

# PREVENTION PROGRAMING

## Foundations of Prevention

Aim: To provide an overview of the theories of prevention and health promotion and to introduce skills in prevention programmes

Foundations of prevention is designed for all types of professionals working in substances abuse prevention services, including addiction prevention specialists, policy makers, programme managers, healthcare providers, law enforcement officers, school counselors and teachers. The training workshop will cover the following key areas:

- An outlines of the core principles of prevention
- Illustrates model programmes that have the best potential for success
- Offers an overview of risk and protective factors in the context of substance abuse prevention
- Provide a straightforward guide to theory and practice (grasping the gold standard in prevention)
- Outline principles for interventions, focusing on the individual, the family, the school, peers the environment and the community
- Presents model policy implications and recommendations for prevention programme planning
- Clarify some definitions of terms used in substance abuse prevention
- List internet resources and places to go for information on prevention

Prevention targets illnesses or disease outcomes and is often associated with the process of reducing existing risk factors and increasing protective factor in an individual, in high-risk groups, in the community or in society as a whole.

Prevention can take place at three stages:

- \* Primary prevention aims to avoid the development of high-risk or potentially harmful behaviour and or the occurrence of symptoms in the first place
- \* Secondary prevention or early intervention, aims to reduce existing risk and harmful behaviour and symptoms as early as possible
- \* Tertiary prevention aims to reduce the impact of the illness/symptom a person suffers. It offers treatment and rehabilitation for the person dependent or addicted to drugs or whose drug use is problematic

An increasingly popular way of classifying prevention initiatives is the following:

- \* Universal prevention programmes – these programmes are the broadest, and addresses large groups of people – such as the general population, or certain sub-categories of the population. Universal programmes mainly have the objective of promoting health and well-being, and of preventing the onset of drug use, with children and young people as the usual prime focus groups
- \* Selective prevention programmes – these types of programme targets young people based on the presence of known risk factors of drug involvement. Targets have been identified as having an increased likelihood of initiating drug use compared to young people in general. These programmes are aimed at reducing the influence of the risk factor, enhancing protective factor, and preventing drug use initiation
- \* Indicated prevention programmes – indicated programmes targets young people who are identified as having already started to use drugs or exhibiting behaviours that make problematic drug use a likelihood, but who do not yet meet formal diagnostic criteria for a drug abuse disorder which requires specialized treatment. Examples of such programmes include providing social skills or parent child interaction training for drug using youth.

## Core Prevention Principles - Long Version

These principles are intended to help parents, educators, and community leaders think about, plan for, and deliver research-based drug abuse prevention programs at the community level.

### Risk factors and protective factors

**PRINCIPLE 1** - Prevention programs should enhance protective factors and reverse or reduce risk factors. The risk of becoming a drug abuser involves the relationship among the number and type of risk factors (e.g., deviant attitudes and behaviours) and protective factors (e.g., parental support). The potential impact of specific risk and protective factors changes with age. For example, risk factors within the family have greater impact on a younger child, while association with drug-abusing peers may be a more significant risk factor for an adolescent. Early intervention with risk factors (e.g., aggressive behaviour and poor self-control) often has a greater impact than later intervention by changing a child's life path (trajectory) away from problems and toward positive behaviours. While risk and protective factors can affect people of all groups, these factors can have a different effect depending on a person's age, gender, ethnicity, culture, and environment.

**PRINCIPLE 2** - Prevention programs should address all forms of drug abuse, alone or in combination, including the underage use of legal drugs (e.g., tobacco or alcohol); the use of illegal drugs (e.g., marijuana or heroin); and the inappropriate use of legally obtained substances e.g., inhalants), prescription medications, or over-the-counter drugs.

**PRINCIPLE 3** - Prevention programs should address the type of drug abuse problem in the local community, target modifiable risk factors, and strengthen identified protective factors.

**PRINCIPLE 4** - Prevention programs should be tailored to address risks specific to population or audience characteristics, such as age, gender, and ethnicity, to improve program effectiveness.

#### Prevention planning - Family Programs

**PRINCIPLE 5** - Family-based prevention programs should enhance family bonding and relationships and include parenting skills; practice in developing, discussing, and enforcing family policies on substance abuse; and training in drug education and information. Family bonding is the bedrock of the relationship between parents and children. Bonding can be strengthened through skills training on parent supportiveness of children, parent-child communication, and parental involvement. Parental monitoring and supervision are critical for drug abuse prevention. These skills can be enhanced with training on rule-setting; techniques for monitoring activities; praise for appropriate behaviour; and moderate, consistent discipline that enforces defined family rules. Drug education and information for parents or caregivers reinforces what children are learning about the harmful effects of drugs and opens opportunities for family discussions about the abuse of legal and illegal substances. Brief, family-focused interventions for the general population can positively change specific parenting behaviour that can reduce later risks of drug abuse.

#### School Programs

**PRINCIPLE 6** - Prevention programs can be designed to intervene as early as preschool to address risk factors for drug abuse, such as aggressive behaviour, poor social skills, and academic difficulties.

**PRINCIPLE 7** - Prevention programs for elementary school children should target improving academic and social-emotional learning to address risk factors for drug abuse, such as early aggression, academic failure, and school dropout. Education should focus on the following skills:

- self-control;
- emotional awareness;
- communication;
- social problem-solving; and
- academic support, especially in reading.

**PRINCIPLE 8** - Prevention programs for middle or junior high and high school students should increase academic and social competence with the following skills:

- study habits and academic support;
- communication;
- peer relationships;
- self-efficacy and assertiveness;
- drug resistance skills;
- reinforcement of anti-drug attitudes; and
- strengthening of personal commitments against drug abuse

#### Community Programs

**PRINCIPLE 9** - Prevention programs aimed at general populations at key transition points, such as the transition to middle school, can produce beneficial effects even among high-risk families and children. Such interventions do not single out risk populations and, therefore, reduce labeling and promote bonding to school and community.

**PRINCIPLE 10** - Community prevention programs that combine two or more effective programs, such as family-based and school-based programs, can be more effective than a single program alone.

**PRINCIPLE 11** - Community prevention programs reaching populations in multiple settings—for example, schools, clubs, faith-based organizations, and the media—are most effective when they present consistent, community-wide messages in each setting.

## Prevention programme delivery

**PRINCIPLE 12** - When communities adapt programs to match their needs, community norms, or differing cultural requirements, they should retain core elements of the original research-based intervention which include:

- Structure (how the program is organized and constructed);
- Content (the information, skills, and strategies of the program); and
- Delivery (how the program is adapted, implemented, and evaluated).

