101:

Things to Know when Prevention was NOT your Training Background
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Introduction

Congratulations! You’ve landed a job at an institution of higher education, or maybe you’ve been working there for a while, and you’ve been told that part of your job is now going to involve “prevention.” But what does that mean? Preventing failing grades? Preventing drop outs?

No…. Your job is about preventing substance misuse, violence, and other negative health and social outcomes. And, yes, that is now mandated by the federal government.

Your training in higher education administration, counseling, student development, social work, or any number of other backgrounds that might lead into working on a college campus probably included very little (one course? one academic assignment?), if any, didactic training on the topic. But now you are the “prevention person” on your campus and are expected to be the resident expert. What’s a person supposed to do? Draw on memories of what prevention looked like back when you were in grade school or college?

Take a deep breath. While you may have some positive memories to fall back on, CHASCo is here to help give you a more structured guide. This manual is a crash course in the history, theory, best practices, and guiding documents of the field. We hope you find it helpful as a foundation for your work and that, combined with ongoing professional development from CHASCo, you can chart a new path for prevention at your own unique institution.
Philosopher and author Mokokoma Mokhonoana once wrote, “It is usually impossible to know when you have prevented an accident.” Then-president of the American Public Health Association, Dr. Linda Rae Murray, expressed a similar sentiment at a commencement address when she said, “When public health works, we’re invisible.” It is somewhat of a puzzle of the senses that, in the field of prevention, when everything is working like it should, nothing happens. Nothing happening is exactly our goal.

A side effect of this invisible nature of prevention is that few people outside of those who have studied it truly know what it is or understand the science behind it. But the field of prevention has more than 70 years of research guiding its best practices, the development of theories behind why people do what they do, and how practitioners can intervene to make healthier choices become easier choices.

Here is a sampling of some of the key milestones in the field of wellness and collegiate alcohol and other drug prevention:

**Timeline of Prevention** (1,2,3,4,5)

**1953:** Straus and Bacon conduct the first wide scale research study of drinking at 57 institutions of higher education.

**1958:** The World Health Organization issues a more comprehensive definition of health, defining it as “a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.”

**1976:** The University of Wisconsin-Steven’s Point becomes the first institution of higher education to launch a campus wellness program.
1985: 64% of institutions of higher education report having a task force or committee focused on alcohol prevention.

1987: The Fund for the Improvement of Post-Secondary Education (FIPSE) begins providing grants to institutions of higher education to support collegiate alcohol and drug prevention programs. $7,780,000 was awarded in 1987 among 92 schools, and the program continued annually through 1994 when $14,412,719 was awarded among 144 schools. As part of the awards, campuses receive funding to administer the Core Alcohol and Drug Survey (often abbreviated as Core Survey) as a measure of baseline status and of program evaluation. These grants make the Core Institute, based out of Southern Illinois University, the keeper of the nation’s largest database of statistics on the use of alcohol and drugs among college students.

1988: The minimum legal drinking age is moved to 21 in all 50 states.

1994: The term “binge drinking” is coined by Henry Wechsler of Harvard University in the publication of results from the College Alcohol Study (CAS) to describe a pattern of drinks in which men consume 5 or more standard drinks in a sitting and women consume 4 or more standard drinks in a sitting. The CAS conducted 4 national surveys involving over 14,000 students at 120 four-year colleges in 40 states in 1993, 1997, 1999, and 2001. The schools and students selected for the study provided a nationally representative sample. In addition, CAS colleges with high levels of heavy alcohol use were resurveyed in 2005.

1995: The Higher Education Center for Alcohol, Drug Abuse, and Violence Prevention (HEC) is founded under the umbrella of the U.S. Department of Education. The mission of the Center is to help college and community leaders develop, implement, and evaluate programs and policies to reduce problems experienced by students related to alcohol and other drug use. Due to federal budget cuts, the Center was closed in 2012. The former co-director of HEC, Dr. John Clapp, came to The Ohio State University in 2013 to open the Higher Education Center for Alcohol and Other Drug Prevention (HECAOD) to meet this still existent national need.

2000: The Department of Health and Human Services launches Healthy People 2010 as a blueprint for improving the nation’s health status. That same year, the American College Health Association launches the companion Healthy Campus 2010 document.

2002: The National Institute for Alcohol Abuse and Alcoholism (NIAAA) creates the Task Force on College Drinking and implemented the Rapid Response to College Drinking initiative. Its central report, A Call to Action: Changing the Culture of Drinking at U.S. Colleges introduces four “Tiers of Effectiveness” which document the efficacy of various prevention programs through a review of published scientific research.

2015: The College Alcohol Intervention Matrix (College AIM) is released as an update to A Call to Action and allows readers to compare effectiveness and cost of multiple individual and environmental level prevention strategies.
Definitions, Theories, and Models of Prevention

Like any professional field, prevention comes with its own language of key terms, acronyms, theories, and models. While not an exhaustive list, this section details some of the most commonly used terms to help bring you up to speed quickly.

Some of the first terms to understand relate to the “who” and the “when” of prevention. In terms of audiences (the “who”) that prevention programs will attempt to influence, you will hear of three categories of prevention:

- **Universal prevention** - refers to activities targeting the entire population within your sphere of influence; ex., all students at your university.
- **Selective prevention** - refers to activities targeting groups within your population considered to be “at risk”; ex., fraternity members, residential students, athletes, etc.
- **Indicated prevention** - refers to activities targeting individuals who are already experiencing symptoms or consequences; ex., students in recovery, sanctioned students, etc.

