Activating Communities to Reduce Risks for Health and Behavior Problems

INTRODUCTION

If my Irish father-in-law were here to introduce me today, you would have heard a different introduction. He would say to you: “I’d like you to meet my son-in-law, Dave. He is a doctor but it is not the kind that does you any good.” It is a real honor to be here from Seattle in what I consider our Sister City, Minneapolis. The Great Northern Railroad first connected our two cities, and we have much in common, such as our two-seasons winter and August. August seems to be coming to Minneapolis a little bit early this year, which is nice. It is also a real honor and privilege to be here as the Konopka Lecturer. Gisa has been a pioneer and a leader in our field of social work; a social networker who has connected many people to one another. I want to thank her for that, for her inspiration, and for this lectureship.

I also want to introduce you to my family. My wife, Maureen, and I have been married for 23 years; our son Quinn is 12; our daughter Nora is 7. My commitment to prevention of health and behavior problems in children and adolescents is built upon my commitment to those two young people. From that foundation I have developed my commitment to the larger professional interests that we will be talking about today.

I dedicate myself in our work and in my remarks today to communicate across racial and cultural boundaries. My commitment is to all our children, and I dedicate myself to that ecumenical vision of youth development.

I was a probation officer in a small town in rural Washington. In that community we used to make jokes about how far out we were. People would say, “This isn’t the end of the world, but you can see it from here.” But even in that rural setting we had delinquent adolescents. The kids I was responsible for on probation were enamored with the idea of “getting loaded,” “getting stoned,” and then ripping people off. My job as their probation officer was to help them turn their lives around. I felt that the way to do this was to help them become reinvested in pro-social activities like school. But school, for my kids on probation, wasn’t a place of learning it was a place of alienation. Family for my children on probation wasn’t a place of love and warmth and bonding, it was a place of conflict. I would hear from moms that their kids were out of control, and we were supposed to fix them. Nothing seemed to work at that stage.

I left probation work with a healthy respect for those who work with delinquent and drug-abusing adolescents; with children who have lost their commitment to school, family, and community and who need to find a way back. I also left with a burning question in my soul: Isn’t there something that we could have done to prevent these youngsters from getting into trouble in the first place? I became enamored with the idea of prevention, because as a probation officer I so often felt as if I were running an ambulance service at the bottom of a cliff. I patched up a few kids, but there would be six or seven or more referred by the Juvenile Court. I became convinced that there must be a way to put a guardrail at the top of that cliff to prevent youngsters from falling off.

Prevention: Correct Diagnosis, Correct Interventions

In the early 1970’s people concerned with the prevention of substance abuse thought that drug education would reduce use among adolescents. Educators taught youngsters about the range of drugs, their effects, and the consequences of use. Well-intentioned people developed these educational prevention programs, and when the evaluations were completed, do you know what they showed? More drug use after the intervention among those who received the information than among those in the control classrooms who did not. I realized then that if we want to work in prevention it is important that we follow the adage: “Above all, do no harm.”

My colleague Rick Catalano and I began to explore effective strategies for the prevention of adolescent health and behavior problems in the area of cardiovascular risk reduction. We found a very interesting and important model called “risk focused prevention.” Cardiovascular disease researchers had discovered that risk for heart disease is not a single-factor phenomenon, but rather arises from a multiplicity of factors that appear to contribute to the likelihood that people will develop heart disease. Out of that understanding a risk-focused approach to preventing cardiovascular disease was developed based on a simple premise: If we want to prevent cardiovascular disease before it happens, we have to identify the risk factors for that health problem and eliminate, reduce, or somehow buffer the effect of exposure to those risk factors. That premise is the foundation for the work that we began to do in the prevention of adolescent health and behavior problems.

If we want to prevent problems before they happen we must identify the factors that put people at risk and either eliminate, reduce, or somehow buffer the effect of exposure to the risk. Thus, if we are serious about wanting to prevent adolescent health and be-
behavior problems, we must begin with an understanding of the factors contributing to their occurrence and target our preventive activities at those risk factors. Surveying the published material on adolescent health risk, our group found some consistent etiologies when looking across risk behaviors such as substance abuse, teen pregnancy, and school failure (Hawksins, Catalano, and Miller, 1992).

