Alternative Peer Groups: Adolescent Recovery From Substance Use

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Sam Houston State University

TCA Conference 2014

Please take a moment and introduce yourselves to someone around you. Find out:

▶ Who are our participants?

▶ What are you doing now to help teens recover from substance use?

▶ What do you want to do to help teens recover from substance use?

Learn how the Alternative Peer Group (APG) intervention assists youth and young adults in recovery from misusing drugs and/or alcohol. Specifically learn:

(a) What youth need to recover from abusing drugs and alcohol

(b) How agencies and school have been successful using the APG intervention

(c) What you can do in your community to make a difference

First, a little background!

American Society of Addictions Medicine

New definition in 2011:

Addiction is a chronic brain disease, not just bad behaviors or bad choices.

- Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

- Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

ASAM Definition: A,B,C,D,E

▶ **Addiction** is characterized by:

1. **Inability to consistently <u>A</u>bstain**;

2. **Impairment in <u>B</u>ehavioral control**;

3. **<u>C</u>raving**; or increased "hunger" for drugs or rewarding experiences;

4. **<u>D</u>iminished recognition of significant problems** with one's behaviors and interpersonal relationships; and

5. **A dysfunctional <u>E</u>motional response**
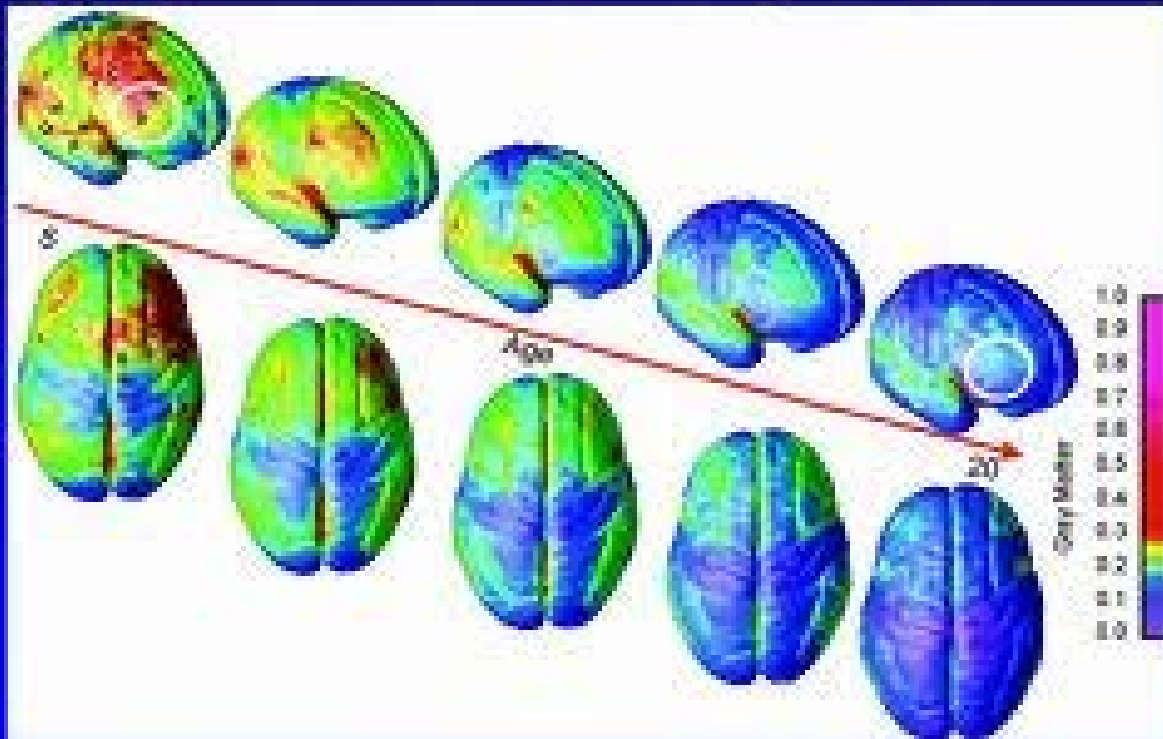
The ACE Study: Adverse Childhood Experiences

Adverse Childhood Experiences: Risk Factors for Substance Abuse

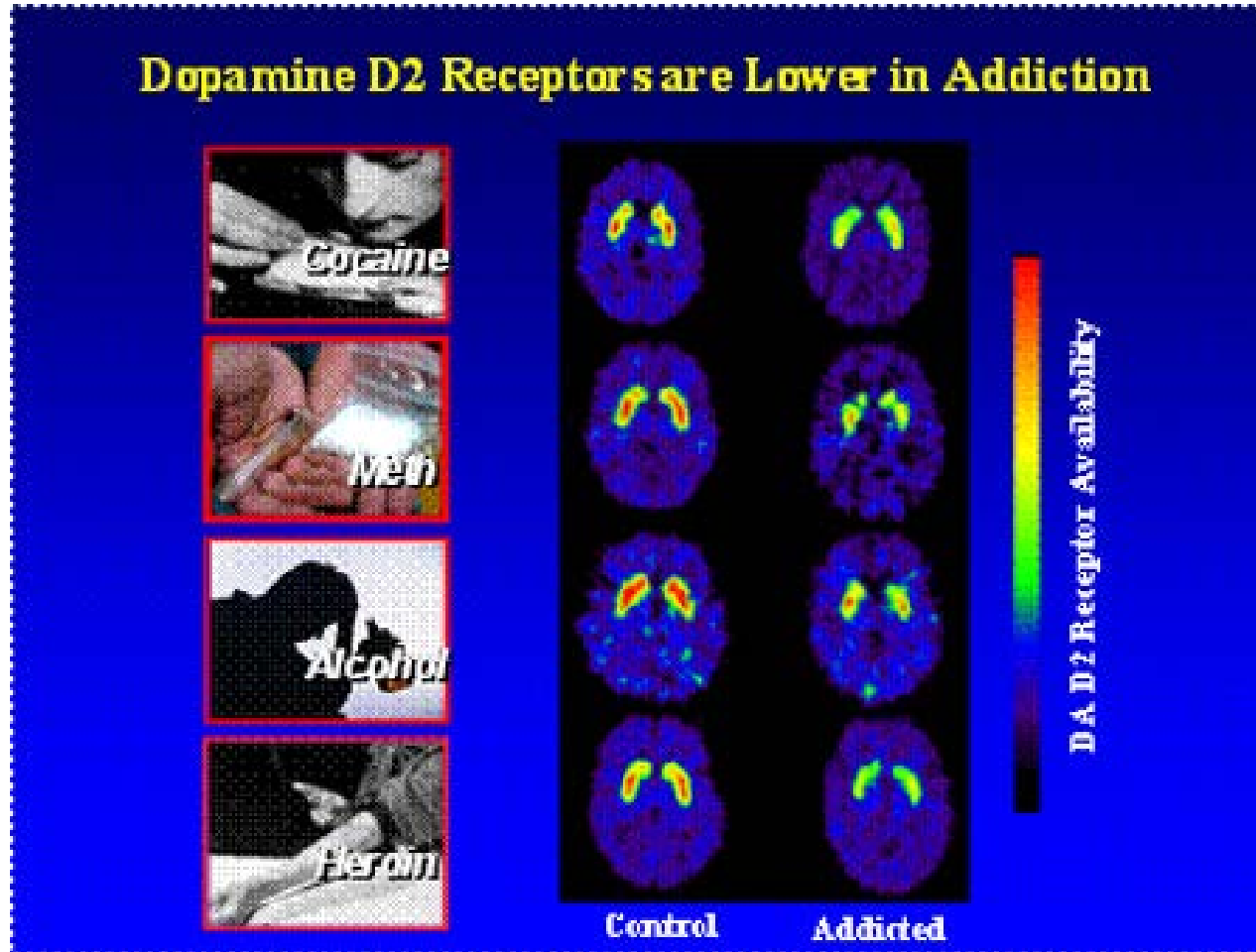# Healthy Brain Development

The Teenage Brain on Drugs: What We See

E.R. Sowell

Drugs and the Teen Brain

The Teenage Brain on Drugs: What We Don't See

Hijacking of the Brain

Addictive Brain Response

If Alcohol Or Other Drugs Makes You Feel Really Good You're At High Risk Of Addiction.

- Floods The Brain With Pleasure Chemicals
- Deprives The brain Of Warning Chemicals
- Creates Intense Euphoria
- Inhibits Anxiety and Fear Even When In Real Threat
- Impairs Judgment and Impulse Control

Straight Talk About Addiction by Terry Gorski – www.relapse.org – www.cenaps.com

HOPE: Brain Recovery with Prolonged Abstinence

BRAIN RECOVERY WITH PROLONGED ABSTINENCE
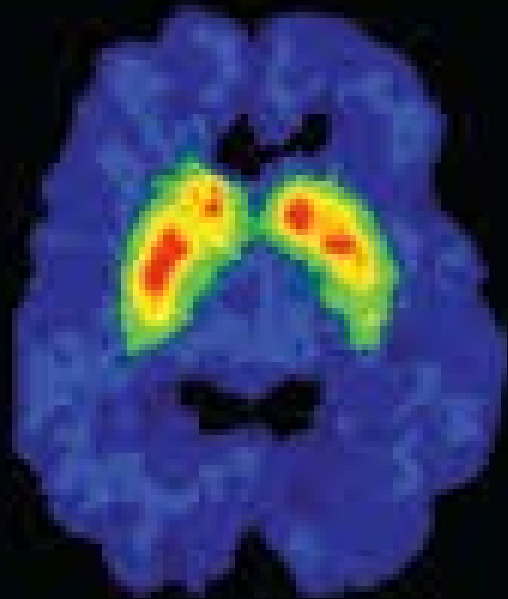
Healthy Person
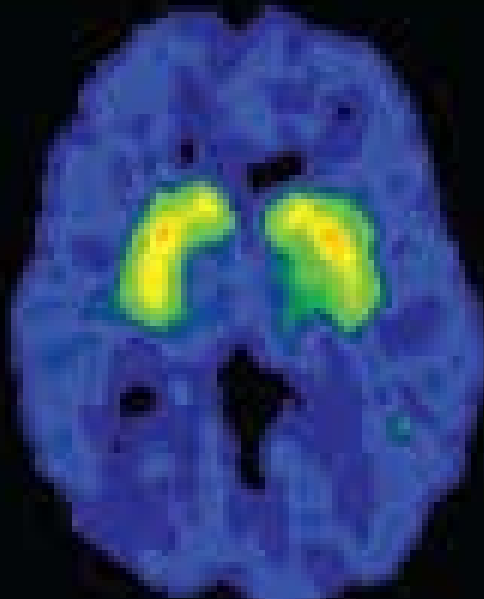
METH Abuser
1 month abstinence
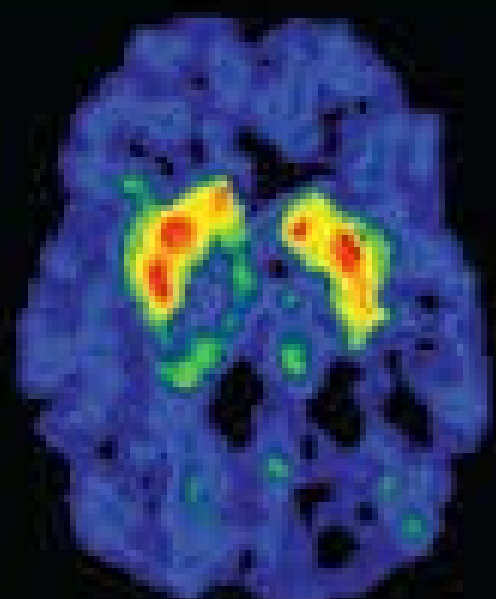
METH Abuser
14 months abstinence

The Drug Danger Zone

The Drug Danger Zone: Most Illicit Drug Use Starts in the Teenage Years
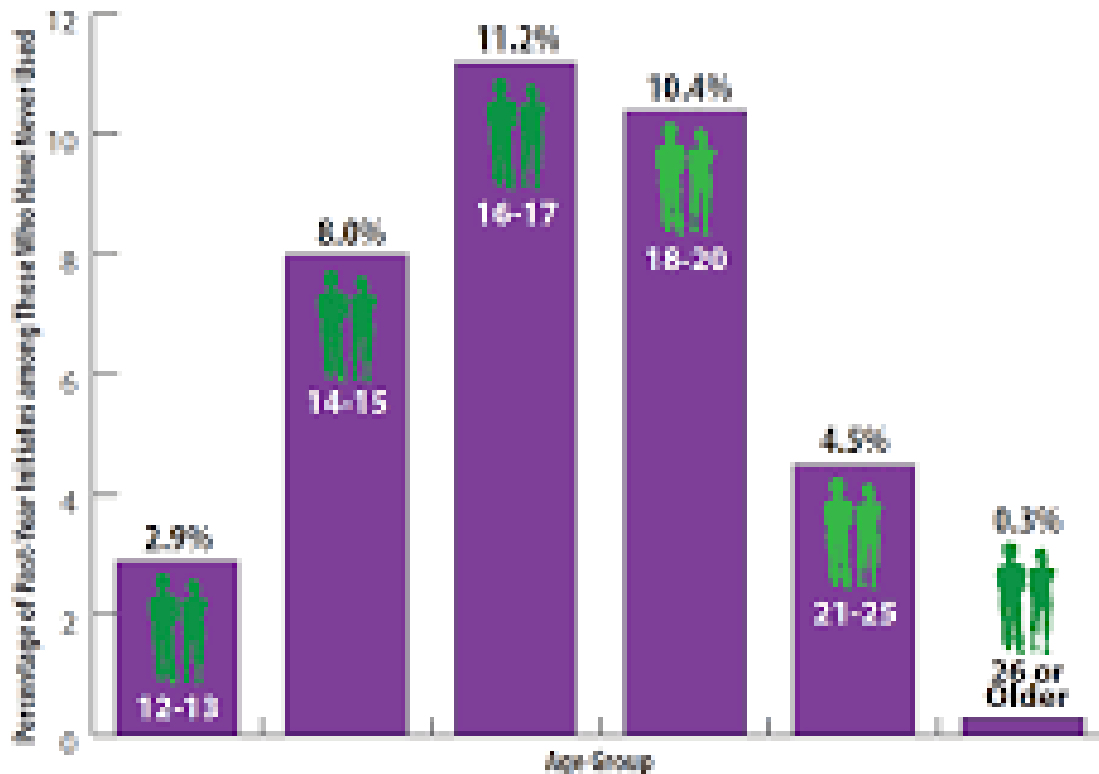
Substance Use Prevalence

- Illicit drugs are holding steady
- Increase in psychotherapeutic drugs
- Alcohol is the most widely used substance by adolescents

Annual Prevalence of Marijuana Use

12.7
36.4
29.8
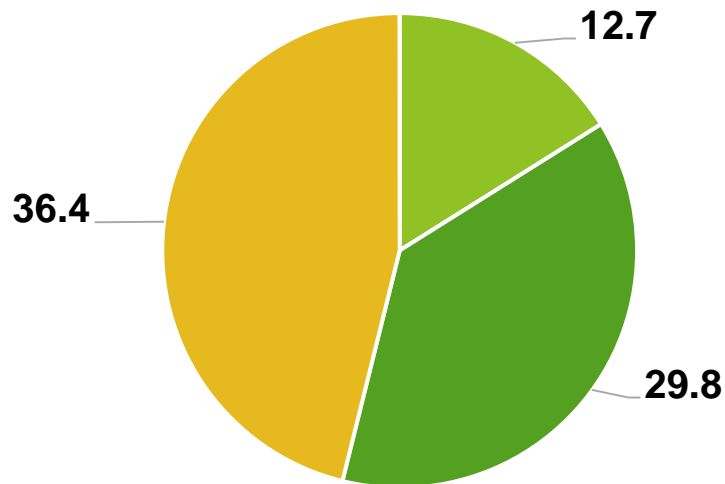
■ 8th graders   ■ 10th graders   ■ 12th graders

Annual Prevalence of Alcohol Use

19%
46%
35%

■ 8th graders   ■ 10th graders   ■ 12th graders

(MTF, 2014)
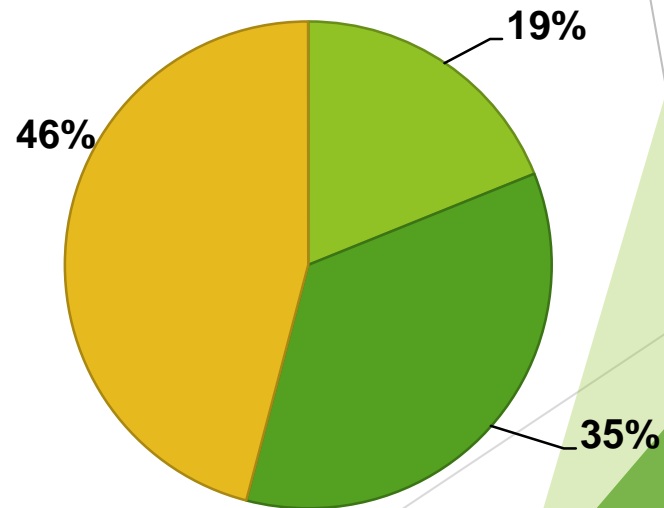
Lifetime Prevalence of Alcohol

Been Drunk
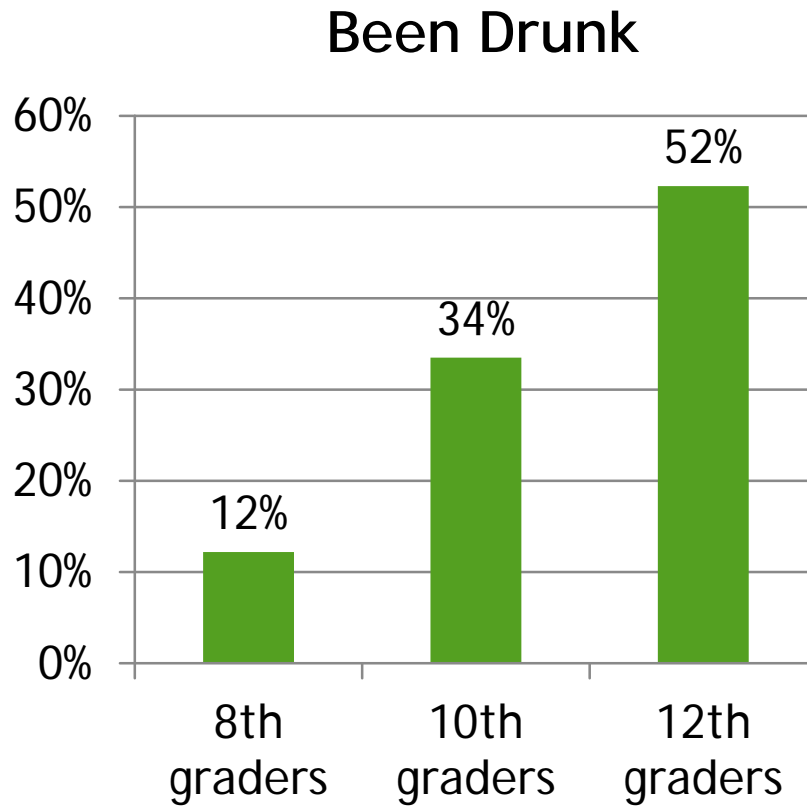
Consequences

▶ Decrease in school performance

▶ High school drop-out

▶ Poor job stability

▶ Limited employment opportunities

▶ Decreased job stability

▶ Lower wages

▶ Greater chance of juvenile offenses

(Bryant et al., 2003; Fergusson et al., 2003; Fothergill et al., 2008; Griffin et al., 2011; Liddle et al., 2009; McLeod et al., 2012)

Risk Factors

- Family
  - History of drug abuse
  - Conflict & chaotic home environment
  - Ineffective parenting
- School
  - Academic failure
  - Lack of commitment
  - Deviant peers
  - Truancy
- Individual
  - Rebelliousness
  - Poor coping skills
  - Mental health problems
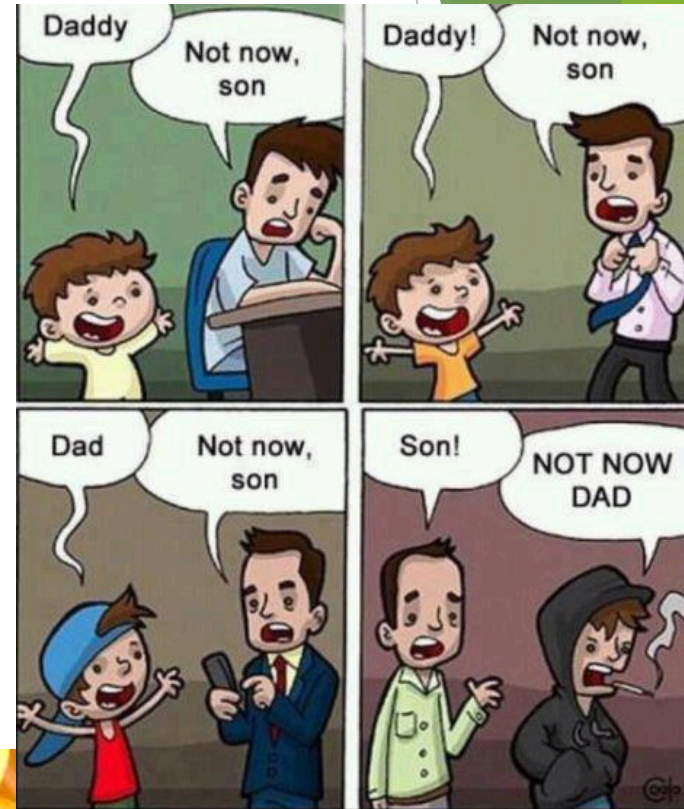
What happens to families?

