

**Report of the Task Force on Effective Drug Abuse Prevention
to the King County Bar Association Board of Trustees**

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Introduction

The Task Force on Effective Drug Abuse Prevention was established as part of the King County Bar Association's Drug Policy Project to study and report on current drug abuse prevention research, policies and programs. This report considers why young people begin to use alcohol, tobacco and other drugs and highlights measures that have been shown to prevent, delay or reduce the harm from such use, including some noteworthy examples developed in Washington State. This report also makes recommendations and articulates principles to help Washington improve, expand and provide adequate funding for the implementation of an effective, statewide substance abuse prevention plan.

As used in this report, the terms "drug abuse prevention" and "substance abuse prevention" are used interchangeably and refer to those non-coercive interventions that are used both before and after the onset of any drug involvement by young people. The Task Force has focused particularly on alcohol, tobacco and other drug use by children and adolescents.¹ There are many drug abuse prevention strategies, including the building of community coalitions, expanded after-school activities, social service referrals and public service announcements.² In this report, however, the Task Force has concentrated on the principal and most widely used drug abuse prevention strategy – drug education programs and other school-based substance abuse prevention programs.

¹ Programs aimed at "preventing" *adult* drug abuse, particularly employer-sponsored "employee assistance programs," fall more into the category of drug addiction treatment rather than preventing or delaying the initiation of drug use, and therefore fall outside the scope of this report.

Another task force of the King County Bar Association's Drug Policy Project is examining issues related to drug addiction treatment.

² U. S. Department of Health and Human Services, Center for Substance Abuse Prevention (1999), *Understanding Substance Abuse Prevention, Toward the 21st Century: A Primer of Effective Programs*, monograph, Washington, D. C., 7. CSAP also includes tobacco and alcohol advertising limitations as a prevention approach, but such measures have been invalidated recently by the U. S. Supreme Court. *See Lorillard Tobacco Company et al. v. Reilly, Attorney General of Massachusetts et al.*, 121 Sup. Ct. 2404, 533 U.S. ____ (2001).

Summary

The prevailing approach to preventing illicit drug use is not working. There has been no rational basis for the “war on drugs,” as the costly attempts to limit the supply of illegal drugs and to punish illegal drug users with incarceration have not only failed to reduce drug use but have also brought about serious collateral harm. “Prevention” programs aimed at youth have also been largely ineffective, based on the faulty premises that juvenile use of alcohol and other drugs can be completely eliminated, and that the chief concern is drug use *per se* rather than the social forces that give rise to drug abuse and other problem behaviors.

Most youth pass through adolescence without experiencing any significant adverse consequences from the use of alcohol, tobacco and other drugs. However, more young people are beginning to use these substances at earlier ages. Although there is no cause-effect relationship, research shows that early initiation of alcohol, tobacco and other drugs is associated with poor school performance, low school attachment and school dropout, antisocial and criminal activity, substance abuse and other problem behaviors. For those young people at risk of abusing alcohol and other drugs, who are not resilient enough to ward off other environmental risks, early intervention is essential. The Task Force believes that, to the extent that children’s cognitive, physical and social development is compromised by the use of alcohol, tobacco and other drugs, it is in the public interest for Washington to develop a more effective, statewide substance abuse prevention strategy.

Alcohol, tobacco and other drug use by our youth should be strongly discouraged, but experimentation with these substances is inevitable for many adolescents. The Task Force believes prevention efforts should be focused on the *harm associated with drug use*, rather than merely the use of drugs. It is important to distinguish between varying degrees of harm associated with different substances and to develop a strategy that reduces the greatest potential for harm. From the public health perspective, therefore, the Task Force concludes that Washington’s substance abuse prevention strategy should emphasize alcohol and tobacco. Alcohol’s close association with aggressive, irresponsible and criminal behavior and tobacco’s highly addictive properties and its well-known, serious damage to physical health should raise the most concern. Investing in strategies to prevent their use by minors will yield significant health benefits and will help prevent many problem behaviors by our youth.

Some programs have shown modest success in preventing or delaying alcohol and other drug involvement by youth. However, those programs focus principally on helping youth to cope with an array of societal influences and to develop an increased sense of self-worth, rather than on the hazards of drug use. Research indicates that programs targeting “high-risk” youth are more beneficial and cost-effective than universal drug education programs such as D.A.R.E., which often rely on fear as a motivating factor and overstate the dangers of certain illicit drugs in comparison with alcohol and tobacco. As a matter of social policy, therefore, the Task Force has concluded that “prevention” resources should be devoted primarily toward programs that build and reinforce social and self-management skills, particularly for youth presenting a higher risk of problem behaviors.

Washington is a national leader in developing programs that target children and adolescents who are at higher risk of drug abuse and other problem behaviors. However, while there appears to be an emerging structure in Washington for youth-focused prevention efforts, led by the State Division of Alcohol and Substance Abuse, that initiative is severely under-funded and is insufficient for the scope of the challenge. Furthermore, additional research is needed to help explain the causes of substance abuse among our youth, and there is also a critical need for more data on the long-term effectiveness of prevention programs.

Having examined current research, policy and programming related to substance abuse prevention, the Task Force recommends that a special working group be authorized by the Legislature to improve Washington's comprehensive substance abuse prevention plan. Promising programs developed here in Washington have been highlighted in this report, but this Task Force does not presume to have the expertise to recommend specific programs or approaches. A special statewide panel, composed of state and local health and educational officials, scholars, clinicians, parents, teachers and students, could build on the work begun by the State Division of Alcohol and Substance Abuse and would be qualified to make specific recommendations to improve the state's comprehensive prevention plan.

As a guide to the statewide panel of experts, the Task Force sets forth the following broad recommendations, based on its survey of current research, for the development of an improved substance abuse prevention plan for Washington:

- Any effective drug abuse prevention strategy must address *the social and psychological problems underlying drug abuse*, so as to help give young people genuine opportunities to lead fulfilling lives. Drug abuse prevention should be part of a broader *youth development* strategy, allowing youth to learn the social and self-management skills needed to make responsible decisions in the broader contexts of their lives.
- Youth-focused prevention programs should aim to prevent and minimize the *harm* associated with the use of alcohol, tobacco and other drugs, which means:
 - 1) preventing the early initiation of alcohol, tobacco and other drug use, which is correlated with problem behaviors of youth;
 - 2) focusing attention on programs targeting "high-risk" youth rather than promoting universal drug education programs that are relatively ineffective; and
 - 3) concentrating especially on preventing use of alcohol and tobacco, which are the substances presenting the greatest risk of harm to youth.
- Drug education programs should provide honest and complete information about alcohol and other drugs, carefully distinguishing between the degrees and types of harm and risk associated with the use of different drugs. Such programs should include a discussion of the appeal of drugs, as well as the physiological and psychological effects that can also lead to excessive and harmful use.

For the people of Washington, investment in research-based prevention programs will help to avert the much higher costs of drug treatment, criminal justice and social and health services that would otherwise arise, estimated to be about \$2 million for each young person who develops a long-term substance abuse problem. Shifting funding away from drug-related criminal enforcement and toward drug abuse prevention will also reflect the proper emphasis on substance abuse as principally a social and public health problem.

I. Youth Involvement with Alcohol, Tobacco and Other Drugs

Longitudinal studies of adolescents have consistently found that most illicit drug use does *not* evolve into persistent use, and that illicit drug use, along with other adolescent behaviors, is intermittent or transitory.³ A recent federal report by the U.S. Center on Substance Abuse Prevention concluded:

Adolescence is a period in which youth reject conventionality and traditional authority figures in an effort to establish their independence. For a significant number of adolescents, this rejection consists of engaging in a number of “risky” behaviors, including alcohol and other drug use...[which] may be a “default” activity engaged in when youth have few or no opportunities to assert their independence in a constructive manner.⁴

Although most youth successfully navigate through adolescence without developing substance abuse problems, some do use alcohol and other drugs excessively, which can undermine motivation, interfere with cognitive processes, contribute to debilitating mood disorders and increase the risk of accidental injury and death.⁵ Over three million American children between the ages of 10 and 18 are experiencing serious troubles with alcohol and other drugs, jeopardizing their chances of success in adulthood.⁶

Children’s limited ability to make informed judgments renders them especially vulnerable to the adverse consequences of drug use, so a delay in their exposure to alcohol and other drugs gives them more opportunities to become socially competent and resilient to risk.⁷ The Task Force believes, therefore, that to the extent that children’s development is impaired due to alcohol, tobacco and other drugs, devising an effective strategy to prevent or delay the use of those substances is an important social policy objective.

³ See, e.g., D. Huizing, R. Loeber *et al.* (2000), *Co-occurrence of Delinquency and Other Problem Behaviors*, U. S. Department of Justice, Washington, D. C., p. 2. Other studies that have followed the development of youth over time have even concluded that adolescents who experiment with illicit drugs are “psychologically healthier” and more likely to mature into better-adjusted adults than adolescents who abstain. See J. Shedler and J. Block (1990), “Adolescent Drug Use and Psychological Health: A Longitudinal Inquiry,” *American Psychologist*, Vol. 45, No. 5, p. 625.

⁴ Maria Carmona and Kathryn Stewart (1996), *A Review of Alternative Activities and Alternative Programs in Youth-Oriented Prevention*, Center for Substance Abuse Prevention, U. S. Department of Health and Human Services, Washington, D. C., p. 5.

⁵ Added to the immediate risks of juvenile drug abuse are the longer-range implications for youth who continue to abuse alcohol and other drugs into adult life, including higher risks of adult lung cancer and coronary disease, HIV/AIDS, violent crime (especially related to alcohol), child abuse and neglect, and unemployment. See the landmark study by J. David Hawkins *et al.* (1992), “Risk and Protective Factors for Alcohol and Other Drug Problems in Adolescence and Early Adulthood: Implications for Substance Abuse Prevention,” *Psychological Bulletin*, Vol. 112, No. 1, p. 64.