**RISK FACTORS FOR YOUTH**

As with cardiovascular disease, risk for adolescent problem behavior exists in many domains of life. There are risks in the broader community within which people grow up. The norms and laws of our society help to define the context within which young people make decisions. For example, when we have higher rates of taxation on alcohol, we have lower rates of consumption of alcohol and lower rates of cirrhosis of the liver. When we have norms in communities that encourage parents to limit beer parties among their minor children, we have lower rates of alcohol use, among youngsters and lower rates of problems associated with alcohol use, including drinking and driving. The social context within which young people grow up contributes to the degree of risk. If youngsters grow up in a community where there are high rates of mobility, they have a greater risk of criminal behavior and substance abuse. Similarly, life transitions for adolescents—from elementary to middle school and middle school to high school—are associated with increased prevalence of alcohol use and delinquent behavior.

We also know that, holding socioeconomic factors constant, community disorganization is an important risk factor. Imagine, if you will, two neighborhoods of poverty. In one the walls are covered with graffiti; streets are littered with garbage; windows are broken; and the prevailing ethos is, “I wish I could get out of this place!” Go across town, still imagine poverty, but here people are trying to maintain the neighborhood. There is not a lot of litter on the streets; if there is a broken window and people can’t afford to repair it, they will put a piece of cardboard or plywood in its place. If you ask them what is it like to live there, they say, “Sure I’d rather have more money, but this is my neighborhood, this is where I live and together with my neighbors we are trying to make this a better place for young people to grow up.” In the second neighborhood, there will be lower rates of crime, substance abuse, and drug dealing than in the first. How well neighborhoods are organized and how strongly people are bonded to their neighborhood determine to some degree the risk people face growing up there.

Risk exists also in the more intimate social contexts in which young people grow up, such as family and school. For example, a family history of alcoholism quadruples the risk of alcoholism in children. However, it is also important to remember that exposure to a single risk factor does not condemn an individual to problem behavior. Estimates of alcoholism in the general population range between 6% and 10%. Studies of children of alcoholics place their rate of alcoholism between 17% and 28%-a quadrupling of risk. But these data also remind us that over three-quarters of children of alcoholics do not grow up to exhibit problem drinking. Being a child of an alcoholic does not condemn a young person to becoming an alcoholic.

Poor family management contributes to risk for all adolescent problem behaviors. Poor family management has three components: 1) failure to set clear expectations for behavior, 2) failure to monitor children, and 3) excessively severe and inconsistent punishment. The connection between child abuse and substance abuse as well as between child abuse and crime is here for the child who sometimes gets away with a given behavior and other times gets hit for the same act. Parents who set clear expectations for their children and then monitor their children in developmentally appropriate ways diminish their risk. You know the adage: “It’s 10 PM. Do you know where your children are?” That’s monitoring. Beyond monitoring, reinforcement is important. If as parents we provide consistent recognition when our children are doing what is wanted as well as consistent, appropriate, moderate discipline when they are not, then we are reducing their risk for all problem behaviors.

Additionally, parental attitudes that are tolerant towards risk behaviors increase the risk of youngsters’ developing these behaviors. For example, if parents involve their children in their own alcohol or other drug-taking behavior, their children are at greater risk of becoming future users of those substances. So, as a parent, if I drink alcohol, it is important to be clear that it is not okay for my child to drink alcohol. In addition, it is not okay for my child to pour me a drink. If I am a smoker, it is not okay to allow my child to light my cigarette, for such participation communicates a norm of tolerance toward the young person’s involvement in those behaviors that has been shown to increase risk.