- Low self esteem, withdrawal, parental unavailability, lack of trust in adults, concern about own addictive tendencies, and adapting to dysfunction

- Barriers in trying to get help for another family member

- Under-servicing for families battling addiction problems

- Lack of understanding of strategies to develop positive family resilience when under pressure from addiction

- More support needed, particularly emotional support.

- Overall there is often a lack of knowledge about the nature of addiction

Protective Factors

- Family
  - Strong family bonding
  - Parental monitoring
  - Parental involvement
  - Parental modeling
  - Lack of conflict
- Individual
  - Positive attitude
  - Good self-esteem
  - Autonomy
- External
  - **Support systems - prosocial groups**
  - Conventional norms about drug use

Studies

- Researchers have found that teens start using drugs and alcohol for four main reasons:

  - (1) to improve their mood

  - (2) to receive social rewards

  - (3) to reduce negative feelings

  - (4) to avoid social rejection

- Teens who reported social reasons for drinking were more likely to report moderate drinking.

- Teens who wanted to improve their mood reported heavy alcohol use.

- Teens looking to reduce negative feelings showed problematic drinking patterns.

(Kuntsche, Knibbe, Gmel, & Engels, 2005)

What is recovery?

- A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

  - Person-driven;

  - Occurs via many pathways;

  - Is holistic;

  - Is supported by peers;

  - Is supported through relationships;

  - Is culturally-based and influenced;

  - Is supported by addressing trauma;

  - Involves individual, family, and community strengths and responsibility;

  - Is based on respect; and

  - Emerges from hope.

What youth need to recover from drug and alcohol misuse.

- According to National Institute on Drug Abuse:
  - Seek help
  - Embrace new habits
  - Take it one step at a time
  - Find treatment

  See NIDA website for details on each step.

The Intervention: Alternative Peer Groups

Our team of researchers collaborated to evaluate a non-profit, community agency recovery program for adolescents and young adults to see if these claims are true.

The TEAM

Clients		
Younger Group	Older Group	Parents

↓

Agency: Palmer Drug Abuse Program		
Executive Director	Staff	Stakeholders

↓

Consultant	
Consultant	Consultant

↓

Faculty	
Doctoral Assistant	Doctoral Assistant
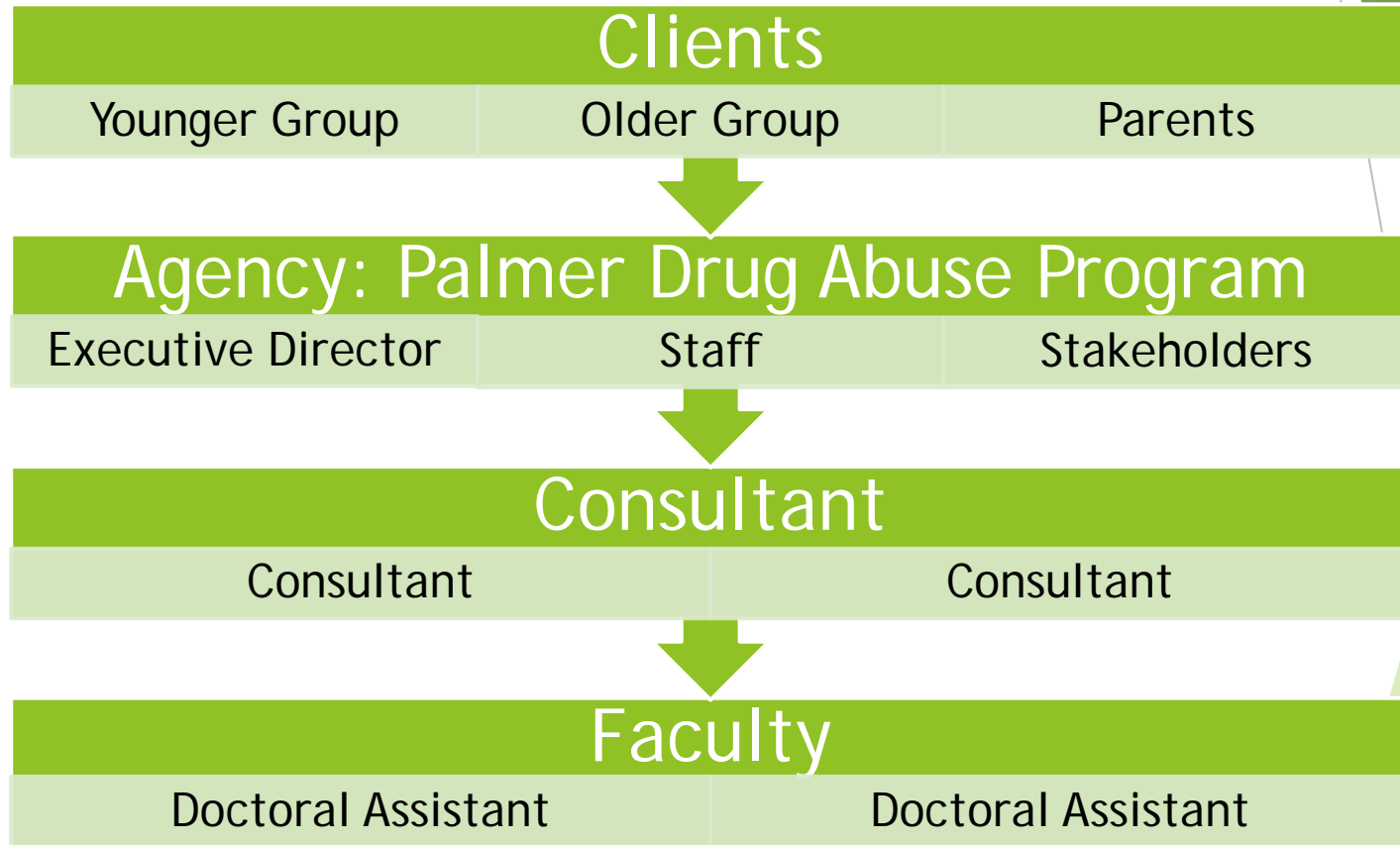
Alternative Peer Group Intervention

Components of the APG

- 12 step meetings
- Individual and family counseling
- Intensive outpatient groups
- After school hangouts
- Weekend social activities
- Collaboration with referring clinicians

Sober High Schools

Clients

▶ Clients: 13 to 18 younger group

18 to 25 older group

▶ Parents

The Agency: Palmer Drug Abuse Program (PDAP)

- Dr. Danielle Lutz, Executive Director, PDAP

- Bruce Nixon, Program Director, PDAP

- Counselors, Interns, Office staff

- Stakeholders: The Board, Community Stakeholders, Mental Health Agencies and Practitioners, the Community at-large

A few words from Dr. Danielle Lutz

Youth can expect to be in a group with their own peers where they can relate to each other in discussing common challenges and choices of positive solutions. They can expect an environment that is safe, sober, and where their information will remain confidential. Additionally, the youth are in an environment where they participate in recovery-oriented social activities. We want the youth to engage in behaviors that are typical for teenagers without the stress of drugs and alcohol being a trigger for other behaviors. (July, 2014)

Consultants

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    Counselor Education

    Sam Houston State University

- Steve Lackey

    Private practice

    Recent doctoral graduate

    Counselor Education

    Sam Houston State University

What we have learned from studying the Alternative Peer Group, or what our results show.
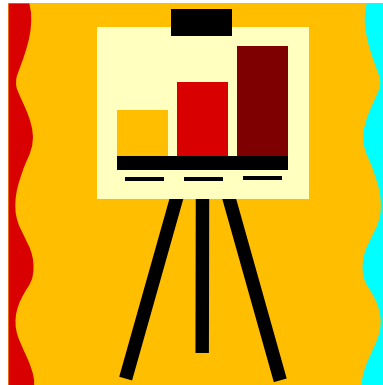
What works?

- Programs that focus on life and social skills are most effective

- Programs that involve interactions among participants and encourage them to learn drug refusal skills are more effective than non-interactive programs.

- Interventions that focus on direct and indirect (e.g., media) influences on substance use appear to be more effective than interventions that do not focus on social influences.

- Programs that emphasize norms for and a social commitment to not using drugs are superior to those without this emphasis.

- Adding community components to school-based programs appears to add to their effectiveness.

- Programs delivered primarily by peer leaders have increased effectiveness.

- Adding training in life skills to trainings that focus on social resistance skills may increase program effectiveness.

- Source: O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities. National Research Council and Institute of Medicine of the National Academies. Washington, D.C.: The National Academies Press.

Programs that focus on life and social skills

▶ it saved my *life*

▶ the number one defining moment in my *life*

▶ an opportunity to have *lifelong* friends and a career

▶ I had to learn to *live my life*

▶ *Life* was more than just surviving

Programs that involve interactions among participants

- it was more a kind of *positive peer pressure*

- the positive confirmation; getting that from *our peers*

- I needed to hear it from *other people*; so I didn't feel alone

- The real magic for me was the word *peer*

Interventions that focus on direct and indirect (e.g., media) influences on substance use appear to be more effective than interventions that do not focus on social influences

- began to participate in my social circles

- my behavior completely changed towards school

- the APG pressure was so magnetically affecting kids

- stay in touch through social media

Programs that emphasize norms for and a social commitment to not using drugs are superior to those without this emphasis.

- Gave us an *alternative peer group* to be associated with

- the only thing you had to do to be a part of this group; *be drug free*

- They made it fun to be *sober*

- A place to date girls and live life *free of drugs*

- Learned how to navigate life *without the use of drugs and alcohol*

Programs delivered primarily by peer leaders have increased effectiveness.

- I was on the *steering committee*

- I was on the very first *steering committee*

- have places of *leadership*; lead meetings; be on committees

Adding training in life skills to trainings that focus on social resistance skills may increase program effectiveness.

- There was a *solution to* dealing with *life's problems*

- it was more of a personal discussion about *life skills*

- began to teach me some *tools*

- I had the *skills* to change

- What you *need to succeed* literally exists within you

A LOGIC MODEL for the PALMER DRUG ABUSE PROGRAM

Inputs

Outputs

Outcomes - Impact

Staff
Partners
Funders
Volunteers
Time
Money
Materials
Office space
Mtg rooms
Equipment
Technology
	Conduct:
	  12 step mtg
	  parent mtg
	  education
	  training
	Provide:
	  counseling
	  activities
	Assess needs
	Develop curr
	
	Research
	Results
		Clients
		Parents
		Agencies
		Board
		Partners
		Schools
		Therapists
		Treatment
		
		Promote
		Funding
			Clients:
			Relationships
			Before/After
			Resentments
				Staff:
				  Clients served
				Public relations
				Evidence-based
				Funding
					Researchers:
					Service
					Experience
					Publications
					Presentations

RESULTS: explore preliminary results for the program evaluation of the Palmer Drug Abuse Program in Houston, Texas

Outcomes - Impact

Clients:
Relationships
  self
  peers
  higher being
Before &After
  life lessons
  accountable
Resentments

Staff:
  Clients served
  Public relations
  Evidence-based
  Funding

Stakeholders:
  Safe community
  Future leaders
  Collaboration

Researchers:
  Service
  Experience
  Publications
  Presentations

What We Learned: Peer Recovery Support Groups

Peer recovery support groups that:

▶ precede formal treatment, strengthen a peer's motivation for change

▶ accompany treatment, provide a community connection during treatment

▶ follow treatment, support relapse prevention

▶ are delivered apart from treatment to someone who cannot enter the formal treatment system or chooses not to do so, provides an opportunity for recovery

What We Learned: Strategies for Peer Support Groups

- Strengths-based rather than focusing on deficits

- Not a focus on telling war stories, but a place to find self-worth

- Encourage leadership; allow participants to "own" the program

- Understand and honor self-direction, empowerment, and choice

- Accept each participant and where he/she is in the recovery process

- Identify peer leaders and use them to help others

- The multiplier effect

What can you do?

- ▶ Be transparent (doing drugs is not a normal part of growing up)

- ▶ Know your community resources; visit and learn

- ▶ Collaborate with community agencies and other stakeholders

- ▶ Start your own alternative peer groups or support one coming to your neighborhood

- ▶ January 26 to February 1 – National Drug Facts Week

- ▶ PeerX Educators' Guide to Prescription Drug Abuse and other resources on the TCA website under this program

  - ▶ Facts, lesson plans, and resources

- ▶ Ask for help

How will you start?

► With a partner, discuss the community resources in your area.

► How can you partner with one, some, or all of them to provide support for teens who are interested in recovery?

► What is the first step you will take?

Dr. Danielle Lutz, Executive Director, Palmer Drug Abuse Program

PDAP has rich history in addressing youth substance abuse since 1971. We are proud to be the founding Alternative Peer Group (APG) model for adolescent recovery and appreciate being a part of the growth of services for youth and their families that supports a high level of success for Houston youth suffering from the devastating effects of drug and alcohol abuse. (July, 2014)

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National Institute on Drug Abuse

Preventing Drug Use
among Children and Adolescents

A Research-Based Guide
for Parents, Educators, and Community Leaders

Second Edition

National Institute on Drug Abuse

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Contents

Preface

Today's youth face many risks, including drug abuse, violence, and HIV/AIDS. Responding to these risks before they become problems can be difficult. One of the goals of the National Institute on Drug Abuse (NIDA) is to help the public understand the causes of drug abuse and to prevent its onset. Drug abuse has serious consequences in our homes, schools, and communities. From NIDA's perspective, the use of all illicit drugs and the inappropriate use of licit drugs is considered drug abuse.

Prevention science has made great progress in recent years. Many prevention interventions are being tested in "real-world" settings so they can be more easily adapted for community use. Scientists are studying a broader range of populations and topics. They have identified, for example, effective interventions with younger populations to help prevent risk behaviors before drug abuse occurs.

Researchers are also studying older teens who are already using drugs to find ways to prevent further abuse or addiction. Practical issues, such as cost-benefit analyses, are being studied. Presenting these findings to the public is one of NIDA's most important responsibilities.

We are pleased to offer our newest edition of the publication, *Preventing Drug Use among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community Leaders, Second Edition.* This edition includes updated principles, new questions and answers, new program information, and expanded references and resources. We also invite you to visit our Web site at www.drugabuse.gov where this publication and other materials related to the consequences, prevention, and treatment of drug abuse are offered. We hope that you will find the guide useful and helpful to your work.

Nora D. Volkow, M.D.
Director
National Institute on Drug Abuse

Introduction

In 1997, the National Institute on Drug Abuse (NIDA) published the first edition of *Preventing Drug Use among Children and Adolescents: A Research-Based Guide* to share the latest NIDA-funded prevention research findings with parents, educators, and community leaders. The guide introduced the concept of "research-based prevention" with questions and answers on risk and protective factors, community planning and implementation, and 14 prevention principles derived from effective drug abuse prevention research. Examples of research-tested prevention programs were also featured. The purpose was to help prevention practitioners use the results of prevention research to address drug abuse among children and adolescents in communities across the country.

Since then, NIDA's prevention research program has more than doubled in size and scope to address all stages of child development, a mix of audiences and settings, and the delivery of effective services at the community level. The Institute now focuses on risks for drug abuse and other problem behaviors that occur throughout a child's development. Prevention interventions designed and tested to address risks can help children at every step along their developmental path. Working more broadly with families, schools, and communities, scientists have found effective ways to help people gain the skills and approaches to stop problem behaviors before they occur. Research funded by NIDA and other Federal research organizations— such as the National Institute of Mental Health and the Centers for Disease Control and Prevention— shows that early intervention can prevent many adolescent risk behaviors.

This second edition, reflecting NIDA's expanded research program and knowledge base, is more than double the size of the first edition. The prevention principles have been expanded to provide more understanding about the latest research, and principles relevant to each chapter accompany the discussion. Additional questions and answers, a new chapter on community planning, and more information on the core elements in research-based prevention programs have been added. Each chapter ends with a "Community Action Box" for primary readers— parents, educators, and community leaders. As in the first edition, the descriptions of prevention programs are presented as examples of research-based programs currently available.

The expanded *Selected Resources* section offers Web sites, sponsored by Federal and private-sector agencies. Some feature registries of effective prevention programs with agency-specific selection criteria and other resources for community planning. The *Selected References* section includes up-to-date books and journal articles that provide more information on prevention research. NIDA hopes that this revised guide is helpful to drug abuse prevention efforts among children and adolescents in homes, schools, and communities nationwide.

Prevention Principles

These revised prevention principles have emerged from research studies funded by NIDA on the origins of drug abuse behaviors and the common elements found in research on effective prevention programs. Parents, educators, and community leaders can use these principles to help guide their thinking, planning, selection, and delivery of drug abuse prevention programs at the community level. The references following each principle are representative of current research.

Risk Factors and Protective Factors

PRINCIPLE 1   Prevention programs should enhance protective factors and reverse or reduce risk factors (Hawkins et al. 2002).

- The risk of becoming a drug abuser involves the relationship among the number and type of risk factors (e.g., deviant attitudes and behaviors) and protective factors (e.g., parental support) (Wills and McNamara et al. 1996).

- 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 (Gerstein and Green 1993; Kumpfer et al. 1998).

- Early intervention with risk factors (e.g., aggressive behavior 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 behaviors (Ialongo et al. 2001).

- 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 (Beauvais et al. 1996; Moon et al. 1999).

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 (Johnston et al. 2002).

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 (Hawkins et al. 2002).

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 (Oetting et al. 1997).

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 (Ashery et al. 1998).

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 (Kosterman et al. 1997).

- 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 behavior; and moderate, consistent discipline that enforces defined family rules (Kosterman et al. 2001).

- 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 (Bauman et al. 2001).

- Brief, family-focused interventions for the general population can positively change specific parenting behavior that can reduce later risks of drug abuse (Spoth et al. 2002b).

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 behavior, poor social skills, and academic difficulties (Webster-Stratton 1998; Webster-Stratton et al. 2001).

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 (Ialongo et al. 2001; Conduct Problems Prevention Work Group 2002b):

- 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 (Botvin et al.1995; Scheier et al. 1999):

- study habits and academic support;

- communication;

- peer relationships;

- self-efficacy and assertiveness;

- drug resistance skills;

- reinforcement of antidrug 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 (Botvin et al. 1995; Dishion et al. 2002).

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 (Battistich et al. 1997).

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 (Chou et al. 1998).

Prevention Program 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 (Spoth et al. 2002b), 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 followup programs in high school (Scheier et al. 1999).

PRINCIPLE 14 Prevention programs should include teacher training on good classroom management practices, such as rewarding appropriate student behavior. Such techniques help to foster students' positive behavior, achievement, academic motivation, and school bonding (Ialongo et al. 2001).

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 (Botvin et al. 1995).

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 of up to $10 in treatment for alcohol or other substance abuse can be seen (Pentz 1998; Hawkins 1999; Aos et al. 2001; Spoth et al. 2002a).

Chapter 1: Risk Factors and Protective Factors

This chapter describes how risk and protective factors influence drug abuse behaviors, the early signs of risk, transitions as high-risk periods, and general patterns of drug abuse among children and adolescents. A major focus is how prevention programs can strengthen protection or intervene to reduce risks.

