

Module One

Introduction

Time

The anticipated time for the module is four hours.

Learning Objectives

Participants will be able to:

- Identify by name at least three other participants
- Practice responding to proponents of various viewpoints of prevention
- Understand the history of drugs in America and its impact on current viewpoints
- Review the building blocks of successful prevention

Materials and Preparation

1. Prepare an overhead or LCD projector with the appropriate slides.
2. Adapt the agenda to your schedule and provide for participants.
3. Place a participant manual on each seat. Be ready to use the following information and work sheets:
 - **Viewpoints of Prevention**
 - **History of Drugs in America**
 - **A Timeline of Prevention**
 - **Evolution and Training of the Prevention Discipline**
 - **Building Blocks for Successful Prevention Programs**
4. Make a copy of the pre-test for each participant, if using pre-post tests.
5. Prepare role-play cards for the Viewpoints of Prevention activity.
6. Have handy a chart pad and markers.
7. Set up a videocassette recorder and monitor to show a video on the history of drugs.

Trainer Note:

If you have multiple trainers, it is advisable for each trainer to present during Section 1. The section can be divided as follows:

- Trainer A can present slide 1, **Welcome** through slide 6, **Introduction** and the getting acquainted activity
- Trainer B can present slide 7, **Attitudes About Drugs** through slide 10, **Viewpoints** and the video
- Trainer C can present slide 11, **Drugs of Abuse** through slide 17, **Introduction**.

Format of Facilitator Notes

Trainer instructions are in *italics*. Suggested narrative is in normal font.

Integrating the Strategic Planning Framework throughout the SAPST

The Substance Abuse Prevention Specialist Training (SAPST) is designed to cultivate readiness in community level prevention providers to operate as prevention professionals in the context of increased accountability to funders, to other providers and of course to communities. Prevention as a field is operating in an environment of increased accountability for the services provided and the outcomes achieved by those services. In order to meet the challenge of achieving measurable positive population level outcomes and the increasingly stringent accountability standards preventionists must employ a data driven, outcomes based planning process.

Which leads to the question: “How does the Substance Abuse Prevention Specialist Training support a data driven, outcomes based planning process such as SAMHSA/CSAP’s Strategic Prevention Framework?” It is incumbent upon the facilitators of this curriculum to draw connections between the information in each of the modules and the Strategic Prevention Framework (SPF) to answer this question. The material covered in modules 1, 2, 4, 5, 6, 7 & 8 (the final module) feeds into what should be contained in a data driven, outcomes based strategic plan. In each module of the SAPST, facilitator notes provide some examples of how the content supports the SPF. Facilitators should be diligent in drawing these and other connections between the modules and the SPF when conducting the SAPST. This helps to solidify the connections for participants, not only between the SPF and the modules, but also among the modules themselves.

The background information provided in Module 1 is useful to understand the general context of prevention, to provide an overview of the “culture” of prevention services as well as some of the likely perspectives that preventionists encounter in their work. The content and exercises regarding “Attitudes about Drugs” and “Viewpoints of Prevention” are means for participants to begin to separate empirical evidence or “hard data” from “soft data” like anecdotal information. Both types of information can be useful to providers in defining needs, assessing capacity, community readiness and developing strategic plans. Empirical evidence or “hard data” such as incidence and prevalence rates is vital to the SPF Assessment Step; data of this nature generally indicates the ATOD- related problems in a community. Anecdotal information such as the prevailing view of a community’s readiness to address specific ATOD-related problems is also important to assess as part of the SPF Capacity Building and Mobilizing Step and account for in a strategic plan (SPF Planning Step).

Slide 1

*Show slide 1, **Welcome Substance Abuse Prevention Specialist Training.***

Welcome participants to the training and introduce yourself, other trainers, and hosts or sponsors.

The purpose of this training is to provide an overview of basic information for substance abuse prevention professionals. This is a basic curriculum that will introduce participants to the prevention field. Becoming truly competent, sensitive and resourceful prevention professionals is an ongoing process involving continuing education and practical experience in the field. The substance abuse prevention profession is a young and evolving profession and, whether you are new to the field or have many years' experience, continuing education and experience will contribute to your expertise in many of the areas we will overview here.

Lead a brief discussion, asking the following questions: What is prevention? What does it look like in your community? What do you want to prevent/create?

Optional activity-

This activity is especially helpful when participants have worked in the treatment field and may be unclear about the differences between prevention and treatment.

I'd like to tell a story that may illustrate the difference between prevention and treatment. Two friends, Susan and Fernando, are fishing on a river when Fernando looks up river and sees a man in the water! He is struggling to stay afloat, so Fernando drops his fishing pole and pulls the man out of the water. The man is sputtering and cold, and Susan calls an ambulance on her cell phone to take the person to a hospital. Susan and Fernando go back to fishing. Pretty soon they look up river again and see a woman in the water! She is struggling, too, so Fernando drops his fishing pole again and pulls the woman out of the water. She is not in very good shape, so Susan calls another ambulance to take her to a hospital. The friends return to fishing when they look up river and see a whole group of people in the water! They are struggling to stay afloat, but look like they are dragging each other down. Fernando drops his fishing pole and starts hauling people out of the water. He looks up and sees Susan walking away, up river. He calls to her to come help pull these people out of the river, and Susan responds that she is going up river to find out why all the people are ending up in the water.

The people in the water represent individuals who are already in trouble with alcohol, tobacco or other drugs. Do you think we will always have some people in the water, or that we will ever completely eradicate substance abuse? We know we will always need ambulances, representing treatment providers, to provide treatment services for those already harmfully involved with substances. We in prevention, however, work up river. We go up river to find out what contributes to people ending up abusing substances and needing treatment services. We want to know exactly what is causing people to fall into *this* river, which may be different from river to river. Perhaps we go upstream and find a fence, built to keep people away from the river, has fallen and needs to be rebuilt. Maybe we find a slippery slope running into the river and can plant vegetation on the slope to prevent people from falling down the slope. Maybe we find a big sign announcing, "The water's great, jump in!" and we can take the sign down and replace it with a warning sign.

So, in prevention, we work to find out what is causing people to abuse substances in *our* community, and then we work to reduce those risks and to build protection against substance abuse. In this curriculum we will offer a research-based process communities can use to assess their community's unique needs in relation to substance abuse and its contributing factors, find where gaps exist in their current prevention plan, use proven prevention strategies to design programs and services that will enhance their particular community's efforts to prevent substance abuse, and evaluate the effectiveness of their efforts.

Ask participants if this story helps clarify what prevention is and how it differs from treatment. Solicit comments and questions toward this end.

