Prevention Brief

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MEET MY NEEDS:
Defining Selective and Indicated Services for Populations At-Risk

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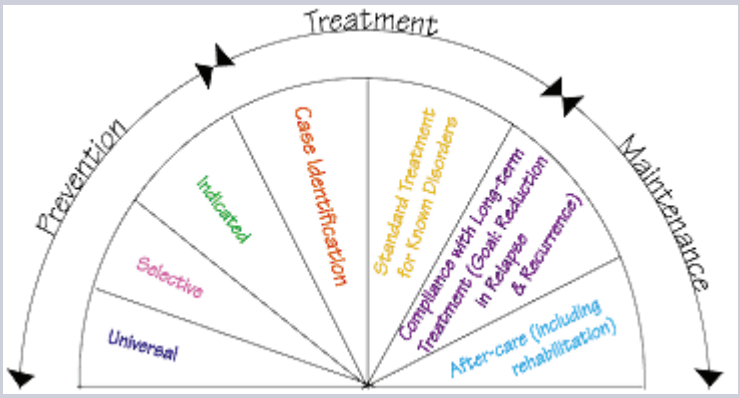
As alcohol and other drug (AOD) prevention programs gain maturity through continued implementation of evidence-based services, these initiatives positively impact an increasing number of California communities. Typically, this expanding pool of participants is described in terms of recruitment, retention, and demographic characteristics. How many youth attended the activity? Which families returned for follow–up services? Is it a rural, urban or suburban area? What is the average age or percentage of boys? Many programs are adept at answering these types of questions. Now they are ready to reflect on how to identify those most in need of services and where these youth and families fit into the bigger picture. Who is today's optimal candidate for inclusion in the target population? What models of prevention are relevant to changing needs and emerging issues of our communities? Strategically approaching who and how we serve our communities will determine the success of the local AOD prevention vision.

How Does the Institute of Medicine Continuum of Care Model Translate to AOD Prevention Practices?

The Institute of Medicine (IOM) proposed a model of categorizing services in 1994. The paradigm is an adaptation of the medical classification system for disease prevention (Gordon, 1987). The IOM model offers a continuum of care that spans three areas: prevention, treatment, and maintenance. There are three classifications within the prevention category: universal, selective and indicated prevention interventions.



UNIVERSAL

Universal prevention strategies address the entire population (national, local community, school, neighborhood), with messages and programs aimed at preventing or delaying the abuse of ATOD. It includes the general population as well as subgroups. For instance, all students in a school district or all families in a county represent a universal prevention approach to service delivery. In this category, the objective is to thwart the onset of ATOD and violence by providing all individuals in the population with prevention services. The universal population shares common ATOD and violence risk factors, though individual-level risk may vary. Universal prevention programs deliver services without screening for or identifying specific risk factors in order that the entire population has the potential to benefit from services.

How do our programs ensure that services reach marginalized or disenfranchised populations or include individuals most vulnerable to negative impacts associated with ATOD and violence? In some instances, program context defines the risk characteristics of the population (e.g., a program site located within a juvenile justice system school or residence). In other cases, program participants are screened and rated for the number or intensity of risk factors they possess (e.g., low attendance rates, failing grades, or high numbers of discipline referrals). Programs may rely on a referral system that includes courts or counselors to recruit potential participants. Targeting the specified high-risk participant means that services are being implemented within the communities of highest need.

This brief is designed to review the evolution in targeted services. It will examine the current AOD prevention trends in an effort to point programs towards a sustainable future of strategic service delivery. In addition to an overview of theoretical frameworks, it will provide methods and strategies relevant to serving high-risk populations. Profiles of service providers and best practices are provided for reference.

California's prevention programs are having considerable impact on our communities. At this stage, active reflection on the past and strategic planning for the future will ensure that service delivery benefits populations most in need of effective prevention programming.

SELECTIVE

Selective prevention is delivered to specific subgroups within a population. These subgroups are considered to be at risk for substance abuse/violence that is defined by the characteristic of that subset of the population. For instance, selective populations include youth residing in high poverty or high crime environments and parents lacking legal immigration status. Selective populations may be identified as at-risk according to biological, psychological, social, or environmental risk factors that research demonstrates to be associated with ATOD/violence issues . Prevention programs serving selective populations may further define the target population according to personal demographics (e.g., age, gender, etc.), geography, or other relevant factors. Selective prevention services are delivered to all of the target population without heed to individual-level risk. In this category of prevention, the same services are provided to an individual who may be abusing ATOD or be gang-affiliated as to an individual who demonstrates no personal risk of abuse or violence. The objective of selective prevention is to serve an entire subgroup based on the theory that their collective ATOD/violence risk-level is higher than that of the general (i.e., universal) population. It is an individual's affiliation with the subgroup that defines their risk, not the assessment of their personal risk status.