What are risk factors and protective factors?

Studies over the past two decades have tried to determine the origins and pathways of drug abuse and addiction—how the problem starts and how it progresses. Many factors have been identified that help differentiate those more likely to abuse drugs from those less vulnerable to drug abuse. Factors associated with greater potential for drug abuse are called "risk" factors, while those associated with reduced potential for abuse are called "protective" factors. 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.

As discussed in the Introduction, risk and protective factors can affect children in a developmental *risk trajectory,* or path. This path captures how risks become evident at different stages of a child's life. For example, early risks, such as out-of-control aggressive behavior, may be seen in a very young child. If not addressed through positive parental actions, this behavior can lead to additional risks when the child enters school. Aggressive behavior in school can lead to rejection by peers, punishment by teachers, and academic failure. Again, if not addressed through preventive interventions, these risks can lead to the most immediate behaviors that put a child at risk for drug abuse, such as skipping school and associating with peers who abuse drugs. In focusing on the risk path, research-based prevention programs can intervene early in a child's development to strengthen protective factors and reduce risks long before problem behaviors develop.

The table below provides a framework for characterizing risk and protective factors in five *domains,* or settings. These domains can then serve as a focus for prevention. As the first two examples suggest, some risk and protective factors are mutually exclusive—the presence of one means the absence of the other. For example, in the Individual domain, early aggressive behavior, a risk factor, indicates the absence of impulse control, a key protective factor. Helping a young child learn to control impulsive behavior is a focus of some prevention programs.

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

Other risk and protective factors are independent of each other, as demonstrated in the table as examples in the peer, school, and community domains. For example, in the school domain, drugs may be available, even though the school has "antidrug policies." An intervention may be to strengthen enforcement so that school policies create the intended school environment.

Risk factors for drug abuse represent challenges to an individual's emotional, social, and academic development. These risk factors can produce different effects, depending on the individual's personality traits, phase of development, and environment. For instance, many serious risks, such as early aggressive behavior and poor academic achievement, may indicate that a young child is on a negative developmental path headed toward problem behavior. Early intervention, however, can help reduce or reverse these risks and change that child's developmental path.

For young children already exhibiting serious risk factors, delaying intervention until adolescence will likely make it more difficult to overcome risks. By adolescence, children's attitudes and behaviors are well established and not easily changed.

Risk factors can influence drug abuse in several ways. They may be additive: The more risks a child is exposed to, the more likely the child will abuse drugs. Some risk factors are particularly potent, yet may not influence drug abuse unless certain conditions prevail. Having a family history of substance abuse, for example, puts a child at risk for drug abuse. However, in an environment with no drug-abusing peers and strong antidrug norms, that child is less likely to become a drug abuser. And the presence of many protective factors can lessen the impact of a few risk factors. For example, strong protection—such as parental support and involvement—can reduce the influence of strong risks, such as having substance-abusing peers. *An important goal of prevention, then, is to change the balance between risk and protective factors so that protective factors outweigh risk factors.*

Chapter 1 **Principles**

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 behaviors) 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 behavior 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 behaviors.

- 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.

Gender may also determine how an individual responds to risk factors. Research on relationships within the family shows that adolescent girls respond positively to parental support and discipline, while adolescent boys sometimes respond negatively. Research on early risk behaviors in the school setting shows that aggressive behavior in boys and learning difficulties in girls are the primary causes of poor peer relationships. These poor relationships, in turn, can lead to social rejection, a negative school experience, and problem behaviors including drug abuse.

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

Some signs of risk can be seen as early as infancy. Children's personality traits or temperament can place them at increased risk for later drug abuse. Withdrawn and aggressive boys, for example, often exhibit problem behaviors in interactions with their families, peers, and others they encounter in social settings. If these behaviors continue, they will likely lead to other risks. These risks can include academic failure, early peer rejection, and later affiliation with deviant peers, often the most immediate risk for drug abuse in adolescence. Studies have shown that children with poor academic performance and inappropriate social behavior at ages 7 to 9 are more likely to be involved with substance abuse by age 14 or 15.

In the Family

Children's earliest interactions occur within the family and can be positive or negative. For this reason, factors that affect early development in the family are probably the most crucial. Children are more likely to experience risk when there is:

- lack of mutual attachment and nurturing by parents or caregivers;

- ineffective parenting;

- a chaotic home environment;

- lack of a significant relationship with a caring adult; and

- a caregiver who abuses substances, suffers from mental illness, or engages in criminal behavior.

These experiences, especially the abuse of drugs and other substances by parents and other caregivers, can impede bonding to the family and threaten feelings of security that children need for healthy development. On the other hand, families can serve a protective function when there is:

- a strong bond between children and their families;

- parental involvement in a child's life;

- supportive parenting that meets financial, emotional, cognitive, and social needs; and

- clear limits and consistent enforcement of discipline.

Finally, critical or sensitive periods in development may heighten the importance of risk or protective factors. For example, mutual attachment and bonding between parents and children usually occurs in infancy and early childhood. If it fails to occur during those developmental stages, it is unlikely that a strong positive attachment will develop later in the child's life.

Outside the Family

Other risk factors relate to the quality of children's relationships in settings outside the family, such as in their schools, with their peers, teachers, and in the community. Difficulties in these settings can be crucial to a child's emotional, cognitive, and social development. Some of these risk factors are:

- inappropriate classroom behavior, such as aggression and impulsivity;

- academic failure;

- poor social coping skills;

- association with peers with problem behaviors, including drug abuse; and

- misperceptions of the extent and acceptability of drug-abusing behaviors in school, peer, and community environments.

Association with drug-abusing peers is often the most immediate risk for exposing adolescents to drug abuse and delinquent behavior. Research has shown, however, that addressing such behavior in interventions can be challenging. For example, a recent study (Dishion et al. 2002) found that placing high-risk youth in a peer group intervention resulted in negative outcomes. Current research is exploring the role that adults and positive peers can play in helping to avoid such outcomes in future interventions.

Other factors—such as drug availability, drug trafficking patterns, and beliefs that drug abuse is generally tolerated—are also risks that can influence young people to start to abuse drugs.

Family has an important role in providing protection for children when they are involved in activities outside the family. When children are outside the family setting, the most salient protective factors are:

- age-appropriate parental monitoring of social behavior, including establishing curfews, ensuring adult supervision of activities outside the home, knowing the child's friends, and enforcing household rules;

- success in academics and involvement in extracurricular activities;

- strong bonds with prosocial institutions, such as school and religious institutions; and

- acceptance of conventional norms against drug abuse.

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

Research has shown that the key risk periods for drug abuse occur during major transitions in children's lives. These transitions include significant changes in physical development (for example, puberty) or social situations (such as moving or parents divorcing) when children experience heightened vulnerability for problem behaviors.

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 or junior high school, they often experience new academic and social situations, such as learning to get along with a wider group of peers and having greater expectations for academic performance. It is at this stage—early adolescence—that children are likely to encounter drug abuse for the first time.

Then, when they enter high school, young people face additional social, psychological, and educational challenges. At the same time, they may be exposed to greater availability of drugs, drug abusers, and social engagements involving drugs. These challenges can increase the risk that they will abuse alcohol, tobacco, and other drugs.

A particularly challenging situation in late adolescence is moving away from home for the first time without parental supervision, perhaps to attend college or other schooling. Substance abuse, particularly of alcohol, remains a major public health problem for college populations.

When young adults enter the workforce or marry, they again confront new challenges and stressors that may place them at risk for alcohol and other drug abuse in their adult environments. But these challenges can also be protective when they present opportunities for young people to grow and pursue future goals and interests. Research has shown that these new lifestyles can serve as protective factors as the new roles become more important than being involved with drugs.

Risks appear at every transition from early childhood through young adulthood; therefore, prevention planners need to consider their target audiences and implement programs that provide support appropriate for each developmental stage. They also need to consider how the protective factors involved in these transitions can be strengthened.

When and how does drug abuse start and progress?

Studies such as the National Survey on Drug Use and Health, formerly 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 by age 12 or 13, which likely means that some may begin even earlier. Early abuse includes such drugs as tobacco, alcohol, inhalants, marijuana, and psychotherapeutic drugs. If drug abuse persists into later adolescence, abusers typically become more involved with marijuana and then advance to other illegal drugs, while continuing their abuse of tobacco and alcohol. Studies have also shown that early initiation of drug abuse is associated with greater drug involvement, whether with the same or different drugs. Note, however, that both one-time and long-term surveys indicate that most youth do not progress to abusing other drugs. But among those who do progress, their drug abuse history can vary by neighborhood drug availability, demographic groups, and other characteristics of the abuser population. In general, the pattern of abuse is associated with levels of social disapproval, perceived risk, and the availability of drugs in the community.

Scientists have proposed several hypotheses as to why individuals first become involved with drugs and then escalate to abuse. One explanation is a biological cause, such as having a family history of drug or alcohol abuse, which may genetically predispose a person to drug abuse. Another explanation is that starting to abuse a drug may lead to affiliation with more drug-abusing peers which, in turn, exposes the individual to other drugs. Indeed, many factors may be involved.

Different patterns of drug initiation have been identified based on gender, race or ethnicity, and geographic location. For example, research has found that the circumstances in which young people are offered drugs can depend on gender. Boys generally receive more drug offers and at younger ages. Initial drug abuse can also be influenced by where drugs are offered, such as parks, streets, schools, homes, or parties. Additionally, drugs may be offered by different people including, for example, siblings, friends, or even parents.

While most youth do not progress beyond initial use, a small percentage rapidly escalate their substance abuse. Researchers have found that these youth are the most likely to have experienced a combination of high levels of risk factors with low levels of protective factors. These adolescents were characterized by high stress, low parental support, and low academic competence.

However, there are protective factors that can suppress the escalation to substance abuse. These factors include self-control, which tends to inhibit problem behavior and often increases naturally as children mature during adolescence. In addition, protective family structure, individual personality, and environmental variables can reduce the impact of serious risks of drug abuse. Preventive interventions can provide skills and support to high-risk youth to enhance levels of protective factors and prevent escalation to drug abuse.

COMMUNITY ACTION BOX

Parents can use information on risk and protection to help them develop positive preventive actions (e.g. talking about family rules) before problems occur.

Educators can strengthen learning and bonding to school by addressing aggressive behaviors and poor concentration—risks associated with later onset of drug abuse and related problems.

Community Leaders can assess community risk and protective factors associated with drug problems to best target prevention services.

Chapter 2: Planning for Drug Abuse Prevention in the Community

This chapter presents a process to help communities as they plan to implement research-based prevention programs. It provides guidance on applying the prevention principles, assessing needs and community readiness, motivating the community to take action, and evaluating the impact of the programs implemented. Additional planning resources are highlighted in *Selected Resources and References.*

How can the community develop a plan for research-based prevention?

Prevention research suggests that a well-constructed community plan incorporates the characteristics outlined in the following box.

THE COMMUNITY PLAN

- **Identifies** the specific drugs and other child and adolescent problems in a community;

- **Builds** on existing resources (e.g., current drug abuse prevention programs);

- **Develops** short-term goals relevant to implementation of research-based prevention programs;

- **Projects** long-term objectives so that plans and resources are available for the future; and

- **Incorporates** ongoing assessments to evaluate the effectiveness of prevention strategies.

Planning Process

Planning usually starts with an assessment of drug abuse and other child and adolescent problems, which includes measuring the level of substance abuse in the community as well as examining the level of other community risk factors (e.g., poverty) [see section on "How can the community assess the level of risk for drug abuse?" for more details]. The results of the assessment can be used to raise community awareness of the nature and seriousness of the problem and guide the selection of programs most relevant to the community's needs. This is an important process, whether a community is selecting a school-based prevention curriculum or planning multiple interventions that cut across the entire community.

Next, an assessment of the community's readiness for prevention can help determine additional steps that are needed to educate the community before beginning the prevention effort. Then, a review of existing programs is needed to determine gaps in addressing community needs and identifying additional resources.

Finally, community planning can benefit from contributions of community organizations that provide services to youth. Convening a meeting of leaders of youth-serving organizations can aid in coordinating ideas, resources, and expertise to help implement and sustain research-based programs. Planning for implementation and sustainability requires resource development for staffing and management, long-term funding commitments, and linkages with existing delivery systems.

How can the community use the prevention principles in prevention planning?

Several prevention principles provide a framework for effective prevention planning and programming by presenting key concepts in implementing research-

based prevention. Consider, for example, **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."** This principle describes how the plan should reflect the reality of the drug problem in that community and, importantly, what needs to be done to address it.

Community-wide efforts also can be guided by **Principle 9: "Prevention programs aimed at general populations at key transition points . . . can produce beneficial effects, even among high-risk families and children."** With carefully structured programs, the community can provide services to all populations, including those at high risk, without labeling or stigmatizing them.

In implementing a more specific program, such as a family program within the educational system, the principles address some of the required content areas. For instance, **Principle 5 states, "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."**

The principles offer guidance for selecting or adapting effective programs that meet specific community needs. *It is important to recognize, however, that not every program that seems consistent with these research-based prevention principles is necessarily effective.* To be effective, programs need to incorporate the core elements identified in research (see Chapter 3). These include appropriate structure and content, adequate resources for training and materials, and other implementation requirements.

For more information on resources to help communities in prevention planning and the research underlying the prevention principles, see *Selected Resources and References*.

Chapter 2 **Principles**

Principles for Prevention Planning

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.

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.

How can the community assess the level of risk for drug abuse?

To assess the level of risk of youth engaging in drug abuse, it is important to:

- measure the nature and extent of drug abuse patterns and trends;

- collect data on the risk and protective factors throughout the community;

- understand the community's culture and how that culture affects and is affected by drug abuse;

- consult with community leaders working in drug abuse prevention, treatment, law enforcement, mental health, and related areas;

- assess community awareness of the problem; and

- identify existing prevention efforts already under way to address the problem.

Researchers have developed many tools to assess the extent of a community's drug problem. Most of these tools assess the nature of the problem—what drugs are available and who is abusing them. Some of them assess the extent of abuse by estimating how many people are abusing drugs. Others assess factors associated with abuse, such as juvenile delinquency, school absenteeism, and school dropout rates. Researchers have also developed instruments that assess individual risk status. It is important when beginning the assessment process to collect sufficient information to help local planners target the intervention by population and geographic area.

As an example, the **Communities That Care** prevention operating system, developed by Hawkins and colleagues at the University of Washington (Hawkins et al. 2002), is based on epidemiological methods. An assessment is conducted to collect data on the distribution of risk and protective factors at the community level. This approach helps local planners identify geographic areas with the highest levels of risk and the lowest levels of protective resources. This analysis tool assists planners in selecting the most effective prevention interventions to address the specific risks of neighborhoods.

Other data sources and measurement instruments (such as questionnaires) that can help in community planning include the following resources.

- **Public access data.** Several large national surveys provide data to help local communities understand how their drug problems relate to the national picture. These include the National Survey on Drug Use and Health, Monitoring the Future Study, and Youth Behavior Risk Study. Information on accessing these data is provided in *Selected Resources and References.*

- **Public access questionnaires.** The studies listed above and many other federally sponsored data sets make the data collection instruments available for adaptation and use by the public. Communities can conduct local studies using these instruments to collect uniform data that can often be compared with national findings.

- **Archival data.** Data from public access files from school systems, health departments, hospital emergency rooms, law enforcement agencies, and drug abuse treatment facilities can be analyzed to identify the nature of the local drug problem and other youth problems.

- **Ethnographic studies.** Ethnographic approaches use systematic, observational processes to describe behaviors in natural settings, such as studying the abuse of drugs by youth gangs, and documenting the individual perspectives of those under observation.

- **Other qualitative methods.** Other qualitative methods, such as convening focus groups of representatives of drug-abusing subpopulations or key interviews with community officials, can be used to gain a greater understanding of the local drug abuse problem.

As each of these methods has advantages and disadvantages, it is advisable, permitting resources, to use multiple strategies to assess community risk to provide the best information possible.

The Community Epidemiology Work Group (CEWG), another data source pioneered in the early 1970s by NIDA and communities nationwide, is composed of researchers from 21 U.S. cities who collect or use archival data to characterize the nature of the drug problem in their locations. CEWG representatives meet with NIDA biannually to inform the Institute and fellow CEWG members of changing drug trends in their cities. The work group has developed a *Guide for Community Epidemiology Surveillance Networks on Drug Abuse* to help other communities use this approach to provide up-to-date information on local drug abuse problems.

Using information obtained through these many sources can help community leaders make sound decisions about programs and policies. Analyzing these data before implementing new programs can also help establish a baseline for evaluating results. To be most informative, periodic assessments need to be made routinely.

For more information on how communities can assess the level or risk of drug abuse in their community, see *Selected Resources and References.*

Is the community ready for prevention?

Identifying a serious level of risk in a community does not always translate into community readiness to take action. Based on studies of many small communities, researchers have identified nine stages of readiness that can guide prevention planning (Plested et al. 1999). Applying measures to assess readiness, prevention planners can then identify the critical steps needed to implement programs (see table on page 20). Although much of the research on the stages of community readiness has examined small communities, large communities find that these stages provide a structure to describe levels of awareness of drug issues in their community and readiness to embrace a prevention program. Awareness is assessed at two levels: that of the public (by examining the nature and level of drug coverage in the news) and that of officials (by determining if they have taken a position on drug abuse in the community).

Community leaders can begin assessing their community's readiness by interviewing key informants in their community. Additional planning and program sources can be found in *Selected Resources and References*. Web sites, contact information, and publications offer further information to guide community efforts.

ASSESSING READINESS*		COMMUNITY ACTION
Readiness Stage	**Community Response**	**Ideas**
1. No awareness	Relative tolerance of drug abuse	Create motivation. Meet with community leaders involved with drug abuse prevention; use the media to identify and talk about the problem; encourage the community to see how it relates to community issues; begin preplanning.
2. Denial	Not happening here, can't do anything about it	
3. Vague awareness	Awareness, but no motivation	
4. Preplanning	Leaders aware, some motivation	
5. Preparation	Active energetic leadership and decisionmaking	Work together. Develop plans for prevention programming through coalitions and other community groups.
6. Initiation	Data used to support prevention actions	Identify and implement research-based programs.
7. Stabilization	Community generally supports existing program	Evaluate and improve ongoing programs.
8. Confirmation/ Expansion	Decisionmakers support improving or expanding programs	Institutionalize and expand programs to reach more populations.
9. Professionalization	Knowledgeable of community drug problem; expect effective solutions	Put multicomponent programs in place for all audiences.

* Plested et al. 1999.

How can the community be motivated to implement research-based prevention programs?

The methods needed to motivate a community to act depend on the particular community's stage of readiness. At lower stages of readiness, individual and small group meetings may be needed to attract support from those with great influence in the community. At higher levels of readiness, it may be possible to establish a community board or coalition of key leaders from public- and private-sector organizations. This can provide the impetus for action.

Community coalitions can and do hold community-wide meetings, develop public education campaigns, present data that support the need for research-based prevention programming, and attract sponsors for comprehensive drug abuse prevention strategies.

But care is needed in organizing a community-level coalition to ensure that its programming incorporates research-tested strategies and programs—at the individual, school, and community levels. Having a supportive infrastructure that includes representatives across the community can reinforce prevention messages, provide resources, and sustain prevention programming. Introducing a school-based curriculum, however, requires less community involvement, but is still a focused preventive effort.

Research has shown that prevention programs can use the media to raise public awareness of the seriousness of a community's drug problem and prevent drug abuse among specific populations. Using local data and speakers from the community demonstrates that the drug problem is real and that action is needed. Providing some of the examples of research-based programs described in Chapter 4 can help mobilize the community for change.

How can the community assess the effectiveness of current prevention efforts?

Assessing prevention efforts can be challenging for a community, given limited resources and limited access to expertise in program evaluation. Many communities begin the process with a structured review of current prevention programs to determine:

✔ *What programs are currently in place in the community?*

✔ *Were strict scientific standards used to test the programs during their development?*

✔ *Do the programs match community needs?*

✔ *Are the programs being carried out as designed?*

✔ *What percentage of at-risk youth is being reached by the program?*

Another evaluation approach is to track existing data over time on drug abuse among students in school, rates of truancy, school suspensions, drug-abuse arrests, and drug-related emergency room admissions. The use of the information obtained in the initial community drug abuse assessment can serve as a baseline for measuring change in long-term trends. Because the nature and extent of drug abuse problems can change with time, it is wise to periodically assess community risk and protective factors to help ensure that the programs in place appropriately address current community needs.