Optional activity-

Have participants form small groups and develop their own prevention story, building on an analogy that works for their community/culture.

Slide 2

*Show slide 2, **Definition of Prevention** and define prevention in the context of this curriculum. Let participants know that you will expand upon this definition of prevention in Module 2.*

In 1997, the Center for Substance Abuse Prevention (CSAP) funded six regional Centers for the Application of Prevention Technologies (CAPTs) to assist those working in the prevention field to apply science-based prevention strategies and programs. In 1989, the Substance Abuse Prevention Specialist Training (SAPST) was developed by CSAP's Western CAPT in response to multiple requests from prevention specialists in state agencies and community-based organizations in the region for assistance in translating research into practice. It is based on the Prevention Generalist Training developed by the Colorado Alcohol and Drug Abuse Division.

The SAPST, updated in 2003, and again in 2005 by representatives from all five regional CAPTs, is designed to disseminate to pre-service or in-service prevention personnel up-to-date research and methods in the prevention field and to contribute to the development of professionally trained substance abuse prevention specialists.

Tell participants that you will overview the contents and agenda of the SAPST in a few minutes, but first you would like to set the stage for the rest of the training.

Slide 3

*Show slide and post easel page labeled, **Expectations**. Ask participants to share their expectations of this training. Record expectations on easel page and post. Refer to this page during and at the end of the training, and look for opportunities to incorporate as many participant expectations as possible.*

Slide 4

*Show the slide and refer participants to the information sheet, **Agenda** and review it. Ask participants if they have any questions about the agenda. Address any disparity between participants' expectations and the agenda. Incorporate expectations as possible as the training progresses, and point out expectations that are clearly beyond the scope of this training. Encourage participants to network with each other and trainers to share resources and meet their needs.*

The process we will be using to teach the curriculum incorporates many different learning styles in an effort to make learning enjoyable and comfortable for everyone. We will be providing a lot of content information on many topics, and participants will be working individually and in cooperative learning groups with their fellow students. We know that you all bring with you a variety of knowledge, backgrounds and experience. Some may want us to slow the pace and others familiar with some of the information may want us to speed up the pace. We will work to strike a comfortable balance, and encourage participants to be flexible so that the needs of everyone can be met.

You all have a valuable resource in your Participant Manuals and I would like to orient you to the manuals at this time. *Orient participants to their manuals now.*

Slide 5

Show slide and post easel page labeled, **Ground Rules**. Ask participants to brainstorm Ground Rules that they believe will support a group environment that is amicable and conducive to learning.

Using the chart pad, write down the suggested ground rules. Be sure to include the following:

- Start and end on time, including breaks
- Give everyone an opportunity to speak
- Respect others' opinions
- Set cellular phones to "vibrate" or "off"
- Have fun!

Display the Ground Rules where everyone can see them. Refer to and use the ground rules in group discussions throughout the SAPST.

Slide 6

Show the slide and post easel page labeled, **Parking Lot**.

If questions are asked that we know we will cover later in the curriculum, or that are outside the scope of what we can address here, we will ask permission to record them on the Parking Lot. Trainers will review "parked" questions frequently so that we remember to address them at the appropriate point in the curriculum or can foster networking among participants to address them. Share any pertinent "housekeeping" information, (e.g. location of bathrooms, telephones, refreshments, etc.).

As part of our evaluation process, we will ask you to complete a pre-test now and a post-test at the end of the curriculum. This process will enable us to evaluate the effectiveness of the SAPST curriculum. The test is only used internally as a measure of our success in meeting the curriculum goals. We ask that you record your names on the test only so that we may compare your pre- and post-test scores. You will receive both your pre- and post-test to take with you at the end of the SAPST. *Distribute a copy of the pre-test to each participant. Collect pre-tests as they are completed and score them. Retain pre-tests until post-tests are submitted on the last day of the SAPST and you have had a chance to score the post-tests and compare them with the pre-test scores.*

Slide 7

Show the slide, **Introduction**, and review it.

Select and lead one of the Getting Acquainted activities listed below. It maybe helpful to prepare an easel page with supportive instructions for your selected activity.

Activity 1: Group Resume

Have participants create a group resume with their tablemates (6-8 people working together).

They are to include the following:

- Their names and work roles
- Skills each member brings to the training
- Years the members together have worked in prevention
- The strangest thing the members have in common, that they are willing to share with the whole class

Have each group take turns reporting to the whole class. Have a co-trainer keep a running tally of the number of years of participants' experience in prevention and report this number to debrief the entire activity, noting the vast experience and varied skills represented. Ask members to network and share their expertise with each other this week.

Activity 2: Sharing Circle

Have participants form a circle in an open space in the room. Have participants toss a nerf ball or other soft object to each other. The receiver shares one of the following about himself or herself:

- *The origin of their name*
- *Where they would travel if money was no constraint*
- *What animal they would like to be.*
- *How they would spend one million dollars*

Toss the object around the circle until everyone has had a chance to share.

Activity 3: The Name Game

This works well if participants are seated in a horseshoe arrangement, or you may have them form a circle. Have everyone remove his or her nametags. The trainer begins by stating his or her first name. Moving clockwise around the circle, have the next participant repeat the trainer's name and state his or her own first name. Continue around the circle, having each participant repeat all the names of those before them until play returns to the trainer who repeats everyone's name in the circle.

Activity 4: Yarn Web

Have participants form a circle. The trainer begins with a ball of yarn, holds the yarn end and tosses the ball to another member in the circle. The receiver shares something they bring to their work in the prevention field, (e.g. the reason they work in this field, what they hope to accomplish by their work, something they hope to contribute, etc.) They then keep a hold of the yarn and toss the ball to another person in the circle until everyone has had a chance to share. Debrief by pointing out the web we form and connect the web to the ongoing networking you hope will continue through the week.

Activity 5: People Bingo

This activity requires that the trainer prepare Bingo cards in advance, with such categories as the following:

- *Where I live*
- *My job*
- *My favorite book*
- *My favorite movie*
- *My birthplace*
- *A significant personal mentor*
- *A personal hero*
- *A word to describe me*
- *Most interesting place I've visited*

Each participant receives a bingo card, and everyone moves around the room asking participants to share the information requested in one square and sign that square. Each fellow participant may sign only one square of an individual's Bingo card. The first person to get all

his/her squares signed is the “winner.” Debrief by asking a few participants to share someone they found who has traveled to an interesting place, or named an interesting hero, etc.