⁶ Joy G. Dryfoos (1991), *Adolescents at Risk: Prevalence and Prevention*, Oxford U. Press, New York.

⁷ The heightened risks associated with early substance use by children have been illustrated recently by a number of researchers, including Nels Ericson (2001), in *Substance Abuse: The Nation’s Number One Health Problem*, U.S. Department of Justice, Washington, D.C., who found that more than 40 percent of youth who start drinking alcohol at age 14 or younger develop alcohol dependence, compared with 10 percent of youth who begin drinking at age 20 or older. See also Bridget Grant and Deborah Dawson (1997), “Age at Onset of Alcohol Use and Its Association with DSM-IV Alcohol Abuse and Dependence,” *Journal of Substance Abuse*, 9, who demonstrate that each year of avoiding alcohol use significantly decreases the risk of future dependence, at p. 103. See also Phyllis Ellickson *et al.* (1998), “Does Early Use Increase the Risk of Dropping Out of High School?” in *Journal of Drug Issues*, Vol. 28, No. 2, who reveal that early use of tobacco by Caucasian, African-American and Asian-American students is a predictor of dropping out of school and that early use of marijuana by Latino students is a predictor of dropping out of school.

Current Trends in Washington and the Nation

Ranked nationally, the prevalence in Washington of alcohol, tobacco and other drug use by teenagers is higher than in a majority of other states. The latest data from the State Division of Alcohol and Substance Abuse reveal the following:⁸

- The percentage of 8th, 10th and 12th graders in Washington who have ever used cigarettes, alcohol and marijuana is higher than the national average.
- The percentage of 8th and 10th graders in Washington who have used alcohol recently is higher than the national average.
- The rate of heavy drinking by 8th, 10th and 12th graders in Washington is higher than the national average.
- The percentage of 8th, 10th and 12th graders in Washington who have used marijuana and cocaine recently is higher than the national average.
- The percentage of high school seniors in Washington who have used marijuana in the past 30 days is at its highest point in the last 15 years.

Findings from across the nation indicate that juveniles are experimenting with alcohol, tobacco and other drugs at younger ages. Particularly significant changes in drug awareness seem to be taking place between the ages of 12 and 13; surveys show, for instance, that 13-year-olds are three times as likely as 12-year-olds to know how to obtain marijuana or to know someone who uses illicit drugs.⁹ In the last decade, the rising prevalence of marijuana usage has been attributed to increased use by 12-to-17 year-olds, and there has been a slight upward trend in first-time cocaine and heroin use by the same age group.¹⁰

The latest findings from a federally-sponsored national survey of high school seniors' use of alcohol and other drugs reveal the following:¹¹

Drug Used	last 12 months	last month
Alcohol	73.2%	50.0%
Marijuana	36.5	21.6
Cocaine	5.0	2.1
Heroin	1.5	0.7

By senior year, about 80 percent of students have consumed alcohol, 63 percent have smoked cigarettes and 49 percent have used marijuana. The use of "hard" drugs, however, is extremely limited.¹² Of greatest concern is the high prevalence of *alcohol* use, not only because of the potential short-term and long-term harm from alcohol abuse, but because alcohol consumption by young people is especially linked with aggressive, irresponsible and criminal behavior.¹³

⁸ David H. Albert (2001), *Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State, 2001 Report*, Division of Alcohol and Substance Abuse, Dept. of Social and Health Services, Olympia, WA, pp. 15-37.

⁹ Nels Ericson (2001), *op. cit.*, p. 2.

¹⁰ White House Office of National Drug Control Policy (1999), *Drug Use Trends*, fact sheet, p. 1.

¹¹ University of Michigan (2000), *Monitoring the Future* study, news release, December 2000.

¹² Nels Ericson (2001), *op. cit.*, p. 2.

¹³ See, e.g., Janet C. Greenblatt (2000), *Patterns of Alcohol Use Among Adolescents and Associations with Emotional and Behavioral Problems*, U.S. Department of Justice, Bureau of Justice Statistics, Washington,

Looking back ten years, increased marijuana use among youth has been especially pronounced. Since 1991, the percentage of 10th and 12th graders reporting use of marijuana in the last month has doubled, and the percentage has more than tripled for 8th graders.¹⁴ During the same period, the fraction of students who believe people are at “great risk” of harming themselves with marijuana has declined from about 75% in 1991 to just over 50% today.¹⁵ By contrast, the percentage of high school students perceiving “great risk of harm” from cocaine and heroin has not declined, remaining at a high level of over 80 percent.¹⁶

The Task Force believes it is very instructive to note that the increase in marijuana use has coincided with *students’ changing perceptions of the risks of marijuana use*. Through observation and experience, most youth who have tried drugs have generally chosen to use a more benign substance such as marijuana instead of “hard drugs.” As the figures above indicate, however, the primary drugs of choice for youth are still alcohol and tobacco, which are more harmful than marijuana from a public health perspective.¹⁷

Statistical Caution: Drug Use vs. Drug Abuse

It is useful to review evidence of the extent of alcohol, tobacco and other drug use by young people, because research shows that early use of these substances is associated with developmental difficulties, drug abuse and other problem behaviors. However, as described below, there is no cause-effect relationship.

The Task Force recognizes that the extent of drug *abuse* cannot be properly ascertained merely by estimating the number of persons who use drugs. Recent research reveals, for example, that a very small percentage of children and adolescents account for the vast majority of alcohol and drugs that are used. Data from the 1997 National Household Survey on Drug Abuse indicate that less than 3 percent of 12 to 14-year-olds and 12 percent of 15 to 17-year-olds consume over 80 percent of the alcohol consumed by their age groups.¹⁸

D.C., p. 6; and P. J. Goldstein (1989), “Drugs and Violent Crime,” in A. Weiner and M. E. Wolfgang, eds., *Pathways to Criminal Violence*, Sage Publications, Newbury Park, CA.

¹⁴ White House Office of National Drug Control Policy, *Drug Use Trends, op. cit.*, p. 2.

¹⁵ University of Michigan (2000), *Monitoring the Future, op. cit.*

¹⁶ *Ibid.*

¹⁷ Government-appointed commissions in North America and Europe have all concluded from scientific evidence that marijuana is less harmful than alcohol, tobacco and other drugs. *See, e.g.*, Advisory Committee on Drug Dependence (1969), *Cannabis*, Her Majesty’s Stationery Office, London; Canadian Government Commission of Inquiry (1970), *The Non-Medical Use of Drugs*, Information Canada, Ottawa; National Commission on Marijuana and Drug Abuse (appointed by President Nixon, 1972), *Marijuana: A Signal of Misunderstanding*, USGPO, Washington, D. C.; Werkgroep Verdovende Middelen (1972), *Background and Risks of Drug Use*, Staatsuigeverij, The Hague; and Senate Standing Committee on Social Welfare (1977), *Drug Problems in Australia – An Intoxicated Society*, Australian Government Publishing Service, Canberra. An Administrative Law Judge for the U. S. Drug Enforcement Administration, Francis Young, concluded that “marijuana in its natural form is one of the safest therapeutically active substances known to man.” U.S. Department of Justice (1988), “In the Matter of Marijuana Rescheduling Petition,” Docket #86-22, September 6, 1988, p. 57. Recent research has found that marijuana causes no residual effect on cognition over time. *See* Constantine G. Lyketos *et al.* (1999), “Cannabis Use and Cognitive Decline in Persons Under 65 Years of Age,” *American Journal of Epidemiology*, Vol. 149, No. 9.

¹⁸ Joel Grube (2000), *Insights from the 1997 National Household Survey on Drug Abuse: Underage Drinking Patterns and Consequences*, Prevention Research Center, Pacific Institute for Research and Evaluation, Berkeley, CA.

The National Academy of Sciences has recently highlighted the range of profound methodological difficulties in estimating levels of drug abuse and in explaining the causes of drug abuse.¹⁹ Researchers have noted the importance of understanding differences in patterns of drug use among segments of the population, and of the need to distinguish between, for instance, the teenage marijuana user, the occasional cocaine user and the crack- or heroin-dependent person for whom drug use is “a career rather than an event.”²⁰

Although the bulk of formal research shows clearly that alcohol and tobacco present the greatest risk of harm to youth, official government reports frequently cite marijuana use as a prime indicator of serious problems. This assertion serves as a justification for continuing the policy of criminal enforcement as part of the “war on drugs.”²¹ The Task Force believes that the federal government’s focus on marijuana not only overstates the harms associated with its use compared with other substances, but also confuses *use* with *abuse*, thereby preventing any credible analysis of the comparable risks of all drugs as well as any rational formulation of priorities for drug control or drug abuse prevention.

It is difficult to determine whether the increasing juvenile involvement with drugs at younger ages will necessarily require more health-related intervention. However, the Task Force assumes that a higher prevalence of drug use by children at younger ages at least increases the risk of drug abuse, and it is for this reason that the Task Force believes the review of drug *use* statistics above is informative.

Criminal Justice Contact – Increased Cost and Increased Harm

During the same period when alcohol and other drug use has increased among youth, there has been an even sharper upward trend in drug-related arrests of youth across the nation. These arrests have taken place during a period of intensified law enforcement efforts as part of the “war on drugs.” Since 1990, the number of males under 18 arrested for drug offenses has increased by over 125 percent, and the number of females under 18 arrested for drug offenses has increased by almost 200 percent.²²

The last decade in Washington has also seen increasing numbers of youth running afoul of the law in connection with illicit drug use. In 1999, there were 2,732 arrests of juveniles for “drug abuse violations” in Washington, comprising about 14 percent of all such arrests (both juvenile and adult), compared with only 1,183 juvenile arrests in 1991, comprising only ten percent of all such arrests at that time.²³

¹⁹ National Research Council (2001), *Informing America’s Policy on Illegal Drugs: What We Don’t Know Keeps Hurting Us*, National Academy Press, Washington, D. C.

²⁰ Peter Reuter (1999), “Drug Use Measures: What Are They Really Telling Us?” *National Institute of Justice Journal*, Washington, D. C., April 1999.