Communities may wish to consult with State and county prevention authorities for assistance in planning and implementation efforts. Also, federally supported publications and other resources are available, as noted in *Selected Resources and References*.

In assessing the impact of individual programs, it is important for communities to document how well the program is delivered and the level of intervention participants receive. For example, in assessing a school-based prevention program, key questions to be asked include:

✔ *Have the teachers mastered the content and interactive teaching strategies needed for the selected curriculum?*

✔ *How much exposure have the students had to each content area?*

✔ *Is there an assessment component?*

The community plan should guide actions for prevention over time. Once communities are mobilized, program implementation and sustainability require clear, measurable goals, long-term resources, sustained leadership, and community support to maintain momentum for preventive change. Continuing evaluations keep the community informed and allow for periodic reassessment of needs and goals.

COMMUNITY ACTION BOX

◎ **Parents** can work with others in their community to increase awareness about the local drug abuse problem and the need for research-based prevention programs.

◎ **Educators** can work with others in their school and school system to review current programs, and identify research-based prevention interventions appropriate for students.

◎ **Community Leaders** can organize a community group to develop a community prevention plan, coordinate resources and activities, and support research-based prevention in all sectors of the community.

Chapter 3: Applying Prevention Principles to Drug Abuse Prevention Programs

This chapter describes how the prevention principles have been applied to create effective family, school, and community programs. It offers information on working with risk and protective factors, adapting programs while maintaining fidelity to core elements, implementing and evaluating programs, and understanding the cost-benefits of research-based prevention. The goal is to help communities implement research-based prevention programs.

How are risk and protective factors addressed in prevention programs?

Risk and protective factors are the primary targets of effective prevention programs used in the family, school, and community settings. Prevention programs are usually designed to reach specific populations in their primary settings, such as reaching children at school or through recreational or after-school programs. However, in recent years it has become more common to find programs for any given target group in a variety of settings, such as holding a family-based program in a school or a church. The goal of these programs is to build new and strengthen existing protective factors and reverse or reduce modifiable risk factors in youth.

Prevention programs can be described by the audience or intervention level for which they are designed:

- *Universal* programs are designed for the general population, such as all students in a school.

- *Selective* programs target groups at risk, or subsets of the general population such as children of drug abusers or poor school achievers.

- *Indicated* programs are designed for people who are already experimenting with drugs.

Tiered programs, such as the **Adolescent Transitions Program,** incorporate all three levels of intervention. Others, such as **Early Risers "Skills for Success" Prevention Program,** may have only two levels of intervention.

Details of the programs used as examples in the following sections are provided in Chapter 4.

In the Family

Prevention programs can strengthen protective factors among young children by teaching parents better family communication skills, developmentally appropriate discipline styles, firm and consistent rule enforcement, and other family management skills. Parents also can be taught how to increase their emotional, social, cognitive, and material support, which includes, for example, meeting their children's financial, transportation, health care, and homework needs. Research confirms the benefit of parents taking a more active role in their children's lives, by talking with them about drugs, monitoring their activities, getting to know their friends, understanding their problems and concerns, providing consistent rules and discipline, and being involved in their learning and education. The importance of the parent-child relationship continues through adolescence and beyond.

An example of a *universal* family-based program is the **Strengthening Families Program For Parents and Youth, 10–14,** which provides rural parents guidance on family management skills, communication,

academic support, and parent-child relationships. Recognizing that it can be difficult to attract parents to this program, the researchers encourage participation through flexibility in scheduling and location. Offering conveniences such as babysitting, transportation, and meals make participation more practical for many rural parents, while enhancing the program's success in reaching its goals.

Another type of family program operates within a school setting. **The Adolescent Transitions Program,** for example, is a *tiered* intervention family program. All families can get involved with the *universal* intervention, which makes available a Family Resource Room where information on parenting is provided. The Family Check-Up, the *selective* level of this program, is an assessment process to identify and help families at greater risk by providing them with information and interventions specific to their needs. Families already engaged in problem behaviors and identified as needing an *indicated* intervention are provided more intense assistance and information tailored to their problem. Such assistance might include, for example, individual or family therapy, intensive parent coaching, therapeutic foster care, or other family-specific interventions. The uniqueness of the *tiered* approach is that the whole school participates in the program and all individuals or families receive the appropriate level of help without being labeled in the process.

In School

Prevention programs in schools focus on children's social and academic skills, including enhancing peer relationships, self-control, coping skills, social behaviors, and drug offer refusal skills. School-based prevention programs should be integrated within the school's own goal of enhanced academic performance. Evidence is emerging that a major risk for school failure is a child's inability to read by the third and fourth grades (Barrera et al. 2002), and school failure is strongly associated with drug abuse. Integrated programs strengthen students' bonding to school and reduce their likelihood of dropping out. Most prevention curricula include a normative education component designed to correct the misperception that many students are abusing drugs.

Chapter 3 **Principles**

Principles for 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.

PRINCIPLE 6   Prevention programs can be designed to intervene as early as *preschool* to address risk factors for drug abuse, such as aggressive behavior, 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.

PRINCIPLE 8   Prevention programs for *middle* or *junior high* and *high school students* should increase academic and social competence.

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.

Chapter 3 **Principles**

Principles for Program 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.

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 followup programs in high school.

PRINCIPLE 14 Prevention programs should include teacher training in good classroom management practices, such as rewarding appropriate student behavior. Such techniques help to foster student's positive behavior, 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 of up to $10 in treatment for alcohol or other substance abuse can be seen.

Most research-based prevention interventions in schools include curricula that teach many of the behavioral and social skills described above. The **Life Skills Training Program** exemplifies *universal* classroom programs that are provided to middle-schoolers. The program teaches drug resistance, self-management, and general social skills in a 3-year curriculum, with the third year a booster session offered when students enter high school.

The Caring School Community Program is another type of school-based intervention. This *universal* elementary school program focuses on establishing a "sense of community" among the classroom, school, and family settings. The community support that results helps children succeed in school and cope with stress and other problems when they occur.

An *indicated* intervention that reaches high school students, **Project Towards No Drug Abuse** focuses on students who have failed to succeed in school and are engaged in drug abuse and other problem behaviors. The program seeks to rebuild students' interest in school and their future, correct their misperceptions about drug abuse, and strengthen protective factors, including positive decisionmaking and commitment.

Recent research suggests caution when grouping high-risk teens in peer group interventions for drug abuse prevention. Such groups have been shown to produce negative effects, as participants appear to reinforce substance abuse behaviors over time (Dishion et al. 2002). Research is examining how to prevent such effects, with a particular focus on the role of adults and positive peers.

In the Community

Prevention programs work at the community level with civic, religious, law enforcement, and other government organizations to enhance antidrug norms and prosocial behaviors. Strategies to change key aspects of the environment are often employed at the community level. These can involve instituting new policies, such as the drug-free school concept, or strengthening community practices, such as asking for proof of age to buy cigarettes.

Many programs coordinate prevention efforts across settings to communicate consistent messages through school, work, religious institutions, and the media. Research has shown that programs that reach youth through multiple sources can strongly impact community norms (Chou et al. 1998). Community-based programs also typically include development of policies or enforcement of regulations, mass media efforts, and community-wide awareness programs. Examples include establishing youth curfew, having advertising restrictions, reducing the density of alcohol outlets in the community, raising cigarette prices, and creating drug-free school zones. Some carefully structured and targeted media interventions have proven to be very effective in reducing drug abuse. For example, a mass media campaign targeting sensation-seeking youth reduced marijuana abuse by 27 percent among high sensation-seeking youth (Palmgreen et al. 2001).

Project STAR is an example of a multicomponent drug abuse prevention program for the community. This project tested whether a coordinated effort that encompassed schools, parents, community organizations, health policies, and the media could make a difference in preventing drug abuse among youth. **Project STAR** reached all children and families in the community. The middle school curriculum was the core of the program and was reinforced by homework and other activities of the parent component. Health policies and mass media components were incorporated as well. Long-term followup studies have shown significant impacts in reducing substance abuse, with benefits lasting well into participants' adult years.

What are the core elements of effective research-based prevention programs?

In recent years, many research-based prevention programs have proven effective. These programs were tested with rigorous designs in diverse communities in a wide variety of settings, and with a variety of populations. The most rigorous design tests the program's effects on a group that receives the intervention (i.e., "experimental group") and compares results to a second group that did not receive the intervention (i.e., "control group").

As communities review prevention programs to determine which best fit their needs, the following core elements of effective research-based programs should be considered.

- *Structure*—how each program is organized and constructed;

- *Content*—how the information, skills, and strategies are presented; and

- *Delivery*—how the program is selected or adapted and implemented, as well as how it is evaluated in a specific community.

When adapting programs to match community characteristics, it is important to retain these core elements to ensure that the most effective aspects of the program remain intact. Core elements help build effective research-based prevention programs.

Each core element contains descriptive features, which are presented in the following sections. Tables are included in each section to provide examples of how these features fit together in programs.

Structure

Structure addresses *program type, audience,* and *setting.* Several program types have been shown to be effective in preventing drug abuse. School-based programs, the first to be fully developed and tested, have become the primary approach for reaching all children. Family-based programs have proven effective in reaching both children and their parents in a variety of settings. Media and computer technology programs are beginning to demonstrate effectiveness in reaching people at the community level as well as the individual level. ***Research also shows that combining two or more effective programs, such as family and school programs, can be even more effective than a single program alone. These are called multicomponent programs.***

The following examples illustrate program structure:

Structure of Prevention Programs		
Program Type	Audience	Setting
Community (Universal)	All Youth	Billboards
School (Selective)	Middle School Students	After-School
Family (Indicated)	High-Risk Youth and Their Families	Clinic

Within these categories, programs have been designed to specifically target the needs of a particular audience, such as an indicated prevention program for high-risk boys. Examples of other subcategories would include urban or rural populations, racial and ethnic minorities, and different age groups. Researchers are testing how to modify effective programs to best address such audience differences.

The setting describes where the program takes place. Prevention programs are usually designed to reach target populations in their primary setting, such as reaching children at school. It is becoming more common, however, for effective programs to be conducted in settings other than their primary setting—for example, holding a family-based program in a school or a school-based program in a youth organization such as Boys/Girls Clubs. Multicomponent programs reach populations in a variety of settings.

Content

Content is composed of *information, skills development, methods,* and *services.* Information can include facts about drugs and their effects, as well as drug laws and policies. Drug information alone, however, has not been found to be effective in deterring drug abuse. Combining information with skills, methods, and services produces more effective results. Programs include skills development training to build and improve behaviors in important areas, such as communication within the family, social and emotional development, academic and social competence in children, and peer resistance strategies in adolescents.

Methods are oriented toward structural change, such as establishing and enforcing school rules on substance abuse, or enforcing existing laws, such as those on tobacco sales to minors. Services could include school counseling and assistance, peer counseling, family therapy, and health care. These content areas are designed to reduce modifiable risk factors and strengthen protective factors.

The table below describes the type of content included in programs.

Content of Prevention Programs				
Program Types	Information	Skills Development	Methods	Services
Community	Drug Trends	Social Skills	Tolerance Policies	Drug-Free Zones
School	Drug Effects	Resistance Skills	Norms Change	School Counseling and Assistance
Family	Drug Abuse Symptoms	Parenting Skills	Home Drug-Testing; Curfew	Family Therapy

Delivery

Delivery includes program *selection* or *adaptation* and *implementation*. The following table describes various delivery approaches.

Delivery of Prevention Programs		
Program Type	Program Selection or Adaptation	Implementation Features
Community	Spanish-Speaking Population	Consistent Multimedia Messages
School	Gender	Booster Sessions
Family	Rural	Recruitment/ Retention

During the selection process, communities match effective research-based programs to their community needs. In Chapter 2, it was suggested that communities conduct a structured review of existing programs to determine what gaps remain, given risk and protective factors in the community and the community's drug problems and needs. This information can then be incorporated into the community plan, which guides the selection of new research-based programs. For initial guidance to aid the selection process, communities can refer to the description of programs in several categories found in Chapter 4. Additional planning and program resources can be found in *Selected Resources and References,* which offers Web sites, contact information, and publications to guide community efforts.

Adaptation involves shaping a program to fit the needs of a specific population in various settings. Scientists have been exploring how best to culturally adapt effective programs to a specific environment (such as a rural environment) and population (only boys, for example). In the process of adaptation, the program's core elements are maintained to ensure the effectiveness of the intervention, while addressing the community's needs. Several research-based adapted programs are now available, such as the **Life Skills Training Program** for inner-city minority youth.

For programs that have not yet been adapted and studied in a research protocol, it is best to implement the program as designed to ensure the most effective outcomes. Implementation refers to how the program is delivered, including the number of sessions, methods used, and program followup. Research has found that *how* a program is implemented can determine its effectiveness in preventing drug abuse.

Use of interactive methods and appropriate booster sessions helps to reinforce earlier program content and skills to maintain program benefits.

How can the community implement and sustain effective prevention programs?

After considering risk and protective factors within the community and selecting and adapting prevention programs to address those risks, the community must begin to implement those programs. In many communities, coalitions formed during the community planning process remain involved in overseeing program implementation. They continue to review progress toward goals and objectives set out in the community plan. Responsibility for actual implementation, however, generally resides within the local public or private community-based organization in the educational, social service, or other local system implementing the programs.

To ensure effective implementation, research-based school and family programs often require extensive human and financial resources and a serious commitment to training and technical assistance. In addition to resources, special attention is needed to attract and keep program participants interested and involved in the programs. This is especially important when involving families in rural and poverty settings. Research has shown that extra effort in providing incentives, maximal schedule flexibility, minimal time demands, free meals, transportation, baby-sitting, personal contact, and endorsement from important community leaders all help to attract and retain program participants. In short, how a program is delivered to specific audiences is critical to its success.

How can the community evaluate the impact of its program on drug abuse?

Conducting evaluations of community prevention programs can be challenging. Many community leaders have consulted with university faculty members and other local and State evaluation experts to assist in designing and implementing evaluation procedures.

Ensuring appropriate evaluation design is important because errors can result in findings that do not show a clear relationship between the program and the outcomes. Were the results truly attributable to the program's effects and not some other source, such as other community events or the maturation of the target groups?

An evaluation should identify what was accomplished in the program, how it was carried out, and its effects. To ensure a thorough evaluation, the program implementer and staff should assess ongoing adherence to program elements. Keeping records of content delivered, session attendance, content feedback quizzes, and independent observations of implementation fidelity can help monitor the effectiveness of program implementation and provide key information on why a program is or is not achieving its intended effects.

Evaluation pitfalls can be avoided by consulting with experts who can guide the evaluation design by:

- using tested data-collection instruments;

- obtaining good baseline, or preintervention, information;

- using control or comparison groups who did not receive the intervention, but whose characteristics are similar to those who did receive it;

- monitoring the quality of program implementation;

- ensuring that postintervention followup includes a large percentage of the target population; and

- using appropriate statistical methods to analyze the data.

In addition to assessing program impact, evaluation is an ongoing process that can provide guidance on maintaining the program's responsiveness to changing community needs.

The evaluation process needs to answer questions about the program and its outcomes, including:

- ✔ *What was accomplished in the program?*

- ✔ *How was the program carried out?*

- ✔ *Who participated in it?*

- ✔ *How much of the program was received by participants?*

- ✔ *Is there a connection between the amount of program received and outcomes?*

- ✔ *Was the program implemented as intended?*

- ✔ *Did the program achieve what was expected in the short term?*

- ✔ *Did the program produce the desired long-term effects?*

What are the cost-benefits of community prevention programs?

Research has demonstrated that preventing substance abuse and other problem behaviors can have a net benefit after accounting for costs. In a recent study, Spoth and associates (2002a) performed cost-effectiveness and benefit-cost analyses on data from two long-term interventions already shown to be effective in preventing substance abuse: Iowa Strengthening Families Program (ISFP; now called **The Strengthening Families Program: For Parents and Youth 10–14),** and Preparing for the Drug-Free Years (PDFY; now called **Guiding Good Choices**). Both interventions were found to have net benefits by preventing adult cases of alcohol abuse and thus saving future costs for alcohol abuse treatment. Benefit-to-cost ratios were $9.60 for each dollar invested in prevention for the ISFP group, and $5.85 per dollar invested in prevention for the PDFY group. For each family in the ISFP condition, there was a benefit of $5,923; and the PDFY condition resulted in a benefit of $2,697 per family. In addition, an analysis of the **Skills, Opportunity, And Recognition (SOAR)** program had a benefit-to-cost ratio of $4.25 for every dollar spent (Hawkins et al. 1999; Aos et al. 2001). An earlier study (Pentz 1998) found that for every dollar spent on drug abuse prevention, communities could save from $4 to $5 in costs for drug abuse treatment and counseling.

COMMUNITY ACTION BOX

Parents can work with others in the community to use the prevention principles in selecting drug abuse programs.

Educators can incorporate research-based content and delivery into their regular classroom curricula.

Community Leaders can work with evaluation experts to evaluate program progress and develop improvements in outcomes.

Chapter 4: Examples of Research-Based Drug Abuse Prevention Programs

To help those working in drug abuse prevention, NIDA, in cooperation with prevention scientists, presents the following examples of research-based programs that use a variety of strategies proven effective in preventing drug abuse. Each program was developed as part of a research protocol in which an intervention group and a comparison group were matched on important characteristics, such as age, grade in school, parents' level of education, family income, community size, and risk and protective factors. The interventions were tested in a family, school, or community setting, all with positive results. Prevention research continues to identify effective programs and strategies, thus this list is not meant to be exhaustive.

Many of these research-based programs include approaches to identifying early risk factors and addressing them long before a child encounters substance abuse. Whether the intervention focuses on improving teachers' skills in classroom management and academic support or on parents' communication skills, early positive support can reduce risks and increase protection. Also, recent research is focused on adapting interventions to address specific risks by gender, ethnic or racial identification, and geographic settings to improve the effectiveness of programs for specific audiences.

The programs are presented within their audience category (universal, selective, indicated, or tiered) and for whom they are designed (elementary, middle, or high school students). Since these programs are only examples, community planners may wish to explore additional programs and planning resources, which are highlighted in *Selected Resources and References*. With NIDA's continued support of research on effective prevention strategies at all levels of prevention, new research-based programs will continue to be made available in the future.

Universal Programs

Elementary School

Caring School Community Program (Formerly, Child Development Project) (Battistich et al. 1997; U.S. Department of Education 2001). This is a universal family-plus-school program to reduce risk and bolster protective factors among elementary school children. The program focuses on strengthening students' "sense of community," or connection, to school. Research has shown that this sense of community has been pivotal to reducing drug use, violence, and mental health problems, while promoting academic motivation and achievement. The program consists of a set of mutually reinforcing classroom, school, and family involvement approaches. These promote positive peer, teacher-student, and home-school relationships and the development of social, emotional, and character-related skills. The program provides detailed instructional and implementation materials and accompanying staff development.

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Classroom-Centered (CC) and Family-School Partnership (FSP) Intervention (Ialongo et al. 2001). The CC and FSP interventions are multicomponent, universal first-grade interventions to reduce later onset of violence and aggressive behavior and to improve academic performance. The CC intervention combines two effective classroom programs, the "Good Behavior Game" and "Mastery Learning," and includes classroom management and organizational strategies, as well as reading and mathematics curricula. The CC intervention also focuses on enhancing teachers' behavior management and instructional skills. The FSP intervention targets the same risk factors of aggression and learning problems, but directly involves parents. It seeks to improve parent-teacher communication, parental teaching, and children's behavior management strategies in the home. Findings show that sixth-graders exposed to the CC intervention in first grade had significantly reduced their aggressive behavior, as compared with control students.

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Promoting Alternative Thinking Strategies (PATHS) (Greenberg and Kusché 1998). PATHS is a comprehensive program for promoting emotional health and social competencies and reducing aggression and behavior problems in elementary school children, while enhancing the educational process in the classroom. This K–5 curriculum is designed for use by educators and counselors in a multiyear, universal prevention model. Although primarily for use in school and classrooms, information and activities are also included for use with parents. PATHS has been shown to improve protective factors and reduce behavioral risk factors that impact youth problem behaviors. Studies report reduced aggressive

behaviors, increased self-control, and an improved ability to tolerate frustration and use conflict-resolution strategies.