Additionally, you will hear of three terms that describe the *timing* (the “when”) of a prevention intervention:

- **Primary prevention** - refers to measures designed to forestall the onset of illness, injury, or consequences; ex., educational workshops, poster campaigns, etc.
- **Secondary prevention** - refers to measures leading to early diagnosis and prompt treatment; ex., depression screenings, Alcohol Screening Day, etc.
- **Tertiary prevention** - refers to measures aimed at preventing relapse following illness, injury, or consequences; ex., drug courts, Alcoholics Anonymous, recovery communities, etc.

As you will see in the subsequent section on theories and models, the factors that drive our decision making and our behaviors are varied and complex. Those factors that influence whether or not behavioral change occurs are broken down into three categories:

- **Predisposing factors** - precede behavior and provide the rationale or motivation for a behavior; ex., knowledge, attitudes, beliefs, personal preferences, existing skills, and self-efficacy beliefs.
- **Enabling factors** - precede behavior and allow for a motivation to be realized; ex., programs, services, resources, training in new skills, environmental factors that affect behavior.
- **Reinforcing factors** - follow a behavior and provide continuing reward or incentive to repeat that behavior; ex., includes social support, peer influence, significant others, material incentives, etc.
In addition to the aforementioned definitions, it will also be helpful to familiarize yourself with the alphabet soup of prevention-related acronyms. These include:

- **AOD**: “alcohol and other drug”
- **AODV**: “alcohol, other drug, and violence”
- **CADCA**: “Community Anti-Drug Coalitions of America”—a nonprofit organization that is committed to creating safe, healthy and drug-free communities globally. CADCA is the umbrella organization of most of the county prevention coalitions that operate in Tennessee.
- **EDGAR 86**: “Education Department General Administrative Regulations Part 86”—the specific section of federal law that lays out the requirements for institutions of higher education regarding drug and alcohol abuse prevention; it mandates, among other things, annual notification to all employees and students of the school’s AOD policies and a biennial review process to document effectiveness of prevention efforts and consistent enforcement of sanctions.
- **NASPA**: “National Association of Student Personnel Administrators”—the professional association for the advancement, health, and sustainability of the student affairs profession in higher education
- **NIAAA**: “National Institute of Alcohol Abuse and Alcoholism”—one of the 27 institutes and centers that comprise the National Institutes of Health (NIH). NIAAA supports and conducts research on the impact of alcohol use on human health and well-being.
- **SAMHSA**: “Substance Abuse and Mental Health Services Administration”—the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA’s mission is to reduce the impact of substance abuse and mental illness on America’s communities.
- **TDMHSAS**: “Tennessee Department of Mental Health and Substance Abuse Services”—the mental health and substance abuse authority for the State of Tennessee. TDMHSAS is the funding source for most of the administrative and programming dollars provided to and by CHASCo.

Three Prevention Models

Multiple textbooks exist explaining the theories, models, and research behind behavior and the complex reasons that people do what they do when it comes to their personal health. This manual will address three such models that will provide some baseline information on the interplay of these influences and how prevention interventions can target various elements of that interplay to increase the likelihood of successful outcomes.

First up is the **Health Belief Model**. It is a type of value-expectancy theory. The desire to avoid illness or to get well (value) and the belief that a specific action would prevent or improve illness
(expectation) can help predict what behaviors an individual will engage in. The Health Belief Model was originally formulated by a group of social psychologists in the US Public Health Service in the 1950s, and it helped explain why simply knowing that a behavior was good or bad did little to predict whether or not an individual took part in that behavior.

Figure 1. Health Belief Model \(^{(6)}\)

Figure 1 shows the various components of the Health Belief Model and how they interact with each other. These components, listed alphabetically, include:

- Cues to action: strategies to activate one’s readiness (i.e., a sign at the local drug store motivates you to consider a flu shot)
- Modifying variables: demographic, sociopsychological, and structural variables that may affect one’s perceptions and thus indirectly influence behavior; ex., educational attainment can have an indirect effect on behavior by influencing the perception of susceptibility, severity, benefits, and barriers. Other variables could include age, sex, ethnicity, personality, socioeconomic status, etc. (i.e., females are more likely to engage in preventative health care like flu shots than males)
- Perceived barriers: one’s belief about the tangible and psychological costs of the advised action (i.e., you believe going to get a flu shot will take too much time)
- Perceived benefits: one’s belief in the efficacy of the advised action to reduce risk or seriousness of impact (i.e., you believe that getting the flu shot last year helped keep you well during the previous winter)
• Perceived seriousness/severity: one’s belief of how serious a condition and its associated symptoms/consequences are (i.e., you believe having to miss work due to the flu would be detrimental to your efforts to get a promotion)
• Perceived susceptibility: one’s belief regarding the chance of getting a condition (i.e., you believe you will be exposed to the flu in your day-to-day interactions and could contract it)
• Perceived threat: the amount of personal risk one feels based on perceptions of seriousness and susceptibility (i.e., you believe you could catch the flu and become ill, which is undesirable)
• Self-efficacy: one’s confidence in one’s ability to take action (i.e., you know where to access the flu shot if you want one)

To give an example, if we are considering creating a campus safe rides program to deter drunk driving, we should not assume that simply building the service and telling students it exists will lead to a full schedule for the drivers. Our intervention and marketing campaign would need to consider, from a potential user’s perspective, what benefits the service would provide (ex., free, safe transportation) and what barriers it might entail (ex., could take longer to get home, increase in student fees). How seriously do our students view drunk driving, and how susceptible do they personally feel to being caught engaging in drunk driving? Do they have the self-efficacy necessary to schedule a ride pickup? Are there cues in places from which they might need a safe ride in order to help activate their motivation? Do they see people who look like themselves using a safe ride program? The more of these questions an intervention can address, the greater the likelihood of targeted students actually choosing a safe ride program over getting behind the wheel themselves.