Activity 6: Commonalities

Have participants stand and find a partner. The pair is to identify something they have in common. Then have each pair find another pair. The foursome is to identify something they have in common which was not previously used by either pair. Foursomes then join with another foursome and identify something the 8 of them have in common which was not previously used by either foursome. The activity continues until the entire class is one group and identifies something they have in common which has not yet been mentioned.

Activity 7: Meet Your Neighbors

Have participants form a circle with their chairs. The trainer begins by standing in the middle of the circle and announcing, “I’d like to know everyone who...”

- ...has blue eyes,
- ...has a brother
- ...has a sister,
- ...was born in this state,
- ...has a pet
- ...has ever written their congressperson,” etc.

Everyone who fits that description must stand and move to another chair at least two chairs away from their original chair, in musical chairs fashion. The trainer also participates. Whoever is left standing without a chair moves to the center of the circle and asks the next question. Continue the game as long as people are enjoying it and learning about each other.

Activity 8: Polling

In a very large group, have participants meet each other at their tables, sharing their names and jobs. Then poll the entire group, asking participants to raise their hands if they have worked in prevention for more than 5 years, if they are new to prevention, if they work in schools, in community agencies, in government, if they are parents, etc. You can toss in a fun question at the end, using humor to bond the group to each other and to you as trainer.

We encourage you all to continue to get to know each other and network throughout the week together. The trainers will be regrouping you periodically throughout the training so that you will have an opportunity to work with many others.

Refer back to the slide, **Introduction**. Explain that now in Section 1 we will look at the history of drugs and prevention in our country.

As we begin to look at these topics, it is important to recognize that we as prevention professionals bring with us our own attitudes about drugs and prevention. Many of these attitudes have roots in the families and communities in which we grew up, as well as in our own life experiences.

Let’s begin looking at some of our attitudes and their influence on our work. Ask participants to organize themselves into groups of about four people they haven’t met yet. Or they can work with their tablemates if already arranged in small groups at tables.

Slides 8-9

No matter how knowledgeable or competent prevention professionals may be, our work—what we do for others—is invariably colored by the attitudes we grew up with. It is important that we become aware of those attitudes. It is also important that we explore and challenge those attitudes which may be counterproductive.

*Show slide, **Attitudes about Drugs** and ask participants to discuss the questions in their groups. Allow participants about 15 minutes for groups to discuss the questions. Reconvene the class and ask volunteers to report any interesting discussion to the large group. Remark on the common, but mistaken, attitude that tobacco and alcohol are not drugs. Point out that attitudes about drugs also have cultural context, and ask participants if cultural context came up in their discussions. Ask how culture can be taken into consideration when addressing attitudes about drugs.*

*Show the next slide, **Attitudes About Drugs** and review it.*

For the sake of common understanding, we will define "substances" to include tobacco, alcohol, all illegal drugs, legal and over-the-counter drugs of abuse (e.g. prescribed medications, sleeping pills, alertness pills, cold, allergy and flu medications,) inhalant substances, even herbs, beverages and other substances that are used for their drug effects. Since much of the research upon which this curriculum is focused is based on adolescents, any use of tobacco, alcohol, or any other substance used for its drug effects by minors is considered substance abuse.

Tell participants you'd like them to join you in an activity which will further explore the attitudes about drugs and the viewpoints of prevention which exist in all communities. Organize participants into groups of 6 persons each. Have them count off 1-6 within each group, so that each person has a number from 1 to 6.

Slide 10

*Show slide, **Viewpoints of Prevention** and refer participants to the corresponding information sheet. Provide the instructions which follow.*

This work sheet describes six prototypical viewpoints of prevention. I'd like you to read the viewpoint corresponding to your assigned number. After you have read your viewpoint, I'd like you to have a discussion in your group. I want you to represent your viewpoint as faithfully as you can. Try to get inside the head of the person representing that viewpoint, and then express your views to the rest of the group from that point of view. Remember, these are not isolated viewpoints; these six systems of thought represent millions of people. During the discussion, you can be flexible—you can even change your mind—but be sure that you initially speak from the point of view assigned to you. And please use the Ground Rules we established earlier for your discussion. The question for discussion before your group is very simple: What do you think is the best way to address the problem of drugs? You will have 15 minutes for your discussion.

Slide 11

*After 15 minutes, show the slide, **Viewpoints of Prevention** and discuss the questions.*

Reassure participants by humorously reminding them that they were only role-playing and that they are not to be held liable for their point of view in real life. Point out that viewpoints of prevention also occur within cultural context. Ask participants how culture might influence individuals' or groups' viewpoints of prevention? Conclude by noting that as prevention professionals, they will be coming into contact with people who hold these views, and it is important to be prepared to encounter and address them.

Our current society is not the only society to have addressed the harmful effects of alcohol, tobacco and other drugs. By reviewing the history of drugs in America, we can understand the roots of some of our current views, policies, and beliefs about drugs. We can also learn from the mistakes of the past.

Video

*Show the video, **Altered States** and refer participants to the information sheet, **History of Drugs in America**. This video is about 60 minutes in length. If you are concerned about time, you may chose to show 30 minutes of the video at this time and offer to show the remainder during the last half hour of the lunch break.*

Be aware that the racial and cultural stereotyping presented and discussed in the video is a real part of our country's history, can evoke strong feelings among participants, and unfortunately influences some people's thinking to this day. Be prepared to debrief concerns expressed by participants. Reinforce the importance to prevention professionals of understanding and providing accurate information about current drug use patterns and methods that challenge stereotyping of all kinds.

Conclude discussion of the video by focusing on and emphasizing just how ingrained alcohol, tobacco, and other drugs are in the fabric of our society and how bound up they are with our history as a nation. Ask if anyone was raised or has lived in another country, and how the history of drugs in other countries differs from that in America, and what the implications of this might be for prevention professionals. Suggest that as prevention professionals we have the opportunity to influence the next stage of the history of drugs in America, and to shape how future generations will view drugs, drug abuse, prevention, and the development of healthy attitudes and behaviors.

Slide 12

*Show slide, **Drugs of Abuse - Classifications** and review it.*

Tell participants that, although, for the most part prevention professionals do not treat chemically dependent individuals, they are often asked questions about alcohol, tobacco, and other drugs (ATOD) and their effects. It is not appropriate for prevention professionals to tell youth, parents, and community members that this is not their area of expertise. While it is wise to refer people to other sources of information, prevention professionals should be able to provide general information when asked about ATOD and their effects. Many of us will take further coursework in this area to increase our knowledge in this area. An update on the effects of alcohol, tobacco & drugs on the brain is included in Module Six.

