U.S. Department of Justice
Office of Justice Programs

Promising Strategies to Reduce Substance Abuse

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ISSUES & PRACTICES REPORT

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The research for *Promising Strategies to Reduce Substance Abuse* was conducted by Drug Strategies, a nonprofit research institute based in Washington, D.C. Drug Strategies' mission is to promote more effective approaches to the nation's drug problems and to support private and public initiatives that reduce the demand for drugs through prevention, education, treatment, and law enforcement (www.drugstrategies.org).

Promising Strategies to Reduce Substance Abuse

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Foreword

Drug and alcohol abuse, drug trafficking, and related criminal activity remain serious problems that affect the lives of most Americans. Under the leadership of President Clinton and in cooperation with the Office of National Drug Control Policy, the U.S. Department of Justice has promoted and pursued an approach that combines prevention, treatment, and enforcement to break the cycle of substance abuse and crime. *Promising Strategies to Reduce Substance Abuse* illustrates this approach through examples of programs that have been adopted successfully by communities across the country. We see this volume as a "toolbox" for elected state and local officials, law enforcement, prosecutors, judges, community organizers, and other policymakers. It contains practical information about a range of proven and promising strategies to reduce substance abuse.

Several themes emerge from the profiled programs that match the themes found in the companion volume, *Promising Strategies to Reduce Gun Violence,* published in 1999 by the Office of Juvenile Justice and Delinquency Prevention. One is that the criminal justice system can and should be used to improve public health as well as public safety. Another is that providing treatment for drug abuse is a cost-effective means of reducing the heavy burden that both drug abuse and incarceration impose on society. If the proximate cause of much criminal activity is the desperate need to feed a drug habit, if criminal activity is frequently committed under the influence of drugs and alcohol, if the psychoactive effects of drug abuse lead people to violent and antisocial conduct, then using the criminal justice system to hold people accountable for their deeds but also to enable them to change their behavior can lead to reduced recidivism, safer communities, and healthier and more productive citizens.

It has long been my goal to develop a continuum of interventions for substance abuse offenders. Incarceration is just punishment for those who commit acts of drug trafficking, for those who do violence to innocent victims, and for those who repeatedly behave in a manner that endangers our safety. Many times, however, the primary victims of substance abuse are the defendants themselves who need help turning their lives around. Drug court programs, for example, are especially effective in dealing with substance-abusing defendants. The prevention, treatment, and law enforcement strategies described in the following pages embody this continuum of accountability.

These programs also demonstrate how crucial broad collaboration is in forging sound and effective strategies. This collaboration has different components: federal, state, and local governments pooling their resources; education, health, and police officials sharing ideas and data; and government, business, and nonprofit sectors building coalitions, all in service of the common goal of combating substance abuse. The problems touch us all, and we all need to be part of the solutions. I am sure that every community can find in these pages an example of a program that will work for it. I hope everyone who reads this will be inspired to dedicate time and energy to support the appropriate organizations, or to create new ones, to implement these tested and promising strategies to reduce substance abuse.

Janet Reno
Attorney General
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Executive Summary

Substance abuse is one of the most pervasive problems facing our nation, costing over $275 billion in health care costs, lost productivity, related crime, and other social costs, and contributing to over 130,000 deaths each year. To help communities address the devastating effects of illicit drug and alcohol abuse, *Promising Strategies to Reduce Substance Abuse* has been developed to highlight best practices in prevention, treatment, and law enforcement.

Prevention, treatment, and law enforcement strategies, discussed in separate chapters, act in concert with one another, comprehensively addressing substance abuse in various contexts. Collaboration among law enforcement, health, and social service agencies can help reduce demand, which fuels drug trafficking activities, often involving violence and crime. Treating addicts and preventing the onset of drug use can complement law enforcement efforts to reduce supply.

Expanded research in drug abuse prevention over the last two decades has identified key elements of successful programming, discussed in the Prevention chapter. Recognizing risk and protective factors is an essential component of successful prevention programs.

Treatment for alcohol and other drug abuse continues to evolve as more is learned about tailoring treatment to specific populations. Advances have been made in pharmacological treatments and in treatment for women, adolescents, and other specific populations. Creating a continuum of care from prison into the community, incorporating HIV prevention in treatment, and delivering essential support services, such as job counseling and child care, are elements of the new approaches to substance abuse.

Criminal justice can have significant impact in reducing illicit drug and alcohol abuse. Law enforcement initiatives addressing substance abuse and related crime are now working more intimately with communities to solve local problems. Local law enforcement also collaborates effectively with federal anti-drug agencies, forming task forces to combat high rates of drug-related crime.

Promising Strategies to Reduce Substance Abuse is intended to serve as a guide to communities by identifying the core elements of promising strategies and providing examples of programs that are making a difference locally.

Overview

Promising Strategies to Reduce Substance Abuse is an assessment of the most effective strategies used nationwide to reduce illicit drug and alcohol abuse and related crime. The report is intended to serve as a guide to communities by identifying the core elements of promising strategies and illustrating these strategies with examples of programs that are making a difference locally. Programs were chosen to represent urban, suburban, and rural communities.

An important trend evident in many of the effective strategies and programs is a close coordination between law enforcement, treatment providers, and prevention professionals to address substance abuse and related problems. These partnerships are vital to the success of programming because they minimize redundancies, help to streamline service delivery, and improve access to expertise and financial resources. All types of initiatives in prevention, treatment, and enforcement seem to work better and have a greater impact if interagency collaboration is well-developed and well-orchestrated. Such collaborations are vital to providing a continuum of care that can effectively intervene at all stages of an individual's life, from birth to adulthood, and in all kinds of community institutions, from the school to the local jail.

The growing emphasis on "what works" among lawmakers and funders requires that communities learn from each other and implement program models with a track record of success. Using programs that are effective in other communities, tailoring those programs to the needs of the specific locality, and evaluating their success is critical to creating a sustainable approach.

Research in drug abuse prevention has flourished for more than two decades and has identified key elements of successful programming that are discussed in the Prevention chapter. Identifying risk and protective factors and focusing on the resiliency and strengths of youths and adults, for example, have become major focuses of prevention programs. The report outlines five basic prevention strategies: teaching prevention in schools, reaching youths outside school, targeting high-risk groups, building family bonds, and empowering communities.

Treatment for alcohol and other drug abuse continues to evolve as more is learned about what works with specific populations. Based on research to date, the National Institute on Drug Abuse recently developed 13 principles of effective treatment (these are discussed later in the report). Four strategies are discussed in the Treatment chapter: treating the family, rehabilitating criminal offenders, assessing and treating juveniles, and connecting with the community.

Criminal justice approaches, which often integrate prevention and treatment components, are critical in preventing crime and disorder associated with alcohol and other drug abuse. The changing nature of law enforcement responses to substance abuse and related crime is demonstrated in local department efforts to work within their communities to solve local problems. These trends are evident at the federal level; the Office of Community Oriented Policing Services (COPS) within the

Department of Justice, for example, directs substantial resources to local community policing initiatives. In addition, over the past decade alternatives to incarceration that combine sanctions, accountability, and treatment for offenders have become increasingly popular. The growth of drug courts exemplifies this trend. In 1989, the first drug court was established; in 2000, more than 400 courts exist nationwide, and nearly 300 are in the planning stages. The Law Enforcement chapter discusses five strategies: community policing, problem-oriented policing, reducing drug availability, alternatives to incarceration, and alcohol-related approaches.

Communities looking to implement promising anti-drug approaches should first assess the areas of greatest need. In some communities underage drinking may be the most prominent problem, in which case prevention, treatment, and enforcement activities should be enhanced. Other communities may face problems of violence linked to illicit drug trafficking requiring law enforcement activities to target "hot spots" of heightened drug activity. Determining the gaps in services currently provided by and for the community is an essential step. The local health department, police department, and other state and local agencies often track data and services that will help identify community needs.

Another consideration for communities is cost. The promising programs highlighted in this report provide information on the cost of implementing and operating the various activities. In addition to cost, other community resources, such as personnel and readiness, must be considered. Is there an existing agency that can incorporate an effective prevention curriculum into its programming? Does the police department have a strong track record of collaborating with social service agencies? The degree to which a community is galvanized around implementing new programs can have a profound effect on the success of those programs.

Most of the promising programs highlighted in the report have been in existence for at least three years, demonstrating their durability. All of the programs have been successful in meeting their goals. For each program the report provides information vital to community replication, broken down into the following categories:

Description—outlines the goals and logistics of the program (i.e., who is served and program capacity, what services does the program provide to the community, how are these services provided, etc.);

Challenges—describes the obstacles to implementing and/or operating the program, and in most cases how those obstacles were overcome or are currently being addressed. In doing this, communities can prepare for the common challenges of implementing the programs and begin to address them in the development stage;

Costs—outlines either the annual budget of the program or the cost of serving an individual over the course of the program. Replication costs are available for many of the programs, as are various costs that communities should foresee when designing a similar program; and

Program Results—details the effectiveness of the program in meeting goals and objectives. Some programs have been evaluated by external or internal investigators using rigorous research designs; however, this standard does not hold true for all of the promising approaches detailed in this report. Some programs

were assessed as promising based on improvement observed in the community, such as reductions in criminal activity and/or substance abuse. All programs detailed in the report have made positive impacts within their communities.

Promising Strategies to Reduce Substance Abuse aims to provide communities with valuable information on successful efforts to reduce substance abuse and related problems nationwide, and to assist them in selecting strategies and programs that will effectively address their specific needs.

Prevention

Effective prevention strategies are critically important in community efforts to combat substance abuse. Virtually everyone is susceptible to alcohol and other drug problems at different points in their lives. Some people, however, are at higher risk for developing serious addiction because of personal, family, or environmental circumstances. The impact of substance abuse often reaches beyond the abuser to family members, friends, co-workers, and society at large.

Extensive research during the past two decades has identified a number of prevention strategies that measurably reduce drug use, including by those at high risk. These strategies share a common goal: strengthening "protective factors," such as well-developed social skills, strong family bonds, attachment to school, and active involvement in the community and religious organizations, while reducing "risk factors" that increase vulnerability to drug abuse. Recent research suggests that resilience is also an important factor; even in high risk, adverse circumstances, many people are able to resist drugs.[1]

While it is impossible to predict with certainty who will develop alcohol and other drug problems, research has uncovered a great deal about the factors which significantly increase risk for millions of children ages 10 to 17. Substance abuse by a parent, lack of parental guidance, or a disruptive, abusive family are very strong predictors, as are school failure, early experimentation with drugs, and living in a community where substance abuse and dealing are pervasive.[2] While these risk factors are all important predictors, the effect of any single factor can be mitigated by other circumstances. Research indicates that two risk factors produce four times the probability of problem behaviors. Children facing multiple risks are much more likely to move from experimentation to serious substance abuse by the time they are teenagers.[3,4]

Promising prevention strategies are often designed to address different levels of risk. *Universal* prevention efforts, like drug education, target all youth without identifying those at particularly high levels of risk. *Selective* interventions concentrate on those who are particularly vulnerable to drugs because of personal, family, and community risk factors. *Indicated* interventions are intensive efforts aimed at youth who are already experimenting with alcohol and other drugs or exhibit other risk-related behavior.[5] Effective prevention promotes the protective factors that reduce the potential for substance abuse and other closely linked behaviors, such as truancy, delinquency, and early pregnancy.

Successful prevention strategies also incorporate the cultural, gender, and age-specific needs of participants. Prevention efforts must address all stages of life; from infancy to adulthood, prevention can reduce both the use and abuse of alcohol and other drugs. Although individual programs differ widely, the federal Center for Substance Abuse Prevention (CSAP) has identified six basic approaches to prevention which are described in *Understanding Substance Abuse Prevention: Toward the 21st Century: A Primer on Effective Programs*[6]:

Information dissemination is designed to increase knowledge and alter attitudes about issues related to alcohol, tobacco, and other drug use and abuse;

Prevention education teaches participants critical personal and social skills that promote health and well-being among youths and help them avoid substance abuse;

Alternative approaches assume that youth who participate in drug-free activities will have important developmental needs met through these activities rather than through drug-related activities;

Problem identification and referral involves recognizing youths who have already tried drugs or developed substance use problems and referring them to appropriate treatment options. This is particularly important for high-risk youth;

Community-based process enhances community resource involvement in substance abuse prevention, for example, by building interagency coalitions and training community members and agencies in substance abuse education and prevention; and

Environmental approaches attempt to promote policies that reduce risk factors and/or increase protective factors related to substance abuse, such as community laws prohibiting alcohol and tobacco advertising in close proximity to schools.

This chapter discusses a wide range of promising approaches that involve schools, families, and communities in prevention efforts that use many of the elements identified by CSAP. The CSAP-identified key elements are not mutually exclusive, and most of the programs detailed in this report include more than one key element. Effective strategies include prevention education; mentoring and other supervised activities for after-school hours; special interventions for high-risk youth; strengthening families; and empowering communities. The programs described below are examples that can help communities tailor strategies to their specific needs.

I. Teaching Prevention in Schools

Schools can play a powerful role in prevention as teachers and administrators often are the first to detect warning signs of possible drug problems, such as poor school attendance or declining academic performance.

Effective school programs teach young people to resist drugs by developing personal and social skills, such as decision making, stress management, communication, social interaction, conflict resolution, and assertiveness. In addition, these programs can enhance awareness and resistance skills. Students learn that most of their peers do not use drugs, and they learn to recognize social and peer influences on drug use. With this new awareness, youths are better able to resist the pressure to use drugs.[7]

Prevention efforts should begin early and continue through adolescence, when pressure to drink, smoke, and use other drugs greatly increases. Without reinforcing skills and anti-drug norms, behavioral results diminish. Programs enhanced with "booster sessions," activities which follow up on the initial program, help prevent or delay the initiation of drinking, smoking, and using other drugs.[8] Delayed initiation is beneficial, giving children time to develop social competence and resistance skills. According to the National Institute on Alcohol Abuse and Alcoholism, each year that children avoid alcohol use significantly decreases their risk of future dependence.[9] The Department of Health and Human Services reports that any delay in beginning to smoke during the early teen years improves the future prognosis for quitting. Delayed onset of smoking is also associated with a lower incidence of disease and death.[10]

Prevention efforts in schools are designed to serve universal (the general population), selective (those identified as at risk), or indicated (those already exhibiting signs of problem behavior) groups of students. Depending on the targeted population, prevention messages range in intensity. For example, Life Skills Training, a *universal* program, teaches personal, social, and drug resistance skills in weekly 45-minute sessions. In contrast, Reconnecting Youth, designed for *indicated* high school students, involves participants in a daily class focused on reducing or controlling drug use.

According to *Making the Grade: A Guide to School Drug Prevention Programs*[11], successful school-based drug prevention programs incorporate a variety of key elements:

- help students recognize internal pressures, like anxiety and stress, and external pressures, like peer attitudes and advertising, that influence them to use alcohol, tobacco, and other drugs;
- develop personal, social, and refusal skills to resist these pressures;
- teach that using alcohol, tobacco, and other drugs is not the norm among teenagers, even if students believe that "everyone is doing it";
- provide developmentally-appropriate material and activities, including information about the short-term effects and long-term consequences of alcohol, tobacco, and other drugs;
- use interactive teaching techniques, such as role plays, discussions, brainstorming, and cooperative learning;
- cover necessary prevention elements in at least ten sessions a year (with a minimum of three to five booster sessions in two succeeding years);
- actively involve the family and the community; and
- include teacher training and support, and contain material that is easy for teachers to implement and culturally relevant for students.

School prevention efforts should also aim to reduce school disorder and improve children's attitudes about school. Research over the past two decades indicates that active involvement in school helps protect young people from many problem behaviors, including substance abuse.[12] A positive atmosphere helps engage students in school, giving them a sense of identity and reducing the likelihood that they will drop out or participate in delinquent behavior, two factors that can increase risk for later substance abuse problems.