²¹ The federal government presents many statistics related to illegal drug use as support for its drug law enforcement policy, but a close inspection reveals those statistics to be “soft facts.” As the statistician Joel Best states: “They are basically guesses and, because having a big drug problem makes the agencies’ work seem more important, the officials’ guesses tend to exaggerate the problem’s size....When it is difficult to measure a social problem accurately, guessing offers a solution; and there usually are advantages to guessing high.” Joel Best (2001), *Damned Lies and Statistics: Untangling Numbers from the Media, Politicians and Activists*, University of California Press, Berkeley, CA, p. 38.

²² In 1999, over 100,000 persons under 18 were arrested for “drug abuse violations” nationwide, compared with just over 43,000 in 1990. Federal Bureau of Investigation (2000), *Crime in the United States 1999*, Uniform Crime Reports, U. S. Department of Justice, Washington, D. C., Table 32, p. 216.

²³ FBI (2000 and 1992), *Crime in the United States, op. cit.*, 1999 and 1991 data, Table 69 in each volume.

African-American high school students report using alcohol, tobacco and other drugs at lower rates than their white counterparts.²⁴ However, despite apparently lower levels of drug use, young African Americans and Latinos are disproportionately targeted by law enforcement for drug-related offenses.²⁵ This is one of the most troubling aspects of the current drug control regime.²⁶

Even experimental or occasional use of alcohol and other drugs may, and often does, result in a youth's contact with the criminal justice system. Such contact may, in itself, be the first slip in a downhill slope towards aggravated problems at home, poor school performance, drug abuse and the stigma of "delinquency." Adolescents' propensity to challenge authority is evidenced by the fact that rising levels of juvenile use of alcohol and other drugs have occurred during the same period of increased law enforcement activity. In consideration of this trend, the Task Force seriously questions the deterrent effect of criminal justice enforcement related to drug use among our youth, and has concluded that *the "war on drugs," with its emphasis on criminal justice enforcement, has been more harmful to youth than the use of the drugs themselves.*²⁷ The Task Force believes that drug use and drug abuse should be treated as a social and public health problem rather than as a criminal justice problem, particularly in regard to our youth.

Opportunity for Cost Savings

For society at large, alcohol, tobacco and other drug abuse by young people does extract a cost in health care, educational failure, mental health services, addiction treatment and juvenile crime. A recent study concluded that each youth who drops out of school and falls into a life of drug abuse and crime will cost society from \$1.7 to \$2.3 million.²⁸ This suggests the practical wisdom of a public policy that seeks to avoid those costs.

The National Institute on Drug Abuse has found that "for every dollar spent on drug abuse prevention, communities can save four to five dollars in costs for drug abuse treatment and counseling."²⁹ Accordingly, increased investment in an effective drug abuse prevention strategy would be a prudent means of saving future public costs. Rather than "getting kids out of trouble," the Task Force believes it would be wiser to "keep kids out of trouble."

²⁴ Only 30 percent of African-American students reported using marijuana in the last year, compared with 40 percent of white students. In addition, white students were seven times more likely than African Americans to have used cocaine in the past year and three times as likely to have ever tried heroin. See Office of Juvenile Justice and Delinquency Prevention (1999), *Juvenile Offenders and Victims*, 1999 National Report, U. S. Department of Justice, Washington, D. C., pp. 58-59, 70-71.

²⁵ African-American youth account for a disproportionately high 29 percent of all arrests for "drug abuse violations." Although the same is thought to be true for Latino youth, there is no reliable data because Latinos are not classified separately from "whites." See Federal Bureau of Investigation (2000), *op. cit.*, pp. 230-232.

²⁶ Another task force of the King County Bar Association's Drug Policy Project is examining the disproportional racial impact of current drug policies and the problem of racial profiling.

²⁷ Another task force of the King County Bar Association's Drug Policy Project is examining the use of criminal sanctions in connection with illicit drugs, including many such unintended consequences of the "war on drugs."

²⁸ Office of Juvenile Justice and Delinquency Prevention (1999), *Juvenile Offenders and Victims*, *op. cit.*, citing a study by Mark Cohen estimating the external marginal costs imposed on society by the average career criminal, heavy drug abuser and high school dropout. For drug abuse, the present value (*i.e.*, the amount needed to be invested today to cover the future cost) is between \$150,000 and \$360,000. This figure does not include costs associated with drug-motivated and other drug-related crime, estimated at between \$220,000 and \$600,000 per youth, discounted to present value.

²⁹ National Institute on Drug Abuse (1997), *Preventing Drug Use Among Children and Adolescents*, Washington, D. C., March 1997.

II. Trying to Explain Juvenile Substance Abuse: Risk Factors and Protective Factors

The findings above reveal that many young people experiment with alcohol, tobacco and other drugs, but the Task Force is concerned about the serious problems that can arise when experimentation evolves into regular or habitual use, and then even further into dependence and addiction. A principal challenge, therefore, is to identify those children and adolescents who are most highly at risk of initiating tobacco use and of using alcohol and other drugs excessively, and to fashion interventions that effectively prevent such abuse. To guide the development of such a prevention strategy, it is important to understand the interplay of factors related to juvenile substance abuse.

All children are vulnerable to the risks of substance abuse, regardless of ethnicity or social class, and it is difficult to predict with certainty which children will use alcohol and other drugs excessively. Poverty is one principal risk factor, but current research has shed light on the other risk factors that increase the likelihood of substance abuse, as well as the important *protective* factors that help to mitigate such problems. This research, much of which has been conducted by scholars from the University of Washington, is helping to guide the design of more effective strategies to prevent substance abuse among our youth.³⁰

Risk Factors

Children and adolescents are exposed to risks in many different domains, including in their homes, at school, with their friends and in the larger community. The various identified risk factors for substance abuse and other problem behaviors have generally been segregated into those domains for better analysis and policy planning:³¹

Community Domain³²

- Availability of alcohol, tobacco and other drugs
- Norms favorable to alcohol, tobacco and other drug use
- Economic and social deprivation
- Community disorganization
- High level of neighborhood transition and mobility

³⁰ The risk factor-protective factor approach has been developed by J. David Hawkins, Richard Catalano and associates from the Social Development Research Group at the University of Washington. The U. S. Department of Health and Human Services (Substance Abuse and Mental Health Services Administration) and the National Institute on Drug Abuse, as well as the Washington State Division of Alcohol and Substance Abuse, have each incorporated this concept into their programs, including needs assessments and the development and evaluation of drug abuse prevention programs.

³¹ J. David Hawkins, Richard Catalano *et al.* (1992), *Communities That Care: Action for Drug Abuse Prevention*, Jossey Bass Publishers, San Francisco, CA. See also Office of Applied Studies, Substance Abuse and Mental Health Services Administration (2000), *Risk and Protective Factors for Adolescent Drug Use: Findings from the 1997 National Household Survey on Drug Abuse*, U. S. Department of Health and Human Services, Rockville, MD.

³² Levels of risk in the community are assessed by measures such as the number of alcohol retail and tobacco sales licenses, the community perception of the availability of illegal drugs, the numbers of children receiving free lunch at school, the number of food stamp recipients, the number of low birthweight babies born, the level of unemployment, the number of community members in jail and prison, the level of residential vacancy and the percentage of households in rental properties.

Risk Factors (cont.)

*Family Domain*³³

- Parent-child conflict
- Family substance abuse and/or mental illness
- Family management problems

School Domain

- Early and persistent anti-social behavior (kindergarten to 3rd grade)
- Poor academic performance in late elementary grades
- Low commitment and attendance
- Dropping out of high school

Peer/Individual Domain

- Rebelliousness and anti-social behavior
- Friends' use of alcohol, tobacco and other drugs
- Favorable attitudes towards alcohol, tobacco and other drugs
- Perception of low risk from the use of alcohol, tobacco and other drugs

While these risk factors are important predictors of substance abuse, the effect of any one risk factor can be blunted by other, more positive environmental influences in a child's life (those "protective factors" are discussed below). However, exposure to two risk factors makes a child *four* times as likely to develop problem behaviors, and exposure to multiple risk factors substantially increases the likelihood that a child will move from drug experimentation to serious substance abuse by the teenage years.³⁴

Although it may seem obvious, it is important to recognize that one of the most prominent risk factors for substance abuse is the availability, both real and perceived, of alcohol and other drugs. Recent state survey data from Washington show how students believe it is easy to obtain these substances:³⁵

Percentage of Washington Students Reporting "Easy to Obtain" Illicit Drugs

	<u>6th Grade</u>	<u>8th Grade</u>	<u>10th Grade</u>	<u>12th Grade</u>
Alcohol	25%	53%	75%	83%
Tobacco	33	62	82	93
Marijuana	11	40	67	77

The figures above seem to confirm the frequently-stated anecdote that "kids know where to get drugs better than adults do." Further, the survey data show that youth find some illegal drugs even easier to obtain than alcohol.³⁶

³³ In addition to harsh and arbitrary parenting, risk factors in the family domain include domestic violence and divorce, unstable foster care arrangements and other situations where children live away from their parents.

³⁴ J. David Hawkins *et al.* (1992), "Risk and Protective Factors for Alcohol and Other Drug Problems in Adolescence and Early Adulthood: Implications for Substance Abuse Prevention," *op. cit.*, p. 85.

³⁵ Linda Becker, Ph.D., Maija Sandberg, Vera Barga and Monica Stanley (2000), *Risk and Protection Profile for Substance Abuse Prevention Planning in Washington State*, Division of Alcohol and Substance Abuse, Olympia, WA, p. 22.

³⁶ For example, the Center on Addiction and Substance Abuse reports that teenagers consider marijuana easier to obtain than beer. See Luntz Research (1996), *National Survey of American Attitudes on Substance Abuse II: Teens and Their Parents*, National Center on Addiction and Substance Abuse, Columbia University, New York.