Slide 13

*Show slide, **Drugs of First Use**.*

Drugs of first use are the most common drugs of initiation among youth and typically precede the use of other illicit drugs such as cocaine, LSD, and heroin. Drugs of first use include tobacco, alcohol, and in some communities inhalants and marijuana.

Prevention efforts focus first on drugs of first use since these drugs are readily available and frequently used by children and adolescents. Further, since research has shown that the age of first use of any drug is related to later drug use by adolescents, focusing early prevention efforts on drugs of first use is a developmentally sound strategy. One study has shown that young people who begin using drugs before the age of 15 are twice as likely to have problems with drugs than those who delay initiation of use until after the age of 19 (Hawkins, Catalano, & Miller, 1992).

A study conducted at the Center for Addiction and Substance Abuse at Columbia found that children who use drugs of first use (tobacco, alcohol, and marijuana) are up to 266 times more likely to use cocaine. A study at the University of Michigan Institute for Social Research found that among high school seniors, daily tobacco smokers were much more likely to use every kind of controlled substance than non-smoking students. The more cigarettes a student smoked, the more likely he or she was to use marijuana and cocaine (Johnston, O'Malley, and Bachman, 1987). Alcohol and tobacco cause more health and related problems than other drugs. More people die each month from alcohol and tobacco related problems than all illicit drugs combined (Torabi, Bailey, and Majd-Tabbari, 1993).

For these reasons it is logical and reasonable for prevention professionals to focus on delaying the initiation and reducing the use of drugs of first use. For national data on current prevalence of use of various drugs by youth and trends in drug use, see the Monitoring the Future survey results at www.monitoringthefuture.org.

Slide 14

*Show slide, **Supply/Demand Reduction**. Slide displays titles only. Click on this slide again to display examples.*

As we begin to look at how we have approached substance abuse prevention in our country, we need an understanding of the difference between two major drug prevention strategies— supply reduction and demand reduction. Supply reduction strategies seek to reduce the supply of available drugs. *Ask participants for some examples of supply reduction initiatives with which they are familiar. (Confiscation of drug shipments, destruction of crops, criminal penalties for possession and distribution, limitations on alcohol outlet density, and "compliance checks" for underage alcohol sales are examples of supply reduction strategies).*

Demand reduction strategies seek to reduce the demand for drugs. *Ask participants for some examples of demand reduction initiatives with which they are familiar. (Assessment and treatment services, drug abuse prevention curricula in schools, sobriety support services, and parenting substance abuse prevention education are examples of demand reduction strategies).*

In substance abuse prevention, we use both supply reduction strategies and demand reduction strategies. Prevention demand reduction programs include K-12 prevention education curricula, resistance skill training, parenting education, and mentoring programs. Prevention supply

reduction strategies include environmental strategies such as limiting availability of drugs through tax increases, limiting hours of sale, and limiting alcohol outlet density.

Slide 15

*Show slide, **Discussion Questions**, and discuss the questions with the entire group.*

*Refer participants to the information sheets, **Timeline of Prevention and Evolution and Training of the Prevention Discipline**. Explain that the first information sheet presents our profession's approach to substance abuse prevention over the last 50 years. The second provides an overview of the development of the field of prevention; ask participants to read these at their convenience.*

Slide 16 (Optional)

*Show optional slide, **Evolution and Training of the Prevention Discipline**, and review it, using the worksheet as your guide. Ask participants to discuss what elements define a discipline. Some elements of a developed discipline include theory, methods, education, training, ethics, certification, college degree, etc. In light of this information, suggest that substance abuse prevention is an emerging discipline.*

Slide 17

*Show slide, **Building Blocks for Successful Prevention Programs**.*

*Ask participants what, in their experience, makes for effective prevention programs. After some discussion, show the slide and refer participants to their work sheet, **Building Blocks for Successful Prevention Programs**.*

These "building blocks" form a crucial knowledge base upon which to build successful and effective prevention programs. One module of the SAPST is dedicated to each of the "building blocks."

The program is facilitated by knowledgeable and competent staff.

The purpose of the SAPST curriculum is to contribute to the development of knowledgeable and competent prevention professionals by advancing prevention science knowledge and its application to prevention program planning.

The program is based on sound theory and uses practice grounded in research.

In Module 2 of the curriculum, three major theoretical approaches currently utilized in the field of prevention are presented, including Risk & Protective Factor Theory, Resiliency Approach and the Developmental Assets Model.

The program is systematically planned and assessed.

In Module 3 we overview the 5-step Strategic Prevention Framework for building successful prevention. In Section 3 we also discuss the role of research, especially as it relates to CSAP's Principles of Effective Substance Abuse Prevention and NIDA Prevention Principles and to enhancing prevention programs using scientifically-defensible methods.

The program is evaluated.

In Module 4 we discuss evaluating prevention programs in detail, offering scientific methods to measure program outcomes and impacts. The logic model is the basic tool of evaluation presented in Module 4.

The program is sensitive to people from a variety of backgrounds and cultures.

In Module 5 we explore various dimensions of culture and consider how to develop culturally sensitive prevention programs.

The program is developmentally appropriate.

Note that in Section 6 we provide information on human development models and the significance of incorporating knowledge of human development into prevention efforts.

The program incorporates the media.

In Module 7 we focus on working with media advocacy and literacy and utilizing positive "social norming" to develop prevention media messages about alcohol, tobacco and other drugs.

The program utilizes a code of ethics.

In module 8 a formal code of ethics from the National Association of Prevention Professionals and Advocates is offered for review and discussion.

The final module of the curriculum will offer the opportunity to apply the information learned in the various modules of the SAPST. Participants will review a poorly designed grant application and propose suggestions for improvement based on prevention knowledge gained in the training.

Slide 18

*Show slide, **Introduction.***

Answer any questions participants may have. Ask them how they might use the information and tools presented in this section. Show the title slide, Introduction, review today's topics and preview Day 2 topic

INFORMATION SHEET

Agenda

These are the modules the Center for Substance Abuse Prevention's Western Center for the Application of Prevention Technologies recommends for training prevention professionals. Create an agenda for participants based on your schedule.

