PRIMARY, SECONDARY AND TERTIARY YOUTH PREVENTION PROGRAMS[1]

SUMMARY

A two-part examination of successful youth prevention programs. Part I will address Primary prevention programs, and Part II Article will address Secondary and Tertiary prevention and treatment programs.

Part I

pre·vent (pri-'vent) : to keep from happening, to prohibit or hamper.[2]

"Prevent" is what a successful youth prevention program will do to keep alcohol or other drug use from happening, or hamper or delay the onset of such use. While there is no single definition of prevention there is general agreement among prevention practitioners on the overall goal of prevention.[3] It is to foster a climate in which:

- Alcohol use is acceptable only for those of legal age and only when the risk of adverse consequences is minimal;
- Prescription and over-the-counter drugs are used only for the purpose for which they were intended;
- Other abusable substances (e.g., gasoline or aerosols) are used only for their intended purposes;
- Illegal drugs and tobacco are not used at all.

Prevention is an interrelated continuum of services that includes intervention and treatment, often referred to as secondary and tertiary prevention.

The focus will be on the primary prevention of alcohol and other drug use among youth will be addressed. For the purpose of this paper primary prevention method is defined as the effort to prevent the use of or the delay of initial onset of alcohol and other drug use. In contrast, secondary prevention is concerned with the early detection and reduction of alcohol, tobacco, and other drug problems once they have begun, and tertiary prevention is concerned with preventing further deterioration and reducing problems associated with the specific disorder or disease.[4]

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[1] This copyrighted material may be copied in whole or in part, provided that the material used is properly referenced, and that the following citation is used in full: Lindsey, V.V. (2003). Primary, Secondary and Tertiary Youth Prevention Programs. *Journal of Addictive Disorders.* Retrieved from http://www.breining.edu.

[2] Definition, Webster Pocket Dictionary 2002.

[3] Prevention Primer, DHHS publication NOSMA 94-2060.

[4] A Promising Future: Alcohol and Other Drug Problem Prevention Services, CSAP.

Experimentation with a wide variety of substances for many adolescents appears to have become an integral part of the coming of age in America.[5] Unfortunately, early experimentation, often leads to regular use for many individuals. To prevent or delay the onset of initial use we need to look at what are some of the factors that increase the risk of becoming involved with alcohol and drugs.

Studies over the past two decades have tried to determine the origins and pathways of drug abuse-how the problems starts and how it progresses.[6] Several factors have been identified that differentiate those who use drugs from those who do not.

Throughout history there have been many prevention programs, and it has been proven over the years that many of them have not been successful. Prevention material and programs had been designed around the use or abuse of alcohol and drug. The ATOD was the focal point and the program focused on the substance and not the individual who was involved in alcohol and drug. This could be one of the reasons that most prevention has not been successful.

In order to effect and make change in prevention, we need to take a different approach and focus on the individual and design programs that fit their needs. However two hopeful trends have been occurring. Over the last decade there has been a substantial amount of research and demonstrative projects and evaluations that have lead to the development of theories "best practices" and "promising approaches to prevention.

Prevention approaches have been categorized in three different areas

- **Universal programs** reach the general population-such as all students in a school.[7]
- **Selective programs** target groups at risk or subsets of the general population-such as children of drug users or poor school achievers.
- **Indicated programs** are designed for people who are already experimenting with drugs or who exhibit other risk-related behaviors.

Through research, the following are three programs that have been deemed "Promising Practice" or "Best practice".

The Development Assets Approach, which at this time is only being, viewed as a "promising approach" and not a "best practice" by the Center for the Application of Substance Abuse technologies.

Search Institute first introduced the developmental asset framework and terminology in 1990 through report titled "*The Troubled Journey: A Portrait of 6th-12th Grade Youth"*, at that time, the survey identified and measured 30 developmental assets.

Over the next several years they continued to review the research as conduct studies. In an effort to learn about the development assets, risk taken and they way youth thrive, they conducted surveys with over 350,000 6th-12th graders in more than 600 communities between

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[5] www.drugabuse.gov/pdf/monographs/47.pdf, Botwin, Gilbert J. PHD.
[6] National Institute On Drug Abuse Publication No. 97-4212.
[7] http://www.drugs.indiana.edu/prevention/assets/home.html

1990 and 1995. To learn about the developmental assets they experienced, the risks they took, the deficits they had to overcome, and the ways they thrived.

They also conducted numerous informal discussions and focus groups, in particular to better understand the developmental realities of youth of color and youth in distressed communities. Through all the focus groups and studies in 1996 the Search Institute revised the developmental assets framework into its current form, a model of 40 developmental assets. The 40 development assets are divided into external and internal assets. The external assets are defined as the relationships and opportunities that are provided to young people, such as; family support, caring neighborhood, caring school climate, services to others, high expectations creative activities and religious community are a few of the external assets that can lead to the prevention of alcohol and other drugs.

The internal assets are skills and values that youth develop to guide them such as; school engagement, achievement motivation, integrity, interpersonal competence, resistance skills and sense of purpose.

The Developmental Asset prevention model focuses on an individuals strengths and assets and does not focus on the individual weakness. This approach is preventive at its core, by building on strengths and by increasing the assets that have been found to be associated with healthy, caring, and responsible people. [8]It is believed that this approach is a promising preventive approach because, although data indicates an association between the presence of assets and the absence of substance abuse, research has not yet conclusively show that increasing assets reduces or delays substance abuse.

Another promising approach is considered *The Resiliency Approach,*[9] which stems from research into young people from troubled backgrounds who later learned to bounce back when the odds were stacked against. In 1955 Emmy Werner began research by studying children born on Kauai, Hawaii. She identified several environment factors that fostered resilience in kids. She identified the following areas:

- The age of the parent of the opposite sex (younger mothers for resilient boys, older fathers for resilient girls)
- The number of children in the family (four or fewer)
- Spacing between children (two years or more was best)
- The number and type of people available to help the mother rear the children (such as grandparents, aunts, uncles)
- Steady employment for the mother, especially if she was a single mother
- The availability of a sibling as a caretaker in childhood
- The presence of multigenerational network of friends, teachers, and relative during adolescence.
- Church attendance

The resiliency approach is not considered a best practice for designing and implementing an effective prevention program. This framework is promising but inconclusive. This study needs to be further researched across cultures.