Based on this evidence, the Task Force repeats that, despite decades of vigorous law enforcement in connection with the “war on drugs,” the growing extent to which juveniles can obtain illicit substances further suggests the futility of the criminal justice response to juvenile drug use. The blanket prohibition of certain drugs has prevented their regulation by the state, causing their distribution and supply, purity and price to be controlled by organized crime and a pervasive black market. The Task Force expects that *more effective regulation and control of those drugs by the state would go a long way toward achieving the goal of reducing their availability to minors.*³⁷

Other risk factors in the community domain, such as economic deprivation and neighborhood disorganization, are extremely difficult to assess. However, the community domain is the most important arena for drug abuse prevention planning, because local attitudes, beliefs and standards establish the context for all other activities. Where schools, households, peer groups and individuals all exist within the community domain, prevention programs are either enhanced or undermined by factors present in the larger community.³⁸ Understanding this, many states are promoting community-wide mobilization as a prevention strategy, which requires long-term planning, significant public investment and a considerable amount of patience.³⁹

Protective Factors

While a child is exposed to various risks, there may be other circumstances that help to dampen negative influences and help the child become more resilient, including:

- strong and positive bonds within a pro-social family
- consistent enforcement of clear rules of conduct within the family
- close parental monitoring
- successful school performance
- strong bonds with other pro-social institutions
- development of healthy norms about alcohol and drug use.⁴⁰

In general, protective factors are those opportunities that allow the child to form attachments with others and to make commitments to people and projects. When youth form meaningful bonds with parents, teachers, mentors and peers, and when they receive consistent recognition and reinforcement of healthy behavior, they are better able to develop the skills needed to succeed.⁴¹ Opportunities to participate meaningfully in school activities and in responsibilities at home reduce the likelihood that youth will engage in alcohol or other drug use or develop substance abuse and other problem behaviors.⁴²

³⁷ The King County Bar Association’s Task Force on the Use of Criminal Sanctions is surveying alternative models for drug control, including state regulatory regimes that would more effectively reduce the availability of alcohol, tobacco and other drugs to minors.

³⁸ Linda Becker *et al.* (2000), *op. cit.*, p. 21.

³⁹ *Ibid.*

⁴⁰ See J. David Hawkins, Richard Catalano *et al.* (1992), *Communities That Care, op. cit.* “Pro-social” institutions include civic and religious organizations, scouting groups and school clubs and athletic teams.

⁴¹ *Ibid.*, p. 72. A key to preventing problem behavior in children is teaching them self-control. A more child-centered approach to teaching problem solving and conflict resolution, whereby children learn to control their own behavior, has proven more effective than direct adult control of children’s behavior.

⁴² *Ibid;* see also Linda Becker *et al.* (2000), *op. cit.*, pp. 50, 85 and 98.

Washington State Profile

In 2000, the State Division of Alcohol and Substance Abuse completed an assessment of the risk factors and protective factors present in communities throughout Washington. Some of the most noteworthy findings from that study include the following:⁴³

- In recent years there has been a considerable increase in the percentage of students who perceive community laws and norms as favorable to drug use (about 50% of high school seniors and 42% of 10th graders).
- About 20 percent of retail liquor establishments sell liquor to underage customers, and a significant number of businesses sell tobacco to underage customers (from 15 percent to 30 percent, depending on the county).
- The percentage of students at risk because of low neighborhood attachment has increased in the last few years (about one third of all students).
- Almost 50 percent of high school seniors and almost 40 percent of 10th graders are at risk due to low commitment to school.

These findings suggest that the prospects for Washington's adolescents are mixed at best. The Task Force is concerned that our youth have inadequate opportunities for meaningful "pro-social involvement," which could be more broadly available with greater public investment. Examples of such pro-social involvement, which research has shown to be associated with reduced levels of substance abuse and other problems, include:⁴⁴

- participation in music, art or performing arts programs
- attendance at religious services once a week
- ability to talk with parents and friends about problems (other than drugs)
- participation in youth groups, clubs or civic activities
- participation in athletic activities

The Task Force believes that these types of alternative activities, which provide young people with opportunities for creativity, personal expression and the strengthening of personal relationships, should be a central feature of any youth-focused prevention strategy.

Co-Occurring Behaviors and the "Gateway Theory" Fallacy

Research has consistently shown that youth involved with alcohol, tobacco and other drugs also engage in illegal activities and other problem behaviors. However, it is extremely important to note that the mere co-occurrence of drug use and problem behaviors does not mean that drug use *causes* other problem behaviors. In fact, long-established research has shown that problem behaviors among youth often *precede* the use of alcohol, tobacco and other drugs.⁴⁵ The more effective drug abuse prevention programs reveal that drug use *per se* is not necessarily the most important indicator of higher risk. Instead, truancy, poor school performance and low school attachment, early sexual activity, depression and suicidal behavior, which are often accompanied by drug use, are often the principal focus

⁴³ Linda Becker *et al.* (2000), *op. cit.*, pp. 22-23, 27-28, 35, 74 and 83.

⁴⁴ Office of Applied Studies, Substance Abuse and Mental Health Services Administration (2000), *Risk and Protective Factors for Adolescent Drug Use: Findings from the 1997 National Household Survey on Drug Abuse*, U. S. Department of Health and Human Services, Rockville, MD.

⁴⁵ See, e.g., P. Reuter, R. MacCoun and P. Murphy (1990), *Money from Crime: A Study of the Economics of Drug Dealing in Washington, D. C.*, RAND, Washington, D. C., who found that most individuals first engage in criminal activities, including theft, as juveniles, a year or two before they become drug users.

for intervention.⁴⁶ Considering these findings, the Task Force believes that merely trying to prevent or reduce alcohol or other drug use by itself will not significantly reduce the incidence of drug abuse and other problem behaviors, and that a more effective strategy would be to *address the risk factors that are thought to underlie most problem behaviors, of which drug abuse is only one example.*

Just as there is no cause-effect relationship between drug use and problem behaviors, no scientific or clinical research has shown any causal relationship between the use of any one drug and the use of another, including the assertion that marijuana use leads to the use of harder drugs.⁴⁷ The Institute of Medicine issued a report in 1999 on numerous aspects of marijuana, including the so-called “gateway theory,” and found no conclusive evidence that the drug effects of marijuana are linked to the subsequent use of other illicit drugs.⁴⁸ Over 72 million Americans have used marijuana, yet for every 120 marijuana users there is only one active, regular user of cocaine.⁴⁹ If there is any association between marijuana and other illegal drugs, it is the fact that it is *illegal*, and that exposure to other drugs when purchasing marijuana on the black market increases the opportunity to use other drugs.⁵⁰

The substances most frequently used by minors are alcohol and tobacco.⁵¹ Furthermore, adolescents who use alcohol and tobacco are more likely to use other illicit drugs.⁵² Although the “gateway theory” is invalid and there is no cause-effect relationship between alcohol and tobacco use and the use of other illicit substances, their correlation strongly suggests that *the most effective substance abuse prevention strategy should emphasize prevention of alcohol and tobacco use by minors.*

⁴⁶ For example, the Reconnecting Youth program (briefly reviewed below on p. 22), developed by the University of Washington School of Nursing, is an intervention that focuses on preventing drug abuse and high school dropout. 40% of the youth in that program have also been very depressed and/or thinking about suicide. By dealing simultaneously with multiple problem behaviors that tend to co-occur, the Reconnecting Youth program has shown significant results in suicide prevention as well as drug abuse prevention. See L. L. Eggert and B. P. Randell (forthcoming), “Drug Prevention Research for Youth at High Risk,” in W. J. Bukoski and Z. Sloboda, *Handbook of Drug Abuse Theory, Science and Practice*, Plenum Books, New York; and also L. L. Eggert *et al.* (forthcoming), “Reconnecting Youth to Prevent Drug Abuse, School Dropout, and Suicidal Behaviors Among High-Risk Youth,” in E. Wagner and H. B. Waldron, eds., *Innovations in Adolescent Substance Abuse Intervention*, Elsevier Science, Oxford, England.

⁴⁷ J. C. Merrill and K. S. Fox (1994), *Cigarettes, Alcohol, Marijuana: Gateways to Illicit Drug Use*, National Center on Addiction and Substance Abuse, Columbia University, New York, introduction.

⁴⁸ Janet E. Joy, Stanley J. Watson, Jr. and John A. Benson, Jr. (1999), *Marijuana and Medicine: Assessing the Science Base*, National Academy Press, Washington, D. C.

⁴⁹ Substance Abuse and Mental Health Services Administration (1999), *National Household Survey on Drug Abuse: Population Estimates 1998*, U. S. Department of Health and Human Services, Washington, D. C., pp. 19, 25, 31.

⁵⁰ See, e.g., W. Hall, R. Room and S. Bondy (1998), *WHO Project on Health Implications of Cannabis Use*, World Health Organization, Geneva, Switzerland.

⁵¹ Alcohol use is prevalent particularly among adolescent males, and tobacco use is most prevalent among adolescent females. Nels Ericson (2001), *op. cit.*, p. 2.

⁵² According to a 1999 national survey, more than 40 percent of youth cigarette smokers report using illicit drugs in the past month, compared to less than 6 percent of non-smokers. Similarly, almost 67 percent of juveniles who regularly drink alcohol report illicit drug use in the past month, compared to less than 6 percent of non-drinkers. Substance Abuse and Mental Health Services Administration (2000), *Summary of Findings from the 1999 National Household Survey on Drug Abuse*, U. S. Department of Health and Human Services, Rockville, MD, p. 15. The same survey revealed that alcohol and tobacco use by minors generally occurs earlier than the use of other illicit substances – the mean age of first cigarette use was 15.4 years old and the mean age of first alcohol use was 16.1 years old, compared to the mean age of first marijuana use at 17.2 years old. *Ibid.*, pp. G-49, G-60 and G-61.