**PRINCIPLE 13** - Prevention programs should be long-term with repeated interventions (i.e., booster programs) to reinforce the original prevention goals. Research shows that the benefits from middle school prevention programs diminish without follow-up programs in high school.

**PRINCIPLE 14** - Prevention programs should include teacher training on good classroom management practices, such as rewarding appropriate student behaviour. Such techniques help to foster students' positive behaviour, achievement, academic motivation, and school bonding.

**PRINCIPLE 15** - Prevention programs are most effective when they employ interactive techniques, such as peer discussion groups and parent role-playing, that allow for active involvement in learning about drug abuse and reinforcing skills.

**PRINCIPLE 16** - Research-based prevention programs can be cost-effective. Similar to earlier research, recent research shows that for each dollar invested in prevention, a savings in treatment for alcohol or other substance abuse can be seen.

## Prevention Principles for Children and Adolescents - short version

- ✚ **Prevention programs should be designed to enhance** "protective factors" and move toward reversing or reducing known "risk factors."
- ✚ **Prevention programs should target all forms of drug abuse**, including the use of tobacco, alcohol, marijuana, and inhalants.
- ✚ **Prevention programs should include skills** to resist drugs when offered, strengthen personal commitments against drug use, and increase social competency (e.g., in communications, peer relationships, self-efficacy, and assertiveness), in conjunction with reinforcement of attitudes against drug use.
- ✚ **Prevention programs for adolescents** should include interactive methods, such as peer discussion groups, rather than didactic teaching techniques alone.
- ✚ **Prevention programs should include a parents' or caregivers' component** that reinforces what the children are learning-such as facts about drugs and their harmful effects-and that opens opportunities for family discussions about use of legal and illegal substances and family policies about their use.
- ✚ **Prevention programs should be long-term**, over the school career with repeat interventions to reinforce the original prevention goals. For example, school-based efforts directed at elementary and middle school students should include booster sessions to help with critical transitions from middle to high school.
- ✚ **Family-focused prevention efforts** have a greater impact than strategies that focus on parents only or children only.
- ✚ **Community programs that include media campaigns and policy changes**, such as new regulations that restrict access to alcohol, tobacco, or other drugs, are more effective when they are accompanied by school and family interventions.

- ✦ **Community programs need to strengthen norms** against drug use in all drug abuse prevention settings, including the family, the school, and the community.
- ✦ **Schools offer opportunities to reach all populations** and also serve as important settings for specific subpopulations at risk for drug abuse, such as children with behaviour problems or learning disabilities and those who are potential dropouts.
- ✦ **Prevention programming should be adapted** to address the specific nature of the drug abuse problem in the local community.
- ✦ **The higher the level of risk of the target population,** the more intensive the prevention effort must be and the earlier it must begin.
- ✦ **Prevention programs should be age-specific,** developmentally appropriate, and culturally sensitive.
- ✦ **Effective prevention programs are cost-effective.** For every dollar spent on drug use prevention, communities can save 4 to 5 dollars in costs for drug abuse treatment and counseling.

## The Nexus of Prevention - Risk Factors and Protective Factors

### What are risk factors and protective factors?

Research over the past two decades has tried to determine how drug abuse begins and how it progresses. Many factors can add to a person's risk for drug abuse. **Risk factors** can increase a person's chances for drug abuse, while **protective factors** can reduce the risk. Please note, however, that most individuals at risk for drug abuse do not start using drugs or become addicted. Also, a risk factor for one person may not be for another.

Risk and protective factors can affect children at different stages of their lives. At each stage, risks occur that can be changed through prevention intervention. Early childhood risks, such as aggressive behaviour, can be changed or prevented with family, school, and community interventions that focus on helping children develop appropriate, positive behaviours. If not addressed, negative behaviours can lead to more risks, such as academic failure and social difficulties, which put children at further risk for later drug abuse.

*Research-based prevention programs focus on intervening early in a child's development to strengthen protective factors before problem behaviours develop.*

The table below describes how risk and protective factors affect people in five domains, or settings, where interventions can take place.

Risk Factors	Domain	Protective Factors
Early Aggressive Behavior	Individual	Self-Control
Lack of Parental Supervision	Family	Parental Monitoring
Substance Abuse	Peer	Academic Competence
Drug Availability	School	Anti-drug Use Policies
Poverty	Community	Strong Neighborhood Attachment

Risk factors can influence drug abuse in several ways. The more risks a child is exposed to, the more likely the child will abuse drugs. Some risk factors may be more powerful than others at certain stages in development, such as peer pressure during the teenage years; just as some protective factors, such as a strong parent-child bond, can have a greater impact on reducing risks during the early years. An important goal of prevention is to change the balance between risk and protective factors so that protective factors outweigh risk factors.

## THEORY AND PRACTICE (Grasping the gold standard in prevention)

### Risk

Risky behaviours seldom are linked to any one cause. Instead, risk factors converge to create a complex web of relationships; interconnections between cause and effects. Awareness of this complexity is changing the way preventionists tackle the task of addressing multiple risky behaviours - including violence, substance abuse, suicidal thoughts, and risky sexual behaviour. It is important to be aware of common risk factors that may lead to any of these problem behaviours.

General risk factors fall into five categories:

1. Family factors - *e.g.*, home life and relationship with parents and siblings
- 2) Community factors - *e.g.*, attitudes, values, and social mores of neighborhood and the media
- 3) Individual factors - *e.g.*, behavioural, emotional, and attitudinal variables
- 4) Peer factors - *e.g.*, beliefs of and pressure exerted by peer group
- 5) School factors - *e.g.*, school environment and academic performance

### Family risk factors

Family risk factors are, perhaps, the most crucial because they affect children's earliest development and shape their beliefs, attitudes, and values about what is appropriate. Studies show that several family factors may significantly increase the chances that a child will engage in risky behaviours.

*Family risk factors include:*

- \* Parental absence
- \* Lack of attention to a child's behaviour
- \* Inconsistent discipline
- \* A chaotic home environment resulting from familial criminality, violence, substance abuse, or mental illness also may cause future problems for offspring

### **Community risk factors**

Community risk factors include socioeconomic status of the community and exposure to media coverage on negative behaviours such as violence, substance abuse, etc. Studies also show that the principal community risk factor is poverty. Researchers have found that children who grow up in high or moderate levels of poverty are at a higher risk for violent behaviour, drug abuse, and mental health problems as adolescents and adults. This is apparently due to a general sense of hopelessness and helplessness.