For brief video explanations of the Health Belief Model, check out https://www.youtube.com/watch?v=hI5LDiz8Le0 or https://www.youtube.com/watch?v=uXLUBjzZVOM.

Another commonly applied model is the Transtheoretical Model, introduced by Prochaska and DiClemente and also known as “Stages of Change.” This model developed in the late 1970s/early 1980s as an effort to integrate processes and principles of change from across various theories, including things like consciousness raising as proposed by Sigmund Freud and contingency management as proposed by B. F. Skinner. Early research into this effort documented that individuals used different strategies depending on where they were in the change process.

Those stages of change included:

• Precontemplation- having no intention to take action within the next six months
• Contemplation- intending to take action within the next six months
• Preparation- intending to take action within the next 30 days and already taking some behavioral steps in that direction
• Action- has changed behavior for less than six months
• Maintenance- has changed behavior for more than six months
These changes are not linear, and an individual can move back and forth between them as they cycle through the different stages. Figure 2 shows how this model is commonly depicted.

Some of the processes of change that the researchers documented and which were being applied at different stages of change were:

- Consciousness raising - increasing awareness about causes, consequences, and cures for a particular problem behavior
- Contingency management- increasing the rewards for healthy behaviors and decreasing the rewards for unhealthy behaviors
- Counterconditioning- substituting healthier alternative behaviors for the unhealthy behavior
- Dramatic relief- experiencing the negative emotions that go along with unhealthy behavioral risks (ex., fear, anxiety, worry)
- Helping relationships- seeking and using social support for the healthy behavior change
- Self-liberation- making a firm commitment to change
- Self-reevaluation- seeing behavior change as an important part of one’s identity
- Stimulus control- removing reminders or cues to engage in the unhealthy behavior and adding cues or reminders to engage in the healthy behavior

Figure 2. The Transtheoretical Model

In early stages, individuals are most likely to apply cognitive and affective strategies like consciousness raising and dramatic relief to get closer to their change goals. In latter stages, they are most likely to apply counterconditioning, contingency management, support, and environmental controls to get closer to maintenance. (See Table 1.)

Although originally tested with people trying to quit smoking, this model can be applied to multiple health behaviors requiring individual change, including alcohol or other drug abuse, treatment of mental
illnesses, diet and/or exercise, cancer screenings, STI/HIV prevention, and more. Prevention practitioners should first assess the current stage of the client(s) and then plan interventions using the appropriate processes of change.

Table 1. Processes of Change that Mediate Progression between the Stages of Change.

<table>
<thead>
<tr>
<th>Stages of Change</th>
<th>Precontemplation</th>
<th>Contemplation</th>
<th>Preparation</th>
<th>Action</th>
<th>Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Processes</td>
<td>Consciousness raising</td>
<td>Dramatic relief</td>
<td>Self-reevaluation</td>
<td>Self-liberation</td>
<td>Counterconditioning</td>
</tr>
</tbody>
</table>

To watch a brief video explaining the Transtheoretical Model, check out [https://www.youtube.com/watch?v=Tlwol2pXsv0](https://www.youtube.com/watch?v=Tlwol2pXsv0).

The final model we will consider in this manual is the **Social Ecological Model**. The Social Ecological Model was developed in the 1980s but was continually revised by Urie Bronfenbrenner until his death in 2005. It recognizes that human behaviors and decision making do not happen in a vacuum and describes the different levels of influence that can impact behavior. Those levels are diagrammed in Figure 3.

The levels of influence identified by Bronfenbrenner were:

- **Individual** -- identifies biological and personal history factors that impact behavior, including knowledge, attitudes, behavior, self-efficacy, developmental history, gender, age, religious identity, racial/ethnic identity, sexual orientation, economic status, financial resources, values, goals, expectations, literacy, stigma, and others. Specific approaches at the individual level may include education and life skills training.
- **Interpersonal** -- examines close relationships, formal and informal, that may influence behavior, including family, friends, peers, co-workers, religious networks, customs or traditions; the interpersonal level not only influences an individual’s behavior, but it also contributes to their experience. Prevention strategies at the interpersonal level may include parenting or family-focused prevention programs, mentoring and peer programs, faith-based programs, etc.
- **Institutional and Community** -- these levels explore the settings (with defined boundaries), such as schools, workplaces, and neighborhoods, in which social relationships occur and seek to identify the characteristics of these settings that are associated with behaviors of interest;
includes the built environment (e.g., parks), village associations, community leaders, businesses, and transportation. Strategies at these levels impact the social and physical environment – for example, by reducing social isolation, improving economic and housing opportunities in neighborhoods, and cultivating positive climates, processes, and policies within school and workplace settings.

- Public Policy/Society -- looks at the broad societal factors without defined boundaries that help create a climate; includes social and cultural norms that support or reject behaviors of interest. Strategies at this most encompassing level include local, state, national and global laws and policies, as well as policies regarding the allocation of resources, or a lack of policies.

A comprehensive prevention program should take into account all of these levels and have elements supporting all of them. For example, a comprehensive violence prevention program could have bystander intervention training, a poster campaign around attitudes towards sexual violence, clearly communicated and easily accessible campus resources for survivors and reporting, coordination with local domestic violence shelters and hospitals, and state or national media campaigns to normalize and promote healthy attitudes.

