CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

A TRAINING MANUAL
FOR ALCOHOLISM PREVENTION PROVIDERS

A graduate project submitted in partial satisfaction of the requirements for the degree of Master of Public Health by Beth Linda Schechter

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ABSTRACT

A TRAINING MANUAL FOR
ALCOHOLISM PREVENTION PROVIDERS

by

Beth Linda Schechter
Master of Public Health

The purpose of this project was to develop and evaluate an instructional manual for providers of alcoholism prevention services. Owing to the absence of explicit guidelines for alcoholism prevention programming in Los Angeles County, this manual was designed to assist the providers to effectively plan alcoholism prevention programs.

Prevention training workshops were developed and conducted by the Investigator. The workshops were utilized in large part as the means to derive information relevant to the development of an instructional manual that could be used as a reference tool and guideline by the prevention providers.

A review of the prevention literature and a needs assessment of alcoholism prevention workers helped the
Investigator to identify specific information regarding the areas which needed special attention in the manual. A needs assessment disclosed that alcoholism prevention workers required training in program planning specifically in prevention theories and definitions; preliminary planning activities; goal and objective development; implementation strategies and evaluation.

A training manual was designed and constructed by the Investigator. The manual included content which addressed the areas defined in the needs assessment. An instrument was constructed to assess the utility, format, and adaptability of the manual for prevention programming. A panel of eight prevention experts reviewed the manual and provided consensual validation for its usefulness. The experts generally agreed that the Investigator had developed a tool that would be useful in the planning and implementation of present and future prevention programs.
Chapter 1

INTRODUCTION

Alcoholism and alcohol abuse have been steadily rising each year. The rate of alcoholism over the last decade increased from one out of fifteen [who drink] to one out of ten, and perhaps now one out of seven (22). There are approximately ten million alcoholics in this country today, which is considered to be a conservative estimate. In order to reduce this drastic rise in alcohol abuse, a new approach must be initiated, that of prevention. Through planned and coordinated activities, many potential alcohol abusers could be reached before alcoholism becomes a problem.

The prevention of problem drinking and alcoholism has received national, state, and county attention and has been included in state and federal priorities and needs. A statement of needs for federal endeavors in health for 1979-80 included the need to "Acquire knowledge regarding the causes, prevention, and treatment of disease and promote preventive measures by which good health can be obtained (1:4)." The National Institute of Alcohol Abuse and Alcoholism, the California State Department of Alcohol and Drug Abuse, the Education Commission of the
States, and the National Council on Alcohol, have all stressed that the development of alcoholism prevention plans and programs was the number one priority for their administrations (30:7). In the Los Angeles County Office on Alcohol Abuse and Alcoholism [OAAA] 1977-78 Alcoholism Program Budget, it was stated that

> Prevention has come to be recognized as the only modality which can significantly reduce the incidence of alcoholism. Prevention will be a major priority for Los Angeles County in fiscal year 1978-79 (22:1.26).

**Statement of the Problem**

The Los Angeles County Office on Alcohol Abuse and Alcoholism in 1980 had contracts with five regional alcoholism prevention providers, and three countywide prevention providers. Specific services requested in the prevention and education contract included: the development of planned and coordinated activities using goals and measurable objectives which could be used for program evaluation, the identification of a target group(s), and determination of alcohol educational requirements of the area to be served.

Alcoholism prevention providers appeared to have little knowledge or understanding of this type of planning as reflected by inadequate contract compliance for fiscal years 1977-78 and 1978-79 and a lack of
demonstrated ability. In addition, the County Board of Supervisors, the Director of the County Department of Health Services, and the Administrator of the County Office on Alcohol Abuse and Alcoholism asked for hard data that supported whether the prevention and education services accomplished what they were supposed to. Owing to the lack of goals and measurable objectives, there was no adequate evaluation guidelines relevant to these programs from within their agencies or from OAAA. It therefore became increasingly difficult to justify the continued funding of these programs to those with financial control. Thus, it became more difficult to get approval for the addition of new prevention programs to the County budget.

The prevention and planning staff at OAAA decided that all prevention programs must have developed goals and measureable objectives by July 1979. There was then a critical need to assist the providers in accomplishing this goal through training sessions which provided practical skills and application of prevention program planning and evaluation.

No matter how much money was allocated for prevention or how politically popular it was, prevention activities had little effect unless they were well planned and coordinated. Planners must have a good grasp of current prevention strategies i.e., decision making
skills, values clarification, communication development, alternatives to drug use, and self-esteem improvement, and must be able to communicate them to others. It was the belief of this Investigator that the achievement and implementation of good program planning for alcoholism prevention required a certain amount of talent, but more importantly, proper training and skill development. Therefore, a critical need existed to train Los Angeles County Alcoholism Prevention Providers in skills that would assist them in planning and implementing prevention programs.

There was an additional need for the development of a Prevention Providers Training Manual which could be used to train future providers as well as serve as a reference for present providers. No such manual existed. Both of the services needed, training sessions and training manual, had been requested by the prevention providers, who showed concern with their lack of expertise in the area of program planning.

**Purposes of the Project**

The purposes of this project were to:

1. Identify and document the training needs of the major Alcoholism Prevention Providers in Los Angeles County.
Assumption

The prevention providers lacked some or all of the skills and knowledge necessary for program planning. It was possible to determine their weaknesses and to document the findings.

2. Facilitate the development of good program planning skills by providing informational and experiential training sessions for the providers in prevention program planning.

Assumption

The training sessions provided the participants with information necessary to aid in improved program planning. The training sessions provided this Investigator with further clarification of the training needs of the providers.

3. Develop a Prevention Providers Training Manual based on the needs identified in a needs assessment process.

Assumption

The participants of the training sessions were assessed via a needs assessment instrument. The needs assessment instrument covered most aspects of the training requirements of the prevention providers.
4. Validate the utility of the training manual by utilizing a group of experts involved in the prevention of alcohol or drug abuse.

Assumption

By offering the manual to experts for review, their recommendations and clarifications aided in further improving its utility. The group of experts presumably had experience in program planning and training.

Project Limitation

Since it is assumed that the manual will be utilized by many different alcohol program professionals, the actual usefulness of the manual will depend upon the individual's prior level of planning knowledge and expertise.

Definition of Terms

Contract - A legal binding agreement made between a provider and the County for the provision of a specified service

Contract Compliance - Performing or providing all services and obligations in accordance with a legally binding contract

Countywide Provider - Contracted to provide services on a County-wide basis
Drug Abuse Prevention - Includes the primary prevention of all potentially harmful substances, including alcohol.

Fiscal Year - The period of time from July 1st of the present year to June 30th of the following year.

Modality - A specific category of service within a broader group of elements that are coordinated to achieve a goal.

Primary Prevention - The application of procedures to reduce the occurrence of drinking problems in a community. It centers upon preventing and minimizing the development of new cases, or lowering the incidence.

Program Planning - The process used to determine what to do and how to do it before taking action when developing a program.

Provider - The furnisher of a specific service or modality.

Regional Provider - Contracted to provide services within one of the five Health Service Regions in Los Angeles County.

Secondary Prevention - Early casefinding and treatment of existing problems, or reducing prevalence.
Student - Any person involved in a learning situation; may or may not be in a school setting

Substance Abuse - All chemical or drug-like substances that are abused

Tertiary Prevention - Provides treatment and rehabilitation services for the chronically ill, so as to prevent further complications or involvement with alcohol.
Chapter 2

REVIEW OF THE LITERATURE

In 1970, President Nixon signed legislation which established the National Institute on Alcohol Abuse and Alcoholism [NIAAA]. Since that time a growing awareness has spread through the land of both urgency and feasibility of mounting programs for the treatment and control of alcoholism (8:5). It is a medical truism, however, that almost no condition has ever been eradicated only by treating its casualties (8:5). It is important to realize that if significant inroads are to be made in terms of decreasing the prevalence of alcoholism, this will be accomplished not through treatment but by reducing the incidence, that is, prevention (41:431).

Alcoholism has been classified as a progressive and degenerative disease which can be cured and most importantly prevented. There is, however, no "right" or "one" way to prevent alcohol problems. Chafetz, Noble and Cohen agreed that alcohol abuse leading to alcoholism, is the product of many factors: biological, social, and psychological, each interacting in different ways in different individuals (8) (9) (40).
If prevention activities are to be effective, there must be a thorough understanding of the theories and strategies that are available in the field of prevention. Prevention efforts have tended to be remedial rather than preventive, with programs being adjuncts to treatment (33:5).

The purpose of this literature review was to provide information relevant to the design and development of a training manual for prevention workers. Therefore, the following sections of this review will lend coherency to the approach used in the development and design of a training manual.

Models of Prevention

The first section of this review includes a description of what current literature can provide relevant to the most current, popular, and feasible models for the prevention of alcohol abuse and related alcohol problems.

The National Institute on Alcohol Abuse and Alcoholism in its Third Special Report to Congress on Alcohol and Health, June 1978, adopted a public health model of prevention.

According to public health principles, problems are seen as stemming from an interaction of three factors: the host, the agent, and the environment. Intervention at any or all of these points is appropriate for the prevention of a problem. In dealing with alcohol problems, the public health model
becomes: Host - the individual and his or her knowledge about alcohol, the attitudes that influence drinking patterns, and the drinking behavior itself; Agent - alcohol, its content, distribution, and availability; Environment - the setting or context in which drinking occurs and the community mores that influence the drinker (40:94).

Although strategies focusing on any of the three factors may overlap or complement work directed at the others the public health model provides a useful framework for understanding and organizing prevention programs.

Blane felt that although the public health model made many contributions to contemporary discussions about reducing alcohol problems and although effective in the control and prevention of many infectious diseases, it did not appear to possess the structural capability for preventing social-behavioral problems (5:178). Blane stated that the public health model placed emphasis on secondary prevention, which was concerned with early identification and early treatment, or arresting a disorder before it became fully developed (5:178).

Although early identification and treatment represent good clinical practice and should be a component of a comprehensive prevention plan, the ultimate preventive effect of secondary prevention was questioned (5:179).

The two models concerned with primary prevention of alcohol abuse, or the reduction of new incidences of the problem, were the social science model termed the
"sociocultural approach" by Whitehead, and the levels of consumption model, termed the "distribution of consumption approach" by Lederman (21) (41).

The sociocultural approach consisted of three distinct but closely related aspects: an emphasis on normative structure, integration of drinking into other socially meaningful activities, and gradual socialization of drinking behaviors (5:176). Many social scientists had observed that societies which prohibited excessive drinking, prescribed moderate drinking, and agreed about the rules governing drinking, had low rates of drinking problems. It had been presumed that societies could substantially reduce alcohol problems by manipulating the normative or set structure, using mass media, public education and general consciousness raising to aid in redefining and clarifying norms (5:176).

Integrated drinking referred to the subordination of drinking behavior to other activities, particularly family, religious and recreational pursuits, rather than it being the prime organizing principle of a social activity. The manner and context in which drinking was socialized had been shown to be important determinates of adult drinking behaviors. Societies which introduced children to alcohol early in life, gradually, and in a value context which supported integrated drinking but forbade
drunkenness, had low problem rates (5:177).

Wilkinson argued that drinking problems could be reduced by encouraging people to develop healthful drinking practices. These include drinking wine with meals, and integrating the use of alcoholic beverages into a wide variety of social settings, such as sport events and in bright cheery taverns where people meet their friends rather than simply to drink (42).

This Investigator felt that although the socio-cultural approach dominated the direction of efforts to reduce alcohol problems in the United States, it is important to consider other approaches.

A third prevention model frequently referred to in the literature was the distribution of consumption approach. This approach, introduced by Lederman in 1956, and expanded upon by Popham, Schmidt, and de Lint of the Addiction Research Foundation in Canada, suggested that per capita consumption should be lowered in order to reduce the incidence of alcoholism. Research on the distribution of alcohol consumption led to the conclusion that: a) the general character of the distribution is possibly unalterable, that is, it tends to remain log-normal; b) alcohol consumption is closely related to liver cirrhosis mortality; and c) per capita consumption is highly correlated with rates of death due to cirrhosis
of the liver (41:434).

Ways and means of lowering alcohol consumption that had been employed or suggested in various countries at various times included: state vs. private control of distribution and sale of alcoholic beverages; reduction of hours of sale; restrictions of number, dispersion, and diversity of alcoholic beverage outlets, increases in the cost of alcohol with adjustments made according to changes in income; lowering alcohol content of beverages and introduction of heavy taxes on distilled spirits as well as beer and wine (5) (29) (41).

The consumption model, as the other two prevention models, had many criticisms. The model had a narrow definition of alcohol problems, confining them to alcoholism and related physical pathologies; its restrictive pricing policies could have increased explosive drinking and its associated social and behavioral problems; general consumption might have been supplemented by an increase in illegally produced alcoholic beverages; attempts legal or illegal to subvert the pricing policy could have reinforced the ambivalent mystique that surrounds the use of alcohol in many Western societies, thus perpetuating alcohol-related problems (5:180-181).

In conclusion, this Investigator saw the consumption approach as an overt attempt to modify behavior with
the use of external manipulative forces. This approach thus ignored the internal motivational forces that lead an individual to adopt and/or continue a drinking behavior.

The accepted models of alcohol abuse prevention provided a good introduction to the prevention field for program planners and workers. Each model contained aspects that aid in the development of a comprehensive prevention program which should not be overlooked. However, none of the models contained all the answers to the difficult question of how to prevent alcohol abuse.

This Investigator believed that the complex nature of alcohol abuse and alcoholism should be considered when planning a prevention program. If the many biological, social, and psychological factors that lead an individual to abuse alcohol are overlooked, then a program cannot be effective.

Approaches to Prevention Programming

Supported by a rationale that had emerged after many years of experimentation, the field of drug abuse prevention has grown in sophistication and professionalism (31:18). Substance abuse became to be understood as a complex phenomenon suggesting deeper problems. There were several opinions of what a substance abuse prevention
Dearden believed that substance abuse was a social phenomenon, and felt that positive alternatives must be provided by fulfilling students' needs for recognition, identity, self-esteem, and leadership. Sensitivity and encounter groups were thought to be one avenue of achieving this goal (12).

Kelley and Conroy believed that basic human needs such as the need for affection, respect, knowledge, understanding, the skill of decision making, and the sense of right is in every human being from the earliest years and that there is a constant interchange of decisions related to these needs. Alcohol and drug abuse indicate a dysfunctional way of coping with one or several of these needs which should in turn be addressed in any program (20:55).

Aubrey reported that difficulties in drug education arose because decisions concerning drugs involved a combination of cognitive-affective elements, and presentation of only factual or intellectual evidence was not enough (2). Boe found that statistics did not motivate and, instead of using a strictly factual approach, students were given opportunities to have experiences in order to gain their own insights. They were then able to make better decisions about drugs if they knew the
alternatives, and had guidelines for themselves through an analysis of attitudes, influences and motivations (6:14).

Barter and Werme also stressed the decision-making issue as well as personal implications and personal choice as important factors to be included (3). Pearce extended this concept to include the total person: spiritual, social, emotional, intellectual and physical. He stressed preparing the individual emotionally for making behavioral choices based on their beliefs (28:86-87).

Several authors felt that scare tactics were ineffective and should be avoided, as should "shotgun" or crash programs, since attitude changes required long periods of time (16) (24) (25). Other authors felt the objective approach should be followed. For example, 1) avoid "preaching" of moralistic or punitive attitudes, 2) attempt to give both sides of an issue, 3) avoid sensationalizing of the drug issue (7:1283). However, understanding and objectivity should not be allowed to be construed as approval of drugs (4).

Prevention prospects lay in three areas, according to Daniel: 1) fortifying personalities to better tolerate life stresses and to use coping methods more dependable than alcohol, 2) reducing stresses that press people into alcoholic escape, and 3) modifying social drinking
customs that perpetuated high alcohol consumption (10:35). Programs that enhanced individual competence and coping skills or improved the environment of families, schools and other youth-serving institutions could also help to prevent many other destructive or negative kinds of behavior associated with drug abuse; for example, truancy, vandalism, juvenile crime, runaways, and similar problems (31:35).

Three main program goals were delineated by Richards: 1) prevent the use of substance abuse, 2) give enough information so that people can make rational decisions for themselves, not necessarily crusading against drugs, and 3) promote an increased understanding of all factors accounting for drug use, including related social attitudes and policies, and work towards changes in these (32).

The goals of substance abuse prevention programs have broadened in recent years from increasing cognitive understanding to changing attitudes, values and behaviors. Therefore, a variety of prevention activities, termed strategies, have been developed and expanded upon since the early 1970's (31).

Prevention activities have been referred to as specific and nonspecific. Nonspecific strategies were usually pursued for reasons other than to prevent alcohol
use; specific were presumed to reduce directly the rate of drinking problems (11:10). This Investigator preferred to describe the following strategies without the label of specific or nonspecific since activities overlap and contain qualities of both.

