REVIEW

Replacing ineffective early alcohol/drug education in the United States with age-appropriate adolescent programmes and assistance to problematic users

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Abstract

Issues. Despite more than a decade of federal sponsorship of ‘evidence-based’ alcohol/drug education, there has been no consistent downward trend in overall prevalence among youth over the past 15 years. Reasons underlying this situation are examined. Approach. Published technical critiques of initial research supporting widely used evidence-based programs are reviewed along with replication studies conducted later by independent researchers not associated with initial program development. Social and institutional barriers in the US against changes in AOD policy and practice for young people are also suggested. Key Findings. Emerging use of diverted pharmaceuticals (now second to cannabis in prevalence) may underlie moderate recent decline in use of alcohol. Early federal certification standards for ‘evidence based’ prevention education have been seriously compromised. Technical critiques of initial evaluations and negative replication studies of these programs are consistent with lack of impact. Finally, fidelity of implementation in regular school settings is commonly flawed. Implications. Failure of these mainly pre-secondary educational programs may underlie recent federal support for forced random AOD testing of secondary school students. A new approach to drug education for adolescent students seems warranted as a positive alternative to personally intrusive surveillance. Conclusion. An interactive approach at the secondary school level that incorporates an age-appropriate educational process is proposed. While advising abstinence, this approach also facilitates identifying and assisting problematic AOD users. [Skager R. Replacing ineffective early alcohol/drug education in the United States with age-appropriate adolescent programmes and assistance to problematic users. Drug Alcohol Rev 2007;26:577 – 584] Key words: adolescent, age-appropriate, alcohol/drug, education.

Introduction

Federal funding to states has been an essential stimulant to school-based alcohol and/or drug (AOD) education in the United States. Recent policy on substance use among youth [1] currently reflects weaker federal commitment. Halfors et al. [2] note that elimination of Safe and Drug Free Schools (SDFSC) state grants was recommended in 2007 White House budget proposals. The Congress has accordingly cut funding by 20% over the last 2 years, affecting state education department support to school districts, county office administrative offices and training of school staff. During the same period the Office of National Drug Control Policy (ONDCP) began vigorous promotion of random AOD testing of students [ONDCP is a component of the Executive Office of the President established under the Anti-Drug Abuse Act of 1988; available at: http://www.whitehousedrugpolicy.gov/about/index_frameb.html]. This may, in part, be a reaction to negative findings in the General Accounting Office (GAO) evaluation of ONDCP's $1.2 billion, 1998–2004 Youth Anti-Drug Media Campaign [3]. It may also reflect lack of confidence in the effectiveness of school-based AOD education. However, the Substance Abuse and Mental Health Services Administration (SAHMSA), which reports to the Congress, continues...
to promote ‘evidence-based’ AOD education. Youth substance use is thus addressed by two administratively and ideologically disconnected Federal agencies.

**Current prevalence of use**

Overall prevalence of use of illicit drugs (including diverted pharmaceuticals) among US grade 12 students on the latest (2006) Monitoring the Future Survey (MTF) exceeded the annual average over the last 15 years [4]. Use of specific illicit drugs fluctuated, but there was no consistent trend. In contrast, alcohol use was at a 15-year low on both lifetime and annual measures. Annual highs and lows for total illicit drugs, cannabis and alcohol are shown in Table 1. There appears to have been little or no progress in reducing use of illicit drugs by young people.

**Emergence of pharmaceutical drugs**

Use of pharmaceutical narcotic painkillers and benzodiazepines appears on the radar screens of state and national surveys. This development is important, especially given increasing federal support for forced AOD testing of students. The MTF reports that 9% of 12th graders used a narcotic other than heroin in the previous year. [Surveys have neglected abuse of over-the-counter medicines, especially cold and cough medicines. This oversight will be corrected in the next (2007 – 08) CSS.] Use of the two prescription painkillers (Oxycontin® and Vicodin®) was reported by 4 and 10%, respectively. On the 2006 California Student Survey (CSS) 15% of 11th graders (modal age 16 years) reported use in the previous year of OxyContin®, Percodan® or Vicodin® on a combined question [5]. [The CSS is sponsored by the Office of the California Attorney General and the state departments of Education and Alcohol and Drug Programs]. The CSS has assessed statewide representative samples of 7th, 9th and 11th grade students in public secondary schools since 1985–86; the 2006–07 CSS will include questions on over-the-counter drugs.] Among California 16-year-olds, prescription drugs (including benzodiazepines such as Xanax® and Vallium®) now rank second to cannabis on use once or more in the preceding year.