III. The Promise and Perils of Substance Abuse Prevention Programs

Changing Approaches to Prevention

The history of drug abuse prevention has shown very limited success. The early days of drug abuse prevention focused on scare tactics and moral suasion, exemplified by *Reefer Madness*, a notorious film produced by the Federal Bureau of Narcotics in the late 1930s, which portrayed a “respectable” young man turned into a crazed criminal after taking one puff of marijuana. The prevailing attitude reflected in that film, however, did not lose credibility until the 1960s, when sweeping cultural change included a generalized challenge to authority, and youth stopped believing negative messages about drugs.⁵³

In the late 1960s, drug education programs in schools began to focus on the pharmacology, the psychological effects and the health hazards of drug use, targeting high school students as they began to experiment with drugs, but such programs had no measurable impact on drug use.⁵⁴ By the late 1970s, two principal theories had developed to guide school-based prevention efforts – “social learning” theory and “problem behavior” theory. “Social learning” theory proposes that adolescents learn by directly modeling the behavior of peers and adults and reinforce the beliefs, attitudes and behavior of those around them. School lessons designed to undermine adolescents’ “misguided” beliefs about substance use by their peers are the type of curriculum components informed by “social learning” theory.⁵⁵ By contrast, “problem behavior” theory posits that adolescents use illicit substances to fulfill certain needs and to cope with social anxiety, rejection, social isolation, boredom, low self-esteem, lack of self-efficacy, *etc.* Lessons designed to teach “life skills” and to foster “pro-social” development and social competency are the central curriculum components arising out of “problem behavior” theory.⁵⁶

To this day, many drug abuse prevention programs are still based on either the “social learning” or “problem behavior” theories, as they attempt to impart social or life skills to youth and also attempt to dispel beliefs regarding the prevalence and frequency of drug use among peers. However, despite the popularity of these programs, their formal evaluation has revealed only limited effectiveness in preventing or reducing alcohol and other drug use among children and adolescents. The “problem behavior” theory has been called into question recently by research demonstrating that “a large proportion of persistent serious delinquents are not involved in persistent drug use,” challenging the notion that similar factors validly predict a wide range of problem behaviors.⁵⁷ Other rigorously-designed and large-scale evaluations of the “social learning” approach have also shown most such programs as ineffective in preventing substance use and/or abuse over the long term.⁵⁸

⁵³ Mathea Falco (1992), *The Making of a Drug-Free America*, Times Books, New York, p. 33.

⁵⁴ For a comprehensive review of earlier school-based prevention programs, see Gilbert J. Botvin (1990), “Substance Abuse Prevention: Theory, Practice and Effectiveness,” in Michael Tonry and James Q. Wilson, eds., *Drugs and Crime*, University of Chicago Press, Chicago, pp. 461-519.

⁵⁵ See A. Bandura (1977), *Social Learning Theory*, Prentice-Hall Books, Englewood Cliffs, NJ.

⁵⁶ See R. Jessor and S. L. Jessor (1977), *Problem Behavior and Psychosocial Development: A Longitudinal Study of Youth*, Academic Press, N.Y.

⁵⁷ Huizing *et al.* (2000), *op. cit.*, p. 5.

⁵⁸ See, *e.g.*, comments by A. V. Peterson, K. A. Kealy *et al.* (2000), “Hutchinson Smoking Prevention Project: Long-term Randomized Trial in School-based Tobacco Use Prevention,” *Journal of the National Cancer Institute*, 92(24), p. 1988.

The Failure of D.A.R.E.

The most widely implemented and well-known school-based “prevention” program is the Drug Abuse Resistance Education (D.A.R.E.) program, which consists of a series of lectures by uniformed police officers to 5th graders. The program focuses on information about the negative effects of drugs and on developing certain attitudes and values in making a moral commitment not to use drugs. The overall thrust of D.A.R.E. has been compared to the type of dogmatic indoctrination common in prevention programs from decades past, as the police use scare tactics in asking: “Do you know what drugs will do to you even if you mess around with them just once?” and “Do you know you must commit yourself to never trying them?”⁵⁹

The D.A.R.E. program has a contract with about 80 percent of the nation’s school districts. With multiple sources of revenue, including private contributions, government grants, special events and license royalties, D.A.R.E. has become a lucrative enterprise with its corporate officers earning six-figure salaries. With friends in Congress, the D.A.R.E. program is the only drug education program to receive non-competitive grants from the government, through special earmarks in federal appropriations bills. National estimates of the annual cost of the D.A.R.E. program are about \$1 billion.⁶⁰

Despite the apparent popularity of the D.A.R.E. program, recent results from disinterested and objective evaluations have demonstrated that D.A.R.E. has not reduced drug use.⁶¹ Further, in some cases the D.A.R.E. program has been linked to *increased* drug use, particularly among suburban youth.⁶² School administrators, faced with a wide variety of federally-supported “prevention” programs, have often chosen the most aggressively marketed package, as D.A.R.E. has relieved schools of having to train teachers or administer the program.⁶³ However, using police officers has divorced the program’s message from students’ daily learning, so the material has not been reinforced in regular classes, and in any event, the program’s “just say no” message has not been persuasive.⁶⁴

In response to criticism, D.A.R.E. officials are now planning a different approach. It remains to be seen whether the re-engineering of D.A.R.E. will render it any more effective, as it is being modeled after the Life Skills Training program (briefly reviewed below), whose own effectiveness has recently been partly discredited.⁶⁵

⁵⁹ Nicholas Pastore (2001), “New DARE Can Succeed If It Is Honest,” *On Balance*, Criminal Justice Policy Foundation, Washington, D. C., p. 9.

⁶⁰ Information obtained from Professor Ted Shepard, Department of Economics, LeMoyne College, Syracuse, NY, June 1, 2001, and from Michael Roona of the Social Capital Development Corporation, Albany, NY, July 25, 2001.

⁶¹ Donald R. Lynam, Richard Milich *et al.* (1999), “Project DARE: No Effects at 10-Year Follow-Up,” *Journal of Consulting and Clinical Psychology*, American Psychological Association, Washington, D. C., Vol. 67, No. 4, pp. 590-593, who state that there are “no reliable short-term, long-term, early adolescent or young adult positive outcomes associated with receiving the DARE intervention.” *See also* S. T. Ennett *et al.* (1994), “How Effective is Drug Abuse Resistance Education? A Meta-Analysis of Project DARE Outcome Evaluations,” *American Journal of Public Health*, Vol. 84, pp. 1394-1401.

⁶² Dennis Rosenbaum (1998), *Assessing the Effects of School-Based Drug Education: A Six Year Multilevel Analysis of Project DARE*, University of Illinois at Chicago, Abstract (April 6, 1998).

⁶³ Matthea Falco (1992), *op. cit.*, pp. 43-44.

⁶⁴ Richard Clayton *et al.* (1991), “Persuasive Communication and Drug Prevention: An Evaluation of the DARE Program,” in Lewis Donohew *et al.*, *Persuasive Communication and Drug Abuse Prevention*, Erlbaum Associates, Hillsdale, NJ.

⁶⁵ Kate Zernike, “Antidrug Program Says It Will Adopt A New Strategy,” *New York Times*, Feb. 15, 2001.

Searching for Effective Prevention Programs

The Task Force acknowledges the critical role of supportive families and communities in helping children to develop the skills needed to resist or postpone using alcohol and other drugs.⁶⁶ As a matter of social policy, however, the Task Force believes that increased public investment in school-based programs that reinforce those necessary social skills should be a high priority. The challenge, however, is to identify those programs that have been proven effective over the long term in delaying or reducing alcohol, tobacco and other drug abuse as well as the harm associated with their use.

Prevention strategies have been designed to address varying levels of risk, and the “dose” of intervention needed depends on the constellation of risk and protective factors present in each situation. *Universal* programs target all youth without identifying those at particularly high levels of risk. *Selective* programs aim interventions at those youth who are deemed more vulnerable to drug use because of personal, family and community risk factors. *Indicated* programs are intensive efforts aimed at youth already using alcohol and other drugs and exhibiting other problem behaviors.⁶⁷

Evaluation of universal school-based drug education programs has revealed that non-interactive, lecture-oriented programs that stress drug knowledge and/or focus on building self-esteem have not effectively prevented or reduced alcohol and other drug use by youth.⁶⁸ Such non-interactive programs, including D.A.R.E., have not provided a means for students to acquire “refusal” skills, nor have they given students adequate opportunities to consider the costs and benefits of drug use to enable them to make rationally-informed decisions about drug use.⁶⁹

Universal school-based drug education programs that are interactive and have a discussion-based format have been shown to be a somewhat more effective prevention strategy. The latest research indicates that students respond more favorably to interactive programs that place mental health clinicians or students’ peers as discussion leaders, rather than police officers or teachers without special training.⁷⁰ This finding presents a valuable opportunity for schools, because although the cost of a mental health clinician in every school would be substantial, the use of peer leaders instead could be a cost-effective way to increase program effectiveness.⁷¹

⁶⁶ See, e.g., Michael D. Resnick *et al.* (1997), “Protecting Adolescents From Harm,” *Journal of the American Medical Association*, 278, showing that 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, at p. 823.

⁶⁷ National Institute on Drug Abuse (1997), *Preventing Drug Use Among Children and Adolescents: A Research-Based Guide*, Rockville, MD.

⁶⁸ Nancy S. Tobler, Michael R. Roona *et al.* (2000), “School-Based Adolescent Drug Prevention Programs: 1998 Meta-Analysis,” *Journal of Primary Prevention*, Vol. 20, No. 4, p. 317.

⁶⁹ *Ibid.*

⁷⁰ *Ibid.*, p. 322. For peer leaders to be effective, however, training, supervision and teacher/staff support are essential. See Botvin, Baker *et al.* (1990), “A Cognitive Behavioral Approach to Substance Abuse Prevention,” *Addictive Behaviors*, 15, 47-63.