**Prevention Strategies**

Many strategies for the prevention of drug and alcohol abuse had been identified in the literature by the Pacific Institute for Research and Evaluation and the National Institute on Drug Abuse. Six of the most commonly used strategies will be described by this Investigator.

**Strategy One: Information**

Several authors felt that alcohol and drug information by itself was insufficient to produce the desired behavioral outcomes of prevention. The Third Interim Report of the Education Commission of the States on Responsible Decisions about Alcohol (1975) indicated that information programs do not in themselves form complete prevention programs, but that they play an important part in decision making about alcohol. They recommended that in addition to information, alcohol abuse prevention programs should seek to increase the participants decision making skills (17:15).
The now defunct White House Special Action Office for Drug Abuse Prevention (1973) determined that careful and judicious use of information about drugs and their effects can and should be an important component of a prevention program. However, the critical questions considered before the strategy is used were: What kind of information? In what setting will it be presented? And, who will do the presenting?

Simpson, of the Orange County Department of Education believed that curiosity was the motivating force that leads young people to initially try a drug or alcohol. It therefore followed that by providing information about the substance we were merely feeding and encouraging that curiosity (39).

**Strategy Two: Affective Education**

Affective education had become the mainstay of school-based drug and alcohol prevention programs (31:23). However, the activities that made-up affective education were not always identified as a form of drug abuse prevention. Affective education had much in common with the human potential movement of the 1960's and 1970's. Techniques that stimulated fantasy and role playing, that helped people to "get in touch with their feelings" in order to understand themselves and communicate more effectively with others could be found in school and community
based affective education programs (31:23).

The variety of affective education curriculums and programs were enormous. Therefore, the Investigator chose to describe those which were considered most important by the National Institute on Drug Abuse and the Pacific Institute for Research and Evaluation, for the prevention of substance abuse. These included:

a. **Valuing and Values Clarification.** Maslow believed that our basic human needs: physiological, safety (security), love and belonging, esteem, self-actualization, to know and understand, and aesthetic needs, evolved into wants, aspirations, and goals (23). If sought after and affirmed constantly, they became values - the personal guideposts for the miriade of decisions made in our daily lives (20:55). Alcohol and drug abuse was thought to be the result of deprivation of one or several of these needs. This deprivation began long before the drug decision was made and manifested itself in detectable behaviors early in a child (20:55).

The valuing process was an approach to promoting good mental health through activities dealing with the realm of feelings and attitudes. Valuing, according to Raths, consisted of prizing one's beliefs and behaviors, choosing one's beliefs and behaviors, and acting on one's beliefs; and rested on the premise that only on the basis
of clearly recognized values can people make conscious, well informed choices and decisions (38). Values clarification was structured activities that were concerned with developing and enhancing valuing.

b. Decision-Making. Much of the psychological work on decision making and risk taking has been rather theoretical, abstract and difficult to translate into real-life terms (15). It was assumed that facts, values and possibly goals were components of a choice, and should have been part of the decision making process (15:253).

This process of decision making involved a series of identifiable steps: 1) define the problem or conflict, 2) list the possible choices or alternative ways of resolving the problem or conflict, 3) investigate the consequences of each of the alternative resolutions or choices, 4) choose the alternative that was most satisfying to the individual or group. Although there were numerous variations on these problem-solving steps in the literature on affective education, these four steps represented the essential process (3:26).

c. Self-Esteem Building. A person's self-esteem and sense of self worth was considered linked into almost all activities and experiences of that persons life. Activities included recognizing and accepting feelings
such as joy, anger, fear, disappointment, or affection; sharing aspects of oneself with other group members, and encouraging individual differences (31:24). If there was trust and confidence in the group and facilitator, a miriade of personal and controversial topics could be discussed and resolved.

Examples of self-esteem related programs were most commonly found in school settings. However, it was thought they could be adapted to community settings as well.

This Investigator felt that activities that enhance self-esteem should be considered for inclusion in all prevention programs.

One effect of alcohol intoxication is the release of inhibitions and the resultant positive feelings one experiences about oneself. If individuals experienced these good feelings through structured activities that improve self-esteem rather than through the use of alcohol, a major motivating reason for alcohol use could be eliminated.

Affective education in and of itself did not stand alone in a school or community based prevention program. The different processes described could be included in a comprehensive prevention program which promoted positive health practices (20:56). It was important that a teacher, facilitator and/or educator felt
comfortable with the affective techniques he or she pre-
sented and functioned well in an informal, open-ended
situation (31:26)

Strategy Three: Alternatives

The alternative approach as another option for
prevention suggested that alcohol use problems could be
diminished as other and satisfying means of fulfilling
human needs were made accessible (26:21). Cohen believed
that drug abuse was a response to an experience defi-
ciency. He felt our institutions were not providing an
adequate context for the kinds of exploration and experi-
ence that meet human needs. Therefore they sustained
some of the underlying motives for drug use (27:1-2).

Nowlis of the Department of Education, Health
Education and Welfare, felt that

At one level young people and adults as well,
need to learn to live wisely in an environment
increasingly dominated by chemicals. At another,
our institutions, family, school, church and com-
munity, need to examine the conditions which con-
tribute to the boredom, loneliness, lack of self
respect, anger, anxiety, and resentment to which
the abuse of drugs may be one response (26:21).

Alternatives offered a wide variety of activities
for the program leader to engage in with the participant.
These activities corresponded to the motives or needs
that led an individual to use drugs. For example, a need
for physical relaxation may have led someone to use
alcohol or tranquilizers. An alternative activity to the use of the drug might have been relaxation exercises or yoga (9). Other activities included physical recreation, political or social service involvement, dance or hobbies.

If the alternative strategy was to be effective, the target individuals motives, needs, and aspirations must have been considered. It also must be realized that this approach was a complex undertaking that required a long-term commitment and unusual organizing skills (31:36).

Stage Four: Life Career Planning

Because of the constant changes which have occurred in today's fast moving society, and the daily advances of knowledge and technology, it is increasingly more difficult for individuals to determine where or how they fit into the job market. Life career planning aided participants in identifying what directions they could take.

Life career planning was a concept and an increasingly important drug abuse prevention strategy that was aimed at helping young people focus on long-range goals for life and work through "real life" experiential learning in the form of actual jobs or on-the-job training. It also included structured intellectual exercises. Life career planning was implemented in a school setting,
within a community-based agency, or in a combination of school and community settings (31).

Strategy Five: Peer and Cross Age Counseling and Tutoring

This strategy enabled individuals, particularly students in a passive school environment to feel that they were important by doing necessary work. Research on the effects of peer and cross age tutoring and counseling programs on student participants consistently showed that students who tutor and counsel make gains in self-concept and, when tutoring others, in the skills they were teaching (14).

This Investigator believed that tutoring and counseling activities could be an effective prevention strategy for school based prevention programs, and were adaptable to community based programs, and should be included in the manual.

Strategy Six: Effective Parenting Programs

Research showed correlations between families and their adolescents' self-esteem and chemical use. Parents and families therefore had the potential to play a primary role in drug abuse prevention. This potential was best realized in a parent-child relationship that would not become fragmented during a period of probable drug
experimentation; rather, the relationship could be a positive influence, even in the event of abusive drug use (26).

Recent developments in psychiatry and psychotherapy revealed that family interaction stabilized dysfunction and projected it forward to the next generation (36:297). Sarris of Project INFO in Whittier, California, felt that:

Destructive and harmful ways of parenting, even in "normal" and healthy families, are passed from one generation to another. This chain can be easily broken, however. Parenting and family communication training can have a positive impact not just on present problems, but in future generations (31:40).

It was found that good parenting skills aided in making family members more considerate of each other, helped parents to build their children's self-esteem, and provided families with healthy, constructive ways of solving the normal conflicts of family life (31:40).

Gordon, developer of Parent Effectiveness Training [PET], has provided a great deal of material and structure to parenting programs. His techniques in combination with other affective and alternative activities have been found to be an effective strategy for the primary prevention of drug and alcohol abuse.
Evaluations

This review of the literature has provided a variety of models, opinions, and strategies regarding the prevention of alcohol abuse. It may be difficult for the reader to determine which of these is best suited for effective prevention programming. This dilemma is not hard to understand.

Primary prevention impact research remains very weak in general, and very large gaps remain in the research literature (35:42). Much of the available evaluation data came from studies which were poorly designed or conducted, for example, no control groups, retrospective data, small samples, etc. and often the data were inappropriately analyzed (35:42). The few evaluative efforts in the field have reported gains in factual knowledge and/or shifts in alcohol related attitudes of the participants, but no measurable effect on alcohol related behavior (13:28). This information was by no means conclusive and it followed that prevention professionals should encourage rigorous outcome evaluations of programs wherever appropriate (35:43).

The Pyramid Project, a research group for the National Institute on Drug Abuse in Walnut Creek, California believed that all levels of government should encourage comparative research designs when providing funds to well
established prevention efforts, and should be provided with the funding needed to implement such designs. In funding new programs, however, formal outcome evaluation were considered premature, and intensive formative evaluation spanning a period of several years was thought to be more productive (35:43). Goodstadt believed that there was a need for more research to answer the many crucial questions concerning both the underlying dynamics and impact of existing and new prevention programs (18:274).

This Investigator agreed with the authors of the Minnesota Prevention Plan, that evaluating a prevention program was difficult to do with precision (26). Since there were so many variables and processes acting at once, it was usually difficult to learn just what effects could actually have been attributed to the program. However, this Investigator felt strongly that a well-run program planned for the use of evaluation to guide its efforts, and evaluation should be incorporated into the steps taken for program planning.

Summary

The literature emphasized that alcoholism was linked to a great deal of suffering and economic loss to both the person and society (19:268). Yet, moderate alcohol use was found to be an accepted part of American life (34:18). Because of these two opposing viewpoints,
the literature revealed that the prevention field was controversial and abstract in nature.

For prevention programming to be considered a worthwhile endeavor, several authors agreed that example programs, models of prevention and existing services should be carefully reviewed for relevancy, scope, intensity and duration, prior to the implementation of new services (34) (35). The needs of a target population and community should also be taken into consideration in order to develop a much needed constituency in support of prevention. In addition, it was emphasized that clear distinctions between treatment and prevention services should be made (11)(33).

This Investigator felt that in order for the prevention of alcohol abuse to become a common theme of many County programs, prevention planners must display the skills and understanding necessary to plan, implement and evaluate a prevention program confidently and competently. For this to be accomplished, training should be provided by those with knowledge in prevention program planning.

Techniques determined as appropriate by this Investigator to train prevention providers in Los Angeles County were: training seminars and workshops, a comprehensive planning manual, and the provision of individual technical assistance as needed.
Chapter 3

METHODOLOGY

The major purpose of this project was to develop a training manual for use by prevention workers in Alcoholism programs funded by Los Angeles County. This chapter describes the procedures and activities which have contributed to the development of this manual.

Chronological Development

The Investigator was a member of the Prevention and Planning Section of the Los Angeles County Office on Alcohol Abuse and Alcoholism [OAAA] from August, 1978 to June, 1979. Prevention services constituted a relatively new and small component of the total alcoholism budget. When this Project was initiated there were six prevention service providers that had contracts with OAAA.

A number of factors led the Investigator to believe that the prevention providers were technically unprepared to provide adequate services to their constituencies. First, the Prevention and Planning Staff at OAAA did not have a clear concept of alcoholism prevention and the office, therefore, did not possess formal policies and procedures applicable to the prevention
contractees. Second, the California State Office on Alcoholism in Sacramento, the major funding source to OAAA, was not staffed by a prevention coordinator and did not have a set of written guidelines for implementing alcoholism prevention services in California. Guidelines existed for all other service modalities. The situation resulted in minimal State involvement and leadership regarding prevention services. Third, the prevention service provider's contracts required that goals, measurable objectives and written evaluation be a component of their programs. However, the instrument used by OAAA to evaluate prevention services made no mention of these stipulations. There was then a crucial part of program planning which was left undocumented by OAAA and left undone by the providers. Fourth, the alcoholism prevention services being provided in Los Angeles County, with the exception of one agency, did not include any of the current prevention strategies mentioned in the Investigator's Review of the Literature [i.e. alternatives, values clarification, parenting workshops, etc.] and were, in fact, treatment rather than prevention oriented.

The Investigator, with the support of the Los Angeles County Alcoholism Prevention Coordinator, re-searched the current "state of the art" of prevention and program planning. Books, articles, and training manuals
were collected and reviewed and a set of prevention training concepts emerged.

Monthly training workshops were implemented by the Investigator for the prevention providers. These workshops provided the material necessary for the development of a comprehensive Prevention Providers Training Manual. The Methodology of the study was designed in large part to obtain the content to be covered at the training workshops and to provide a manual which could be used long after the workshops had ended. The manual, therefore, emphasized skills determined as lacking through a needs assessment of the Prevention Providers in Los Angeles County.

The following methodological phases were utilized to develop the manual.

Phase I: Development of a Needs Assessment Questionnaire

A. Development of Prevention Training Workshops

The first phase of development involved the design of workshops which covered all areas of prevention program planning. Content of the workshops was based on current prevention and program planning theories and methods.

A panel of prevention service workers (N=18) who had contracts with OAAA and whose programs needed
re-structuring, attended the workshops in order to learn new skills or to enhance existing ones. Each of the eight consecutive sessions covered steps that were determined as useful for program development through planning, prevention and public health research. These sessions included target group and constituency identification, needs assessment methodologies, goal and measurable objective development, rationales for evaluation and selecting and utilizing current prevention strategies:

The panel members were pre-tested for their immediate knowledge at each session in order to stimulate interest in the topic covered. For the purposes of variety and to maintain interest, the format of presentation differed with each workshop and included one or all of the following: lecture, lecture with handouts, small group exercises, individual exercises, take-home worksheets, and guest speaker presentations.

At the conclusion of the workshop series, panel members were tested for outstanding training needs and wants with a needs assessment questionnaire (see Appendix D).

B. Development of the Pre-test

In order to design an accurate needs assessment instrument, a pre-test was developed and utilized on a panel of prevention specialists.
The pre-test provides a means of catching and solving unforeseen problems in the administration of the questionnaire such as the phrasing and sequence of questions, or its length. It may also indicate the need for additional questions or the elimination of others (37:545).

The Investigator composed a 27 item questionnaire which consisted of demographic items, for general background information on the target population; fixed-alternative items, to insure that the answers were given in a frame of reference that was relevant to the purpose of the project and in a form that was usable in the analysis; and open-ended questions to provide a better indication of whether respondents had any information about the issue, whether they had a clearly formed opinion about it, and how strongly they felt about it (37:313-314). Combinations of open and closed questions are often very efficient in getting at complex information according to Selltiz (37:317). The questions were directly from the information covered at the training workshops and that which is included in the manual (see Appendix G).

The questionnaire was divided into three sections: a) general background information of the respondents, b) their knowledge and understanding of prevention, which was used to determine areas for emphasis in the manual, and c) the usefulness and format of the training manual.
A pre-test evaluation form and cover letter explaining its purpose was also included (See Appendices A and B).

C. Administration of Pre-Test

The pre-test was administered to a panel of eight substance abuse prevention specialists. To be considered a prevention specialist, members had to be currently working for Los Angeles County in the drug or alcohol abuse prevention field as program planners or administrators, and have had demonstrated knowledge about substance abuse prevention. The panel members may have attended the training workshops, but it was not mandatory. Members identified themselves on the evaluation form.

The pre-test was administered through the mail upon completion of the workshop series. Three weeks were allowed for response time. Follow-up phone calls were made on all unreturned questionnaires.

Phase II: Needs Assessment of Training Workshop Participants and Other Alcoholism Prevention Providers

A. Development of the Needs Assessment Questionnaire

Modifications of the pre-test instrument, which became the final questionnaire, was the result of responses and recommendations made by the prevention
specialists who were used as pre-testers. The final editing was to ensure that every element of the questionnaire passed inspection: the content, form and sequence of questions; the spacing, arrangement, and appearance of material; and that the questionnaire was as clear and easy to use as possible (37:546).

The final needs assessment questionnaire consisted of 25 open-ended and fixed alternative items. For many purposes, a combination of open and closed questions is most efficient; an interview or questionnaire need not consist entirely of one type or the other (37:317). These questions represented information covered at the training workshops and content that was included in the training manual (See Appendices D and G).

B. Administration of the Questionnaire

The questionnaire was administered to a panel of eighteen Los Angeles County Alcoholism prevention workers and planners who will be the ultimate recipients of the training manual. The Investigator attempted to determine outstanding training needs of all alcoholism prevention workers within the Los Angeles County System with the questionnaire.