Although school programs can demonstrate impressive results in prevention, families and communities shape the larger social context in which children make decisions about alcohol, tobacco, and other drugs. According to the 1997 report of the National Longitudinal Study on Adolescent Health, close relationships with parents and teachers are powerful protective factors for teens. The closer teens are to their parents and the more connected they feel to school, the less likely they are to smoke, drink, or use other drugs.[13]

Prevention is most effective when school lessons are reinforced by a clear, consistent social message that teen alcohol, tobacco, and other drug use is harmful and unacceptable.[14] In many communities, police officers work as school resource officers (SRO) to monitor students, provide advice and prevention information, and link students to supervised recreational activities, mentoring, and other services.

The following programs demonstrate the effectiveness of these essential elements in building comprehensive school-based strategies to prevent alcohol, tobacco, and other drug use.

Child Development Project, Cupertino, California

Program Type: Teaching Prevention in Schools.
Target Audience: Elementary school students, their parents and teachers.
Years in Operation: 1992-present.
Program Goals: To increase student attachment to school, thereby reducing risk factors that contribute to substance abuse and other high-risk behaviors.
Contact Information: Denise Wood, Developmental Studies Center, Oakland, CA, 800–666–7270.

Description: The Child Development Project (CDP) is a philosophical approach to interacting with elementary school students, their families, teachers, and school administrators. The program focuses on an entire school rather than targeting only high-risk students. Although CDP does not address substance abuse directly, its character building program is designed to reduce risk factors for alcohol and other drug use. Since 1992, CDP has expanded to approximately 100 schools in six states and is recognized by the Center for Substance Abuse Prevention as a promising High Risk Youth program and by the National Association of Elementary School Principals.

D.J. Sedgewick Elementary School in Cupertino, California, was one of the pilot schools to implement the program in 1992. Teachers at Sedgewick were unhappy with the school's antagonistic atmosphere and wanted a more effective way to discipline students. The same children were repeatedly getting into trouble, and there was no evidence that the existing forms of punishment were working. The staff chose CDP because it aims to create a school community in which students feel safe and cared for and are encouraged to develop their academic and practical skills. The program increases students' attachment to the school community and establishes a system of positive reinforcement which reduces risk factors and promotes protective factors.

CDP has four basic principles: build supportive relationships; attend to the social and ethical dimensions of learning; honor students' intrinsic motivation; and teach in ways that support students' learning styles. These principles are expressed through five program components. The first component is a reading and language arts curriculum which addresses social and ethical values. Culturally-appropriate books are selected according to the student group, and are read aloud to give students a shared experience. The second component of the program is collaborative classroom learning, which emphasizes working together and provides students with meaningful, challenging tasks. Component three, developmental discipline, is a classroom approach to creating caring relationships among all members of the classroom. Teachers use problem-solving techniques rather than reward and punishment to teach students responsibility and competence. The fourth component gets parents involved with their children's education by assigning homework tasks which the family must complete together. The final component is a school wide activities program that creates a sense of school community. One activity, the Buddies program, pairs young students with older partners for academic and social activities.

Challenges: CDP can only work if the principal, teachers, and staff members all commit to following the program design. The program requires a change in the overall atmosphere of the school and consistent implementation. For example, if one teacher continues to discipline students by sending them to the principal's office while another works with students to solve problems, the program will not be fully effective. Sedgewick was fortunate to have the support of the entire school staff, and the school screens prospective teachers to ensure they are willing to follow the CDP philosophy.

Costs and Funding Sources: Instructional and curricular materials for the program cost approximately $550 per classroom teacher. Training by CDP staff members costs approximately $40,000 per year. Sedgewick receives approximately $125,000 in grant money annually for initiatives aimed at improving literacy, including CDP.

Program Results: An internal evaluation of CDP conducted by researchers from the Developmental Studies Center in Oakland, California, showed decreased substance use among fifth and sixth graders in schools that fully implemented the program. The evaluation was conducted in six communities: Cupertino, Salinas, and San Francisco, California; Louisville, Kentucky; Dade County, Florida; and White Plains, New York. In each city, two control schools and two program schools were examined, and data were collected from classroom observation, student and teacher questionnaires, and student achievement scores. Over four years the following changes in drug use were observed:

> Alcohol use among students fell from 48 percent to 37 percent in program schools while rising from 36 percent to 38 percent in control schools;
>
> Cigarette use declined from 25 percent of students to 17 percent in program schools while declining from 17 percent to 14 percent in control schools; and
>
> Marijuana use declined from 7 percent of students to 5 percent in program schools while rising from 4 percent to 6 percent in control schools.

Students also reported that after the program was implemented they enjoyed school more, were more motivated to learn, were better skilled at resolving conflicts, and felt more socially competent.

Another accomplishment of the Child Development Project is that it changed the atmosphere at Sedgewick. Students are now more excited about

learning and feel more a part of the school community. Teachers report that parents have also commented on the change in the school.

Life Skills Training, Garland, Texas

Program Type: Teaching Prevention in Schools.
Target Audience: Middle school students.
Years in Operation: 1997-present.
Program Goals: To teach alcohol and other drug prevention skills to all middle school students.
Contact Information: Janet Harrison, Chief Executive Officer, Greater Dallas Council on Alcohol and Drug Abuse, 214–522–8600; research information, Gilbert Botvin, Institute for Prevention Research, 212–746–1270; curriculum information, 800–636–3415, www.lifeskillstraining.com.

Description: Life Skills Training (LST) is one of the best-evaluated substance abuse prevention programs available, having been evaluated in 12 rigorous field trials over the past two decades. LST provides information on alcohol, tobacco, and marijuana and addresses substance use risk and protective factors. In 1997, Life Skills Training was implemented in 13 middle schools in the Garland Independent School District. In the 1999-2000 school year the program reached approximately 3,968 sixth graders, 3,789 seventh graders, and 3,851 eighth graders.

A universal approach designed for all students, the curriculum targets middle and junior high school students at the age when substance use increases most dramatically. The three-year curriculum consists of 15 sessions in the first year (sixth or seventh grade), ten sessions in the second year, and five to eight sessions in the third year. The curriculum uses a variety of interactive techniques, including discussions, brainstorming, role playing, and skill rehearsal. In many schools, teachers act as facilitators, presenting effective behaviors, coaching students, and providing positive feedback. In Garland, the Greater Dallas Council on Alcohol and Drug Abuse (GDCADA) runs LST and employs two full-time program staff (a Program Manager and LST Specialist) and approximately eight part-time LST instructors to teach the course to students.

The content of the program falls into three general categories. The first module contains information about tobacco, alcohol, and marijuana use, including the immediate effects of these substances on the body, using a classroom exercise. Students learn, for example, that contrary to myth, smoking does not help people relax. Nicotine is a stimulant which causes hands to tremble and the heart to beat faster.

The second module develops personal or self-management skills. LST provides students with a variety of techniques for effectively managing anxiety, including deep breathing, mental rehearsal, and muscle relaxation. LST provides students with a formula for making competent decisions, provides training in goal setting and planning for the future, and involves students in semester-long projects that help them achieve individual goals.

The third module of the curriculum hones students' social skills. To help students feel comfortable in social situations and less vulnerable to peer pressure, LST provides training in general social techniques, such as conversational skills and cross-gender communication. In order to help students effectively resist peer pressure, the curriculum provides students with training to tactfully resist pressure to use tobacco, alcohol, or other drugs, as well as how to assert themselves and express their feelings directly.

Challenges: One of the challenges to implementing Life Skills Training in Garland and other sites is starting the program at the beginning of the school year, when class schedules and routines are often in flux. A related challenge is scheduling LST classes so that they do not interfere with state-mandated testing. In fact, many schools report that one of the major challenges to implementing the Life Skills Training Program is committing the time to complete the program. With many competing demands on class time, it can be difficult to secure the 15 class sessions needed to complete the program in the first year. However, studies have clearly shown that the success of LST depends on implementation of the program as designed.

Costs and Funding Sources: In Garland, LST is funded through the Texas Commission on Alcohol and Drug Abuse, which provides $250,000 for the program in all 13 schools. This amount covers curriculum materials for program instructors and students, and instructor salaries and trainings. Schools using teachers to run the program do not have to hire

additional personnel, so costs are limited to curriculum materials and teacher training. The cost to provide LST to one class of 30 students for one year is $250. Additional costs for training teachers is $2,000 per day for a minimum of one to two days of training.

Program Results: The LST program has consistently been shown to reduce cigarette smoking, problem drinking, and marijuana use, with impact slightly diminished by the six-year follow-up. Moreover, the size of these reductions has been significant, with reductions in smoking, drinking, and marijuana use ranging from 50 percent to 75 percent in the participating schools, compared with nonparticipating control schools. The program has also been found to effectively decrease use of inhalants, narcotics, and hallucinogens and increase students' knowledge and attitudes about smoking, drinking, and marijuana use.

These effects have been observed in schools where the program was implemented by health professionals, older peer leaders, and regular classroom teachers. Other evaluation studies have demonstrated the effectiveness of the program in both urban and suburban schools, and among white, African-American, and Hispanic youth.

LST has received numerous professional awards and endorsements from professional groups, including the American Medical Association and the American Psychological Association. Most recently, LST was one of two programs highlighted by the Centers for Disease Control and Prevention as "Programs That Work."

Reconnecting Youth, Midland, Texas

Program Type: Teaching Prevention in Schools
Target Audience: High-risk high school students.
Years in Operation: 1997-present.
Program Goals: To increase school performance and decrease drug use and emotional distress.
Contact Information: National, Nan Macy, Public Information Specialist, University of Washington School of Nursing, 206–685–4733. Texas, Lyn White-Giesler, 915–552–7455.

Description: Reconnecting Youth is a school-based drug prevention program targeting high-risk high school students; the program is designed to reduce drug use and aggression, as well as academic failure and dropping out of school. The school districts of Midland and Odessa, Texas, implemented Reconnecting Youth in four schools in 1997; approximately 200 students participate each year.

Reconnecting Youth seeks to reduce risk, build resiliency, and provide training in communication skills, anger management, social problem solving, social resistance skills, and peace building. Reconnecting Youth targets students who fall behind their peers in school, have high absenteeism, experience a drop in grades, or drop out of school. Reconnecting Youth includes a semester-long course, school bonding activities, and a school system crisis response plan. The Reconnecting Youth class is taught for 55 minutes each day and includes four modules: Decision-Making, Personal Control, Self-Esteem Enhancement, and Interpersonal Communication. The program is taught by teachers, other school personnel, or outside specialists. In Texas, Reconnecting Youth is run by a program specialist rather than school personnel. The program requires a teacher-to-student ratio of 1:12, a selection process for both participants and facilitators, and proper facilitator training.

Reconnecting Youth has three primary goals: (1) increase academic performance by enhancing school bonding, school attendance, and grades, and increasing the number of pre-college courses taken; (2) decrease drug involvement by increasing control over drug use; and (3) decrease emotional distress by lessening risk factors, such as depression, and increasing protective factors, such as self-esteem.

Challenges: The most difficult part of implementing the program in Texas was obtaining the cooperation of the schools. School officials are often reluctant to release pretest information, including students' attendance records and grades, which is critical to evaluating. School officials were more cooperative after the Texas Education Association authorized that a half credit be given to students taking the course. Texas is the only state that gives academic credit for the course.

Costs and Funding Sources: Costs vary depending on how the program is implemented. If school staff teach the program, the only required costs are training, materials, and student incentives. The initial five-day training for facilitators costs $500/day for six

people, plus trainer travel and expenses. A recommended one-day follow-up training every six months costs $750/day plus trainer expenses. The curriculum alone costs $139. In addition, the Texas program employs specialists to teach the program, four facilitators, and one director. The Texas Commission on Alcohol and Drug Abuse provides an annual grant of $235,000 to operate Reconnecting Youth in four Midland and Odessa schools.

Program Results: Curriculum developers have conducted three studies using external evaluators that clearly demonstrate that the program results in improved academic performance; decreases drug use; reduces anger, depression, aggression, hopelessness, suicidal behaviors, and stress; decreases bonding to deviant peers; and improves self-esteem, self-control, bonding to school, and social support. Evaluations of the program have observed reduced use of cocaine, hallucinogens, opiates, depressants, tranquilizers, stimulants, and inhalants. Tobacco, alcohol, and marijuana use were not affected. The program also reduced drug use control problems (e.g., used more than intended) and adverse drug use consequences (e.g., feeling guilty or problems with friends or family as a result of substance use).

Reconnecting Youth received an "A" in Drug Strategies' reports *Making the Grade: A Guide to School Drug Prevention Programs* and *Safe Schools Safe Students*. The program is also recommended by the U.S. Department of Education, was recognized by the National Institute on Drug Abuse as one of the year's top three prevention programs in 1996, and is considered a model program by the Center for Substance Abuse Prevention.

In Midland and Odessa, students in Reconnecting Youth report improved communication with their teachers. Teachers report that problem students have shown improved performance and control on how they behave and interact with others. At the end of the school year the students participate in a graduation ceremony attended by the school board and media.

II. Reaching Youths Outside School

After-school hours are high-risk periods for alcohol and illicit drug use, unprotected sex, and violence among youths. Approximately one-third of all violent juvenile crimes occur between the hours of 3 p.m. and 7 p.m., when many children are unsupervised.[15] Targeted programs during these vulnerable hours can help prevent, reduce, or delay the onset of alcohol, tobacco, and other drug use. After-school programs can also reinforce social skills learned in school and at home.

Many communities are implementing after-school programs that include substance abuse prevention. Activities range from programs that offer alternative activities with a drug prevention message to programs for high-risk youth that involve more intense intervention, specifically addressing risk and protective factors for substance abuse.

Police departments have taken an active role in developing after-school programs to keep youths out of trouble. Recently, the police chief of Mountlake Terrace, Washington, won a National Crime Prevention Council award for his role in creating the Neutral Zone, a youth center which provides an array of youth services, including substance abuse counseling. Five years after creating the Neutral Zone, gang-related crime dropped more than 90 percent. The program has been replicated in numerous other cities in Washington state.

Millions of American children participate in elementary, middle, or high school sports programs, and many others join community teams, providing prime opportunities to reach large numbers of youth with prevention messages. Coaches and other supervisors can be trained to recognize warning signs of substance abuse and deal with at-risk athletes. For example, the Drug Enforcement Administration's Team Up Anti-Drug Sports Program trains coaches and school administrators to take active roles in prevention and education in their schools.

Creating a safe place for youths to gather after school can help protect them from risk factors in the community, in peer groups, or at home. For example, the Safe Haven in Madison, Wisconsin, provides educational opportunities and supervised recreation for 150 at-risk elementary school children, teaching them conflict resolution and other behavioral skills, and involving their parents in the program. The program was developed through a partnership involving the city, the local school district, and a nonprofit community center.

Mentoring is an increasingly popular prevention/intervention strategy that helps youths deal with the risks they face in their daily lives. While informal mentoring occurs naturally for children who have positive adult influences, many young people have few positive adult role models. Formal mentoring programs assist these children by structuring one-to-one relationships with caring adults, that can reduce risk factors for substance abuse, such as social isolation and insufficient supervision. A positive adult role model also offers new perspectives to youths living in situations rife with substance abuse and violence.[16]

Well-developed and executed mentoring programs can effectively reduce drug use. A 1995 national evaluation of Big Brothers/Big Sisters of America, which connects middle class adults with disadvantaged youths, found that young people in the program were almost 50 percent less likely to begin using drugs than their peers not involved in the program. An even stronger effect was found for minority Little Brothers and Sisters, who were 70 percent less likely to initiate drug use than similar minority youths.[17] In response to the success of mentoring programs, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) developed the Juvenile Mentoring Project (JUMP) in 1994 to support mentoring programs for at-risk youths in communities across the country. OJJDP highlights several elements of effective mentoring programs:

> Creating collaboration between community-based providers and local education agencies to improve school performance and reduce school drop out rates and juvenile delinquency;
>
> Performing thorough background checks for all volunteer mentors to establish a safe environment for participating children;
>
> Assessing young participants carefully so appropriate matches can be established that maximize opportunities for success;
>
> Designing mentor and project activities that enrich and enhance youth opportunities and experiences; and
>
> Gathering and routinely reporting program data for evaluation purposes.