At school, those who have not yet learned to control their impulses without resorting to excessive or violent behaviors are at an elevated risk of both substance abuse and delinquent behavior. If we were to ask kindergarten teachers to nominate the 100 worst hellions in their classes, and if we were to follow them for the next 12 years, we would find that about 40 of those youngsters would go on to be chronic, serious delinquents with substance abuse problems. About 60% of them would not. As a risk factor, early child aggressiveness is a better predictor of delinquency than either a family history of crime or a family history of alcoholism. In the later elementary grades, academic failure also begins to become a stable predictor of risk for a number of health and behavior problems. Children come to school with different abilities and different readiness to read, but if by fourth and fifth grade we in our schools are not teaching them in such a way that they are mastering the material, whatever their intellectual ability or backgrounds, we are failing to guarantee their academic success, and we are contributing to their risk of later health and behavior problems. Ensuring that all children succeed academically in school inhibits risk. Conversely, a lack of commitment to school appears to be a risk factor.

There are also risk factors within individuals and within their peer groups. For those who are working with delinquent or drug-abusing adolescents or those with school problems, many of these risk factors are identified in stories told from clinical cases. Those who lose their commitment to school say that is because school is for losers: “Me? I’m a head banger, I’m a punk, I’m an outsider.”
Those who develop an outsider identity in opposition to family, school, and community are at greater risk of developing health and behavior problems. Often the pattern of early aggressive behavior becomes a set of school problems, which results in school failure, early delinquency initiation, and a host of associated risk behaviors. Association with peers involved in risk behaviors is also a strong predictor of problem behaviors in adolescents. We know that young people who come from well-managed families, who are doing all right in school, and who have a commitment to education are not likely to be hanging out with others who are involved in problem behaviors, unless those behaviors are the community norm. And if everybody is doing it, they will have friends that do it. If adolescent individuation includes a redefinition of substance abuse or violence or sexual activity as part of the acceptable risk-taking behavior, then early involvement is to be anticipated. Early initiation is a consistent risk factor for all problem behaviors. The earlier any problem behavior occurs the greater the likelihood that the behavior will continue into adulthood.

There are some generalizations that can be drawn from this review of risk factors. The first is that risk exists in multiple domains, and it is the interaction or piling up of risks that puts a young person “in harm’s way.” Thus, attacking a single risk factor is unlikely to lead to successful prevention. Second, some factors pose increased risk at different points during development. Academic difficulties, for example, really begin to be a stable risk factor in the late grades of elementary school. Third, research has shown that the greater the number of risk factors to which one is exposed, the greater is his or her risk. So, for example, Michael Rutter has shown that exposure to four risk factors increases risk for psychopathology 10 times (Rutter, 1979). Fourth, a number of common risk factors during development appear to predict diverse problems. Certain experiences during childhood appear to predict risk for affective disorders, for conduct disorders, for substance abuse disorders, for school drop-out, and for teen pregnancy. Fifth, although the levels of risk factors may be different in different ethnic or racial communities, the way these risk factors operate is similar across ethnic groups. What is different is often the level of a given risk factor (e.g., tolerance toward drinking).

**Protective Factors**

Protective factors appear to buffer the exposure to risk. The work of Garmezy (1985) in Minneapolis, Rutter (1990) in England and Werner (Wemer & Smith, 1982) in Hawaii all point to important factors that appear to protect youngsters who were exposed to high levels of risk from developing health and behavior problems. Protective factors have been identified in three areas. One area is that of individual characteristics: by the lack of birth, some people are more intelligent than others; by the lack of birth, some people are born with a resilient temperament. Those people have some degree of protection against certain adolescent health and behavior problems.

The second set of protective factors is found in the relationship between the youngster and his or her environment. Specifically, the importance of a Caring adult is a recurring theme in the resiliency literature. It might be an aunt, it might be a teacher, it might be a grandparent, it might be a youth worker, a minister, or a principal; it might be Mom herself. Someone took an interest in the young person and a bond developed-a strong emotional attachment between that young person and the adult.