Attendance at the workshops was not required since not all prevention workers who could have benefited from the sessions were able to attend.
The questionnaire was administered by mail approximately one month following the completion of the training workshops. A three week response time was allowed with follow-up phone calls made on unreturned questionnaires. The questionnaire was administered anonymously but because of the small target population, the Investigator was able to identify respondents by information and comments made. Many respondents did identify themselves.

C. Results of the Needs Assessment Questionnaire

Analysis of the returned needs assessment questionnaire provided the investigator with answers to the following questions: 1) What was the current level of knowledge and understanding of prevention program planning among the respondents? 2) What were their latent and manifest prevention training needs? 3) Would a training manual be a useful tool for them? 4) What would they like included in the training manual? 5) What aspects of program planning should be emphasized in the training manual?

Phase III: Format for Analyzing the Needs Assessment Data

All incoming questionnaires were numbered sequentially upon receipt. A tally sheet and comparison tables
were made for Sections I: General Background Information, and III: Training Manual Usefulness and Format; all answers were recorded on the sheet. Because of the small target population, all tabulating was done by hand.

Section II: Knowledge and Understanding of Prevention, was more laborious to analyze owing to the subjective nature of the questions. Answers were compared for similarities with information used for the training workshops. This section determined knowledge in the areas of target group identification, goals and objectives, needs assessment, evaluation and prevention strategies. Health program planning requires specific activities occur in order to be effective, therefore, it was not difficult to determine if the respondents actually understood the planning process. Results were presented in narrative statements.

Those areas of program planning determined as weak by analysis of the responses, and those skills stated by the respondents as lacking, were emphasized in the training manual (See Appendix G).

Phase IV: Development of the Training Manual

The content contained in the training manual was collected over a period of approximately eight months. Information and ideas included in the manual came from a variety of sources including: 1) current literature on
the prevention of alcohol abuse, 2) existing training manuals for drug and alcohol abuse prevention, 3) health planning literature, 4) educational literature, 5) prevention experts and specialists, and 6) existing prevention programs in Los Angeles and other Counties. Some of this information can be found in the Review of the Literature portion of this project [See Chapter 2].

The manual was developed upon completion of the training workshops, the needs assessment, and a thorough review of the prevention literature had been conducted.

A. Development of Manual Content and Format

The manual was designed to be self instructional which enables the prevention workers to acquire knowledge about program planning without the necessity of attending a class or workshop. The information contained in the manual was similar to that covered at the training workshops and was geared to the specific needs of these workers. For example, skills that were determined as lacking by the needs assessment were emphasized. Since the majority of prevention workers who will be using the manual lack any formal training or background experience in prevention, the manual was written in concise, simple terms, and covered basic concepts and strategies of program planning, implementation and evaluation.
The arrangement of the Sections of the manual was similar to the sequence used for the training workshops. That is, they were divided into the progression of steps necessary to successfully deliver prevention services from planning to evaluation. Each section included pre/post tests and exercises for planners to undertake (See Appendix G).

Phase V: Evaluation of the Manual

The manual was evaluated by a panel of eight substance abuse prevention specialists in Los Angeles County. These individuals needed to demonstrate expertise in prevention program planning.

Evaluators were asked to rate the manual with regard to several dimensions: 1) quality of information; 2) quality of content, and; 3) utility. A cover letter and evaluation questionnaire was included with the manual (See Appendices E and F).

A. Selection of a Panel of Experts

The panel of experts were selected owing to their leadership roles in prevention activities in Los Angeles County. The "experts" included: past chief of the prevention section at the Office of Alcohol Abuse and Alcoholism, present prevention Coordinator at the Los Angeles County Drug Abuse Program Office, past prevention
Coordinator of OAAA, and directors of large County prevention programs.

The panel members were contacted by phone prior to their receipt of the manual. For purposes of clarifying questions and obtaining commitment to participate. They were mailed a rough draft of the manual with a cover letter, evaluation questionnaire, and a self-addressed stamped envelope in which to return the manual and evaluation questionnaire. A two week period was allowed (See Appendix H).

B. Development of the Evaluation Questionnaire

The questionnaire contained eight items of fixed alternative and open-ended types. The Investigator chose this format to allow for and encourage personal comments and expression, and to stimulate specific replies to very specific questions.

The questionnaire focused on the following areas:
1. Overall reaction to the manual.
2. Use of the manual as a tool to train new and existing prevention workers, and as a guideline for the development and restructuring of prevention programs.
3. Quality of information including its completeness and accuracy.
4. Quality of content including the clarity, wording, interest, sequence, and writing style of the information.

5. Utility of the manual including its advantages, usefulness, and its adaptability to the intended target population.

6. Comments and suggestions regarding individual sections and the entire manual.

The above areas were chosen for evaluation to ensure that the manual would be assessed as a whole rather than as fragmented sections. This way major gaps or weak spots could be identified and corrected.

The Investigator strived to design the questionnaire in a manner to be as effortless to use as possible and to assure an ample response rate. Therefore, simple rating scales were developed for several of the questions. This allowed the evaluators to judge each item on a continuum that did not require commentary. Question 8, however, did allow for individual comments and suggestions (See Appendix F).

Phase VI: Presentation of the Results of the Manual Evaluation

The evaluation questionnaire was divided into its eight questions and each was discussed narratively. Those findings that could best be presented in table
format were. These included questions 1, 2, 4, 5, and 6. These items were presented in tables showing the percentage of replies for each choice, followed by a discussion of responses.
Chapter 4

FINDINGS

The purpose of this chapter is to analyze the results of the pre-test questionnaire, the needs assessment questionnaire, and the manual evaluation questionnaire.

Results of the Pre-Test of the Needs Assessment Questionnaire

The needs assessment pre-test questionnaire was mailed to eight selected alcoholism prevention specialists in Los Angeles County. Five were completed and returned. Analysis and revision of the returned questionnaires resulted in the elimination of four items and the rewording of two items. A pre-test evaluation form accompanied the questionnaire (see Appendix B).

The overall responses to the pre-test were generally positive. Respondents indicated that it was thorough and relevant to the overall project. Many of the comments and suggestions were helpful to the Investigator. One respondent warned, "often comments suggest changes that are more a matter of style than substance." One Respondent suggested that the training manual must be concise
and "how to" as possible, even at the risk of being oversimplistic.

Following analysis, the pre-test was modified into a 25 item questionnaire and mailed to the target population five weeks following their completion of the prevention training workshops.

**Results of the Needs Assessment Questionnaire**

The needs assessment questionnaire was mailed to fourteen alcoholism prevention workers in Los Angeles County. The Investigator received ten completed questionnaires (N=10) within six weeks of the mailing. Follow-up phone calls were made at the four week deadline and resulted in the return of one questionnaire (See Appendix D).

The results of the questionnaire can best be presented by analysis of each of its sections. A general discussion of each section follows.

**General Background Information**

Analysis of section one disclosed that the ten prevention workers surveyed were affiliated with the agencies that provided prevention and education, outpatient, technical assistance services or a combination of these. The ten Respondents worked in a variety of agency positions including prevention and education coordinators or assistants, program or project directors or assistants,
Sixty percent of the Respondents had previously obtained training specific to alcoholism services and the subject of alcoholism. However, only thirty percent had attended two or more of the Investigator's prevention training workshops. Seventy percent had college degrees; one Associate in Arts, two Bachelor's of Arts, and four masters degrees. Only one Respondent had no formal education or alcoholism prevention training prior to attending the workshops.

a. Additional Prevention Training

Ninety percent (N=9) of the Respondents believed they had the capability to implement an alcoholism prevention program. However, all Respondents expressed the need for additional training in either program planning, implementation methodologies, evaluation, definitions of prevention, or combinations of these. Implementation and evaluation were the most requested areas with sixty percent responding in favor of implementation and seventy percent in favor of evaluation.

b. Preferred Learning Situations

Twenty percent of the Respondents felt training sessions, a manual, and technical assistance were equally beneficial as learning situations. Thirty percent chose
all three methods plus an additional suggestion. Thirty percent preferred the use of technical assistance only, and twenty percent preferred a training manual only. All ten Respondents chose the training manual and individual technical assistance most often.

Section I revealed a diversity of backgrounds among the Respondents. Even though the educational attainment and perceived abilities of them differed, all overwhelmingly felt there was room for improvement in their prevention knowledge. Most also preferred a detailed training manual as a learning tool, equal with the provision of individual technical assistance, which is actually an ideal situation.

Understanding of Prevention Programming

In the analysis of Section II, the Investigator followed the advice of Selltiz who believes that the first step in analyzing the data of an exploratory study was to develop working hypotheses that would yield classificatory principles (37). The Investigator entertained the postulates with regard to analyzing Section II:

1. The answers to the items will reflect the actual knowledge of the target group about the subject.

2. The answers to the items provide information about gaps and weak spots in the knowledge of
the target group.

3. The gaps and weak spots in knowledge enable determination of areas that should be emphasized in the training manual.

Owing to the extreme length of the questionnaire and responses, the Investigator chose to discuss questions of particular relevance to the overall project. Each question will be presented in bold type and framed in the center of the page, followed by selected responses and discussion.

a. Target Population Identification

QUESTION #1: BRIEFLY DESCRIBE THE TARGET POPULATION YOUR PREVENTION ACTIVITIES WILL BE DIRECTED TOWARDS

Selected Responses:

- Women/lesbians of Los Angeles County and the gatekeepers of these women
- Primary, elementary and secondary students enrolled in the Pasadena Unified School District
- Pre-delinquent youth at high risk to alcohol abuse and who come from the East and Northeast Health Districts
- Four high schools in the target community
- Women of childbearing and pre-childbearing age, physicians and auxiliary health personnel
-Youth, elderly, bi-cultural groups, women

Discussion:

The rationale behind this question was to attempt to elicit information regarding the necessity of a clearly delineated target population. Most Respondents understood the importance of a "defined target population." However, most of the identified target populations were considered too global by the Investigator. For example, all the students in Pasadena public schools and all women of childbearing age in Los Angeles County are extremely large target populations for programs with limited resources, and should be narrowed down for effective planning.

**QUESTION #2: WHEN INITIALLY PLANNING A PREVENTION PROGRAM, PLANNERS SHOULD CONSIDER AS MANY DIFFERENT TARGET GROUPS AS POSSIBLE. (circle one)**

Responses:

- Strongly Disagree - Thirty percent (N=3)
- Disagree - Twenty percent (N=2)
- Agree - Twenty percent (N=2)
- Strongly Agree - Thirty percent (N=3)

Discussion:

This question attempted to elicit information regarding the importance of initially limiting the target population. Fifty percent (N=5) of the Respondents
understood that all groups should be considered. However, this notion is not feasible for any prevention provider in Los Angeles County because of their limited resources.

b. Goals and Objectives

| QUESTION #3: THE DIFFERENCE BETWEEN A GOAL AND AN OBJECTIVE IS: |

Selected Responses:

- A goal serves as a long term achievement
- A goal is the overall aim
- A goal is the overall accomplishment desired
- A goal is a broad, general statement of intent, what you want to achieve
- Goals can be broad and more general
- Objectives are the steps you take to reach a goal
- Objectives are focused items aimed at achieving goals
- Objectives are the means for accomplishing a goal
- Objectives are measurable, time-limited, specific

Discussion:

This question attempted to determine Respondents grasp of information regarding the differences between goals and objectives. Respondents understood the basic concept of a goal and saw objectives as steps necessary
to reach goals. Sixty percent (N=6) emphasized that objectives should be measurable and specific. Others did not clearly define an objective, although they understood the general concept.

When asked to identify a given statement as a goal, objective or activity, ninety percent correctly identified a goal, seventy percent correctly identified an objective and forty percent correctly identified an activity. The activity was most often confused with an objective.

c. Needs Assessment

| QUESTION #5: IT IS IMPORTANT FOR PLANNERS TO BE AWARE OF THE VALUES AND BELIEFS OF THE SELECTED TARGET GROUPS, AS WELL AS THE SURROUNDING COMMUNITY IN ORDER TO PLAN AN EFFECTIVE PREVENTION PROGRAM. (circle one) |
|-----------------------------|------------------|------------------|------------------|------------------|
| Strongly disagree | Disagree | Agree | Strongly Agree |

Responses:

Agree - Twenty percent (N=2)

Strongly Agree - Eighty percent (N=8)

Discussion:

All Respondents were in agreement as to the importance of this point. The question was formulated to elicit information regarding the importance of identifying the beliefs and values of the target population and its surrounding community during the planning stages.
Selected Responses:

- The effort itself cannot be concentrated. An overall approach is needed due to the need that is present.

- Select a specific target group, match what you can provide to what the group needs via assessments etc., work with structured, planned programs that have expectations and outcomes on the part of planners and target population, evaluate and modify.

- Know the community, negotiate needs. Keep community aware of what you want to do and how you'll do it.

- The people - community must be involved from very start, survey, needs assessment, assess community resources.

- Planning should include assessment of actual need, community readiness, existing services, gaps and resources.
Discussion:

This question was designed to elicit information regarding the necessity of identifying a plan of action in the preliminary stages of planning [particularly in the areas of needs assessment and problem identification]. Many of the Respondents did not understand how to obtain this preliminary information. Forty percent (N=4) emphasized the need to involve the community in planning. Thirty percent (N=3) briefly mentioned a community needs assessment. Twenty percent (N=2) did not understand the question. The use of existing research and data was not mentioned.

d. Evaluation

**QUESTION #11: BRIEFLY DESCRIBE SOME OF THE EVALUATION INSTRUMENTS THAT CAN BE USED TO EVALUATE PREVENTION PROGRAMS. INCLUDE THOSE THAT MAY BE EXISTING AND THOSE THAT CAN BE DEVELOPED.**

Selected Responses:

- Attitude indicators
- Pre/post tracking
- Knowledge
- Study of applicable statistics
- Subjective criteria-direct observation, written comments by target group
- Likert scales
-Self-concept scales
-Long-term tracking of participants

Discussion:

This question attempted to elicit information regarding the variety of evaluation instruments and techniques available for the prevention planner.

Seventy percent (N=7) of the Respondents identified pre-post tests as a means of evaluating program effectiveness. Fifty percent (N=5) suggested looking at behavioral indicators, such as reduction in consumption or specific behaviors related to alcohol abuse in the target population. Twenty percent (N=2) listed attitude scales. However, most Respondents had a limited knowledge of the evaluation instruments and techniques which could be used or developed for measuring program effectiveness.

e. Prevention Strategies

<table>
<thead>
<tr>
<th>QUESTION #12: LIST SOME &quot;AFFECTIVE&quot; PREVENTION STRATEGIES THAT COULD BE USED WITH YOUR TARGET GROUP.</th>
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</thead>
</table>

Selected Responses:

- Peer and cross-age teaching
- Role playing
- Values clarification
- Creative drug education
- Alternative involvement
- Decision making and coping skills
- Self-esteem activities
- Life-style community orientation
- Long-term training workshops for gatekeepers
  including some values and attitudes activities
- Consciousness raising
- Assertiveness training
- Media presentations
- School mandated alcohol information programs
- Limit alcohol availability

Discussion:

The intention of this question was to obtain information about specific types of affective prevention strategies that would be feasible within each of the Respondents target group. The Respondents answers included a spectrum of ideas. Many individuals listed cognitive or behavioral techniques such as media presentations, information and limit of availability as affective strategies.

Thirty percent (N=3) could identify six affective strategies. [See Review of the literature, chapter two, for a discussion of prevention strategies] Thirty percent identified four affective strategies, ten percent
(N=1) identified two, ten percent (N=1) identified one, and twenty percent (N=2) could not identify any affective strategies.

f. Steps of Program Planning

QUESTION #13: BRIEFLY DESCRIBE THE SEQUENCE OF STEPS YOU WOULD TAKE TO PLAN, IMPLEMENT AND EVALUATE A PRIMARY PREVENTION PROGRAM.

Selected Responses:
- Assess need for services, select target population, develop techniques that can be most effective, implement program in the areas most frequented by target population
- Determine the problem, research the facts, establish goal, set objectives, consider target population, select a vehicle, prepare budget, evaluate during and following program
- Identify area to impact, define area parameters, consider approaches, prepare Cost Benefit Analysis, select best solutions, determine evaluation procedure, implement, evaluate
- Survey, gather and interpret data, develop goals and objectives, identify resources, duration and implementation scheduling, determine who does what, evaluate
Discussion:

The purpose of this question was to elicit information regarding the program planning process. Many misconceptions existed among the Respondents such as the listing of certain tasks in different order. In general, most understood that program planning is a process involving a series of logically arranged steps.

Twenty percent (N=2) of the Respondents mentioned a revision and modification process. Twenty percent (N=2) discussed the consideration of a budget and existing resources in the initial planning stages. The needs assessment step was often incorrectly listed as the activity conducted prior to target group identification. The evaluation process was rarely detailed.