The U.S. Navy's Drug Demand Reduction Task Force (DDRTF) developed the Drug Education for Youth initiative (DEFY), a mentoring program that works with Weed and Seed neighborhoods. DEFY, targeting youths ages 9-12, improves youths' self-image, communication skills, and awareness of the dangers of alcohol and other drug use through weekend camping and continued mentoring. The first two DEFY programs began in 1993 in Pensacola, Florida, and Oakland, California, and there are now 65 DEFY/Weed and Seed sites.

Providing constructive and healthy activities for youths—coupled with substance abuse prevention—can offset the attraction to alcohol, tobacco, or other drugs. Community youth development programs, such as Boys and Girls Clubs, can integrate prevention education into traditional activities. A 1992 evaluation of such programs offered in public housing developments found greater reductions in drug use among participating youngsters than among youths not involved.[18]

The following programs are examples of how communities have used mentoring initiatives and youth development programs to prevent substance abuse by reaching youths after school.

Big Brothers & Sisters of Wichita, Kansas

Program Type: Reaching Youths Outside School.
Target Audience: Children ages 5-17 at risk for substance abuse.
Years in Operation: 1969-present.
Program Goals: To prevent destructive behavior and promote positive attitudes and habits among youths.
Contact Information: In Wichita, Mike Keller, 316–263–3300; National office, Jerry Lapham, 215–567–7000; national@bbbsa.org; www.bbbsa.org.

Description: For nearly a century, Big Brothers and Big Sisters of America (BBBSA) has been providing adult support and friendship to children. Through a careful matching process, volunteers interact regularly with youngsters in one-to-one relationships. Of the 514 local BBBSA agencies nationwide, the Big Brothers & Sisters program in Wichita, Kansas, is the largest, with over 1,300 matches of adult mentors with area youths in 1999. Wichita, like the other local agencies, uses a case management approach developed by the national organization. Case managers screen children and volunteers, make and supervise matches, and handle match closures. In Wichita, each case manager handles 65 cases; monthly contacts with volunteers, children, and parents are made to ensure success.

Little Brothers and Sisters are referred by educators, social workers, counselors, parents, and others, and are considered at risk of substance abuse and other destructive behavior. The goal of the program is to prevent such problems and promote positive habits and attitudes through support, role-modeling, and exposure to healthy activities. Volunteers make a year-long, once-a-week commitment to their matches. Youngsters in the program range in age from 5-17; 83 percent of them come from single parent homes, 76 percent live at or below the poverty level, 54 percent have been abused or neglected, and 52 percent come from alcoholic and/or drug addicted families. Serving children of substance-abusing parents is crucial, since they are at high risk; children of alcoholics, for example, are four times more likely to develop alcoholism than other youths.

In addition to growing its core mentor numbers, the organization is expanding its programming to provide on-site mentoring in schools and at Boys and Girls Clubs. The agency is also planning to implement outreach programs targeting Hispanic mentors and youths, senior citizen mentors, and a program in collaboration with community organizations and the police department aimed specifically at alcohol, tobacco, and other drug prevention.

The success and popularity of Big Brothers and Big Sisters of America can be attributed to its rigorous published standards and required procedures, including mandatory volunteer orientation; volunteer screening, involving a background check, extensive interview, and home assessment; youth assessment, which involves parent and child interviews and a home assessment; carefully considered matches; and ongoing supervision. The program was named a Model Program in *Blueprints for Violence Prevention* by the Center for the Study and Prevention of Violence at the University of Colorado.

Challenges: The biggest challenge in Wichita is recruiting volunteers. Currently, there are approximately 700 boys and girls awaiting matches. While the organization needs both male and female volunteers to meet demand, male volunteers are especially hard to get. Little Brothers wait an average of two years, while African American Little Brothers wait an average of three years. To address this challenge, the program has made strides in finding volunteers by working with local companies and universities to recruit mentors. Advertisements are also posted on billboard space donated to the organization. While the waiting list is still long, it has decreased significantly from previous years.

Costs and Funding Sources: The national average cost within the BBBSA system of making and supporting one adult and child match is $1,000 a year, and includes recruitment and training of volunteers, administrative costs, employee salaries, and various activities. The annual budget in Wichita is $2.5 million. Funding comes from three main sources: the United Way; in-kind and cash donations, including grants from private foundations and state, city, and county government; and revenue from an annual fundraiser, Bowl For Kids Sake, which raised over $600,000 in 1999.

Program Results: An evaluation of eight local BBBSA agencies, including the one in Wichita, found volunteer mentors had the greatest impact preventing alcohol and other drug abuse when comparing participating youths with similar nonparticipating youths. In 1992 and 1993, nearly 1,000 boys and girls in eight cities (including Wichita), ages 10 through 16, entered into an evaluation study to determine the effectiveness of BBBSA. Half of the children were matched with a mentor, while the other half were assigned to a waiting list or control group. On average, the matched children met with their mentors about three times a month for at least one year. Researchers found that 18 months later, the Little Brothers and Little Sisters were:

46 percent less likely to begin using illicit drugs;

27 percent less likely to begin using alcohol; and

53 percent less likely to skip school.

Minority youths were 70 percent less likely than their peers to initiate illicit drug use.

The evaluation was conducted by Public/Private Ventures, a national research organization based in Philadelphia. In addition to Wichita, evaluated programs were located in Phoenix, Arizona; Minneapolis, Minnesota; Rochester, New York; Columbus, Ohio; Philadelphia, Pennsylvania; and Houston and San Antonio, Texas.

A major accomplishment in Wichita was meeting the goal of 1,000 active matches by the year 2000, making the Wichita program (which was already the largest per capita BBBSA site) the largest overall site nationwide. The success of the program has prompted a state-funded initiative to create satellite Big Brothers and Sisters facilities in all 105 Kansas counties. According to local Wichita data:

0.5 percent of Little Sisters become pregnant, compared to 5.5 percent of area girls;

1 percent of participants are arrested, compared to 7.6 percent of local youths; and

60 percent of participants show improvement in grades, 57 percent in school attendance, and 61 percent in relationships with teachers.

Self-Expression Teen Theater, Toledo, Ohio

Program Type: Reaching Youths Outside School.
Target Audience: High-risk minority adolescents.
Years in Operation: 1986-present.
Program Goals: To provide teenagers with information on substance use so they can make healthy decisions.
Contact Information: Charles Muhammad, Executive Director, 419–242–2255.

Description: Self-Expression Teen Theater (SETT) trains young people to educate their peers about the dangers of alcohol and other drug use, premature sexual activity, and other risky behaviors, and helps youths explore positive alternative activities. The program was begun in 1986 in response to a needs assessment which revealed that Hispanics and African Americans in Toledo had high rates of alcohol and other drug use. Since it began, SETT has trained over 1,200 peer educators, given more than 500 performances, and conducted over 200 youth-led workshops focusing on substance abuse and its relation to violence.

SETT targets primarily Hispanic and African American youths ages 11-18 to be peer educators. Peer educators conceive, write, and perform skits on topics including substance abuse, teen pregnancy, suicide, violence, and academic failure. Performances illustrate the importance of communication between young people and adults, and provide youths in the audience with information on treatment and prevention services in their community where they can seek help. The troupe performs in schools, churches, public housing projects, and malls.

SETT performers receive 80 hours of training covering substance abuse, violence prevention, health education, community resources, communication, and performing arts. Ten hours of training are dedicated to culturally specific information. Peer educators are trained by experts in the community, such as certified alcohol, tobacco, and other drug abuse counselors.

Parents of SETT members are highly involved in the program. The Parent Advisory Board meets monthly to review group training and activities and explore ideas for further programming and development. Representatives from community organizations providing services for youths are often present at the board meetings, which allows parents to remain up-to-date on available community resources.

SETT's How-To-Training Manual and consultation services are available to communities and organizations interested in replicating the program.

Challenges: One of the implementation challenges for SETT was finding the most efficient and effective way to involve local agencies in the program and to take advantage of their expertise and knowledge. Local and state agencies and organizations were invited to make presentations during the 80 hour youth peer training, and now 14 organizations, including the police department and children's services agencies are regularly present at training sessions. An additional 73 organizations are involved in the

program in various ways. Another problem, which is ongoing, is the struggle to find and retain qualified employees willing to work in the inner city. As SETT's positive effects on the community become better known, more people have become interested in working in the program.

Costs and Funding Sources: The average annual program budget of $138,472 covers all expenses, including a full-time project director, a full-time office manager, a part-time project coordinator, contract workers such as coaches and training assistants, evaluation, rent, and program materials, such as costumes. SETT receives funding from the Ohio Department of Alcohol and Drug Addiction Services ($100,000), City of Toledo Department of Neighborhoods ($30,000), and the Marshall Field Foundation ($2,000). Additional funding comes from general donations received from performances.

Program Results: In the program's target area of Toledo, 60 percent of all students graduate from public high schools. However, 93 percent of SETT peer educators graduate from high school, and 87 percent are attending or have graduated from college.

The program is currently being evaluated by researchers at the Wright State University School of Medicine in Dayton, Ohio. Results of the evaluation should be available in fall 2000.

SETT won Most Outstanding Exemplary Program Award for Prevention from the Ohio Department of Alcohol and Drug Addiction Services in 1993 and 1999, and the Exemplary Program Award from the Center for Substance Abuse Prevention in 1993. The program has been replicated in Lima, Ohio, and Atlanta, Georgia.

III. Reaching High-Risk Groups

Targeted prevention services can effectively reach people at high risk for drug problems who may be impervious to universal prevention efforts offered in schools and other community settings. High-risk populations include children of substance abusers, pregnant teens, and juvenile offenders. These efforts, which often involve home visits, counseling, and parent training, enhance resilience and promote individual strengths.[19] The federal Center for Substance Abuse Prevention (CSAP) has identified seven factors contributing to resilience. These factors, described in *Understanding Substance Abuse Prevention: Toward the 21st century: A Primer on Effective Programs*[20], include:

> A strong relationship with a parent or caring adult who provides a consistent nurturing environment;
>
> Feelings of success and self-respect;
>
> Strong internal and external resources, such as good physical health, self-esteem, a sense of humor, and a supportive network that includes family, school, and community;
>
> Social skills, including good communication and networking skills, and the ability to make good decisions;
>
> Problem-solving skills that help children overcome obstacles;
>
> Hope that adverse circumstances can be overcome with perseverance and hard work; and
>
> Surviving previous stressful situations.

Parental substance abuse is one of the strongest predictors for alcohol and other drug problems among youth. Children of alcoholics, for example, are four times more likely than others to develop alcoholism later in life.[21] Targeting prevention services to particularly vulnerable young people is crucial. Kids Connection, a prevention program in Cincinnati, Ohio, has won national awards for its programs that target children of alcoholics and other drug abusers. The program helps children understand addiction, teaches skills, and encourages youths to cope without alcohol or other drugs. Kids Connection works with local treatment facilities, teachers, and mental health professionals to identify children in need.

Some groups, such as juvenile offenders, are at greater risk to become substance abusers. Interventions designed for this population can work in various settings, including correctional facilities and residential treatment centers. Children with emotional and behavioral problems are also considered at high risk, as they are significantly more likely to have alcohol and other drug abuse problems than youths in general.[22] Youngsters involved in the foster care system are another target population for prevention services, since their families often have histories of substance

abuse.[23] Initiatives to assist foster families can be integrated into programs for abused, neglected, orphaned, or troubled adolescents.

As substance abuse and sexual activity often overlap, targeting prevention/intervention services to pregnant teens and young women can benefit both the women and their children. Home visits by nurses to teach young mothers healthy lifestyles is one effective approach. The national Prenatal and Infancy Home Visitation by Nurses Program conducts intensive and comprehensive home visits during a woman's pregnancy and during the first two years after childbirth. An evaluation of the program found significantly reduced substance abuse among mothers and children in the program compared with similar nonparticipants.[24] In-home visits are designed to ensure women's prenatal health and pregnancy outcomes; improve the care provided to infants and toddlers; and facilitate women's own personal development by helping them plan future pregnancies, continue their education, and participate in the work force.

The following examples demonstrate successful prevention programs that target high-risk individuals.

Prenatal and Infancy Home Visitation by Nurses, Oakland, California

Program Type: Targeting High-risk Groups.
Target Audience: Low-income first-time mothers and their children under age two.
Years in Operation: 1997-present.
Program Goals: Improve the health of pregnant women and their babies.
Contact Information: Peggy Hill, of the Center for the Study and Prevention of Violence at the University of Colorado, 303–864–5207.

Description: The Prenatal and Infancy Home Visitation by Nurses program assists low-income, first-time mothers by helping them improve their prenatal health, and after childbirth provides care to infants and toddlers to ensure the children's health and development. The program also helps women plan future pregnancies, continue their education, and participate in the work force. Originally piloted in the early 1970s in Elmira, New York, the program is currently being replicated in 19 states. In Oakland, California, the program began in November 1997, and the first group of 100 mothers will soon graduate. Prenatal and Infancy Home Visitation by Nurses has been identified as a Model Program in *Blueprints for Violence Prevention* by the Center for the Study and Prevention of Violence at the University of Colorado.

The program hires and trains registered nurses to conduct home visits with pregnant women before delivery and to continue visiting once or twice a week until the child is two. One reason for the program's success is that nurses have a caseload limited to 25 families, allowing them to bond with the mothers and children and give them individual attention. The program focuses on five aspects of development: health, parenting skills, environmental health (living conditions), life skills, and the creation of solid support networks. Women are encouraged to seek higher education, reduce their alcohol, tobacco, and other drug use, and cultivate other positive behaviors. Nurses involve family and friends in the program and refer mothers to other community health services when necessary. Detailed records are kept on each family—their needs, services provided, and the family's progress and outcomes. Mothers are referred mainly through area health organizations; much of the recruitment in Oakland is done through the Women, Infant and Child (WIC) program and through the county's health maintenance organization.

The program was evaluated at three sites with three different population groups: Elmira, New York, in the 1970s (primarily white women); Memphis, Tennessee, in the 1990s (primarily African American women); and Denver in 1994 (primarily Mexican-American women). While the three programs have ended, results in all of the studies were promising. Based on the success of the earlier programs, the Department of Justice began funding new program sites three years ago.

Challenges: The city of Oakland had no centralized tracking system for at-risk mothers, which made recruiting mothers a challenge. Program staff had to contact each agency working with the target population, inform them about the program, and set up a recruitment system. Recruiting is complicated because many mothers are not willing to let nurses into their homes on a weekly basis for two years. Although Oakland originally targeted 200 mothers for the program, only 112 agreed to participate. Staff have taken

these lessons into account, and today there is better coordination among agencies providing services to young mothers.

Costs: Program costs vary depending on local nurses' salaries. In Oakland the average salary of a registered nurse is $65,000 plus benefits; the site employs four nurses. Other program costs include the salary for a part-time program coordinator, training, rent, computers, and medical supplies. Total cost for the first year of the program in Oakland was approximately $400,000 (100 mothers) and about $350,000 in the second year. The program costs approximately $3,200 per family per year during the start-up phase and $2,800 per family per year after the nurses have been trained and are working to full capacity.

Program Results: Studies have demonstrated that the program reduces neurological impairment in children by helping mothers improve their diet and reduce alcohol, tobacco, and other drug use, and also minimizes childhood abuse and neglect. A 15 year follow-up study of the program in Elmira, New York, by researchers from the University of Colorado, Cornell University, the University of Rochester, and the University of Denver compared participating mothers and infants with a control group receiving basic prenatal care. Mothers were randomly assigned to either the program or control group. The evaluation found that program participants had:

- 79 percent fewer reported cases of child abuse and neglect;
- fewer subsequent children (1.1 versus 1.6);
- longer intervals between the births of their first and second children (67 months versus 37 months);
- 30 fewer months on welfare (60 months versus 90 months);
- 44 percent fewer alcohol and other drug-related behavioral problems and 69 percent fewer arrests among mothers; and
- 56 percent fewer arrests and days of alcohol consumption among the 15 year old children.