*Community risk factors include:*

- \* Community disorganization
- \* Lack of community bonding
- \* Lack of cultural pride
- \* Availability of alcohol and other drugs
- \* Lack of youth services
- \* Multicultural in-competency

### **Individual risk factors**

Individual risk factors encompass a person's behaviour, psychological profile, emotional problems, and attitudes. With behavioural risk factors, it is difficult to tell which comes first - the risk or the result. Researchers have identified chronic school absence and poor academic performance as risk factors for violence and substance abuse. But violent behaviour or substance abuse also could lead to excessive school absences and poor performance academically. Some behavioural risk factors seem to accompany, rather than cause, risky behaviours. Youths who are truant and perform poorly in school are more likely to engage in risky behaviours and vice versa. Likewise youths who use substances are more likely to experience suicidal thoughts and become sexually active earlier than youths who do not use substances.

Psychological and social variables include emotional control, personal functioning, and social relatedness. Children with low levels of emotional control and poor social skills may be more prone to various risks including membership in delinquent peer groups, weak school attachments, and inadequate problem solving skills.

*Individual risk factors include:*

- \* Inadequate life skills
- \* Lack of self-control, assertiveness, and peer-refusal skills
- \* Lack of trust
- \* Low self-esteem
- \* Emotional problems and psychological disturbances
- \* Early anti-social behaviour e.g., lying, stealing, aggressiveness, shyness, hyperactivity

### **Peer risk factors**

We don't know whether youth with an increased motivation to use drugs, behave violently, or engage in other risky behaviours choose peers who act the same way or whether association with these peers leads to risky behaviours as a result of peer pressure. The outcome, however, is the same. *Peer risk factors are* among the strongest predictors of adolescent problem behaviours. If a youth associates with peers who engage in risky behaviours, then that youth is more likely to join them. In the chain of risk factors for drug use tested by Kumpfer and Turner (1991), for example, association with delinquent and negative peers was the formal pathway to use.

According to Kumpfer *et al.* the three major peer risk factors for drug use are:

- \* Association with delinquent peers
- \* Association with any peers who have favorable attitudes toward problem behaviours
- \* Susceptibility to peer pressure

### **School risk factors**

School risk factors can significantly contribute to future problems for adolescents.

*School risk factors include:*

- \* A lack of school bonding
- \* Ambiguous or lax rules for student conduct
- \* Student or staff attitudes that are favorable to risky behaviours

- \* School failure
- \* Poor academic motivation
- \* Rejection by classmates
- \* Students who repeat a grade are more likely to experience emotional distress and to smoke
- \* The availability of alcohol, tobacco, and drugs at school also has a great influence on whether a student will initiate risky behaviours

### **What are the early signs of risk that may predict later drug abuse?**

Some signs of risk can be seen as early as infancy or early childhood, such as aggressive behaviour, lack of self-control, or difficult temperament. As the child gets older, interactions with family, at school, and within the community can affect that child's risk for later drug abuse.

Children's earliest interactions occur in the family; sometimes family situations heighten a child's risk for later drug abuse, for example, when there is: a lack of attachment and nurturing by parents or caregivers; ineffective parenting; and a caregiver who abuses drugs. But families can provide protection from later drug abuse when there is: a strong bond between children and parents; parental involvement in the child's life; and clear limits and consistent enforcement of discipline. Interactions outside the family can involve risks for both children and adolescents, such as: poor classroom behaviour or social skills; academic failure; and association with drug-abusing peers.

*Association with drug-abusing peers is often the most immediate risk for exposing adolescents to drug abuse and delinquent behaviour.* Other factors—such as drug availability, trafficking patterns and beliefs that drug abuse is generally tolerated—are risks that can influence young people to start abusing drugs.

### **What are the highest risk periods for drug abuse among youth?**

Research has shown that the key risk periods for drug abuse are during major transitions in children's lives. The first big transition for children is when they leave the security of the family and enter school. Later, when they advance from elementary school to middle school, they often experience new academic and social situations, such as learning to get along with a wider group of peers. It is at this stage—early adolescence—that children are likely to encounter drugs for the first time.

When they enter high school, adolescents face additional social, emotional, and educational challenges. At the same time, they may be exposed to greater availability of drugs, drug abusers, and social activities involving drugs. These challenges can increase the risk that they will abuse alcohol, tobacco, and other substances.

When young adults leave home for college or work and are on their own for the first time, their risk for drug and alcohol abuse is very high. Consequently, young adult interventions are needed as well.

*Because risks appear at every life transition, prevention planners need to choose programs that strengthen protective factors at each stage of development.*

### **When and how does drug abuse start and progress?**

Studies such as the National Survey on Drug Use and Health, formally called the National Household Survey on Drug Abuse, reported by the Substance Abuse and Mental Health Services Administration, indicate that some children are already abusing drugs at age 12 or 13, which likely means that some begin even earlier. Early abuse often includes such substances as tobacco, alcohol, inhalants, marijuana, and prescription drugs such as sleeping pills and anti-anxiety medicines. If drug abuse persists into later adolescence, abusers typically become more heavily involved with marijuana and then advance to other drugs, while continuing their abuse of tobacco and alcohol. Studies have also shown that abuse of drugs in late childhood and early adolescence is associated with greater drug involvement. It is important to note that most youth, however, do not progress to abusing other drugs.



Scientists have proposed various explanations of why some individuals become involved with drugs and then escalate to abuse. One explanation points to a biological cause, such as having a family history of drug or alcohol abuse. Another explanation is that abusing drugs can lead to affiliation with drug-abusing peers, which, in turn, exposes the individual to other drugs.

Researchers have found that youth who rapidly increase their substance abuse have high levels of risk factors with low levels of protective factors. Gender, race, and geographic location can also play a role in how and when children begin abusing drugs.

*Preventive interventions can provide skills and support to high-risk youth to enhance levels of protective factors and prevent escalation to drug abuse.*

## Protection

Protective factors are generally, but not always, the converse of risk factors. For example, where a delinquent peer group is a substance abuse risk factor for a variety of risky behaviours, a conventional peer group is a protective factor. The impact of protective factor varies throughout the developmental process, with the most salient protective factors - strong family bonds; consistent parental discipline; and success in school - influencing children's earliest development.

Protective factors include:

- \* Having a strong connectedness to parent(s)
- \* Feeling that religion and prayer are important
- \* Having parents or another adult who expresses high expectations for school achievement

## RESEARCH-BASED PREVENTION PRINCIPLES

Clearly relevant to the effectiveness of substance abuse prevention programs are research-based, domain-specific prevention principles. Effective interventions share certain principles in common that guide prevention providers in structuring client services. The principles listed below have been identified through expert or peer consensus efforts; many have also been published in peer-reviewed journals. Appropriate use of these research-based prevention principles can assist prevention providers in designing services that are both innovative and effective, and in modifying proven models to respond to the specialized needs of targeted groups.