The decline in alcohol prevalence may be linked to substitution of diverted prescription drugs.

Several factors could account for this phenomenon: television advertisements for psychoactive prescription drugs addressing everything from shyness to ‘restless leg syndrome’ (‘Ask your doctor about . . .’); believing that medicines are safer than illicit drugs; availability at home and from friends; and internet purchase. Some prescription painkillers containing oxycodone are available in rapid release form. Percoset® has a half-life of 4 – 6 hours, thus is not likely to be detected after 24 hours [personal communication from John P. Morgan, Professor of Pharmacology, City University of New York]. This information is probably making the rounds, especially among students in schools that have adopted random drug testing for cannabis and other substances with longer retention profiles. The distinction between psychoactive prescription medicines vs. alcohol and illicit drugs is compromised. The former are medicines if used for the ‘right’ reasons and at the prescribed dosage, ‘recreational’ drugs if used to get high.

**Current AOD prevention education**

There are also two faces of AOD education in the United States. One is Drug Abuse Resistance Education (DARE), the police-sponsored curriculum developed, administered and evaluated independently of federal quality control. The other is the ‘evidence-based’ programmes sponsored by the Substance Use and Mental Health Services Administration (SAMHSA).

**DARE**

DARE may still be the most widely adopted AOD education programme, although reliable statistics on the number of schools using it are not available. The website claims implementation in 75% of US school districts and 43 countries ‘around the world’ [see http://www.dare.org/home/about_dare.asp]. In response to criticisms based on independent evaluations, an ‘even better and improved’ version funded by the Robert Wood Johnson Foundation has been under development for several years. [Take Charge of Your Life] has been under development and evaluation for 6 years. In response to a personal query a DARE official indicated that a final report would be released in summer, 2007. According to the same source, recent federal funding has been provided though ‘earmarks’ (special authorisations attached to bills passed by the Congress.) This characterisation fails to acknowledge that independent evaluations of the original DARE programme found no evidence of reduced AOD use among students and in one study higher prevalence among suburban youth [6,7]. Lynam et al. reported similar negative findings in

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**Table 1. Last 15-year highs vs. lows in prevalence of any illicit drug, alcohol and cannabis in the previous year for 12th grade US students**

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<tr>
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<th>Low</th>
<th>High</th>
<th>2006</th>
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<tr>
<td>Alcohol</td>
<td>66.5 (2006)</td>
<td>77.7 (1991)</td>
<td>66.5</td>
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a 10-year follow-up of DARE graduates [8]. That this programme continues to enjoy federal approval is illustrated in the website note that a Presidential Proclamation has, since 1988, declared an annual ‘National DARE Day’. It is also the only AOD education programme enjoying partial funding directly from the Congress.

**Evidence-based AOD education programmes**

Concern in the research community over the ineffectiveness of DARE stimulated the Substance Abuse and Mental Health Services Administration (SAMHSA) in the development of a formal certification process for more effective AOD education. Local funding for programmes identified as ‘evidence-based’ was first made available in 1988 under the Safe and Drug Free Schools and Communities Act (SFDSC).

**Certification process.** A detailed summary of how programme certification evolved is provided by Hallfors and colleagues [2]. Most importantly, in 1998 the Department of Education (DoE) [9] defined four ‘principles of effectiveness’ to be applied by state agencies, one of which requires that curricula be certified as ‘evidence-based’ (US Department of Education, 1998). The four principles were incorporated later into the ‘No Child Left Behind’ Act (NCLB) [10].

Several lists of qualifying programmes have emerged in the last decade. Among federal agencies, the National Institutes on Drug Abuse (NIDA) list [11] identified only 23, if randomised control group trials (or well-matched comparison groups where randomisation was impractical) were conditions of approval. In contrast, SAMHSA now lists 158 programmes in its National Registry of Evidence-based Programs and Practices (NREPP) [12]. Hallfors et al., in a recent survey of lists used by state education authorities, found SAMHSA’s seriously compromised NREPP list the most influential in local programme choice [15]. NREPP has dropped its original classification of curricula into ‘model’, ‘effective’ and ‘promising. It now includes programmes ‘…if the developer provided a single study using a single group pre- to post-test design that showed just one positive behavioral outcome with significant change’. These authors noted further that for most of the lists, including NREPP, ‘…the greatest problem is that…‘evidence” about program effectiveness comes from a single small efficacy trial by program developers’ [2, p. 79].