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Web site: www.prevention.psu.edu/PATHS

Contact for Training:

PATHS Training, LLC
Carol A. Kusché, Ph.D.
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Skills, Opportunity, And Recognition (SOAR) (Formerly, Seattle Social Development Program) (Lonczak et al. 2002; U.S. Department of Education 2001; Hawkins et al. 1999). This universal school-based intervention for grades one through six seeks to reduce childhood risks for delinquency and drug abuse by enhancing protective factors. The multicomponent intervention combines training for teachers, parents, and children during the elementary grades to promote children's bonding to school, positive school behavior, and academic achievement. These strategies are designed to enhance opportunities, skills, and rewards for children's prosocial involvement in school and their families.

Long-term followup results show positive outcomes for participants, including reduced antisocial behavior, misbehavior, alienation and teen pregnancy, and improved academic skills, commitment to school, and positive relationships with people.

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Middle School

Guiding Good Choices (GGC) (Formerly, Preparing for the Drug-Free Years) (Hawkins et al. 1999; Kosterman et al. 1997; U.S. Department of Education 2001; Spoth et al. 2002b). This curriculum was first researched as part of the Seattle Social Development Project at the University of Washington to educate parents on how to reduce risk factors and strengthen bonding in their families. In five 2-hour sessions, parents are shown how to (1) create age-appropriate opportunities for family involvement and interaction; (2) set clear expectations, monitor children, and apply discipline; (3) teach their children peer coping strategies; (4) adopt family conflict management approaches; and (5) express positive feelings to enhance family bonding. Dr. Richard Spoth of Iowa State University independently tested this intervention for rural parents and found the program to be effective in inhibiting alcohol and marijuana use. Special efforts were made to ensure recruitment and retention of study participants.

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Life Skills Training (LST) Program (Botvin et al. 1995, 1997, 2003; U.S. Department of Education 2001). LST is designed to address a wide range of risk and protective factors by teaching general personal and social skills, along with drug resistance skills and normative education. This universal program consists of a 3-year prevention curriculum for students in middle or junior high school. LST contains 15 sessions during the first year, 10 booster sessions during the second, and 5 sessions during the third year. The program can be taught either in grades 6, 7, and 8 (for middle school) or grades 7, 8, and 9 (for junior high schools). LST covers three major content areas: (1) drug resistance skills and information, (2) self-management skills, and (3) general social skills. The program has been extensively tested over the past 20 years and found to reduce the prevalence of tobacco, alcohol, and illicit drug use relative to controls by 50 to 87 percent. When combined with booster sessions, LST was shown to reduce the prevalence of substance abuse long term by as much as 66 percent, with benefits still in place beyond the high school years. Although LST was originally tested predominantly with White youth, several studies have shown that the LST program is also effective

with inner-city minority youth. Moreover, an age-appropriate version of the LST program for upper elementary school students was recently developed and shown to reduce tobacco and alcohol use (Botvin et al. 2003). It contains 24 classes (8 classes per year) to be taught during either grades 3 to 5 or 4 to 6.

Contact for Materials and Training:

National Health Promotion Associates, Inc.
Life Skills Training
711 Westchester Avenue
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Lions-Quest Skills for Adolescence (SFA) (Eisen et al. 2002; U.S. Department of Education 2001). SFA is a commercially available, universal, life skills education program in use in schools nationwide. A rigorous school-based trial of SFA funded by a NIDA research grant compared the effectiveness of SFA delivered in sixth grade with "standard" drug prevention programs in preventing or delaying the onset of students' tobacco, alcohol, and illegal substance use through middle school. The 40-session version of SFA tested includes social influence and social cognitive approaches to teaching cognitive-behavioral skills for building self-esteem and personal responsibility, communicating effectively, making better decisions, resisting social influences and asserting rights, and increasing drug use knowledge and consequences (Quest International, 3rd edition 1992.) Some of the results after 1 year indicate that exposure to the program can help deter initiation of regular cigarette smoking and marijuana use; these results held across all racial/ethnic groups studied. Additional findings after 2 years indicate lower initiation and regular marijuana use across all groups, as well as lower binge drinking rates among Hispanic students.

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Project ALERT (U.S. Department of Education 2001). This drug prevention curriculum is a 2-year, universal program for middle school students that reduces the onset and regular use of substances among youth. The 14-lesson program is designed to prevent drug use initiation and the transition to regular use. It focuses on substances that adolescents typically use first and most widely—alcohol, tobacco, marijuana, and inhalants. Project ALERT uses participatory activities and videos to help students establish nondrug norms, develop reasons not to use, and resist prodrug pressures. The program has prevented marijuana use initiation, decreased current and heavy smoking, curbed alcohol misuse, reduced prodrug attitudes and beliefs, and helped smokers quit. The program has proven successful with high- and low-risk youth from a variety of communities.

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Project STAR (Chou et al. 1998; U.S. Department of Education 2001). Project STAR is a comprehensive drug abuse prevention community program with components for schools, parents, community organizations, and health policymakers. An additional component targets mass media to encourage publicizing positive efforts for drug prevention. The middle school component is a social influence curriculum that is incorporated into classroom instruction by trained teachers over a 2-year timetable. In the parent program, parents work with children on homework, learn family communication skills, and get involved in community action. Strategies range from individual-level change, such as teaching youth drug resistance skills, to school and community-change, including limiting youth access to alcohol or drugs. Long-term followup studies showed significant reductions in drug use among participants, when compared with adolescents in the community who had not received prevention intervention.

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The Strengthening Families Program: For Parents and Youth 10–14 (SFP 10–4) (Formerly, the Iowa Strengthening Families Program) (Spoth, Redmond, and Shin 2000, 2001). This program offers seven sessions, each attended by youth and their parents. Program implementation and evaluation have been conducted through partnerships that include state university researchers, Cooperative Extension System staff, local schools, and community implementers. Longitudinal study of comparisons with control group families showed positive effects on parents' child management practices (for example, setting standards, monitoring children, and applying consistent discipline) and on parent-child affective quality. In addition, a recent evaluation found delayed initiation of substance use at the 6-year followup. Other findings showed improved youth resistance to peer pressure to use alcohol, reduced affiliation with antisocial peers, and reduced levels of problem behaviors. Importantly, conservative benefit-cost calculations indicate returns of $9.60 per dollar invested in SFP.

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High School

Life Skills Training: Booster Program. The 3-year LST universal classroom program contains 15 booster sessions during the first year, 10 during the second, and 5 during the third year. See the Life Skills Training description above for background and contact information.

Lions-Quest Skills for Adolescence. (Eisen 2002; U.S. Department of Education 2001). See description above for background and contact information.

Project ALERT Plus. An enhanced version of Project ALERT has been added as a high school component and is being tested in 45 rural communities. See the Project ALERT description above for background and contact information.

The Strengthening Families Program: For Parents and Youth 10–14. (Formerly, the Iowa Strengthening Families Program). See description above for background and contact information.

Selective Programs

Elementary School

Focus on Families (FOF) (Catalano et al. 1999, 2002). A selective program for parents receiving methadone treatment and their children, FOF seeks to reduce parents' use of illegal drugs by teaching them skills for relapse prevention and coping. Parents are also taught how to better manage their families to reduce their children's risk for future drug abuse. The parent training consists of a 5-hour family retreat and 32 parent training sessions of 1.5 hours each. Children attend 12 of the sessions to practice developmentally appropriate skills with their parents. Results from an experimental evaluation of FOF found positive program effects on parents at the 1-year followup, especially in parenting skills, rule-setting, domestic conflict, drug refusal skills, and drug use. At the 1-year assessment, significantly fewer children

in the experimental condition reported having stolen something in the previous 6 months. After 2 years of family skills training, positive effects were still evident in parents' drug refusal skills, and positive effects had emerged in parent problemsolving skills in general situations. No statistically significant differences in drug use were found between those in experimental versus control conditions, although the direction of difference still favored experimental participants. Importantly, the strength of program effects on children was substantially stronger at the 2-year followup. Note that the direction of differences on all primary child outcome measures were stronger at the second-year assessment than at the end of the first year. These findings suggest that interventions to prevent relapse among parents and substance abuse among their children may produce immediate, as well as delayed, or "sleeper" effects on targeted risk and protective factors and substance use. The promise of the FOF program is evident in the early reduction in family-related risk factors—*particularly for very high-risk families*—with an overall trend toward positive program effects on child outcomes.

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The Strengthening Families Program (SFP) (Kumpfer et al. 1996, 2002). SFP, a universal and selective multicomponent, family-focused prevention program, provides support for families with 6- to 11-year-olds. The program began as an effort to help drug-abusing parents improve their parenting skills and reduce their children's risk for subsequent problems. It has shown success in elementary schools and communities. Strengthening Families has three components: a behavioral parent training program, children's skills training program, and family skills training program. In each of the 14 weekly sessions, parents and children are trained separately in the first hour. During the second hour, parents and children come together in the family skills training portion. The session begins with families sharing dinner. Barriers to attendance are reduced by providing child care, transportation, and small incentives. This approach has been evaluated in a variety of settings and with several racial and ethnic groups. Spanish-language manuals are available. Primary outcomes include reduced family conflict, youth conduct disorders, aggressiveness, and substance abuse, as well as improved youth social skills, parenting skills, and family communication and organization.

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Middle School

Coping Power (Lochman and Wells 2002). Coping Power is a multicomponent child and parent preventive intervention directed at preadolescent children at high risk for aggressiveness and later drug abuse and delinquency. The child component is derived from an anger coping program, primarily tested with highly aggressive boys and shown to reduce substance use. The Coping Power Child Component is a 16-month program for fifth- and sixth-graders. Group sessions usually occur before or after school or during nonacademic periods. Training focuses on teaching children how to identify and cope with anxiety and anger; controlling impulsiveness; and developing social, academic, and problemsolving skills at school and home. Parents are also provided training throughout the program. Results indicate that the intervention produced relatively lower rates of substance use at postintervention than seen among the controls. Also, children of families receiving the Coping Power child and parent components significantly reduced aggressive behavior, as rated by parents and teachers.

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High School

Adolescents Training and Learning to Avoid Steroids (ATLAS) (Goldberg et al. 2000). ATLAS is a multicomponent selective program for male high school athletes, designed to reduce risk factors for use of anabolic steroids and other drugs, while providing healthy sports nutrition and strength-training alternatives to illicit use of athletic-enhancing substances. Coaches and peer teammates facilitate curriculum delivery with scripted manuals in small cooperative learning groups, taking advantage of an influential coaching staff and the team atmosphere where peers share common goals. Seven 45-minute classroom sessions and seven physical training periods involve role-playing, student-created campaigns, and educational games. Instructional aids include pocket-sized food and exercise guides and easy-to-follow student workbooks. Parents are involved through parent-student homework and are given the booklet, *Family Guide to Sports Nutrition*. Attitudes and alcohol and illicit drug use, as well as nutrition behaviors and exercise self-efficacy, remained significantly healthier among ATLAS program participants at a 1-year followup.

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Web site: www.ohsu.edu/som-hpsm/atlas.html

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Indicated Programs

High School

Project Towards No Drug Abuse (Project TND) (Sussman et al. 2002). This indicated prevention intervention targets high school age youth who attend alternative or traditional high schools. The goal is to prevent the transition from drug use to drug abuse, considering the developmental issues faced by older teens, particularly those at risk for drug abuse. At the core of Project TND is a set of 12 in-class sessions that provide motivation and cognitive misperception correction, social and self-control skills, and decisionmaking material targeting the use of cigarettes, alcohol, marijuana, and hard drugs and violence-related behavior, such as carrying a weapon. The classroom program has been found to be effective at 1-year followup across three true experimental field trials. The 12-session version is effective across outcome variables, and many effects are maintained at 2-year followup.

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Reconnecting Youth Program (RY) (Eggert et al. 1995, 2001; Thompson et al. 1997). RY is a school-based indicated prevention program for high school students with poor school achievement and potential for dropping out. Participants may also show signs of multiple problem behaviors, such as substance abuse, depression, aggression, or suicidal behaviors. Students are screened for eligibility and then invited to participate in the program. The program goals are to increase school performance, reduce drug use, and

learn skills to manage mood and emotions. RY blends small group work (10–12 students per class) to foster positive peer bonding, with social skills training in a daily, semester-long class. RY skills, taught by an RY specially trained teacher or group leader, include self-esteem enhancement, decisionmaking, personal control, and interpersonal communication. Early experiments have shown that participation in RY improved school performance (20-percent increase in GPA), decreased school dropout, reduced hard drug use (by 60 percent), and decreased drug use control problems, such as adverse consequences and progression to heavier drug use. Recent studies of a refined RY program model (with skills training on depression and anger management and increased monitoring of drug use) have found greater decreases in hard drug use, depression, perceived stress, and anger control problems.

Contact for Materials:

Reconnecting Youth: A Peer Group Approach
 to Building Life Skills (Revised Edition)
National Educational Service
304 West Kirkwood Avenue, Suite 2
Bloomington, IN 47404

Phone: 800-733-6786 or 812-336-7790
Fax: 812-336-7790
E-mail: nes@nesonline.com
Web site: www.nesonline.com

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Contact for Training:

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Tiered Programs

Elementary School

Early Risers "Skills for Success" Risk Prevention Program (August et al. 2001; August et al. 2002; August et al., in press). Early Risers is a selective, multicomponent, preventive intervention for children at heightened risk for early onset of serious conduct problems, including licit and illicit drug use. The program's focus is on elementary school children with early aggressive behavior. It is designed to deflect children from the "early starter" developmental pathway toward normal development by effecting positive change in academic competence, behavioral self-regulation, social competence, and parent investment in the child. Early Risers has two broad components: CORE, a set of child-focused intervention components delivered continuously in school and over the summer for 2 or 3 years, implemented in tandem with FLEX, a family support and empowerment component tailored to meet family-specific needs and delivery through home visits. Recent findings reveal that program participants showed greater gains in social skills, peer reputation, prosocial friendship selection, academic achievement, and parent discipline than did controls.

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Fast Track Prevention Trial for Conduct Problems (Conduct Problems Prevention Research Group 2002c). Fast Track is a comprehensive preventive intervention for young children at high risk for long-term antisocial behavior. Based on a developmental model, the intervention includes a *universal* classroom program (adapted from the PATHS curriculum) for high-risk children selected in kindergarten; it also includes training for parents. Children receive social skills training, academic tutoring, and home visits to improve

academic and social competencies and reduce problems. In first grade, the classroom intervention builds skills in (1) emotional understanding and communication, (2) friendship, (3) self-control, and (4) social problemsolving. The *selective* intervention reaches parents and children at higher risk for conduct problems. Parenting strategies provide skills to support school adjustment, improve the child's behavior, build parents' self-control, promote appropriate expectations for the child's behavior, and improve parent-child interaction. By the end of third grade, 37 percent of the intervention group were free of serious conduct problems, compared with 27 percent of the control group.

Contact for Materials and Research:

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E-mail: prevention@psu.edu

Middle School

Adolescent Transitions Program (ATP) (Dishion et al. 2002). ATP is a school-based program that uses a tiered approach to provide prevention services to students in middle and junior high school and their parents. The *universal* intervention level, directed to parents of all students in a school, establishes a Family Resource Room to engage parents, establish norms for parenting practices, and disseminate information about risks for problem behavior and substance use. The *selective* intervention level, the Family Check-Up, offers family assessment and professional support to identify families at risk for

problem behavior and substance use. The *indicated* level, the Parent Focus curriculum, provides direct professional support to parents to make the changes indicated by the Family Check-Up. Services may include behavioral family therapy, parenting groups, or case management services.

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Chapter 5: Selected Resources and References

Below are resources relevant to drug abuse prevention. Information on NIDA's Web site is followed by Web sites for other Federal agencies and private organizations. These resources and the selected references that follow are excellent sources of information in helping communities plan and implement research-based drug prevention programs.

Selected Resources

National Institute on Drug Abuse (NIDA)
National Institutes of Health (NIH)
U.S. Department of Health and
  Human Services (DHHS)

NIDA's Web site (www.drugabuse.gov) provides factual information on all aspects of drug abuse, particularly the effects of drugs on the brain and body, the prevention of drug abuse among children and adolescents, the latest research on treatment for addiction, and statistics on the extent of drug abuse in the United States. The Web site allows visitors to print or order publications, public service announcements and posters, science education curricula, research reports and fact sheets on specific drugs or classes of drugs, and the *NIDA NOTES* newsletter. The site also links to related Web sites in the public and private sector.

Other Federal Resources

Center for Substance Abuse Prevention (CSAP)
  Substance Abuse and Mental Health Services
  Administration (SAMHSA), DHHS
5600 Fishers Lane
Rockwall 2, 9th Floor, Suite 900
Rockville, MD 20857
Phone: 301-443-9110
www.prevention.samhsa.gov

Centers for Disease Control and Prevention (CDC), DHHS
1600 Clifton Road
Atlanta, GA 30333
Phone: 404-639-3534
Phone: 800-311-3435 (toll-free)
www.cdc.gov

Safe and Drug-Free Schools Program
  U.S. Department of Education (DoE)
400 Maryland Avenue, SW
Washington, DC 20202
Phone: 800-872-5327 (toll-free)
www.ed.gov

Drug Enforcement Administration (DEA)
  U.S. Department of Justice (DOJ)
2401 Jefferson Davis Highway
Alexandria, VA 22301
Phone: 202-307-1000
www.dea.gov

Knowledge Exchange Network, SAMHSA, DHHS
P.O. Box 42490
Washington, DC 20015
Phone: 800-789-2647 (toll-free)
www.mentalhealth.org

**National Clearinghouse for Alcohol and
  Drug Information (NCADI), SAMHSA, DHHS**
Phone: 800-729-6686 (toll-free)
www.ncadi.samhsa.gov

**National Institute on Alcohol Abuse and Alcoholism
  (NIAAA), NIH, DHHS**
6000 Executive Boulevard, Willco Building
Bethesda, MD 20892
Phone: 301-443-3860
www.niaaa.nih.gov

National Institute of Mental Health (NIMH), NIH, DHHS
6001 Executive Boulevard, Room 8184, MSC 9663
Bethesda, MD 20892
Phone: 301-443-4513
www.nimh.nih.gov

National Institutes of Health (NIH), DHHS
9000 Rockville Pike
Bethesda, MD 20892
Phone: 301-496-4000
www.nih.gov

National Library of Medicine (NLM), NIH, DHHS
8600 Rockville Pike
Bethesda, MD 20894
Phone: 301-594-5983
Phone: 888-346-3656 (toll-free)
www.nlm.nih.gov

**Office of Juvenile Justice and Delinquency Prevention
  (OJJDP), DOJ**
810 Seventh Street
Washington, DC 20531
Phone: 202-307-5911
www.ojjdp.ncjrs.org/pubs/substance.html

Office of National Drug Control Policy (ONDCP)
P.O. Box 6000
Rockville, MD 20849
Phone: 800-666-3332 (toll-free)
www.whitehousedrugpolicy.gov

**Substance Abuse and Mental Health Services Administration
  (SAMHSA), DHHS**
5600 Fishers Lane
Rockville, MD 20857
Phone: 301-443-8956
www.samhsa.gov

Other Selected Resources

**American Academy of Child and Adolescent Psychiatry
  (AACAP)**
3615 Wisconsin Avenue, NW
Washington, DC 20016
Phone: 202-966-7300
www.aacap.org

American Academy of Family Physicians (AAFP): KidsHealth
11400 Tomahawk Creek Parkway
Leawood, KS 66211
www.familydoctor.org

American Academy of Pediatrics (AAP)
141 Northwest Point Boulevard
Elk Grove, IL 60007-1098
Phone: 847-434-4000
www.aap.org

American Psychological Association (APA)
750 First Street, NE
Washington, DC 20002
Phone: 800-374-2121 (toll-free)
Phone: 202-336-5510
www.apa.org

American Society of Addiction Medicine (ASAM)
4601 North Park Avenue, Arcade Suite 101
Chevy Chase, MD 20815
Phone: 301-656-3920
www.asam.org

**Blueprints for Violence Prevention, Center for the Study
  and Prevention of Violence**
Institute on Behavioral Science
University of Colorado at Boulder
900 28th Street, Suite 107
439 UCB
Boulder, CO 80309
Phone: 303-492-1032
www.colorado.edu/cspv/blueprints/

**Center on Addiction and Substance Abuse (CASA)
  at Columbia University**
633 Third Avenue, 19th Floor
New York, NY 10017
Phone: 212-841-5200
www.casacolumbia.org

Community Anti-Drug Coalitions of America (CADCA)
901 North Pitt Street, Suite 300
Alexandria, VA 22314
Phone: 800-542-2322 (toll-free)
www.cadca.org

Drug Strategies, Inc.
1150 Connecticut Avenue, NW, Suite 800
Washington, DC 20036
Phone: 202-289-9070
www.drugstrategies.org

Join Together
One Appleton Street, 4th Floor
Boston, MA 02116
Phone: 617-437-1500
www.jointogether.org

Latino Behavioral Health Institute
P.O. Box 1008
Thousand Oaks, CA 91360
Phone: 213-738-2882
www.lbhi.org

**National Asian Pacific American Families Against
   Substance Abuse (NAPAFASA)**
340 East Second Street, Suite 409
Los Angeles, CA 90012
Phone: 213-625-5795
www.napafasa.org

National Criminal Justice Reference Service (NCJRS)
P.O. Box 6000
Rockville, MD 20849
Phone: 800-851-3420 (toll-free)
Phone: 301-519-5500
www.ncjrs.org

National Families in Action (NFIA)
2957 Clairmont Road, NE, Suite 150
Atlanta, GA 30329
Phone: 404-248-9676
www.nationalfamilies.org

National Hispanic Science Network (NHSN)
Center for Family Studies
Department of Psychiatry & Behavioral Sciences
University of Miami School of Medicine
1425 NW 10th Avenue, 3rd Floor
Miami, FL 33136-1024
Phone: 305-243-2340
www.hispanicscience.org

National Prevention Network (NPN)
808 17th Street, NW, Suite 410
Washington, DC 20006
Phone: 202-293-0090
www.nasadad.org/Departments/Prevention/prevhme1.htm

Partnership for a Drug-Free America
405 Lexington Avenue, Suite 1601
New York, NY 10174
Phone: 212-922-1560
www.drugfreeamerica.org

Society for Prevention Research (SPR)
1300 I Street, NW, Suite 250 West
Washington, DC 20005
Phone: 202-216-9670
www.preventionresearch.org

Selected References

The following references have been selected as
either summaries of the literature of the past several
years or as the latest findings on specific aspects of
prevention research, which have been cited in this
publication. For a more comprehensive list of research
citations, please consult the NIDA Web site at
www.drugabuse.gov.