INDICATED

Indicated prevention aims to address individually-defined risk. In this category, services are provided to individuals who do not meet DSM-IV criteria for clinical level disorder (e.g., ATOD dependency) or violence-related criminal conviction, but who demonstrate early indicators of abuse or participation in violence. For instance, youth who are known to use ATOD or who admit gang affiliation qualify for indicated prevention services. "Indicated prevention approaches are used for individuals who may or may not be abusing substances, but exhibit risk factors that increase their chances of developing a drug abuse problem." Identifying indicated populations, allows for delivery of prevention services appropriate for the individually-defined risk. Indicated prevention services target the specific risk behavior, such as binge drinking, and/or circumstances associated with risk behavior, such as academic failure or juvenile justice offense. Indicated prevention is designed to reduce first-time AOD abuse or sub-clinical level problem behaviors and to minimize the duration and or severity of early danger signs related to clinical level behaviors. Typically, indicated populations are identified through program recruitment screening or referrals from family, school staff, youth/family service providers, courts, or the youth themselves.

What Are the Priority Populations for Prevention Services?

Institute of Medicine Classifications

Universal preventive interventions are activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.

Selective preventive interventions are activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

Indicated preventive interventions are activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels.

Unfortunately there is no shortage of at-risk, underserved populations within our state. Reliance on community assessment to identify local priority populations ensures that services are reaching those most critically in need of prevention programming. This need-driven approach to service delivery aligns with the California Department of Alcohol and Drug Programs' (ADP) focus on the IOM prevention classifications. In addition, the Safe and Drug Free Schools and Communities (SDFSC) Governor's Program will provide selective and indicated prevention programs customized to each SDFSC community. ADP has identified the following populations as high priority populations in terms of targeted prevention services to be served by the SDFSC grants:

- youth in foster care
- high risk experimental users (e.g., binge drinkers)
- children of known substance abusers.

While these are established as three distinct priorities for service, the populations often overlap. For instance, the ADP reports that almost 60% of women engaged in prenatal substance abuse treatment services have an active child welfare case. Of these child welfare cases, over 20% of the children are in foster care. By nature, these populations fall within the "selective" category of the IOM model. Within these populations, individuals are at dire personal risk of experiencing the negative impacts of ATOD and violence. Indicated prevention is appropriate for an overwhelming proportion of these three populations.

Youth in Foster Care

- About 680,000 children (2.7%) aged 12 to 17 years have been in foster care at some point in their lives.
- Adolescents in foster care are more likely than adolescents not in foster care to be at high risk for substance abuse. ,
- These children have higher rates of substance use than peers who have never been in foster care (34% vs. 22%).

California currently has more than 80,000 abused and neglected children in its foster care system (estimates range

from 76,000 to 86, 000). This represents about 20 percent of all foster children in the United States. Children in the foster care system experience a unique constellation of risk factors associated with both the circumstances of their placement into the child welfare system and with living within the foster care system itself. For example, more than 6,000 children who have been in foster care for less than one year have had three or more different residential placements. The risks that foster youth face do not end when they leave the system. Nearly a third of youth become homeless within a year of emancipating, or "aging out," at 18 years, from the foster care system. One in five emancipated foster youth is incarcerated. These daunting developmental trajectories are part and parcel of these children's increased risk for and rates of substance abuse and violence.

It may seem that youth in the foster care system, particularly those residential institutions or "group homes," do not have access to alcohol, tobacco or other drugs. This is not the case. Access to substances and exposure and participation in violence (including gang-related activity) occurs via home visits, friends and family visiting residential facilities, facility staff, and, with authorized and unauthorized trips off-site. The latter instance includes runaway incidents, cutting class or skipping an activity and briefly leaving the facility, and authorized off-site employment or excursions. Opportunity for exposure to and engagement in ATOD and/or violence among youth placed in foster family settings is comparable to that of non-foster youth counterparts.