When that caring adult holds healthy beliefs and clear standards for behavior, then the young person is even less likely to be involved in risk behaviors. The teacher who says: “Hey, you can’t miss school. If you miss school, I am coming out and I am going to get you because you have a future and I care about you,” or “I don’t care if other kids in your neighborhood are doing it, it is not good enough for you to be using drugs. You are too important for that, you are going to be somebody.” A combination of individual traits, social connectedness, and clear healthy standards for behavior appears to protect young people from developing health and behavior problems.

**PRINCIPLES OF PREVENTION**

As we design prevention programs, we need to keep in mind some basic principles:

1) Our prevention programs must address known risk factors. The early drug abuse prevention programs failed because a lack of information about drugs was not a risk factor for drug abuse.
2) Not only do we need to focus on addressing known risk factors, but we need to do so in a way that we know has an impact on the targeted factors so as to change the degree of risk. There is a story of a fellow who found out that 90% of accidents occur within three miles of the home. His solution was to move. He understood the risk factor, he didn’t have a plausible theory of intervention.
3) We also need to focus on increasing protective factors.
4) We need to address risk factors at appropriate developmental stages. If, for example, academic difficulties in elementary school are risk factors for later health and behavior problems, then we should not wait until high school to develop alternative programs. We have to start in the elementary grades.
5) The next principle is to intervene early before problem behavior stabilizes. If, in fact, early initiation of substance use and criminal activity is a risk factor for serious and chronic future disorders, then it becomes important for us to focus our preventive activities before that first initiation and to concentrate on the period from before birth through childhood into early adolescence as the important developmental period for prevention activities.
6) We need to include those at highest risk whether interventions are specifically targeted or community wide. We advocate the community approach for two reasons: it avoids problems of labeling and self-fulfilling prophecies, and we want to include participants who can model the skills and adaptive behaviors as well as those who are struggling to learn. They can learn from one another. The central point here, however, is that we must focus our efforts where the levels of multiple risk exposure are highest. The temptation often is to go where the intervention is most easily implemented, not where the needs are greatest.
7) Finally, if exposure to multiple risks is associated with a greater risk for individuals, it means that our preventive strategies will have...
to have multiple interventions. It won't be enough to implement the DARE program and think we have stopped substance abuse. It won't be enough to put a peer-counseling program in and think we are going to prevent delinquency. It won't be enough to implement our parenting program, Preparing for the Drug-Free Years, and think that we will somehow wipe out drug abuse among adolescents. We are going to have to have multiple programs with multiple risk reduction strategies working together to have a significant impact on risk in community areas with high-risk exposure.

**The Social Development Strategy: Reducing Risk by Promoting Protective Factors**

Our work in prevention seeks to reduce risk by enhancing protective factors. We are guided by a model that we call the social development strategy. The goal of the social development strategy is to promote healthy behaviors in young people. We know that youngsters who develop healthy beliefs and clear standards for behavior are less likely to violate those norms by engaging in health-compromising behaviors. Norms and standards are important. For example, Johnston’s (1991) annual surveys of high school seniors in the U.S. found that in 1979 11% of high school seniors were daily users of marijuana. By 1991 the proportion of daily users of marijuana had dropped to about 2% among high school seniors. What accounts for the changes? It wasn’t a decrease in availability. What had changed was an increase in the perception of risk associated with the use of marijuana together with an increase in social disapproval of use. From 1979 to the present youngsters in America began to be less and less socially approving of marijuana use. The norms or standards changed, and that is what has brought about the decline in the use of marijuana among high school seniors. Healthy beliefs and clear standards for behavior form the first protective factor addressed by the social development strategy.

And yet today in America there are many youngsters who are using marijuana, as well as other drugs. How come? Why, in the face of this massive normative change, are some youngsters unaffected? I would suggest that it is because what is missing is the second protective factor identified in the social development strategy: bonding to the social groups who hold the new standards. Those youngsters are not bonded to the schools that have drug- and tobacco-free policies. These young people are not bonded to the communities who say it is not okay to use drugs. Because they are not bonded to those units, those units’ norms are not affecting their behavior. Bonding is what provides the motivation to live according to the norms and standards offered by a community, by a family, or by a group. Bonding consists of two important elements: one is the emotional element—the attachment, a sense of closeness, warmth, and caring. The other element of bonding is commitment or investment in the goals and priorities of the particular person or group.