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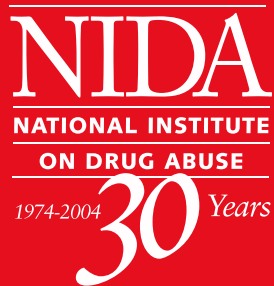Consulting and Clinical Psychology* 69(4):614–626, 2001.

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What Are Peer Recovery Support Services?

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Table of Contents

Aisha says she knows many people who tried treatment for a substance use disorder; they also tried 12-Step meetings. Neither worked. Her friends are back on the street, still using. Anyway, Aisha doesn't have time to attend treatment sessions or go to meetings; she has a full-time job and is busy raising her two grandchildren because their mother is in prison.

Roger has just been released from jail. He has been clean for the 90 days of his incarceration, and he thinks he can stay clean if he can just find a job and a place to live with other people in recovery.

Elizabeth tells her treatment counselor that payday is her trigger, and that she needs an alcohol- and drug-free place to go and socialize on Friday evenings. She adds that it would be helpful if she could bring her children.

Luis says he understands that his AA meeting is not the place to discuss the complications he is encountering with his hepatitis C medications. But he needs someone to talk to because managing his response to the medications and his recovery at the same time is just too much for him to handle.

Bodie has been in recovery for a year. He is looking for an opportunity to be of service and to strengthen his recovery by giving back to the community. He loves gospel music and sings in his church choir.

Introduction

What do all these people have in common? Although they are at different points in the process of recovering from a substance use disorder, each is expressing a need for some form of social support to help them through the process. Equally important, each is also a potential source of social support for others.

In this paper on *What Are Peer Recovery Support Services*, you will be introduced to a new kind of social support services designed to fill the needs of people in or seeking recovery. The services are called peer recovery support services and, as the word peer implies, they are designed and delivered by people who have experienced both substance use disorder and recovery. Through the Recovery Community Services Program (RCSP), the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT) funds grant projects across the country to develop and deliver these services.

The peer recovery support services developed by the RCSP projects help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Because they are designed and delivered by peers who have been successful in the recovery process, they embody a powerful message of hope, as well as a wealth of experiential knowledge. The services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery.

Social Support for Recovery

Research has shown that recovery is facilitated by social support (McLellan et al., 1998), and four types of social support have been identified in the literature (Cobb, 1976; Salzer, 2002): emotional, informational, instrumental, and affiliational support. RCSP projects have found these four types of social support useful in organizing the community-based peer-to-peer services they provide to recovering people. (Some typical examples are shown in Figure 1 below.) These four categories refer to types of social support, not discrete services or service models.

For example, a project that is planning social support services to address recovering people's employment needs might consider whether a job referral (informational support) by itself is adequate, or whether emotional support (such as supportive coaching to prepare for an interview), and/or instrumental support (such as help cleaning up a criminal record) might also be needed. In general, the more robust the types of social support available to address any given recovery concern, the more likely that a person seeking help will walk away with useful information, a new insight or skill, or more confidence to help with the tasks ahead.

Peer Leaders and the Peer Service Alliance

RCSP projects use the term peer to refer to all individuals who share the experiences of addiction and recovery, either directly or as family members or significant others. In a peer-helping-peer service alliance, a *peer leader* in stable recovery provides social support

Figure 1-Type of Social Support and Associated Peer Recovery Support Services

Type of Support	Description	Peer Support Service Examples
Emotional	Demonstrate empathy, caring, or concern to bolster person's self-esteem and confidence.	Peer mentoring Peer-led support groups
Informational	Share knowledge and information and/or provide life or vocational skills training.	Parenting class Job readiness training Wellness seminar
Instrumental	Provide concrete assistance to help others accomplish tasks.	Child care Transportation Help accessing community health and social services
Affiliational	Facilitate contacts with other people to promote learning of social and recreational skills, create community, and acquire a sense of belonging.	Recovery centers Sports league participation Alcohol- and drug-free socialization opportunities

services to a *peer* who is seeking help in establishing or maintaining his or her recovery. Both parties are helped by the interaction as the recovery of each is strengthened.

RCSP projects use many other titles besides peer leader and peer to describe the parties to the peer service alliance. On the peer leader side of the equation, titles include recovery (or peer) mentor, guide, or coach; peer services interventionist; firestarter; and peer resource specialist. (Firestarters are peer leaders responsible for building local recovery communities in Native American communities.) The peer who seeks help also is given different titles in different RCSP projects, such as member (of the peer services organization), mentee, or simply peer. Most project leaders have consciously sought to find and use identifying terms that distinguish their peer services and service providers from those in formal,

professional treatment programs or in mutual aid groups conducted by lay persons. For this reason, terms such as counselor, case manager, or sponsor, as well as client, consumer, or patient, are avoided.

The RCSP projects' attention to language reflects the need to clearly distinguish the role of the peer leader from the role of the treatment counselor or other professional and the 12-Step sponsor (White, 2006). RCSP projects are intended by CSAT to enhance—not duplicate, replace, or compete with— valuable services already available in a community. Thus, in addition to using language which is not associated with treatment or mutual aid programs, axioms such as the following are commonly heard: "Peers do not diagnose;" "Peers do not provide therapy;" "Peers do not give advice." Similarly, it is common to hear, "You need to ask your sponsor, not me, for help working the 12-Steps," or "That's a question for the doctor or nurse."

Peer Recovery Support Service Activities

The RCSP peer recovery support service projects have developed a variety of peer services. Not all programs provide all services, and some peer leaders may provide more than one service. The following is a useful overview of the four major types of recovery support services emerging in RCSP projects: (1) peer mentoring or coaching, (2) recovery resource connecting, (3) facilitating and leading recovery groups, and (4) building community:

Peer Mentoring or Coaching

Although the name given to this service activity varies from project to project, the terms mentoring or coaching refer to a one-on-one relationship in which a peer leader with more recovery experience than the person served encourages, motivates, and supports a peer who is seeking to establish or strengthen his or her recovery.

The nature and functions of mentoring or coaching vary from one RCSP project to another. Generally, mentors or coaches assist peers with tasks such as setting recovery goals, developing recovery action plans, and solving problems directly related to recovery, including finding sober housing, making new friends, finding new uses of spare time, and improving one's job skills. They may also provide assistance with issues that arise in connection with collateral problems such as having a criminal justice record or coexisting physical or mental challenges.

The relationship of the peer leader to the peer receiving help is highly supportive, rather than directive. The duration of the relationship between the two depends on a number of factors such as how much recovery time the peer has, how much other support the peer is receiving, or how quickly the peer's most pressing problems can be addressed.

RCSP projects distinguish the role of the peer mentor or coach from that of a 12-Step sponsor in several ways. For example, the sponsor works within the 12-Step framework and is expected to help the person in early recovery understand and follow the specific guidance of the 12-Step program. The typical RCSP recovery mentor or coach, on the other hand, is often described as helping peers in early recovery make choices about which recovery pathway(s) will work for them, rather than urging them to adopt the mentor's or coach's own program or any specific program of recovery. The mentor or coach is often described as devoting a greater amount of time than the typical 12-Step sponsor to connecting the person in early recovery to community health, employment, housing, educational, and social services and resources and often has more specific knowledge about a larger range of available services and resources.

Peer Recovery Resource Connecting

The service activities of peer leaders in connecting peers to recovery resources might be likened to case management in substance use disorder treatment. The purpose of resource connecting services is to connect the peer with professional and nonprofessional services and resources available in the community that can help meet his or her individual needs on the road to recovery. The peer leader working in a peer setting to provide recovery resource connecting services often has had personal experience navigating the service systems and accessing the resources to which referral is being made, and can bring those personal experiences to bear.

Peer recovery support services provided in RCSP projects typically can help peers with their most pressing early recovery needs—finding a safe place to live and a job. Thus, peer leaders are likely to refer peers to safe housing or to sources of information about housing and to a wide variety of resources and services that provide assistance in developing job readiness or finding jobs. Peer leaders also help peers navigate the formal treatment system, advocating for their access and gaining admittance, as well as facilitating discharge planning, typically in collaboration with treatment staff.

Peer leaders also encourage and support participation in mutual aid groups and provide specific information about the various groups that exist in the community. They encourage and facilitate participation in educational opportunities. Depending on the particular needs of the population they serve, they also may focus on developing linkages to resources that address specialized needs, such as agencies providing services related to HIV infection or AIDS, mental health disorders, chronic and acute health problems, parenting young children, and problems stemming from involvement with the criminal justice system.

> Self-disclosure and using one's own story as means of enhancing the value of the service is an important dimension of the recovery mentoring or coaching role. In addition, a peer mentor or coach implicitly holds himself or herself out as a recovery role model. As described by William White, this core competency entails "modeling of core recovery values (e.g., tolerance, acceptance, gratitude); the capacity for self-observation, self-expression, sober problem-solving; recovery-based reconstruction of personal identity and interpersonal relationships; freedom from coercive institutions; economic self-sufficiency; positive citizenship and public service." (White, 2006)

Facilitating and Leading Recovery Groups

In addition to conducting one-on-one coaching or mentoring and resource connecting activities, many peer leaders facilitate or lead recovery-oriented group activities. Some of these activities are structured as support groups, while others have educational purposes. Many have components of both.

The group activities that are structured as support groups typically involve the sharing of personal stories and some degree of collective problem-solving. Many of these groups are formed around shared identity, such as belonging to a common cultural or religious group, or shared experience related to the substance use disorder, such as the need to re-enter the community following incarceration, being HIV positive, or facing challenges in parenting. Many, but not all, group activities conducted by peer leaders have a spiritual component.

The group educational activities tend to focus on a specific subject or skill set, and may involve the participation of an expert as well as peer leaders. Typical topics and activities include training in job

skills, budgeting and managing credit, and preventing relapse, as well as courses particularly targeted to people in recovery, such as conflict resolution grounded in recovery skills.

> A number of RCSP projects have expanded beyond just linking people to existing resources and services to creating new recovery support services in the community. These efforts have ranged from active recruitment of recovery-friendly employers to the organization of a recovery-friendly network of dentists who offer free or deeply-discounted services to people whose early recovery is jeopardized by dental problems developed during their addiction. One project has increased the statewide stock of recovery housing through a technical assistance initiative that helps peer leaders establish and operate recovery homes that adhere to an agreed-upon set of standards.

Building Community

A person in early recovery is often faced with the need to abandon friends and/or social networks that promote and help sustain a substance use disorder, but has no alternatives to put in their place that support recovery. Peer recovery support service providers can help such peers make new friends and begin to build alternative social networks. Peer leaders in RCSP projects often organize recovery-oriented activities that range from opportunities to participate in team sports to family-centered holiday celebrations and to payday get-togethers that are alcohol- and drug-free. These activities provide a sense of acceptance and belonging to a group, as well as the opportunity to practice new social skills.

> A number of RCSP grantees have created recovery community centers as "places where recovery happens." Many types of peer service activities—such as mentoring and coaching, connecting to resources, support and educational groups—take place at these centers. At the core of the effort is the nurturing of a caring recovery community, with shared norms and values, which is dedicated to supporting the recovery of all who seek it. These centers "bring recovery to Main Street" and, by making recovery visible, carry a message of hope to the larger community.

Volunteer and Staff Peer Leaders

Peer recovery support services capitalize on the often recognized desire among many in recovery to "give backî to their communities by providing services to others. Most of the RCSP peer leaders who give back by providing peer recovery support services have done so as volunteers. In some projects, however, peer leaders are paid for their services as staff. In a few projects, peer leaders are not staff, but receive stipends for their work.

All recovery support programs require effective management and all peer leaders, irrespective of their status as paid staff, volunteers, or recipients of stipends, require effective supervision. The range of supervisory tasks may vary, however, depending on the status of the peer leaders as paid or unpaid volunteers or staff. Recruiting and retaining effective volunteers, for example, requires somewhat different techniques than hiring and keeping effective paid staff. The tenure of volunteers may be shorter than that of paid staff, requiring constant recruiting and training of volunteers. A project that relies on volunteers may use community organizing strategies to develop a strong volunteer base, while a project that relies solely on paid staff will be more likely to use standard employee recruitment processes. Moreover, staff time is typically allocated differently in a volunteer-oriented organization. Little staff

time is devoted to direct service; staff effort is primarily directed at recruiting, training, and supervising peer leaders; developing and maintaining an organizational culture that incorporates principles of self-care; and various other tasks related to organizational development, stakeholder development, and sustainability.

Whether the project uses paid or volunteer peer leaders also may affect how the project translates the range of peer leader direct service roles and functions into specific job or volunteer position descriptions. The project that relies primarily on volunteers who can dedicate 20 hours of service each month may distribute peer service roles and functions into volunteer positions that are narrower in scope than the roles and functions included in job descriptions developed by a project that relies primarily on peer leaders in full-time staff positions. A paid peer leader, for example, might be expected to provide one-on one mentoring and facilitate groups; a volunteer position might include mentoring or facilitation, but not both.

The Adaptability of Peer Recovery Support Services

One strength of peer recovery support services has been their adaptability to many stages and modalities of recovery, as well as to different service settings and organizational contexts. This adaptability makes them an effective vehicle for extending support for recovery beyond the treatment system and into the communities where people live and to people following different pathways to recovery. On the other hand, because of the variations in settings, organizational contexts, and recovery stages and pathways, identifying commonalities in peer recovery support services can be challenging.

Different Recovery Stages and Approaches

Peer leaders can provide social support services to individuals at all stages on the continuum of change that constitutes the recovery process. The Prochaska, Norcross, and DiClementi (1995) stages of change model has identified the stages of precontemplation, contemplation, determination/preparation, action, maintenance, and relapse. Whether peers are familiar with these stages of change or not, most can relate to the idea that recovery takes place in stages.

RCSP projects have developed peer recovery support services that meet needs of people at different stages of the recovery process. The services may:

- Precede formal treatment, strengthening a peer's motivation for change

- Accompany treatment, providing a community connection during treatment

- Follow treatment, supporting relapse prevention

- Be delivered apart from treatment to someone who cannot enter the formal treatment system or chooses not to do so.

Furthermore, peer services can provide social support within the context of many different pathways to recovery, including pathways that are predominantly religious, spiritual, or secular; involve medication assistance; or focus on cultural survival and renewal as avenues to recovery.

Varied Service Settings

RCSP grant projects deliver peer services in a variety of settings including recovery community organizations, recovery centers, churches, child welfare organizations, recovery homes, drug courts, pre-release jail and prison programs, parole and probation programs, behavioral health agencies, and HIV/AIDS and other medical or social service centers. Peer leaders work in urban and rural communities

with many different populations, including those defined by age (e.g., adolescents, elders), race or ethnicity (e.g., Asian/Pacific Islander American, Latino or Hispanic American, Native American, Caucasian), gender (e.g., women) or by co-existing conditions (e.g., HIV/AIDS and other infectious diseases, mental health disorders, homelessness, or a criminal record).

Variations in Organizational Contexts

Some RCSP projects are free-standing nonprofit recovery community organizations operated by members of the recovery community. Others reside within a host agency. These host agencies include those involved in the field of substance use disorders, including treatment providers; agencies that focus on the continuum of social service needs of specific populations, including those related to substance use; and agencies with a primary focus on challenges such as HIV/AIDS, post incarceration re-entry to the community, or children at risk of abuse or neglect. Each type of organizational context has its own culture and perspective on substance use disorders and recovery and presents its own opportunities and challenges in the establishment and operation of a peer recovery support service program.

These stages of recovery, pathways to recovery, service settings, and organizational contexts can present very different challenges to the peer recovery support services program. One project, for example, may be a new free-standing recovery community organization that is faced not only with the task of designing and delivering peer recovery support services, but also with the tasks of building a board of directors and developing the fiscal infrastructure to handle a Federal grant. Another may be housed in a host agency that is a seasoned nonprofit that has been handling Federal grants successfully for years, but is rooted in a service system that is inexperienced with working with people in or seeking recovery. One may work almost exclusively with peers who have completed formal treatment, while another may work with peers who have not yet acknowledged that their substance use is a problem.

Some Important Cross-Project Principles

Notwithstanding important differences among RCSP projects, certain core principles cut across projects. One key principle is having shared values. In the RCSP experience, shared values have, in turn, given rise to other key principles, including a preference for strength-based approaches and a service philosophy that nurtures self-direction, empowerment, and choice.

Shared Values

RCSP project participants have identified core values that inform the task of organizing the recovery community to provide peer recovery support services. These include:

■ **Keeping recovery first**—Placing recovery at the center of the effort, grounding peer services in the strengths and inherent resiliency of recovery rather than in the pathology of substance use disorders.

■ **Cultural diversity and inclusion**—Developing a recovery community peer support services program that honors different routes to recovery and has leaders and members from many groups at all levels within the organization.

■ **Participatory process**—Making sure the recovery community directs or is actively involved in project design and implementation, so that recovery community members can identify their own strengths and needs, and design and deliver peer services that address them.

- **Authenticity of peers helping peers**—Drawing on the power of example, as well as the hope and motivation, that one person in recovery can offer to another; providing opportunities to give back to the community; and embracing the notion that both people in a relationship based on mutuality can be helped and empowered in the process.

- **Leadership development**—Building leadership abilities among members of the recovery community so that they are able to guide and direct the service program and deliver support services to their peers.

Many projects have identified additional core values, but virtually all subscribe to at least these five. RCSP projects have used these core values as a platform on which to build codes of ethics and as a guide to their development of practice guidelines for peer leaders.

Focus on Strengths and Resiliencies

A peer recovery support services program that incorporates a strengths perspective builds on people's resiliencies and capacities rather than providing services focused primarily on correcting their deficits, disabilities, or problems. Emphasis is on uncovering, reaffirming, and enhancing the abilities, interests, knowledge, resources, aspirations, and hopes of individuals, families, groups, and communities. This approach assumes that the ability to recognize one's own strengths and identify internal and external resources enhances a person's chances of success in setting and achieving goals and in realizing his or her aspirations.

