WHAT ARE WE TRYING TO PREVENT?

As the California AOD prevention community moves toward science-based prevention, we want more than ever to understand “what works” to achieve useful outcomes. The focus for action remains at the local (county, city, community) level, where county alcohol and drug programs (county ADPs) continue to enjoy broad discretion under federal funding guidelines from CSAP and SDFSC (DOE). However, new accountability and reporting requirements are emerging. Local agencies are under increasing pressure to be clear what they are trying to prevent, and how they go about it. Credible methods and measurable results are becoming a necessity.

Assistance is available through training and TA offered by the Community Prevention Institute and by CSAP and other federal agencies that offer demonstrated prevention methods and approaches (such as WestCAPT). However, county ADP agencies and other local organizations still must decide which methods and approaches to use. What are critical AOD issues from local perspectives? How can effective local responses be developed that will meet stringent state requirements and federal guidelines?

The following perspective is offered to help county ADP programs frame their search for answers to these questions, and to engage other local agencies and community based organizations (CBOs) providing AOD prevention services. A second article in the next edition of this newsletter will address long-standing practical difficulties and policy challenges that stand in the way of realizing the perspective outlined below. A third article will report on efforts to overcome these difficulties and challenges.

Problem-oriented prevention. What are we trying to prevent? While there is no one right answer, the field needs to clarify what approach(es) to pursue as a matter of common interest, so our joint efforts can be mutually supportive. Currently, most approaches to community level AOD prevention follow a “problem-prevention” perspective to reduce illness, harm, and loss. This perspective is pursued through several disciplines including: Public health, education, social welfare, public safety, community planning, advocacy, and health service delivery. This perspective operates through corresponding local agencies, community organizations, and unofficial groups. In practice, these community-level entities are usually involved some form of problem-reduction (harm reduction), and in efforts to delay or reduce AOD use. These efforts often mesh with other community practices, programs and policies that serve related objectives.

This “problem reduction” approach makes sense for AOD-related community issues that involve groups of people, including innocent bystanders, and that drain community resources. The four AOD problem-areas of greatest concern to local communities usually are drinking/driving, public drinking and disruptive behavior, young people’s AOD experiences, and AOD-related violence, among other concerns.

This problem-oriented perspective has considerable potential for improvement and broad application, provided (a) the scope, or theory of problem-oriented prevention is clear, and (b) the scale, or level, of application is specified. This article summarizes prevailing thoughts on both points.
Some may say that a problem-oriented perspective is not the only one nor necessarily the best one for dealing with society’s AOD-related difficulties. This article does not take issue with that assertion, and welcomes vigorous debate on which prevention perspectives best serve the field. We do want to point out, however, that the problem-oriented perspective is predominant and has enormous untapped potential. Here we focus on making the best of it, while keeping an open mind for other possibilities.

A. Theories of problem-oriented community prevention initiatives. Three theories for community-level problem-prevention approaches are currently in use.

(1) Prevent alcohol and drug (AOD) problems directly. Community AOD problems are viewed as problematic drinking and drug-use behaviors, and supporting circumstances (settings or events) that encourage such behaviors. Action focuses on curtailing the specific troublesome behaviors or circumstances. For example: Intervene immediately with young people to reduce dangerous AOD use; provide regulated beer gardens at community fairs to stop public drunkenness at community events; create social host ordinances to discourage problematic house parties. Such direct action approaches tend to be program-oriented. Prevention workers seek to change problematic practices and places already in operation, mostly through short-term programs or special activities. Positive results usually can be seen quickly, and outcomes usually are closely tied to project outputs. However, questions often remain how long the problem-reductions remain, and whether the problems have been displaced to other people and to other circumstances.

(2) Prevent “root causes” that cause AOD problems in the first place. Community AOD problems are viewed as a result of certain forces that have a particular impact on the community. Reducing the impact of the forces will therefore reduce the AOD problems. Examples: Provide early childhood development services to distressed families with AOD-related problems; provide economic development opportunities in poor neighborhoods to keep young people from entering the drug trade; raise AOD retail prices, reduce accessibility, and limit exploitative promotional activities to reduce elevated levels of high-risk availability. “Root-cause” prevention approaches tend to be policy-oriented. Prevention workers seek to change problematic settings and circumstances through basic policies and fundamental changes in practice. Definitive results often take a while to appear, and it may be difficult to attribute positive results, which will be influenced by many factors, to specific policy outputs.