As a probation officer, I was trying to bond youngsters to school and to family after problems had occurred. I would suggest to you that today in America we are not so much in a war against drugs as we are in a war for the bonding of our young citizens to family, to school, and to community. I want you to imagine a youngster who comes from a poorly managed family, who has early behavior problems, who by fourth or fifth grade is falling behind academically, who is losing his or her commitment to school. Finally, in the fifth grade, we say, “Would you like to learn some skills to say no to drugs and join the ‘Just Say No Club’?” What do you think that young person will say? He or she will probably “just say no.” Why? Because by that point that young person isn’t bonded to school and doesn’t care what we have to offer in the way of norms and standards for behavior. The unit isn’t something of which he or she feels a part.

We really have only two ways to motivate behavior: fear and bonding. As a motivator of behavior, fear works very well over a very short time, but it doesn’t produce behavioral change that is maintained. Over the long term, what works is informal social control represented by bonding: “If I did that my mom would be embarrassed. If I did that my friends would think I was a loser. If I did that I wouldn’t feel comfortable with myself.” The behavior becomes a violation of the standards of the group to which the young person is bonded.

In the social development strategy three conditions must be present in any social unit for people to become bonded. The first consists of opportunities for active involvement—a chance to make a contribution to that group. It means that in first grade sometimes I get to feed the gerbils. In a school classroom, when teachers subdivide the class into cooperative learning groups where students are working together to master the material, teaching and learning from one another, there is an opportunity for active involvement. In a family where a 12-year-old has chores and responsibilities for helping manage family rules or family finances or family activities or family meals, that is active involvement.

The second condition that needs to be present consists of skills for participation in those activities. If youngsters are provided with an opportunity for active involvement, we must make sure they have the skills that are developmentally appropriate to be successful. Those skills change with development. Young people need skills for social initiation, that is, making friends, so as to become part of a social group during childhood. They need skills for impulse control so as to know how to get their needs met without hitting, kicking, screaming, or scratching in the first grades of elementary school. As they mature, they need cognitive skills to learn to read and to compute; they need to learn problem-solving and decision-making skills. Ultimately, they need to learn skills to refuse offers and social influences to do things that are against their norms and standards. And so we must ensure the development of those skills in our preventive programs.

Third, people need recognition and reinforcement for skillful performance, if they are to become bonded to that social unit. I am not talking about bribery or about having to pay kids all the time. I am talking about recognizing people when they are putting out effort and when they are doing what is expected of them. It builds bonding.

I would submit to you that drug dealers and street gangs act as if they understand the social development model, perhaps bet-
ter than we do. Imagine an 8-year-old child in the neighborhood. The drug dealer says to him, “Would you like to make ten bucks?”

“Sure. What do I have to do?”

“Well, take this little packet across the street to the third house on the right and give it to the guy who opens the door and come back and you’ll get ten bucks.”

What have we created for that youngster? We have started giving him an opportunity for active involvement. Eight years old and he can do it. He can get to the street, look both ways, cross, can count to three to find the right house. The skills necessary for running drugs at the entry-level are not very advanced. When he gets to the house and knocks on that door and the man comes to the door he gives the guy the package, the youngster has demonstrated skillful performance. He then comes back and ten dollars is his. What does he have? Recognition and reinforcement for skillful performance. And what is occurring? The dealer is skillfully building bonding to a group that doesn’t hold healthy beliefs and clear standards. Those of us who do hold such beliefs must create those conditions for bonding in our families, in our neighborhoods, in our schools and youth clubs if we expect to counter the attractions of youth gangs and drug dealing.

IMPLEMENTING THE SOCIAL DEVELOPMENT MODEL

There are implications for prevention in the use or the social development strategy. Today we know that risk-focused prevention works. The social development model has been implemented to reduce risk factors and enhance protective factors. Our research has found that as a result of these programs, children are more bonded to school and other family and less likely to initiate drug use and delinquent behavior after exposure to those preventive interventions.