Furthermore, the evaluation data showed that, given the fewer number of subsequent pregnancies and reduced dependence on government welfare programs, the costs of the program were recovered in four years. A report from the RAND Corporation estimated that by the time the children reached the age of 15, the cost savings were four times greater than the original investment when reductions in welfare expenditures, crime, and health care costs are taken into account.

The Oakland program has produced some impressive changes among women in the program. Although it is too early for site-specific evaluation data, program staff say that there have been no reported incidents of child abuse, many women have reduced tobacco use, few premature babies were born, and approximately 95 percent of the women have received their GED, job training, or have entered college.

Residential Student Assistance Program, Westchester County, New York

Program Type: Targeting High-risk Groups.
Target Audience: Adolescents in the juvenile justice system.
Years in Operation: 1988-present.
Program Goals: Delay the onset and reduce the use of alcohol and other drugs and improve youths' self-esteem and communication skills.
Contact Information: Ellen Morehouse, Student Assistance Services, 914–332–1300, sascorp@aol.com.

Description: The Residential Student Assistance Program (RSAP) is a substance abuse prevention/intervention program serving adolescents in the juvenile justice system in Westchester County, New York. Started in 1988 with a five-year demonstration grant from the Center for Substance Abuse Prevention, the program is based on successful Employee Assistance Programs (EAPs) used by business and industry to identify and aid employees affected by substance abuse. Goals of the program are to delay the onset of, or reduce, alcohol and other drug use; develop peer resistance skills; improve self-image and sense of self-worth; and enhance communication and interpersonal skills. In 1999, RSAP was selected as a national high-risk youth replication model by the Center for Substance Abuse Prevention.

RSAP targets youths between the ages of 14 and 17, most of whom are African American or Hispanic. The program is implemented in six Westchester County locations: a locked county correctional

facility; a nonsecure residential facility for juvenile offenders; a facility for adolescents with severe psychiatric problems; and three foster care facilities for abused, neglected, orphaned, and troubled youths. Highly trained Student Assistance Counselors (SACs) work with youths in the facilities. The SACs assess all new residents for substance abuse and provide drug users and children of drug users with individual and group counseling. The SACs also implement small (6-8 residents) discussion groups in which adolescents talk about their own substance abuse or that of a family member, other family problems, and stress. The discussion groups help the youths and counselors get acquainted and begin changing the participants' attitudes about alcohol and other drugs. The facility also hosts 12-Step meetings, and residents are referred for treatment outside the residential facility when necessary. The SACs assist residents in developing an Adolescent Resident Task Force which meets regularly and works to increase self-referral for prevention and treatment activities.

The Student Assistance Counselors also work with the staff of the residential facilities. They coordinate a Residential Facility Staff Task Force which includes employees of the youth residential facility. The group meets weekly to discuss policy and program issues that affect prevention. SACs train residential staff to implement drug prevention strategies, and an EAP is available to help those experiencing personal problems. The Westchester County program employs five full-time counselors (four work full-time in individual facilities and one splits time between two facilities) and one supervisor. Together, they serve approximately 600 adolescents per year.

RSAP is currently being replicated in Massachusetts, and similar programs in Alaska, Arizona, Connecticut, and Florida are in the planning stages of implementation.

Challenges: One of the major obstacles to implementing RSAP was recruiting, hiring, and retaining project staff qualified to work with program participants. Initially, staff were hired based solely on their experience in working with adolescents, but program developers soon learned staff also needed to be trained and experienced in substance abuse prevention to be successful. Changing the qualifications of the counseling staff helped ensure success. Another obstacle was building support among all staff working in the residential facilities where the program was being implemented. RSAP encouraged facilities to implement EAPs for their staff members, offered staff training at all levels, and formed a staff task force representing personnel from clinical to maintenance staff.

Working program activities into the adolescents' already busy schedules presented difficulties. As a result, the staff decided to present the program in the school setting, where most prevention programs are traditionally offered. Staff had to help school personnel understand that while the program might require children to miss a class or two, the benefits would significantly improve their schooling. Realizing that their students would learn more if they were not using drugs or distracted by family issues, most teachers acknowledged RSAP's importance.

Costs and Funding Sources: The RSAP program in Westchester County was initially funded by a five-year demonstration grant from the Center for Substance Abuse Prevention. When federal funds ran out, all six of the facilities where the program was being implemented picked up the costs of the program. The program budget consists only of the salary of the full-time or part-time student assistance counselor working in the facility and some supervision by the agency implementing the program. For communities looking to replicate the program, expenses would include hiring on-site counselors, staff supervision, and training. RSAP offers a five-day training which costs $375, and on-site training costs range from $500 to $1,000 per day, depending on the location. Training fees include the implementation manual, which can also be purchased separately for $125. A $20 informational video is also available.

Program Results: An independent evaluation of RSAP conducted by Dobler Research Associates of Sand Lake, New York, showed promising results. The evaluation, which compared 125 adolescents who took part in the program with 201 youths who did not, yielded the following information:

> 82 percent of youth who did not drink, 83 percent who did not use marijuana, and 78 percent who did not smoke before entering the program remained nonusers;
>
> 72 percent of youth who drank, 59 percent who used marijuana, and 27 percent who

smoked before entering the program reported discontinued use at post-test;

past month alcohol use fell 46 percent (versus a 2 percent drop among the control group);

marijuana use dropped 45 percent (versus a 12 percent increase in the control group); and

tobacco use fell 16 percent (versus an 8 percent increase in the control group).

A major accomplishment of RSAP is that it achieved such significant prevention results with adolescents who are considered at highest risk because of multiple risk factors. The combination of a sound theoretical basis for the program and quality staff helped ensure success. While program staff believe in involving parents in prevention, the target audience for the program did not have the parental resources available to most children. For young people without parental support, RSAP proved effective prevention can be achieved.

IV. Building Family Bonds

Parents are powerful influences in the lives of their children. Through words and actions they can provide key guidance on alcohol, tobacco, and other drug use. Parents have a critical role to play in prevention—not only within the family, but also in collaboration with schools and community groups. Research shows that the more often parents talk with their children about the dangers of alcohol and other drugs, the less likely it is that their children will experiment with them.[25] Increasingly, prevention programs are being designed to enhance parent-child communication and improve other family skills. Parental disapproval of delinquency and drug use can counteract the peer pressure youngsters experience to engage in these activities.

Substance abuse prevention programs have traditionally been part of school and community efforts, but a new trend is toward family-based prevention programs. School and community programs, while essential, are not sufficient because many schools do not begin to address the problem of substance abuse until adolescence; substance abuse often begins earlier. According to the 1999 *Monitoring the Future* study, by the time children are in eighth grade, more than 50 percent of them have tried alcohol, 44 percent have tried cigarettes, 22 percent have tried marijuana, and 20 percent have tried inhalants.[26] Family-centered approaches train and support families who are trying to keep their children free from alcohol and other drugs.

Family programs employ a variety of tools, including homework assignments, brochures, home study guides, workshops, and audio and videocassettes. Recent research suggests that the most effective programs promote positive relationships between parents and children.[27] They provide training in communication, especially as young people move into adolescence, and they work to reduce conflict, which can damage bonds between parents and children.

The National Institute on Drug Abuse (NIDA) recommends that family-based prevention programs incorporate the following principles[28]:

Reach families of children at each stage of development;

Train parents in behavioral skills to reduce conduct problems in children, improve parent-child relationships, provide consistent discipline and rulemaking, and monitor children's activities during adolescence;

Include an educational component for parents with drug information for them and their children;

Direct services to families with children in kindergarten through 12th grade to enhance protective factors; and

Provide access to counseling services to families at risk.

Family-based programs serve families based on the child's stage of development, ranging from birth to young adulthood. The federal Center for Substance Abuse Prevention recommends three family-centered approaches that show great potential. The first, parent and family skills training, teaches parents how to build protective factors and reduce risk factors linked to substance abuse. These risk factors include communication problems, too lax or too stringent discipline, parental substance use, and child abuse or neglect. Family protective factors include close-knit

familial relationships, consistent discipline, and parental supervision of children's daily activities. These programs can improve poor parent-child communication, child behavior, and parenting skills, and reduce family conflict. Such interventions are directed at families with children who have no apparent risk factors for substance abuse as well as those at moderate and high risk.[29]

Programming differs depending on the target population. For example, Preparing for the Drug Free Years is a program that aims to improve parents' child-rearing techniques, parent-child bonding, and children's peer resistance skills in five weekly sessions, four of which are parent-only. Treatment Foster Care, however, trains foster families to care for teenagers with histories of chronic, severe criminal behavior. Both programs have been found to reduce drug use among participants.

The second approach, family in-home support, provides crisis intervention (such as food, shelter, clothing) and long-range training that addresses the root causes of the crisis. These programs aim to decrease domestic violence, child abuse and neglect, and child placement in foster care, and are most effective with high-risk children. In-home services can also reduce youth crime rates by helping youngsters improve their social skills, anger management, school attendance, and attitudes toward authority.[30]

Family therapy, the third approach, helps family members improve the way they communicate, manage family life, and solve problems. Programs are aimed at families with children at high risk and are designed to improve family functioning and reduce antisocial behavior among both parents and children. Family therapy is often integrated with other prevention efforts, such as in-home support and school-based counseling.[31]

Media campaigns aimed at educating youths and their parents about the dangers of substance abuse are also used to develop family prevention skills. The Office of National Drug Control Policy (ONDCP) launched the National Youth Anti-Drug Media Campaign in 1998, which aims to teach youths about drugs, educate parents about the dangers of drugs, and encourage adults to communicate with their children. Anti-drug advertisements will run through 2002.

Preventing substance abuse by building family bonds is a growing trend among the nation's communities; the following programs are noteworthy examples of the different approaches.

Dare to be You, Ute Indian Reservation, Colorado

Program Type: Building Family Bonds.
Target Audience: Preschoolers and their families.
Years in Operation: 1989-present.
Program Goals: Improve communication between parents and their children and train teachers and community members to provide services to target families.
Contact Information: Jan Miller-Heyl, Colorado State University, 970–565–3606.

Description: Dare to be You is a substance abuse prevention program for families with preschoolers. Developed by researchers at the University of Colorado, the program was inspired by the need for family-based prevention efforts on the Ute reservation, which was experiencing high rates of substance abuse, unemployment, and teenage pregnancy. The program began in 1989, has served approximately 180 families (the entire population of the reservation is 1,400), and remains popular among residents.

There are three components of the Dare to be You program. The family component provides training in communication, parenting skills, and social skills for children and parents. The school component trains and supports child care providers and teachers, and the community component trains community members who will provide ongoing support to the target children and their families. Goals of the program include improving parents' sense of competence, helping parents understand appropriate child management strategies, improving children's and parents' relationships with their peers, and boosting children's developmental levels. Parents are given incentives to complete the program: they receive a free meal each session, child care is provided, and each family receives $200 at the end of the program.

The Ute program is run through the reservation's Head Start program, and classes are held in the Head Start building. Sessions run concurrently, so while parents are learning skills in one room, their children are receiving developmentally appropriate information

in the same building. Teenagers from the community (sometimes older siblings of preschoolers in the program) are trained and paid to be helpers. Some of the children who entered the program as preschoolers have returned as teen workers. There is a strong emphasis on hiring multicultural teen workers, since Ute youths typically have poor relationships with youths outside their community.

Dare to be You was selected as an Exemplary Prevention Program by the National Association of State Alcohol and Drug Abuse Directors, chosen as a High Risk Youth replication model by the Center for Substance Abuse Prevention, and is a winner of the Colorado Governor's Award for Excellence in Substance Abuse Prevention.

Challenges: The major obstacle to implementing Dare to be You on the Ute reservation was securing adequate meeting space. Head Start has donated use of its classrooms; however, it continues to be logistically difficult to share work space. Dare to be You can be implemented through any community organization in contact with the target audience.

Costs and Funding Sources: The estimated cost of putting 25-30 families through the program is $25,000. This amount varies depending on the local cost of living. Program expenses include staffing (including teen worker salaries), parent incentive money, rent (if necessary), and supplies. Training costs approximately $3,000 for 35 people; everyone involved in the program, including teen workers and agency supervisors, receives the training. The Ute program was originally funded as a demonstration project by the Center for Substance Abuse Prevention. Current funding to support the program's $11,000 annual budget is provided by a local foundation.

Program Results: Researchers at the University of Colorado evaluated the program at four sites in Colorado; Montezuma County, Colorado Springs, San Luis Valley, and the Ute reservation. The program was implemented in community centers, day care, and Head Start facilities, and included Hispanic, African-American, and White parents and their preschool children. The evaluation involved 780 parents, 498 in the intervention group and 282 in the control group.

Parents in the experimental group reported multiple positive benefits which reduce substance abuse risk factors for their children:

- increased satisfaction with their parenting role (15.5 percent more than control group);
- increased sense of personal worth (13.5 percent more than control families);
- a more positive relationship with their children (6.5 percent more than control families); and
- a 13.7 percent decrease in the use of harsh punishment to discipline their children (use of harsh punishment decreased less than one percent among control families).

Children in the program experienced a 6 percent increase in their developmental level compared to their peers in the control group.

Dare to be You has had a positive impact on the Ute reservation and is now a household name in the community. One of the major accomplishments of the program is that it has been institutionalized in the community; all Head Start teachers on the reservation are now trained Dare to be You providers, and they reinforce the themes of the program to preschoolers on a daily basis. Moreover, teen workers who assist with the program have become role models in their community.

Functional Family Therapy, Las Vegas, Nevada

Program Type: Building Family Bonds.
Target Audience: Youths ages 11-18 in the juvenile justice system and their families.
Years in Operation: 1996-present.
Program Goals: Change negative family behavior patterns and assist families in accessing community resources.
Contact Information: Kathie Shafer, Project Coordinator, University of Utah, 801–585–1807.

Description: Functional Family Therapy (FFT) is a prevention/intervention program for at-risk children (ages 11-18) and their families. The program

mainly targets youths in the juvenile justice system, aiming to reduce delinquency and substance use. The family focus of the program has evolved from the hypothesis that the family setting is the entry point to addressing problem behavior among adolescents. FFT has been identified as a Model Program in *Blueprints for Violence Prevention* by the Center for the Study and Prevention of Violence at the University of Colorado.

In Las Vegas, the fastest growing city in the country, FFT is the sole source of counseling services for all youths in the juvenile justice system. The program is provided by the Family Project—a collaborative effort between the University of Nevada, Las Vegas (UNLV) and the Clark County Family and Youth Services Division. The juveniles entering the system range from relatively low-risk children to youths with multiple antisocial behaviors and related syndromes. To address the diverse needs of these children and their families, FFT is designed as a phased program, with modules that complement one another. Each phase has special intervention and assessment activities aimed at accomplishing specific goals of individual families. The phases include:

> Engage and motivate youths and their families by decreasing the intense negativity so often characteristic of these families;
>
> Reduce and eliminate problem behaviors and patterns by improving family communication and parenting and problem-solving skills; and
>
> Generalize changes across problem situations by increasing the families' knowledge of and ability to avail themselves of community resources.

In Las Vegas, four full-time counselors, two from UNLV and two provided by the county, work with families. FFT is a short-term intervention that, on average, conducts eight to 12 one-hour sessions for mild cases and up to 26-30 hours of direct service for more intensive cases. Often, counselors handle 15 cases at a time, and cases average three months in length. Upon completion, participants are assessed at one-month, six-month, and one-year follow-ups. In the last two years, 480 families have been referred to the Las Vegas program.

In addition to the Las Vegas site, FFT is being implemented in 25 locations nationwide. One major innovation is that all sites enter individual case data into a national network called the Clinical Services System that enables researchers to monitor and compare data.