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[8] Western Region Center for the Application of Prevention Technologies
[9] Western Region Center for the Application of Prevention Technologies

Research over the last 20 years has helped to identify many factors that put young people at risk for becoming involved with alcohol and drugs, or that protected them from becoming involved.

Factors associated with greater potential for drug use are called "risk" factors, and those associated with reduced potential for such user are called "protective" factors.

The research conducted by the National Institute on Drug Abuse has revealed that there are numerous factors that put a person at risk for drug use. (For this paper when we speak of drug use, we are including alcohol). Each risk factor effects the psychological and social development of our youth.

The Risk and Protective Factors is a scientific based prevention focus, which is based on the work of J. David Hawkins, Ph.D., and Richard F. Catalano, PhD along with a research team at the University of Washington in Seattle. These researchers began a 30-year study of youth who were involved with alcohol and other drugs and who were involved with the juvenile justice system. During this research they identified factors that increased the youths chances of being involved with drugs and the juvenile delinquency. The following factors are:

Community Risk Factors [10]

Availability of Drugs: The more available drugs are in a community, the higher the risk that young people will abuse drugs in the community. Perceived availability of drugs is also associated with risk.

Community Laws and Norms Favorable toward Drug Use; Community norms-the attitudes and policies a community holds about drug use and crime – are communicated in a variety of ways; through laws and written policies, thorough informal social practices through the expectations parents and other members of the community have of young people.

Transitions and Mobility: Even normal school transition predicts increases in problems behaviors. When children move from elementary school to middle school or from middle school to high school, significant increases in the rate of drug use, school misbehavior and delinquency result. When communities are characterized by frequent nonscheduled transition rate, there is an increase in problem behaviors. Communities with high rates of mobility appear to be linked to an increase risk of drug and crime problems.

Low Neighborhood Attachment and Community Disorganization; Higher rates of drug problems, juvenile delinquency and violence occur in communities or neighborhoods where people have little attachment. The less homogeneous a community is in terms of race, class and religion, the less connected its residents may feel to the overall community and the more difficult it is to establish clear community goals and identity.

Extreme Economic Deprivation; Children who live in deteriorating and crime ridden neighborhoods characterized by extreme poverty are more likely to develop problems with delinquency, teen pregnancy, school dropout an violence. Children who live in these areas and have behavior and adjustment problems early in life – are also more likely to have problems with drugs later on.

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Family Risk Factors

Family History of the Problem Behavior: If children are raised in a family with history of addiction to alcohol or other drugs, the risk of having alcohol and other drug problems themselves increases.

Family Management Problems: This risk factor has been shown to increase the risk of drug use, delinquency, teen pregnancy, school dropout and violence. Poor family management practices include lack of clear expectations for behavior, failure of parents to monitor their children and excessively severe or inconsistent punishment.

Family Conflict: Persistent, serious conflict between primary caregivers or between caregivers and children appears to enhance risk for children raised in these families. Conflict between families members appear to be more important that family structure. Domestic violence in families increases the likelihood that young people will engage in delinquent behaviors and substance abuse, as well as become pregnant or drop out of school.

Parental attitudes and Involvement in Drug Use, Crime and Violence: Parental attitudes and behavior toward drugs, crime and violence influence the attitudes and behaviors of their children. Parental approval of young people's moderate drinking, even under parental supervision, increases the risk of the young persons using marijuana. Furthermore, in families where parents involve children in their own drug or alcohol behavior there is an increased likelihood those children will become drug abusers in adolescence.

School Risk Factors

Early and Persistent Antisocial Behavior; Boys who are aggressive in grades K-3 are at high risk of substance abuse and juvenile delinquency. This risk factor includes persistent antisocial behavior, skipping school and getting in fights with other children, these students are at higher risk for substance abuse.

Academic Failure Beginning in Elementary School: Beginning in the late elementary grades, academic failure increases the risk of drug abuse, delinquency, violence, and pregnancy and school dropout. It appears that the experience of failure – not necessarily ability increases the risk of substance abuse.

Lack of commitment to school: Low commitment to school means the young person has ceased to see the role of student as a viable one. Many young people who have lost this commitment to school are at higher risk for substance abuse.

Individual/Peer Risk Factors

Alienation/Rebelliousness: Young people, who feel they are not part of society, are not bound by rules, don't believe in trying to be successful or responsible, or who take an active rebellious stance toward society, are at higher risk for drug abuse.

Friends who Engage in the Problem Behavior: Young people who associate with peers who engage in problems behavior are more likely to engage in the same problem behavior. This is one of the most consistent predictors that research has identified. Even when young people come from well-managed families and do not experience other risk factors, just hanging out with friends who engage in the problem behavior greatly increases the child's risk of that problem. However, young people who experience a low number of risk factors are less likely to associate with friends who are involved in the problem behavior.

Favorable Attitudes Toward the Problem Behavior: During the elementary school years, children usually express anti-drug, anti-crime, and pro-social attitudes. They have difficulty imagining why people use drugs, commit crimes and drop out of school. However, in middle school, as others they know participate in such activities, their attitudes often shift toward greater acceptance of these behaviors. This acceptance places them at higher risk.

Earlier Initiation of Problems Behavior: The earlier young people begin using drugs, committing crimes, engaging in violent behavior, the greater the likelihood that they will have problems with these behaviors later on.

Constitutional Factors: Constitutional factors are factors that may have a biological or physiological basis. These factors are often seen in young people with behaviors such as sensation seeking, low harm-avoidance and lack of impulse control. These factors appear to increase the risk of young people abusing drugs.