Yet if you wanted to come to Seattle to see the program in the schools where we tested it originally, I couldn’t show it to you. I can show it to you in many other communities but not in the original schools. Why? Because the schools didn’t own the programs; we did. They were involved, but it was really our program. And so we had to return to the cardiovascular disease prevention programs to find what they were doing so successfully. They were empowering communities to take ownership of the risk reduction strategies. They were not doing it for or to communities, but with communities. We began to realize that what was needed to be effective in institutionalizing prevention programs was a merger of empirical knowledge of risk and protective factors with warm-hearted caring at the level of community. We need to reach out to empower communities to take ownership of the prevention strategies. Communities need to own and operate strategies, to control the prevention programs. Prevention should not be something that human service agencies or researchers or educators do for or to communities. To be successful, prevention programming must be something that communities do for themselves.

To be successful, people in communities must work together across old disciplinary boundaries, across agencies, across organizations and groups. Law enforcement and education, health professionals and social workers, religious professionals and business people—a wide variety of people must join forces. We must get the right people involved, people who can accurately diagnose the issues in their community and appropriately select from a range of prevention strategies to meet their community’s unique needs. Who is at greatest risk? How does the community set high and yet attainable standards? How does the community evaluate results? We who are involved with prevention are going to have to mobilize those who care so they can work together to reduce risk and enhance protective factors.

Over the past five years we have been working with 25 communities in Washington, 39 communities in Oregon and now communities in South Carolina, Kansas, Colorado, Maine as well as other places around the country. In these communities we are testing a strategy for empowering communities to reduce risk and enhance protective factors. We call this strategy Communities That Care, and it has three basic phases. The first is to introduce the strategy to the community and involve both community leaders and grass roots citizens in its ownership. We start with the community leaders, because they are the elected; they are the opinion shapers, they are the leaders of this community. We also believe we must show community leaders respect. The success of the program is going to be their responsibility. Ultimately, they will have to provide the resources to implement new preventive interventions. In our programs we ask that the mayor, police chief school superintendent, a business leader, a religious leader and often a leader in the judicial system come to a three-quarter-day orientation to learn about risk factors, protective factors, and the social development strategy, and to determine whether such an approach would be appropriate for their community.

When we began this strategy we wondered whether we would be able to get all those VIP’s to participate. We said that unless they all came, we could not be able to work with that community. In Oregon when we initiated this process we hoped to work with 25 communities. Police chiefs, mayors, school superintendents and business leaders from 39 Oregon communities came to the training and said they wanted to participate.

Today, key leaders of communities across the United States are concerned about health and behavior problems of their young people and they are willing to talk and think and work together to make a difference. We are increasingly convinced that we can’t be categorical anymore. We involve key leaders in looking at the diversity of their community, identifying those at highest risk, and drawing in those not represented at the initial meeting. We invite them to explore the barriers to prevention in their community.

If the community’s key leaders decide that this is a process they want to implement, we ask them to create a Community-wide prevention board that represents the entire range of that community’s diversity. The community board members will actually be the doers who will begin the process of program implementation and will ultimately make the difference.
Once the key leaders have appointed their community’s prevention board, we embark on training and team building. We provide a three-day workshop for the community board members where the most important thing they learn is how to conduct a risk and resource assessment of their own community. Using existing information from sources including police records, school records, health department records, and census records, they learn how to conduct a community risk assessment in which they will analyze this archival data on key risk factors in their own community and compare the result with the norms in their state. They learn how to conduct a community resource assessment to identify the positive activities already going on in the community that are building bonds, providing opportunities, skills, and rewards for youngsters; and creating clear norms and standards for behavior.