⁷¹ Kitsap County, Washington has successfully used peer mentors in the schools to work with younger children who need additional social and academic support. Although not in the context of a universal drug education program, the Kitsap County program has received special recognition for using teen mentors as positive role models to help younger children gain self-confidence and reduce their risk for problem behaviors. Linda Becker *et al.* (2000), *op. cit.*, p. 75

Interactive programs specifically targeting tobacco have been particularly effective, where youth see the message of lifetime abstinence as more reasonable than in the case of alcohol, where abstinence is restricted only until the legal age is reached. The message of complete lifetime abstinence from tobacco is lost in a generalized prevention program dealing with the use of all substances; hence the need to develop and implement tobacco-only prevention programs.⁷² Based on this finding, the Task Force strongly believes that tobacco-only prevention programs should be widely implemented in the schools.

“System-Wide Change”

Of all the universal, school-based prevention programs, the most effective have followed the “system-wide change” model, which involves a wholesale transformation of the school atmosphere, engaging students more fully and involving the students’ families and community, while attempting to alter the social norms and expectations.⁷³ One of the most celebrated of these comprehensive prevention programs is the **Child Development Project**, established in Oakland, California in 1981.

The Child Development Project is a research-based school improvement initiative intended to transform elementary schools into “caring communities of learners.” The principal goal of the project is to enhance pro-social characteristics in children that allow them to resolve conflicts with greater skill, and that give them an increased sense of social competence. With participation of parents and extended families, and with training and a high level of commitment of teachers and school administrators, the Child Development Project focuses on building a strong sense of community in school and further promotes change in classroom climate, curriculum and teaching style.⁷⁴ The program is based on the presumption that the risks of substance abuse can be reduced by nurturing a student’s desire to learn, by cultivating supportive relationships and by promoting a sense of common purpose. Formal evaluation of the program has revealed a decrease in the early use of alcohol and tobacco and, as distinguished from other “prevention” programs, the positive effects have been found to continue for many years afterward.⁷⁵

The “system-wide change” approach recognizes the importance of culture in changing behavior and of the utility of involving the larger community in reinforcing classroom instruction and discussion. The strategy requires competent and committed school leadership as well as significant commitments from community and family members, so it would be difficult to replicate in many locations. Nevertheless, the few examples of “system-wide change” have been shown to reduce early initiation of alcohol, tobacco and marijuana, thereby helping to reduce youth substance abuse and other problem behaviors. The Task Force believes the “system-wide change” model could be successfully implemented in Washington, perhaps in a strategically selected neighborhood in Seattle.

⁷² Nancy S. Tobler, Michael R. Roona *et al.* (2000), *op. cit.*, p. 323.

⁷³ See Michael R. Roona, Andrei V. Streke and Diana G. Marshall (publication forthcoming), “Effective School-Based Drug Education Programs for Adolescents,” in *Encyclopedia of Primary and Health Promotion*.

⁷⁴ U. S. Department of Education (1995), *Education Programs That Work*, Washington, D. C.

⁷⁵ D. Solomon, V. Battistich, M. Watson, E. Schaps and C. Lewis (2000), “A Six-District Study of Educational Change: Direct and Mediated Effects of the Child Development Project,” *Social Psychology of Education*, Vol. 4 pp. 3-51; V. Battistich, E. Schaps, M. Watson and D. Solomon (1996), “Prevention Effects of the Child Development Project,” *Journal of Adolescent Research*, Vol. 11, pp. 12-35; D. Solomon *et al.* (1996), “Creating Classrooms that Students Experience as Communities,” *American Journal of Community Psychology*, Vol. 24, pp. 719-748.

“Social Influences” and “Comprehensive Life Skills”

In addition to the “system-wide change” model, there are two other types of universal school-based prevention approaches that are easier to implement, although they have shown less promise, especially over the long term. One is the “social influences” model and the other is the “comprehensive life skills” model. Each are aimed at youth exhibiting “normative” adolescent behaviors such as experimental drug use.⁷⁶

The “social influences” programs inform students about the negative short- and long-term consequences of drug use, provide information to change the perception that “everyone is doing it,” and examine pro-drug media influences. In an interactive setting, students use role-playing, rehearsals, immediate feedback and positive reinforcement from peers to build a set of “refusal” skills.⁷⁷

One of the most comprehensive prevention efforts using the “social influences” approach is the **STAR Project**, initiated in Kansas City in the mid-1980s and replicated in Indianapolis. The STAR Project involves schools, mass media, parents, community volunteers and health policymakers. Classroom sessions seek to teach resistance skills and to clarify misperceptions about drug use. Classroom teaching is reinforced with community prevention efforts (such as better monitoring of convenience stores and other outlets for alcohol) and media campaigns, and also with structured at-home discussions between parents and their children about alcohol and other drugs.⁷⁸ Formal evaluation of the STAR program showed reductions in tobacco and marijuana use among middle school students, including among “high-risk” students.⁷⁹ The classroom instruction was deemed the most essential element of the program, as the media and community prevention efforts would have had little effect without “high-quality prevention teaching.”⁸⁰ This suggests that the classroom setting might be the most effective environment for drug education, at least for middle school students.

Another noteworthy program following the “social influences” model is **Project ALERT** (Adolescent Learning Experiences in Resistance Training), developed at the RAND Corporation, and replicated in many locations. The ALERT program provides a two-year period of classroom lessons in a specific sequence taught by trained teachers and counselors to middle school students. Parent involvement is included through a home-learning program. The program emphasizes resisting pro-drug social influences and attempts to show that students overestimate the frequency and/or quantity of drug use by their peers.⁸¹ Evaluation of Project ALERT has shown some beneficial effects on alcohol use, but no effect on tobacco use.⁸²

⁷⁶ Nancy S. Tobler, Michael R. Roona *et al.* (2000), *op. cit.*, p. 317.

⁷⁷ *Ibid.*, p. 318.

⁷⁸ National Institute on Drug Abuse (2001), “Studying Comprehensive Drug Abuse Prevention Strategies,” *NIDA Notes*, research news, Vol. 14, No. 5, pp. 1-2

⁷⁹ Mary Ann Pentz, J. H. Dwyer, D. P. Mackinnon *et al.* (1989), “A Multicommunity Trial for Primary Prevention of Adolescent Drug Abuse,” *Journal of the American Medical Association*, Vol. 261, pp. 3259-66; and Mary Ann Pentz, E. A. Trebow, William B. Hansen *et al.* (1990), “Effects of Program Implementation on Adolescent Drug Use Behavior,” *Evaluation Review*, Vol. 14, pp. 264-289.

⁸⁰ C. Anderson Johnson, Mary Ann Pentz, Mark Weber *et al.* (1990), “Relative Effectiveness of Comprehensive Community Programming for Drug Abuse Prevention with High-Risk and Low-Risk Adolescents,” *Journal of Consulting and Clinical Psychology*, Vol. 58, No. 4, pp. 447-456.

⁸¹ Phyllis L. Ellickson (1998), “Preventing Adolescent Substance Use: Lessons from the Project ALERT Program,” in Jonathan Crane, ed., *Social Programs That Really Work*, Russell Sage, New York.

⁸² Michael R. Roona, Andrei V. Streke and Diana G. Marshall (publication forthcoming), *op. cit.*, draft 2, p. 9.

The “comprehensive life skills” programs are similar to the “social influences” model, but in addition to helping foster students’ *interpersonal* skills (such as refusal skills), the “comprehensive life skills” programs attempt to impart a broader spectrum of skills such as assertiveness, decision-making, coping, communicating and goal setting – skills built on the more *intrapersonal* sense of competence.⁸³

The most well-known and long-standing “comprehensive life skills” program is the **Life Skills Training** (LST) program, developed more than 20 years ago at Cornell University and implemented in many school districts across the country.⁸⁴ The LST program reports marked decreases in alcohol, tobacco and marijuana use among participating youth, but those findings have lately been called into question, particularly because of the evaluation methodology.⁸⁵ Recent independent analysis has shown the LST program yielding some beneficial effects with regard to teen tobacco use, but no favorable long-term effects with alcohol use.⁸⁶ The D.A.R.E. program, in its current attempt to refashion itself as a more interactive program, is borrowing pages from the LST playbook, but this Task Force is skeptical about the prospects for the new D.A.R.E. model because of the questions surrounding the effectiveness of the LST program, among other reasons.

Identifying the Key Elements

Despite the mixed findings from the evaluation of universal drug education programs, research has identified the central features of a school-based substance abuse prevention strategy:⁸⁷

- 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;
- Help students develop personal, social and refusal skills to resist these pressures;
- Teach that alcohol, tobacco and other drug use is not as pervasive as it seems, even if students believe “everyone is doing it;”
- Provide developmentally-appropriate material and activities, including information about the short-term effects and long-term consequences of using alcohol, tobacco and other drugs;
- Use interactive teaching techniques, such as role playing, discussions, “brainstorming” and cooperative learning;
- Actively involve the family and community; and
- Include instructor training and support, and provide material that is easy to implement and culturally relevant for students.

⁸³ *Ibid.*, p. 318.

⁸⁴ See G. J. Botvin, E. Baker, N. Renick, A. D. Filazzola and E. M. Botvin (1984), “A Cognitive-Behavioral Approach to Substance Abuse Prevention,” *Addictive Behaviors*, Vol. 9, pp. 137-147

⁸⁵ Dennis Gorman (1998), “The Irrelevance of Evidence in the Development of School-Based Drug Prevention Policy, 1986-1996,” *Evaluation Review*, Vol. 22, No. 1, pp.118-146; See also Joel H. Brown (2001), “Youth Drugs and Resilience Education,” *Journal of Drug Education*, Vol. 31, No. 1.

⁸⁶ Michael R. Roona, Andrei V. Streke and Diana G. Marshall (publication forthcoming), *op.cit*, draft 2, p. 9.

⁸⁷ Drug Strategies, Inc. (1999), *Making the Grade: A Guide to School Drug Prevention Programs*, Office of Justice Programs, U. S. Department of Justice, Washington, D. C.