Despite the fact that foster children are eligible for an assortment of services, including health care, mental health counseling and educational assistance, the system that provides these services is fractured, unorganized, overwhelmed by demand and insufficient operating capacity. This limitation is coupled with the fact that prior to placement in the system, foster youth frequently demonstrate irregular school attendance and absence of support systems and so are unlikely to have been exposed to any youth development programming, including exposure to ATOD and violence prevention services. Given the severe and complicated needs of these children, ATOD and violence prevention are often low on the list of service priorities. These are youth who fall through the cracks both in and out of the foster care system when it comes to services like those provided through SDFSC programs. Yet, these are youth experiencing incredibly high levels of risk for substance abuse and violence.

"Child welfare advocates, judges, child welfare administrators and academics estimate that drug and alcohol abuse is a significant factor in up to 80 percent of foster care cases."

"While children in foster care are eligible for services, they often do not receive the help necessary to treat their trauma or meet their developmental needs."

The Little Hoover Commission (1999) Now In Our Hands: Caring for California's Abused & Neglected Children.

Sacramento City Schools Serves Foster Youth

The Foster Youth Services of Sacramento City Schools serves district schools and youth by matching foster students with the specific social, emotional and academic support services needed for success.

It provides needed support services for foster youth, including:

Tutoring Program - Provides tutors for one-on-one tutoring, currently serving elementary age students.

Counseling – Provides academic & social/emotional counseling for middle/high school students.

Friendship Club – Research based prevention program for middle school foster youth & their friends.

ILP – Independent Living Program

Clerical Assistance - can help with collecting educational and health records.

Source: http://www.scusd.edu/chess_division/YouthDevelopment.htm

Strategies for Service in the Foster Care System

Multidimensional Treatment Foster Care (MTFC): families are recruited, trained, and closely supervised to provide MTFC-placed adolescents with treatment and intensive supervision at home, in school, and in the community; clear and consistent limits with follow-through on consequences; positive reinforcement for appropriate behavior; a relationship with a mentoring adult; and separation from delinquent peers.

The Comprehensive Student Assistance in Residential Settings Project, referred to as the Residential Student Assistance Program (RSAP) targets foster youth in group residential facilities. It is modeled after the Employee Assistance Program (EAP), which has been used successfully by businesses to identify and aid employees whose work performance has been negatively affected by alcohol, other drugs, or personal and family problems. RSAP uses highly trained staff, placed full- or part-time in the foster care residential facilities, to provide culturally sensitive AOD use prevention services. RSAP staff work with youth individually and in small groups, conduct training for facility staff, coordinate programs and services directed at decreasing the incidence and prevalence of AOD use among youth, and provide follow-up treatment and referrals. Research indicates RSAP program's effectiveness in both preventing and reducing substance use among participants.

Structured one-to-one mentoring programs that match volunteers with youth in foster care is another effective strategy for this population. Benefits of mentoring programs serving foster youth align with those of mentoring programs in general, including :

- Improved school attendance
- Decreased school drop-out rates
- Improved self-esteem and self-confidence
- Improved conflict resolution and decreased aggressive behavior
- Development of new aspirations, skills, and interests
- Increased sense of community and connectedness
- Less likely to be a victim or perpetrator of a crime
- Decreased teen pregnancy
- Decreased substance abuse

A comprehensive guide to structuring mentoring services for foster youth is available online at: http://www.emt.org/userfiles/FosterYouthSeries5.pdf.

25% of students in California's non-traditional high schools report binge drinking on 3 or more occasions in the past 30 days. (WestEd)

Nearly 1 out of every 5 teenagers (16 percent) has experienced "black out" spells where they could not remember what happened the previous evening because of heavy binge drinking. (American Academy of Pediatrics, AAP Releases New Findings on Teens and Underage Drinking, Washington, D.C., 1998.)

High-risk Experimental Users: Binge Drinkers

Binge drinking or heavy episodic drinking is commonly defined as consuming 5 or more alcoholic beverages for males or 4 or more for females (SAMSHA) consecutively within several hours . Through its Healthy People 2010 initiative, the federal government has set a national goal to reduce binge drinking among high school seniors from 32% in 1998 to 11% in 2010. According to results from the California Healthy Kids Survey, rates of current binge drinking among middle and high school students ranges from 2% (7th graders) up to 25% (youth at non-traditional schools).