RCSP peer recovery support service programs have adopted the strengths perspective in multiple contexts. In the relationship between a peer leader and a peer seeking help, for example, recovery planning does not start with a process that identifies deficits and disabilities, but rather with a conversation intended to uncover the peer's interests, abilities, and goals. One of the peer's goals is likely to be a sustained change in substance use behavior. Goals are likely to address other life domains as well, such as housing, employment, education, family and social relationships, recreational opportunities, and physical, mental, or spiritual health.

As the individual's goals become clear, the peer leader can help the peer identify the resources and skills that need to be marshaled to attain the goals. The peer may already possess some of these resources, skills, and talents and may even have demonstrated them during the active stages of a substance abuse disorder; he or she may need help in developing others, in some cases seeking an external source for help in developing new capacities. These ingredients—the articulation of the peer's own goals and desires, in his or her own words, and an enumeration and affirmation of his or her specific capacities to marshal resources to achieve them—form the foundation of an empowering recovery plan.

RCSP projects also have adopted strengths-based approaches to the recovery community, as well as to the larger community. By engaging the recovery community in all aspects of the identification, planning, and delivery of peer recovery support services, projects have expressly built upon the strengths and insights of those who are working to achieve and sustain their own recovery goals and are willing to give back to the community through the peer recovery support effort. Similarly, they actively work within the larger community to identify and strengthen existing services and resources that can support recovery. Peer services function as a bridge to a larger network of community support. As one project director noted, "We are building our community's capacity to care."

Many RCSP projects have benefited from conducting comprehensive community strengths and needs assessments. This type of assessment—which may be ongoing throughout the life of the project—

identifies services and resources available both in the recovery community and in the community at large that can support recovery. The assessment creates multiple opportunities for people in and seeking recovery, as well as family members, significant others, and stakeholders, to identify, in their own words, what has worked for them, what they think is needed, and what they can contribute to the peer effort. In addition to helping ensure that a project develops services that fill gaps, rather than competing with services and resources already available in the community, the strengths and needs assessment identifies important resources within the recovery community and the larger community that can contribute to the development of strong peer services and/or provide assistance that recovering people need. The assessment also facilitates the building of important stakeholder relationships and serves as a foundation for effectively connecting people to resources in the community that support recovery.

Many peer recovery support service programs have developed peer leader training programs to help peer leaders build skills in strengths-based recovery planning. These include training in the use of motivational interviewing techniques, adapted for peer leaders. In addition, many programs have found it important to continually reinforce their commitment to strength-based services through program procedures and guidelines and ongoing supervision. Both peer leaders and peers seeking help may be more familiar with service systems that are focused more on naming and reducing deficits and pathologies than on naming and nurturing strengths. Moreover, the stigmas associated with substance use disorders encourage patterns of shame and blame. Training and positive reinforcement can help prevent peer leaders from slipping back into deficit-based ways of thinking.

Self-Direction, Empowerment, and Choice

Embedded in the shared values of RCSP peer recovery support services is a philosophy of self-direction, choice, and empowerment. The many pathways to recovery are acknowledged, the person seeking recovery is assumed to be fully capable of making informed choices, and his or her preferences are respected.

In practice, carrying out the principles of self-direction, empowerment, and choice has sometimes been challenging to peer leaders. In the first place, they have often needed to become well-informed about pathways to recovery different from their own. In some cases, project leaders have had to combat their own misconceptions about, and prejudices against, certain recovery modalities, such as recovery assisted by medication or grounded in religious belief.

Furthermore, the assumption that the person seeking recovery is fully capable of making informed choices may not always fit the circumstances, particularly when neurological impairment is significant or when acute or severe psychiatric symptoms are associated with an active substance use disorder or early recovery. This can require a peer leader to know when to strike a delicate balance between respect for the peer's rights of choice and a need to keep the recovery process simple for the time being.

Several RCSP projects use asset mapping to uncover the community's natural assets (people, organizations, places, and things) that support recovery and to build stronger connections between these assets and people who are seeking recovery. In addition, these projects seek to foster mutually beneficial relationships with the individuals and organizations that are responsible for these assets. These asset-mapping strategies, and the asset-based community development theory (Kretzmann & McKnight, 1993) on which they are based, are a comfortable fit with the strength-based philosophy of most RCSP peer recovery support services.

The Many Values of Peer Recovery Support Services

Historically, the substance use disorder and recovery field led the way in recognizing the importance of peer support services for a person seeking to come to terms with a life-changing condition. Utilization of peer support is, by now, a common practice in many fields. In the medical world of today, for example, there is scarcely a specialty where peer support is not recognized as a valuable adjunct to professional medical and social interventions. Improved outcomes are particularly notable when peer support services are provided to people with chronic conditions that require long-term self-management. Thus, the peer recovery support services offered by RCSP grant projects and others stand in a long, well-documented, and copied evidence-based tradition.

Peer recovery support services can fill a need long recognized by treatment providers for services to support recovery after an individual leaves a treatment program. In addition, peer recovery support services hold promise as a vital link between systems that treat substance use disorders in a clinical setting and the larger communities in which people seeking to achieve and sustain recovery live. Using a nonmedical model in which social support services are provided by peer leaders who have experienced a substance use disorder and recovery, these services extend the continuum of care by facilitating entry into treatment, providing social support services during treatment, and providing a posttreatment safety net to those who are seeking to sustain treatment gains.

These services are proving to be very adaptable, operating within diverse populations, stages of recovery, pathways to recovery, service settings, and organizational contexts. Notably, they build on resources that already exist in the community, including diverse communities of recovering people who wish to be of service. By serving as role models for recovery, providing mentoring and coaching, connecting people to needed services and community supports, and helping in the process of establishing new social networks supportive of recovery, peer leaders make recovery a presence in their communities and send a message of hope fulfilled.

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A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

PEERx SHARE A DOSE OF REALITY: PRESCRIPTION DRUG ABUSE IS DRUG ABUSE

Educators Guide

Table of Contents

NIH | National Institute on Drug Abuse

PEERx Educators Guide

PEERx Educators Guide

Introduction

The purpose of the PEERx Educators Guide from the National Institute on Drug Abuse (NIDA) is to provide you with information and ideas for raising awareness about the dangers of prescription drug abuse among teens. This guide pulls together many of NIDA's science-based materials about prescription drug abuse and offers suggestions for how to use them as complete lessons or as supplements to existing lesson plans.

The guide is divided into four parts.

1. **Prescription Drug Abuse Facts:** This section provides an overview about prescription drug abuse, such as the definition of prescription drug abuse and facts about commonly abused prescription drugs. Also included are additional resources for more indepth information about how prescription drug abuse can affect the brain and body. This section can be used as background information as you prepare a lesson and as a resource for teens who are completing projects or who would like more information about prescription drug abuse.

2. **Lesson Materials:** This section focuses mainly on the PEERx materials that provide engaging activities to help raise teen awareness about the dangers of prescription drug abuse. PEERx activities range from watching interactive videos to designing t-shirts.

3. **Example Lesson Plans:** NIDA has developed several curricula about drug abuse and addiction. This section highlights lessons from two curricula—Mind Over Matter and *Brain Power!*—that focus on prescription drug abuse. These lessons can be used in full, supplemented with PEERx materials, or they can provide a template as you develop your own lesson about the dangers of prescription drug abuse.

4. **Other Resources:** This section of the guide provides resources to help you and your students share the facts about prescription drug abuse with your community. You'll find promotional tools such as social media and newsletter language about teen prescription drug abuse, infographics, and information about how to get involved in NIDA's National Drug Facts Week, a national health observance during which schools and organizations across the country host events to teach teens the facts about drug abuse and addiction.

PEERx Educators Guide

Background

National Institute on Drug Abuse

The National Institute on Drug Abuse (NIDA) is a part of the National Institutes of Health, U.S. Department of Health and Human Services. NIDA supports most of the world's research on how drug abuse affects the brain and body, including how it leads to addiction. In addition to supporting and conducting research, NIDA disseminates its findings through science-based materials such as Web sites, publications, and curricula supplements.

Teen Prescription Drug Abuse and PEERx

Prescription drug abuse among teens is a significant problem. In 2012, the Monitoring the Future study reported that 14.8% of high school seniors used a prescription drug not prescribed for them or for nonmedical reasons in the past year.[1] Findings also showed that after marijuana, prescription and over-the-counter medications account for most of the top drugs abused by 12th graders in the past year, with Adderall and Vicodin being the most commonly abused prescription drugs.

In response to this serious public health problem, NIDA developed PEERx, an online educational initiative to discourage abuse of prescription drugs among teens. A component of the NIDA for Teens program, PEERx provides science-based information about prescription drug abuse prevention. PEERx has a variety of free resources, including Choose Your Path videos, which allow you to assume the role of the main character and make decisions about whether to abuse certain prescription drugs. PEERx also includes an Activity Guide for planning events in schools and communities, a partner toolkit, fact sheets about prescription drugs, and other helpful resources. Some of these resources are provided in this guide; for the full PEERx program visit http://teens.drugabuse.gov/peerx.

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[1] Monitoring the Future 2012: http://www.drugabuse.gov/related-topics/trends-statistics/monitoring-future/monitoring-future-survey-overview-findings-2012

PEERx Educators Guide

Prescription Drug Abuse Facts

This section of the PEERx Educators Guide defines prescription drug abuse, provides information about how many teens abuse prescription drugs, and provides important facts about the most abused prescription drugs. For detailed information and facts, reference the additional resources listed at the end of this section.

What Is Prescription Drug Abuse?

Prescription drug abuse is when someone takes a medication in an inappropriate way, such as:

- Without a prescription

- In a way other than as prescribed

- For the "high" elicited

Most Commonly Abused Prescription Drugs

Opioids (such as the pain relievers OxyContin and Vicodin), central nervous system depressants (e.g., Xanax, Valium), and stimulants (e.g., Concerta, Adderall) are commonly abused prescription drugs.

Medications available without a prescription—known as over-the-counter drugs—can also be abused. DXM (dextromethorphan), the active cough suppressant found in many over-the-counter cough and cold medications, is one example. It is sometimes abused to get high, which requires taking large and potentially dangerous doses.

Number of Teens Abusing Prescription Drugs

For the latest trends in youth prescription drug abuse and perceived risk of prescription drug abuse, see NIDA's Monitoring the Future study as well as the National Survey on Drug Use and Health from the Substance Abuse and Mental Health Services Administration.

- The Monitoring the Future study is an annual survey of teens in grades 8, 10, and 12 that looks at drug abuse and perceptions of drug abuse among teens. For the latest results, visit http://www.drugabuse.gov/related-topics/trends-statistics/monitoring-future/monitoring-future-study-trends-in-prevalence-various-drugs.

- The National Survey on Drug Use and Health is an annual survey of households in the United States that provides national and state-level data on the use of tobacco, alcohol, and illicit drugs (including nonmedical use of prescription drugs), and mental health. For the latest results, visit http://www.samhsa.gov/data/NSDUH.aspx.

Myths About Prescription Drugs

Teens often have misconceptions about prescription drugs that may contribute to the increased abuse of these drugs in recent years. These misconceptions include:

Myth: Prescription drugs are safer to abuse than other drugs because they are prescribed by a doctor.

Fact: When used as prescribed, these medications *are* safe and effective. However, with nonmedical use, the health effects of prescription drugs can be as dangerous as those experienced from illegal drug use. Doctors take many factors into account when prescribing a drug for a person who needs it: dose size, the person's weight and height, how long the drug should be taken, and much more. The bottom line is that drugs affect everyone differently.

Myth: Using stimulant medications prescribed for attention deficit hyperactivity disorder (ADHD)—such as Adderall and Ritalin—offer an academic edge (e.g., increased energy and focus).

Fact: Stimulant medications affect people with ADHD differently than people without ADHD. For people who do not have ADHD, stimulants flood the brain with dopamine, causing a dopamine overload. So instead of having a calming effect as they would on people with ADHD, stimulants taken without a medical reason can disrupt brain communication and cause euphoria. Repeated abuse of stimulants can:

- Increase blood pressure, heart rate, and body temperature.
- Decrease appetite and sleep.
- Cause feelings of hostility and paranoia.
- Increase a person's risk for addiction.[2]

Reasons for Abuse

Teens may cite a number of reasons to abuse prescription drugs, including:

- To get high
- To counter anxiety or sleep problems
- To boost their academic performance
- To help treat pain

Availability

Many teens who use prescription drugs for nonmedical purposes get the drugs from a friend or relative, either for free, by buying them, or taking them without asking.

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[2] Sara Bellum Blog: "Prescription Stimulants Affect People with ADHD Differently," http://teens.drugabuse.gov/blog/post/prescription-stimulants-affect-people-adhd-differently

Prescription Opioids Key Facts

Overview

Opioids are commonly prescribed to relieve pain. They are often prescribed by doctors after surgery or to help patients with severe acute or chronic pain. Studies have shown that if taken exactly as prescribed by a medical professional, opioids are safe, can manage pain effectively, and rarely cause addiction. The problem occurs when they are abused. In fact, painkillers are one of the most commonly abused drugs by teens after tobacco, alcohol, and marijuana.

Common opioids and their uses are listed below.

Type	Conditions They Treat	Common Street Names
Oxycodone • OxyContin • Percodan • Percocet **Hydrocodone** • Vicodin • Lortab • Lorcet **Diphenoxylate** • Lomotil **Morphine** • Kadian • Avinza • MS Contin **Codeine** **Fentanyl** • Duragesic **Propoxyphene** • Darvon **Hydromorphone** • Dilaudid **Meperidine** • Demerol **Methadone**	• Severe pain, often after surgery • Chronic or acute pain • Cough and diarrhea	• Hillbilly heroin, OC, oxy, percs, happy pills, or vikes

Effects on the Brain

Opioids attach to specific proteins called opioid receptors, which are found in the brain, spinal cord, gastrointestinal tract, and other organs. When opioid drugs attach to these receptors in certain brain regions, they can diminish the perception of pain.

Opioids can also cause a person to feel relaxed and euphoric by affecting areas of the brain connected with how we perceive pleasure. These feelings can be intensified when opioids are abused. Repeated abuse of opioids can lead to addiction—compulsive drug seeking and abuse despite known harmful consequences.

Negative Effects

Opioids can produce drowsiness, cause constipation, and, depending on the amount taken, affect a person's ability to breathe properly. In fact, taking just one large dose could cause severe breathing complications or death.

PEERx Educators Guide

Central Nervous System Depressants Key Facts

Overview

Central nervous system (CNS)—the brain and spinal cord—depressants slow down (or "depress") the normal activity that goes on in the brain. Doctors often prescribe them for people who are anxious or can't sleep. When taken as directed, they can be safe and helpful. But when people take someone else's prescription drugs or take the drugs for entertainment or pleasure, they may experience dangerous consequences.

Common CNS depressants and their uses are listed below.

Type	Conditions They Treat	Common Street Names
Barbiturates • Mephobarbital (Mebaral) • Sodium pentobarbital (Nembutal)	• Seizure disorders • Surgical procedures	• Barbs, reds, red birds, phennies, tooies, yellows, or yellow jackets
Benzodiazepines • Diazepam (Valium) • Alprazolam (Xanax) • Estazolam (ProSom)	• Acute stress reactions • Panic attacks • Convulsions • Sleep disorders	• Candy, downers, sleeping pills, or tranks
Sleep Medications • Zolpidem (Ambien) • Zaleplon (Sonata) • Eszopiclone (Lunesta)	• Sleep disorders	• A-minus or zombie pills

Effects on the Brain

Most CNS depressants affect the brain in the same way—they enhance the activity of gamma-aminobutyric acid (GABA), a naturally occurring chemical in the brain that sends messages between cells. GABA works by slowing down brain activity. Although different classes of CNS depressants work in unique ways, they ultimately increase GABA activity, which produces a drowsy or calming effect.

Negative Effects

Although CNS depressants can help people suffering from seizures, anxiety, or sleep disorders, they can be addictive and should be used only as prescribed. During the first few days of taking a CNS depressant, a person usually feels sleepy and uncoordinated. With continuing use, the body becomes accustomed to these effects, and they lessen. This is known as tolerance, which means that larger doses are needed to achieve the same initial effects. Continued use can lead to physical dependence and, when stopped, withdrawal.

Prescription Stimulants Key Facts

Overview

As their name suggests, prescription stimulants increase—or "stimulate"—activities and processes in the body. This increased activity can boost alertness, attention, and energy. It also can raise a person's blood pressure and heart rate. In the past, stimulants were used to treat a variety of conditions, including asthma and other respiratory problems, obesity, and neurological disorders. As their potential for abuse and addiction became apparent, doctors began to prescribe them less often. Now, stimulants are prescribed for treating only a few health conditions, including ADHD, narcolepsy (a sleep disorder), and, in some instances, depression that has not responded to other treatments.

Common stimulants and their uses are listed below.

Type	Conditions They Treat	Common Street Names
Dextroamphetamine • Dexedrine • Adderall **Methylphenidate** • Ritalin • Concerta	• ADHD • Narcolepsy (sleep disorder) • Depression	• Skippy, the smart drug, vitamin r, bennies, black beauties, roses, hearts, speed, uppers

Effects on the Brain

The brain is made up of nerve cells that send messages to each other by releasing chemicals called neurotransmitters. Common stimulants, such as amphetamines (e.g., Adderall) and methylphenidate (e.g., Ritalin), have chemical structures that are similar to certain key brain neurotransmitters called monoamines, including dopamine and norepinephrine. Stimulants enhance the effects of these chemicals in the brain and body.

When doctors prescribe stimulants, they start with low doses and increase them gradually until they fully treat the condition for which they are prescribed. However, when taken in doses and by routes other than those prescribed (e.g., snorting or injecting), stimulants can increase the dopamine in the brain very quickly, disrupting normal communication between brain cells, producing euphoria, and increasing the risk of addiction.

Negative Effects

Stimulant abuse can be extremely dangerous. Taking high doses of a stimulant can cause an irregular heartbeat, dangerously high body temperatures, and the potential for heart failure or seizures. For some people, taking high doses of certain stimulants, or repeatedly abusing them, can lead to feelings of hostility or paranoia.

More Resources About the Effects of Prescription Drug Abuse

The NIDA for Teens Web site provides detailed fact sheets written for teens about prescription drugs. These fact sheets can be found at the following URLs and used online or printed as handouts.

- Prescription and Over-the-Counter Medications Fact Sheet: http://teens.drugabuse.gov/drug-facts/prescription-drugs

- Prescription Opioids Fact Sheet: http://teens.drugabuse.gov/drug-facts/opioids-and-pain-reliever-facts

- Central Nervous System (CNS) Depressants Fact Sheet: http://teens.drugabuse.gov/drug-facts/central-nervous-system-cns-depressants-facts

- Prescription Stimulants Fact Sheet: http://teens.drugabuse.gov/drug-facts/prescription-stimulants

- Dextromethorphan Fact Sheet: http://teens.drugabuse.gov/drug-facts/dextromethorphan-dxm-and-cold-medicine-facts

In addition to the NIDA for Teens prescription drug fact sheets, NIDA provides several publications about prescription drugs and the effects of their abuse. These publications can be found online or in the appendix of this guide.

- Prescription and Over-the-Counter Medications (DrugFacts)
  - Online: http://www.drugabuse.gov/publications/drugfacts/prescription-over-counter-medications
  - Page 1 of the appendix

- Commonly Abused Prescription Drugs Chart
  - Online: http://www.drugabuse.gov/sites/default/files/rx_drugs_placemat_508c_10052011.pdf
  - Page 4 of the appendix

- Prescription Drugs: Abuse and Addiction (Research Report)
  - Online: http://www.drugabuse.gov/publications/research-reports/prescription-drugs
  - Page 6 of the appendix

- Stimulant ADHD Medications—Methylphenidate and Amphetamines (DrugFacts)
  - Online: http://www.drugabuse.gov/publications/drugfacts/stimulant-adhd-medications-methylphenidate-amphetamines
  - Page 22 of the appendix

Partner Success Story: Drug Education Council

The Drug Education Council, a partner agency of the Baldwin County United Way and the United Way of Southwest Alabama, is dedicated to promoting a drug-free society, preventing chemical dependency, and providing quality education, information, and intervention programs.