The primary focus of substance abuse prevention is to reduce substance use. One single risk factor does not necessarily condemn a youth to a life of abuse and addiction, however multiple risk factors greatly increases the chances of involvement with alcohol and other drugs.

In an effort to provide primary prevention tools to prevent or delay the initial onset of alcohol and other drug use among use, you must work with youth at the level where they are. You must access the youth's risk factors. In addition to accessing the risk factors you must also access the protective factors. The following risk factors are also a component of the research based on the work of J. David Hawkins and his research team.

Individual Characteristics [11]
Research has identified four individual characteristics as protective factors. Children are born with the following characteristics and these characteristics are difficult to change; gender, a resilient temperament, a positive social orientation and intelligence. Intelligence, however, does not protect against substance abuse.

Bonding
Children may have many risk factors, but bonding makes up for many other disadvantages caused by such risk factors. Children who form a bond and an attachment to their families, schools, friends and community and have set goals and are committed to achieving goals, which are valued by his support group, are less likely to develop problems in adolescence.

Healthy Beliefs and Clear Standards
Adolescents thrive when they have set boundaries, beliefs, and clear standards. When youth know what the standards are and the consistent consequences for breaking the standards they are more likely to follow the standards.

National Institute on Drug Abuse (NIDA) has identified important principals for an effective prevention program.[12] The principals are programs in the family, school, and community. NIDA-

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[11] Western Region Center for the Application of Prevention Technologies
[12] www.drugabuse.gov

supported researchers have tested these principles in long-term drug abuse prevention programs and have found them to be effective.

The most effective and the Best Practice program found by NIDA is the Risk and Protective Factors.

In an effort to provide effective prevention program and to increase the skills of an effective prevention counselor we interviewed a few young people who are currently involved with alcohol and drugs, youth who have used in the past and youth who have never been involved with alcohol and other drugs.

I spoke with three youth who had never been involved with alcohol and drugs, or who may have had their first drink of alcohol at the age of 18, and at the age of 21-22 only may drink on rare occasions.

These youth appear to fit in the resiliency approach.
- 2 of the male youth came from homes where their mother was a young mother
- All three mothers had steady employment
- All three youth attended Church on a regular basis
- 2 of the youth had an older sibling who helped with childcare
- 2 of the youth had grandparents, aunts or uncles to assist the mother
- The number of children in all families were three or more

These youth appeared to fit in the resiliency approach more, but after further review of the approach, these youth did not fit into this model because this model focuses on youth who come from troubled background. These three youth did not come from troubled backgrounds therefore they did not have to learn to bounce back when the odds were stacked against them.

These youth could have easily also fit into the *Developmental Assets Approach*. These youth had the external and internal assets as follows:
- Parent involvement in schooling
- Family support
- With there church affiliation, they provided services to others
- Clear family boundaries
- Positive peer influence
- Religious community
- Bonding to school, each of these three youth were involved in extracurricular activities at school
- Each appeared to be very caring with high integrity
- Great resistance skills
- Positive view of personal future, even though each of these youth were told by their school counselor that they would not be able to achieve the goals they had set for themselves.

These youth had high protective factors and low risk factors; they
- There were drugs in the community but it was not as readily available as in other high-risk communities. There were drugs at their respective schools, but they were not as exposed to them.

- They were attached to their neighborhood due to their affiliation with the community church.
- Limited Family Management Problems
- They were not economically depraved, they did not live in crime ridden neighborhoods or extreme poverty
- Their parents had a strong no use attitude regarding alcohol, drugs and tobacco
- 2 of the three youth were honor roll students
- They did not affiliate with youth who were involved with problems behavior

These youth had healthy beliefs and clear standards, along with positive bonding. They appeared to have the four individual characteristics research identified as protective factors. These are factors that children are born with and are hard to change:
- Gender
- A resilient temperament
- Positive social orientation
- Intelligence

According to research, these youth had the characteristics to fit within the Risk and Protective factors for reduction of drugs.

The following 2 youth are youth who had been involved with drugs, they actually abused drugs, but did not progress to addiction

One youth came from a family who had a history of mental illness, but not drug abuse, while the other youth came from a home where drug abuse was prevalent.

According to the *Resiliency Approach* these youth met the following criteria:
- One mother was young single mother; the other youth came from a two-parent family.
- Both youth came from a family with less than four children
- One of the youth's sibling was less than 2 years apart
- Both youth had extended family for support
- Neither mother had steady employment
- There was no sibling as a caretaker
- There was extensive church attendance for one youth, the father was a preacher, while the other youth had not church attendance

These youth appear to meet this promising approach, because both you come very adverse backgrounds with use of drugs and mental illness. Both of these youth tried drugs, abused drugs, but bounced back when the odds were stacked against them.

After review of assessments and observation of the following 6 youth, I found similarity as follows;

- Chaotic home environments; parents were involved themselves with alcohol and other drugs, of suffering from a mental illness, or so involved in work that they did not have time for parenting.
- Lack of and ineffective parenting skills; these children lacked respect for their parents,
- No parental involvement in youth treatment or recovery program

- Suspended or expelled from mainstream school
- Failure in school performance
- Low to no community attachment, the youth were not attached to their neighborhood or community or did not feel safe in that environment.
- One area these students did not all have in common was economics. 2 of the youth come from families with 2 working parents with government jobs, 1 youth from low income and the other middle class family.
- Friends, who engage in problem behavior, these youth's friends typically were other youth who were involved with alcohol and other drugs, expelled from school, on probation or had other behavioral issues.
- These youth first began using drugs or alcohol prior to age 13

With the following similarities with the above youth, they appear to fit into the best practice model of *Risk and Protective Factors Approach.* According to the Risk and Protective approach these youth further lacked the protective factors need to resist alcohol and other drugs. The Protective factors that these 6 youth lacked are:

- Individual Characteristics, these youth did not a resilient temperaments or positive social orientation, however the majority of these youth were very intelligent.
- They all lack positive bonding; these youth were not attached to positive families, school or community, however they were attached to some friends, who were also involved with alcohol and or drugs.
- They did not exhibit healthy belief or standards. These youth did not have positive, clear standards for behavior.