The following checklist can assist in determining whether specific programs include research-based prevention principles:

### **Prevention Principles for Community Programs**

To be comprehensive, does the program have components for the individual, the family, the school, the media, community organizations, and health providers? Are the program components well integrated in theme and content so that they reinforce each other?

Does the prevention program use media and community education strategies to increase public awareness, attract community support, reinforce the school-based curriculum for students and parents, and keep the public informed of the program's progress?

Can program components be coordinated with other community efforts to reinforce prevention messages (for instance, can training for all program components address coordinated goals and objectives)?

Are interventions carefully designed to reach different populations at risk, and are they of sufficient duration to make a difference?

Does the program follow a structured organizational plan that progresses from needs assessment through planning, implementation, and review to refinement, with feedback to and from the community at all stages?

Are the objectives and activities specific, time-limited, feasible (given available resources), and integrated so that they work together across program components and can be used to evaluate program progress and outcomes?

### **Prevention Principles for School-Based Programs**

- Do the school-based programs reach children from kindergarten through high school? If not, do they at least reach children during the critical middle school or junior high years?
- Do the programs contain multiple years of intervention (all through the middle school or junior high years)?
- Do the programs use a well-tested, standardized intervention with detailed lesson plans and student materials?
- Do the programs teach drug-resistance skills through interactive methods (modeling, role-playing, discussion, group feedback, reinforcement, extended practice)?
- Do the programs foster prosocial bonding to the school and community?
- Do the programs:
- teach social competence (communication, self-efficacy, assertiveness) and drug resistance skills that are culturally and developmentally appropriate;
  - promote positive peer influence;
  - promote anti-drug social norms;
  - emphasize skills-training teaching methods; and
  - include an adequate "dosage" (10 to 15 sessions in year 1 and another 10 to 15 booster sessions)?
- To maximize benefits, do the programs retain [core elements of the effective intervention design](#)
- Is there periodic evaluation to determine whether the programs are effective?

### **Prevention Principles for Family-Based Programs**

- Do the family-based programs reach families of children at each stage of development?
- Do the programs train parents in behavioral skills to:
- reduce conduct problems in children;
  - improve parent-child relations, including positive reinforcement, listening and communication skills, and problem solving;
  - provide consistent discipline and rulemaking; and
  - monitor children's activities during adolescence?
- Do the programs include an educational component for parents with drug information for them and their children?
- Are the programs directed to families whose children are in kindergarten through 12th grade to enhance protective factors?
- Do the programs provide access to counseling services for families at risk?

## **PREVENTION MODELS**

These are the models with the greatest potential for success: **school-based programmes; peer-focused programmes; family-based programmes; and community-based programmes.**

### **SCHOOL-BASED PREVENTION PROGRAMMES**

Four main programming strategies:

- \* Information-based programmes – disseminate information on risky behaviours
- \* Affective education programmes – values clarification, goal setting, decision making, self-esteem building, and stress management
- \* Social influence programmes – resistance skills, life skills, and normative beliefs
- \* Comprehensive programmes – combining a variety of strategies

School-based prevention programmes attempt to decrease the level of consumption of alcohol and other drugs among young user, ideally stopping experimentation before it starts. Substance abuse prevention programmes in school are pretty straightforward. They focus on educating students on the risks involved with alcohol and other drugs. Some programmes also include components designed to help participants alter their behaviours, such as training about how to resist peer pressure to use substances.

School-based prevention strategies are more successful when they are designed to target specific risk factors. The effectiveness of each programme type depends upon whether it targets risk factors that are particularly important in determining risky behaviours.

**Examples of successful and less successful school based prevention efforts**

Successful	Less successful
<ul style="list-style-type: none"> <li>- Changing normative beliefs</li> <li>- Increasing personal commitment to resisting risky behaviour</li> <li>- Showing the dangers of risky behaviours</li> <li>- Strengthening ability to withstand peer pressure</li> </ul>	<ul style="list-style-type: none"> <li>- Self-esteem training</li> <li>- Stress management</li> <li>- Decision making</li> <li>- Goal setting</li> </ul>

**PEER-FOCUSED PREVENTION PROGRAMMES**

Several theories suggest that beginning at about age 12, peer influence takes precedence over all other sources of influence, including parents, school, and even the mass media. It becomes the single most important factor in determining a variety of behaviours throughout adolescence. It makes sense, then, to try making this influence positive rather than negative. By creating programmes that attempt to shape peer influence, we can capitalize on a process that will occur anyway.

A structured peer programme can provide adolescent with the knowledge, skills, and motivation to manage their relationships and conflicts productively, resist using drugs or alcohol, or steer clear of many other risky behaviour. Four main programming strategies:

- \* adolescents can influence their peers directly through education – an adolescent describing the consequences of his violent behaviour can have a strong impact on other adolescent who could relate to his situation
- \* adolescent can learn by observing how peers behave – if a peer handle anger and solve problems peacefully and constructively, then youth may try behaving that way as well
- \* peer influence can work by changing peer group norms – structured programmes can help change the norms by fostering the development of highly visible peer groups who discourage substance use behaviours
- \* peer programmes can educate students about true versus perceived dominant peer norms – teaching adolescents about the true versus perceived group norms concerning substance use could result in a decline in substance use initiation

**FAMILY-BASED PREVENTION PROGRAMMES**

The case for family-centered preventive approaches is strong. While school and community-based prevention programmes are essential, they are not sufficient. If families are to be successful in preventing risky behaviours during the early year of children development, both parents and children need to develop the behaviours and skills that will enable them to manage themselves in ways that support healthy growth.

Well-documented family-based programme methodologies aimed at prevention can be divided into three categories:

1. parent and family skill training
2. family in-home support
3. family therapy

These approaches focus on the dynamics within the family as a whole and within the community rather than on the individual child within the family. For substance abuse, these approaches do not directly address issues of substance among youth. Rather they address known risk factor and protective factor that increase or decrease the likelihood that children will begin or continue to abuse substances. Some general best practices recommended for family centered prevention approaches include:

- \* family-centered intervention can be made more attractive and accessible by providing vital services that remove barriers to participation, such as transportation, child care and meals
- \* intervention should be conducted in settings and locations that are comfortable, natural, and easily accessible to parents and children – it is ideal to bring the intervention to the target population, using their schools, workplaces, homes, churches and community centres
- \* when community support is needed, family-centered interventions can be easily integrated into the community.
- \* Family centered approaches are highly compatible with and can be easily integrated into most substance abuse prevention programmes. For example, school-based intervention could include a parent and family skills training component or even family therapy intervention. Doing so could strengthen both programmes

## COMMUNITY-BASED PREVENTION PROGRAMMES

The approach to preventing risky behaviour has been to focus on individuals rather than on their environment. Such approaches assumed that the most important causes of risky behaviours lie within individuals. This assumption does not fully take into consideration the fact that individuals exist and function in a variety of environment contexts that exert an influence on attitudes, behaviour, and perceptions of the norms of appropriate and inappropriate behaviour.