As part of NIDA's 2013 National Drug Facts Week, the Drug Education Council held a press conference and a Prescription Drug Abuse Summit. These events brought together local experts to discuss the growing problem of youth prescription drug abuse. The PEERx materials were shared as examples of how educators could raise awareness of the issue among teens.

The event gained local media attention and resulted in a proclamation by the Alabama Governor, Robert Bently, supporting National Drug Facts Week and the efforts of the Drug Education Council to raise awareness about prescription drug abuse.

PEERx Educators Guide

Lesson Materials

This section of the PEERx Educators Guide describes various activities and materials related to prescription drug abuse that can be used to engage teens. You'll find:

- Articles to start a conversation about prescription drug abuse

- Interactive videos that teens can use to understand the negative consequences of abusing prescription drugs

- Creative activities such as developing public service announcements (PSAs) and t-shirts to help spread the word about the dangers of prescription drug abuse

- Posts from NIDA's Sara Bellum Blog, which is written for teens and includes short, topical posts about drug abuse, brain science, and addiction. Often, guest bloggers write posts about their drug abuse prevention efforts. You can use the blog as an educational tool either by asking students to respond to a post or to write a new post for submission to NIDA.

Starting a Discussion

In collaboration with Scholastic, NIDA developed a series of short articles each with an accompanying teacher's guide about different aspects of prescription drug abuse. These articles are part of the *Heads Up: Real News About Drugs and Your Body* lesson supplements series. Each article provides background information and key facts that can help teens learn about the topic. The teacher's guide provides tips and discussion questions for facilitating the conversation. A poster illustrates the key dangers of prescription drug abuse.

1. "Straight Talk on Prescription Drugs" is a teen reporter's interview with NIDA Director Nora D. Volkow, M.D., about prescription drug abuse. The article discusses questions such as "What are the effects of prescription drug abuse—either one-time or long-term use?" and "What is the likelihood of someone becoming addicted to prescription drugs?"

2. "Prescription Pain Medications: Just Because a Doctor Prescribes Them Doesn't Mean They Are Safe To Abuse" explains what prescription opioids are, why they require a prescription, and the dangers of abusing them.

3. "Prescription Stimulants" describes what prescription stimulants are, why they help people with ADHD, why they require a prescription, and the danger of abusing them.

The compilation also includes an online scavenger hunt that encourages teens to explore the *Heads Up: Real News About Drugs and Your Body* Web pages to answer questions about the myths and facts of prescription drug abuse.

PEERx Educators Guide

Complete *Heads Up: Real News About Drugs And Your Body* Materials

The complete *Heads Up: Real News About Drugs and Your Body* prescription drug compilation can be found online and in the appendix of this guide.

- Student articles:
    - o Online: http://www.scholastic.com/smp/pdfs/nida/NIDA9-Stu_Comp.pdf
    - o Page 26 of the appendix

- Scholastic Teacher's Guide:
    - o Online: http://www.scholastic.com/smp/pdfs/nida/NIDA9-TE_Comp.pdf
    - o Page 38 of the appendix

- Prescription drug abuse poster:
    - o Online: http://www.drugabuse.gov/sites/default/files/rxdrugsposter.pdf
    - o Page 46 of the appendix

Choose Your Path Interactive Videos

The Choose Your Path activity includes two interactive videos that allow teens to assume the role of the main character and make decisions about whether to abuse prescription drugs, such as Xanax or Adderall. After each scene, the viewer selects what the main character will do next and sees the results of that decision. The videos illustrate realistic scenarios in which teens might be confronted with a decision about whether to abuse prescription drugs.

These videos highlight everyday pressures that affect teens. Having teens control the videos and make decisions throughout the storyline reinforces that they can make positive choices on their own.

How It Works

First, a video clip sets up the scenario. At the end of each scene, viewers choose between two different paths. After viewers make their selection, the chosen scenario plays out. The video can be restarted to explore the outcomes of different decisions.

These questions can accompany your discussion after watching the Choose Your Path videos:

1. What would you do if faced with the same situations as the characters?

2. What are safe ways for the main characters to react to the stressful situations they face?

3. What are the dangers of taking a friend's or family member's prescription drugs?

PEERx Educators Guide

Choose Your Path: BFF or the Ex?

Find this video at http://teens.drugabuse.gov/videos/choose-your-path/bff-or-ex.

Depending on which path you take in this video, a teenager is offered either Xanax or Vicodin by a friend.

Xanax is a central nervous system (CNS) depressant prescribed to people for anxiety and sleeping problems. CNS depressants slow down the normal activity in the brain; when abused, they can have dangerous consequences. Most CNS depressants affect the brain in the same way—they enhance the activity of gamma-aminobutyric acid (GABA), a naturally occurring chemical in the brain that sends messages between cells. GABA works by slowing down brain activity. Although different classes of CNS depressants work in unique ways, they ultimately increase GABA activity, which produces a drowsy or calming effect.

Vicodin is an opioid prescribed to people to treat pain. Opioids are often prescribed by doctors after surgery or to help patients with severe acute or chronic pain. Opioid prescriptions are also known as "painkillers" or "pain meds."

Opioids affect the brain in the same way as illicit opiates like heroin. Studies have shown that if taken exactly as prescribed by a medical professional, opioids are safe, can manage pain effectively, and rarely cause addiction. The problem occurs when they are abused.

Opioids attach to specific proteins called opioid receptors, which are found in the brain, spinal cord, gastrointestinal tract, and other organs. When opioid drugs attach to these receptors in certain brain regions, they can diminish the perception of pain. Opioids can produce drowsiness, cause constipation, and, depending on the amount taken, affect a person's ability to breathe properly. In fact, taking just one large dose could cause severe breathing problems or death. Repeated abuse of opioids can lead to addiction—seeking out and using the drug over and over despite known harmful effects.

Play the video to find out what might happen if someone takes Xanax or Vicodin not prescribed for them.

PEERx Educators Guide

Choose Your Path: The Big Test

In this video, a teenager must decide whether to abuse Adderall when he is preparing for a test. Adderall is a stimulant medication prescribed to people with attention deficit hyperactivity disorder (ADHD).

Stimulants increase activity in the body, such as increasing a person's heart rate and the release of dopamine in the brain. When stimulants are abused, this fast release of dopamine can increase a person's chances of becoming addicted.

Stimulant abuse can be extremely dangerous. Taking high doses of a stimulant can cause an irregular heartbeat, dangerously high body temperatures, and the potential for heart failure or seizures. For some people, taking high doses of certain stimulants, or repeatedly abusing them, can lead to feelings of hostility or paranoia.

Play the video to find out what might happen if someone takes Adderall not prescribed for them.

Complete Choose Your Path Videos

Both videos can be found at http://teens.drugabuse.gov/our-projects/peerx/choose-your-path.

Create Your Own Interactive Video

The PEERx activity Peer Into Your Path provides step-by-step instructions for teens to create their own Choose Your Path storylines. In doing so, teens have to think about the effects of prescription drugs and the scenarios in which teens might abuse them. This allows them not only to learn about the dangers of abusing prescription drugs, but also to think about how they might react when faced with the opportunity to abuse drugs. Following you will find the complete activity instructions. A blank decision tree for this activity can be found online and in the appendix of this guide.

Activity Instructions

1. **Get creative!**
   Now that you've explored the different paths and fully understand the power of decision-making, you're ready to create your very own Choose Your Path adventure. This activity is a great opportunity for you to flex your creativity and writing skills. Just use the facts on the PEERx Web site about prescription drug abuse to make your storyline as compelling as possible. You have a lot of options: write about a typical day in the life of a teen and tap into your own experiences for ideas. Or, you can create a story about someone whose life is totally different from yours or your friends'. Make sure you weave in facts about the dangers of prescription drug abuse.

2. **Fill in a decision tree.**
   Use the blank [decision tree](#) to help you outline your story. This helps you navigate your own story about abusing prescription drugs, just like the official Choose Your Path videos. Start by typing in the boxes to develop your story, or print the tree and hand write your ideas in the boxes. You can use all the same characters from Choose Your Path or create your own!

   Don't forget that these video adventures are shot from the main character's point of view, meaning that you see things as they happen through the eyes of the main character. Basically, any person watching or reading this storyline is the main character.

3. **Make sure to include two paths.**
   Your Choose Your Path adventure should start off with one decision, such as should you go on a date with Mario? Or not? Should you miss the bus and take a ride from a friend? Should you say hi to that cute boy or girl at the mall? Let your imagination run wild! Remember that in every scene your reader should be faced with two decisions. One decision should have a negative consequence of abusing prescription drugs and another outcome based on a healthier decision. Just remember, at the end of your story, you will need to have outcomes based on the decisions that you made. The decisions are yours!

4. **Lights, camera, action!**
   If you like, take it one step further. Bring your adventure to life! Grab a camera, some friends to be your actors, and find or make the props you need to videotape one or more of the scenes in your story.

5. **Share your masterpiece.**
   Share your written storyline or put your video on YouTube and send your masterpiece our way! Email your Choose Your Path adventure to peerx@iqsolutions.com.

Complete Peer Into Your Path Instructions and Downloads

Find the complete Peer Into Your Path Activity:

- Online: http://teens.drugabuse.gov/our-projects/peerx/peer-into-your-path

- Page 47 of the appendix

Partner Success Story: Operation UNITE

Operation UNITE is a nonprofit organization serving 32 counties in Kentucky by providing narcotics investigations, substance abuse treatment and referrals, youth programs, family support, and community education initiatives. Its recent prescription drug abuse prevention efforts in schools offer a replicable strategy for other organizations seeking to reach teens about this critical public health issue.

During NIDA's 2013 National Drug Facts Week, Operation UNITE held events in collaboration with school anti-drug clubs to educate students about the dangers of prescription drug abuse. Organizers used PEERx resources, including the interactive Choose Your Path videos, which allowed students to assume the role of the main character and make decisions about whether to abuse prescription drugs, such as Adderall or Xanax. Students selected which path to take and watched the consequences of that decision play out on screen.

Students also developed skits, and one group even wrote their own rap, using only information from the PEERx Web site. They acted out their skits and selected the best one to present to the entire school. Through these efforts, Operation UNITE reached 750 students and teachers.

PEERx Educators Guide

Activities

The PEERx initiative provides suggestions for a number of activities for teens, as part of the PEERx Activity Guide, to help teach and reinforce information about the dangers of prescription drug abuse. These activities can be used as part of a lesson or as events themselves.

Following is a list of the different activities with brief descriptions of each.

- **Wear the Message:** Have students bring in t-shirts or other clothing items and use NIDA's Downloads Creator to iron on designs. Students also can personalize their own iron-on shirts with their own messages.

    o Find detailed instructions for this activity on the PEERx Web site:
       http://teens.drugabuse.gov/our-projects/peerx/get-involved/wear

    o For a complete list of the PEERx downloads, visit
       http://teens.drugabuse.gov/our-projects/peerx/downloads

- **Hold a School Assembly:** There's no better way to spread the word throughout your school about the dangers of prescription drug abuse than to hold an assembly that everyone can attend.

    o Find detailed instructions for this activity on the PEERx Web site:
       http://teens.drugabuse.gov/our-projects/peerx/get-involved/assemble

- **Predict the Future:** Make Prescription Drug Abuse Fortune Tellers to show the possible side effects of abusing prescription drugs.

    o Find detailed instructions for this activity on the PEERx Web site:
       http://teens.drugabuse.gov/our-projects/peerx/get-involved/predict

    o Find a sample fortune teller on page 68 of the appendix.

- **Write and Broadcast a Radio PSA:** Write radio public service announcements (PSAs), record them, and pick the best one. Then contact local radio stations to ask them to play the winning PSA or to interview the student with the winning project.

    o Find detailed instructions for this activity on the PEERx Web site:
       http://teens.drugabuse.gov/our-projects/peerx/get-involved/broadcast

- **Host a "Relieve the Stress Fest!":** Demonstrate a variety of simple stress reduction techniques.

    o Find detailed instructions for this activity on the PEERx Web site:
       http://teens.drugabuse.gov/our-projects/peerx/get-involved/de-stress

PEERx Educators Guide

- **Create a Classroom Crime Scene Investigation:** Start at the end where a teen is in the hospital as a result of prescription drug abuse. Work backward to find out what drug the person took.
  - o Find detailed instructions for this activity on the PEERx Web site: http://teens.drugabuse.gov/our-projects/peerx/get-involved/investigate

- **Participate in Drug Facts Chat Day:** Encourage students to participate in Chat Day by asking the scientists the best questions.
  - o Find detailed instructions for this activity on the PEERx Web site: http://teens.drugabuse.gov/peerx/get-involved/chat

- **Hold an Art or Poster Design Contest:** Students' posters should show the effects of prescription drug abuse on the brain. Display the most compelling posters around your school.
  - o Find detailed instructions for this activity on the PEERx Web site: http://teens.drugabuse.gov/our-projects/peerx/get-involved/design

- **Issue a Proclamation for Prescription Drug Abuse Awareness Day:** A proclamation is a great way to spread the word!
  - o Find detailed instructions for this activity on the PEERx Web site: http://teens.drugabuse.gov/our-projects/peerx/get-involved/proclaim

Complete Activity Guide

Find the PEERx Activity Guide:

- Online: http://teens.drugabuse.gov/our-projects/peerx/get-involved

- Page 48 of the appendix

Partner Success Story: California Health Collaborative

The California Health Collaborative serves the needs of individuals with limited access to health care resources. Their Lock It Up Project is a community-based prevention project that raises awareness of the risks associated with prescription drug abuse among youth and young adults in Fresno County, California.

The California Health Collaborative, as part of its Lock It Up project, developed a curriculum to raise awareness about prescription drug abuse. The curriculum is taught to teens by college students in Fresno area high schools. The PEERx Choose Your Path videos are included in the curriculum unit on "Refusal Strategies" and the PEERx Activity Guide is included in the appendix.

Sara Bellum Blog Posts About Prescription Drugs

A team of NIDA scientists and science writers created the Sara Bellum Blog to connect teens in middle and high school with the latest scientific research and news about drug abuse and addiction. Since its creation in 2009, the Sara Bellum Blog has covered a wide range of topics related to drug abuse and addiction, including facts about drugs of abuse, peer pressure, and mental health. NIDA publishes one or two posts each week, and the latest post can be found at http://teens.drugabuse.gov/blog.

Sara Bellum Blog posts about prescription drug abuse can be used as additional reading or as information sources on specific aspects of teen prescription drug abuse. You can assign students to respond to a post or to write a new post for submission to NIDA.

Following is a list of several topical posts, links to the original posts, and a brief summary.

- During National Drug Facts Week: The Truth About Prescription Drugs
    - o Did you know that prescription and over-the-counter drugs are the most commonly abused substances by high school seniors (after marijuana and alcohol)?
    - o Full post: http://teens.drugabuse.gov/blog/post/truth-about-prescription-drugs

- Medications and Alcohol Don't Mix
    - o If you take any medications—either those prescribed by a doctor or over-the-counter cold and allergy medicine—it's not a good idea to drink alcohol. Often, the medication label will warn you not to—because of the possible dangerous side effects.
    - o Full post: http://teens.drugabuse.gov/blog/post/medications-and-alcohol-dont-mix

- Prescription Stimulants Affect People With ADHD Differently
    - o Prescriptions are only meant to be taken by the person who was proscribed them, at the dosage prescribed, because prescriptions help treat certain conditions and do not have the same effects on everyone.
    - o Full post: http://teens.drugabuse.gov/blog/post/prescription-stimulants-affect-people-adhd-differently

- Prescription Drugs on TV
    - o Did you know that the United States and New Zealand are the only countries in the world that allow prescription drug companies to market medications directly to the public?
    - o Full post: http://teens.drugabuse.gov/blog/post/prescription-drugs-tv

- Girls and Boys Have Different Reasons for Prescription Drug Use
    - Teenage girls are now more likely than boys to abuse prescription drugs like pain pills and ADHD medications. The thing is—they have different reasons for doing so.
    - Full post: http://teens.drugabuse.gov/blog/post/girls-and-boys-have-different-reasons-prescription-drug-use

Additional Posts Related to Prescription Drug Abuse

Find additional Sara Bellum Blog posts about prescription drugs at the following links.

- Blog Category "Prescription Drug Abuse": http://teens.drugabuse.gov/blog/category/prescription-drug-abuse

- Blog Tag "Prescription Drugs": http://teens.drugabuse.gov/blog/category/343

- Blog Tag "Prescription Drug Abuse": http://teens.drugabuse.gov/blog/category/342

- Blog Tag "PEERx": http://teens.drugabuse.gov/blog/category/341

PEERx Educators Guide

Example Lesson Plans

Two of NIDA's curricula offer materials about prescription drug abuse. Mind Over Matter is for grades 5–9 and *Brain Power!* is for grades 6–9. These lessons can be used in full, in part, or as an outline for developing your own lesson about prescription drug abuse.

Mind Over Matter (Grades 5–9)

The Mind Over Matter lesson on prescription drug abuse defines the problem and talks about the effects prescription drugs can have on the brain and body. The character, a fictional youth scientist, leads students through an exploration of what prescription drugs are and how they can affect the brain and body.

Complete Lesson

The information from the lesson is summarized in a short magazine about prescription drugs that can be found:

- Online: http://teens.drugabuse.gov/sites/default/files/PrescriptionDrugs.pdf

- Page 70 of the appendix

A step-by-step outline of the lesson plan is also online at http://teens.drugabuse.gov/educators/curricula-and-lesson-plans/mind-over-matter/prescription-drug-abuse.

Brain Power! (Grades 6–9)

Brain Power!, a curriculum with six modules, discusses prescription drug abuse in the third module called, "Drugs in the Cupboard." This module explains how prescription drugs and some household products can damage the brain and body when used improperly.

Complete Lesson

Find this module:

- Online: http://www.drugabuse.gov/publications/brain-power/grades-6-9/drugs-in-cupboard-module-3

- Page 72 of the appendix

PEERx Educators Guide

Partners Toolkit

NIDA has partnered with a number of Federal, national, state, and local organizations to help raise awareness about the dangers of teen prescription drug abuse. To support their efforts, NIDA provides an online toolkit with social media language, drop-in articles, and Web badges at http://teens.drugabuse.gov/our-projects/peerx/peerx-partner-toolkit.

Other Resources

Through the PEERx program, NIDA has developed a number of additional materials and partnerships that you may find helpful as you seek to educate teens about the danger of prescription drug abuse.

Partner Resources

- The PEERx Partner Toolkit provides social media messages and background information about prescription drugs and PEERx: http://teens.drugabuse.gov/peerx/peerx-partner-toolkit.

- A spotlight on how PEERx partners raise awareness about the dangers of prescription drug abuse and a full list of PEERx partners can be found at http://teens.drugabuse.gov/peerx/peerx-partners.

Additional Materials

- In April 2013, NIDA wrote a guest blog post about the dangers of teen prescription drug abuse for the National Education Association's Health Information Network: http://www.neahin.org/blog/teen-prescription-drug-abuse.html.

- In November 2012, NIDA discussed the rise and dangers of teen prescription drug abuse with the American School Counselor Association as part of their ASCAway program. The complete podcast can be found at http://ascaway.podbean.com/2012/11/16/ascaway-teen-prescription-drug-abuse.

- NIDA's Easy-to-Read Drug Facts Web site provides a plain language fact sheet about the dangers of opioid prescription drugs: http://www.easyread.drugabuse.gov/painkiller-abuse-facts.php.

NIDA Infographics

NIDA has developed several infographics about teen prescription drug abuse that can be found on the NIDA Web site. These infographics are listed from newest to oldest. Please note that older infographics may not reflect the latest drug abuse statistics.

- Online: http://www.drugabuse.gov/related-topics/trends-statistics/infographics.

- Sample infographics: Pages 83-86 of the appendix.

PEERx Educators Guide

Keep in Touch!

If you decide to use the NIDA for Teens resources, please let us know. We are very interested in hearing how educators use these resources. We can also provide further information and answer questions. Email us at peerx@iqsolutions.com.

National Drug Facts Week

Another opportunity to raise awareness about teen prescription drug abuse in your community is to take part in National Drug Facts Week. Each year, National Drug Facts Week takes place at the end of January and is a week during which schools and communities organize events to help teens learn the facts about drug abuse and addiction. The PEERx activities are great event ideas for National Drug Facts Week.

Learn more about National Drug Facts Week at http://drugfactsweek.drugabuse.gov/index.php.