According to the Center For Substance Abuse Prevention[13] there are six prevention Strategies, these are primary prevention strategies:

1. Dissemination of information, For this strategy to be effective it is important to provide information about the nature and extent of drug use, abuse and addiction. The Information further explains the effects on individuals, families and the communities. This information can be disseminated in a variety of ways which includes;
   - Media campaigns
   - Brochures
   - Health fairs
   - Radio and television public service announcements

2. Prevention Education, prevention education is an interactive method for prevention, it involves two-way communication between students and the educator. Some methods include;
   - Classroom and group settings
   - Peer to peer lead groups
   - Interactive role plays

3. Alternative Activities, this strategy is used to have participants participate in healthy activities that do not involve alcohol or drugs. The belief is that if youth participate in fun healthy activities this offsets the need usually filled by drugs. These activities include;
   - Community drop in centers
   - Mentoring programs

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[13] Center for Substance Abuse Prevention, 1993, Prevention Primer

- Drug-free dances,
- Other drug free recreational activities, skating, bowling, etc

4. <u>Community –Based Processes,</u> this strategy involves the community to become more effective in proactive in providing prevention and treatment services to the people who are involved with alcohol and other drugs. The community should assist in enhancing the efficiency and effectiveness of the programs that are offered in the community. Some of these include;
   - Systematic planning
   - Multi-agency coordination and collaboration
   - Community team building

5. <u>Environmental Approaches,</u> seeks to change and establish community standards, norms codes and attitudes. The change influences the incidence and prevalence of alcohol and drug abuse in the general population. Some of the methods used include;
   - Review and modification of advertising practices
   - Review and modification of school drug policies
   - Product pricing strategies (i.e. tobacco sales)

6. <u>Problem Identification and Referral,</u> seeks to identify those who are involved with alcohol and other drugs, assess their behavior to see if it can be reversed through education. Methods used which preclude identification if treatment is needed are referrals such as;
   - Driving under the influence educational programs
   - Employee assistance program
   - Student assistance programs

To prevent alcohol and other drug use among youth, prevention programs should be designed to enhance the youth protective factors while decreasing the risk factors.

For effective intervention all six strategies are key components. At times you are only able to effective one component "The Family". If you can effect the family chances are that you may have a better chance at prevention substance use and abuse. Youth, generally model the behaviors they see in the family. Families that constructively with conflict and have a high degree of bonding appear to model more healthy behaviors, therefore their children are less likely to suffer from the effects of alcohol, tobacco and other drugs.

When youth come from families where parents and siblings are involved with alcohol, tobacco and other drugs this increases the risks that the younger siblings will also become involved. However, not all youth who get involved with alcohol and other drugs come from families that are involved in alcohol and drug, permissive attitudes about drugs can also increase the youths risk of becoming involved.

Children of Alcoholics (COAs) may face special problems as a result of living in a home with a parent who is an alcoholic. [14] However, most COAs do not develop serious problems coping with life as a result. Although there is a genetic component to vulnerability for alcohol dependence, COA issues are not related primarily to alcohol use and problems, but instead they

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[14] National Institute on Alcohol Abuse and Alcoholism No. 9 PH 288 July 1990

are related to social and psychological dysfunction that may result from growing up in an alcoholic home.

Not all youth who come from environments where there are many risk factors for drug or alcohol use get involved with drugs or alcohol. These youth seem to possess personal resilience that helps them to resist getting involved with alcohol, tobacco or other drugs.

To increase protective factors an intervention should be tailored to reduce the dysfunction and strengthen the aspects of the family life that are nurturing. In prevention one size does not fit all. Each youth and family has different needs, and an approach that does not deal with cultural variations, working families; discipline, communication and other aspects of families can be ineffective and destructive.

Cultural Competency plays a crucial complex role in prevention. [15]Culture is the shared values, norms, traditions, customs, arts, history, folklore, music and institutions of a group of people. Culture competence means understanding and appreciating the cultural differences and similarities within, among and between groups.

Prevention programs that combine information about the harms of substance along with fostering skills such as communication, problems solving or refusal skills have shown to be more effective then one shot just say no programs.

Conclusion – Part I

To be an effective prevention program, programs should be long term and interactive. Prevention should include family members in an effort to increase knowledge about drugs and their harmful effects. Family focus prevention programs are an effective method because it does not isolate the youth or the parent. Everyone is getting the same information at the same time. This method will help to reinforce the information learned. It is important and challenging to identify the protective factors and determine how they can be taught and instilled in youth who reside in high-risk environments.

Understanding what determines vulnerability to substance abuse is crucial to the development of effective prevention programming.[16] At this point, there is no evidence that a single, unique factor determines which individuals will abuse drugs; rather, drug abuse appears to develop as the result of a variety of genetic, biological, emotional, cognitive, and social risk factors that interact with features of the social context. Thus, both individual-level factors and social context-level factors appear to make an individual more or less at risk for drug abuse and influence the progression from drug use to drug abuse to drug addiction.

To be an effective primary prevention specialist it is imperative to look at the whole individual factors that put youth at risk for alcohol and other drugs. To focus only on the risk is not as effective as also focusing on and building on the protective factors. An effective prevention specialist will incorporate and address each aspects of the individuals life, such as; family, community, school, and peers. Furthermore, prevention must include skills to resist drugs, increase bonding and social competency. Additionally youth should be offered alternative activities such as peer groups, outing and activities. Family members are an important and crucial part of prevention.

[15] Cultural Competence Fore Evaluators, 1992
[16] http://www.whitehousedrugpolicy.gov/prevent/research.html

Part II

Substance use and abuse varies at different stages and at different degrees among the youth population. The goal of primary prevention is to target youth who have never experimented with alcohol and drugs and prevent or delay the use of alcohol and other drugs. It is important that primary prevention is started at an early age. I feel it must be started begin prior to age of 8. [17] According to the Ohio State University youth's Intellectual development does not begin until age 10 or 11. It is believed that youth grades K-3 are seeking approval from adults. This is the time to begin to begin teaching alcohol and drug prevention methods.