SECTION 1 Introduction

- Welcome
- Expectations
- Agenda
- Participant Manuals
- Ground Rules
- Parking Lot
- Pretest
- Getting-Acquainted Activity
- Attitudes About Drugs and Drug Prevention
- Viewpoints of Prevention
- History of Drugs in America
- Evolution of the Prevention Discipline
- Building Blocks of Successful Prevention

SECTION 2 Prevention Research

- Current Approaches to Prevention

SECTION 3 Prevention Program Planning

- The Strategic Prevention Framework
- The IOM Classification
- Prevention Principles
- Enhancing Prevention Programs
- Cultural Competency
- Sustainability

SECTION 4 Evaluation

- Building a Logic Model
- Developing an Evaluation Plan
- Measures and Sources of Evaluation Data
- Internal and External Evaluation

SECTION 5 The Cultural Context of Prevention

- Some Elements of Culture
- Dimensions of Diversity

Culture and Prevention Programming
Gathering Information about Communities

SECTION 6 Using Human Development in Prevention

Changes
Maslow's Hierarchy of Needs
Emotional Development
Social Development
Moral Development
Prevention Strategies Focused on Emotional, Social, and Moral Development
Brain Development
The Medicine Wheel Model of Human Development

SECTION 7 The Media and Prevention

The Role of Media in Prevention
Media Advocacy
Media Literacy
Social Marketing
Scare Tactics

SECTION 8 Bringing It All Together

Ethics in Prevention
Review
Applying the Information
Closing

INFORMATION SHEET

Viewpoints of Prevention

Represent your viewpoint faithfully in the discussion. You can be flexible—you can even change your mind—but be sure that you initially speak from the point of view described below.

1. THE MORAL CRUSADER

You fervently believe that alcoholism and other drug dependence is a sin. People who lapse into addiction are morally flawed and will no doubt go to hell unless they are reformed. People who are strong willed resist the temptations of drugs and follow the righteous path.

The key to prevention is warning and redeeming: warning people not to be tempted by the evil of drugs and redeeming those who have fallen under the spell and wish to rejoin society.

The question you want answered: If it's bad to use drugs—and it's obviously bad—why shouldn't we try to get everyone on the straight and narrow and throw the ones who refuse in prison?

2. THE SOCIOECONOMIC AND ETHNIC CHAUVINIST

Everything you've seen leads you to believe that alcoholism and other drug dependence is a malady of the poor and nonwhite. These people use drugs to escape from their miserable existence, and drug use continues the cycle of their poverty. They use drugs because they don't know any better and they perpetuate their travails by becoming dependent.

The key to prevention is isolation: keeping addiction in the ghettos and not letting it spread to the middle and upper classes.

The question you want answered: What's wrong with doing a little triage—cutting off the people who have willingly sold themselves out and trying to protect the rest of us?

3. THE DOCTOR

Addiction is clearly a disease. People who are drunk, high, or otherwise under the influence of drugs need to be cleansed of the substance within them. You no more tolerate the resistance of the addicted patient than you would tolerate the resistance of a tubercular patient.

The key to prevention is removal: getting drugs out of patients and getting drugs out of society.

The question you want answered: Why don't we just set up treatment facilities around the country and help those afflicted?

4. **THE SCARE MONGER**

People just don't understand the consequences of using drugs. You can overdose, you can become a drunk, you can get into a fatal car crash, lose your mind, and so on. If people only realized what horrible things could befall them if they used drugs, they'd keep far away.

The key to prevention is fear: showing people as graphically as possible the lurid consequences of drug use.

The question you want answered: Why should we hold back on showing people just how horrible using drugs is?

5. **THE EDUCATOR**

We live in an enlightened age in which knowledge is power. If people use drugs, it's only because they're not familiar with them. Once they know what all the drugs are, how they affect the mind and body, and some of the history behind different kinds of drugs, they won't be interested in trying them.

The key to prevention is knowledge: giving people as much information as possible about drugs and drug use.

The question you want answered: Why shouldn't we trust people's innate intelligence and give them all the facts so they can make a safe and healthy decision about drugs?

6. **THE BLAMER**

The reason we're in such a sorry state is because some people aren't pulling their weight. Parents are bringing up their kids too leniently. Schools aren't setting good examples. Television, movies, and music are replete with unhealthy role models. And politicians are bought off by the big tobacco and alcohol corporations.

The key to prevention is accountability: making sure that everyone toes the line about the harmfulness of drugs.

The question you want answered: Why can't we get tougher laws that will hold parents, schools, media, and politicians to doing their part to prevent drug abuse?

History of Drugs in America

Alcohol

Alcoholic beverages have been a part of the Nation's past since the landing of the Pilgrims. According to "Alcohol and Public Policy: Beyond the Shadow of Prohibition," a publication commissioned by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and prepared by the National Academy of Sciences, the colonists brought with them from Europe a high regard for alcoholic beverages, which were considered an important part of their diet. Drinking was pervasive because alcohol was regarded primarily as a healthy substance with preventive and curative powers, not as an intoxicant. Alcohol was also believed to be conducive to social and personal health. It played an essential role in rituals of conviviality and collective activity, such as barn raisings. While drunkenness was condemned and punished, it was viewed only as an abuse of a God-given gift.

The first temperance movement began in the early 1800's in response to dramatic increases in production and consumption of alcoholic beverages, which also coincided with rapid demographic changes. Agitation against ardent spirits and the public disorder they spawned gradually increased during the 1820's. In addition, inspired by the writings of Benjamin Rush, the concept that alcohol was addicting and that this addiction was capable of corrupting the mind and the body took hold. The American Society of Temperance, created in 1826 by clergymen, spread the antidrinking gospel. By 1835, out of a population of 13 million people, 1.5 million had taken the pledge to refrain from distilled spirits. The first wave of the temperance movement (1825 to 1855) resulted in dramatic reductions in the consumption of distilled spirits, although beer drinking increased sharply after 1850.

The second wave of the temperance movement occurred in the late 1800's with the emergence of the Women's Christian Temperance Movement, which, unlike the first wave, embraced the concept of prohibition. It was marked by both the recruitment of women into the movement and a mobilization to close down saloons. The movement set out to remove the destructive substance and the industries that promoted its use from the country. The movement held that while some drinkers may escape problems of alcohol use, even moderate drinkers flirted with danger.

The culmination of this second wave was the passage of the 18th amendment to the U.S. Constitution and the Volstead Act, which took effect in 1920, prohibiting the sale, manufacture, or transportation of alcoholic beverages within the United States. Although Prohibition was successful in reducing per capita consumption and some problems related to drinking, the social turmoil it produced resulted in its repeal in 1933.

Since the repeal of Prohibition, the dominant view of alcohol problems has been that alcoholism is the principal problem. With its focus on treatment, the rise of the alcoholism movement depoliticized alcohol problems as the object of attention; the alcoholic was considered to be a deviant from the predominant styles of life of either abstinence or "normal" drinking. The alcoholism movement is based on the belief that chronic or addictive drinking is limited to a few, highly susceptible individuals suffering from the disease of alcoholism.