It is important to note that *all* of the above features are essential for an effective drug education program, particularly the necessary training and commitment of instructors and the active involvement of the family and community. Research has shown time and again that partial or selective implementation of the elements of a drug education program will render it ineffective.⁸⁸

Although some universal school-based programs seem to have modest effects in preventing or reducing substance use among youth, recent research has shown that certain models are more appropriate with certain age groups than with others, and that certain models are more effective with regard to certain drugs. For instance, the “social influences” model seems to be effective in reducing alcohol and marijuana use among middle school students, but is clearly ineffective with elementary and high school students. Conversely, the “comprehensive life skills” model seems to be more effective in reducing alcohol and marijuana use at the elementary and high school levels, and more effective at reducing tobacco use at all grade levels.⁸⁹ Applying the same intervention to different age groups could result in different outcomes; for example, teaching middle school students to conform to social norms might result in a reduction in alcohol use, whereas teaching high school students to conform to social norms might result in an increase in alcohol use (where drinking to get drunk is normative behavior at that age). These findings indicate the need for a more sophisticated understanding of the different stages of development of each grade level and the varying degrees to which students at different ages will be receptive to different approaches.

The Proper Outcome Measure – Use or Abuse?

In its review of many of the major, school-based universal drug education programs, the Task Force has found that the weight of the evidence reveals those programs’ limited effectiveness in reducing alcohol, tobacco and other drug use, particularly over the long term.⁹⁰ The Task Force believes that prevention programs’ seemingly marginal effectiveness can be explained largely by the fact that the outcome measure is drug *use* rather than drug *abuse*. Conflating drug use with drug abuse, as discussed above, can lead to the assumption that all drug use is harmful, and also deflects attention away from the proven hazards of alcohol and tobacco. If the outcome measure of prevention programs were substance abuse, or more appropriately, the *harm caused by excessive substance use*, the programs referred to above would be deemed very successful, as only a very small number of youth experience serious problem behaviors.⁹¹

⁸⁸ See, e.g., R. Windsor, T. Baranowski *et al.* (1994), *Evaluation of Health Promotion, Health Education and Disease Prevention Programs*, Mayfield Press, Mountain View, CA, 2nd edition, and also G. Botvin, E. Baker *et al.* (1984), “Prevention of Alcohol Misuse Through the Development of Personal and Social Competence,” *Journal of Studies on Alcohol*, 45(6), who report program failures due to lack of teacher training or commitment or teachers not including elements of a program with which they are uncomfortable, such as role playing.

⁸⁹ Michael R. Roona, Andrei V. Streke and Diana G. Marshall (publication forthcoming), *op. cit.*, pp. 10-12.

⁹⁰ A team of RAND researchers recently confirmed this finding. Examining the results from the “gold standard” prevention programs such as ALERT and Life Skills Training, the RAND study looked at their effects on lifetime cocaine consumption and found very small effects – an average reduction of 8 percent in cocaine use over a 40-year period. J. P. Caulkins, C. P. Rydell, S. S. Everingham, J. Chiesa and S. Bushway (1999), *An Ounce of Prevention, A Pound of Uncertainty: The Cost-Effectiveness of School-Based Drug Prevention Programs*, Drug Policy Research Center, RAND Corporation, Santa Monica, CA.

⁹¹ Michael R. Roona, Andrei V. Streke and Diana G. Marshall (publication forthcoming), *op. cit.*

Unique Opportunities in Washington State – Targeted Programs

Universal prevention programs generally fail to target the small number of youth who account for most of the alcohol and other drug abuse. Resources are now devoted to reducing the prevalence of use among the vast majority of youth who will never develop substance abuse problems, and the Task Force is concerned that inadequate resources are devoted to the small number of youth who presently have real problems. The Task Force believes that the “**selective**” and “**indicated**” programs, which focus on high-risk youth, are a more cost-effective and efficacious strategy for preventing substance abuse, and believes they should receive greater emphasis from state and educational policymakers.

Washington is a national leader in the current effort to design and implement prevention programs intended for higher-risk youth. Three programs developed at the University of Washington have been recognized by the National Institute on Drug Abuse, the U. S. Department of Education, the U. S. Department of Health and Human Services and the Office of National Drug Control Policy as some of the most promising strategies in the country aimed at preventing substance abuse and other problem behaviors:

Incredible Years

The Incredible Years program is designed for pre-school and elementary school settings, focusing on children who are experiencing conduct problems, such as aggression, non-compliance and defiance, behaviors that are predictive of delinquency, violence and other antisocial behavior. The training series includes separate curricula for parents, teachers and children, all with the goal of promoting children’s social adjustment and competence. Workshop leaders are trained and certified and there is extensive collaboration with school administrators, day care facilities and clinicians. Formal evaluation of the program has shown reduced levels of aggressiveness, impulsiveness and defiance, particularly for children who live in conditions of deprivation and/or in distressed family situations, including divorce and child abuse and neglect.⁹² The federal Office of Juvenile Justice and Delinquency Prevention (OJJDP) has noted an increase in conduct problems among more children at earlier ages and has expressed particular concern over escalating aggression in pre-school and elementary school. OJJDP has highlighted the Incredible Years program as a model prevention strategy for such children, and the program has been adopted by hundreds of agencies serving youth in 43 states.⁹³

⁹² C. Webster-Stratton, T. Hollinsworth and M. Kolpacoff (1989), “The Long-Term Effectiveness and Clinical Significance of Three Cost-Effective Training Programs for Families with Conduct-Problem Children,” *Journal of Consulting and Clinical Psychology*, Vol. 56, No. 4, pp. 550-553; *see also* T. K. Taylor, F. Schmidt, D. Pepler and H. Hodgins (1998), “A Comparison of Eclectic Treatment with Webster-Stratton’s Parents and Children Series: A Randomized Control Trial,” *Behavior Therapy*, Vol. 29, pp. 221-240.

⁹³ Office of Juvenile Justice and Delinquency Prevention, U. S. Department of Justice, Washington, D. C.

Reconnecting Youth

Developed at the University of Washington School of Nursing, the Reconnecting Youth program is a high school dropout, suicide and substance abuse prevention program, featuring a semester-long curriculum designed to promote school performance, to decrease involvement with alcohol and other drugs, and to improve mood management. Taken as a separate class in school, the program offers opportunities for healthy activities, including parent involvement. Evaluation of the program has shown significant results with improved school performance and decreased drug involvement, depression, anger and aggression and suicidal and self-destructive behaviors.⁹⁴

Social Development Research Group

Established in 1981 at the University of Washington School of Social Work, the Social Development Research Group has been conducting the Seattle Social Development Project, now called _____ (SOAR), as a research-based program to reduce school failure, delinquency and substance abuse. The program is designed to be a *universal* prevention program, although the research on which it is based – the seminal work on the risk factor/protective factor paradigm – was originally focused on high-risk children.⁹⁵

SOAR is intended for an elementary classroom setting, including all grades from first through sixth. The program's instructional curriculum aims to strengthen bonds between children, families and schools. Children are taught to work in cooperative learning groups, parents are taught to monitor, reward and discipline their children, and teachers are specially trained in classroom management techniques so as to resolve conflict and maintain order. Initial evaluations of the project showed reductions in school expulsions, delinquent behavior and alcohol use, and girls in the program delayed their alcohol, tobacco and other drug use.⁹⁶ More recently, the Washington State Institute for Public Policy conducted an independent cost-effectiveness analysis of the Seattle Social Development Project and found that the program would save the taxpayer \$3,268 for each participant, the difference between the cost of the program and the estimated avoided criminal justice costs.⁹⁷

Washington is fortunate to have such exceptional resources available locally for the design and implementation of substance abuse prevention programs. The Task Force believes Washington should capitalize on these resources in developing an improved statewide, youth-focused, substance abuse prevention plan.

⁹⁴ L. L. Eggert and B. P. Randell (forthcoming) in W. J. Bukoski and Z. Sloboda, *Handbook of Drug Abuse Theory, Science and Practice*; and L. L. Eggert *et al.* (forthcoming) in E. Wagner and H. B. Waldron, eds., *Innovations in Adolescent Substance Abuse Intervention*, *op. cit.*

⁹⁵ J. David Hawkins *et al.* (1992), "Risk and Protective Factors for Alcohol and Other Drug Problems in Adolescence and Early Adulthood: Implications for Substance Abuse Prevention," *op. cit.*

⁹⁶ *Ibid.*

⁹⁷ Washington State Institute for Public Policy (1998), *Watching the Bottom Line: Cost Effective Interventions for Reducing Crime in Washington*, Olympia, WA. The research estimated a 25 percent reduction in felony offenses by age 25 as a result of intervention. The six-year program costs a total of \$2,991 per student, but the program was estimated to save taxpayers an estimated \$3,068 per student in avoided criminal justice costs and an estimated \$3,991 per student from associated crime victim costs (1997 dollars).

IV. Improving Washington's Drug Abuse Prevention Strategy

Despite some progress in furthering our understanding of the factors associated with substance abuse, prevention science is still in its infancy. The bulk of recent research, based on the “risk and protective factor” paradigm outlined in this report, has illustrated the need for youth to develop healthy bonds with peers and adults, to take on meaningful responsibilities, to be recognized and rewarded and ultimately, to develop an increased sense of self-worth and to make informed decisions. However, researchers are still struggling to explain what accounts for the success of prevention programs that “work.”⁹⁸ Furthermore, putting prevention theory into practice has been extremely difficult, as prevention programs have too often suffered from faulty design, insufficient resources, inadequate training and commitment of teachers and a lack of support from school administrators.

If Washington is to deal effectively with preventing and minimizing the harm from substance abuse, more resources should be allocated for research-validated, school-based and community-based prevention programs, and also for measures to ensure their proper implementation. Washington is just beginning to establish a statewide structure for implementing youth-focused substance abuse prevention programs, but much more work needs to be done. What follows is a brief review of state-sponsored prevention programs, which the Task Force believes could inform the development of an improved comprehensive, statewide substance abuse prevention plan.