Challenges: One of the challenges program providers faced in Las Vegas was creating a partnership with the juvenile justice system. The goal was to formally integrate FFT into the system in order to create a continuum of care for juveniles and their families. Program developers dedicated a great deal of time to developing effective communication with justice personnel. Probation officers were taught to make appropriate referrals to the program and to respect the confidentiality of therapy.

A potential obstacle for communities looking to implement FFT is the year-long training process, which includes basic training, on-going supervision, and use of the Clinical Services System. Program developers insist on strict adherence to the program model.

Costs and Funding Sources: In Las Vegas the cost of serving one family ranges from $500 to $1,300. The year-long process of training and supervision required to become an FFT-certified site costs $20,500. A community can expect to pay, on average, $2,000 per family served.

Program Results: Thirteen evaluations of Functional Family Therapy have been conducted over the past 30 years, including studies by the University of Utah and the University of Nevada. The studies indicate that FFT can reduce criminal recidivism among high-risk youths between 25 and 60 percent. A cost-effectiveness study of the program estimated that spending $2,000 on one family resulted in $14,000 in cost savings by:

> Deterring adolescents from moving into higher cost treatment services;
>
> Preventing younger children in the families from entering the system of care;
>
> Preventing juveniles from entering the adult criminal system; and
>
> Avoiding future crime victim costs.

Since siblings of the adolescents being served in Nevada generally experience lower arrest rates and minimal contact with the juvenile justice system, it appears that FFT creates systemic change within the families it serves. Another study found that counselors were able to get 86 percent of referred families into at least two program sessions, indicating that FFT providers are successfully engaging families.

Strengthening Families Program: For Parents and Youth 10-14, Pella, Iowa

Program Type: Building Family Bonds.
Target Audience: Youths ages 10-14 and their parents.
Years in Operation: 1992-present.
Program Goals: Prevent teen substance abuse by increasing family bonds.
Contact Information: Sherry Maakestad, Crossroads of Pella, 515–628–1212; for replication information, Virginia Molgaard, Ph.D., Institute for Social and Behavioral Research, Iowa State University, 515–294–4518.

Description: Youths and families in more than 80 Iowa communities participate in the Strengthening Families Program: For Parents and Youth 10-14 (SFP 10-14), a parent, youth, and family skills-building curriculum designed to prevent teen substance abuse and other problem behaviors, strengthen parenting skills, and build family strengths. Developed in 1992 by the Institute for Social and Behavioral Research at Iowa State University, the program is based on the Strengthening Families Program developed at the University of Utah.

For the past six years, Crossroads, a private social service agency in Pella, Iowa (population 15,000), has run two SFP 10-14 programs annually for fifth to eighth graders and their parents, one in the local public school and one in a private school. The programs typically average 15 families annually in seven two-hour weekly sessions. In addition, four two-hour booster sessions are provided between three and 12 months following conclusion of the original sessions. During the sessions, parents and youths meet separately for the first hour, and then during the second hour practice what they have learned together. The seven parent-oriented sessions focus on making house rules, encouraging good behavior, employing discipline, building bridges, protecting against substance abuse, and using community resources. The child-oriented sessions focus on building personal goals, appreciating parents, dealing with stress, handling peer pressure, and reaching out to others. Family sessions involve supporting and attaining goals, appreciating family members, understanding family values, and building family communication. The booster sessions generally include handling stress and conflict, and improving family communication.

In addition to schools, other possible venues for SFP 10-14 include religious facilities and community centers. While the program can involve 12 families at once, group size should be reduced in special situations, such as court-ordered treatment. Three group leaders are required to implement the program: one to lead the parent session, and two to lead youth sessions. All three leaders facilitate the family sessions.

Over 600 SFP 10-14 facilitators have been trained in Iowa, and programming has reached more than 1,000 families in the state, including those in inner-city settings. Increasingly, the program is expanding outside of Iowa, and is currently being replicated in nearly 40 states. SFP 10-14 has been identified as a Promising Program by the Center for the Study and Prevention of Violence at the University of Colorado and as a Model Family Program for Delinquency Prevention by the Office of Juvenile Justice and Delinquency Prevention.

Challenges: A major obstacle to program success is recruiting and retaining families. Schools, social services agencies, and other community agencies are relied upon to recruit families by hosting informational meetings for parent leaders who in turn also assist in recruitment. Advertisements promote the program as help for parents during the teen years, as opposed to a support program for at-risk families. In Pella the program offers on-site child care to help retain families. SFP 10-14 program sites have demonstrated a 94 percent retention rate of families who attend the first meeting.

Costs and Funding Sources: To replicate SFP 10-14, curricula for the 11 sessions including a one-day training session, plus manuals and videotapes, costs $535. The manuals contain instructions for 33 hours of activities, such as learning games, discussions, skill-building activities, and family projects.

Training consists of a lesson on program background and research results, discussion of techniques and teaching philosophy, an overview of program logistics and recruitment, and hands-on practice of selected activities. Agencies at various sites have implemented the program without hiring new staff, keeping costs at a minimum.

The two programs in Pella cost about $4,500 annually. Child care is provided on-site, and Crossroads conducts publicity campaigns to recruit families.

Program Results: Evaluation studies of SFP 10-14 conducted by the Institute for Social and Behavioral Research at Iowa State University have found lowered alcohol, tobacco, and marijuana use among participating youngsters when compared with similar children in a control group. Four years following baseline assessment:

> 31 percent of program youths had ever been drunk, compared to 46.5 percent of the control group;
>
> 13 percent of program youths had smoked cigarettes in the past month, compared to 24.5 percent of the control group; and
>
> 8.3 percent of program youths had used marijuana, compared to 17.6 percent of the control group.

Two major accomplishments of the Pella program are successfully involving parents in prevention activities, often a difficult task, and forming a partnership with the schools, facilitating recruiting and publicity.

V. Empowering Communities

Communities can find solutions to many of their own problems. Community-led initiatives addressing the problems of substance abuse and related crime have proliferated throughout the last decade. Community coalitions aimed at underage drinking, Weed and Seed initiatives, and other programs have sprung up in cities and towns nationwide, supported by foundations, individual donors, and the federal government.

A community coalition is comprised of community stakeholders—service providers, residents, community and business leaders, educators, government officials, law enforcement officers, and others—who combine human and financial resources to address a particular issue or set of issues within the community. The emergence of crack cocaine in the 1980s prompted many communities to form anti-drug coalitions, a number of which still exist today. Coalitions, by mobilizing the community, have helped to change public policy and have empowered residents by giving them a sense of ownership and investment.

The federal government and private foundations recognize the value of building community coalitions to address substance abuse and have spent hundreds of millions of dollars to support these efforts. The Robert Wood Johnson Foundation, for example, created Fighting Back coalitions to help communities reduce the demand for alcohol and other drugs. The Center for Substance Abuse Prevention has spent over $300 million on its Community Partnership program, which has supported nearly 500 coalitions nationwide. The Drug-Free Communities Act, signed into law in June 1997, provides financial support and technical assistance to community coalitions seeking to reduce adolescent substance abuse. The Office of Juvenile Justice and Delinquency Prevention manages the Drug-Free Communities Support Program, which provides annual grants of up to $100,000 to community coalitions for youth substance abuse prevention efforts. Funding for the program, which was $10 million in FY 1998, has increased annually and will be $43.5 million in FY 2002. There are currently 213 grantees from 45 states and the U.S. Virgin Islands and Puerto Rico.

While most coalitions are established for the same purpose—bringing the community together to address substance abuse—the structure and activities of coalitions can differ markedly, making it difficult to offer one blueprint of how coalitions work. However, studies conducted in 1999 by the Center for Substance Abuse Prevention and the Community Anti-Drug Coalitions of America identified some key elements of successful coalitions[32,33]:

> Understanding the community's needs and resources;
>
> Widely shared and comprehensive vision;

Clear and focused strategic plan;

Diverse membership (including key community leaders, local government officials, and volunteers);

Strong leadership and committed partners;

Diversified and relevant funding (coalitions should not accept funding that may compromise their mission); and

Well-managed structure (including organized administration, effective communication among members/volunteers/staff, and a comprehensive evaluation plan).

The growth of coalitions has also spurred the creation of national organizations to support them. The Community Anti-Drug Coalitions of America and Join Together are two major organizations that provide technical assistance to new and existing coalitions.

Some communities have developed coalitions focused specifically on curbing youth alcohol use. These coalitions have demonstrated an impact by effecting environmental changes that reduce youth access to alcohol, through legislation and public awareness. For example, the Coalition to Reduce Underage Drinking in North Carolina helped pass legislation that sets penalties for adults who supply alcohol to minors and limits the amount of revenue that stores in certain low-income neighborhoods can generate from alcohol sales. In addition, the Coalition worked with retailers to create a media campaign designed to change adult attitudes about youth drinking. Recognizing the devastating effects of underage drinking on communities, the Office of Juvenile Justice and Delinquency Prevention supports coalition efforts through its Combating Underage Drinking Program.

Another Department of Justice program, Weed and Seed, targets the relationship between substance abuse and crime in America's cities. Weed and Seed is a community-based, multiagency initiative designed to control, reduce, and prevent violent crime and drug abuse. Law enforcement agencies and prosecutors cooperate in "weeding out" criminals who participate in violent crime and drug abuse to prevent their return to the target area; "seeding" brings human services to the area, encompassing prevention, intervention, treatment, and neighborhood revitalization. A community-oriented policing component connects weeding and seeding efforts. An important feature of Weed and Seed is that each site must form a local steering committee, made up of all key community stakeholders and chaired by the U.S. Attorney for that district. The committee is then responsible for establishing goals and objectives, developing programs, providing guidance, and assessing achievement.

The inclusion of local residents, services, and institutions contributes to community ownership of programs, which is important for finding local funding. In Fort Wayne, Indiana, for example, funding for the anti-drug coalition comes from money collected from individuals arrested for driving under the influence or some other drug offense. In Kansas City, Missouri, residents approved a 0.25 percent increase in the sales tax to support community anti-drug efforts. Nonprofit community organizations also offer win-win partnerships with local business and industries looking to support a good cause and garner local publicity.

Evaluation of community coalitions is providing data about what makes coalitions successful. The following programs exemplify how communities can combine grassroots efforts with research-based theories of intervention to address illicit drug and alcohol problems.

Midwestern Prevention Project, Marion County (Indianapolis), Indiana

Program Type: Empowering Communities.
Target Audience: Pre-middle school youths, their parents, and communities.
Years in Operation: 1987-present.
Program Goals: To reduce youth drug use by coordinating anti-drug efforts among schools, parents, and communities.
Contact Information: Karen Bernstein, University of Southern California, 323–865–0325.

Description: The Midwestern Prevention Project (MPP) delivers anti-drug messages to youths through schools, parents, and communities. The program aims to reduce drug supply and demand by combining prevention activities with policy changes. The program began in 1984 and is now being used in five states. The Midwestern Prevention Project was named

a Model Program in *Blueprints for Violence Prevention* by the Center for the Study and Prevention of Violence at the University of Colorado. In 1987, the MPP was implemented in all 133 public schools in Marion County, Indiana.

The MPP consists of five components: school program, mass media, parent program, community organization, and health policy. The program is introduced in sixth or seventh grade, before youths make the transition into middle or junior high school. The program is administered by teachers and student leaders elected by the class and trained by the teacher. During the first year there are between ten and 13 classroom sessions discussing resistance skills, promoting a nondrug use environment, and creating an antidrug climate in the school. The second year of the program provides five follow-up sessions which reinforce the skills learned in the previous year. Throughout high school, peer counseling and support activities are available.

The mass media component begins the same year as the school component and continues for five years. Each year there are approximately 30 reports about the program on television, radio, and in newspapers. The reports are designed to keep community members involved by keeping them informed of new program components and what students are learning in the program.

The parent component, taking place during years two and three, gets parents involved in supporting a drug-free environment in their homes and in middle school. A group consisting of the principal, four to six parents, and two students meets throughout the school year to institutionalize drug prevention in the school, monitors the school grounds to ensure a drug-free environment, and plans and implements parent skills training twice each year. Each of the schools in Indianapolis has a parent committee led by a parent involved in the Parent Teacher Association.

During years three through five, community leaders are trained and form a community organization to implement drug abuse prevention services. These services complement what is being done in the schools and with the parents. During the fourth and fifth year, members of the community organization form a health policy subcommittee to implement policy changes designed to reduce the supply of and the demand for drugs. Policy changes might include ordinances restricting cigarette smoking in public areas or mandating drug-free zones. Indianapolis has had eight committees, including a medical action committee which produced a resources list of all local substance abuse treatment facilities serving youth. The list was distributed to area schools and hospitals. The government committee produced a brochure detailing parents' legal responsibilities concerning youth and alcohol, such as the possible repercussions of allowing alcohol to be served at a graduation party in the home. Over 150,000 of these brochures were distributed to parents.

Challenges: One of the challenges to implementing the MPP in Marion County was coordinating program development among the key players, including teachers, the school superintendent, local officials in law enforcement, and the business community. In order to address this problem, the Lilly Endowment, the project funder, required that all schools in the district commit to participating in the program before awarding the grant.

Costs and Funding Sources: The program was funded by a $6 million grant from the Lilly Endowment. Additional funding was provided by the University of Southern California for evaluation of the program. It costs approximately $175,000 over a three-year period for a school to implement the MPP, which includes providing curriculum materials for 1,000 students and training 20 teachers and 20 members of the parent group.

Outcome Measures: The University of Southern California and the Kaufman Foundation are conducting an ongoing evaluation of the Midwestern Prevention Project in Kansas City, Missouri, which was the first city to implement the program. Results from the evaluation show that the positive effects of the program endure over time.

By the end of high school, the program youth showed the following net reductions* in drug use:

4.9 percent daily cigarette use;

7.2 percent monthly drunkenness; and

2.9 percent marijuana use more than twice a week.

*Percent increase in control group minus percent increase in program group.

By early adulthood (age 23), program youths continued to show less drug use than the control group:

- 1.9 percent less cigarette use;
- 1.5 percent less marijuana use more than twice a week;
- 6.2 percent less lifetime amphetamine use; and
- 8.1 percent less lifetime inhalant use.

Project Northland, Ten Minnesota Communities

Program Type: Empowering Communities.
Target Audience: Youths, their parents, and communities.
Years in Operation: First phase: 1991-1994; second phase: 1996-1999.
Program Goals: To prevent underage drinking through community and family supported alcohol education.
Contact Information: Project Northland curriculum materials, 800–328–9000; in Minnesota, 612–624–0057.

Description: Project Northland is a communitywide intervention designed to reduce adolescent alcohol use. The program was developed at the University of Minnesota and piloted in ten Minnesota communities to help prevent underage drinking. The program is a multilevel program involving students, parents, businesses, and community residents and organizations. The Minnesota program served 2,400 students from 24 school districts, including schools on seven Native American reservations with high rates of death and disability from alcohol abuse. Each community site had a part-time field coordinator to assist in implementation.

Through Project Northland, community strategies, action-based curricula, and peer leadership activities all encourage positive individual behavior and environmental change. The first phase of the intervention includes eight sessions each year for sixth, seventh, and eighth grade students that focus on the risks of drinking. These sessions are designed to prevent alcohol use through normative education, social resistance skills training, and decision making. Each of the middle-school years revolves around a specific theme and incorporates individual, parent, and community training.

sixth grade—a strong family component targets student and parent communication by requiring parents and children to complete homework assignments together that describe adolescent alcohol use. Group discussions on family communication are held in schools. Also in the first year, a communitywide task force is created to address teen alcohol use.

seventh grade—a student- and teacher-led classroom curriculum focuses on resistance skills and normative expectations regarding teen alcohol use. Discussions, games, problem-solving, and role plays are all components of this curriculum. A peer participant program creates alternative alcohol-free activities, and parents continue to be involved. The task force focuses on alcohol-related environmental policies, and businesses get involved by providing discounts for children who pledge to be alcohol- and drug-free.

eighth grade—students work on becoming active citizens by interviewing community leaders about adolescent drinking and conduct town meetings to make recommendations for the community's help in preventing alcohol use.