In response to a proliferation of lists (including others from private organisations), a committee of the Society for Prevention Research developed a set of rigorous criteria [13] specifying 12 conditions from (1), defined samples from defined populations to (12), monitoring and evaluation tools for eventual users of a programme. Programmes satisfying these criteria (‘Blueprints’ list) were selected by the Center for the Study of Violence Prevention [14]. That list identifies only three AOD prevention curricula as ‘model’ and four as ‘promising’. Only two of SAMSHA’s ‘promising’ programmes (although all three of the ‘model’ programmes) are intended for the general school population (‘universal’ curricula in the agencies’ additional classification by target population).

Gandhi et al. [16] examined seven lists of ‘scientifically proven’ programmes including the Department of Education’s List of Exemplary and Promising Prevention Programs, the NREPP list, the National Institute of Drug Abuse Guide to Effective Drug Prevention Programs and the CSPV Blueprint project. The five programmes cited most frequently on these lists were then reviewed critically [the five programmes were: Life Skills Training, Midwestern Prevention Program, Project ALERT, Project Northland and CASASTART]. The authors concluded that, even for these, supporting evidence was usually weak. ‘At immediate posttest, few reports showed substantial impact, and even fewer studies showed substantial impact at longer follow-ups . . . Most of the programs are more effective in changing attitudes and increasing knowledge than they are in changing drug use behavior’ (p. 64). The Federal process for certifying AOD education programmes has floundered.

**Technical reviews of listed programmes.** Added to concerns about the validity of initial claims of programme effectiveness, several negative technical reviews of data analysis procedures have been published over the last decade. These reviews expose significant methodological flaws in evaluation studies for several programmes believed widely to be ‘gold standard’. In addition, later independent studies failed to replicate significant programme effects. Finally, new problems arose once the evidence-based programmes were disseminated. These are (a) frequency of adoption and (b) fidelity of delivery in regular classrooms.

Randomised, pretest/post-test control group designs can still result in flawed findings when questionable strategies are applied in later data analysis. Gorman identifies shifting outcomes to new criteria, searching for subgroups that appear to show positive results in spite of insignificant overall results, recalculating criterion variables by combining a significant result with others that are not significant, shifting to weaker confidence limits, etc. [17–19].

Questionable statistical manipulations are not surprising where there is personal interest in proving that a programme is effective, especially when developers perform summative evaluations of their own programmes. The ideal of ‘independent, outside evaluation’ has been ignored in the federal certification of
AOD education programmes. Petrosino & Soydan [20], in a meta-analysis of criminal recidivism reduction programme evaluations, concluded that: . . . studies in which evaluators were greatly influential in the design and implementation of treatments report consistently and substantially larger effect sizes than other types of evaluators’ (p. 444) [the authors suggest that deliberate dishonesty is likely to be rare (except in the pharmaceutical industry)].

Since 1995 Gorman has published negative reviews of specific AOD education evaluations, including Life Skills Training [21], Project Alert [22] and Seattle Social Development Project [18]. The first two appear on the short but presumably rigorous Blueprints list (Life Skills Training as one of the three ‘model’ programmes and Project ALERT in the ‘promising’ category).

Replication studies. Independent outside evaluations have often failed to confirm evaluations by programme developers. Hallfors et al. [23] re-evaluated Reconnecting Youth, an ‘indicated’ programme for youth exhibiting problem behaviours and ‘model’ programme on SAMHSA’s early list of approved programmes. Positive findings in the initial efficacy trial [24] were not replicated. St Pierre [25] re-evaluated Project ALERT [26], also a model programme on the early (shorter) NREPP list, and failed to find reductions in substance use or in mediator variables relating to use. Additional analyses revealed that there were no overall effects by student risk level, gender, school or quality of implementation.

Questioning theoretical underpinnings. Gorman’s reviews focused not only upon the quality of programme evaluations, but also upon the validity of socialisation theories adopted for most current programmes that train children in ‘resistance skills’ or address development of social skills more broadly. His independent review of two ‘large-scale’ school-based social influence programmes (one of them Life Skills Training) failed to find reductions of practical significance in alcohol use [27,28].

