on both points.

A. **Scope of problem-oriented community prevention initiatives.** Three basic theories for community-level problem-prevention approaches are currently in use.

1. **Prevent alcohol and drug (AOD) problems directly.** Community AOD problems are viewed as problematic drinking and drug-use behaviors and the settings and circumstances that encourage or tolerate them. Action focuses on curtailing the specific troublesome behaviors and circumstances. For example: Intervene immediately with young people engaged in especially dangerous AOD use – take action at once to sanction behaviors and to modify circumstances of those behaviors; design community fairs to be alcohol-free (if child- and family-oriented) or permit alcohol only in well-managed “beer gardens”; create social host ordinances to discourage problematic house parties; institute community-based policing to provide direct contact with law-enforcement; combat drug paraphernalia sales and vending of precursor materials; encourage physician involvement with aftermaths of AOD use through brief intervention techniques such as SBIRT. Direct action approaches tend to be program-oriented. Prevention workers seek to change problematic practices and places already in operation, mostly through short-term programs or special activities. Positive results usually can be seen quickly, and outcomes are closely tied to project outputs. However, questions arise about how long problem-reduction programs last, and whether AOD problems are displaced rather than reduced.

2. **Prevent “root causes” that cause AOD problems in the first place.** Community AOD problems are viewed as a result of certain forces that have a particular impact on the community. Reducing the impact of these forces will therefore reduce concomitant AOD problems. Examples: Provide early childhood development services to distressed families with AOD-related problems; provide economic development opportunities in poor neighborhoods to keep young people from entering the drug trade; raise AOD retail prices, reduce accessibility, and limit exploitative promotional activities to reduce elevated levels of high-risk availability. “Root-cause” prevention approaches tend to be policy-oriented. Prevention workers seek to change problematic settings and circumstances through policy changes and fundamental changes in practice. Definitive results often take a while to appear, and it may be difficult to attribute positive results specifically to AOD-related initiatives since many other factors will also be involved.

3. **Engage in positive development programs and policies that bypass AOD problems.** Community AOD problems are viewed as potential conditions that can be avoided by positive community development and person-oriented development initiatives. Examples: Secular youth development programs provide guidance and support for healthy living that divert young people from involvement with drinking and drug use; rigorous application of mores and customs among religious communities and traditional communities that use similar approaches; community planning to design safe and healthy communities that exclude opportunities for high-risk AOD abuse. Positive development programs accentuate positive development influences (and some seek to exclude negative development influences). Prevention workers assist communities to institute positive norms, beliefs and expectations (and sometimes to supercede, change, or exclude problematic norms, beliefs and expectations). Two complexities are involved in observing change in AOD problems: (1) How are changes in community AOD problems accounted for in relation to positive development objectives? Is there an evaluation of the extent to which the developmental initiatives divert participants from future AOD problems, or in other ways reduce community AOD problems? (2) Do development initiatives treat norm change as precursors to, or as products of, behavior-change expectations?
Each of these three approaches can claim evidence of effectiveness. The three approaches can be compatible with each other. Most communities can benefit from multiple prevention initiatives using all three theories. Selecting the approach(es) to follow can be helped by consideration of the scale at which prevention initiatives will be undertaken.

B. Scale of community-level prevention efforts. The concept of scale is critical to making effective use of these three theories in community contexts. “Scale” refers to the size of the prevention effort in relation to a person. Community-level prevention efforts make use of three scales: The individual level; the organizational level; and the institutional level, described below.

(1) Low-scale, individual-sized efforts. Small-scale efforts focus on beliefs and behaviors of individuals or small groups in particular types of settings and circumstances. Examples: School-age prevention education programs at the individual school site; oversight for identified problem bars; cleaning up drug use and alcohol-related problems in designated public parks; stopping teenaged drinking parties in private homes; creating a safe-place after-school program; adoption of personal social host policies for responsible alcohol service. Many model programs recognized by CSAP and other federal agencies operate at this level for selected individuals and designated groups. Examples are Dare to be You, which has family, community and school components, and Strengthening Families, a family skills training program.