In summary, the data from Section II revealed that the Respondents had a good grasp of the basic concepts necessary for prevention programming. However, they seemed to lack the concrete information necessary to effectively plan, implement and evaluate a program. This was apparent in their inability to accurately identify an objective or an activity, and their lack of creativity regarding evaluation techniques. Their answers, in general were more theoretical than factual.

The Investigator determined that if the training manual was to reflect the needs of the Respondents, it
must have covered the following topics in a clear, "how-to" way:

1. Identification of a target group
2. Needs assessment methodologies
3. Developing goals and measurable objectives
4. Overview of popular prevention strategies and activities
5. Developing and adopting evaluation instruments and techniques specific to each program

The Training Manual

The final section attempted to determine what content areas in prevention program planning needed to be included in the development of the training manual. Nine subject areas were included as choices (See Appendix D).

Forty percent (N=4) of the Respondents wanted all nine areas included. Thirty percent (N=3) were in favor of six of the areas. The two most popular items, with all in favor of their inclusion in the manual, were item E, developing goals and objectives and item I, developing evaluation instruments. The two least favored items were B, current trends in prevention with sixty percent in favor and G, planning curriculum for prevention sessions with seventy percent in favor. None of the items had an
overwhelmingly negative response.

All of the Respondents felt they would use a training manual to orient newcomers to their agencies and as a reference or learning tool for prevention workers.

The final section of the questionnaire disclosed that two of the subject areas might be left out of the manual, item B - current trends in prevention and item G - planning curriculum for prevention sessions. However, the three Respondents that voted for the least subject areas may have had different needs than the majority of the target population. Two of them had earned Masters degrees, and may have had less of a need for an in depth training manual than the others. The four respondents who voted in favor of all nine subject areas were currently involved in the actual delivery of prevention services. Therefore, they may have had a more acute awareness of the training needs among prevention workers.

Even though there were differences of opinions regarding what should be included in a training manual, all Respondents felt that a manual of this sort would be a valuable addition to their prevention library.

Results of the Training Manual Evaluation Questionnaire

Eight Los Angeles County Prevention experts received a rough draft of the manual and an evaluation
questionnaire (See Appendix F). Eight completed questionnaires were returned (N=8).

The results of the questionnaire can best be presented by analysis of each of its sections. A general discussion of each section follows. Each question will be presented in bold type and framed in the center of the page, followed by the response rate and discussion.

General Assessment

**QUESTION #1: AFTER READING THIS TRAINING MANUAL, MY OVERALL REACTION IS:**

<table>
<thead>
<tr>
<th></th>
<th>Very Positive</th>
<th>Positive</th>
<th>Negative</th>
<th>Very Negative</th>
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<tbody>
<tr>
<td>N</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>0</td>
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<tr>
<td>%</td>
<td>25</td>
<td>63</td>
<td>12</td>
<td>0</td>
</tr>
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</table>

Discussion:

In question #1, 88% (N=7) responded very positive or positive, and 12% (N=1) responded negative.

Eighty-eight percent (N=7) of the Respondents reacted positively or very positively to the manual. Twelve percent (N=1) had a negative reaction to it. One Respondent felt the format to be "talking at" the reader which would therefore be "shelved".
QUESTION #2: IF YOU HAD THIS MANUAL AVAILABLE TO YOU, WOULD IT BE USED AS:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>A. A tool for orienting new staff to program planning?</td>
<td>7  100</td>
</tr>
<tr>
<td>B. A tool for educating existing staff about program planning?</td>
<td>6  86</td>
</tr>
<tr>
<td>C. A guideline for the development of a new prevention program?</td>
<td>7  100</td>
</tr>
<tr>
<td>D. A guideline for the restructuring of existing services?</td>
<td>6  86</td>
</tr>
</tbody>
</table>

Discussion:

All but one Respondent answered this question (N=7).

**Items A and C** - one hundred percent (N=7) of the Respondents indicated that they would use the manual as a tool for orienting new staff to program planning, (Item A) and as a guideline for the development of a new prevention program (Item C).

**Item B** - eighty six percent (N=6) indicated they would use the manual as a tool for educating existing staff about program planning. Fourteen percent (N=1) said they would not.

**Item D** - eighty six percent (N=6) indicated that they would use the manual as a guideline for the restructuring of existing services. Fourteen percent (N=1) said
they would not.

**Item E** - Three additional uses for the manual were suggested:

- As a resource for specific projects such as objective development and evaluation
- For the training of providers in other modalities
- For use in long-range planning.

**QUESTION #3: IF THE INFORMATION CONTAINED IN THE MANUAL WAS PRESENTED IN CONJUNCTION WITH A TRAINING WORKSHOP, WOULD THE MANUAL BE MORE USEFUL TO YOU?**

<table>
<thead>
<tr>
<th>YES 8 (100%)</th>
<th>NO 0</th>
</tr>
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</table>

PLEASE EXPLAIN WHY.

Discussion: One hundred percent (N=8) of the Respondents felt a workshop would be useful. All but one Respondent indicated that a workshop would provide needed examples and discussion of each of the sections in the manual. One Respondent believed a workshop should be used as a summary only. Another felt the manual would not be used unless accompanied by a workshop.
Format Structure

<table>
<thead>
<tr>
<th>QUESTION #4: QUALITY OF INFORMATION</th>
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</tr>
<tr>
<td><strong>EXCELLENT</strong></td>
</tr>
<tr>
<td>Completeness: (Were all components of Prevention program planning included?)</td>
</tr>
<tr>
<td>Accuracy: (Was the information correct?)</td>
</tr>
</tbody>
</table>

Discussion: (See Table 1)

A majority, eighty eight percent (N=7) felt the completeness of information was excellent to good. Twelve percent (N=1) responded that it was fair. One hundred percent (N=8) felt the accuracy of information was excellent to good.

<table>
<thead>
<tr>
<th>QUESTION #5: QUALITY OF CONTENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td><strong>EXCELLENT</strong></td>
</tr>
<tr>
<td>Clarity: (Was the information presented succinct and clear?)</td>
</tr>
<tr>
<td>Wording: (Was the vocabulary used in the manual easily understood?)</td>
</tr>
<tr>
<td>Interest: (Did you find it interesting?)</td>
</tr>
<tr>
<td>Sequence of Presentation: (Was the information organized in an orderly and cohesive manner?)</td>
</tr>
<tr>
<td>Writing Style: (Was the mode of presentation pleasing?)</td>
</tr>
</tbody>
</table>
Table 1
Response Rate to Questions #4, #5, and #6

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
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<tbody>
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<td>N %</td>
<td>N %</td>
<td>N %</td>
<td>N %</td>
</tr>
<tr>
<td>Completeness</td>
<td>3 38</td>
<td>4 50</td>
<td>1 12</td>
<td>0 0</td>
</tr>
<tr>
<td>Accuracy</td>
<td>5 63</td>
<td>3 37</td>
<td>0 0</td>
<td>0 0</td>
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<tr>
<td><strong>QUALITY OF CONTENT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Content Clarity</td>
<td>4 50</td>
<td>3 38</td>
<td>1 12</td>
<td>0 0</td>
</tr>
<tr>
<td>Content Wording</td>
<td>5 63</td>
<td>3 37</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Interest</td>
<td>2 25</td>
<td>4 50</td>
<td>1 12</td>
<td>1 12</td>
</tr>
<tr>
<td>Sequence of Presentation</td>
<td>4 50</td>
<td>4 50</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Writing Style</td>
<td>2 25</td>
<td>2 25</td>
<td>4 50</td>
<td>0 0</td>
</tr>
<tr>
<td><strong>UTILITY OF MANUAL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriateness</td>
<td>4 50</td>
<td>3 38</td>
<td>1 12</td>
<td>0 0</td>
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<tr>
<td>Adaptability</td>
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<td>2 25</td>
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<tr>
<td>Usefulness</td>
<td>3 37</td>
<td>3 38</td>
<td>2 25</td>
<td>0 0</td>
</tr>
</tbody>
</table>

Discussion: (See Table 1)

A majority, eighty eight percent (N=7) felt the content was clearly presented. Twelve percent (N=1) responded that it was fair. One hundred percent (N=8) felt the wording was excellent to good. Seventy five percent (N=6) indicated that the interest was excellent to good. Twenty five percent (N=2) felt it was fair to poor. One hundred percent (N=8) indicated that the sequence of
presentation was excellent to good. Fifty percent (N=4) responded excellent or good for writing style, while fifty percent (N=4) felt it was fair.

<table>
<thead>
<tr>
<th>QUESTION #6: UTILITY OF MANUAL</th>
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</thead>
<tbody>
<tr>
<td>APPROPRIATENESS: (Was it relevant to the intended target population?)</td>
</tr>
<tr>
<td>ADAPTABILITY: (Is it relevant and useable by all alcoholism prevention planners?)</td>
</tr>
<tr>
<td>USEFULLNESS: (Was the manual structured for maximum use?)</td>
</tr>
</tbody>
</table>

Discussion: (See Table 1)

A majority of Respondents, eighty eight percent (N=7) felt the appropriateness of the manual for the intended target population was excellent to good. Twelve percent (N=1) indicated it was fair. Seventy five percent (N=6) felt the adaptability of the manual was excellent to good. Twenty five percent (N=2) indicated this aspect was fair. Seventy five percent (N=6) felt the usefulness of the manual was excellent to good. Twenty five percent (N=2) indicated the usefulness as fair.

Comments made regarding the sixth question included "training sessions would allow for maximum usefulness of the manual" and "the manual was adaptable to all alcoholism prevention planners except the more
sophisticated."

**QUESTION #7: WOULD YOU AGREE THAT THIS MANUAL IS A GOOD TOOL AND SHOULD BE DISTRIBUTED IN ITS FINAL FORM TO PREVENTION PROVIDERS?**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
<th>N</th>
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<td>YES</td>
<td>7</td>
<td>88</td>
<td>NO</td>
<td>1</td>
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</tbody>
</table>

Discussion:

Eighty eight percent (N=7) of the Respondents felt the manual was a good tool and should be distributed in its final form. Twelve percent (N=1) indicated that it was not and felt essential prevention data was left out of the text (specifically, information about environmental and institutional programs as well as techniques for networking and social policy change).

**QUESTION #8: PLEASE WRITE COMMENTS, SUGGESTIONS AND CONCERNS YOU MAY HAVE ABOUT INDIVIDUAL SECTIONS AND WITH REGARD TO THE GENERAL IMPROVEMENT OF THE MANUAL.**

Discussion:

Question #8 asked for comments, suggestions and concerns about individual sections and with regard to the general improvement of the manual. Comments included the following:
Overall Format and Presentation:
- It must be visually more inviting
- Needs more completed examples to accompany the exercises at the end of each chapter
- Pre/Post tests should be expanded and be more "finely tuned"
- Set up format in an interesting way; use more examples
- The basic tenets are broadly applicable
- Needs work, almost seems like it was put together after the various sections were written

Overall Information Covered:
- More prevention specific data is essential
- Must include institutional and environmental programs
- Should have included something on networking such as forming a task force or coalition of people to plan prevention programs
- Appreciate attempts to demystify prevention

Evaluation Section:
- Should mention more about process and impact evaluation
- Could use additional explanation and more specifics on "how to" evaluate
- Liked the sample evaluation instruments used

Needs Assessment:
- This section is good, but seems like it could conclude better

Goals and Objectives:
- Very good, different types of objectives should be better delineated

In conclusion, the comments and suggestions indicated that certain aspects of the manual needed modification and further elaboration, while other aspects were favorably received. The Investigator considered the comments and suggestions helpful for the improvement of the manual.
Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

The major purpose of this study was to develop and evaluate a training manual for assisting alcoholism prevention providers to plan effective programs. Evaluation of the manual provided consensual validation of the utility of the manual as a tool for prevention workers and as an aid for program planners. This chapter will briefly discuss the conclusions of the study and recommendations for further improvement of the manual.

Conclusions

Most of the Respondents involved in the needs assessment possessed an understanding of the basic steps necessary for program planning. However, when they were asked to explain any part of the process in detail, most were unable.

The results of the needs assessment disclosed that certain aspects of program planning were not clearly understood, viz., defining a narrow target population, needs assessment methodologies and evaluation techniques.

Respondents indicated that a training manual would be useful as a reference and training tool, particularly
if used in conjunction with individual technical assistance.

All of the Respondents felt goals and objectives and evaluation should be emphasized in the manual. The least favored areas were current trends in prevention and planning curriculum for prevention sessions. These were excluded or limited in the manual even though the Investigator believed they may have been useful to other prevention workers not included in the study.

The overall rating of the manual by the prevention experts was positive. Areas that were suggested for inclusion in the manual by the Respondents were in many instances already included. This indicated to the Investigator that the Respondents may not have thoroughly read the manual.

Aspects of the manual that were criticized, often represented a difference of style or experience. However, some valuable comments were made.

Some of the experts did not have current prevention related jobs and as a result, current prevention involvement. Therefore, the results of the manual evaluation may have been slightly different if the prevention experts chosen had been currently involved in the field.
The overall conclusions of the study are:

1. The study began after the prevention training workshops had been initiated. Thus, a method for pre-testing prior knowledge had not been developed. The relationship between the target population's knowledge before and after the completion of the workshops could not adequately be determined and compared through the needs assessment.

2. The population of alcoholism prevention providers and "experts" in Los Angeles County was very small, owing to the recent interest in the field and to the paucity of resources allocated to prevention in the County budget. The findings of this study would probably have differed slightly if the target population had been larger. Findings may have disclosed that a larger target population needed either a more indepth or a more simplistic manual.

3. The Investigator developed a manual containing what she believed was basic essential information about planning a prevention program. A comprehensive manual of this type had never been developed before. Prevention experts who evaluated the manual validated its usefulness and appropriateness.

4. The training manual that was developed for this study contained several areas that could be
strengthened. These areas will be discussed further under recommendations.

5. The manual developed for this study contained information that could be considered complicated by some. Although the Investigator attempted to simplify and condense the information, the manual became a lengthy document. For this reason it is doubtful whether the intended target population will actually read the entire manual. Therefore, the ideal environment would utilize information in the manual in conjunction with a training workshop. In this type of setting, ideas could be discussed and sample exercises could be performed as a group.

Recommendations

On the basis of the study the following recommendations are made:

1. A comprehensive prevention providers training manual should be considered for use by prevention workers in Los Angeles County alcoholism programs.

2. The training manual should be expanded to include: a) a more in depth discussion of evaluation techniques; b) completed sample exercises which could substantiate the material covered in each section; c) information about networking, prevention theory and other prevention programming techniques; d) a more in
depth resource list and e) a more visually pleasing appearance.

3. If this study was to be replicated, a method for comparing the knowledge of the participants prior to and following the completion of the training workshops should be developed.

4. If the program planning process described in the manual is to be followed through by the Office on Alcohol Abuse and Alcoholism, a prevention contract monitoring instrument should be developed that requires the completion of this planning process for contract compliance.

5. A long term follow-up of alcoholism prevention programs using the manual is suggested to determine the manual's effectiveness.

6. An expansion of this study is suggested to include a larger target population and the involvement of prevention workers and experts from drug and alcohol abuse prevention programs throughout California.

7. More stringent criteria for the selection of prevention experts should be used.

8. Prevention training workshops should be regularly presented in conjunction with the manual for Los Angeles County alcoholism prevention providers.
BIBLIOGRAPHY


22. Los Angeles County 1977-78 Alcoholism Program Budget, Department of Health Services, Office on Alcohol Abuse and Alcoholism.


APPENDICES
APPENDIX A

PRE-TEST COVER LETTER
July 3, 1979

Enclosed is a needs assessment questionnaire that will be distributed to the Los Angeles County Alcoholism Prevention Providers. The information from the questionnaire will be used in the development of a training manual that will instruct its' users in the steps necessary to plan, implement, and evaluate an alcoholism prevention program.

In order to pre-test the questionnaire, I have sent you and others who currently work or have worked in the prevention field a copy. Please answer the questionnaire thoroughly and honestly. I have also enclosed a pre-test evaluation form to be answered once the questionnaire is completed. Upon completion of both, please return them to me by July 20th, 1979. I have enclosed a self-addressed, stamped envelope for this purpose.

Your cooperation, which is greatly appreciated, will serve as a stepping stone to the completion of my master's degree. If you feel you are, for any reason, unable to complete the questionnaire, please return it to me in the enclosed envelope. For comments and/or questions feel free to call me at (213) 455-2324.

Thank you again.