Secondary prevention focuses on youth who have begun experimentation, use and abuse of drugs. The following definitions are used to describe the target of secondary prevention.[18]

- *Experimentation.* The individual has one or perhaps a few experiences with a particular drug out of curiosity or because of peer pressure.
- *Occasional use.* This is usually unplanned and generally occurs in social situations where the drug is readily available.
- *Regular use.* Drug taking becomes routine.
- *Drug dependency.* The individual's psychological and physical well-being is so closely linked to the chosen chemical that it becomes a necessity. At this stage of addiction, physical withdrawal signs occur if the drug is abruptly discontinued.

Experimentation does not constitute that a youth will continue to use. Some youth at this stage may realize they do not like the effects be it physical or psychological decided they will not continue to use alcohol or drugs. However, this may be a time when secondary prevention is beneficial. During the experimentation phase may be a good time to assist in the prevention of occasional or regular use. Youth who are experimenting are curious and probably do not require an inpatient or outpatient treatment program. But they do require further education and prevention information to prevent or delay further use of alcohol and other drugs.

When working with youth it is important to realize that not all youth who become involved with alcohol and other drugs will continue on with regular or occasional use, or become dependent. And it is equally important to realize that all youth who are referred to treatment are not all regular users, or are dependent on alcohol and other drugs. It is crucial to remember that when youth are referred for treatment they are referred from a variety of organizations for a variety of reasons.

Many youth are referred because they have been caught using, admitted to using or are in possession of drugs. Youth are referred to counseling at different stages of substance use and abuse and it is important that their issues and concerns are addresses on an individualized basis.

Prevention is part of an interrelated continuum of services that also includes intervention and treatment, often referred to as secondary and tertiary prevention.[19] Primary prevention often relies on the development of policies, regulations and behavioral norms to change drinking and other drug practices. In contrast, secondary and tertiary prevention includes activities related to activities used to change behavior of individuals who are involved with or suffer from problems related to alcohol and other drug use. Services and activities include but are not limited to;

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[17] http://ohioline.osu.edu/4h-fact/0015.html

[18] http://cpmcnet.columbia.edu/texts/guide/hmg04_0006.html

[19] Center for Substance Abuse, Prevention Primer

crisis intervention, targeted education, peer group intervention, detoxification services, inpatient and outpatient treatment.

Experimentation is at the end spectrum of primary prevention, it is to prevent or delay use. Since Experimentation is closely associated with primary prevention, we will focus on use and abuse not experimentation. In conjunction with the DSM-IV the term substance abuse is used in the general sense to cover both substance abuse disorders and substance dependence. Many youth recovery programs appear to have a high rate of youth who relapse, when in essence the youth has never been in recover and had no intention on discontinuing use.

Terence T. Gorski states, "Because adolescents lack power in their lives, they are experts at compliance.[20] When the power of their parents, the legal system, and the school system is brought to bear, most adolescents are capable of playing the games. The result is a perfect patient during treatment and a rapid return to chemical use when the adolescent is returned to a less restrictive environment. High Relapse rates results".

But is it considered relapse. The definition of relapse is "regression to a former state, such as recurrence of an illness during recuperation or after recovery to lapse back, as into illness or addiction,[21] to regain, to return to a former state.[22]

Many youth programs are asked, "What is your success rate?" I always answer that question: "Success according to whom?" Each party involved with the youth who was referred to treatment has there own agenda and standards for success.
- Probation; they need for the youth to complete court and probation requirements. Example; Complete 3 months of a treatment program
- School: They need for the youth to return to school therefore they need to attend 1 month of counseling
- The Treatment programs goal is to educate the youth and get them clean and sober
- The parents wants their child fixed so they will quit causing problems
- The youth just wants to get off probation, return to school, get their parents off their back and tell the treatment program what they want to hear.

Most youth in the use and abuse stage have no intention of getting clean and sober. The youth does not realize any negative consequences associated with alcohol and drug use. They are on probation because the cops were messing with them, so what they caught with marijuana on school campus they are attending school and are a C average. However their parents drink, use drugs, are not around, are abusive, so the parents are the problem not the youths drug use.

The youth has not realized that his choice to use alcohol and other drugs may have been the cause of them being on probation, expelled from school, or referred to the treatment program has anything to do with their drug use. And why should they quit using they haven't associated any negative effects?

All of the above parties have a vested interested in the youth becoming clean and sober except for the youth. For an effective secondary prevention program it is important to understands the youth desire and motivation for change.

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[20] Bell, Tammy, Preventing Adolescent Relapse 1990
[21] Webster Pocket Dictionary, 2002
[22] Webster Pocket Dictionary, 2002

During the past 20 years, considerable research has focused on different ways to motivate substance abusers to initiate and continue treatment. A series of motivational techniques have been identified to enhance a clients motivation to chance which include[23]

- Motivation is key to change
- Motivation is multidimensional
- Motivation is a dynamic and fluctuating state
- Motivation is interactive
- Motivation can be modified
- The clinicians style influence client motivation

One research that is being widely used today is the *Transtheoretical Model of Change*. The "Transtheoretical Model" (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska & Velicer, 1997) is an integrative model of behavior change. This model helps a person modify or change behaviors, it focus on the decision making of the individual where the individual currently is at in the process of change. There are hundreds of different theories of human behavior. Prochaska and his colleagues researched many different theories to determine whether there were instead a limited number of processes for change that applied across different theories.

They found that while researchers and individuals may have many different theories about behavior change, the actual process of change is remarkably similar across different studies using a variety of theoretical approaches.[24]

The Transtheoretical Model is developed is from an examination of 18 psychological and behavioral theories about how change occurs. They developed this model that shows the stages and process of behavior change and called it the Transtheoretical Model because it applies different theories.