Figure 3. The Social Ecological Model

To watch a brief video explaining the Social Ecological Model, check out https://www.youtube.com/watch?v=e9UyplfevyQ.
As you can see, one takeaway message for prevention strategies is that **knowledge is necessary, but not sufficient**, to change behavior. While increasing knowledge will likely be an outcome of most prevention programs, we should not expect measurable behavior change if increasing knowledge is our only outcome. How many of us know that eating a fresh from the oven chocolate chip cookie is probably not in our best dietary interest, and yet we still partake at least occasionally in that treat? Or we know that consistently getting eight hours of sleep at night will help us feel and perform our best during the day, and yet we allow ourselves to watch “just one more” episode of whatever we’re currently binging on Netflix? The theories and models we have just addressed help us think through what other elements of human decision-making we need to consider and try to influence if we truly want to increase the likelihood of a sustainable behavior change.
Best Practices for Prevention

Having now examined different theoretical models that can guide our prevention strategies, this section will introduce some best practices in prevention intervention, including general principles and specific approaches.

Elements of Successful Prevention Programs

Back in 2003, a team of researchers led by Maury Nation conducted a review of successful prevention programs and identified nine elements that were common to all of them. Those elements included:

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensiveness</td>
<td>Multicomponent programs that address critical domains (e.g., family, peers, community) that influence the development and perpetuation of the behaviors to be prevented; these programs could include a combination of interventions in multiple settings</td>
</tr>
<tr>
<td>Varied teaching methods</td>
<td>Programs involve diverse teaching methods that focus on increasing awareness and understanding of the problem behaviors and on acquiring or enhancing skills; programs should be careful not to rely on knowledge, information, or group discussion as the major change mechanism</td>
</tr>
<tr>
<td>Sufficient dosage</td>
<td>Programs provide enough intervention to produce the desired effects and provide follow-up as necessary to maintain effects; effects of most prevention programs decline over time, so booster sessions focusing on prior skills or the development of new ones can be helpful to sustain results</td>
</tr>
<tr>
<td>Theory driven</td>
<td>Programs have a theoretical justification, are based on accurate information, and are supported by empirical research</td>
</tr>
<tr>
<td>Positive relationships</td>
<td>Programs provide exposure to adults and peers in a way that promotes strong relationships and supports positive outcomes</td>
</tr>
<tr>
<td>Appropriately timed</td>
<td>Programs are initiated early enough to have an impact on the development of the problem behavior and are sensitive to the developmental needs of participants</td>
</tr>
<tr>
<td>Socioculturally relevant</td>
<td>Programs are tailored to the community and cultural norms of the participants and make efforts to include the target group in program planning and implementation</td>
</tr>
<tr>
<td>Outcome evaluation</td>
<td>Programs have clear goals and objectives and make an effort to systematically document their results relative to the goals; effectiveness should not be judged primarily on the basis of anecdotal or case study results</td>
</tr>
<tr>
<td>Well trained staff</td>
<td>Program staff support the program and are provided with training regarding the implementation of the intervention; implementation is most effective when staff are sensitive, competent, and well-supervised</td>
</tr>
</tbody>
</table>

A Comprehensive Prevention Process

Programming is really just the tip of the iceberg in terms of effective prevention. A good prevention program is part of a larger, more comprehensive prevention process. EverFi has created a graphic
depicting just that phenomenon, with programming sitting atop a pyramid of prevention components (see Figure 4).

At the base of the pyramid is Institutionalization. In many instances, the staff member tasked with prevention work is buried in the college or university’s organizational structure under multiple layers of supervision. In order for prevention efforts to be successful in higher education settings, senior administrators need to buy in to the process and be willing to support the efforts through resource allocation and accountability.

The next level up the pyramid is Critical Processes. This level involves the behind the scenes efforts to ensure that prevention strategies are based on strategic planning and localized data when possible. It is also at this level that processes are put in place for policy review and communication across the campus’s affected constituents.

Nearing the top of the pyramid is the Policy level. Effective prevention efforts have well written policies that are enforced and efficiently adjudicated. Policies set the tone for the values and expectations of the campus, and no amount of work by a prevention practitioner will overcome a conflicting policy or a supportive policy that is not enforced.

Lastly, the Programming level sits on top. Remember that programming should involve universal, selective, and indicated target audiences and contain the nine elements previously mentioned as components of effective prevention programs. When all levels of the pyramid are in place, prevention efforts are highly likely to be successful.

Figure 4. The Process of Successful Prevention.\(^{10}\)
In summary, there are things we know make for good prevention programming and things that are not so good. A prevention program is most likely to be effective when it is rooted in theory and evidence, is comprehensive in scope, is repeatable, is relevant to your community, and is collaborative. In contrast, programs least likely to be effective are single shot, standalone programs that rely primarily on scare tactics or an increase in knowledge alone to change behavior.

A Note on Scare Tactics (Don’t Use Them!!)

It is worth mentioning that a default approach to prevention, particularly among individuals with no formal training in the field, is to use fear based messages as a way to “scare” their population into healthy behavior. You have probably witnessed many of these approaches yourself—a presentation showing pictures of diseased genitalia intended to deter sexual activity, a crashed car and/or other staged accident scene intended to discourage drunk driving, testimonials from people who have served jail time for the choices they made around substance use or illegal activity, etc. But as common as they are, scare tactics have never been documented in the literature as effective at changing behavior. In fact, some of them have even been shown to increase the chances of a target audience engaging in the very behavior organizers were trying to prevent!