(3) Engage in positive development programs and policies that bypass AOD problems. Community AOD problems are viewed as potential conditions that can be avoided by positive community development and person-oriented development initiatives. Examples: Secular youth development programs provide guidance and support for living healthy, successful lives that divert young people from involvement with drinking and drug use; rigorous application of mores and customs among religious communities and traditional communities that use similar approaches; community planning initiatives that focus on creating safe and healthy communities are designed to exclude opportunities for high-risk AOD abuse. Positive development programs accentuate positive development influences (and some seek to exclude negative development influences). Prevention
workers seek to institute positive norms, beliefs and expectations (and sometimes to
supercede, change, or exclude problematic norms, beliefs and expectations). Two
complexities are involved in observation of resulting changes in AOD problems: (1)
How are changes in community AOD problems accounted for in relation to positive
development objectives? Is there an evaluation of the extent to which the developmental
initiatives divert participants from future AOD problems, or in other ways reduce
community AOD problems? (2) Are desired developmental changes counted as
precursors to, or as products of, problematic uses of alcohol and drugs?

Each of these three approaches can claim evidence of effectiveness. The three
approaches are not incompatible with each other. Most communities can benefit from multiple
prevention initiatives using all three theories. Selecting the approach(es) to follow can be helped
by consideration of the scale at which prevention initiatives will be undertaken.

B. Scale of community-level prevention efforts. The concept of scale is critical to making
effective use of these three theories in community contexts. “Scale” refers to the size of the
prevention effort in relation to a person. Community-level prevention efforts make use of three
scales: The individual level; the organizational level; and the institutional level, described
below.

(1) Small-scale, individual-sized efforts. Small-scale efforts focus on beliefs and behaviors
of individuals or small groups in particular settings and circumstances. Examples:
Oversight for a problematic bar; cleaning up AOD use in a public park; stopping
tenaged drinking parties in private homes; creating a safe-place after-school program;
personal social host policies for responsible alcohol service.

(2) Middle-scale organizational-level efforts. Middle-scale efforts focus on the polices and
practices among the community’s organizations and groups. Examples: Neighborhood
association policies on alcohol at block parties and house parties; rental property
management association policies on AOD use reflected in lease agreement and property
oversight standards; school board policies on drinking and drug use at school sites (in
contrast to treatment of individual students or staff); fraternal organization rules for
responsible alcohol use at social and community events.

(3) Large-scale, institutional efforts. Institutional efforts focus on public policies,
community-wide beliefs, and historical practices among major community sectors (public
agencies, the business community, the residential community, the faith community,
health and human service providers, etc.). Examples: Community standards for
promotions and advertising of alcoholic beverages at youth-related events; conditional
use permit (CUP) regulations on retail alcohol outlets; community support for alcohol-
free holiday events such as sober graduation and First Night alcohol-free new year’s
celebrations; acceptance of sober housing facilities and respect for sober-living life styles
as a positive community resource.

Based on the AOD problems they wish to attack, community designers can strengthen
their local AOD prevention initiatives by deciding how to apply the selected problem-reduction
theory across the levels of scale at which the theory can be applied. AOD prevention initiatives
can “nest” so that the smaller-scale efforts are included in larger-scale efforts, reinforcing each other in a multi-scaled ecology that shifts toward healthier, less-problematic community living. Planning one community event, for example, can lead to a general policy that applies to several community settings and circumstances (see the Mendota article in this newsletter).

This “nesting” orientation can be applied to link local communities with a statewide efforts. Consider California’s exemplary tobacco control efforts, for example, that use the “nesting” strategy to work through “air cover” statewide advertising campaigns; state and regional support for prevention methods, program planning and evaluation; and localized community education and control activities (for an excellent example of California’s comprehensive tobacco control efforts and their success, click here.).

Community action to prevent AOD problems. Community AOD prevention enjoys a wonderfully wide palette of possibilities for action. How to choose a specific course of action that fits within available resources? Two considerations are critical for making effective choices:

Use clear knowledge of the community’s AOD problems in community contexts of groups, settings, and circumstances as the basis for selecting AOD problems for action; and;

Create a local decision-making to choose effectively among possible courses of action to address identified AOD problems.

The next edition’s newsletter will address both considerations.