Sincerely,

Beth Schechter
Master's in Public Health Candidate
APPENDIX B

PRE-TEST EVALUATION FORM
PRE-TEST EVALUATION FORM

1. Was the questionnaire easy to read? yes ___ no ___
   Comments __________________________________________________________

2. Were the questions clearly written? yes ___ no ___
   Comments __________________________________________________________

3. Were the questions written in a logical sequence? yes ___ no ___
   Comments _________________________________________________________

4. Did the questions cover a wide enough range of prevention topics? yes ___ no ___
   Comments _________________________________________________________

5. Were there any questions that you felt were redundant or unnecessary? yes ___ no ___
   Comments _________________________________________________________

6. Did you understand the overall intent of the questionnaire? yes ___ no ___
   Comments _________________________________________________________

7. Were there any questions you did not understand? yes ___ no ___
   Comments _________________________________________________________

8. Suggestions for improvement _________________________________________
   _________________________________________________________________
   _________________________________________________________________
APPENDIX C
NEEDS ASSESSMENT INSTRUMENT
COVER LETTER
Enclosed is a questionnaire on prevention program development. The results of this questionnaire will be used to determine your prevention training needs and the content to be included in a prevention providers training manual.

The questionnaire covers many areas of prevention planning, implementation, and evaluation; all of which were covered at workshops sponsored by the Office on Alcohol Abuse and Alcoholism (OAAA).

Please answer the questionnaire as thoroughly as you can without the use of notes. Upon completion, please return it to me in the enclosed self-addressed, stamped envelope by September 5, 1979.

I hope to have the training manual completed and distributed to you by February 1980. Your cooperation, which is greatly appreciated, will serve as a stepping stone to the completion of my master's degree as well as to the development of a prevention training manual. If you would like additional copies of the questionnaire, or if you have any questions feel free to call me at (213) 455-2324 or (213) 393-0791.

Best wishes for a successful year in your alcoholism prevention efforts.

Sincerely,

Beth Schechter
Master of Public Health Candidate
APPENDIX D

NEEDS ASSESSMENT INSTRUMENT
NEEDS ASSESSMENT INSTRUMENT

Section I

GENERAL BACKGROUND INFORMATION

1. Type of service(s) provided by the agency you work for: (please check one or more)
   
   ___ recovery
   ___ outpatient
   ___ information and referral
   ___ prevention and education
   ___ administrative
   ___ technical assistance
   ___ drinking driver program
   ___ detox
   ___ other (Please specify)

2. What is your position? ____________________________

3. Please briefly describe the duties you perform that you feel are relevant to prevention and education activities:

   ____________________________________________
   ____________________________________________
   ____________________________________________

4. Education/Training:
   A. Degrees held:
      ___ Associate in Arts
      ___ Bachelors
      ___ Masters (Please specify)
      ___ Doctorate (Please specify)

   B. Certificates or specialized training you've had in the alcoholism field (briefly describe)

      ____________________________________________
      ____________________________________________
      ____________________________________________
5. Does your agency have a prevention and education contract with Los Angeles County?  yes  no

Does your agency have a prevention and education contract with the National Institute on Alcohol Abuse and Alcoholism (NIAAA)?  yes  no

6. Do you feel you have the skills necessary to implement an alcohol abuse prevention program?  yes  no

Please check area(s) in which you would like additional training:
  ____ program planning
  ____ definitions of prevention
  ____ implementation strategies
  ____ evaluation of programs
  ____ other (please specify)

7. Have you attended any prevention training seminars provided by the Office on Alcohol Abuse and Alcoholism?  yes  no

If yes, how many? ____

8. If you had an opportunity to obtain further prevention and education training, what would be the best learning situation(s) for you? (please check one or more)

   ____ a. training sessions held at varied providers agencies
   ____ b. a training manual providing detailed instructions in prevention program planning
   ____ c. the provision of individual technical assistance
   ____ d. other (please specify)
Section II

The purpose of this section is to indicate your current level of understanding of the planning, implementation, and evaluation of prevention programs. Please answer each question as best you can.

1. Briefly describe the target population your prevention activities will be directed towards:

________________________________________________________________________

________________________________________________________________________

2. When initially planning a prevention program, planners should consider as many different target groups as possible (circle one).

strongly disagree disagree agree strongly agree

Please briefly explain your choice

________________________________________________________________________

________________________________________________________________________

3. The difference between a goal and an objective is:________

________________________________________________________________________

________________________________________________________________________

4. Once an objective has been developed it should never be changed.

true____ false____

5. It is important for planners to be aware of the values and beliefs of the selected target group, as well as the surrounding community in order to plan an effective prevention program. (circle one)

strongly disagree disagree agree strongly agree

Please briefly explain your choice

________________________________________________________________________

________________________________________________________________________

6. Briefly outline the steps you can take to assure that your program has the greatest impact given the amount of your annual prevention program allocation.

________________________________________________________________________

________________________________________________________________________
7. Potential or existing alcohol problems are often hidden; therefore, it may be difficult to determine whether or not there is a need for your prevention program. Please explain the significance of this statement as it applies to your target group.

8. The statement, "To reduce the incidence of alcohol abuse among youth in East Los Angeles," is an example of a program ________________.

9. The statement, "Organize group into subgroups of three or four to discuss possible alternatives to getting high with drugs," is an example of a program ________________.

10. The statement, "To reduce by 20% the number of students at Pasadena High School who are caught using alcohol by school personnel," is an example of a program ________________.

11. Briefly describe some of the evaluation instruments that can be used to evaluate prevention programs. Include those that may be existing and those that can be developed: ________________.

12. List some "affective" prevention strategies that could be used with your target group:
   1. ________________  4. ________________
   2. ________________  5. ________________
   3. ________________  6. ________________

13. Briefly describe the sequence of steps you would take to plan, implement, and evaluate a primary prevention program.
Section III

This section will attempt to determine what subject areas in prevention program planning should be included in the development of a Prevention Providers Training Manual. Please check the most appropriate right hand column.

<table>
<thead>
<tr>
<th>1. SUBJECT AREAS (possible chapters)</th>
<th>must be included in manual</th>
<th>can be included in manual</th>
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<tr>
<td>A. Definitions and discussions of primary, secondary and tertiary prevention of alcohol use and misuse</td>
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<td></td>
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<tr>
<td>B. Current trends in prevention</td>
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<td></td>
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</tr>
<tr>
<td>C. Methodologies for conducting an accurate needs assessment</td>
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<td>D. Methodologies for the identification of appropriate target groups</td>
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<tr>
<td>E. Developing program goals and measurable program objectives</td>
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<tr>
<td>F. Description of prevention strategies and how they are applicable</td>
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<tr>
<td>G. Planning curriculum for prevention sessions: concepts, objectives, activities.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>H. Discussion of the purposes of evaluation; why, how and when to evaluate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. How to develop evaluation instruments: techniques and examples</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
2. Would you use a training manual to orient newcomers in your agency to prevention planning activities?
   yes ____ no ____

3. Would you use a training manual as reference/learning tool for current prevention workers in your agency?
   yes ____ no ____

4. Additional comments or suggestions

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
APPENDIX E

COVER LETTER FOR MANUAL EVALUATION QUESTIONNAIRE
April 28, 1980

Dear

A copy of the Alcoholism Prevention Providers Training Manual that I have developed is enclosed. The draft you have is in rough form, so feel free to write your comments directly on it.

The manual is intended for use by prevention planners with minimal expertise in prevention or program planning. For this reason, it is written in a manner which may seem simplistic to you at times. Please consider this when you are evaluating it.

I am aware of the demands upon your busy schedule and I greatly appreciate you taking the time to evaluate this manual. Your contribution to this project will be formally acknowledged in the final draft of the Alcoholism Prevention Providers Training Manual.

As a graduate student, I have strict time limits to meet. Therefore, please return the manual and evaluation questionnaire to me, no later than May 11, 1980. I have enclosed a stamped mailer for this purpose.

Cordially

Beth Schechter
1187 Canyon Trail
Topanga, Ca. 90290
(213) 455-2324
APPENDIX F

TRAINING MANUAL EVALUATION QUESTIONNAIRE
TRAINING MANUAL EVALUATION

QUESTIONNAIRE

This questionnaire includes items regarding the various aspects of the training manual you have read.

Please read each question carefully and check the appropriate response as indicated. Feel free to add any comments which you believe would lead to the improvement of the manual.

Your Name__________________________________________________________

Agency______________________________________________________________

Your Position/Title____________________________________________________

Address________________________________________________________________

Phone__________________________________________________________________

Most recent work experience in prevention_________________________________________

________________________________________________________________________

________________________________________________________________________
SECTION I: GENERAL ASSESSMENT

1. After reading this training manual, my overall reaction is:

<table>
<thead>
<tr>
<th>Very Positive</th>
<th>Positive</th>
<th>Negative</th>
<th>Very Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

If negative or very negative was checked, please comment on your reasons:

________________________________________________________________________

________________________________________________________________________

2. If you had this manual available to you, would it be used as:

<table>
<thead>
<tr>
<th></th>
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<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. A tool for orienting new staff to program planning?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. A tool for educating existing staff about program planning?</td>
<td></td>
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<tr>
<td>C. A guideline for the development of a new prevention program?</td>
<td></td>
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<tr>
<td>D. A guideline for the restructuring of existing services?</td>
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<td></td>
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<tr>
<td>E. Other?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

________________________________________________________________________

3. If the information contained in the manual was presented in conjunction with a training workshop, would the manual be more useful to you?

Yes____ No____

Please explain why.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
SECTION II: FORMAT STRUCTURE

4. Quality of Information:
   Completeness. (Were all components of prevention program-planning included?)
   Accuracy. (Was the information correct?)

5. Quality of Content:
   Content Clarity. (Was the information presented succinct and clear?)
   Content Wording. (Was the vocabulary used in the manual easily understood?)
   Interest. (Did you find it interesting?)
   Sequence of Presentation. (Was the information organized in an orderly and cohesive manner?)
   Writing Style. (Was the mode of presentation pleasing?)

6. Utility of the Manual:
   Appropriateness. (Was it relevant to the intended population?)
   Adaptability. (Is it relevant and usable by all alcoholism prevention planners?)
   Usefulness. (Was the manual structured for maximum use?)

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
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</tr>
</tbody>
</table>
SECTION II: FORMAT STRUCTURE (cont.)

7. Would you agree that this manual is a good tool and should be distributed in its final form to prevention providers?

Yes____ No ____

8. Please write comments, suggestions and concerns you may have about individual sections and with regard to general improvement of the manual.
APPENDIX G

TRAINING MANUAL
A TRAINING MANUAL
FOR
ALCOHOLISM PREVENTION PROVIDERS

Beth Schechter
May 1980

copyright 1980
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INTRODUCTION

PREVENTION - A PERSPECTIVE

"Is Prevention really a field, or just a theory?"

"It seems so abstract."

Primary prevention efforts have the greatest potential for producing beneficial results for the population at large. If primary prevention is successful, this will eliminate the need for diagnosis, treatment and rehabilitation. In addition, the social and economic losses to society and the individual produced by alcoholism will be avoided. -Dr. Ernest Noble, past Director of NIAAA

Prevention has existed ever since it was discovered that diseases were caused by organisms. Thus began rat control to lessen the fleas that carried plague; sanitation and water chlorination to eliminate cholera and typhoid; and immunizations against other harmful diseases.

PREVENTION MODELS

The prevention of problem drinking however is a much more recent phenomenon. The National Institute of Alcohol Abuse and Alcoholism, a division of the Department of Health, Education and Welfare, adopted the popular Public Health Model for the prevention of alcohol problems. This concept includes the relationship between an Agent (the individual) the Host (alcohol) and the Environment (the setting or context in which drinking occurs). This model has been successfully used in dealing with the prevention of infectious diseases. However, if has been found less useful when dealing with
the primary prevention of alcoholism.

Two other models are referred to when focusing on primary prevention—the Distribution of Consumption and the Sociocultural Approach. In 1956, Lederman introduced the "logically based" consumption model, i.e., lessen the consumption of alcohol and you will lower the rate of alcohol problems and alcoholism. The dilemma arises when a method for lessening consumption is attempted. That is, most methods formulated under this approach seem punitive and unrealistic—including State vs. Private control of distribution and sale of alcoholic beverages; restrictions on the hours of sale of alcohol; restrictions on the number and location of liquor outlets; increases in the costs of alcohol; and the introduction of heavy taxes on distilled spirits, as well as beer and wine.

The consumption model has been criticized for its potential to cause reactions similar to those experienced during prohibition, such as illegally produced alcoholic beverages and the reinforcement of the mystique surrounding alcohol use.

The sociocultural approach explores internal motivations and environmental influences for drinking. These include individual mores and values and the norms and standards set by society. According to this model, a society which condones the use of alcoholic beverages in a variety of settings by a majority of people, will tend to have more alcohol related problems. Alcohol use is deeply rooted in our society, in our rituals and traditions and encouraged, even promoted by
advertising, in films, radio and television.

If this model were successfully adopted, our society would have very specific and widely agreed upon rules regarding the use and abuse of alcohol. Drinking would be integrated into our lives, rather than considered a separate occurrence, often clandestine activity. Bars and taverns would be bright, cheery and sociable places to meet friends, rather than simply a place to drink.

These models contain aspects that can aid you in the development of a comprehensive prevention program. However, none of the models contain all the answers to the difficult questions of why people drink abusively and how to prevent this abuse, which is often associated with many biological, social and psychological factors. It is up to a creative and resourceful prevention worker to explore the best way to reach their potential target audience and design the most rational approach to use.

My intention for this manual is to provide prevention workers with instructions and techniques to plan and successfully implement and evaluate a prevention program. A step-by-step approach is used and is presented in a self-instructional manner. Pre/post tests and example problems have been included to better prepare you for actual program design.

Prevention programs can be exciting and educational for those who design them as well as those who participate in them. I hope that this manual will help to simplify the seemingly impossible task of
preventing alcohol abuse and that it will provide a basis for the development of many new prevention programs.

Beth Schechter
THE DEFINITION OF PREVENTION

"No one ever seems to know what prevention really is; how we can provide prevention services when the definitions are so unclear."

There is nothing complicated about the term "prevention". Public health terminology divides prevention into three categories: primary, secondary and tertiary.

Primary prevention can be defined as the application of procedures to reduce the occurrence of drinking problems in a community. It centers upon preventing and minimizing the development of new cases, or lowering the incidence. This contrasts with secondary prevention which includes early case-finding and early treatment of existing problems, or reducing prevalence. Tertiary prevention provides treatment and rehabilitation services for the chronically ill, so as to prevent further complications or involvement with alcohol.

Prevention, when referred to in this manual, is concerned with the elimination of new alcohol problems.

The confusion about prevention usually revolves around the provision of prevention services. The Los Angeles County Office on Alcohol Abuse and Alcoholism refers to prevention services as "planned and coordinated activities (what's that?) integrating facts, concepts, values and skills (what are those?) which promote responsible decision making (how vague!) regarding the use of alcohol."
The modality now referred to as "prevention" currently stands alone as a complex, controversial and mysterious indirect service.

The following sections will break down the why's, how's and when's of prevention services and hopefully eliminate the mystique that surrounds the term "primary prevention".
PLANNING A PREVENTION PROGRAM - AN OVERVIEW

"Sure it's easy for them to say plan a program; but where do you begin?"

Believe it or not, there are specific steps you can take to plan a prevention program. Oh sure, there are innumerable techniques and formats that could be used but most of them overlap in one or more ways. The steps used in this manual could, in fact, be used for planning in many fields, not just health.

There are six steps that will be examined in detail in subsequent sections. The following is a brief discussion of the roles each step plays in program development.

1. Problem Identification - This is really a definition of the problem.
   a. Narrows the problem down from a global perspective to a specific one. For example: alcoholism in the United States, in California, in Los Angeles County, in Central Region, in East Los Angeles, in the Maravilla Housing Project.
   b. Defines the problem in your specific target population. This includes the identification of a target group.
   c. Supplies a baseline of demographic data (age, income, occupation, etc.) and some attitudinal and behavioral information about the target population.
2. **Needs Assessment** - This is an identification of target population's needs which arises from defining the target population for your program.
   a. Determines what the knowledge, attitudes and behaviors within the target population are which contribute to or perpetuate the problem. For example: knowledge that alcohol is a drug; attitude that drinking is a sign of one's manhood; behavior of drinking on certain occasions.
   b. Identifies what types of interventions or programs might be appropriate for the target population.

3. **Selection and Prioritization of Needs**
   a. Identifies specific needs in terms of programmatic possibilities. For example: using the target population in La, the adult males in Maravilla may need programs which deal with cultural values about alcohol use; the children may benefit from a values awareness and cognitive education program.
   b. Determines which needs are program priorities based on several relevant factors, such as resources (including staff, time and money), accessibility, materials, etc.

4. **Setting Goals and Objectives**
   a. Provides concrete guidelines for program activities.
   b. Provides explicit guidelines for developing and/or choosing methods of evaluation.
   a. Provides an opportunity to select activities and strategies that will meet program goals and objectives.
   b. Specifies types of materials, resources, agenda and curricula to be used.

6. **Evaluation**
   a. Determines how successfully objectives were met.