The second phase, delivered during the students' last two years of high school, incorporates five major components to reduce alcohol availability and reinforce no-use norms: community organizing, parent education, youth participation, media campaigns, and school curriculum. Program staff work with youth in more sophisticated ways for example, developing community action projects focused on teen alcohol issues, creating original videos that focus on alternatives to drinking, community response to teen drinking, and dramatizations of the negative consequences of drinking; and learning about the state legislative process.

Challenges: One challenge in implementing the program is creating a community partnership that embraces the program's goals. In Minnesota, staff used media messages to help create a partnership within the community; articles in newspapers and school newsletters helped publicize the program.

Minnesota staff conducted a community leader survey to assess what changes the community would support. Another obstacle can be obtaining agreement from the schools to participate, particularly considering potential shifts in school leadership and administration. A nonlegal binding agreement was used in Minnesota communities to keep schools on board.

Costs and Funding Sources: The complete Project Northland curriculum for one school costs $549, plus $150 for each set of sixth grade workbooks (one set includes 30 workbooks; individual books can also be purchased). Training sessions (which last two to three days) are held in various sites throughout the country and cost $1,500 per day. Additional costs include salaries for part-time program coordinators. Project Northland was developed, implemented, and evaluated in Minnesota through a five-year grant from the National Institute on Alcohol Abuse and Alcoholism.

Program Results: Project Northland successfully prevents youth substance abuse. While the primary focus of the program is on alcohol, it has impacted tobacco and marijuana use as well. A study comparing Project Northland youths with similar noninvolved youngsters found that participating youths were:

30 percent less likely to drink in the past week;

20 percent less likely to drink in the past month;

20 percent less likely to smoke regularly; and

15 percent less likely to use marijuana.

The second phase of the program was completed in 1999, and evaluation of its effectiveness in preventing teen alcohol use is currently underway.

The program has also indirectly contributed to the passage of five alcohol-related city ordinances, including the establishment of responsible beverage server training, stricter requirements for the renewal and granting of liquor licenses, and limitations on liquor establishment operating hours. Project Northland received an "A" in *Making the Grade: A Guide to School Drug Prevention Programs* and has been identified as a Promising Program by the Center for the Study and Prevention of Violence at the University of Colorado.

Troy Community Coalition for the Prevention of Drug and Alcohol Abuse, Troy, Michigan

Program Type: Empowering Communities.
Target Audience: Youths, their families, and communities.
Years in Operation: 1985-present.
Program Goals: To reduce underage drinking by educating youths, their parents, and the community.
Contact Information: Mary Ann Solberg, Director, 248–740–0431.

Description: The Troy Community Coalition formed when the town began to experience an increase in youth alcohol abuse in the mid-1980s. To address the problem, the school district created a three-pronged approach: implement a new health and peer pressure resistance program, develop a parent group, and create a community program. This community program developed into the Troy Community Coalition for the Prevention of Drug and Alcohol Abuse. After operating on a small budget for about one year, the coalition won a $1.3 million grant from the Center for Substance Abuse Prevention.

The coalition follows a cradle-to-grave strategy, implementing programs for all sectors of the community ranging from pre-schoolers to senior citizens. The coalition works with schools, parent groups, the police department, the court system, and the city commission, among others. For example, the coalition offers a parenting class to help parents talk with their children about alcohol, encourages the police to make sure bars and store do not sell alcohol to minors, and successfully advocated legislation requiring alcohol to be safeguarded, because youths were stealing alcohol from grocery store shelves. In addition, the coalition trains pediatricians to work with parents to help them understand the problems associated with underage drinking.

Through a decade of programming, the coalition has identified several key elements of success:

Public officials are vital to the work of coalitions;

Coalition programs must match or exceed community perceptions of quality;

Creative methods must be used to recruit, retain, and recognize volunteers; and

Coalitions must be funded, at least in part, locally. Creative use of data and outcomes attracts this funding.

Challenges: A major obstacle to the coalition's work in Troy is denial among residents that there are alcohol and other drug problems in the community. The coalition conducts public awareness campaigns to educate the public and demonstrate existing problems. Data collection is a vital activity for informing the creation of programs. The coalition monitors adult and school surveys, emergency room data, police data, etc., to make sure the community's needs are being addressed and met. For example, the coalition observed an increase in alcohol abuse among newly retired senior citizens and created a senior volunteer bureau to address this problem.

Another challenge is maintaining vital relationships with partners in public and private sectors despite constantly changing leadership. Continued public education is needed to explain the mission of the coalition, the problems in the community, and how partnerships can help solve these problems. The coalition must constantly educate new leaders and volunteers to maintain and enhance these linkages, which are vital to the success of the coalition. For example, the linkage with the police department alerts the coalition to emerging drug problems so it can develop appropriate programming.

Costs and Funding Sources: The coalition operates on a $300,000 annual budget, which includes four full-time staff and one part-time employee, and receives funding from the city government (it is a lineitem in the annual city budget). The school district supplies office space and other services, while corporate donations, small foundation grants, individual donors, and fundraisers make up the remaining budget. Troy staff believe that all fundraisers, in addition to collecting money, should send significant prevention messages as well. For example, an annual celebrity dinner sponsored by local corporations and attended by adults and children is alcohol-free.

Program Results: The coalition's efforts to reduce teenage drinking resulted in significant reductions between 1991 and 1998:

12th-grade students who reported consuming alcohol in the past month decreased from 62.1 percent to 53.3 percent; and

eighth-grade students who reported consuming alcohol during the past month decreased from 26.3 percent to 17.4 percent.

In addition, the coalition has been successful in changing community norms. For example, when the National Football League wanted to host a youth competition in Troy sponsored by Budweiser, the county commission (which works closely with the community coalition) declined the offer unless a new sponsor was found. The next year, the NFL resubmitted a proposal with a new sponsor. Another coalition accomplishment is receiving significant community funding. Since its inception, the coalition has worked to establish win-win relationships with businesses and organizations who in turn support the coalition. For example, the coalition assisted one of its corporate sponsors in the development of an anti-drunk driving promotion. The coalition's work has also prompted various public policy changes that have strengthened the community's resistance to alcohol and other drug abuse.

Treatment

Substance abuse treatment is the most cost-effective way to reduce addiction, improve the health of drug abusers, and relieve the growing burden of drug-related health care costs. With treatment, addicts can get off drugs, get jobs, and become productive members of society. Addiction to alcohol and other drugs is similar to other chronic illnesses, such as diabetes and hypertension, in that successful treatment requires permanent behavior change. As with all chronic illnesses, relapse is a possibility, and failure to comply with treatment weakens the chances for successful recovery.

An untreated addict can cost society an estimated $43,200 annually, compared with an average $16,000 for a year of residential care or $1,500 for an outpatient program.[34] A 1994 California study (CALDATA) found that $1 invested in alcohol and other drug treatment saved taxpayers $7 in future costs.[35] The federal government's 1997 National Treatment Improvement Evaluation Study evaluated the effectiveness of treatment services for 5,000 clients in publicly funded programs. Treating these low-income clients saved society an average of $9,000 per client, compared to $3,000 spent on treatment. The study found a 3 to 1 ratio of benefits to costs.[36]

Services offered by substance abuse treatment programs vary, as do the modalities, staff, and target populations. The four most common types of substance abuse treatment are[37]:

Outpatient methadone programs—provide methadone to reduce cravings for heroin. Counseling, vocational training, and case management are often used to stabilize patient functioning;

Long-term residential programs—offer drug-free treatment in a residential community of counselors and recovering addicts. Patients generally stay in the programs a year or more;

Short-term inpatient programs—keep patients up to 30 days. Most of these programs focus on medical stabilization, abstinence, and lifestyle changes. Staff are primarily medical professionals and trained counselors; and

Outpatient drug-free programs—use a wide range of approaches, including problem-solving groups, specialized therapies, cognitive-behavioral therapy, and 12-step programs.

Studies of successful drug treatment programs have identified certain elements that enhance effectiveness. Length of time in treatment, intensity of treatment, and aftercare are key factors in helping addicts stay clean. According to extensive national studies of tens of thousands of addicts, one-third of those who stay in treatment longer than three months are still drug-free one year later. The recovery rate jumps to two-thirds when treatment lasts a year or longer.[38]

The National Institute on Drug Abuse has identified 13 principles of effective treatment that are described in *Principles of Drug Addiction Treatment: A Research-Based Guide* (1999). These principles are as follows:

No single treatment is appropriate for all individuals;

Treatment needs to be readily available;

Effective treatment attends to multiple needs of the individual (such as medical, psychological, social, vocational, and legal problems);

Treatment and services plans must be assessed continually and modified as necessary to ensure that the plan meets the individual's changing needs;

Remaining in treatment for an adequate period of time is critical for treatment effectiveness;

Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment;

Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies;

Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way;

Medical detoxification is merely the first stage of addiction treatment and by itself does little to change long-term drug use;

Treatment does not need to be voluntary to be effective;

Possible drug use during treatment must be monitored continuously;

Treatment programs should provide assessments for HIV/AIDS and other infectious diseases, and counseling to help patients modify or change behaviors that place them or others at risk of infection; and

Recovery from drug addiction is a long-term process and frequently requires multiple episodes of treatment.

Although treatment has proven effective, programs are still scarce. The National Academy of Sciences' Institute of Medicine estimates that programs are available for only one quarter of the almost six million people needing treatment.[39] The federal government estimates that the need for substance abuse treatment in the United States will grow 57 percent over the next 20 years.[40] The shift to managed health care among both public and privately funded treatment providers has reduced the availability of long-term substance abuse treatment. Instead, coverage is provided only for short-term interventions. Failure to provide adequate, appropriate treatment services reduces success rates and contributes to public skepticism about investing in treatment programs.

This chapter discusses various promising treatment approaches involving families, communities, and the criminal justice system. Effective strategies include treating parents with their children, rehabilitating criminal offenders, addressing the unique needs of adolescents, and connecting with the community to serve hard-to-reach clients. The programs described below may serve as examples to other communities trying to develop strategies to meet their own needs.

I. Family-Based Treatment

Treatment for a parent means prevention for a child. Children whose parents receive substance abuse treatment have lower health care costs than children of parents who do not receive treatment.[41] In addition, children of untreated addicts are at significantly higher risk of abusing substances themselves. Providing treatment services to addicts and their children helps break the inter-generational cycle of substance abuse. However, treatment has historically been largely inaccessible to pregnant addicts and parents without access to transportation, child care, and affordable services.

Pregnant addicts have a particularly difficult time getting treatment, in large part because most treatment models were originally designed for male addicts. The 1997 Uniform Facility Data Set found that only 20 percent of treatment facilities surveyed offered programs for pregnant or postpartum women; 7.2 percent provided prenatal care, 4.8 percent offered perinatal care, and 10.2 percent offered child care.[42] Lack of specialized treatment options translates into greatly increased health and social costs. According to a 1995 study in Washington state, Medicaid expenses during the first two years of life for an infant born to an untreated substance-abusing woman were 1.4 times higher than those incurred for

infants born to treated substance-abusing women.[43] The difference in dollar terms amounted to $1,800 per infant.

Other deterrents for pregnant addicts are the risks of prosecution and of losing their children. An increasing number of states are prosecuting women under criminal laws for using drugs during pregnancy. For example, several women have been jailed under South Carolina's child-endangerment law, which targets women who use illegal drugs while pregnant. The U.S. Supreme Court, which upheld the state's right to prosecute these women in 1998, is now considering whether a South Carolina public hospital is violating pregnant women's constitutional rights by testing them for crack cocaine use. Public clinics are generally required to report a pregnant woman to child welfare agencies if her urine tests are drug-positive.[44] As a result, many pregnant drug users regard prenatal care as a potential legal trap and choose to forgo it. Recent studies show that prenatal care substantially improves a baby's health, even if the mother continues to use drugs during pregnancy.[45]

Women account for almost one-third of the total number of substance abusers in treatment.[46] The Substance Abuse and Mental Health Services Administration's 1998 Services Research Outcomes Study, which surveyed several thousand addicts five years after their discharge from treatment, found that women responded better to treatment than men. Women reported almost twice as great a reduction in illicit drug use after treatment than men did.[47] The 1997 National Treatment Improvement Evaluation Study also found that women addicts showed marked improvement in the year following treatment.[48] Among women in the treated group, arrests declined by two-thirds, while drug use dropped by almost half.[49]

Certain aspects of women's lives are particularly important in addressing their treatment needs. Children are a central reality in the lives of most women. Unless programs provide help with children, women often cannot participate. Several treatment outcome studies have found that women who have their children with them during residential treatment are less likely to drop out and are more successful after treatment than women whose children are not with them during treatment.[50,51,52] Moreover, having children accompany mothers in both nonresidential and residential treatment provides an opportunity to teach women parenting skills in a safe therapeutic setting.

Sexual abuse, domestic violence, and depression are widespread among women addicts; these problems must be addressed in order to prevent relapse. Research indicates that women-only programs tend to be more effective than coed, primarily because women feel more comfortable talking to other women about their experiences.[53] Programs should offer access to comprehensive services, such as family planning, physical and mental health care, job training, parenting, and family building skills. This model departs from traditional drug treatment, which concentrates almost exclusively on addressing addictive behavior rather than the constellation of other problems that often contribute to addiction in women.

Despite the challenges, new treatment programs for pregnant, postpartum, and parenting substance abusers have begun to target high-risk families, providing treatment as well as parent training and job readiness skills. An emerging trend is to combine prenatal care with drug treatment to protect unborn babies from exposure to drugs and to prepare pregnant women for parenthood. The Center for Addiction and Pregnancy in Baltimore found that infants of untreated women were more than twice as likely (26 percent) to require neonatal intensive care unit (NICU) hospitalization than infants of treatment patients (10 percent). Taxpayers save nearly $5,000 per child in NICU costs.[54]

Families in crisis often lack the ability to support each other. Some treatment programs are working with addicts and their families to enhance chances for recovery and family stability. For example, La Bodega de la Familia, a treatment facility in New York City serving families with a relative in the criminal justice system, incorporates family members and in-home visits into the treatment process. La Bodega requires that substance abusers have a family member willing to participate in the treatment program to assist case managers in developing an action plan for the addict and the family. Since children often suffer because of the substance abuse or incarceration of a parent or sibling, family-based interventions are an effective way to integrate prevention and treatment.

By involving the family in the treatment process, addicts need not be distracted by the risks of losing

their children, and at the same time their families serve as support networks in treatment and recovery. Consequently, strengthening family relationships is a major objective for the following family-based treatment programs.

Center for Addiction and Pregnancy, Baltimore, Maryland

Program Type: Family-Based Treatment.
Target Audience: Substance-abusing women and their families.
Years in Operation: 1991-present.
Program Goals: To provide multiple types of medical services to substance-abusing women and their families.
Contact Information: Center for Addiction and Pregnancy, 410–550–3020; Dr. Lauren Jansson, 410–550–3415.

Description: The Center for Addiction and Pregnancy (CAP) offers a comprehensive, multidisciplinary treatment program for substance-abusing women and their families. The program, established in 1991, is housed in one wing of the Johns Hopkins Bayview Medical Center. The CAP program combines substance abuse/mental health treatment, pediatrics, obstetrics/gynecology, family planning, and nursing.

CAP's main goals are to reduce the number and severity of obstetric complications, including HIV infection; to deliver healthier infants to mothers who no longer abuse drugs or alcohol; to provide effective family planning services acceptable to the patient; and to ensure initial and long-term pediatric assessments and care to the infants and siblings of program patients. Upon admission, women are placed into residential care for seven days, during which they receive eight hours of interdisciplinary, individual, and group counseling per day. After this one-week residential stay, the women are transferred to an outpatient program, where they attend six and a half hours of programming each day. As women progress, they go through three levels of treatment that lessen in intensity in accordance with their progress. Ancillary services, including methadone maintenance, psychiatric therapy, and specialized services for HIV-positive women are offered when necessary.