The disease concept of alcoholism focuses on individual vulnerability, whether it be genetic, biochemical, psychological, or social/cultural in nature. According to this view, if the collective problems of each alcoholic are solved, society's alcohol problem will be solved.

Nevertheless, the pre-Prohibition view of alcohol as a special commodity has persisted in American society and is an accepted legacy of alcohol control policies. Following the repeal of Prohibition, all States restricted the sale of alcoholic beverages in one way or another to prevent or reduce certain alcohol problems. In general, however, alcohol control policies disappeared from the public agenda as both the alcoholism movement and the alcoholic beverage industry embraced the view that “the fault is in the man and not in the bottle.”

This view of alcoholism has also been the dominant force in contemporary alcohol-problem prevention. Until recently, the principal prevention strategies focused on education and early treatment. According to this view, education was intended to inform society about the disease and to teach people about the early warning signs so that they could initiate treatment as soon as possible. Efforts focused on “high-risk” populations and attempted to correct a suspect process or flaw in the individual, such as low self-esteem or lack of social skills. The belief was that the success of education and treatment efforts in solving each alcoholic’s problem would solve society’s alcohol problem as well.

Contemporary alcohol-problem prevention began in the 1970’s as new information on the nature, magnitude, and incidence of alcohol problems raised public awareness that alcohol can be problematic when used by any drinker, depending upon the situation. There was a renewed emphasis on the diverse consequences of alcohol use—particularly trauma associated with drunk driving, fires, and violence, as well as long-term health consequences.

Drugs for Nonmedical Purposes

The history of nonmedical drug use and the development of policies in response to drug use also extend back to the early settlement of the country. As with alcohol, the classification of certain drugs as legal or illegal has changed over time. These changes sometimes had racial and class overtones. According to Mosher and Yanagisako (1991), for example, Prohibition was in part a response to the drinking practices of European immigrants, who became the new lower class. Cocaine and opium were legal during the 19th century and were favored drugs among the middle and upper classes. Cocaine became illegal after it became associated with African-Americans following Reconstruction. Opium was first restricted in California in 1875, when it became associated with Chinese immigrant workers. Marijuana was legal until the 1930’s, when it became associated with Mexicans. LSD, legal in the 1950’s, became illegal in 1967, when it became associated with the counterculture.

By the end of the 19th century, concern had grown over the indiscriminate use of these drugs, especially the addicting patent medicines. Cocaine, opium, and morphine were common ingredients in various potions sold over the counter. Until 1903, cocaine was an ingredient of Coca-Cola®. Heroin, which was isolated in 1868, was hailed as a nonaddicting treatment for morphine addiction and alcoholism. States began to enact control and prescription laws, and in 1906, Congress passed the Pure Food and Drug Act. It was designed to control opiate addiction by requiring labels that revealed the amount of drugs contained in products, including opium, morphine, and heroin. It also required accurate labeling of products containing alcohol, marijuana, and cocaine.

The Harrison Act (1914) imposed a system of taxes on opium and coca products, with registration and record-keeping requirements, in an effort to control their sale or distribution.

However, it did not prohibit the legal supply of certain drugs, especially opiates.

Current drug laws are rooted in the 1970 Controlled Substances Act. Under this measure, drugs are classified or scheduled according to their medical use, their potential for abuse, and their

likelihood of producing dependence. The act contains provisions for adding drugs to the schedule and rescheduling of drugs. It also establishes maximum penalties for the criminal manufacture or distribution of scheduled drugs.

Creation of Agencies to Address Alcohol and Drug Abuse

Increases in per capita alcohol consumption as well as increases in the use of illegal drugs during the 1960's raised public concern about alcohol and other drug problems. Prevention issues gained prominence on the national level with the creation of the NIAAA in 1971 and the National Institute on Drug Abuse (NIDA) in 1974. In addition to mandates for research and the management of national programs for treatment, both institutes included prevention components. To further prevention initiatives at the Federal level, the Anti-Drug Abuse Act of 1986 created the U.S. Office for Substance Abuse Prevention (OSAP), which consolidated alcohol and other drug prevention activities under the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). The ADAMHA block-grant mandate called for States to set aside 20 percent of the alcohol and drug funds for prevention. In a 1992 reorganization, OSAP was changed to the Center for Substance Abuse Prevention (CSAP), part of the new Substance Abuse and Mental Health Services Administration (SAMHSA). While SAMHSA retained its major program areas, the research institutes of NIAAA and NIDA moved to the National Institutes of Health. The Office of National Drug Control Policy (ONDCP) was established by the Anti-Drug Abuse Act of 1988. ONDCP's primary objective was to develop a drug control policy that included roles for the public and private sectors to "restore order and security to American neighborhoods, to dismantle drug trafficking organizations, to help people break the habit of drug use, and to prevent those who have never used illegal drugs from starting." In early 1992, underage alcohol use was included among the drugs to be addressed by ONDCP.

Although Federal, State, and local governments play a substantial role in promoting prevention agendas, much of the activity takes place at grassroots community levels. In addition to funding from CSAP's Community Partnerships grant program, groups receive support from private sources, such as the Robert Wood Johnson Fighting Back program.

Today, despite the best efforts of Federal, State, and local governments, drug abuse continues to pose serious threats to the health and social and economic stability of American communities. However, two hopeful trends have been occurring. The knowledge gained through prevention research (e.g., the results of demonstration projects and program evaluations) has led to the development of formal theories, best practices, promising approaches, and rigorous evaluation methods. And, in the late 1990's, policies, laws, and norms have been changing to influence the incidence and prevalence of drug use: Tobacco companies have been forced to stop unethical advertising campaigns geared toward teenagers, and many communities have increased the price of alcohol and tobacco through excise taxes and passed ordinances prohibiting billboard advertisements by the alcohol industry.