They identified five stages of behavior change. Each stage has its own characteristics and can occur at anytime and in almost any order. The five stages of change are, ***Precontemplation, Contemplation, Preparation, Action and Maintenance***. A person can begin at precontemplation advance to action; move back to contemplation, maintenance and back to precontemplation. The stages of change can be seen as a spiral because people tend to circle through the stages rather then linear.

The definitions of the five stages of The Transtheoretical Model of change as a process are as following:[25]
Precontemplation(Not thinking about it) is the stage in which people are not intending to take action in the foreseeable future, usually measured as the next six months. People may be in this stage because they are uninformed or under-informed about the consequences of their behavior. Or they may have tried to change a number of times and become demoralized about their ability to change. Both groups tend to avoid reading, talking or thinking about their high-risk behaviors. They are often characterized in other theories as resistant or unmotivated or as not

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[23] U.S. Department of Health and Human Services TIP Series 35
[24] State of California, Building Quality HIV Prevention Counseling Skills
[25] Changing for Good, J. Prochaska, J. Norcross and C. DiClements, 1992

ready for health promotion programs. The fact is traditional health promotion programs are often not designed for such individuals and are not matched to their needs.

The Precontemplators has no intention of changing the behavior in the near future, they are unaware that a problem exist. When the Precontemplators seek counseling they are generally seeking counseling because they are pressured from family, required by the courts, employers or schools. During this stage the client is resistant and has no intention of modifying their behavior.

Contemplation(Thinking about It) is the stage in which people are intending to change in the next six months. They are more aware of the pros of changing but are also acutely aware of the cons. This balance between the costs and benefits of changing can produce profound ambivalence that can keep people stuck in this stage for long periods of time. We often characterize this phenomenon as chronic contemplation or behavioral procrastination. These people are also not ready for traditional action oriented programs.

At this stage, the person recognizes a problem exist and is seriously thinking about changing behaviors, but has not yet made a commitment. Contemplators spend considerable effort and amount of time weighing the pros and the cons of the problems and solutions. They are seriously considering change but they may not have the motivation to endure the effort that change requires

Preparation(Ready for Action) is the stage in which people are intending to take action in the immediate future, usually measured as the next month. They have typically taken some significant action in the past year. These individuals have a plan of action, such as joining a health education class, consulting a counselor, talking to their physician, buying a self-help book or relying on a self-change approach. These are the people that should be recruited for action-oriented smoking cessation, weight loss, or exercise programs.

This person has every intention of making a change and has plans to do so within the next month or has taken may have taken action previously but failed. This type of person could be someone who has wanted to quit smoking and has cut down on the number of cigarettes that they smoke, or they may have decided that they would only drink on weekends.

Action is the stage in which people have made specific overt modifications in their life-styles within the past six months. Since action is observable, behavior change often has been equated with action. But in the Transtheoretical Model, Action is only one of five stages. Not all modifications of behavior count as action in this model. People must attain a criterion that scientists and professionals agree is sufficient to reduce risks for disease. In smoking, for example, the field used to count reduction in the number of cigarettes as action, or switching to low tar and nicotine cigarettes. Now the consensus is clear--only total abstinence counts. In the diet area, there is some consensus that less than 30% of calories should be consumed from fat. The Action stage is also the stage where vigilance against relapse is critical.
At this stage the client has made changes and modifications to their behavior, attitude or environment. While action is a dramatic and rewarding stage it is not the same thing as successfully achieving and maintaining a behavior change.

Maintenance is the stage in which people are working to prevent relapse but they do not apply change processes as frequently as do people in action. They are less tempted to relapse and increasingly more confident that they can continue their change.

This stage is attained when the client has successfully maintained their behavior change for six months or longer. This stage is a maintenance stage and therefore is viewed as on going and continued maintenance. The person must continue to focus on preventing relapse while on the road to recovery.

Anthony (1993) identifies recovery as " a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles."[26] It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life

The youth who are at the precontemplation stage has no desire to discontinue use. They have been forced into treatment and their only goal is to get out of the program. As mentioned earlier one way of motivation the client is the style of the clinician. It is important that the clinician has a motivational interviewing style.

Motivational interviewing is a style of interviewing a client that elicits their motivation for change. According to the CSAT Consensus Panel successful Motivational Interviewing will contain the following:[27]
- Express empathy
- Communicate respect for and acceptance of clients and their feelings
- Establish a nonjudgmental, collaborative relationship
- Be a supportive and knowledgeable consultant
- Compliment rather than denigrate
- Listen rather then tell
- Gently persuade, with the understanding the change is up to the client
- Provide support throughout the process of recovery
- Develop discrepancy between clients' goals or values and current behavior, helping clients recognize the discrepancies between where they are and where they hope to be
- Avoid argument and direct confrontation, which can degenerate into a power struggle
- Adjust to, rather than oppose, client resistance
- Support self-efficacy and optimism; that is, focus on clients' strengths to support the hope and optimism needed to make change.

OARS is a strategy that is useful in Motivational interviewing. OARS is a term coined by Miller & Rollnick,. Some of the terms are directive and non-directive:
- Open-ended Questions
- Affirmation
- Reflective Listening
- Summary

It is important that during the initial stages of interviewing and assessing the clients needs and stage of motivation that clinicians ask open ended questions, therefore giving the client an opportunity to expound on information and not just answer with a yes or no. This technique keeps conversations going and is helpful in keeping the focus on the client.

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[26] William Anthony, Director of the Boston Center for Psychiatric Rehabilitation
[27] DHHS Publication No.(ADP) 99-8554

Affirmation allows the counselor to communicate true understanding and express genuine empathy. The affirmations build on the clients' strengths, past success and goals. One affirmation that assist in building clients confidence is thanking the client for coming in for counseling.