In spite of the organizers’ good intentions, the use of scare tactics can have one or more of the following less than helpful effects on the target audience:

- A behavioral “paralysis” where participants don’t know what to do to avoid the described consequence, especially if abstinence from a particular behavior is not seen as a viable option
- A “game” mentality where the participants are determined to continue a negative behavior to “prove” to the organizers that the consequence they described won’t happen to them
- A loss of the organizers’ credibility as the participants process that behaviors they and their peers have engaged in previously did not lead to the consequences being featured in the intervention

For all of these reasons, CHASCo encourages its member schools to avoid the use of scare tactics in their prevention efforts and to instead consider some or all of the specific strategies that follow and are currently considered best practices in our field.

Environmental Prevention Strategies

Environmental prevention strategies seek to address the underlying conditions in a community that can lead to healthy or unhealthy behaviors. These could include policies, programs, and practices that promote well-being or reduce risk. Environmental prevention could take place in many formats, and ideally, would utilize multiple designs. Here are some general examples, but you can also consider some specific examples compiled by CHASCo of practices used by member schools. Check the CHASCo website for the most current listing.
• **Campus policies**  
  College and university policies that restrict the accessibility of alcohol can effectively deter student drinking **when they are well enforced**. Such policies could include bans on alcohol advertisements on campus, dry campus policies, scheduling Friday classes, or party registration policies, to name a few. CHASCo institutions who elect to complete prevention plans will find that the planning process will require consideration of their local policies and if and how they could be improved.

• **Mandated population-level education**  
  Requiring all students complete some type of evidenced-based in person or online education curriculum can change the environment and culture around behaviors you wish to prevent. Some schools choose to assign the curriculum as an online pre-matriculation requirement and tie its completion to a student’s ability to enroll in classes for the upcoming semester.

  “AlcoholEdu” by EverFi and “eCheck Up To Go (eCHUG)” by San Diego State University probably have the most name recognition in this category, but there are other options available through various vendors. CHASCo has negotiated discounted rates for its member schools to utilize eCHUG, so contact the CHASCo director if you would like more information about that product.

• **Late night social activities**  
  The use of school-sponsored social activities during typical peak drinking times is another common tactic universities use to alter the environment of their campuses. The activities would generally be held on Thursday, Friday, or Saturday nights with a 9:00pm or later start time and a midnight or later end time to coincide with time frames that tend to be common drinking periods for students. They could also be held around holidays like Halloween, St. Patrick’s Day, or Cinco de Mayo that are associated with alcohol consumption. The activities are never advertised as “alcohol-free alternatives,” but that is, in effect, the purpose they serve. San Diego State University has one of the most well-established programs of this sort called Aztec Nights. Additional information about its program can be found at [https://as.sdsu.edu/aztecnights/](https://as.sdsu.edu/aztecnights/). Many CHASCo member schools use money available from their prevention plans to fund similar late night activities.

• **Universal screenings**  
  A newer effort at changing the environment is the use of universal screenings in student health clinics and counseling centers. When implemented, all students seen in one or both of those settings are asked a standard set of questions around their use of alcohol, experience with depression, suicide ideation or other area of interest. The screening allows for the gathering of information that might not have come up in the student’s appointment otherwise, and students who screen positive can quickly be referred to the appropriate resource.

• **Community partnerships**  
  One last example of how environmental factors can be used as a best practice is community partnerships. All of our campuses exist as part of a larger community, and working with your local partners is key to preventing problems within one sphere bleeding over into the other. To
give a specific example, the Safer California Universities Project was an NIAAA-funded grant that allowed 14 schools in the California State University system to implement a variety of interventions aimed at curbing high risk alcohol use among their students. The schools in the program partnered successfully with local law enforcement to offer well-publicized DUI check points, off campus party patrols, crackdowns on sales of alcohol to minors, and a wide-scale media campaign during the first few weeks of the academic year. You can read more about the project and download a free toolkit if you are interested in trying something in your own community at https://prev.org/SAFER/interventions.html.

Many counties in Tennessee have local prevention coalitions. If you are unsure about your own county, the State of Tennessee has a website that lists community based prevention coalitions at https://www.tn.gov/behavioral-health/substance-abuse-services/prevention/prevention/join-an-anti-drug-coalition0.html. CHASCo encourages its member campuses to partner with their community coalitions when possible.

**Social Norms Marketing**

Another well-researched best practice is the strategy of social norms marketing. Social norms in general refer to the perceptions we all have of what is typical behavior (descriptive norms) or what is considered acceptable or unacceptable behavior (injunctive norms). Those perceptions commonly guide our behavioral decision making (i.e., “when in Rome, do as the Romans do”). The social norms marketing strategy involves publicizing messaging around the healthy behaviors of the students on your campus that might fly in the face of ingrained stereotypes. If students become aware of the true attitudes and behaviors of their fellow students around substance use and violence prevention, they may feel less pressure to engage in behavior that goes against their values or comfort levels.

**Figure 5. Sample Social Norms Marketing image from University of Tennessee Chattanooga.**[11]
Social norms marketing can take place as a universal campaign or as a targeted campaign for particular groups of students. In a universal campaign, you are likely to see messages along the lines of “Most University of X students don’t drive after drinking” or “88% of University of X students did not use tobacco in the past 30 days.” The messages are often accompanied by a campaign branded tag line and always include a source statement for the data being referenced. Targeted campaigns would have similar messaging but use images and specific phrasing to make them relevant to the desired population. For example, a targeted campaign message could look something like “3 out of 4 fraternity men at University of X say they would confront a brother who made a racist comment.”