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INFORMATION SHEET

A Timeline of Prevention

TIME	NATIONAL PERSPECTIVE	STRATEGY	ACTIVITIES
1950's	Drugs are a problem of the ghetto, used to escape pain and to avoid reality.	scare tactics	films and speakers
early 1960's	Drugs are used to escape pain and to avoid reality, but they're more than just a problem of the ghetto.	scare tactics	films and speakers
late 1960's	Drugs are used to intensify life, to have psychedelic experiences. Drug use is considered a national epidemic.	information	films and speakers
early 1970's	A variety of drugs are used for a variety of reasons: to speed up experiences, to intensify experiences, to escape, to expand perceptions, to relieve boredom, and to conform with peer behavior.	drug education	curricula based on factual information
mid 1970's	Users become more sophisticated and society develops an increasing tolerance of drug use.	affective education and alternatives to drug use	curricula based on communication, decision making, values clarification, and self-esteem
late 1970's to mid 1980's	Parents begin to form organizations to combat drug abuse.	affective education, alternatives to drug use, and training	social skills curricula, refusal skill training, parenting education
mid 1980's to mid 1990's	Drug use is very complex.	parent, school, and community partnerships	research-based curricula, linkages, and peer programs

TIME	NATIONAL PERSPECTIVE	STRATEGY	ACTIVITIES
mid 1990's to 2000's	The gap between research and application is gradually bridged.	replication of evidence-based models and application of evidence-based approaches	environmental approaches, comprehensive programs targeting many domains and strategies, evaluation of prevention programs, media campaigns, and culturally sensitive programs

Evolution of the Prevention Discipline

Hundreds of years ago, barbers who used techniques like “blood-letting” practiced medicine. Fifty years ago, teachers or athletic coaches who had no formal training in counseling or human behavior conducted school counseling. And 20 years ago, the treatment of alcohol and other drug problems was provided by alcoholics and addicts in recovery, who used only their own recovery experience to help others. Today, physicians undergo years of academic training and extensive internships. Nearly all school counselors complete graduate-training programs specifically designed for this field. Finally, more and more universities have undergraduate and graduate courses in addiction counseling.

Professions often evolve in this way. As the public comes to understand the value of or need for a discipline, standards for training and practice are developed. States develop certification and/or licensure requirements, and universities develop programs to train people to work in the profession.

In medicine, barbers weren’t very effective in curing illnesses and diseases. Teachers and coaches were ill equipped to handle the complex problems of youth in the 1960’s. Recovering individuals did not know how to treat abusers of multiple drugs, culturally and ethnically diverse clients, women and their children, addicts involved with the criminal justice system, and clients with co-occurring disorders. Therefore, the stimulus to develop standards of training and practice for a profession is often the lack of expertise of practitioners to handle the complexity of the discipline.

The alcohol, tobacco, and other drugs (ATOD) prevention field is in the beginning stages of this evolution. Society’s need to solve ATOD problems, combined with a growing body of knowledge of “what works,” is stimulating an effort to increase the professionalism of prevention providers. In addition, the prevention field has had the burden of explaining why some highly publicized, widespread prevention programs have failed to demonstrate an impact on the ATOD use patterns of youth. Consequently, Federal and State governments have begun developing certification standards for prevention providers. Universities are developing courses and internships in prevention. In addition, government entities that distribute prevention dollars are beginning to insist that prevention programs use “scientifically defensible” prevention strategies and programs and use established practices to evaluate the outcomes of funded programs. A well-trained staff is necessary to meet these requirements.

This curriculum is designed to help professionalize the prevention field. We know there are many prevention providers who want to increase their effectiveness and are eager to find out “what works.” And we know that many college students are interested in working in prevention and need training and experience to develop entry-level competence. We designed this curriculum as a general overview of the prevention field and as a stimulus for further learning.

INFORMATION SHEET

Attitudes About ATOD

Close your eyes and visualize an alcoholic. Now visualize a crack addict. What were your visualizations like? What was the ethnic background of your alcoholic? What sex was your crack addict? Did you see a seedy, down-and-out person going through garbage cans? Did you visualize a well-known comedian or a professional athlete? Does a 15-year-old caught with a marijuana joint have a problem? What about the same kid with a bottle of beer?

It's essential for professionals who work in the ATOD prevention field to examine their attitudes about ATOD. Obviously, knowledge is important and can affect our attitudes. But sometimes we're not even aware of how firmly attitudes are entrenched. For example, most of us know that addiction to alcohol and other drugs is not a function of sex, ethnicity, or socioeconomic class. However, your visualization just now of an alcoholic and a crack addict may have reflected some stereotypes. That's normal and isn't necessarily harmful, as long as we understand that our stereotype does not reflect reality. For example, if you work in a prevention program that has a largely white clientele, it would be erroneous to assume that crack is not used in the community. A 15-year-old with a joint or a beer may or may not have a substance problem. Only an assessment can determine this.

Prevention providers are encouraged to examine their attitudes about ATOD and to learn as much about substances as possible. While you certainly don't need to be an expert in pharmacology, you do need to understand basic information about categories of drugs and their effects. This information should be based on science and not on scare tactics.

Definitions of Use, Misuse, Abuse, and Dependence/ Addiction

Most helping professionals who don't have extensive training in ATOD find it difficult to determine if a client's substance use is problematic. They may rely on personal experience and information (or misinformation). Consider the following scenario: A high school counselor gets a call from a student's parent. The young man is 17 years old, came home from a party on Saturday night smelling of alcohol and admitted to drinking at the party.

His parents belong to a religious group that prohibits the use of alcohol, so neither has any experience with alcohol or other drug use. They want to know if their son has a problem. The high school counselor did her share

**Definitions
of Use,
Misuse,
Abuse, and
Dependence/
Addiction –
continued**

of experimentation in adolescence but is a moderate user as an adult. She assures the parents that nearly all adolescents experiment and they have nothing to worry about. Is she right?

Distinguishing between different levels of use can be helpful to the mental health professional in determining the type of intervention that's appropriate for a client. Yet these distinctions aren't appropriate for diagnosis. They simply provide a guide for the mental health professional in recommending the course of action for a client. The following definitions are offered to frame the discussion of alcohol- and drug-abuse progression. You should understand that multiple definitions of use, abuse, and misuse exist. These are the definitions we are using for this discussion.

Most people use alcohol or other drugs (including caffeine and tobacco) at some point in their life. We define "use" as the ingestion of alcohol or other drugs without experiencing negative consequences. Any drug can be "used" according to this definition. However, the type of drug taken and the characteristics of the individual contribute to the probability of experiencing negative consequences. For example, it's illegal for minors to drink alcohol. Therefore, any use by a minor is considered abuse, and the probability that our high school student will experience negative consequences from drinking alcohol may be far greater than that probability for an adult. Similarly, the chances that an adult will experience negative consequences from shooting heroin are greater than the chances that he or she will experience negative consequences from drinking alcohol.

When a person experiences negative consequences from the use of alcohol or other drugs, it is defined as "misuse." Again, a large percentage of the population misuses alcohol or other drugs at some point. Many people overuse alcohol, become ill, and experience the symptoms of a hangover. This is misuse. However, misuse doesn't imply that the negative consequences are minor. Let's say that an adult uses alcohol on an infrequent basis. It's her 30th birthday, and her friends throw a surprise party. She drinks more than usual and, on the way home, is arrested for driving while under the influence (DUI). She may not have problems with alcohol, but in this instance, the consequence isn't minor.