Counselors show that they are listening to clients through reflecting or paraphrasing what the client has said. This method is a way to eliminate any misunderstandings. It test whether what the speaker means is what the listener understands. There are three levels of reflection; *Repeating*, then is when you use the clients' words and repeat the essence of what was said. *Rephrasing,* whereas you say the same thing in a slightly different way, and *Paraphrase*, where you restate to capture the meaning and emotion of what was said and adding something that was not said or implied.

Summarizing what was said during session or over a course of several sessions allows you to highlight concerns, ambivalence, discrepancies or success. Always support the client through affirmation of the client's strengths and motivation to change and be sure to summarize the counseling session to ensure the client of you interest in their progress or lack of.

This Stage of Change model is pertinent to youth as well as the adult population and the techniques work for both populations. However as in an effort to be effective treatment must be client centered and based on the client's age, level of development and Motivation to change. The majority of youth who are referred to outpatient treatment who have been identified as experimentation, use and abuse are most likely to be at the **Precontemplation Stage**. These youth have not yet considered change, is unwilling or unable to change. These youth tend to be rebellious and need to be in control. They are reluctant for change because they need additional information about the need to change some of their behaviors while feeling capable and confident that they can make the change. The Goal of Precontemplation is; *To Identify Defenses And Raise Awareness*. During this stage and the different stages of change, the following strategies for the clinician are suggested[28]

- Establish rapport, ask permission, and build trust
- Raise doubts or concerns in the client about substance using patters by:
  - Exploring the meaning of events that brought the client to treatment or the results of previous treatments
  - Eliciting the client's perceptions of the problems
  - Offering factual information about the risks of substance use
  - Providing personalized feedback about assessment findings
  - Explore the pros and cons of substance use
  - Helping a significant other intervene
  - Examining discrepancies between the client's and others' perceptions of the problem behavior.

Also be sure to express concern and keep the door open for communication.

When you have a client who acknowledges concerns and is considering the possibility of change bus is ambivalent and uncertain this client is contemplating change and is considered to be in the **Contemplation stage.** The Goal of the Contemplation stage is; *Decide for Change* and the following motivational strategies for clinicians are suggested.

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[28] Richardson, Helen and Tomlin, Kathleen LPC,CADC2

- Normalize Ambivalence (Uncertain, especially as related to contradictory emotions, unsure how to proceed, *Webster dictionary*)
- Help the client "tip the decisional balance scales" toward change by
  - Eliciting and weighing pros and cons of substance use and change
  - Changing External to internal motivation
  - Examining the clients personal values in relation to change
  - Emphasizing the clients free choice, responsibility, and self efficacy for change
- Elicit self motivational statements of intent and commitment from the client
- Elicit ideas regarding the clients perceived self-efficacy and expectations regarding treatment.
- Summarize self-motivational statements

For the client who is committed to and planning to make a change is at the **Preparation Stage** but this client is only preparing and is still considering what to do. The Goal for Preparation Stage is: *Get Ready To Make Change*. The clinician can assist the client in the following manner.

- Clarify the clients own goals and strategies for change
- Offer a menu of options for change or treatment
- With permission, offer expertise and advice
- Negotiate a change-or treatment-plan a behavior contract
- Consider and lower barriers to change
- Help the client enlist social support
- Explore treatment expectancies and the clients role
- Elicit from the client what has worked in the past either for him or others whom he knows
- Assist the client to negotiate potential barriers
- Have the client publicly announce plans to change

Once the client begins to actively take steps to change they are in the **Action Stage.** The Goal for Action Stage is *Monitor and Assist Action Plans* and as a clinician you can do the following;

- Engage the client in treatment and reinforce the importance of remaining in recovery
- Support realistic views of change through small steps
- Acknowledge difficulties for the client in early stages of change
- Help the client identify high-risk situations through a functional analysis and develop appropriate coping strategies to overcome these.
- Assist the client in finding new reinforces of positive change
- Help the client assess whether she ahs a strong family and social support.

For the client that has achieved the initial goal of sobriety and is maintaining the client is in the **Maintenance Stage**. The Goal for Maintenance is; *Reassure, Assist, Improve Resolve for Change* and will benefit from the clinicians help in the following areas;

- Help the client identify and sample drug-free sources of pleasure
- Support lifestyle changes
- Affirm the clients resolve and self-efficacy
- Help the client practice and use new coping strategies to avoid return to use
- Maintain supportive contacts
- Develop a fire escape plan if the client resumes substance use
- Review long-term goals with the client

Many times we realize that the best-proven techniques are not always successful. It may take a person weeks, months and even years to progress to contemplation stage. A client can be at the precontemplation stage and jump directly to the Action Stage; Example

This is an example of an actual client biopsychosocial and how the stages of change was used to help prevent further use and abuse of alcohol and other drugs and reduce the risk that alcohol and other drugs caused in the youths life.

Mary is a 15-year-old African American Female who currently resides in a group home environment, and appears to be fairly healthy. The client is sexually active and states that she does not always use protection during sexual intercourse. The client is in the tenth grade and states her grades are average. She has not had any problems with school and states her classes are not difficult and she is bored with school. Mary is currently working in a clothing store and has been working there for the past 2 months.

Mary reports that she does not spend the majority of her free time with friends that use alcohol and other drugs. She states she has friends who are clean and sober and she does hang out with them. She states her biological mother and grandparents uncles and 2 aunts have experienced alcohol and drug problems. She reports that some family members are chemically dependent, but she denies being chemically dependent. She reports that she has received treatment in the past for emotional or psychological problems, she reported using alcohol and marijuana for the past 3 years. She drank more approximately seven or more drinks per day on the days that she drank in the past month. She was intoxicated for the first time at age 11. Mary is not at all bothered by alcohol and drug problems even though she has been arrested three times for selling drugs and is on probation.

Mary admits to selling drugs in order to buy drugs, clothes and food.   She does not feel like she needs to stop using drugs because all she uses is alcohol and marijuana and these are not considered bad. At this time she is at the precontemplation stage. She has no desire to or intention of stopping the use of alcohol and marijuana.