The above explanations of the six steps are meant to introduce you to the variety of activities that occur within each step of the planning process. Now each step will be examined much more closely.
SECTION ONE

PROBLEM IDENTIFICATION
PRE/POST TEST 1

1. When planning for prevention we try to consider as many different groups of people as possible.  T    F

2. Owing to limited funding amounts, the first steps in planning for prevention is to limit your resource material.
   T    F

3. Identifying a target group enables one to develop a program that is more relevant to that group.  T    F

4. List two ways in which to narrow down your target population:
   1. 
   2. 

5. We must be aware of the values and beliefs of the target group in order to conduct effective program planning.  T    F

6. A program that has not focused in on a specific target population will most likely be headed in many directions and not have a clear sense of what they have accomplished.  T    F

7. When you identify your target population, you do not consider individuals who may be a high risk.  T    F

8. One reason it is a good idea to describe your target population in writing is because it will serve as a reference to all program planners and workers in your agency.  T    F

9. A description of your target population should include demographic data.  T    F

10. Problem identification and needs assessment are related activities.  T    F
PROBLEM IDENTIFICATION - Where To Begin?

"It seems everyone could be included at risk as a potential alcohol abuser!"

All alcoholism prevention workers are trying to prevent the establishment of new cases of alcohol abuse in a given community. Because of this common predetermined purpose, the problems associated with alcohol abuse are clearly spelled out. It then becomes important to narrow the community down to a workable size.

A community in its true sense means more than a particular geographic location. A community is most often defined by its members and their interests and life styles. For example; the lesbian women in Los Angeles County are a community, as are all Mexican American males from ages 15-30 in East Los Angeles. When identifying your problem, you must first "research" the community at large. This gives you a global perspective of the problem. Alcoholism among gay women in the United States may be a place to start - alcoholism among gay women in Hollywood may be a community to research and plan for.

Once the problem is determined and the community clearly defined, then your target population within the community should be identified.

Example 1.
Alcoholism prevention among Mexican American males ages 15-30 (problem) in the Maravilla housing project (target population)
Thus your target population becomes Mexican American males ages 15-30 in the Maravilla housing project.

Example 2.
The prevention of binge drinking among high school students (problem) (community)
at Pasadena High. (target population)

Example 3.
The prevention of excessive drinking among gay women, (problem) (community)
who regularly participate in consciousness-raising groups (target population)
in Los Angeles County.

The identification of a specific target population usually determines the geographic location in which you will work and/or the commonalities of your particular group members.

Several ways to narrow down the target population:

1. Identify those who are potentially at risk.
2. Specify age, ethnic, cultural, socio-economic status and any other common grounds.
3. Identify those who can be reached through channels of communication that are within the budget of your services.
4. Determine a common activity or location where the group can be reached.
5. Choose those who will diffuse information to others.
6. Identify those who are closely related in their interests or life styles.

Why Bother to Specifically Identify the Target Population?

There is one glaring reality amongst planners in the field of alcohol abuse prevention - prevention is an awesome task!! If we began by trying to work with all potential abusers in Los Angeles County, then we could theoretically include all persons who are not currently admitted alcoholics as our target population.

By being very specific about your target population, you can develop a program whose scope, impact and quality will be maximized. This point is extremely important since prevention workers must be concerned with limited resources, including staff, money and materials and stretching these as far as possible while maintaining top quality. A program that has not focused in on a specific target population will most likely be headed in many directions and not have a clear sense of what they have accomplished. Boundaries within which to do evaluation can only be developed if the specifics of your program are well defined, with the identification of your target population being of prime importance.

As stated earlier, theoretically the entire population of Los Angeles County could be considered at risk for alcohol abuse. The process of defining a specific target population weeds out low risk individuals and identifies high risk groups. By working with identified high risk individuals it will be easier to focus in on their
particular needs and to develop a program whereby evaluations will demonstrate the worthwhile nature of the endeavor.

What do I do with all this information?

It is a good idea to describe your target population in writing. This will serve as a reference for all program planners and workers. The description may also be necessary to justify the program to the funding source.

The description should include:

1. The geographic location of the target population.
2. Demographic data such as: age, socio-economic status, ethnicity, occupation, etc.
3. A listing of cultural beliefs, attitudes and values that may affect the problem. (These are further expanded and analyzed in the needs assessment process)
4. The identification of key people (gatekeepers) in the target population who may assist in program development or implementation.

It must be stressed that problem identification is an important preliminary activity prior to designing every program. It is part one of a two part initial research process that a well planned program includes; part two being a needs assessment.
SECTION TWO

NEEDS ASSESSMENT
PRE/POST TEST #2

1. A needs assessment is considered most beneficial when there is an opportunity and commitment for planning new services or restructuring existing ones.  T  F

2. In order to gain an overall understanding of the target population a needs assessment should be conducted.  T  F

3. The best way to begin a needs assessment is to survey the target population and gather as much information about it that you can.  T  F

4. When the needs assessment has been completed, further feedback from the target population should be ignored.  T  F

5. A needs assessment can determine the existing knowledge of the target population.  T  F

6. Subjective means of gathering information about the target population such as thorough personal interviews, is one valid method of getting needs assessment information.  T  F

7. It is important to be aware of the community's viewpoint on alcohol abuse before planning an alcohol abuse prevention program.  T  F

8. If there is no apparent need for a program, then the idea should be dropped.  T  F
NEEDS ASSESSMENT - Burden or Blessing?

"We could spend all our time and money doing a needs assessment and never provide any services."

"Yeah, then we'd never get re-funded."

It's true that the needs assessment process requires a considerable expenditure of energy and money. Therefore, a needs assessment is considered most beneficial when there is an opportunity and commitment for planning new services or restructuring existing ones. If this commitment is absent, no purpose is served by the assessment process.

Basic to prevention services is the need to offer alternatives to existing detrimental beliefs, behaviors and practices to your target population. This is often a difficult task to provide. For this reason the message of your program must be prepared carefully and thoughtfully if it is to be acceptable and relevant to the target population. The needs assessment allows the planner to thoroughly investigate information that could make the difference between a poorly or well planned program. Because of this, the most important time to carry out a needs assessment is in the early stages of program development. The data will be important in defining the goals and objectives of the program and in identifying the problems it will eventually address.
There are several reasons why it is a good idea to do a needs assessment:

1. It can give you information about the target population.
2. It can identify priority problems and needs to focus in on during program development.
3. It can provide an overall understanding of the target population, including their values, beliefs and cultural practices.
4. It can provide objective (statistical) and subjective (opinions) information about the target population.
5. It can identify existing resources (monetary, material and human) available within the community.
6. It can determine the strategies that would be feasible for program implementation.
7. It can provide information that can lead to the development of a prevention program which is acceptable and relevant to the target population as well as to those providing the service.
8. It can provide a basis for understanding evaluation.

WHERE TO BEGIN?

Before you spend your money a preliminary search may identify information and data already compiled in the community. Investigations starting from scratch are lengthy and costly. There are many sources that may have much of the information you need:
1. The State Alcoholism Authority in Sacramento
2. Health departments and health organizations
3. The County Office of Program Planning and Research
4. The National Council on Alcoholism (NCA)
5. Colleges and universities - USC Norris Library has knowledge of local studies and will assist you in any way with information gathering.
6. Funding agencies such as the Los Angeles County Office on Alcohol Abuse and Alcoholism and The National Institute on Alcohol Abuse and Alcoholism
7. Clearinghouses such as the National Clearinghouse for Alcohol Information (NCALI) and Pyramid in Walnut Creek, California, provide materials, information and personal help with your needs assessment and program.
8. Los Angeles County Regional Planning Office
9. Los Angeles County Bureau of Records and Statistics
10. Criminal Justice Office
11. Social Welfare Department

The last four sources mentioned are non-alcoholism related that may have a great deal of public data available for use by your program. This type of data is useful for describing a community in general or to identify special service needs.

When dealing with statistics, it is important to consider the validity and reliability of the data collected. Data that is valid
is logical, well-founded, and able to be substantiated. Reliable
data contains accurate and dependable information.

The Use of Social Indicators

Very often a prevention programs' only means of evaluation is to
demonstrate that certain alcohol related problem behaviors have been
reduced as a possible result of the program. These may include the
consumption of alcohol, conviction rates (drunk driving, felonies),
arrest rates (public inebriacy, purchasing liquor under age), traffic
accidents (fatal and non-fatal), school problems (drunk in class,
absenteeism), employment and occupational problems (absenteeism,
unemployed, lowered productivity, drunk on the job), etc.

It might be a good idea to gather baseline data on problem areas
within the target population you would like to focus on. Then you
could compare these data with the data you gather during and after
your program.

Collecting New Information

Once you have a good supply of statistics and other data from exis-
ting sources you can begin surveying your target population for
information.

It would be a long and tedious task to survey your entire target
population, even though this would give you a good deal of useful
information. The next best thing is to identify leaders within the
target population, also known as gatekeepers and interview them. "Gatekeepers" are those who interface with the target population on a regular basis and/or are in a leader capacity. If your target population is youth at a particular school, the gatekeepers may be the principal, teachers, school president, coaches, parents, club presidents, etc. If your target population is lesbian women in consciousness raising groups, your gatekeepers may be the leaders of the group, counselors who participate, or sub-group leaders.

**How To Survey**

For a prevention program it is important to ascertain community viewpoints (attitudes and values) on problems and needs. An extensive survey can be complicated and time consuming. Therefore, information that you feel will assist you in developing a meaningful program should be determined prior to embarking on the task. Surveys can be done in a variety of ways:

1. through the mail  
2. in personal interviews  
3. on the telephone  
4. at a community forum  
5. at a gatekeepers workshop

**What Kinds of Questions should be Included in the Survey?**

1. They should be concise and to the point  
2. They should be easy to understand
3. Should ask for opinions about the community and the service you plan to provide
4. Should determine attitudes about alcohol abuse
5. Should identify demographic information
6. Should ask for specifics about the target population that you feel would be useful
7. Should determine ways of presentation that your target population would be receptive to.

Some Pointers For Doing a Needs Assessment

1. Provide a way for feedback to reach you.
2. Be convinced that the target population needs the services you provide and communicate this to those you interview
3. Give the gatekeepers a chance to participate in the program planning and/or implementation
4. Be open to program suggestions and ideas the gatekeepers may have
5. Be flexible
6. Be aware of possible "hidden agenda" items. For example, teachers may strongly deny any alcohol problems in a given school, but may in fact be saying a problem exists but they can't speak of it
EXERCISE FOR NEEDS ASSESSMENT AND PROBLEM IDENTIFICATION

You have been hired by the City of San Gabriel to develop an alcohol abuse prevention program. Your budget is $20,000. What steps can you take to determine what services would be most appropriate for San Gabriel.

Steps necessary for problem identification

Steps necessary for identifying potential target populations

Steps necessary for doing a needs assessment of chosen target population
SECTION THREE

SELECTION AND PRIORIZATION OF NEEDS
1. Analysis of subjective data is one step of the prioritization process.  
   T   F

2. Most of the problems identified in the needs assessment will be included in your prioritized needs.  
   T   F

3. Resources need not be considered at this point of program planning.  
   T   F

4. Needs and problems should be matched with the values, attitudes, practices or statistics that verifies them.  
   T   F

5. The prioritization phase eliminates those needs and problems that would not be feasible for your program to handle.  
   T   F
Selection and Prioritization of Needs

"A lot of information about my target population is great, but what do I do with it?"

A very important step occurs following the needs assessment. Hopefully your needs assessment has provided you with a good deal of general and specific information about your target population. This information needs to be examined in terms of programmatic possibilities. Some points to consider:

1. Determine which of the general data (statistics taken from existing sources) relate to your target population and are important to know. For example: the number of teenagers in a geographic area who are arrested yearly for drunk driving.

2. Determine which of the subjective data (attitudes, values and practices identified through gatekeepers and community) are relevant and realistic to your program. For example: it is probably necessary to know that teenagers often drink due to peer pressure.

3. Prioritize needs and problems based on importance in the community and on what your program can handle.

4. Determine which of the needs or problems you have identified can be incorporated into a prevention program.

5. Identify program and community resources available to develop and implement the program. Include staff, money,
time, materials, other interested persons, and facilities.

6. Match the needs and problems with relevant values, attitudes, practices and other data identified in the needs assessment; and in turn match those with a strategy that the target population will be receptive to.
**SAMPLE WORKSHEET**

**Target population** - Juniors and Seniors at Polytechnic High

<table>
<thead>
<tr>
<th>Needs/Problems</th>
<th>Sources</th>
<th>Values/attitudes/practices</th>
<th>Possible Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-10 students found drunk in class per month</td>
<td>teachers</td>
<td>-it's &quot;hot&quot; to drink at school</td>
<td>develop a values awareness program for the teachers to implement</td>
</tr>
<tr>
<td>Boys drink more than girls</td>
<td>student leaders</td>
<td>-good girls don't drink</td>
<td>same as above</td>
</tr>
<tr>
<td>Grades have been getting lower--Monday absences on the rise</td>
<td>school records</td>
<td>-student apathy about grades</td>
<td>Provide career workshops based on student interest, coordinate with businesses around town</td>
</tr>
<tr>
<td>Three Polytech students killed month in car accident. Two had been drinking</td>
<td>police records</td>
<td>-weekend binge common</td>
<td>coordinate weekend activities, provide alternatives</td>
</tr>
<tr>
<td>Empty beer cans and bottles found around campus</td>
<td>Janitors</td>
<td>-fear of not being one of the crowd</td>
<td>alternatives</td>
</tr>
</tbody>
</table>
This phase of your program planning should eliminate those needs and problems that would not be feasible for your program to handle. It should also determine which of the strategies you could effectively implement and then evaluate.

This is a time to be realistic about the capabilities of your agency—consider types and number of staff needed and their abilities, money necessary, materials you would like to use, as well as, commitment to the program and to prevention. Remember, prevention activities are well planned, coordinated and integrated facts, skills, practices and values which promote responsible decision making regarding the use of alcohol. This can rarely be achieved in a routine lecture or by a film presentation alone.

You are now ready to begin developing the actual program sessions or activities that will occur. Keep in mind that what you have written in this phase of the planning process can be changed. You may find that the goals you had in mind may be too idealistic and difficult to accomplish. Stay flexible and open to new ideas throughout this phase.
EXERCISE 2 - Selection and prioritization of needs

Target population - Spanish speaking adults at Maravilla Housing Project. Fill in some needs/problems, values/attitudes/practices, and possible activities to do with this target population. Do this spontaneously. Don't worry about your facts being correct.
**EXERCISE 2 - Selection and prioritization of needs**

<table>
<thead>
<tr>
<th>Needs/problems</th>
<th>Sources</th>
<th>Values/attitudes/practices</th>
<th>Possible activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public inebriate arrests on the rise</td>
<td>police</td>
<td>-It's manly to drink</td>
<td>Training of residents as tutors to others</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-It's manly to be able to hold one's liquor</td>
<td></td>
</tr>
<tr>
<td>Women reporting abuses by husbands</td>
<td></td>
<td>-girls can drink too</td>
<td></td>
</tr>
</tbody>
</table>
SECTION FOUR

GOALS AND OBJECTIVES
PRE/POST TEST 4

1. Goals are long-term and far-reaching. T F
2. Many objectives can be developed to reach a particular goal. T F
3. Objectives are always measurable. T F
4. If objectives are not accomplished, this is an indicator of program failure. T F
5. Objectives must be strictly adhered to throughout a prevention program. T F
6. Goals are really useless since they are so idealistic. T F
7. The only effective objectives are those that measure specific outcomes. T F
8. It is important to determine the evaluative criterion for each objective. T F
9. If an objective has been accomplished, a specific activity, outcome, or performance will have taken place. T F
10. Activities are developed to accomplish objectives. T F
NEXT STEP--Developing Goals and Objectives

"Writing goals and objectives seems like so much busy work. I never seem to understand their purpose."

One of the most important, and sometimes, one of the most difficult tasks of program development is to state in a clear, precise way, its goals and objectives. Very often, the distinction between the two is confused or fuzzy. They are actually quite different from each other.

Goals are statements of broad intent regarding what it is the program hopes to accomplish or achieve overall. They are long-term and far-reaching. They set initial limitation for the program.

Objectives are clearly written statements which describe a desired accomplishment in specific observable terms. They define specific outcomes and are measurable.

Key points about objectives:
1. They indicate specifically what the target population is expected to achieve.
2. They consist of a concrete action verb and reference to a specific activity, performance or outcome that will occur.
3. They may need modification as the program progresses.
4. They are measurable.
5. They provide guidelines for program activities.
6. They provide guidelines for program evaluation.
7. They do not always measure program success.

Being able to determine clear goals and objectives is vital for program planning, implementation and evaluation.

Writing Goals

The overall goal of an alcoholism related primary prevention program is to prevent the use of alcohol. This of course is unrealistic in today's society since alcohol use is an integral part of life for many people. It therefore becomes important for you, as the program planner, to identify a specific and rational goal based on the particular services you wish to provide.

