

Module One

Introduction

Time

The anticipated time for the module is 4 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

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

- Defining Culture
- Dimensions of Culture

- 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 The Ethics of Prevention and Bringing It All Together

- Ethics in Prevention
- Review
- Applying the Information
- Closing

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 tows 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 of Use, Misuse, Abuse, and Dependence/Addiction – 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.

References:

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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