Binge drinking during adolescence has long-term, negative health consequences, including obesity, high blood pressure, poor health and continued high risk behaviors during young adulthood. Binge drinking during high school, especially among males, is strongly predictive of binge drinking in college. Clearly, binge drinking is a serious form of experimental substance use. Furthermore, it is a behavior more likely to occur among high-risk student populations (i.e., those attending non-traditional high schools). Fifteen percent of these students reported binge drinking on 1 to 2 of the past 30 days; 25% reported engaging in binge drinking 3 or more days of the past month! The severity of this issue demands immediate and focused efforts of the prevention community.

Predictors of Binge Drinking Behavior

Individual Risk Factors (Johnston; NHSDA)

- Being male
- Being an older teen
- Being white, Hispanic, American Indian/Alaskan native (compared to black or Asian youth)

Environmental risk factors (National Institute on Alcohol Abuse and Alcoholism. 1997. "Youth Drinking: Risk Factors and Consequences." Alcohol Alert NO. 37. http://pubs.niaaa.nih.gov/publications/aa37.htm)

- parents with alcohol dependence
- lack of parental support, monitoring, and communication
- peers who drink

Indicated Prevention Strategies Targeting Binge Drinkers

There are multiple prevention strategies that effectively target excessive use of alcohol. One common theme across programs is incorporation of a harm reduction approach. In the harm reduction model, individuals are deemed responsible for their own choices. Prevention efforts are focused on "where they are" and transition from the current level of use in tenable increments of increasing levels of improved self-care, health, safety, and well-being. "Unlike prevention programs for youth that focus exclusively on abstinence and promote a zero-tolerance, "just say no" approach, programs based on harm reduction are designed to accommodate those who have already "said yes" (or who are leaning in that direction) when it comes to experimenting." It is a compassionate and practical approach to the reality of substance use. The core principles of harm reduction include:

Excessive behaviors occur along a continuum of risk ranging from minimal to extreme.

Changing addictive behavior is a stepwise process, complete abstinence being the final step.

"Programs that recognize the reality of adolescent substance use, and that begin with a focus on reducing the potential for related harm, are more likely to be successful than programs that focus on abstinence alone." This theory of prevention may be implemented in a variety of ways.

Individual-level Prevention

Informational and educational strategies that include an interactive and democratic forum for youth and professionals may be a useful component to an overall program strategy, but not as the primary approach.

Programming focused on changing social norms is associated with reduction of high risk drinking among high school students. It is worth noting that research indicates that students' drinking behaviors are influenced more by an individual's immediate peer group than by their broader peer population. Findings in the literature also suggest that youth who identify with the "in" crowd of peers are more likely to be influenced by social norms when it comes to intentions to engage in high risk drinking behavior. Effectiveness of social norms programming has not been found to generalize to college student populations. The research indicates that social norms prevention strategies are suited to selective or indicated populations, especially so for youth who are already engaged in heavy episodic drinking, more so than universal prevention programming.

Skills-based prevention programs targeting high risk drinking have shown moderate levels of effectiveness in reducing problem behavior. This approach relies on transferring skills associated with decision-making, coping techniques, and self-control in order to moderate behavior. It assumes that youth lack the capacity to engage in responsible behavior, including experimental use behavior. Implementation of skills-based programming as an indicated prevention strategy requires a screening or referral method for identifying participants demonstrating problem behaviors.

Personalized feedback and/or brief interventions have been associated with rates of effectiveness in reducing heavy episodic drinking demonstrated in more intensive prevention programming. This type of approach may entail individual-level feedback on drinking patterns, personal beliefs about drinking, and risks associated with these factors compared to local or national norms. This approach successfully reduces heavy episodic drinking rates among youth engaged in the behavior. This indicated prevention strategy is associated with reduction in heavy drinking in indirect (i.e., written feedback), single session, and repeated session formats. Successful implementation depends on efficient screening, referral, and outreach systems.

Environmental-level Prevention

Environmental prevention is suited to universal prevention more so than selective or indicated approaches. Nonetheless, environmental prevention strategies have demonstrated success in reducing heavy episodic drinking. This indicates that strategic application of environmental prevention practices may be a useful component of a comprehensive indicated strategy.