Sample goals

For adult men - Promote responsible drinking habits.

For high school students - Increase awareness of alcohol use and misuse among teenagers.

You must determine how goals will be accomplished in the form of program objectives.
Developing Objectives

Objectives may describe three things:

1. an activity that will occur during the program
2. an outcome that will occur as a result of the program
3. a performance that will occur as a result of the program

An objective always describes:

1. what is expected to be accomplished
2. the conditions (if any) under which the expected will take place
3. the evaluative criterion for determining if an objective is to be considered accomplished

Sample Objectives

Activity objective - Program participants will identify five ways in which a host or hostess can promote responsible drinking at a party.

1. Expected - can identify
2. Conditions - none
3. Evaluative criterion - five ways should be identified

Outcome objective - One month following the completion of this program, there will be a 15% decrease in liquor consumption by students reporting previous use.

1. Expected - a decrease in liquor consumption
2. Conditions - one month following program
3. Evaluative criterion - a 15% decrease will occur
Performance objective - Upon completion of the program, 12th grade health instructors will be able to demonstrate the effective use of values awareness techniques in alcohol education sessions.

1. Expected - demonstrate effective use of values awareness
2. Conditions - upon completion of the program
3. Evaluative criterion - must know specific techniques of values awareness

As you are writing objectives, keep in mind the specific outcomes or indicators, you, as the program leader or planner will be looking for to determine if the objectives have been accomplished.

Consider all the objectives necessary to fully accomplish your overall program goal. It will probably take several objectives to achieve a desired goal.

Remember, objectives should be within your program's capacity to accomplish. (Expecting to change 50% of the target population's behavior is unrealistic) They also should be flexible enough to alter slightly during program implementation if it appears they will not be accomplished as is.
Exercise 3 - Program Goals and Objectives

Develop a goal for an alcohol abuse prevention program for your target population. Write an activity, outcome and performance objective to achieve the goal. Identify the 1) expected, 2) conditions, and 3) evaluative criterion for each objective.

Goal:

Activity Objective:

1. Expected:
2. Conditions:
3. Evaluative Criterion:

Outcome Objective:

1. Expected:
2. Conditions:
3. Evaluative Criterion:

Performance Objective:

1. Expected:
2. Conditions:
3. Evaluative Criterion:
SECTION FIVE

IMPLEMENTATION
PRE/POST TEST

1. There are currently six prevention strategies. T F

2. Affective education includes programs that explore values related to the use of alcohol. T F

3. Effective Parenting Training is a program which trains counselors to identify people who will make poor parents. T F

4. The information strategy is considered obsolete and therefore, useless. T F

5. The alternatives strategy allows for a great deal of creativity and imagination on the part of the program developer. T F

6. Prevention strategies are very clear cut and well established. T F

7. Prevention activities are most often geared towards young people. T F

8. The alternatives strategy is based on the premise that people turn to drugs because of a lack of other satisfying experiences. T F

9. Strategies should be planned for the purpose of accomplishing objectives. T F

10. A program that does not mention any information about alcohol cannot truly be considered an alcohol abuse prevention program. T F
PREVENTION STRATEGIES CAN BE FUN

"Will someone please tell me what you can do to prevent alcohol abuse?"

What causes a person to use and abuse alcohol? Authorities now feel it is a combination of many factors including psychological, emotional, physical and intellectual. So what should be the focus of an alcohol abuse prevention program?

There has been a lot of talk lately about helping an individual make the right choices. There is also emphasis being placed on understanding values and personal motivations that lead an individual to make decisions. There are in fact, alcohol and drug abuse prevention programs that don't even mention the substance being abused in their content.

So what should a prevention program consist of? Since the goals of substance abuse prevention programs have broadened in recent years from increasing cognitive understanding to changing values, attitudes and behaviors, a variety of prevention activities, termed strategies, have been developed/expanded upon. Six of these strategies will be discussed briefly here. References for further investigation are included at the end of this section.

Strategy One - Information

This approach is most commonly used in a lecture presentation that consists of facts and general discussion about alcohol and its
effects. This approach by itself has been found to be insufficient to produce the desired behavioral outcomes of prevention. It has been suggested that information be combined with other approaches.

Strategy Two - Affective Techniques

These techniques, more than any other, may seem unrelated to the subject of alcohol abuse prevention. The most well known approaches rarely mention the term alcoholism or deal with any alcohol information. They are more concerned with increasing awareness about values, building self esteem, improving decision making and coping skills. Each approach requires familiarity on the part of the group leader if it is to be at all effective. Combinations of affective techniques with other strategies is both popular and successful.

Strategy Three - Alternatives

This approach is based on the premise that people today often lack meaningful and satisfying experiences in their everyday lives and therefore turn to drugs as a way to fill this gap. Dr. Allen Cohen of the Pacific Institute for Research and Evaluation believes that drug abuse is a response to an experience deficiency. He feels that our institutions are not providing an adequate context for the kinds of exploration and experience that meet human needs. Therefore they sustain some of the underlying motives for drug use.

Alternatives offer a wide variety of activities for participants to engage in. These activities can correspond to the motives or needs
that lead an individual to use drugs. For example, a need for physical relaxation may lead a person to use alcohol or tranquilizers. An alternative activity to the use of the drug may be relaxation exercises, meditation or yoga. Other activities may include physical recreation, political or social service involvement, dance or hobbies.

The alternatives strategy is a complex undertaking that requires long-term commitment and unusual organizing skills on the part of the group leader.

Strategy Four - Life Career Planning

Many people today have difficulty determining how or where they fit into the job market of our constantly changing society. Life career planning is a concept and an increasingly important prevention strategy that aims at helping people, particularly young adults, focus on long range goals for life and work. "Real life" experiential learning in the form of actual jobs or on the job training, can be initiated, as well as structured and intellectual exercises and workshops.

Strategy Five - Tutoring and Counseling

This strategy includes the training of group participants as peer counselors and tutors, and as cross-age counselors. This provides participants with a worthwhile skill and a chance for understanding themselves while they are counseling others with similar problems. This type of strategy could be implemented at a school, church,
youth group, club, business, or offered through your agency. The training program for counselors consists of alcohol education and basics of counseling and listening.

Tutors work with individuals in subjects they excel in; for example: reading, english-spanish, spanish-english, mechanics, sewing, painting, etc. It is up to the program leader to identify potential counselors and tutors and their areas of expertise.

**Strategy Six - Effective Parenting Programs**

Research has shown correlations between families and their adolescents self-esteem and chemical use. It has been found that good parenting skills can aid in making family members more considerate of each other, can help parents to build their children's sense of self worth, and provide families with healthy, constructive ways of solving the normal conflicts of family life. Therefore, parents and families have the potential to play a primary role in the prevention of alcohol abuse.

Parenting workshops are often based on the work of Thomas Gordon, developer of Parent Effectiveness Training (P.E.T.). This technique, in combination with other prevention strategies, can make for an interesting and worthwhile prevention program.

A helpful series of books to have readily available when planning a prevention program is *Balancing Head and Heart: Sensible Ideas for the Prevention of Drug and Alcohol Abuse*, by Eric Schaps, Ph.D.
(see resource section for address of publisher). This three book series has one entire book devoted to strategies.

Another place to turn to for information about strategies is the Pyramid Project in Walnut Creek, California. This is a program funded by the National Institute of Drug Abuse for the sole purpose of providing technical assistance to drug and most alcohol programs with planning, implementation and evaluation. They are particularly well versed in prevention. There is always the National Institute of Alcohol Abuse and Alcoholism and the National Clearinghouse for Alcohol Information. Addresses of all these agencies can be found in the resource section.

**Pulling It All Together**

Once you have done a thorough investigation of the strategies you could use in your program, you should match objectives with appropriate strategies. You must also take a look at the resources needed to carry out certain strategies and to accomplish your objectives. You may want to implement a strategy that upon closer examination is too large of an investment in time and money for your program to handle.

At this time you have another chance to determine if your objectives are realistic for your program goals. Consequently, you may discover that your objectives sound better on paper than in reality. If this is the case, you may need to alter your program goals. However, the
steps discussed in this and the previous sections are done simultaneously in many instances and serve as a system of checks and balances. Therefore, having to begin again with new goals and objectives probably will not happen.
EXERCISE 4 - Implementation

Develop goals and objectives for an alcohol abuse prevention program for Juniors and Seniors at a local high school. Determine activities that could be used to accomplish the objectives. Note: there are many more activities than described in this chapter.

**GOAL:**

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>ACTIVITIES</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>

Suggestion: check goals, objectives and activities for feasibility with the resources actually available to your agency for a prevention program.
SECTION SIX

EVALUATION
PRE/POST TEST

1. Evaluation is our only way of measuring a program against the goals and objectives it has set out to accomplish.  
  T  F

2. Evaluation is done for the sole reason of determining strong and weak points of a program.  
  T  F

3. Evaluation is important for agency and program development.  
  T  F

4. The only appropriate time for evaluation is upon completion of a program.  
  T  F

5. Data about a target population collected during the needs assessment can be used for comparisons following the program.  
  T  F

6. An evaluation plan is an oral agreement with all program leaders about what types of evaluation will be done.  
  T  F

7. Written evaluation reports are useful when justifying program effectiveness to the funding source.  
  T  F

8. Evaluation instruments that are not pre-tested as valid and reliable should not be used.  
  T  F
IS EVALUATION A THORN IN OUR SIDE?

It is very difficult to evaluate something that has not occurred. This is exactly what you are attempting to do when evaluating alcohol abuse prevention services. How can you begin to know how many potential cases of alcohol abuse you will prevent by your program? You can't! That is why you must design specific activities, outcomes and performances into your program that can be evaluated.

Evaluation is our only way of measuring the effects of a program against the goals and objectives it has set out to accomplish. This provides information for decision-making about the program and for improving future programming. Other reasons for evaluation include: to refine activities and approaches being used to determine strong and weak points of the program, to compare services provided with resources available, to determine if the services are meeting the target population's needs, and to assess the effectiveness of your agency as a prevention provider.

Very often providers are asked to justify the services they are providing to the funding source. This type of imposed evaluation can become a chance to claim accountability for a good program rather than to fear the discovery of poor qualities by the evaluators. This can be accomplished by performing ongoing evaluation within your agency so that negative program qualities can be weeded out internally. Of course a successful program will be re-funded.
Planning Evaluation

It is a good idea to build evaluation into the planning process. Techniques for evaluation should be determined prior to implementation. Any data that needs to be collected should be available at evaluation time. This type of data can be used as indices to measure changes in the target population's behavior as a result of your program. (For examples see section on needs assessment). Evaluation instruments that will be used should also be prepared prior to implementation. Instruments that may be useful for your program include those already developed such as attitude scale and personality inventories, as well as those that can be written specifically to monitor your services such as pre/post tests and feedback questionnaires.

Developing an evaluation plan can aid in organizing your evaluation activities. This can be developed after the completion of the needs assessment, the prioritization process, the writing of goals and objectives and the selection of activities. The plan is a short written description of what the program will consist of, the objectives to be measured, the desired outcomes, the data to be collected prior to program implementation, evaluation methods and instruments to be used, and a means for reporting findings to the funding source or to supervisors.
What To Do With All The Information?

Now that an evaluation has been completed the information should be put to use. If evaluations are used for program decision making about future programming then it should be prepared into some organized manner.

Since prevention programs are often part of a larger agency that provides other services, some sort of formal report of achievements may be requested by the director. If this is not the case, surely the funding source will ask for results. Either way, a report is a good way to organize the large amount of data you have collected.

In summary, there are many good reasons for evaluating a program:

1. Evaluation determines if objectives have been met and to what degree
2. Evaluation detects problems or weaknesses
3. Evaluation demonstrates program effectiveness (particularly useful when justifying program existence to community, government, funding source, etc.)
4. Evaluation determines modifications that should be made to improve the quality of services.

Evaluation need not be a terminal process. It can occur throughout a program, particularly an ongoing one to determine modifications that can improve further services.

Remember: if you take the initiative with evaluation, you will discover and improve weak spots in the program before anyone else.
Evaluation need not be an imposed and loathed activity, it can instead be used for program and agency development and enhancement.
Exercise 5 - Evaluation

Identify several evaluation methods you feel would be useful and realistic for your specific program.

List several activities you would include in your agency's prevention program.

Determine what means of evaluation would be most appropriate for each of the above activities.

Identify plans or measures you could take in your agency to improve evaluation.
SAMPLE

EVALUATION INSTRUMENTS
1. What did you like best about this program? ______________________________________________________

___________________________________________________________________________________________

2. What did you like least about this program? ______________________________________________________

___________________________________________________________________________________________

3. Would you recommend it to a friend?
   YES _____
   NO _____
   NOT SURE _____

WHY?_________________________________________________________________________________________

___________________________________________________________________________________________

4. Do you think the program helped you in any of the following ways:
   a. Feel better about myself ___________________ A Little ___________________ A Lot ___________________
   b. Get along better with my friends ___________________ A Little ___________________ A Lot ___________________
   c. Get along better with my family ___________________ A Little ___________________ A Lot ___________________
   d. Do better in school ___________________ A Little ___________________ A Lot ___________________
   e. Improved my pride in myself and my community ___________________ A Little ___________________ A Lot ___________________
5. If you were grading the program, what grade would you give it? (Check One)
   A
   B
   C
   D
   E
   F

6. Suggestions for improvement:

   ____________________________________________
   ____________________________________________
   ____________________________________________

   EM/1X/rc
   11/5/78
1. How many times a week during the semester did the program staff visit the classroom? ______________

About how long was each session? ______________

2. What was your understanding of the purpose of these sessions? ______________

3. Did you observe any positive changes in the behavior of the students that might be attributable to the program?

<table>
<thead>
<tr>
<th></th>
<th>Great</th>
<th>Some</th>
<th>No</th>
<th>Some Decline</th>
<th>Great Decline</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Class discipline</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>b. Class attendance (e.g., tardiness, unexcused absences)</td>
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<tr>
<td>c. Attitudes towards each other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>d. Attitudes towards school</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>e. Attitudes towards drugs</td>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

4. Would you recommend this program for another classroom? Why? ______________
5. Overall grade for the program ________________________

6. Suggestions for improvement: ____________________________________________

DV/LW/rc
11/6/78
Prevention-Education Evaluation
Drug Abuse Program Office - Los Angeles County

<table>
<thead>
<tr>
<th>Agency:</th>
<th>Activity:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Leader(s):</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td>Time begin:</td>
</tr>
<tr>
<td></td>
<td>Time end:</td>
</tr>
</tbody>
</table>

Rating Group Effectiveness

### A. Goals

<table>
<thead>
<tr>
<th>Poor</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confused; diverse; conflicting; indifferent; little interest.</td>
<td>Clear to all; shared by all; all care about the goals; feel involved.</td>
<td></td>
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</tr>
</tbody>
</table>

### B. Participation

<table>
<thead>
<tr>
<th>Poor</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>One or two dominate; most passive; some not listened to; several talk at once or interrupt</td>
<td>All are really listened to; everyone has an opportunity to participate</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### C. Leadership

<table>
<thead>
<tr>
<th>Poor</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group needs for leadership not met; group depends too much on single person or on a few persons</td>
<td>As needs for leadership arise various members meet them (distributed leadership); anyone feels free to volunteer as he sees a group need</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### D. Decisions

<table>
<thead>
<tr>
<th>Poor</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needed decisions don't get made; decision made by part of group; others uncommitted</td>
<td>Consensus sought and tested; deviates appreciated and used to improve decision; decisions when made are fully supported</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
E. Trust

<table>
<thead>
<tr>
<th>Poor</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members distrust one another; are polite, careful, closed, guarded; are afraid to criticize or to be criticized</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Members trust one another; they reveal to group what they would be reluctant to expose to others; they respect and use the responses they get; they can freely express negative reactions without fearing reprisal</td>
</tr>
</tbody>
</table>

F. Creativity and Growth

<table>
<thead>
<tr>
<th>Poor</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members and group in a rut; operate routinely; persons stereotyped and rigid in their roles; no progress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Group flexible; seeks new and better ways; individuals changing and growing; creative; individually supported</td>
</tr>
</tbody>
</table>

OVERALL RATING: 1 2 3 4 5 6 7 8 9 10

Rater: ____________

Comments: ____________________________________________________________

________________________________________

________________________________________

EV/1/75
1/2/75
APPENDIX "A"

PROPOSED INSTRUMENT TO ASSESS
KNOWLEDGE, ATTITUDES, AND BEHAVIOR
ABOUT ALCOHOL AND ALCOHOLISM
SEVENTH GRADE *

This is not a test, you will not be graded!