If you choose to use the social norms marketing strategy, be sure to consider the contexts in which your students would most likely see the messages. The traditional social norms marketing campaign relies on posters, fliers, and other print materials to display its messages. However, those formats may not be the best options in today’s digital world. Consider things like social media ads, computer lab screen savers, online platforms students use to conduct university business, etc. Even if you go with traditional print materials, think about locations where students are most likely to see them. Things like billboards, cafeteria table tents, and shuttle bus stops might get more looks like a poster stuck on a departmental bulletin board.

Additional information on social norms theory and social norms marketing campaigns can be found through the National Social Norms Center housed at Michigan State University, http://socialnorms.org/.

CHASCo has a long history of providing funding to its member schools for social norms marketing campaigns. The CHASCo website, www.tnchasco.org, has examples of some of those campaigns (see Figure 5), and the CHASCo director and Executive Committee Programming Chairperson are also available to offer technical assistance to any campus working on a campaign.

**Motivational Interviewing**

A third example of a best practices strategy is motivational interviewing (MI). MI is a technique that has been used in counseling environments for decades but has also established a strong foothold in the realm of AOD prevention work. It involves a meeting or series of meetings with individual students or small groups to uncover each student’s personal rationale for substance use and openness to the idea of change. The trained facilitator uses open-ended questions to elicit a student’s “hook,” that is, a potential motivating factor relevant to the student for moving towards a healthier behavior. For some students, the hook could be a realization that their alcohol use has cost them some friendships or perhaps has negatively impacted their grades. For others, it could be that they don’t like the weight they have gained from drinking or that they find they lose motivation and productivity when they are high. Perhaps it’s even something as simple as they don’t like their clothes smelling of cigarette smoke all the time. Whatever is important to that student becomes the driving force behind the facilitator’s follow up questions to assess how motivated the person is to trying to change.

When using MI, the Transtheoretical Model becomes key in determining where a person is regarding their readiness to change. A student who is assigned a motivational interviewing intervention due to a sanction for a policy violation may be in precontemplation with no interest in changing his behavior. On the other hand, a student who has experienced a medical emergency or who has self-selected into your
intervention may very well be in the contemplation, preparation, or even action stages. Depending on the stage, you can expect varying levels of resistance and/or ambivalence to change. Keep in mind that students are the “experts” in their sessions, so roll with whatever resistance they present rather than trying to immediately debate their logic or convince them of a need they don’t perceive. If students are pre-contemplative, you can try to increase their risk perception by providing normative feedback on how their drinking behaviors compare with local or national norms. If students are contemplative, help elicit reasons for change or risks of not changing that they identify. In preparation or action stages, help your clients determine their best next steps to change and provide them with positive reinforcement. With any of the stages, asking clients where they would rate themselves on interest in or ability to change and then following up with what it would take for them to rate themselves higher can shine light on their motivations and provide potential hooks for further discussion.

It is important to remember that with motivational interviewing, any step towards positive change is considered a win. You may not get the students to the ideal health behavior during your sessions, but moving them along the motivation and behavior change continuum is a desirable outcome.

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**Brief Alcohol and Screening Intervention for College Students (BASICS)**

One example of a specific intervention based on motivational interviewing is the Brief Alcohol Screening and Intervention for College Students (BASICS). There is no official certification involved in becoming a BASICS facilitator, but trainers are available around the country to provide background, skill building, and technical assistance for campuses. CHASCo has periodically sponsored BASICS trainings over the years, as well. The book “Brief Alcohol Screening and Intervention for College Students: A Harm Reduction Approach” by Linda A. Dimeff, John S. Baer, Daniel R. Kivlahan, and G. Alan Marlatt and available from Guilford Press ([www.guilford.com](http://www.guilford.com)) is an excellent resource with reproducible handouts and assessment instruments for individuals who may be interested in learning more about BASICS.

**Bystander Intervention**

A final best practice that we will discuss is bystander intervention. This practice is based on the fact that most of the social and personal problems associated with alcohol, drugs, and violence are witnessed by others, the healthy majority. Activating that majority to intervene can thus help prevent many harms. Unfortunately, human nature seems to pull us towards inaction when we are bystanders, assuming that someone else will deal with a situation or that it is none of our business. However, research in the field of social psychology documents that people trained to feel responsible for addressing things they see and armed with skills to act are much more likely to intervene. Bystander intervention has been used successfully in many prevention areas, including both violence prevention and substance abuse prevention.

Multiple curricula exist to train individuals and groups in bystander intervention, but a common element of them is the recognition that there are different strategies through which a person could intervene.
For example, some of the commercially available programs refer to the “3 D’s.” Those D’s of intervention are:

- Direct,
- Distract,
- Delegate

A Direct intervention involves the direct confrontation of the offender, such as directly taking the keys from an intoxicated person about to drive. A Distraction intervention could be directed at the offender or at other bystanders with a goal of creating a diversion that allows for the potential victim to be removed from the situation or that distracts the offender from completing his plan of action. For example, someone intervening could strike up a conversation with the offender or potential victim (i.e., “Excuse me, but you look really familiar to me. Do we have class together?” or “I’m so sorry, but I think your car may be getting towed!”). A Delegation intervention involves seeking help from other bystanders or from authority figures who may be better equipped to address a situation, like contacting campus security when you smell marijuana from a residence hall room. Individuals may feel more comfortable with one or more of these options than others, but the important thing is that acting in any way is better than not acting at all.