(2) Middle-scale, organizational-level efforts. Middle-scale efforts focus on the polices and practices among the community’s organizations and population sub-groups. Examples: Neighborhood association policies on alcohol at block parties and house parties; rental property management association policies on AOD use reflected in lease agreement and property oversight standards; work site AOD use policies; school board policies on drinking and drug use at school sites (in contrast to treatment/referral programs for individual students or staff); city policies for drinking in public parks; fraternal organization rules for responsible alcohol use at social and community events. Community prevention initiatives consider these programs and policies in their surrounding community contexts. What do the local problem contexts – the at-risk settings and circumstances in which AOD problems occur – contribute to people’s AOD problems? What can be done to reduce or eliminate the contribution of these contexts to the participants’ AOD problems?

(3) Large-scale, institutional efforts. Institutional efforts focus on public policies, community-wide beliefs, and historical practices among major community sectors (public agencies, the business community, the residential community, the faith community, health and human service providers, etc.). Examples: Community standards for promotions and advertising of alcoholic beverages at youth-related events; work with pharmacists and drug companies to render certain pharmaceuticals distasteful or unattractive for abuse; conditional use permit (CUP) regulations on retail alcohol outlets; community-wide bans on smoking in public places; community support for alcohol-free holiday events such as sober graduation and First Night alcohol-free New Year’s celebrations; acceptance of sober housing facilities and respect for sober-living lifestyles as a positive community resource.

Based on the AOD problems they wish to attack, community designers can strengthen their local AOD prevention initiatives by carefully selecting the scale(s) at which the theory will be applied. The local AOD prevention initiatives can “nest” so that the lower-scale efforts are included in larger-scale efforts, reinforcing each other in a multi-scaled ecology that shifts toward healthier, less-problematic community living. Planning one community event, for example, can lead to a general policy that applies to several community settings and circumstances.

This “nesting” orientation can also be used to link local communities with a statewide efforts. Consider California’s exemplary tobacco control efforts, for example, that use the “nesting” strategy to work through “air cover” statewide advertising campaigns; state and regional support for prevention methods, program planning and evaluation; and localized community education and control activities (for an excellent example of California’s comprehensive tobacco control efforts and their success, click here.).

Community action to prevent AOD problems. Community AOD prevention enjoys a wonderfully wide palette of possibilities for action. How can local agencies and organizations choose a specific course of action that fits within available resources? Two considerations are critical for making effective choices:

- Establish clear documentation (data) to identify the community’s AOD problems in community contexts of groups, organizations, settings, and circumstances as the basis for selecting AOD problems for action;
- Create a local decision-making process that selects possible courses of action to address the identified AOD problems.

The next edition’s newsletter will address both considerations.
Regional Trainer Activities: A Sampler

During the past few months Prevention by Design Regional Trainers (RTs) have contacted fifty-five of fifty-eight counties. RTs provided technical assistance and support to more than forty, strengthening County ADP capacity to plan outcome-based prevention initiatives and measure successes in prevention. We would like to take this opportunity to offer some snapshots of RT services in action, and to invite County ADPs to contact their RTs for help in these areas.

**Strategic Planning**
Several regional trainers have met with County prevention staff in large and small, urban and rural, northern and southern Counties to assist them with developing strategic prevention plans. These plans create a useful framework for planning multi-faceted prevention activities, stating staffing and resource needs, setting realistic time frames, and identifying needs for technical assistance and training.

**Evaluation**
An RT met with northern rural County prevention staff to develop evaluation requirements for sub-contracted prevention providers. Once the requirements were developed, the RT met with all of their prevention providers and developed evaluation plans that included outcomes to be measured, which tools to use, and how to collect and analyze data.

**Training in model prevention practices**
An RT helped seven county ADPs in the Bay Area obtain Responsible Beverage Service training when county prevention coordinators recognized a common need in their counties for effective RBS programs. The RT worked closely with the Community Prevention Institute (CPI) and with the Marin Institute to plan the program, recruit RBS trainers, and prepare follow-up plans for continuing training and support.