Today's date is: __________________________

QUESTIONS ABOUT YOURSELF

1. Your age is: ________

2. Your sex is: Male _____ Female _____

3. Who lives with you at home?
   - Mother ______
   - Father ______
   - Sister(s) ______ How old are they? ______
   - Brother(s) ______ How old are they? ______
   - Others (Please identify, for example uncle, grandmother, friend)

4. What is your ethnic origin or heritage? (check only one)
   - American Indian ______
   - Armenian ______
   - Black ______
   - European ______
   - Mexican ______
   - Other Spanish ______
   - Oriental or Asian ______
   - Other ______

*Proposal for Primary Prevention Demonstration Project
Ayudate - March 1979
QUESTIONS ABOUT ALCOHOLISM

Below is a short list of questions about alcoholism. You may not know the answers to all of these questions, but try your best. Some of the questions do not even have right or wrong answers. This is not a test and I will not be grading your papers.

1. Alcoholics are people who (check all the answers you agree with):
   a. drink too much once in a while True False
   b. usually can't stop drinking once start until they get drunk True False
   c. have problems because of their drinking True False

2. Nobody can become an alcoholic by drinking just beer. (check one)
   True False

3. Most alcoholics have jobs and live with their families.
   True False

4. Almost all alcoholics are men; there are very few women alcoholics.
   True False

5. If we put alcoholics in jail, they would never drink too much again after they got out.
   True False

6. If alcoholics really wanted to, they could easily "pull themselves together" and stop drinking without anyone's help.
   True False

7. Alcoholics must drink every single day.
   True False

8. There are a lot more alcoholics in this country than drug addicts.
   True False

DRINKING EXPERIENCE POLL

Circle your answers.

1. Have you ever drunk alcohol (at least one glass)? (circle one)
   yes no
If not, skip to question 8.
2. If so, how may times? (circle one)
   1  2-4  5-10  11-20  over 20
3. When you drank, was it usually (circle one)
   alone?  with others?
4. When you drank, what kind of drink was it? (circle one or more)
   beer  wine  whiskey  other:
5. How old were you when you had your first drink? (circle one)
   under 8  9  10  11  12  13  don't remember
6. Where and with whom did you have your first drink? (circle one or more)
   with parents  with relatives  with friends
   at home  at a friend's home  at a relative's home
   in a car  in a restaurant  in school
   alone  other:
7. If you drink now, where and with whom do you drink? (circle one or more)
   with parents  with relatives  with friends
   at home  at a friend's home  at a relative's home
   in a car  in a restaurant  in school
   alone  other:
8. Do you think you can or could handle alcohol as well as or better than
   someone who is:
   40 years old  yes  no
   21 years old  yes  no
   9 years old  yes  no
9. Do you think there should be a legal drinking age? (circle one)
   yes  no
10. If you do, what should it be? (circle one)
    under age 10  11-15  16  17  18  19  20  21  over 21

QUESTIONS ABOUT ALCOHOL

Below is a short list of statements about alcohol. You may not know whether
they are true or false, but try your best. This is only a fun quiz, and I
won't be grading your paper.

<table>
<thead>
<tr>
<th>Statement</th>
<th>TRUE</th>
<th>FALSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Alcohol is a drug.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>TRUE</td>
<td>FALSE</td>
<td></td>
</tr>
<tr>
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<td>-------</td>
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<td>T</td>
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</table>

**PRESURE POINTS POLL**

**A. Personal Pressures**

1. Do you do what you think is right? (Circle one answer)
   - always
   - usually
   - sometimes
   - rarely

2. Do you give in to pressures from friends, parents, or other people?
   - never
   - sometimes
   - often

3. How important is it to you that your friends generally think the same way you do?
   - very important
   - somewhat important
   - not very important
B. Peer Pressures
4. Do your friends ever pressure you to do or not do something?
   often  
sometimes  
rarely
5. Have you given in to this kind of pressure?
   often  
sometimes  
rarely
6. Describe on the back of this page the influences that friends may have over people.
C. Parental Pressures
7. Do you feel pressured by your parents to act in a certain way?
   often  
sometimes  
rarely
8. Have you done something which you knew would be against your parents' wishes?
   often  
sometimes  
rarely
9. Explain on the back of this page why you did or might do something against your parents' wishes.
D. Societal Pressures
10. Do advertisements, newspapers, television and other media have any influence on the decisions you make?
    a great deal  
some  
very little
11. Do your community, religion, and government have any influence in the decisions you make?
    a great deal  
some  
very little
12. Describe on the back of this page the influence society may have over individual decisions.
PRIMARY PREVENTION EVALUATION INSTRUMENT

1. Which objectives in the work agreement have been met particularly well?

2. Has the program had benefits that were not anticipated before it began?

3. Describe any special or unanticipated problems that impeded the attainment of the contract objectives.

*Developed by Ed Weinstock, Drug Abuse Program Office, Los Angeles County"
### Demographic Characteristics

<table>
<thead>
<tr>
<th>4. Total number of participants enrolling in programs</th>
<th>As Defined in the Contract</th>
<th>Site Visit Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Total number of participants completing program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Geographic breakdown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>From target area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outside target area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Ethnic breakdown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>From target ethnic group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outside target ethnic group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Age breakdown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-17</td>
<td></td>
<td></td>
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<tr>
<td>18-30</td>
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</tr>
<tr>
<td>Over 30</td>
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</tr>
</tbody>
</table>

### Referral Sources

Where are participants referred from. Indicate how many or what percentage are walk-in with no specific referral.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Number of Referrals</th>
<th>Contact Person</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

### Consultation

List agencies or schools to whom consultation services are provided. Briefly indicate the extent and nature of these services.

<table>
<thead>
<tr>
<th>Agencies/Schools</th>
<th>Purpose of Consult-Visits</th>
<th>Contact Person</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation Measures (e.g., information change, attitude change, interactional skills, changes in self esteem, etc.)</td>
<td>Evaluation Method (e.g., knowledge test, attitude scale self-report, course evaluation form, school records, etc.)</td>
<td>When and how frequently is evaluation done</td>
<td>Results (that was accomplished; e.g., how much did students learn, how far did attitudes change, recidivism changes, school dropout rates, etc.)</td>
</tr>
</tbody>
</table>
If objectives were modified, give revised objective and reason for change.

<table>
<thead>
<tr>
<th>Original Contract Objective*</th>
<th>Revised Objective</th>
<th>Reason for Change</th>
</tr>
</thead>
</table>

*Obtain from work agreement
14. Are any other program statistics collected? If yes, what are they? (Append any statistical reports available.)

15. Are any qualitative and/or subjective (i.e., non-numerical) measures of program performance collected? (Append examples)

16. Describe any specific changes you have made in your program as the result of program evaluation or feedback.
Community Relations

17. Publicity regarding services:
   a. Media presentations
   b. Brochures
   c. Public talks
   d. Newspaper stories
   e. Mailings
   f. Other

   (Obtain documentation of above, if available)

Relations with Other Community Agencies

18. Does agency coordinate prevention efforts with other community agencies?
   Yes _____ No _____

19. If yes, specify the agencies and some brief indication of common activities and how responsibilities divided.

   Agency: ____________________________

   Nature of Coordination: ____________________________

20. Does the agency participate in community planning activities? (If different from activities described in previous question)
   Yes _____ No _____

   If yes, give examples:

21. Does the agency attempt to obtain community support in any form, that is, contributions or volunteer or consultant time?
   Yes _____ No _____

   Approx. # of donated hrs. ______

   Approx. Dollar value of donated materials ______

   Others: Services ______
22. Are participants referred to other services or agencies?
   Yes____ No____

23. If yes, list the services or agencies and approximate number of referrals.
   Service/Agency # of Referrals

Orienteration and Training

24. Describe orientation for new employee.

25. Is there one employee responsible for inservice training?
   Yes____ No____

26. If yes, give name:________________________________________

27. List inservice training programs or sessions conducted for staff.
   Training Program Number of Date/sessions Number of employees attending Verification

28. Have training programs been evaluated? If yes, indicate by whom and how and given results.
INFORMATION SOURCES

National Institute on Alcohol Abuse and Alcoholism (NIAAA)
National Clearinghouse for Alcohol Information (NCALI)
P.O. Box 2345
Rockville, Maryland 20852

NIAAA is a major source of funding for alcohol programs and an information center on current trends and practices.

NCALI is an information service of NIAAA. It is a central point where information is gathered from worldwide sources and disseminated. Publications are available on alcohol-related topics covering a wide range, from alcohol and highway safety to physiology of alcohol, prevention studies, and occupational alcoholism. They reply to all personal inquiries.

PYRAMID
39 Quail Court, Suite 201
Walnut Creek, California 94596
(800) 227-0438 Toll Free

PYRAMID is a nationwide pool of consultants specializing in program planning, community action, training, youth programs, alternatives, organizational development, prevention, and evaluation. They provide direct assistance and materials to state and local program personnel who request their services. PYRAMID either acts as a consultant to help work on specific problems facing an agency or identifies appropriate individuals who will be able to help.

National Institute on Drug Abuse (NIDA)
11200 Rockville Pike
Rockville, Maryland 20852

Primarily a source of funding for drug abuse programs. NIDA has materials and prevention and education which would be helpful to any prevention programmer.

National Clearinghouse for Drug Abuse Information
5600 Fishers Lane
Rockville, Maryland 20852

Distributes publications and refers specialized and technical inquiries to Federal, state, local and private information sources.
National Coordinating Council on Drug Education (NCCDE)
1526 18th Street N.W.
Washington, C.D. 20036

NCCDE is the largest nonprofit drug information and programming network, with more than 100 national member organizations. These organizations work together toward specific goals: evaluation of drug education and information materials and films, including alcohol; identification of effective programs, and dissemination of noteworthy approaches and materials.

DO IT NOW Foundation
Institute for Chemical Survival
P.O. Box 5155
Phoenix, Arizona 85015

A national nonprofit organization that researches, writes, and publishes a wide variety of literature on all aspects of drug and alcohol problems.

National Association of Prevention Professionals
850 W. Barry, Suite GA
Chicago, Illinois 60657
(312) 477-0569

Made up of prevention professionals from many disciplines who are interested in informing the public and human service professionals of current prevention efforts and thinking; supporting research and evaluation efforts in prevention, and publicizing their findings; lobbying in behalf of prevention efforts.

Center For Multicultural Awareness
2924 Columbia Pike
Arlington, Virginia 2204
(703) 979-0100

A resource center for the prevention of drug abuse among minority groups, and a centralized source of information, technical assistance, and new ideas for the prevention of drug abuse among minority youth. Its services include information on drug abuse prevention strategies and techniques and new or relevant publications.
Addiction Research Foundation of Ontario  
33 Russell Street  
Toronto, Ontario  
Canada M5S251  
(416) 595-6000  

Conduct research, educational and clinical studies of alcohol and drug use and abuse. A great deal of high quality information has come from here.

U.S. Office of Education  
400 Maryland Avenue S.W.  
Washington, D.C. 20202

National Institute of Education  
1200 19th St. N.W.  
Washington, D.C. 20208
SOURCES FOR EVALUATION INSTRUMENTS

Affective

Available from: Dissemination Office
Center for the Study of Evaluation
Graduate School of Education
University of California
405 Hilgard Avenue
Los Angeles, California 90024

Improving Educational Assessment and An Inventory of Measures of Affective Behavior. Edited by Walcott H. Beatty (Chairman, ASCD Commission on Assessment of Educational Outcomes).
Available from: Association for Supervision and Curriculum Development, NEA
1201 Sixteenth Street, N.W.
Washington, D.C. 20036

Search for Affective Instruments and Measurement Procedures. No. 4: Measurement of Affective and Humanizing Education. By Wright, Doxsey and Mathiesen.
Available from: Interstate Education Resource Service Center
1610 University Club Building
136 E. South Temple
Salt Lake City, Utah 84111

Family/Communication Skills:

Summary of Research of Effectiveness Training Programs (Revised, June 1976) and a list of tests and measurements used in evaluating effectiveness training programs by researchers and evaluators in the field.
Available from: Effectiveness Training, Inc.
531 Stevens Avenue
Solana Beach, California 92075
(714) 481-8121
Families of the Slums: An Exploration of Their Structure and Treatment, by Salvador Minuchin, et al. This is a lengthy report of a study involving delinquents and their families. Various analyses were conducted (e.g., verbal behavior analysis, family interaction tests, etc.) on changes in relations in families of those participating in this study. An extensive bibliography and various appendices are included. 1967

Self-Esteem:

Ardyth Norem-Hebeisen
Department of Psychological Foundations
Division of Educational Psychology
College of Education
University of Minnesota
330 Burton Hall
Minneapolis, Minnesota  55455
(612) 376-3024

Ms. Norem-Hebeisen has worked in the primary prevention field (particularly affective education) for a number of years and has developed some self-esteem scales.
INTRODUCTION

The Pyramid Project

Pyramid is sponsored by the Prevention Branch, Division of Resource Development, National Institute on Drug Abuse. Pyramid provides technical assistance in a broad range of areas to Single State Agencies and community prevention programs across the country. Assistance is provided through the sharing of information-ideas, data, and literature - and through on-site consultation.

Additional information about Pyramid can be obtained from the Pyramid Project, 39 Quail Court, Suite 201, Walnut Creek, California 94596, (Tel. 800/227-0438) or from the Prevention Branch, National Institute on Drug Abuse, 5600 Fishers Lane, Rockville, Maryland 20857.

The Media Center

The Media Center was initiated by the National Institute on Drug Abuse to assist the Pyramid Project in meeting requests from the field for information on prevention audiovisual materials. The Center's activities focus on:

- collecting and cataloging information on prevention audiovisuals (16mm films, videocassettes, slides, and tapes in subject areas such as alternatives, affective education, family life education);
- screening selected materials for informal review;
- providing information about prevention audiovisuals in response to individual requests; and
- publishing periodic film reports.

Films in Review

The films described in Pyramid Media Reports represent a broad range of subject areas for a variety of audiences. Each entry contains production and distribution information, availability data, and a summary of the contents of each film. Rental prices and
purchase costs are, of course, subject to change.

All entries in this report were screened by previewers who were asked to rate the films according to an informal set of criteria, including accuracy, clarity, relevance to primary prevention, and technical quality. The summaries are "reaction reports," rather than evaluations, based on the previewers' perceptions.

One important point to keep in mind about the use of films in drug abuse prevention programs is that films are not "programs." They have a significant part to play if used as tools. They are good dialogue focusers, discussion starters, and can serve as mirrors for the observers to see some part of their own past or present development, or level of understanding. Films do not have to be wholly appropriate for the audience suggested. Grown-ups often like films produced for children, and vice versa.
ANSWER SHEET FOR PRE/POST TESTS

Section One - Problem Identification

Section Two - Needs Assessment

Section Three - Selection and Prioritization of Needs

Section Four - Goals and Objectives

Section Five - Implementation

Section Six - Evaluation
APPENDIX H
PREVENTION EXPERTS
PREVENTION EXPERTS

Miriam Black
Project Focus/Glendale Guidance Clinic
Program Director
417 Arden
Glendale 91203
(213) 240-0783

Debra Blaze-Temple
Office on Alcohol Abuse and Alcoholism
Assistant Modality Manager
849 S. Broadway
Los Angeles 90012
(213) 974-7201

Catherine Carlton
San Fernando/Antelope Valley Health Services Region
Administrator, Family Planning and Prenatal Services
7533 Van Nuys Blvd.
Van Nuys 91320
(213) 997-1800 extension 461
Most recent work experience in prevention: Alcohol Services Coordinator, San Gabriel Health Services Region 4-25-79

Irene Gilbert Hiscock Gibson
Los Angeles County Department of Health Services
Planner, Drug Abuse Program Coordinator - Coastal Health Services Region
Drug Abuse Program Office
849 S. Broadway
Los Angeles 90012
(213) 974-7151

Joe Hori
Los Angeles County Department of Health Services
Contracts Administrator
313 N. Figueroa
Los Angeles 90012
(213) 974-9675
Most recent work experience in prevention: former Chief of Planning and Prevention, Office on Alcohol Abuse and Alcoholism, 1-1979
PREVENTION EXPERTS (cont.)

Marsha Kelback
East Los Angeles Child and Youth Clinic
Assistant Administrator
929 N. Bonnie Beach Place
Los Angeles  90063
(213) 267-2901
Most recent work experience in prevention: former prevention Coordinator, Office on Alcohol Abuse and Alcoholism, 4-79

Linda Mandel
California Women's Commission on Alcoholism
Associate Director/Training Specialist
239 E. Manchester Blvd.
Inglewood  90301
(213) 678-1147
Most recent work experience in prevention: currently involved in Fetal Alcohol Syndrome Project, trainer of U.C.L.A. Prevention Skills Class

Anita Peckham
Los Angeles County Department of Health Services
Prevention Coordinator, Drug Abuse Program Office
849 S. Broadway
Los Angeles  90012
(213) 974-7162