That young people initiate AOD use because of ‘peer pressure’ may seem highly plausible. However, while users tend to have friends who use, correlation does not prove causation. Early tests of the peer pressure hypothesis revealed that training in refusal skills had no impact on alcohol initiation [29]. Most significantly, a widely acclaimed analysis of research on social learning concluded that imitation (rather than social pressure or simple conformity) is the dominant basis for all human social learning [30] [Judith Rich Harris’ work on group socialisation received an achievement award from the American Psychological Association and her later book-wide distribution beyond the small community of social psychologists]. Learned social behaviour derives from spontaneous imitation of appealing social models rather than on abstractions about ‘what everyone does’.

This conclusion is supported in recent findings favouring ‘person’ (as opposed to group) socialisation theory. Early regular substance users enjoyed and retained high social standing among peers regardless of whether they continued vs. ceased using AOD later in the school year [31]. Compared to abstainers, early users had greater social impact, were more central in the peer network and were more popular among their peers. This finding casts doubt on the assumption that demonstrating that a minority of peers have tried AOD (the normative theory of socialisation) will reduce initiation among others significantly.

When asked why peers used AOD, 16-year-olds on the California Student Survey consistently endorse ‘to see what it’s like’ (two-thirds) and ‘to have fun’ (55–60%). Slightly more than half cite ‘because friends use’, although this alternative suggests affiliation rather than pressure. Negative motives such as ‘bored, nothing to do’ are endorsed regularly by the fewest respondents. Current theories of prevention are likely to miss the mark with youth curious about what it is like to get high or expecting to have fun with their friends. Cook-Sather’s [32] arguments for eliciting the views of young people apply here.

In conclusion, most drug education programmes regarded officially as rigorously evaluated have, in reality, been based on flawed science (‘pseudoscience’ in Gorman’s characterisation). The responsibility for this situation rests heavily upon the government agencies involved. Failure to require independent, outside evaluation is at the heart of this technical debacle.

Problems with adoption and implementation. A 1999 survey of almost 2000 public and private middle schools revealed that only about one-third of public and one-eighth of private schools had adopted evidence-based AOD curricula [33]. Hallfors & Godette [34] surveyed 81 Safe and Drug Free Schools district coordinators in 11 states and found that, while evidence-based curricula had been adopted by 59%, only 15% of schools had achieved high-fidelity implementation. St Pierre & Kaltreider [33] reported local resistance to adoption of an evidence-based AOD programme in a study implementing a version of Project ALERT (EXSELS model). They identified community politics in support of DARE as a major reason underlying this resistance. Only one school did not offer the police programme in grades 5–6, even though administrators ‘acknowledged its ineffectiveness’ (p. 484) [telephone communication with a SAMHSA representative revealed that no current data were available on the extent of adoption of evidence-based drug education programmes in US schools].
This author reported earlier that concern over implementation fidelity of evidence-based AOD programmes was the basis for a 2003 national conference sponsored by NIDA [1]. Flawed AOD programme delivery had been identified some time earlier by Silvia & Thorne [35]. A later paper by Ringwalt et al. [36] reported that in the 1999 national study of public and private middle school teachers 79.8% adapted their AOD programme curricula according to classroom conditions, especially when addressing students who were sexually active or had discipline problems. Despite local reports indicating frequent adoption, Halflors & Godette [37] observed that a national survey of programme co-ordinators received few reports of quality implementation of evidence-based AOD programmes. Dusenbury et al. proposed several measures of implementation quality and noted that teachers in their study of Life Skills Training varied in both adherence and quality of delivery [38]. All made adaptations. Experienced teachers were likely to adhere more closely, but also promote more interaction and engagement. A case has been made for systematic adaptation of ‘hybrid’ AOD programmes in the light of cultural differences among students [39].

One of the evaluations of Reconnecting Youth, cited above, reported that many programme teachers working with students at risk of dropping out were unwilling to give up regular instructional time [23]. Non-participation and programme attrition was so marked that secondary outcome analyses were conducted for the less than half of targeted students who actually attended the AOD class. Immediate post-treatment analyses showed no positive treatment effects and one negative one—‘worse anger outcomes’ (p. 2258). The minority of experimental group students actually exposed to the programme scored worse than controls on 6-month follow-up on high-risk peer bonding and pro-social weekend activities. A parallel study of the same intervention focused upon three dimensions of fidelity: adherence, exposure and quality [40]. To the surprise of the authors, increased quality predicted more anger and alcohol use, better adherence more cannabis use, and exposure (student attendance) more drinking, anger and bonding to high-risk peers. These authors speculated that negative findings on anger and peer associations was consistent with negative outcomes identified earlier by Dishion et al. [41] that result when high-risk youths are grouped together.