By Mary's third session, which was the beginning of treatment planning, she progressed from the Precontemplation Stage to Actions Stage According to the Transtheoretical Model. Mary did not agree to quit using alcohol or marijuana but she did agree to change some of her high-risk behaviors. Mary agreed to reduce the Harm that Alcohol and Marijuana could cause in her life. She agreed to the following plan;
- To not use drugs before, during or after school
- Not to sell drugs at school
- She will not drink, use and drive and will not drive with others who are under the influence
- She will use condoms each time she has sexual intercourse
- She will attend individual counseling sessions weekly
- She will attend AOD groups

This client at this time does not feel she needs to complete stop using, but understands that she can reduce her risk of further involvement with the juvenile justice system, continue to attend school and reduce her risk of HIV, STD's and pregnancy by changing some of her behaviors. In secondary prevention is valuable to incorporate a Harm Reduction model for Precontemplators. When incorporating a Harm Reduction Method as part of secondary prevention remember to incorporate the following methods:

HARM REDUCTION PRINCIPLES/CONCEPTS: [29]
Be nonjudgmental
Avoid being parental/authoritarian
Meet the client where they are
Avoid having preconceived goals
Provide guidance and consultation
Provide support
Value the client's information
Be aware of power differences (skills, education, race, money)
Build rapport/trust
See small changes as success
Recognize denial as normal
Emphasize client's strengths
Emphasize personal responsibility for outcomes
Avoid unnecessary labeling
Normalize drug use

Principals of Harm Reduction
Harm reduction is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence.[30] Harm reduction strategies meet drug users "where they're at," addressing conditions of use along with the use itself.

Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use

Most therapeutic services for drug users, including drug treatment, are designed to serve the priorities of providers instead of the needs of consumers. Drug education and prevention campaigns are largely ineffective, attempting to scare people away from using drugs instead of equipping them with accurate information about drugs and drug use, including their adverse and harmful effects.

Therefore if your client is determined to stay in the precontemplation stage because they do not perceive any long-term dangers or adverse effects of alcohol and drug use, as the motivational clinician you can assist them to get advance to the Action stage. Once they are in the action stage and begin to increase knowledge of how alcohol and drugs affects their life and how gateway drugs. "Gateway drugs" are drugs that serve as the "gate" or path that almost always precedes the use of illicit drugs such as marijuana, cocaine, heroin, and LSD.[31] These gateway drugs serve as almost essential precursors to the use of other drugs, and often lead to adoption of the drug-using lifestyle. Gateway drugs, or drugs-of-entry, serve to initiate a novice user to the drug-using world.

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[29] http://www.metrokc.gov/health/apu/harmred/princ.htm
[30] http://www.harmreduction.org/prince.html
[31] http://www.drugs.indiana.edu/publications/iprc/factline/gateway.html

Conclusion – Part II

There is no timeframe on how long a client may be in the precontemplation. It is important to work with the client where they are at in their use and willingness to abstain from use and abuse. It is imperative if you have a youth that refuses to abstain after exploring the pros and cons of substance use, and you have elicited the clients perception of the problem that you work with the youth on reduces harm that the drugs and alcohol can cause in their life. It is important to distinguish between

Primary prevention is a safety net that provides individuals with information and resources raise their awareness of both risky and healthy behaviors, and helps shape environments to promote health and protect people from harm.[32]

Intervention or secondary prevention is the next level safety net for those who are involved with alcohol and other drugs with the goal of preventing further use. Intervention may target those who have begun to experience problems with substances can benefit from secondary prevention. All individuals are not at the point where they wish to abstain from the use of alcohol and drugs. It is the Clinician responsibility to work with the client to access their level and Motivation for Change. To further assist the resistant client who's goal is not to stop using alcohol and other drugs, they can move in to the Action Stage by reducing alcohol consumption to low risk levels, thus prevention the development of further alcohol or drug related problems.

SUGGESTED ADDITIONAL READING AND RESOURCES

❑ *Webster Pocket Dictionary 2002.* Definition of Prevention
❑ *Prevention Primer, DHHS Publication NOSMA 94-2060*, Overall goal of prevention
❑ *A Promising Future; Alcohol and Other Drug Problem Prevention Services, CSAP* Secondary prevention
❑ *www.drugabuse.gov/pdf/monographs/47.pdf, Botwin, Gilbert J. PHD* Prevention and the delay of the initial onset of use.
❑ *National Institute On Drug Abuse Publication No. 97-4212* Studies on the origins and pathways of drug abuse problems.
❑ *www.drugs.indiana.edu/prevention/assets/home.html* Categorical prevention approaches
❑ *Western Region Center for the Application of Prevention Technologies* The Developmental Approach
❑ *Western Region Center for the Application of Prevention Technologies* The Resiliency Approach
❑ *Western Region Center for the Application of Prevention Technologies,* Community Risk and Protective Factors and Individual Characteristics
❑ www.drugabuse.gov. Important principals for effective prevention programs
❑ *Center for Substance Abuse Prevention, 1993, Prevention Primer*, Six Prevention Strategies
❑ *National Institute on Alcohol and Alcoholism No. 9 PH 288 July 1990,* Issues related to Children of Alcoholics
❑ Cultural Competence Fore Evaluators, 1992, Definition of Culture
❑ *www.whitehousedrugpolicy.gov/prevent/research.html*, Understanding the vulnerability to substance abuse
❑ Ohio State University
❑ Columbia University College of P& S Complete Home Medical Guide
❑ Center for Substance Abuse, Prevention Primer, encyclopedia of alcohol, tobacco and other drug prevention terms

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[32] Center for Substance Abuse, Prevention Primer

- Bell, Tammy, Preventing Adolescent Relapse, 1990
- Webster Dictionary
- U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Rockville, MD
- U.S. Department of Health and Human Services TIP Series 35
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- Public Health, Seattle and Kings County, HIV program, Harm Reduction Principals and concepts
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- Indiana Resource Center, Factline on Gateway Drugs
- Center for Substance Abuse, Prevention Primer

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