The following are strategies with demonstrated effectiveness in reducing high-risk drinking among youth:

- Media or public health campaigns: recommended as a component, not primary approach to prevention.
- Substance-free events
- Regulated alcohol advertising and sponsorship
- Developing youth's social capital on school campus/in community (e.g., service learning programs, volunteerism)
- High academic expectations evidenced by school policies and practices
- Enforcement of alcohol policies
- "Dry" environments (specific to college campus and/or residences)
- Regulated alcohol prices and alcohol tax
- Restricted hours and days of alcohol retail availability
- Regulate density of alcohol retail outlets
- Merchant/server education and policy enforcement

Children of Known Substance Abusers

Research indicates that up to 66% of child fatalities involve parents or caretakers who abuse alcohol and other drugs. Children of known substance abusers are commonly referred to as children of alcoholics (COAs) or children of substance abusers (COSAs). Though commonly used, the terms are loosely defined and may reflect parent/caregiver current use status or a history of abuse. Parental substance abuse impacts a child's normal development. A family history of or current AOD abuse increases children's risk for negative economic, social, emotional, physical and mental health outcomes. Parents/caregivers with AOD abuse or dependence issues are more likely to experience domestic violence, divorce, unemployment, mental illness and legal problems. As a result, their capacity for effective parenting is substantially compromised. Children of known substance abusers experience higher risks than their peers for:

- childhood depression, anxiety, eating disorders and suicide attempts
- AOD dependence (3-4 times more likely; 1 in 4 COAs become alcoholics)
- experiencing physical and sexual abuse
- witnessing spousal abuse (6 times more likely)
- adult relationships with substance abusers (i.e., female children of substance abusers are more likely to, in adulthood, have relationships with substance abusing men; increases likelihood of repeated patterns of abuse/victimization).

Substance abuse in families is associated with chaotic and dysfunctional environments, often with high levels of conflict, deficient communication systems, and inappropriate boundaries. Youth living within these environments are more likely to have lower self-esteem and less internal locus of control. COAs/COSAs commonly experience difficulty in school, including inability to concentrate on academic tasks due to preoccupation with stressors at home. In addition, these youth are more likely than their peers to have learning disabilities, be truant, repeat more grades, transfer schools and be expelled.

SCREENING TOOLS

Screening Tool: Modified CAST: CAST-6

Items are a subset of questions appearing on the Children of Alcoholics Screening Test, developed by Jones and Pilat, and have been rigorously tested.

1. Have you ever thought that one of your parents had a drinking problem?
2. Did you ever encourage one of your parents to quit drinking?
3. Did you ever argue or fight with a parent when he or she was drinking?
4. Have you ever heard your parents fight when one of them was drunk?
5. Did you ever feel like hiding or emptying a parent's bottle of liquor?
6. Did you ever wish that a parent would stop drinking?

Scoring:

3 or more yes answers - probably a COA

Screening Tool: Children of Alcoholics Screening Test (CAST)

1. Have you ever thought that one of your parents had a drinking problem?
2. Have you ever lost sleep because of a parent's drinking?
3. Did you ever encourage one of your parents to quit drinking?
4. Did you ever feel alone, scared, nervous, angry or frustrated because a parent was not able to stop drinking?
5. Did you ever argue or fight with a parent when he or she was drinking?
6. Did you ever threaten to run away from home because of a parent's drinking?
7. Has a parent ever yelled at or hit you or other family members when drinking?
8. Have you ever heard your parents fight when one of them was drunk?
9. Did you ever protect another family member from a parent who was drinking?
10. Did you ever feel like hiding or emptying a parent's bottle of liquor?
11. Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking?
12. Did you ever wish that a parent would stop drinking?
13. Did you ever feel responsible for or guilty about a parent's drinking?
14. Did you ever fear that your parents would get divorced due to alcohol misuse?
15. Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem?
16. Did you ever feel caught in the middle of an argument or fight between a problem drinking parent and your other parent?
17. Did you ever feel that you made a parent drink alcohol?
18. Have you ever felT that a problem drinking parent did not really love you?
19. Did you ever resent a parent's drinking?
20. Have you ever worried about a parent's health because of his or her alcohol use?
21. Have you ever been blamed for a parent's drinking?
22. Did you ever think your father was an alcoholic?
23. Did you ever wish your home could be more like the homes of your friends who did not have a parent with a drinking problem?
24. Did a parent ever make promises to you that he or she did not keep because of drinking?
25. Did you ever think your mother was an alcoholic?
26. Did you ever wish that you could talk to someone who could understand and help the alcohol-related problems in your family?
27. Did you ever fight with your brothers and sisters about a parent's drinking?
28. Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?
29. Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking?
30. Did you ever take over any chores and duties at home that were usually done by a parent before he or she devel oped a drinking problem?

Scoring: Total Number of Yes Answers

0-1 Most likely parent is not alcoholic. A score of 1 might suggest problem drinking.