**Review prevention plans**
RTs worked with prevention coordinators in several counties to improve reporting by their prevention providers. The RTs helped county staff develop final report outlines and tools so the providers could report on outcomes in addition to process measures. The trainers also assisted counties with selecting core indicators for prevention programming.

**Subcontracting assistance**
Diverse counties needed assistance with subcontracting for prevention services. RTs assisted county prevention coordinators to develop frameworks for annual work plans based on logic model planning.

**Data**
RTs assisted an MBA prevention coordinator from a rural county with developing a format and a process to collect, analyze and archive data. County representatives were trained to organize data within the "risk and protective" factor framework. Prevention staff members were then assisted with setting priorities for agency efforts.

**Trainings**
The RTs conducted many trainings throughout the state, among them:
- "Prevention 101" training for new program staff members;
- Logic model training for prevention staff;
- Assessing and establishing core indicators for counties;
- Environmental prevention basics.

**Environmental Prevention**
Regional trainers assisted several small rural MBA counties in the selection of problem AOD environments to be targeted for prevention initiatives. The RTs help county ADP staff develop environmental assessment and evaluation protocols.

These examples are a sample of the services that are available to all California county Alcohol and Drug agencies with no charge. Please contact us if we can assist you.

---

**Featured Website of the Month: Prevention by Design!**

[www.preventionbydesign.org](http://www.preventionbydesign.org)

Articles about prevention, back issues of the newsletter, information about Prevention by Design’s many services, all in one convenient e-location. We welcome your comments and suggestions.
WHO WE ARE

REGIONS AND REGIONAL TRAINERS

REGION IA
Counties: Del Norte, Humboldt, Trinity, Shasta, Tehama, Plumas, Butte
Trainer: REBECCA BERNER, rberner2@csuchico.edu

REGION IB
Counties: Siskiyou, Modoc, Lassen, Glenn, Sutter, Yuba, Nevada, Sierra
Trainer: DANIELLE CAMPBELL, kidccampbell@msn.com

REGION II
Counties: Mendocino, Lake, Colusa, Yolo, Sonoma, Contra Costa, Napa, Marin, Solano, Sacramento
Trainer: MELINDA MOORE, mkassocts@aol.com

REGION III
Counties: San Francisco, San Mateo, Alameda, Santa Clara, San Benito, Monterey, Santa Cruz
Trainer: STEPHEN PURSER, spurser@uclink.berkeley.edu

REGION IV
Counties: Placer, El Dorado, Amador, Calaveras, San Joaquin, Stanislaus, Tuolumne, Merced, Fresno
Trainer: GALEN EL-ASKARI, galen@waltonelaskari.com

REGION V
Counties: Alpine, Mono, Inyo, Mariposa, Madera, Kings, Kern, Tulare
Trainer: RANDY DAVIS, rad19@csufresno.edu
Trainer: JOLENE EDWARDS, jolene@mindinfo.com

REGION VI
Counties: San Luis Obispo, Santa Barbara, Ventura
Trainer: To Be Hired

REGION VII
Counties: Los Angeles, San Bernardino, Riverside, Orange
Trainer: MICHAEL BROWNING, mikebrowning@alumni.usc.edu

REGION VIII
Counties: San Diego, Imperial
Trainer: RICHARD BURHENNE, rburhenne@yahoo.com

BERKELEY OFFICE
510-540-4717 Fax: 510-540-4731

Project Director
Fried Wittman, fwittman@uclink4.berkeley.edu

Associate Director
Sarah Calhoun, ta_pom@uclink.berkeley.edu

PREVENTION RESOURCE INFORMATION SPECIALIST
Allyson West, awest@uclink.berkeley.edu

Prevention Research Methods and Analysis Specialist
David Kattari, dkattari@yahoo.com

Administrator
Marie Frank, mfrank@uclink.berkeley.edu

The opinions, finding, and conclusions herein stated are those of the authors and not necessarily those of the State of California, Department of Alcohol and Drug Programs.