Prenatal assessment and care are provided by nurse midwives and an obstetrician, and infants are delivered on the medical center campus. Pediatric care consists of routine child health care maintenance, as well as developmental screenings every three months and formal psychological assessments at six, 12, and 24 months. A structured parenting program provides individual and group training to all mothers, especially those identified as having exceptional parenting needs. A children's service coordinator conducts pediatric outreach and in-home assessments as well as overall case management for CAP children and their siblings.

Participants, primarily from Baltimore, are predominantly African American. The majority of women have less than a high school education, live in poverty, are single, and have an average of three children. CAP admits between 35 and 40 women per month and performs approximately 200 deliveries annually.

Challenges: A challenge to implementing the CAP program was integrating the many disciplines involved. Having all staff members work together without a particular hierarchy encouraged effective working relationships and facilitated the free flow of information, allowing staff to learn about disciplines outside of their expertise.

One of the major obstacles currently facing the CAP program is the cost restrictions of managed care. Although the program historically could provide long-term intensive services, women are now much more limited in their time in the program and access to special services. To address this problem, the program is seeking to provide longer-term services through foundation grants and state funds. In addition, the program is working with managed care companies to address the lack of services.

Another programmatic challenge is retaining women in treatment. A significant number of women entering the program drop out quickly. CAP is working on ways to make treatment more user-friendly, such as offering vouchers and hiring treatment advocates. The program also provides transportation and child care to help reduce barriers to treatment.

Costs and Funding Sources: The total expenditures of the program are $3.7 million annually, including salaries for CAP's 37 full-time employees. Funding for the program comes from managed care companies and Medicaid.

Program Results: A cost-effectiveness study of CAP conducted by researchers at Johns Hopkins University, the National Institute on Drug Abuse, and the Maryland State Alcohol and Drug Abuse Administration found that providing treatment services to pregnant women significantly reduced the costs of medical care for their infants. The evaluation compared two groups of pregnant drug-abusing women—100 who received treatment, and 46 who did not. Drug use of mothers at time of delivery was measured using urinalysis. The outcomes were as follows:

> The total neonatal intensive care unit (NICU) costs for infants born to mothers who did not receive substance abuse treatment totaled $12,183, significantly more than the $900 in NICU costs for the treated women's infants;
>
> Factoring in the $6,639 in costs to provide addiction treatment services to mothers, total cost savings of the program were $4,644 per mother-infant pair;
>
> Infants born to treated women averaged less than one day in NICU, compared with more than ten days for control group infants;
>
> Women in treatment were significantly less likely to use illicit drugs at the time of delivery than women who did not participate in treatment (37 percent and 63 percent, respectively).
>
> Infants of treated women had a mean birth weight approximately 400 grams heavier and a gestational period approximately three weeks longer than the infants whose mothers did not get treatment for drug abuse.

The cost-effectiveness study won the 1999 Hazelden Foundation Dan Anderson award, which honors clinical research endeavors seeking to improve treatment services.

La Bodega de la Familia, New York, New York

Program Type: Family-Based Treatment.
Target Audience: Families of drug users.
Years in Operation: 1996-present.
Program Goals: Provide services to families of drug users to increase the likelihood of drug users remaining in treatment.
Contact Information: Carol Shapiro, Program Director, 212–982–2335.

Description: La Bodega de la Familia, begun in 1996, is an alcohol and other drug treatment program focusing on families of drug users. The theory behind La Bodega is that a substance abuser will be more successful in treatment if supported by their family. La Bodega serves a population of 60,000 in a 56-block area of Manhattan's Lower East Side, referred to by locals as Loisaida. Loisaida was chosen as the program site by the Vera Institute of Justice because the community has high levels of drug use and related crime (the building housing La Bodega was formerly the site of a drug market), but also has many churches and health clinics providing crucial support to drug users and their families. The Lower East Side is 33 percent Hispanic (largely Puerto Rican), 30 percent Asian, 29 percent white, and 8 percent African American. Forty-four percent of the children live in poverty.

At La Bodega, case managers help family members of addicts develop a plan to keep their relatives in treatment. Field counselors offer 24-hour support to families in drug-related emergencies, such as encounters with police or relapse; follow-up on client referrals; and act as advocates in law enforcement settings. The program also provides walk-in support and prevention services for all neighborhood residents, including clients who no longer need intensive family case management. Ongoing prevention services include support groups for young mothers, victims of family violence, and community members returning home after incarceration. The bilingual staff at La Bodega helps families deal with substance abuse-related problems, such as domestic violence, child

abuse, and neglect, HIV/AIDS, and truancy. Programs designed to end the generational cycle of drug abuse and criminal activity among youths include mural painting projects, back-to-school nights, and poetry, writing, and photography workshops.

On average, La Bodega maintains a caseload of 90 families. To date, La Bodega has served over 1,400 individuals. Sixty percent of the families required crisis intervention support, 50 percent reported multigenerational substance abuse, 35 percent reported multigenerational involvement with the criminal justice system, and 28 percent had histories of domestic violence.

La Bodega is led by two advisory boards, one national and one local. The Community Advisory Board, consisting of service providers, government partners, and community residents, provides expertise on treatment, helps facilitate referrals, and helps clients resolve medical, financial, and legal problems. The National Advisory Board consists of family therapists, judges, academics, doctors, and law enforcement officials who help guide the staff of La Bodega and put them in touch with other experts across the country.

Challenges: One of the greatest obstacles in starting La Bodega was getting law enforcement and health organizations to shift their focus from the individual to the family. Treatment programs often focus exclusively on the drug user, and law enforcement agencies on the offender. But as La Bodega developed, local agencies saw the wisdom in utilizing the family as a natural resource. Law enforcement officials realized that the program increases public safety because the family is the first to know when one of its members relapses into drug abuse and becomes a possible danger to the community. In addition, clients of La Bodega are more likely to contact police when danger, such as domestic violence, arises because they have a healthy relationship with authorities. As an example of confidence in La Bodega's services, the New York Division of Parole has assigned four parole officers to work full-time with caseloads comprised solely of La Bodega participants.

Costs and Funding Sources: The annual budget of La Bodega de la Familia is $1.2 million, which includes staff salaries, walk-in support services, and 24-hour support services. Funding comes from both city and state organizations, including the New York City Department of Mental Health and the New York State Department of Parole.

For communities interested in implementing a similar program, La Bodega staff recommend adding a family component to an already existing organization. In New York clients are already receiving treatment services funded by the New York Division of Parole; La Bodega incorporates families into the treatment to make it more successful. Other program necessities include a local advisory board consisting of criminal justice and health officials and program participants, a neutral program space within the community being served, a project coordinator, and one family case manager for every 25 families.

Program Results: The Vera Institute is currently conducting an evaluation of La Bodega which will be completed in the spring of 2001. The evaluation will collect quantitative data from 100 families served by La Bodega and 100 control families. Funding for the evaluation is being provided by the National Institute of Justice and the Fan Fox and Leslie R. Samuels, Robert Wood Johnson, and Jacob and Vealeria Langeloth foundations.

Preliminary results on the qualitative aspect of the evaluation are promising. Parole officers involved with the program are pleased that their relationship with La Bodega allows them to follow up on parolees' treatment progress and say they enjoy the opportunity to focus on the social service aspects of their job. Addicts report that they are more motivated to succeed in treatment when family members are involved because they do not want to disappoint them. Treatment clients say it is easier to deceive a parole officer, whom they might see only once a week, about their drug use than family members they see every day.

In 2000, La Bodega plans to incorporate under the umbrella of Family Justice Inc. to provide training and technical assistance to criminal justice and treatment agencies nationwide. The training will focus on incorporating families into all aspects of substance abuse treatment. La Bodega is already offering training and technical assistance to national drug courts and to New York State parole and probation staff.

PAR Village: Integrated Addiction and Mental Health Delivery Systems, Largo, Florida

Program Type: Family-Based Treatment.
Target Audience: Substance-abusing women and their children.
Years in Operation: 1989-present.
Program Goals: Provide gender-specific treatment for women.
Contact Information: Debra Dahl, Clinical Director, 727–538–7245.

Description: PAR Village is a fully integrated substance abuse and mental health treatment facility near Tampa, Florida, that has been providing gender-focused rehabilitation and treatment to chemically dependent women and their children since 1989. Although PAR Village accepts a wide variety of women and children, its three target populations are women who are pregnant, injection drug users, or HIV positive. While some women voluntarily enter the program, most are referred by the Florida Department of Corrections or the Department of Children and Families.

Women at PAR Village receive a customized treatment regimen that includes substance abuse classes, physical rehabilitation, spirituality courses, educational and vocational training, anger management workshops, life skills and parenting classes, and career counseling. Unlike most family-based programs, PAR Village also provides comprehensive services to the children of addicted mothers from birth to age 10, including physical therapy, pediatric counseling, speech pathology, Head Start, and occupational counseling, among others.

A staff of 30 provides services to about 100 women and 60 children each year. Each PAR Village case manager, or "primary counselor," is assigned an average caseload of ten clients. Primary counselors coordinate treatment individually for their clients, manage customized treatment regimens, and coordinate activities with outside treatment specialists, doctors, foster care and social workers, and corrections department officials. Staff also collaborate with local social service agencies and referral sources to ensure that clients without health insurance can receive needed medication.

During the course of treatment, women must pass through four stages tailored to their capabilities. Each level has distinct goals, and advancement is marked by an increase in the level of client responsibility. Before a client graduates to the next treatment stage, progress is evaluated by the professional staff and by the client's peers at PAR Village. Families in the program reside in ten on-site homes for 16-18 months. This home environment, as opposed to dormitory style living, provides a more natural atmosphere for treatment and allows the professional staff to work around the clock with the families.

Challenges: PAR Village's family-based strategy was challenged at the outset by foster care workers who thought that a drug treatment facility was an inappropriate living environment for young children. PAR's good track record persuaded opponents to permit the strategy to be tested. Family-based treatment has proved to be a successful method of attracting women to the program by alleviating the fear of being separated from their children and eliminating the need to find interim child care during the rehabilitation process. PAR Village also works with an association of judges and child welfare officials in Tampa to ensure that recovering mothers are not separated from their children as long as they are receiving treatment.

Funding has been a persistent problem for PAR Village. After initial grants from the National Institute on Drug Abuse (NIDA) and the Center for Substance Abuse Treatment (CSAT), funding declined significantly. While enough funding was secured to maintain quality services, the diversity of new funding sources has led to increased paperwork for the program's counselors. As a result, staff turnover is relatively high. Consequently, PAR Village is attempting to streamline its administrative procedures to reduce the amount of paperwork assigned to its primary counselors.

Costs and Funding Sources: PAR Village's annual budget is $1.6 million. This includes staff salaries, operational costs of the facilities, and administrative costs. Funding comes from several sources, including the Florida Departments of Corrections and Children and Families, and the federal Department of Housing and Urban Development. In addition, support comes from Head Start, the United Way, Medicaid, and Temporary Assistance for Needy Families.

PAR Village benefits from some special advantages that would ordinarily increase overhead costs for any community looking to replicate the program. The ten houses at the facility were donated, as were the vehicles used to transport clients. The 16-acre tract of land where the facility is situated was provided by a local resident. Furthermore, many of PAR Village's therapists and counselors volunteer their services.

Program Results: A five-year evaluation of PAR Village, conducted by the University of Southern Florida and PAR's own in-house research center, found that six months after completing treatment:

Nearly two-thirds (64.7 percent) of clients are drug-free, and 88 percent are arrest-free;

95 percent of clients attain the educational/vocational skills necessary for employment, and more than one-third (35 percent) are employed; and

73 percent of clients attain custody of their children.

PAR Village has been recognized by CSAT and NIDA as a model treatment program.

II. Rehabilitating Criminal Offenders

Alcohol and other drug problems are the common denominator for most offenders in the criminal justice system. Drug offenders constitute a rising proportion of offenders in U.S. prisons. According to the Bureau of Justice Statistics (BJS), between 1980 and 1996 the number of drug offenders in state prisons skyrocketed from 19,000 to nearly 240,000. In federal prisons during this time, the number grew from 4,900 to over 55,000.[55,56] According to the National Institute of Justice's Arrestee Drug Abuse Monitoring Program (ADAM), which tracks drug use among arrestees in 34 cities, the percentage of men testing positive for drugs ranges from 42.5 in Anchorage to 78.7 in Philadelphia. Among women, percentages range from 33.3 in Laredo to 82.1 in New York City.[57] According to BJS, four in ten violent offenders were under the influence of alcohol when they committed their crimes.[58]

Despite the growing numbers of substance abusers in the criminal justice system, treatment remains scarce. The percentage of inmates who reported being treated for drug abuse dropped significantly between 1991 and 1997. One in ten state prisoners reported receiving treatment in 1997, down from one in four in 1991, according to BJS data.[59] Without treatment, three in four offenders are rearrested within three years, continuing the costly cycle of addiction and crime. Providing treatment to offenders is a less expensive alternative than incarcerating them for future illicit drug and alcohol-related crimes. The most expensive drug treatment programs cost about $10,430 per year for each offender, compared to $20,142 per year for incarceration.[60]

The major contributors to relapse among addiction treatment patients are low socioeconomic status, co-occurring psychiatric conditions, and lack of family or other social supports. Often, criminal offenders have multiple risk factors for relapse, making long-term abstinence even more difficult to achieve. However, treatment even for this population has resulted in maintained abstinence for some, and significantly reduced drug use for others, which in turn lead to reduced crime and social costs.

According to the National Institute on Drug Abuse, the therapeutic community treatment model has been found to be quite effective in reducing drug use and criminal recidivism.[61] Therapeutic communities are intensive, long-term, residential treatment programs. Program participants are segregated from the general prison population so that the "prison culture" does not overwhelm progress toward recovery. Treatment gains can be lost if inmates are returned to the general prison population after treatment. Moreover, relapse and criminal recidivism are significantly lower if the offender continues treatment after returning to the community. A 1996 18-month follow-up study of prisoners in Delaware State Prison found that inmates who participated in a therapeutic community and continued treatment in a work-release program and aftercare were significantly more likely to remain drug free than those not treated (76 percent versus 19 percent).[62] The effects were still visible after three years, with one-third of treated offenders remaining drug-free, compared to 5 percent of the comparison group.[63]

Women are the fastest-growing population in jails and prisons, largely due to drug offenses and crimes committed to support addiction, like theft and prostitution. Increased use of mandatory minimum sentencing laws for drug offenses has contributed to the explosive growth of the nation's prison population. According to the Center for Substance Abuse Treatment, mandated sentencing without the parallel development of treatment services has had a particularly devastating impact on women in prisons.[64] In 1997, 79,600 women were serving sentences in federal and state prisons, six times the number incarcerated in 1980.[65] More than two-thirds of the women inmates in federal prisons have been incarcerated for drug offenses.[66]

The criminal justice system is an important treatment entry point which can interrupt and shorten a career of drug use. The criminal justice system refers drug offenders into treatment in a variety of ways, such as diverting nonviolent offenders and stipulating treatment as a condition of probation or pretrial release. There are also specialized courts (to be discussed in greater detail under Alternatives to Incarceration) that handle drug cases and mandate treatment for participants. According to the National Institute on Drug Abuse, individuals in court-mandated treatment stay longer and perform as well as or better than those who participate in treatment voluntarily.[67] The threat of criminal sanctions can be a strong motivator to stay in treatment.

Providing treatment to addicted offenders requires collaboration between criminal justice and treatment systems, which have traditionally operated with different goals. Criminal justice and treatment personnel must work together to develop services that respond to offenders' overlapping criminal and drug problems. Such collaborations include client screening, placement, testing, monitoring, and supervision, and the systematic use of sanctions and rewards. Cross-training helps familiarize staff from both systems with each other's philosophy, approach, language, goals, and objectives, and fosters an environment of mutual respect.