The last two decades has been marked by an increase awareness of the environmental contexts that contribute to various risky behaviours. Environmental factors such as general accessibility to tobacco, alcohol and other drugs in the community or people's collective attitude towards violence or substance abuse can greatly affect the incidence of risky behaviour in a community population.

Advantages of community-based intervention:

- \* The breath of coverage – e.g. a community-based approach for reducing tobacco use by youth involves requiring anyone involved in any way with the sale and distribution of tobacco products to participate in a merchant education programme. The coverage or exposure is enhanced because of the shift in the focus of the intervention from individual buyers to all points of purchase.
- \* Visibility and repetitive reinforcement – this can strengthen norms against behaviour such as substance abuse or violence. Counter-advertising campaign through many mass media public service announcements are a relatively easy way to send multiple message about dangers of various risky behaviours
- \* Potential for maximising outcomes – the utility of community approaches lies in the fact that they can be focused on policy changes. Policies provide clear parameters on what is acceptable behaviour. The likelihood of reducing risky behaviour in adolescents depends partly on the uniformity of standard operating procedures

### Example of a model community-based programme methodology

The Torjman Model – (Torjman 1986)

This model attempts to draw together several traditions, incorporating strategies aimed at reducing the alcohol supply as well as the demand. In this context, "supply" refers to level of direct access to alcoholic beverages and "demand" refers to motivation or interest in acquiring alcohol. Torjman's framework identified the person, the drug and the environment as three targets for action designed to prevent alcohol-related risks or problems. Each target is associated with several key components that affect alcohol use.

- \* **The person** – interventions intended to reduce demand for a drug by improving a person's ability to refrain from taking it, to avoid opportunities to take drugs, or to resist influences in the environment that encourages drug use. Focal areas are, knowledge, attitudes, intentions, and skills. The strategy works by providing information about alcohol use and its consequences, changing people's feeling about appropriate alcohol use, and ultimately giving people the skills and the motivation to alter their drinking habits
- \* **The drug** – intervention intended to reduce injury or avoid problems associated with the drug's toxic effect. The intent is to separate people from the drug, or at least to reduce the risk of the drug's use in specific contexts. Components include, for example with alcohol, pricing, composition, labeling, and packaging.

- \* **The environment** – when the environment is the focus the components include, advertising and promotion, availability, legal sanctions, and the socio-cultural context within which alcohol is consumed. The way alcoholic beverages are marketed, ease of buying them, enforcement of laws restricting sale or use of alcohol, and associations of alcohol with certain social environment all greatly influence a person's alcohol use. A prevention strategy focusing on the environment attempts to alter these factors in away that makes alcohol less appealing and harder to get

*Best practice recommendations for community-based prevention programmes:*

- Gathering baseline information to determine the extent of the problem in the community
- Using a community-based integrated, multi-component approach
- Involve community members and organizations from the earliest stages
- Involve adolescent in all aspects of the programme
- Link your new initiatives with existing programmes
- Use existing materials

### Behavioral Signs of Substance Use and Abuse

A combination of the following signs should alert you to the possibility that a person is using illicit substances and to the importance of exploring that possibility through an interview and/or drug testing:

1. Sudden decline in school achievement. Since alcohol and other types of drug intoxication interfere with learning, it is not surprising that rapidly deteriorating school performance frequently results. Poor functioning in school that contrasts sharply with earlier adequate functioning, especially in the absence of a school change or other obvious explanation, should arouse suspicion.
2. Cigarette smoking.
3. Marked shift in the child's peer reference group, especially association with known or suspected drug users.
4. Serious erosion of parental trust in the child.
5. Support by the child for the idea of legalizing marijuana.
6. Marked personality changes. Although childhood and especially adolescence are often marked by mood swings and some instability, evidence of social withdrawal, a new guardedness in communication with other family members, inexplicable depression or other evidence of psychological disruption such as changes in sleeping patterns, are all possible indicators of drug involvement.
7. Withdrawal from extracurricular activities that were previously important to the child, such as athletics, religious or youth programs, band, etc.
8. Cutting classes, tardiness or truancy from school.
9. Deterioration in appearance and personal hygiene.
10. Increased secretiveness unexplained phone calls, heightened hostility to inquiry, and sudden onset of hypersensitivity.
11. Going out every night. Youth who are intensely involved with weekday social activity consisting primarily of "hanging around" (as opposed to scheduled youth activities or activities on weekends) may be drug involved.
12. Unexplained disappearance of family funds, or family and personal possessions (this may be related to a need for money to purchase drugs.)
13. Aggressive behavior such as recurrent fighting, violent hostility, or other evidence of social alienation.
14. Heavy use of over-the-counter preparations to reduce eye reddening (e.g., injected conjunctiva produced by acute marijuana intoxication), nasal irritation (resulting from "snorting" cocaine), or tell-tale bad breath (produced by alcohol or cigarettes).

### Physical Symptoms of Alcohol and Other Drug Use

Behavioral manifestations, not physical appearance, are the red flags of alcohol and other drug use. **Generally, physical symptoms or sequelae of substance abuse will not be obvious.** For example, smoking marijuana or crack cocaine may not usually cause coughing, wheezing, or other obvious irritation of the upper respiratory system. While a reddening of the eyes often occurs, eye irritation can have a variety of other causes, so this symptom is hardly pathognomonic. Even acute intoxication with marijuana may not be apparent. Many experienced marijuana users are able to hide the outward signs of the drug's intoxicating effects, thereby disguising their use and fooling even the most astute physicians. Although some clinicians have noted a quality of listlessness, unhealthy pallor and complaints of tiredness in their young, drug-using patients, these symptoms may not always be apparent even in advanced stages of use. While weight loss and other evidence of malnutrition may occur following continued use of cocaine or other stimulant drugs, these signs are unlikely to result from recently initiated or occasional use.

## Evidence of I.V. Drug Use

Given the risks of such secondary infections as hepatitis and AIDS, and of anaphylactic reaction to the injected material, any evidence or admission of I.V. drug use should be regarded as indicating a need for assessment by an experienced drug treatment professional.