**Implementation Science**

While each of the previously described strategies is considered a current best practice, it is important to keep in mind that “best practices” are constantly evolving as additional research is done on existing or new interventions. This evolution also means that the way a best practice was implemented at one or more specific institutions may not translate exactly to how it could look at your school. The relatively new field of Implementation Science aims to help us understand how to take research findings and actually put them into practice with our unique populations. In general, implementation science recognizes that every intervention may need to be tweaked in order to fit unique campus environments and cultures.

Although you don’t want to change things so much that you break away from the theoretical underpinnings of the intervention, you do need to consider your organizational context, population characteristics, and local resources to know what is feasible for your campus. Don’t be afraid to fail. Culture change is hard, and it takes time. There is a plethora of published research covering successful interventions, but as a field, we have not done as well at explaining in that research exactly how those interventions were implemented, or at publishing our intervention failures from which others could learn. In your own efforts to implement best practices, keep notes of what you tried, and if you fail, revisit your theoretical models and see what could be tweaked to try again.
A Word of Caution

Regardless of the strategies you may ultimately decide to employ, be aware that the most commonly used strategies among colleges and universities are not necessarily the most effective, and vice versa. Administrators at 330 4-year colleges and universities in the United States have been surveyed every three years as a part of the College Alcohol Survey run by George Mason University. Included among the survey questions is for the respondents to rank on a scale of 1 to 5 (with 1 being strongly disagree and 5 being strongly agree) the accuracy of the statement “Our campus utilizes the most effective alcohol abuse prevention strategies based on professional literature, conference workshops, training, etc.” The mean score on that item in 2015 was 3.64, which is hardly an improvement over the 3.57 mean score when the question was originally introduced in 2003\(^\text{(12)}\).

A review of results from the 38 schools who participated in EverFi’s Sexual Assault Diagnostic Inventory\(^\text{(13)}\) shows that three of the five most commonly reported sexual violence prevention strategies (awareness events, tabling events/health fairs, and invited speakers) are shown by research to be least effective, while four of the five least used sexual violence prevention strategies (social norms marketing, academic course engagement, bystander intervention, and small group social norms) are among the most promising.

These numbers can increase confusion for administrators and other professionals new to the prevention field, as they often look to peer institutions for programming ideas. If you can’t always trust that peer institutions are using effective strategies, where can you turn for ideas? This question leads into our next and final section on research tools and guiding documents.
Guiding Documents and Research You Should Know

Fortunately, there are lots of free tools available in online and print versions to help you plan your prevention efforts and assess their efficacy.

NIAAA Tools

A great starting point for prevention, specifically in higher education environments, is the website www.collegedrinkingprevention.gov, which is maintained by the NIAAA. The website is a repository of information, including fact sheets, reports, and presentations that can be helpful to both the beginner and the more seasoned prevention practitioner. To ground yourself in how the website seeks to categorize interventions, check out the 2002 document, “A Call to Action: Changing the Culture of Drinking at U.S. Colleges,” as well as its 2007 update, “What Colleges Need to Know: An Update on College Drinking.” “A Call to Action” reviews many of the strategies used at the time of publication to prevent high risk drinking and ranks them into “Tiers of Effectiveness” based on the amount of published research that supports their success rates at reducing substance misuse. “What Colleges Need to Know” provides a follow up on how colleges were utilizing the 2002 report and offers updated recommendations and statistics.

Once you are familiar with the ranking system, you should next familiarize yourself with the “College Alcohol Intervention Matrix (AIM).” This tool was published in 2015 and updated in 2019. It is available as a print copy (see Figure 6) or digital download through the website or as an interactive tool while on the website. The tool is divided into sections, with matrices that review current environmental and individual interventions, and with planning worksheets. If using the interactive version online, the environmental interventions are categorized based on effectiveness and cost at https://www.collegedrinkingprevention.gov/CollegeAIM/EnvironmentalStrategies/default.aspx. Click on any of the bolded strategies to learn more about them, as well as see how much supporting research they have. Similarly, the individual strategies can be viewed at https://www.collegedrinkingprevention.gov/CollegeAIM/IndividualStrategies/default.aspx. A strategy planning worksheet can be downloaded or completed online at https://www.collegedrinkingprevention.gov/CollegeAIM/Resources/Worksheet_for_Choosing_Alcohol_Interventions.pdf and allows a practitioner or task force to think through current strategies and their effectiveness, strategies they may wish to add, and what next steps should be considered to improve the overall efforts on their campuses.

Figure 6. The College AIM Print Edition.
Another great tool is the Alcohol Prevention Compass, developed by EverFi and available at https://compass.everfi.com/tool/compass/. This visualization depicts 34 different strategies and plots their effectiveness, cost, and scale of impact on a graph. On the website, you can click on a strategy to see where it falls on the graph, learn more about the strategy, and see the available research that led to its placement on the compass. Print versions of the compass can be obtained by contacting an EverFi representative. The website also provides an avenue for campuses to receive a custom compass depicting the strategies currently used by individual institutions, which can be useful for guiding discussions with decision makers and senior administrators at your school. Keep in mind, though, that EverFi is a for-profit company, and while they offer many consultative services for free, their end goal is to sell you their online education products, so expect some frequent sales pitches.