2-5 Has had problems due to at least one parent's drinking behavior. This is a child of a drinker or possibly an alcoholic.

6+ More than likely the child of an alcoholic. Stage of alcoholism needs to be determined.

Prevention Strategies for Success in Reducing Risks in Children of Known Substance Abusers

Children of known substances abusers may be classified as selective or indicated populations depending on problem behaviors demonstrated by youth themselves. Research clearly demonstrates that this population experiences an increased risk for developmental disruption and compromised well-being. Serving this population requires effective screening tools, referral systems, and creative and tenacious recruitment efforts in order to provide for difficult-to-engage youth and families. Evidence specific to program effectiveness with COAs/COSAs is limited. Programs may consider implementing services demonstrated to be effective in addressing the specific risk factors associated with children of known substance abusers. In addition, the following strategies are provided for consideration:

Student Assistance Programs (SAPs) are a comprehensive prevention strategy providing individualized services to indicated populations. SAPs are designed for a school context, but integrate other contexts as well. Prevention programming is provided in group or individual settings to youth and families. A common tri-fold approach includes a formal process for identifying students who are abusing substances or who are at risk, a structure for incorporating relevant professional services, and a rehabilitation component aimed at facilitating the transition of students completing treatment.

Strengthening Families Program (SFP) is a family intervention that includes a parent training component and a youth social skills training component. Sessions are designed for school or community-based settings. Research indicates SFP reduces risk factors, increases resilience, and decreases ATOD use among elementary school children of substance abusers.

What Are Effective Components of Indicated Prevention Programs?

Screening Tools - Consistent use of valid and reliable diagnostic tools to establish eligibility and identify and monitor individual needs.

Multi-faceted Services - Comprehensive and holistic approach to the individual across multiple domains such as school, home, and peer contexts.

Staffing - Sufficient levels of appropriately trained staff to provide intensive levels of individually tailored prevention programming. Adequate level of staff support is also essential. Specific professional development in ATOD issues, professional boundaries, and cultural competence is recommended.

GETTING ON TRACK

It is always a good time to prioritize or recommit to prioritizing the delivery of prevention practice to the intended population. Gaining sophistication in targeted prevention programming is a process. Determine what is viable given the program priorities and circumstances and move forward at your own pace.

- Examine what populations are in greatest need of services; your program has served historically; and your program is serving currently.
- Measure what portion of your program's participant population are appropriate for "selective" or "indicated" services. Do you have the capacity/resources to provide services effectively? Are you having an impact or are you meeting the intended need?
- Assess the extent to which the participant population is aligned with your county's prevention priority populations. Assess program population alignment with the priority populations identified by the funding agency.
- Define what specific selective or indicated services your program provides.
- Identify the facets of your program that are appropriate for serving indicated populations.
- Determine what program components are needed to develop or strengthen your indicated prevention programming services.
- Access support and resources from program partners, program developers, and technical assistance providers.

Recommended Components for Indicated Prevention Services Targeting COAs/COSAs:

- Information and education
- Skill development related to coping and social competence
- Social support
- Opportunities to express feelings
- Healthy alternative activities

Examples of Selective, Indicated and Tiered Prevention Programs

SELECTIVE
- Adolescents Training and Learning to Avoid Steroids (ATLAS)
- Coping Power
- Focus on Families (FOF)
- The Strengthening Families Program (SFP)

INDICATED
- Reconnecting Youth (RY)*
- Project Toward No Drug Abuse (Project TND)

SELECTIVE-INDICATED
- Adolescent Transitions Program (ATP)
- Early Risers "Skills for Success" - Risk Prevention Program
- Fast Track Prevention Trial for Conduct Problems

**Recent research fails to lend support to RY as an effective program for high-risk youth.*

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The **SDFSC TA Prevention Brief** is a publication of the California Governor's Program Safe and Drug-Free Schools and Communities Technical Assistance Project, managed by the Center for Applied Research Solutions (CARS) and funded by the California Department of Alcohol and Drug Programs (ADP).

The SDFSC TA Prevention Brief Series provides information on topics relevant to grantees grounded in your experiences and explained through research. A copy of this publication can also be found on our website at www.ca-sdfsc.org. If you would like to suggest a topic, contact Kerrilyn Scott-Nakai, Project Director, at kerrilyn@emt.org.

To learn more about the Safe and Drug Free Schools and Communities Technical Assistance Project and other publications by the Center for Applied Research Solutions (CARS), please contact our office.

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