## Drug Abuse Prevention Curriculum Content

Research has identified that prevention programs need to be comprehensive and have sufficient intensity to reasonably expect that the skills can be taught (Sussman & Johnson, 1996). Content areas that are necessary for an effective curriculum include:

- **Normative education.** Helps students realize that use of ATOD is not the norm for teenagers. Students generally overestimate the proportion of their peers actively involved in ATOD. Hence, it is easier to be pressured by the myth that everybody is doing it. Student surveys and opinion polls are used to help students understand actual use rates.
- **Social skills.** Improving verbal skills may help students increase their ease in handling social situations. Decision making, communication skills, and assertiveness skills are particularly important during the late elementary and middle school years when puberty changes social dynamics between young people themselves as well as with the adults in their lives.
- **Social influences.** Helps students recognize external pressure (e.g. advertising, role models, peer attitudes) to use ATOD and to develop the cognitive skills to resist such pressures.
- **Perceived harm.** Helps students understand the risks and short- and long-term consequences of ATOD use. The message must come from a credible source and be reinforced in multiple settings.
- **Protective factors.** Supports and encourages the development of positive aspects of life such as helping, caring, goal setting, and challenging students to live up to their potential and facilitating affiliations with positive peers (Hawkins, Catalano, & Miller, 1992).
- **Refusal skills.** Learning ways to refuse ATOD effectively and still maintain friendships was a strategy heavily relied on in many early curricula. Recent research indicates that it is most relevant in supporting teens who do not want to use drugs and in conjunction with other activities such as social influences and normative education.

## Policy implications and recommendations for substance abuse prevention

The following is a list of generic policy recommendations arising from the lessons learned from the evaluation of numerous prevention intervention programmes around the world. These recommendations are based on the experience of the organisations, the analysis of the details provided by the organisations and the feedback provided by the local experts. It should be recognised that these recommendations are not all encompassing, and there are many views on policy development that have not been highlighted here, but are nevertheless valuable.

### Policy planning and development

- Policy makers should be fully aware of the extent of the drug abuse problem and its social and economical consequences.
- Policy makers should acknowledge the advantages of drug abuse prevention strategies as an indispensable element in the response to the drug problem, and should therefore allocate funding to this type of activity.
- Clear policies with specific and relevant aims and objectives regarding drug abuse prevention should be developed and matched with adequate financial resources to facilitate their implementation.
- Drug abuse prevention requires long-term commitment. To ensure continuity and to achieve the desired objectives, appropriate and relevant legislation should be adopted.

### Research/Needs Assessment

- Epidemiological and social research into the prevalence and nature of drug abuse amongst or affecting the target population of any initiative should be commissioned. This will help develop the most appropriate and potentially effective responses possible to address the drug problem.
- Programmes, projects and policies should be based on a needs assessment that allows the understanding of issues at local and national levels, and which enables funds to be directed where they are most needed.

### Evaluation

- Evaluation should be integrated into policies, projects and programmes from the outset, and should continue throughout. This will help to establish evidence of effectiveness and to review the learning intrinsic to the work process.
- Policy makers should invest in the provision of information, training in evaluation methods, and appropriate tools, in order to disseminate evaluation principles and practice throughout a country.
- Appropriate levels of funding should be built into programmes to allow evaluative procedures to be undertaken as part of the work.
- Administrative arrangements should be made to ensure that prevention policies are implemented. This includes setting up specific working groups or feedback committees to monitor continuously, and to assess the impact of prevention policies.

### Partnerships

- When possible, agencies directly or indirectly involved with the drug problem should engage in multi-sectoral and inter-institutional collaboration to pool resources and develop a common strategy.
- Given the central role of the Government in supporting and sustaining drug abuse prevention programmes of civil society organisations, appropriate levels of funding and support should be made available to those non-government organisations who are better placed to implement policy through practice.
- Governments should promote the decentralisation of drug demand reduction, and - given that these entities in many instances have more operational capacities than institutions at the national level - should strengthen the technical capacity of partners (Municipalities and local Governments) to tackle the drug abuse problem.

### Use of existing resources

- Local and national experts in the field of drug abuse prevention should be consulted, along with the target group, and involved in any planning and decision-making processes relevant to policy and the development of programmes and projects.
- Parents and youth should be recognised as valuable resources for drug abuse prevention activities.
- Social settings, such as schools, the workplace, health centres, the community and the correctional system are useful for the consistent and systematic implementation of drug abuse prevention programmes.

### Approach

- A range of programmes, consisting of universal, selective and indicative components, needs to be developed in order to serve the needs of different target groups, depending on the nature and extent of the drug abuse problem.
- Consideration should be given to combining drug abuse prevention activities with treatment, support, rehabilitation and detoxification services in order to ensure a continuum of care for young people at high risk.
- As part of the work in prevention of drug abuse, employment, recreational and educational opportunities need to be provided to young people to increase their choices for a healthier life style.
- Consideration should be given to strengthening the capacity of families to engage in effective parenting by teaching the skills needed to support the healthy development of their children.
- Consideration should be given to approaches that focus on targeting children in their own community and home environment, in order to decrease the number of children attending institutional care or resorting to living on the streets.
- The gender issue, and its implications for drug abuse prevention activities, should be considered when planning and developing policies.
- Drug abuse prevention and access to information should be regarded as a basic children's' rights.

- Where resources are limited, combining work on health issues such as HIV/AIDS with drug abuse prevention can increase the impact on the health awareness and behaviour of young people.
- Drug abuse and HIV/AIDS prevention, and health education in general, should be part of the national school and college curriculum.

### **Training**

- Individuals, as well as organisations, should be provided with relevant training in drug abuse prevention practices, in order to enhance their capacity to deliver efficient and effective programmes within a country.

### **Networking**

- Partnerships and networks should be created to respond in a multidisciplinary way to the highly complex problem of drug abuse.
- Networks between existing agencies minimize competition, help to pool resources and avoid the unnecessary duplication of effort. Such networking should, therefore, be initiated and maintained through financial and technical support and through appropriate Government management controls.
- The creation of a youth movement through the setting-up of youth groups and their subsequent networking with international, national and local youth organizations should be encouraged, in order to ensure the participation of youth in the decision-making processes that affect their lives.

## **Definitions of terms used in the substance abuse field**

### *Alternatives to Drug Use*

Programmes designed to provide activities and to facilitate a sense of self-worth without using drugs. Founded on the belief that some people, particularly young people, engage in illicit drug use because they cannot find worthwhile and self-fulfilling activities in which to engage. Programmes range from providing leisure activities to forming activity or interest groups.

### *Community-based Prevention*

Community-based interventions can be implemented through different actors and with different political implications for the community. Community-based prevention can entail: The creation of local networks between key people and groups with a high level of empowerment and ownership, based on their own initiative. The creation of local networks between existing agencies and institutions, through the means of a task force and with a lesser extent of community empowerment.