Figure 7. Alcohol Prevention Compass Image.\(^{(15)}\)

Evidenced-Based Practice Resource Center

SAMHSA also offers a free tool called the Evidenced-Based Practice Resource Center. This tool is not specific to higher education environments, but it is a database of various interventions, toolkits, resources, and information on a variety of substance use and mental health topics that is easily searchable. From its website, https://www.samhsa.gov/ebp-resource-center, you can search by topic, population, or target audience to review relevant materials and other documents that might be similar to your search terms.

This section in no way provides an exhaustive list of the resources currently available to help with prevention efforts, but it will hopefully give you enough information to get started and to feel more confident that you are selecting proven strategies for your unique campus. Additional resources and supporting documentation are available in the appendix of this manual.
Conclusion

As you are now aware, there is a great deal of science underlying prevention work to help increase the chances of meeting our goal of “nothing” happening. CHASCo is here to help you each step of the way as you begin navigating your new responsibilities and making decisions about the strategies you want to employ at your institution. Keep in mind that culture change will take time, and anticipate having to explain on occasion why you are using the specific strategies you select rather than just providing more educational information or attempting to scare students into positive behaviors. Those of us within CHASCo are in the fight together, and we stand in solidarity with you in your efforts to utilize effective strategies for your students.

In the words of John F. Kennedy during his 1961 inaugural address:

“All of this will not be finished in the first one hundred days. Nor will it be finished in the first one thousand days, nor in the life of this Administration, nor even perhaps in our lifetime on this planet. But let us begin.”
References

2. Kilmer, J., Cronce, J., and Larimer, M. (2014.) College student drinking research from the 1940s to the future: Where we have been and where we are going. Journal of Studies on Alcohol and Drugs. 17, 26-35.
3. Foundation Concepts of Global Community Health Promotion and Education (Hernandez, 2011)
4. Wellness: The History and Development of a Concept (Miller, 2005)
5. EverFi Annual Research Summit (2017)
Appendix- Additional Resources

Textbook Resources


Web-based Resources

Coalition for Healthy and Safe Campus Communities (CHASCo)
This website of the statewide prevention coalition for higher education institutions in Tennessee includes prevention resources, training opportunities, and information about upcoming in person and online business meetings and professional development.

Centers for Disease Control and Prevention (CDC)
The Guide to Community Preventive Services is a resource for evidence-based recommendations from the Community Preventive Services Task Force about what works to improve public health.

Center for the Advancement of Public Health at George Mason University
Creating a Strategic Plan for College Students provides resources around strategic planning, including a “Promising Practices Action Planner” and a “Promising Practices Task Force Planner.” Implementation in the College contains multiple documents, standards, and workbooks about interventions taking place on college campuses. Although some of the information is becoming dated, like the “Promising Practices: Campus Alcohol Strategies” from 2001, it is still a useful resource in learning about efforts at a variety of campuses. Reviewing College Initiatives offers guidance and self-assessment tools for evaluating prevention efforts. This site also offers access to the most recent results of the College Alcohol Survey.
Center for Community Health at the University of Kansas

Community Tool Box offers step by step guides and models related to community building to address social determinants of health, engaging stakeholders, action planning, building leadership, improving cultural competency, evaluation, and sustainability over time. Toolkits are available for 16 areas of planning and program administration.

Higher Education Center for Alcohol and Drug Misuse, Prevention, and Recovery

Prevention 101 is a five-part video series designed for new prevention professionals that explores the foundations of collegiate substance misuse prevention.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

Alcohol Policy Information System provides detailed information on alcohol-related policies in the United States at both state and federal levels. Detailed state-by-state information is available for more than 30 policies. Safer Campuses and Communities website is based on a NIAAA-funded study that examined a variety of environmental-level strategies that could be implemented on campuses and in their surrounding communities. A free toolkit for implementing the collaborative model is available online.

National Institute on Drug Abuse (NIDA)

NIDA’s College-Age and Young Adults page provides the most recent data on substance use among this age group, including patterns of marijuana use, non-medical use of prescription drugs, cocaine, and newer trends like synthetic drugs, e-cigarettes, and hookah use. It also provides other links of interest to educators, residence hall supervisors, counselors, clinicians, and researchers who work with this age group, as well as students and parents.

Substance Abuse and Mental Health Services Administration

Center for the Application of Prevention Technologies is a national substance abuse prevention training and technical assistance site. Resources on the site include:

- Evaluation tools and resources from federal and nonfederal sources
- Strategic Prevention Framework, a five-step planning process that guides the selection, implementation, and evaluation of evidence-based, culturally appropriate, sustainable prevention activities

Report to Congress on the Prevention and Reduction of Underage Drinking (2013) includes policy summaries and state summaries identifying current legislative and other ongoing efforts. This report is compiled by the Interagency Coordinating Committee on the Prevention of Underage Drinking and is available through www.StopAlcoholAbuse.gov and the SAMHSA Store.

U.S. Department of Education

National Center on Safe Supportive Learning Environments offers training, technical assistance activities, and resources to support assessment, capacity building, strategic planning, implementation, and evaluation. Resources on this site include:

- Using a Public Health and Quality Improvement Approach to Address High-Risk Drinking with 32 Colleges and Universities (2014)
- College Alcohol Risk Assessment Guide: Environmental Approaches to Prevention (2009)
• *Methods for Assessing College Student Use of Alcohol and Other Drugs* (2008)

**U.S. Department of Justice**

*Underage Drinking Enforcement Training Center* provides federal and non-federal resources, such as:

• College e-kit web section
• Promising Practices: Campus Alcohol Strategies (includes an Alcohol Task Force Action Planner)
• *Party Patrols: Best Practice Guidelines for College Communities* (2010)