During the four months after their training, the members of the community board carry out a community risk and resource assessment. These are lay people, not researchers; they are people who don’t ordinarily use data. We have found that without this process of risk and resource assessment, when community coalitions begin, people often come with their favorite program in mind as the answer. They wait until it is time to talk about what should be done, and then they say, “I have the program, I have the answer for this problem.” People then often argue about their favorite interventions. Conducting the risk and resource assessment allows the community board to take a different approach, to begin to profile itself as an environment of risk and protection, comparing their community profile with state norms. For example, the state of Kansas has now formulated risk profiles for the entire state and for all counties within the state against which various regions and local communities can compare their own risk profiles. We can graph and plot relative risk in any community in Kansas against the state and county norms. At a glance, people in each community are now able to array their risk factors and identify priority areas for intervention.

With their risk and resource profile in hand, the community board can develop a prioritized action plan to address those risk factors that they have decided to target because they are elevated in comparison to other risk factors in that community. This method provides an empirical base for planning. Those who come to the planning table with strong interventions outside the priority areas begin to see that they may not have the program needed right now.

Once the risk and resource assessment is completed, the community board reports back to the key leaders. At this point it is clear that involving the key leaders in the first place was a very good idea because the community board can say to the key leaders that there is a need to divert resources to support specific activities for risk reduction. They can then develop a viable plan to implement the strategies they have identified for reducing risk and enhancing protective factors in their community.

We have found in our work with Washington and Oregon communities using this strategy that once they have their community profile, board members need information on promising programs to implement to reduce specific risks they have identified in their communities and to enhance protective factors. We have evaluated a host of preventive interventions to identify how well they address known risk factors and the extent to which they meet the criteria of reducing risk, enhancing protective factors, and intervening at appropriate developmental periods.

Prenatal care and early home-based education programs for mothers of infants and early childhood education programs with home visits to parents are effective in reducing risk and enhancing protective factors. Parent training is effective at different developmental periods in reducing risk and enhancing protective factors. It is especially important to focus on the schools. Organizational changes in schools can improve bonding and create environments that promote for youngsters’ opportunities for involvement. Then teachers learn how to manage and teach better in their classrooms, kids become more bonded, more academically successful, and less likely to engage in problem behaviors outside the classroom.

Last but not least in this developmental progression of programs are the school curricula for drug abuse prevention and promotion of social competence. Today in America that last piece is almost all we have really seriously been doing in a concerted way. Making sure that we have the DARE program, or Here’s Looking At You 2000, or any number of curricula in the schools has become the focus. Yet by itself a drug curriculum will not be enough to significantly reduce the risks faced by many of our young people throughout development.

We have also included in our menu of promising approaches community mobilization itself, for involving people in communities is protective.

Remember, how we carry out a preventive program is as important as what we do. Imagine the principal who says, We need a new drug policy for our school, so we are going to create a committee of children, parents, teachers, and administrators—all those who have a stake in this school community. They will think through what our new policy should be regarding drugs.” In terms of the social development model, what this principal has created are opportunities not active involvement.

Now imagine if we get some “head bangers” and some “skaters” as well as student council leaders, teachers, parents and school administrators. What do you think the first meeting is going to be like? Chaos, unless we teach people some basic skills for participating in that group: one person talks at a time, you don’t interrupt other people, you don’t put people down. We also need to teach brainstorming and problem-solving skills.

Imagine that we taught those skills that the committee worked well together, and it was successful in developing a good policy. Then the principal announces the policy at an assembly, and at the assembly all the members of the committee are sitting up on the stage. What do we have then? Recognition for participation. I would submit to you that the school that develops a drug policy in that way creates the conditions for bonding to that school, and fewer youngsters in that school will violate the drug rules than in a school whose administrators create policy by fiat.

Finally, we work with communities on how to mobilize me-
dia to support risk reduction activities. In some communities there is a weekly newspaper column recognizing wonderful things kids have done in the community. That is recognition for skillful performance. We involve the media in promoting the stories that build the conditions for bonding in our communities and that promote the normative standards for behavior that are important for healthy development of young people.

We must ask communities to reweave their social fabric to create protective environments for young people to grow up in. To reduce risk by enhancing those conditions that build bonding and clear normative standards for behavior. It is a challenge for all of us and it can be done!

REFERENCES