The following examples highlight the kinds of programs that show promise for wide replication.

Delaware KEY/CREST, Wilmington, Delaware

Program Type: Rehabilitating Criminal Offenders.
Target Audience: Substance-abusing offenders in Delaware prisons.
Years in Operation: 1988-present.
Program Goals: Reduce drug use and criminal recidivism.
Contact Information: Sandra Buell, Regional Director for KEY/CREST, Spectrum Behavioral Services, 302–325–9500. Kathy English, Delaware Department of Corrections, 302–739–5601.

Description: Alcohol- and other drug-addicted offenders in four Delaware prisons have access to the KEY/CREST program, where they receive substance abuse treatment in a therapeutic community setting while in prison, followed by work-release and aftercare services in the community.

The KEY program, developed in 1988, provides treatment to inmates in the last 12 to 18 months of their incarceration. Offenders learn to change the behaviors that led them to drug use. Clients are housed in the therapeutic community setting, separate from other inmates, and they spend seven days a week focusing on treatment. To avoid distraction, participants do not have access to television or telephones during the day. Treatment includes individual counseling, group therapy, educational seminars, HIV education, family and parenting education, and 12-step programs. Clients are also encouraged to participate in GED and vocational programs offered by the prison. KEY counselors work with 20 clients at any given time. Other staff include a program director, a clinical supervisor, and an administrative assistant.

Upon leaving the correctional facilities, KEY participants enter one of three CREST Outreach Centers, which operate work-release programs based on a therapeutic community model. Developed in 1992 as a National Institute on Drug Abuse demonstration project, CREST is designed to help inmates make a smooth transition into society. Residents of CREST receive six months of intensive substance abuse treatment presented in two phases. During the first three-month phase, clients adapt to life outside of prison by learning job skills, visiting their families

and communities, attending AA meetings, and continuing their substance abuse treatment with a strong focus on relapse prevention. During the next phase, clients work full time in the community but return to the facility in the evenings. They also take part in community service activities as a form of restitution to the community.

After completing CREST, clients go through a six-month aftercare program during which they return to CREST weekly for group sessions, drug testing, and counseling. At any given time there are approximately 572 clients in the four KEY programs, 328 in the three CREST programs, and an additional 350 clients in aftercare. The Delaware Department of Corrections contracts with Spectrum Behavioral Services to run all three components of the program.

Challenges: One of the challenges to implementing KEY/CREST was convincing those in the corrections field that it was beneficial and cost effective to treat substance-abusing criminal offenders. Many people in the criminal justice field did not believe that it was possible to change an offender into a law-abiding citizen. Changing people's perceptions so that they would not view the treatment program as merely an "easy way out" for offenders required extensive training of the correctional staff. Soon after the program began, correctional officers observed that offenders in the therapeutic communities were less violent than offenders in the general prison population.

Getting offenders into treatment is an ongoing challenge for KEY/CREST. Some offenders do not believe they need treatment and are unwilling to take part in the rigorous therapeutic community. Delaware prisons have increased the number of participants in treatment by sanctioning offenders who choose not to participate and offering incentives to those who do. Offenders who are identified as needing treatment, but are unwilling to participate, are not considered for early release (early release is a result of good time credits and other behavioral incentives).

Costs and Funding Sources: KEY/CREST programs are funded through the Delaware Department of Corrections. The programs receive approximately $4 million per year from the state, funding treatment for approximately 13,000 inmates yearly. It is estimated that treatment costs are $7.50-$8.00 per day for each offender in the program (this is for treatment only and does not include food and other services that all inmates receive).

Program Results: An evaluation of the CREST program by researchers at the University of Delaware showed promising results. The evaluation included 279 people divided into four groups: CREST dropouts, CREST graduates without aftercare, CREST graduates with aftercare, and a control group of offenders with substance abuse problems assigned to a traditional work-release program with little alcohol and other drug treatment. Three years after release from prison:

> 69 percent of inmates completing CREST and aftercare remained arrest-free, compared to 55 percent of those completing CREST only, 28 percent of CREST dropouts, and 29 percent of the control group.
>
> 35 percent of inmates completing CREST and aftercare remained drug-free, compared to 27 percent who completed CREST, 17 percent who dropped out, and 5 percent of the comparison group.

Forever Free, Frontera, California

Program Type: Rehabilitating Criminal Offenders.
Target Audience: Substance-abusing women in California prisons.
Years in Operation: 1991-present.
Program Goals: Provide alcohol and other drug treatment to incarcerated women and encourage them to continue treatment after their release.
Contact Information: The Department of Corrections Office of Substance Abuse Programs, Contract Manager, 916–327–3707, or David Conn at Mental Health Systems Inc., 619–689–2633.

Description: Since 1991, Forever Free has been providing substance abuse treatment to inmates at the California Institute for Women (CIW) in Frontera. Developed through a partnership between the California Department of Corrections and the Department of Alcohol and Drug Programs, Forever Free has provided approximately 4,000 female inmates with substance abuse treatment.

Most women who participate in Forever Free do so voluntarily. When offenders enter the prison system, they are screened for substance abuse. If they are found to have an alcohol or other drug problem and meet the criteria for entering the program (such as adequate length of stay in prison and no violent history), prison officials suggest they volunteer. Some women are involuntarily placed in the program by prison officials.

Participants in Forever Free are housed separately from other inmates in a 240-bed facility. They spend four hours a day at prison work assignments, such as cooking or grounds work, and four hours a day in treatment. There are two treatment tracks, one lasting four months and the other six. Track placement depends on length of incarceration. Women who are sentenced to more than six months may remain in Forever Free for the duration of their sentence.

The State Department of Corrections contracts with Mental Health Systems Inc. to run the treatment program. Forever Free utilizes a behavioral change approach, and treatment includes counseling, relapse prevention, problem solving, re-socialization, 12-step groups, and case management. Women's issues, such as dependency, physical and sexual abuse, and coping with the stress of motherhood are also addressed. Prior to parole, transition plans are developed for program participants which detail their arrangements for employment, housing, and further treatment. Clients are encouraged to voluntarily enter community residential substance abuse treatment, funded by the state, upon parole. The State Department of Corrections contracts with community treatment providers, who reserve a number of beds for Forever Free clients at a reasonable cost.

Thirty percent of program participants are African American, 23 percent are Hispanic, and 44 percent are white. The average age of clients is 35. Forever Free serves approximately 720 clients per year and has a staff of 17, including 13 counselors, one supervising counselor, one transition counselor, an administrative assistant, and a project director.

Challenges: The biggest obstacle for Forever Free is finding qualified inmates. Because most inmates in CIW are serving short terms for lesser offenses such as parole violation, they often do not remain in prison long enough to receive successful treatment. To solve this problem, CIW tries to engage women in the program as soon as they enter prison. Women who are serving only a few months in prison are also allowed into the program if they agree to enter a residential treatment facility upon their release.

Costs and Funding Sources: The total budget for the program during FY 1999/2000 was approximately $1.6 million. Nearly half of the budget, $739,000, is for post-release community treatment services. The remaining amount includes program staff, staff training, and in-prison treatment. The Department of Alcohol and Drug Programs also sets aside community treatment beds for Forever Free participants at no cost.

Program Results: The California Department of Corrections contracted with an evaluator to examine the impact of Forever Free on program participants who left prison in 1995 and 1996. The evaluation compared four groups of women: all women who entered the program, women who dropped out of the program, women who received only the in-prison program, and women who continued to receive treatment after being paroled. Program retention during these years was high; 94.8 percent of women completed the program. Women who completed the in-prison program and at least three months of community treatment fared the best.

Twelve months after parole:

- Only 9 percent of women receiving 120 days or more of community treatment were re-incarcerated; and
- 38 percent of women who dropped out of the program and 39 percent of the in-prison only group had returned to custody versus 32 percent of women receiving continuing care.

Twenty-four months after parole:

- Only 25 percent of women receiving more than 120 days of treatment after being paroled were returned to custody after two years; and
- 60 percent of program drop-outs were reincarcerated, compared to 48 percent of the continuing care group.

Despite changes in staff and prison management, Forever Free has sustained effective programming for

almost ten years. A major accomplishment of the program is that 50 percent of participants agree to enter a residential treatment program upon release from prison.

New Vision Therapeutic Community, Kyle, Texas

Program Type: Rehabilitating Criminal Offenders.
Target Audience: Substance-abusing prison inmates in Texas.
Years in Operation: 1992-present.
Program Goals: Provide substance abuse treatment and other services to inmates to help them succeed after prison.
Contact Information: Shirlee Livingston, Program Director, 512–268–0264.

Description: New Vision, begun in 1992, was the first in-prison therapeutic community in Texas. Currently, the program is offered in four Texas prisons and has been replicated in Oklahoma and New Mexico. The primary goal of the program is to provide residents with the skills necessary to live as productive members of society after their release from prison. In order to be considered for the treatment program, offenders must be assessed as having a substance abuse problem, be in the last nine to 12 months of their sentence, and need only medium or less security. New Vision serves 520 clients in its program (approximately 750 offenders per year).

New Vision provides clients with educational seminars and lectures, therapeutic groups, individual and group counseling, and 12-step meetings. Counseling is also offered to offenders and their families on Saturdays and Sundays. The program consists of three phases: orientation, main treatment, and re-entry. During orientation, offenders are introduced to the therapeutic community and learn the rules and policies of the program. They also become familiar with the concepts of substance abuse, the addiction process, and relapse.

During the main treatment phase of the program, participants begin to identify the problems contributing to their addiction, accept responsibility for their addiction, and formulate long- and short-term recovery goals. During the last phase, re-entry, clients and counselors design relapse prevention and continuum of care plans which include employment, housing, and peer support groups. Movement through the phases depends on the individual client's progress; there is no specified duration for any phase. After completion of the program, some offenders serve as role models for program participants and assist in facilitating group activities.

Upon prison release, New Vision participants enter a community aftercare program that helps them reintegrate into society. Offenders are paroled to a three-month residential work-release program, which is followed by up to 12 months of outpatient counseling. Participants meet with their parole officers regularly, undergo monthly urine tests, and have frequent contact with case managers to review progress and any problems.

New Vision staff consist of a program director, two administrative staff, a family therapist, a training coordinator, and 26 counselors. There is one counselor for every 20 clients. The program also utilizes volunteer interns from local colleges and universities.

Challenges: The biggest obstacle to creating New Vision was convincing therapists, who had been trained to work within a different model of treatment, to try the therapeutic community model. To convince them, program developers used evidence of other successful in-prison therapeutic communities. Another problem was achieving cooperation between the treatment and correctional staff, which was addressed through cross-training, allowing staff to learn more about the treatment model and to appreciate the various roles in the in-prison treatment design.

Costs and Funding Sources: The annual budget for New Vision is $1.4 million. Program funding is provided by the Texas Department of Criminal Justice and the Texas Department of Substance Abuse Treatment. In order to replicate the program, qualified staff would be required, including a program director, administrative staff, and a counselor to client ratio of 1:20. Staff training would also be a significant cost.

Program Results: A 1997 three-year follow-up study of 394 New Vision participants was conducted by researchers at Texas Christian University. Recidivism rates were examined for three groups of offenders: prison treatment and aftercare, aftercare dropout, and an untreated comparison group. One of the major findings of the evaluation was that

completion of the New Vision aftercare component is a critical factor in maintaining treatment success. The recidivism rates were as follows:

prison treatment and aftercare	25 percent
aftercare dropout	64 percent
untreated	42 percent

The study further divided the subjects by severity. High-severity offenders had more serious criminal and drug-related problems and were viewed as more likely to be reincarcerated. However, offenders completing treatment and aftercare had significantly lower recidivism rates than dropouts and untreated offenders. Recidivism rates for the high- and low-severity offenders were as follows:

High-severity

prison treatment and aftercare	26 percent
aftercare dropout	66 percent
untreated	52 percent

Low-severity

prison treatment and aftercare	22 percent
aftercare dropout	52 percent
untreated	29 percent

III. Assessing and Treating Adolescents

The number of adolescents in alcohol and other drug abuse treatment programs increased by more than a third between 1992 and 1997; however, young people continue to be greatly underserved.[68] According to the National Household Survey on Drug Abuse (1999), of an estimated one million youths ages 12 to 17 assessed as drug dependent, only 175,000 had received treatment.[69] Since most substance abuse treatment is designed for adult addicts, appropriate services for adolescents can be hard to find. According to the federal Center for Substance Abuse Treatment (CSAT), less than one percent of the more than 6,700 publicly funded treatment programs nationwide are designed exclusively for adolescents.[70]

Adolescent users differ from adult users in many ways. Young teens begin with experimentation and occasional use, while adults have often experienced a decade or more of addiction and have developed severe problems, such as job loss, criminal histories, and medical complications. The types of drugs abused also tend to vary with age. Marijuana and alcohol are the most prevalent among treatment clients under age 18, while opiates and cocaine are associated with older clients. Adolescents also have unique treatment needs. Teen treatment models tend to be less confrontational than treatment for adults. Concurrent mental illness, legal problems, educational needs, family and community environment, and emotional, intellectual, and physical development must all be considered in planning effective youth treatment.

Treatment for adolescents should incorporate a wide range of social services, provide aftercare services to reinforce progress, and encourage family involvement. Teaching parents the skills to support their children through treatment can enhance family stability and increase chances for success. Learning to appropriately monitor their children and identify warning signs of relapse enables parents to participate in their children's recovery.

Teen treatment programs should consider youths' ethnicity and gender when designing services. Norms, values, and health beliefs may differ across cultures, and these factors can have a significant impact on treatment. Gender-related factors also affect an adolescent's involvement in treatment. For example, adolescent females may require more attention with regard to problems such as sexual abuse.

Most adolescent treatment that does exist is aimed at youths with serious drug habits; relatively few are designed to help teens who are just beginning to develop problems. As a result, these teens are often referred to programs focused on severely troubled addicts, which may exacerbate rather than reduce their drug use. Different levels of pathology require different treatment environments; not all programs are equally effective for young people. Early intervention offered through a school-based student assistance program, for example, can substantially reduce drinking and marijuana use before more intensive services are needed and is far less costly than making treatment available only after teens develop an addiction, drop out of school, or commit crimes.

In addition to developing more youth-specific treatment approaches, it is important to screen young people to identify those most likely to need treatment, such as teens who exhibit warning signs of abuse, including substantial behavioral changes, significant changes in academic performance, trauma injuries, and contact with the juvenile justice or child welfare systems. Homeless and runaway teens in shelters and all teens who receive mental health assessments should be screened for addiction treatment needs. According to the Substance Abuse and Mental Health Services Administration, adolescents with severe emotional and behavioral problems are significantly more likely to have substance abuse problems than other adolescents.

Involvement in the juvenile justice system is an important consideration when developing appropriate substance abuse treatment for teens. According to CSAT, programs designed for this population should be holistic and include juvenile justice, substance abuse treatment, schools, community-based organizations, and other providers of health and social services in one plan. Case management is critical to coordinate services for these children and to act as the central monitoring and tracking source for each child.

CSAT identifies essential elements to treating juvenile offenders in *Strategies for Integrating Substance Abuse Treatment and the Juvenile Justice System* (1999).[71] They include:

> Focusing treatment on risk factors associated with criminal behavior, such as antisocial attitudes and peers, rather than on risk factors that are not particularly associated with criminal behavior, such as self-esteem;
>
> Concentrating more intensive services on those who are at risk of re-offending; and
>
> Offering comprehensive treatment that addresses all related behaviors, especially the need for academic and vocational education and work skills training.

Since juveniles placed in detention facilities are unlikely to receive the special programs necessary for treatment or reintegration into society, alternative placements have increased dramatically in recent years. Options include intensive community supervision, day treatment, evening and weekend programs, and tutoring.

While programs designed for adolescents are still scarce, the following examples highlight how communities are utilizing successful approaches to treat young people.