### *Community Development*

Community development, with the aim of improving the community's health or drug abuse situation, is a process by which a community defines its own needs, considers how those needs can be met and decides collectively on priorities for action. The term refers to actions that involve the whole of the community or just its key actors, and which aid the positive development of that community. Often the aim is to impact on a certain issue, e.g. drugs, or a certain target group within that community (e.g. young people).

### *Community Empowerment*

Interventions which encourage a community to develop collective ownership and control over health-related choices and activities. To achieve this, the community may also need to gain collective control of the wider social, political and economic factors that influence their access to health. 'Empowerment' is the process of increasing personal, interpersonal or political power so that individuals can take action to improve their lives.

### *Demand*

The concept of demand for drugs is commonly used in the broader sense of the level of interest in a particular community in using drugs, and not just in purchasing them.

### *Demand Reduction*

A term used to refer to the aim of reducing consumer demand for controlled and other drugs or substances. Demand reduction is a broad term used to encompass a range of policies and programmes seeking a reduction of the desire and preparedness to obtain and use drugs.

### *Dependence*



As applied to alcohol and other drugs, dependence is a need for repeated doses of the drug to feel good or to avoid feeling bad.

### *Drug*

In common usage, this term often refers specifically to psychoactive drugs, and often, even more specifically, to illicit drugs. However, tobacco, alcohol, and other substances in common non-medical use are also drugs, in the sense that they are taken primarily for their psychoactive effects.

### *Drug Abuse/Use*

In the context of international drug control, drug abuse constitutes the use of any substance under international control for purposes other than medical and scientific ones, including use without prescription, in excessive dose levels, or over an unjustified period of time.

### *Drug Misuse*

The use of a substance for a purpose not consistent with legal or medical guidelines, as in the non-medical use of prescription medications. The term is preferred by some to the term 'abuse', in the belief that it is less judgmental. Drug misuse may also refer to high-risk and excessive use, or use that infers harm to the user and those close to him or her such as friends or family.

### *Drug Policy*

Policies designed to affect the local or international supply and/or demand for drugs. Drug policy covers a range of strategies including education, treatment, drug laws, policing and border surveillance. In this context, 'drug policy' may include pharmaceutical, tobacco or alcohol policies.

### *Epidemiology*

The study of the prevalence and incidence of illness in the population. Also the study of the patterns and underlying causes of - for example - the problem of drug use.

### *Evaluation*

The systematic and scientific collection, processing and analysis of data related to programme or project implementation in order to assess the effectiveness and efficiency of the programme. Evaluation methodology can consist of both quantitative and qualitative approaches.

### *Evaluation Indicators*

Elements related to the objectives that are measured, preferably expressed in numbers. These allow monitoring of expected change in relation to the initial situation.

### *Process Evaluation (Formative)*

Assessing the implementation of the intervention and its effects on the various participants. Process evaluation questions whether and how the intervention took place; whether it was performed in conformity with its design and the proper process and methodology of the intervention; and whether the designated target group was reached. Process evaluation helps to explain outcome data and is useful for the discussion of future interventions.

### *Summative Evaluation (Outcome and Impact)*

An assessment of the final results of the programme in relation to the stated objectives. Outcome: The results achieved at the end of the project in relation to the aims (e.g. measure of behaviour change, measure of knowledge change within the target group). Impact: The overall impact of the project on the trends/behaviour/prevalence in a region or country.

### *Harm Reduction*

With regards to alcohol or other drugs, harm reduction refers to policies or programmes that focus directly on reducing the harm resulting from their use, both to the individual and to the larger community. The term is used particularly in reference to policies or programmes that aim to reduce harm without necessarily requiring abstinence. Examples of harm reduction include needle/syringe exchanges to reduce rates of needle-sharing among injecting drug users, and the use of shatterproof glassware to reduce glass injuries in settings where alcohol is consumed.

### *Health Promotion*

Health promotion aims to change the underlying individual, social and environmental determinants of health, and takes a holistic approach. The Ottawa Charter for Health

Promotion, drawn up at the first International Conference on Health Promotion in Ottawa, Canada, in 1986, outlines the basic principles of health promotion. These are: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services. In short, health promotion does not just focus on the absence of a certain disease or illness, but rather strives for the positive mental and physical well-being of an individual or groups of people within a society in order to avoid negative health outcomes.

### *Life Skills*

These are abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life. Life skills education is designed to facilitate the practice and reinforcement of psychosocial skills in a culturally and developmentally appropriate fashion. It contributes to the promotion of personal and social development, the protection of human rights, and the prevention of health and social problems. Five 'areas' of life skills have been identified: self-awareness/empathy, interpersonal relationships, decision making/problem solving, creative and critical thinking and coping with emotions and stress.

### *Narcotic Drug*

A chemical agent that can induce stupor, coma or insensitivity to pain. The term often refers to opiates or opioids, which are called narcotic analgesics. In common parlance and legal usage it is often used imprecisely to mean illicit drugs, irrespective of their pharmacology.

### *Peer Education*

The use of educators of similar age or background to their students to convey educational messages to a target group. Peer educators often work by endorsing 'healthy' norms, beliefs and behaviours within their own peer group or 'community', and challenging those which are 'unhealthy'.

### *Peer Influence*

When applied to drug use or abuse, peer influence can be described as one of a set of external social environmental pressures which influence experimentation or continuation with drug consumption. Peer influence includes cognitive factors, such as the perception of peers' behaviour and the perceived drug use norms of the peer group, as well as situational factors, such as direct peer pressure and the importance of socializing and conformity in groups. Peer pressure is one type of peer influence.

### *Peer Pressure*

When used in reference to drug abuse amongst adolescents or young adults, this term refers to the notion that peers put pressure on individuals to conform to group norms which may include the illegal use of drugs. The individual who is the focus of the presumed pressure is seen to be subject to influence, and may be passive in the face of active pressure. The concept has contributed to the development of primary prevention strategies which emphasize skills training and ways in which to refuse offers of drugs.

### *Prevention*

Prevention targets illnesses or disease outcomes and is often associated with the process of reducing existing risk factors and increasing protective factors in an individual, in high-risk groups, in the community or in society as a whole. Prevention can take place at three stages:

- Primary prevention aims to avoid the development of high-risk or potentially harmful behaviour and/or the occurrence of symptoms in the first place
- Secondary prevention, or early intervention, aims to reduce existing risk and harmful behaviour and symptoms as early as possible
- Tertiary prevention aims to reduce the impact of the illness/symptoms a person suffers. It offers treatment and rehabilitation for the person 'dependent' or 'addicted' to drugs, or whose drug use is problematic.