You may be wondering about the heavy user of alcohol or other drugs who doesn't appear to experience negative consequences. First of all, remember that these definitions are meant to provide the helping professional with a simple conceptualization as a guide. Second, the probability of experiencing negative consequences is directly related to the frequency and level of use. If a person uses alcohol or other drugs on

**Definitions
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continued**

an occasional basis, the probability of negative consequences is far less than if one uses them on a daily basis. However, because we are talking about probability, it's possible that a person could be a daily, heavy user and not experience negative consequences that are obvious to others. We say "obvious" because people may be damaging their health without anyone being aware of this for a long time.

We define "abuse" as the continued use of alcohol or other drugs despite negative consequences. As we discussed previously, the probability of negative consequences is proportional to the amount one uses, and if a problem is developing with alcohol, it's likely that continued use will become abuse. As an example, let's go back to the DUI the woman got after her birthday party. For people who do not have an alcohol or other drug problem, getting a DUI would be so disturbing that they would avoid alcohol altogether or at least refrain from driving after drinking alcohol. If, a month after receiving the DUI, the woman was again drinking and driving, this would be considered abuse.

Addiction/dependence is the "compulsive" use of alcohol or other drugs regardless of the consequences. We worked with a man who had received three DUIs in one year. He was on probation and would be sentenced to one year in prison if he were caught using alcohol. Yet he continued to drink. We define this man as clearly addicted to alcohol because the negative consequences did not affect his use.

**Justification
for Theory**

As disciplines develop, they create a body of theories that drive both research and application. A theory is a "formulation of apparent relationships or underlying principles of certain observed phenomena which has been verified to some degree" (Guralnik, 1984, p. 1475). This curriculum advances the current theories used in substance abuse prevention, which include the perspectives of risk and protection factors, resiliency, and the assets model. Some theories and related research have reached high levels of scientific rigor, which means that they've been tested and have shown some consistent correlations or outcomes. All disciplines support certain theories that attempt to explain why a certain condition exists. In substance abuse prevention, for example, the theory of risk and protection predicts that the greater the number of risk factors, the greater the likelihood that young people will abuse substances at some point in their development. The ultimate goal of this curriculum is to move the field of substance abuse prevention to "praxis."

Praxis means the combination of both theory and practice. The practice of substance abuse prevention should be enlightened and informed by theory.

***Justification
for Theory –
continued***

One of the challenges we face in prevention is understanding theory and the findings from research to the degree that we can apply them to our substance abuse prevention programs. When we achieve this goal, we have engaged in “prevention praxis.” If our field didn’t have a theoretical base, we’d simply run prevention programs with what we thought or felt were the right ideas. We’d try to glean progress from only our own observations and wouldn’t consider what had been tried, tested, changed and tested again. Theory really helps us understand how to prevent substance abuse and answers questions about why some youth use substances and others do not.

The Substance Abuse Prevention Specialist Training curriculum presents in depth the three most dominant theoretical perspectives today. This doesn’t mean that other theories don’t exist or that these are the three best theories available. Theories change like most things do in life. Thomas Kuhn (1970) identified four steps or changes theories cycle through; they are normal science, anomalies, crisis, and revolution. Theory that is accepted as the dominant view in the field is considered normal science. Researchers experiment with new applications of the established theory, extend and refine it, and accumulate knowledge. The second step is the anomalies stage. During this stage, people question why the theory doesn’t fit the social problem they’re trying to solve. Things happen in the social world that the theory can’t explain. The third stage is crisis. During this step, questions abound and people severely critique the theory; the field shifts its interests, and new theories emerge that propose alternative ways of looking at the social problem. Anomalies amount and accumulate as people begin formally attacking the perspective. The fourth state is called revolution. During revolution the old theory is overthrown, and a new theory establishes itself as the reigning paradigm.

The point of explaining this process is to show that the theories of today may not be the theories of tomorrow. So you may be thinking, why even consider any theory at all if it will go through this process eventually? The answer is that all theories help us understand the larger social context of substance abuse prevention. Without theories to guide us, we simply employ old techniques that may “feel” like they work, but in fact may be harmful. Theories, like research knowledge, change over time. This is normal, expected, and a valid part of a developing discipline.

Building Blocks of Successful Prevention Programs

The Substance Abuse Prevention Specialist Training curriculum is designed to provide some crucial elements of knowledge for the prevention professional. This curriculum isn't designed to answer every question a professional has about prevention, nor is it equipped to be the only learning tool about the field. Instead, this curriculum is designed to jumpstart the learning process for new professionals in the field. It contains science-based information, orients the professional to current issues in prevention, and provides a few of the many essential building blocks you need to know when working in prevention programs or coalitions.

As with any developing profession, key elements or essential facts need to be presented and explored to train new members in the field. This curriculum has many core modules that are important to understand before implementing prevention programming. Just as the discipline of medicine began by advancing fundamental courses all doctors would need, this curriculum contains fundamental information for all preventionists. This curriculum, as mentioned earlier, is to be viewed as the first step to gaining knowledge about the field of substance abuse prevention. Like any discipline, as this body of knowledge grows and expands, the professional must grow and expand to properly apply the principles identified by science. We may find that strategies we employ in our prevention programs are no longer working or have been shown to need more rigorous evaluation.

We are at an exciting time in the evolution of prevention. We know more than ever about what works in substance abuse prevention programming. At the same time, new cohorts of substance abuse prevention specialists and coordinators are demonstrating interest in the field. College campuses are offering courses in substance abuse prevention, and students can earn degrees in this field. This curriculum captures some of the fundamental building blocks that all students and prevention professionals need to incorporate into their practice to help advance effective and efficient substance abuse prevention programming at the national, State, county, and community levels.

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Elements of Successful Prevention Programs

The program is facilitated by knowledgeable and competent staff.

Purpose of the Substance Abuse Prevention Specialist Curriculum

The program is based on sound theory and uses practices grounded in research.

Module 2: Prevention Research

The program is systematically planned and assessed.

Module 3: Prevention Planning

The program is evaluated.

Module 4: Evaluation

The program addresses participants from a variety of backgrounds and cultures, and it uses a code of ethics.

Module 5: The Cultural Context of Prevention

The program is developmentally appropriate.

Module 6: Using Human Development in Prevention

The program incorporates the media.

Module 7: Prevention and the Media