NCLB legislation passed early in the first term of the current Bush administration has intensified the linked deficiencies in local adoption of evidence-based programmes and later fidelity of implementation [10]. Achieving basic learning goals is tied to regular accountability assessments under NCLB. Should student achievement scores not increase to pre-specified levels, under-performing schools face public exposure and, after 5 years of failure, take-over by the state department of education, apparently regardless of what factors external to the school bear on student performance. Take-over could mean replacement of staff or other unpalatable sanctions. School districts are also liable for restructuring. AOD education is likely to have a low priority in this pressurised atmosphere.

Summary. The anticipated impact of evidence-based AOD programmes has been diminished by lax quality control at the federal level, faulty initial evaluations, failure to replicate in follow-up studies, continued competition from DARE and recent diversion of resources to surveillance strategies such as drug testing. If there are diminishing expectations in the federal executive about the effectiveness of current AOD education, it is time to rethink the problem. This includes bringing young people into that process as well finding a new paradigm for youth policy and practice.

Barriers to paradigm change in AOD prevention education and related services

The accumulating evidence of institutional and programme failure summarised above has affected neither policy nor practice. Negative research findings on programme quality, adoption and implementation seem to disappear into a void. Alternative approaches have not been proposed by either the research or educational communities. The need for a new paradigm is especially apparent in the lack of effective strategies for young people aged 13 – 14 years and older. The speculations that follow suggest conditions that may account for this paralysis of vision. [In the context of a scientific paper these are clearly personal speculations. However, they are based on a many years of relevant experience. The hope is that the speculations are interesting and provocative, even if not demonstrated in scientific studies.]

Ideological

Current AOD education is a facet of the nation’s war on drugs and thus shaped by the principle of zero tolerance. The overall policy goal is universal abstinence. AOD education must prevent initiation. Debate about whether this is a realistic goal is off the agenda. Proposals for change that incorporate principles of harm minimisation are dismissed as ‘giving the wrong message’. Pragmatism is equivalent to defeatism in a nation committed to war as a metaphor for a social policy.

Limitations of evaluative research

Programme evaluation research tests the effectiveness of what already exists. Negative results may lead to suggestions on improving delivery or design, but have
not as yet led to rejection of the current paradigm. Basic research on group socialisation remains highly relevant, but alternatives incorporating those principles have not been recognised.

**Funding is power at the state and local level**

State and local educational authorities accept assurances of current programme quality as long as funding is available. Local officials and state office staff are typically unaware of technical critiques and independent evaluations showing negative results for AOD programmes listed as ‘evidence-based’. They are not likely to accept the findings of such studies even if informed.

**Opposition to current practice risks personal credibility for state and local administrators and programme developers**

State education departments and local school officials have assured local educators that the evidenced-based programmes work (the motto of the Center for Substance Abuse Prevention, initially a spin-off from NIDA, but now under SAMHSA, has been: ‘We know what works’). It would be embarrassing for administrators and staff at any level to admit that they have been wrong all along. Instead, critics of these programmes must be wrong. If this reluctance applies to public officials, it must apply even more powerfully to developers of current programmes.

**Pressure to find positive results in evaluation research**

In the research community it is common knowledge that positive findings are more likely to find publication in more prestigious journals. This does not mean that negative studies go unpublished—in a lower-tier journal. The same pressures that lead developers to reanalyse, readjust, find new criteria for success, etc., all effectively criticised in studies by Gorman and others, can affect researchers as well. [The relatively new journal *Prevention Science* is exemplary in its publication of critiques of current programmes. However, it still has some distance to go to catch up with the professional prestige to be gained from an article in the *Journal of the American Medical Association.*]

**Competition from DARE**

The new *Take Charge of Your Life* programme is almost certainly shaped by the same paradigm that underlies current evidence-based programmes. It is already competing with the latter. As a police programme it will continue to have great political appeal. Its proponents have been tough infighters in the struggle for local resources. In many communities, faith in its value will persist whatever current and later evaluation results may reveal.