An increasingly popular way of classifying prevention initiatives is the following:

- Universal Prevention Programmes – These programmes are the broadest, and address large groups of people - such as the general population - or certain sub-categories of the population. Universal programmes mainly have the objective of promoting health and well-being, and of preventing the onset of drug use, with children and young people as the usual prime focus groups

- Selected Prevention Programmes – This type of programme targets young people based on the presence of known risk factors of drug involvement. Targets have been identified as having an increased likelihood of initiating drug use compared to young people in general. These programmes are aimed at reducing the influence of the 'risk factors', developing/enhancing protective factors, and preventing drug use initiation.
- Indicated Prevention Programmes – Indicated programmes target young people who are identified as having already started to use drugs or exhibiting behaviours that make problematic drug use a likelihood, but who do not yet meet formal diagnostic criteria for a drug abuse disorder which requires specialized treatment. Examples of such programmes include providing social skills or parent-child interaction training for drug-using youth.

#### *Protective Factor*

A factor that will reduce the probability of occurrence of an event perceived as undesirable. This term is often used to indicate the characteristics of individuals or their environment which reduce the likelihood of experimentation with or misuse of drugs. For example, there is some evidence from research in developed countries that each of the following attributes is, statistically at least, 'protective' in relation to illicit drug use: being female; being of high socio-economic status; being employed; having high academic attainment; practicing a religion; and being a non-smoker.

#### *Risk Factor*

A factor which increases an individual's risk of taking drugs. The factors are complex and change constantly at the individual, community and societal levels.

#### *Supply Reduction and Control*

A broad term used for a range of activities designed to stop the production, manufacture and distribution of illicit drugs. Production can be curtailed through crop eradication, or through large programmes of alternative development. Supply control is a term often used to encompass police and customs activities.

## Internet Resources

Adolescence Directory On-Line (Indiana, United States)

<http://education.indiana.edu/cas/adol.adol.html>

"Adolescence Directory On-Line (ADOL) is an electronic guide to information on adolescent issues. It is a service of the Center for Adolescent Studies at Indiana University. Educators, counselors, parents, researchers, health practitioners and teens can use ADOL to find Web resources for": What's new?; Conflict and Violence, Mental Health Issues; Health and Health Risk Issues; Counselor Resources; Teens Only; Welcome; and their other web sites: Teacher Talk Forum; Teacher Talk; and Center for Adolescent Studies Home Page.

The Health Risks for Adolescents web page: <http://education.indiana.edu/cas/adol/risk.html>

Alcohol and Other Drugs web page: <http://education.indiana.edu/cas/adol/atod.html>

Adolescent Substance Abuse and Recovery Resources (United States):

<http://www.winternet.com/~webpage/adolrecovery.html>

"The links on this web site are mostly teen-oriented ... The site is being developed as a statement of gratitude for sobriety, recovery and life itself. It is provided in the hope that somehow it might be useful in your search."—Terry

Alcohol and Other Drugs (Health Canada): <http://www.hc-sc.gc.ca/hppb/alcohol-otherdrugs/>

American Council for Drug Education (United States): <http://www.acde.org>

Australian Parents for Drug-Free Youth (Australia): <http://www.cyberlink.com.au/pdf/>

Centre for Education & Information on Drugs and Alcohol (Australia): <http://www.ceida.net.au/>

Center for Substance Abuse Research (Maryland, United States): <http://www.bsos.umd.edu/cersar/>

Cocaine Anonymous World Services: <http://www.ca.org>

The Community Epidemiology Work Group (Washington, D.C., United States):

<http://www.cdmgroup.com/cewg/>

Connecticut Clearinghouse : A Resource Center for Information About Alcohol, Tobacco, and Other Drugs (Connecticut, United States): <http://ctclearinghouse.org/>

DARE America (United States): <http://www.dare-america.org>

Development Associates, Inc. (Virginia, United States): <http://www.devassoc1.com/index.html>

Drug Use : A Web Site on Illegal Drugs (Constructive Information on Illegal Drug Abuse) (California, United States): <http://www.druguse.com/>

Mission statement: "... to deter those who have not used illegal substances; help those who are using to get off them; and offer former users, friends, and family an outlet to help others and relate experiences."

Drugs, Drug Testing, Narcotics, Cocaine, Crack ... (United States)

<http://www.mninter.net/~publish/index2.html>

Publisher Group Web Site for parents, teachers, students, DARE officers, researchers and others.

Drugs – the facts, the risks, the reality (Victoria, Australia):

<http://hna.ffh.vic.gov.au/phb/hdev/drug/cover.html>

Elks Drug Awareness Program's Library (United States): [ftp://ftp.elks.org/DAP/1\\_readme.txt](ftp://ftp.elks.org/DAP/1_readme.txt) ;

<http://www.elks.org/drugs>

Hazelden (Minnesota, United States): <http://www.hazelden.org/>

Health Education Unit and Library (Australia):

<http://www.edfac.usyd.edu.au/centres/healthed/INDEX.HTM>

Healthtouch: Drug & Alcohol Abuse (United States): <http://www.healthtouch.com>

The Higher Education Center for Alcohol and Other Drug Prevention (United States):

<http://www.edc.org/hec>

Indiana Prevention Resource Center at Indiana University (Indiana, United States):

<http://www.drugs.indiana.edu>

Mission statement: "The Indiana Prevention Resource Center is a statewide clearinghouse for prevention technical assistance and information about alcohol, tobacco, and other drugs."

International Council on Alcohol and Addictions (ICAA) (Lausanne, Switzerland):

<http://www.who.ch/ina/ngo/ngo056.htm>

Iowa Substance Abuse Information Center (Iowa, United States): <http://www.isiac.cedar-rapids.lib.ia.us/ISAICHome.html>

Mission statement: "The Iowa Substance Abuse Information Center (ISAIC) was established as a special service of the Cedar Rapids Public Library. Its mission is to support education, prevention, and treatment efforts in Iowa through timely access to accurate information concerning substance abuse, gambling, and related topics."

Join Together Online (Massachusetts, United States): <http://www.jointogether.org>

Mission statement: "Join Together is a national resource for communities fighting substance abuse and gun violence."

Mickey's Place in the Sun : Drugs and Drug Prevention (Florida, United States):

<http://people.delphi.com/mickyong/drugs.html>

Mickey Young's personal web page with information ["helpful to citizens, parents, seniors, youth, law enforcement, policymakers, media, community leaders, businesses, educators, and service providers] on: alcohol and other substance abuse and prevention resources: clearinghouses; directories; drug abuse new; drugs and crime; government agencies; international resources; organizations; policy and research; programs and strategies; school resources; surveys and statistics; tobacco; treatment; self-help; support; and workplace resources.

National Association for Addiction Sciences, Inc. (Indiana, United States):

<http://user.centralnet.net/naas>