Current Strategies and Programs in Washington

Washington State's 1994 Violence Prevention Act created the Community Public Health and Safety Networks and directed them to focus efforts on eight, specific at-risk youth behaviors, including: teenage pregnancy, suicide, substance abuse, dropping out of school, violence, child abuse/neglect, domestic violence and out-of-home placements.⁹⁹ Relevant state agencies also address these same concerns through many of their programs and activities.¹⁰⁰

The State Division of Alcohol and Substance Abuse (DASA) is the primary state agency designated to develop drug abuse prevention strategies. Its two main prevention goals are to delay the onset of use and to reduce the misuse of alcohol, tobacco and other drugs. DASA has adopted a “risk and protective factor” approach as the cornerstone of its efforts to prevent alcohol and other drug abuse by children and adolescents in Washington State.

DASA's prevention programs include the following:

⁹⁸ The National Institute on Drug Abuse acknowledges that very little is known about why certain drug abuse prevention programs work, and is currently awarding grants for research into this question. See Center for Scientific Review (2001), *RFA – Drug Abuse Prevention Programs*, National Institutes of Health, Bethesda, MD.

⁹⁹ See RCW 70.190.

¹⁰⁰ Washington State budgeted approximately \$162.8 million during the 1999-2001 biennium for prevention programs related to the 8 outcomes identified in the 1994 legislation. About 60% of these monies were from state sources, 36% from the federal government, and 4% from other sources. See Washington State Institute for Public Policy (2001), *How Much Money Does Washington State Spend on Prevention Programs for Youth?*, Olympia, WA.

DASA Prevention Services

Prevention services are designed to reduce the incidence of new chemical dependency and early intervention of early users. DASA primarily contracts with 36 counties and has government-to-government agreements with tribal nations. Services are tied to risk factors. Additionally, DASA provides funds for individual training events on reducing risk factors and increasing protective factors. One of the primary performance measures for this program is to increase the number of 6th, 8th and 10th graders who abstain from using alcohol, tobacco or marijuana for a 30-day period. DASA also passes funds to the Office of the Superintendent of Public Instruction for substance abuse prevention services for grades K-12. Funding for all of these services totaled almost \$16 million for the 1999-2001 biennium.

Children's Transition Initiative (CTI)

Based on statewide risk and protective factor data, and prevalence data collected through the 1998 Washington State Adolescent Health Behavior Survey, DASA has begun piloting a new Children's Transition Initiative (CTI), the goal of which is to prevent children, ages 9-16, from using alcohol, tobacco and other drugs. Through CTI, existing county programs will identify discrete youth populations at high risk for drug initiation. Prevention programming will be specifically tailored for each group, depending on their individual risk factors, protective factors and assets. To date, more than 100 children and families have been enrolled into CTI services in Clark, Ferry, Lewis, Pierce, Columbia, Spokane and Grant counties. The DASA budget for CTI for the 2001-2003 biennium is \$380,000.

Drug Information Clearinghouse

DASA contracts with the Washington State Alcohol & Drug Clearinghouse to provide communities, schools and individuals with access to information about alcohol, tobacco and other drugs. Available resources include videos, posters and written materials. The budget for this program for the 2001-2003 biennium is \$380,000.

Community Prevention Training System

DASA provides training support and funds to county and tribal prevention programs through DASA's Regional Prevention Managers. This program, established in 1994, was budgeted at \$340,000 for the 1999-2001 biennium.

Washington State Substance Abuse College Task Force

The mission of the task force is to provide support for the development and continuation of substance abuse prevention programs on all college and university campuses in Washington through networking, technical assistance and an annual conference. The program was established in 1985, and since 1988 has been funded by DASA for travel, training, and administrative assistance. The 2001-2003 budget is \$40,000.

Other state-sponsored prevention programs and activities are conducted by the Department of Community, Trade and Economic Development and the Office of the Superintendent of Public Instruction, including the following:

Community Mobilization Against Substance Abuse and Violence

This program makes grants to local communities to develop and implement comprehensive strategies to reduce the demand and supply of illegal drugs and the misuse of alcohol and tobacco by minors. The program received \$6 million in funding during the 1991-2001 biennium.

Prevention and Intervention Services Program (PISP)

PISP is a school-based drug and alcohol abuse prevention and early intervention program. Intervention specialists assist K-12 students to overcome problems of substance abuse and strive to prevent the abuse of and addiction to alcohol and other drugs, including nicotine. The goal of the program is to provide prevention and intervention services in schools to enhance the classroom environment for students and teachers and better enable students to realize their academic and personal potentials. This program received funding of \$10.2 million during 1999-2001 biennium.

Safe and Drug-Free Schools

This program provides tobacco, alcohol and other drug and violence prevention activities in schools throughout the state. A variety of programs focused on increasing safety and improving school climate are funded through this program. Funding amounted to \$10.6 million during the 1999-2001 biennium.

Alcohol Awareness and Parent Training

Eight school districts have been awarded grants for the purpose of providing training for parents regarding how to communicate effectively with their children. Grades K through 3 are especially targeted. Funding for this initiative amounted to \$300,000 during the 1999-2001 biennium.

State Incentive Grant

In July 1998, Washington State received a 4-year, \$8.9 million State Incentive Grant (SIG) from the federal Center for Substance Abuse Prevention to fund initiatives to reduce use of alcohol, tobacco, marijuana and other drugs, to reduce factors that put youth (grades 4-10) at risk for substance abuse and to enhance factors that provide protection for youth against these risks. DASA is the lead agency for managing this grant, with the Department of Social and Health Service's Research and Data Analysis Division as the primary evaluator.¹⁰¹ In March 1999, the Governor issued a Washington State Substance Abuse Prevention Plan, and state agencies participating in SIG are engaged in the process of changing the system by which substance abuse prevention services are planned, funded, delivered and monitored in this state. 18 community projects in 15 counties are currently receiving SIG funding.

¹⁰¹ In April 2001, DASA published an evaluation progress report, *Washington State Incentive Grant – State and Community-Level Evaluation Report Autumn 2000*.

This Task Force applauds the state’s attempt to implement a substance abuse prevention strategy, but is also troubled by the apparent ineffectiveness of this effort, despite the expenditure of millions of dollars. The prevalence of alcohol, tobacco and other drug use by minors in Washington has not decreased, particularly among younger children, and so the risks of substance abuse and other problem behaviors have not decreased.

The Task Force looks forward to the results of the Children’s Transition Initiative (CTI), which seems to be based on the kind of rigorous research that has been the foundation for effective prevention programs. Unfortunately, however, the Task Force suspects that significant funding is also being devoted to abstinence-only programs that have been shown to be ineffective (particularly through the “Safe and Drug-Free Schools” program), and also to universal programs aimed at all youth rather than the more cost-effective and efficacious programs targeted at “high-risk” youth.

The effort to improve Washington’s prevention strategy is clearly in flux at the moment, and the Task Force hopes to help move this effort in the right direction by making the following recommendations:

Recommendations for a More Effective Prevention Strategy

This Task Force conducted a fairly lengthy review of current research, policy and programming related to substance abuse prevention, including some promising programs that have been developed here in Washington. However, despite the collection and analysis of a considerable amount of data, the Task Force does not presume to have the expertise to recommend specific programs or approaches. Those choices would be better left to the scholars, practitioners and public officials working every day in the field. Instead, the Task Force identifies below the principal goals for Washington’s prevention strategy and makes one major recommendation, supported by a series of broad, conceptual recommendations, to guide the next phase in the development of that strategy:

■ *Prevention Goals*

The Task Force believes Washington’s overall prevention goals should be:

- 1) to prevent or delay the use of alcohol, tobacco and other drugs among young people;
- 2) to reduce the harm from and curb the progression of alcohol, tobacco and other drug use among youth who have already begun;
- 3) to reduce the other problem behaviors that can co-occur with the use of alcohol, tobacco and other drugs; and
- 4) to increase the availability of school- and community-based prevention services, especially for vulnerable groups and high-risk individuals.

■ *Major Recommendation – Substance Abuse Prevention Panel*

To achieve the goals articulated above, The Task Force recommends that **a special working group of statewide experts be authorized by the Legislature to improve upon Washington’s comprehensive substance abuse prevention plan.** This special statewide panel, composed of state and local educational and health officials, scholars, clinicians, parents, teachers and students, should build on the work already begun by the State Division of Alcohol and Substance Abuse and would be qualified to make specific recommendations for a comprehensive prevention plan to be authorized by the Legislature. The plan should incorporate state-of-the-art substance abuse prevention programming that meets Washington’s needs.

■ *Supporting Recommendations*

For the people of Washington, an investment in research-validated programs to prevent, delay and reduce the harm from the use of alcohol, tobacco and other drugs will help to avert the much higher costs of drug treatment, criminal justice and social and health services that would otherwise arise. Reallocating funding away from drug-related criminal enforcement and toward substance abuse prevention will also reflect the proper emphasis on substance abuse as principally a social and public health problem. As a guide to the experts on the recommended statewide substance abuse prevention panel, the Task Force sets forth the following broad recommendations, based on its survey of current research, for the development of a substance abuse prevention plan in Washington:

- 1) Any effective substance abuse prevention strategy requires that attention be paid to *the social and psychological problems underlying substance abuse*, so as to help give our young people genuine opportunities to lead fulfilling lives. Drug abuse prevention should be part of a broader *youth development* strategy, reaching beyond mere drug education and helping young people to develop the needed social and self-management skills to make responsible decisions in the broader contexts of their lives.
- 2) To be most cost-effective, prevention programs should focus primarily on those youth who are most at risk of developing a range of problem behaviors, which include substance abuse, but also include poor school performance and low school attachment, delinquency, depression and suicidal behavior.
- 3) The appropriate outcome measure for prevention programming should not be drug use, but rather drug *abuse*, or more specifically, the *harm resulting from excessive drug use*. From this perspective, a core feature of Washington’s prevention strategy should be the prevention of alcohol and tobacco use among minors.
- 4) Abstinence-only programs in schools, while generally ineffective or counterproductive in preventing alcohol and other drug use, seem to be effective in preventing tobacco use; therefore, tobacco-only abstinence programs are highly recommended.
- 5) Adequate training and commitment of teachers, counselors and discussion leaders is essential for an effective school-based prevention program, as is commitment and support from administration.

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