**A new AOD education paradigm for secondary school students**

The stability in overall use prevalence reported at the beginning of this paper raises questions about how and when AOD education should take place. The argument will emerge that, despite technical critiques of initial programme evaluation studies, failure to replicate findings reported by programme developers, doubts about extent of local adoption and problems with fidelity of delivery in regular schools, some preteen children may have been ‘inoculated’ successfully against later drug use through exposure to current programmes. Nevertheless, the majority of young people has tried, or currently consumes, alcohol, and a significant minority, other drugs. How should we react to this continuing reality?

St Pierre *et al.* in a second analysis on their Project ALERT replication study, reported that characteristics of leaders, specifically conscientiousness, sociability and individuation (all three for adult leaders and the latter two for teen leaders), were associated with lower levels of alcohol and cannabis use among participants [42]. This finding suggests that interpersonal skills of the leader/teacher are critically important. It is consistent with the National Longitudinal Study of Adolescent Health conclusion that *connection* to adults [43] and the school [44] are the best predictors of avoidance of health risk among adolescents, including alcohol and drug use. Young people are more likely to internalise information on healthy life choices when they feel such positive connections.

How do adults establish positive connections with teenagers? The short answer is by treating them with respect. Epstein [45], in a review of studies on AOD and brain functioning, reminds us that: ‘…we also know from extensive research both in the US and elsewhere that then we treat teens like adults, they almost immediately rise to the challenge’ (p. 63). In his recent book Epstein documents an artificial ‘extension of childhood’ that has infantilised youth and at the same time isolated them from adults [46]. Finally, Thomas Hine’s seminal history of adolescence from classical Greece to 20th-century United States [47] reveals something we should know already. Adolescence did not emerge as a recognised phase of life until the first half of the last century. Before then 12- or 13-year-olds went to work on family farms, apprenticeships for a few, or for the many in jobs where they were expected to behave as adults and worked alongside adult co-workers. The exception was the elite few whose social and economic status destined them to university
education after leaving their closely supervised, often residential, secondary schools.

Youth drug education under a new paradigm should address the general secondary school population. First and foremost, it should offer a genuinely interactive process encouraging participants to share issues, experiences and information in a non-judgmental group context. In such a process youth prove eager to share personal experience and concerns. This approach leads to teachable moments when positive input from adult and peers is most likely to be internalised. The content should include strategies for minimising harms among those youth who nevertheless choose to use alcohol and other drugs. Finally, a safe, open and interactive process facilitates identification and assistance for those youth whose relationship to alcohol and/or drugs is problematic. This paradigm joins education and assistance in an integrated process that respects the intelligence of young people [48]. These and related principles are summarised in Table 2, which contrasts current early drug education with the secondary school approach proposed here.

The interactive process summarised in the table is not a skill many regular teachers use or need to learn. Group facilitation is a form of group process, not a standard teaching technique. Facilitators do not need degrees in counselling psychology or social work to perform effectively. Professionals in those fields are accustomed to using formal clinical strategies in working with clients. Authority is established in advance through credentials, rather than directly in the interactive experience. Not everyone can learn to carry out effective group facilitation with young people but many, including semi-professionals, can.

Table 2. Contrasting current vs. proposed paradigm for youth drug education and related services

<table>
<thead>
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<th>Current</th>
<th>Proposed</th>
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<tr>
<td>Pre- or early secondary</td>
<td>Secondary, age 14 and older</td>
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<tr>
<td>Curriculum dominant, information and skill development/practice</td>
<td>Process dominant, students share experience</td>
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<tr>
<td>Didactic, adult centred</td>
<td>Facilitated, interactive, non-judgemental</td>
</tr>
<tr>
<td>Sequenced content</td>
<td>Flexible, seeks/creates ‘teachable moments’</td>
</tr>
<tr>
<td>Abstinence only goal</td>
<td>Advocates abstinence, but also addresses reducing harm/risk for users</td>
</tr>
<tr>
<td>Focus on AOD only</td>
<td>Includes issues and experiences related to both use and abstinence</td>
</tr>
<tr>
<td>Does not identify/assist users</td>
<td>Identifies/assists problematic AOD users</td>
</tr>
<tr>
<td>Indoctrinates, only negative information on AOD</td>
<td>Acknowledges positive aspects of AOD use in order to establish credibility</td>
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References

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