

# BEST PRACTICES IN COMMUNITY-BASED PREVENTION FOR YOUTH SUBSTANCE REDUCTION: TOWARDS STRENGTHS-BASED POSITIVE DEVELOPMENT POLICY

Jeong Woong Cheon  
*University of Kansas School of Social Welfare*

*Substance use among youth remains a major public health and safety concern. One fundamental way to address youth substance use prevention is to keep young people on a positive trajectory by engaging them in positive activities from early years of their childhood. In this article, the author offers a best practice analysis of systematic review about 12 selected community-based preventions, and proposes policy changes towards incorporating a strengths perspective. A substantive, methodological, and value-based critical analysis of the strongly effective preventions was conducted. A strengths-based positive youth development perspective is specified as one feasible needed improvement and subsequent policy changes in the school district as well as in the local, state, and federal levels are proposed along with the suggestion of a mandated community youth participation strategy. © 2008 Wiley Periodicals, Inc.*

## INTRODUCTION

Use of alcohol, tobacco, and other drugs among youth remains a major public health and safety concern in American society as well as in other countries. In recent years, heightened concerns about adolescent substance use have amplified the need for implementation of effective prevention programs and policies. Individuals and society would benefit from effective preventive action to change the personal and social conditions that promote substance use. The word *substance* includes tobacco, alcohol, and other illegal drugs.

---

Correspondence to: Jeong Woong Cheon, University of Kansas School of Social Welfare, 1545 Lilac Lane, Twente Hall, Lawrence, KS 66044. E-mail: [jwcheon@ku.edu](mailto:jwcheon@ku.edu)

---

**JOURNAL OF COMMUNITY PSYCHOLOGY**, Vol. 36, No. 6, 761–779 (2008)

Published online in Wiley InterScience ([www.interscience.wiley.com](http://www.interscience.wiley.com)).

© 2008 Wiley Periodicals, Inc. DOI: 10.1002/jcop.20256

The target population of this topic is at-risk youth age 10 to 18. Unlike most young people, youth who are deemed at-risk may be exposed to various risk factors, including extreme economic deprivation, academic failure, poor family management practices, and early onset of drug use (Hawkins, Catalano, & Miller, 1992). In particular, at-risk youths are vulnerable to the lure of substance abuse (LoSciuto, Hilbert, Fox, Porcellini, & Lanphear, 1999). Adolescents' attitudes about the dangers and acceptability of drug use are also changing. When compared to adolescents in 1991, teens today view drug use as less harmful and more acceptable (Stewart, 2001).

Despite overall decreases in rates of substance use in the United States over the past 20 years, recent statistics from a variety of sources report high levels of substance use and provides a historical context. For illustration, smoking prevalence among 8th and 10th graders increased by more than 50% between 1991 and 1996; a decline began in 1996. Findings from the Monitoring the Future study, a national longitudinal survey of American youth, indicate that prevalence of cigarette use reached its recent peak in 1996 with 8th and 10th graders. In 2006, a quarter (25%) of eighth graders have tried cigarettes, and 1 in 11 (9%) already has become a current smoker (Johnston, O'Malley, Bachman, & Schulenberg, 2007).

Prevalence of alcohol use in 2001 was found to be 78% among 12th graders, 67% among 10th graders, and 47% among 8th graders. In 2002, daily use of marijuana among 8th and 12th graders was reported to be 1.2% and 6%, respectively (Johnston, O'Malley, & Bachman, 2003). Today, nearly 48% of young people have tried an illicit drug by the time they finish high school. Although a number of drugs showed slow declines in use, the most recent 2007 Monitoring the Future study clearly indicates that "the problems of substance abuse among American young people continue to remain sufficiently widespread to merit concern" (Johnston, O'Malley, Bachman, & Schulenberg, 2007, p. 10).

It is reasonable to be concerned about these statistics. Then, what can be done to prevent youth substance problems more effectively? To address this question, a number of different prevention approaches have been employed to reduce the impact and incidence of substance problems. Traditionally, most programmatic interventions were school-based programs (Wagenaar et al., 2000). Schools provide a route for communicating with a large proportion of young people and school-based programs have been widely developed and evaluated. Some of these programs have shown beneficial effects and successful programs require intense implementation and dozens of sessions across multiple years (Thomas, 2006). In particular, programs emphasizing social influences and using diverse activities had positive findings (Springer et al., 2004).

Despite the gains that these school-based prevention programs have made, some programs were found to be ineffective to prevent the problems of adolescent substance use. It is clear that a school-based program alone is not enough for substance prevention. Schools are only one channel through which to reach young people, and they cannot be expected to affect all of the influences on adolescent substance use. To complement school-based programs, school-community partnership and community-based approaches have emerged as a more viable way of reducing the risk of substance use (Adelman & Taylor, 2003; Hyndman et al., 1992).

However, until recently, less attention has been paid to community-based programs (Hanlon, Bateman, Simon, O'Grady, & Carswell, 2002). In addition, although there have been some evaluation and systematic review research, most studies focused on school-based (Hansen, 1992; Tobler & Stratton, 1997; Thomas,

2006) and family-based prevention of substance use (Austin, Macgowan, & Wagner, 2005). Few studies evaluated community-based prevention programs on youth substance problems and no evidence-based best practice analysis exist to date (Springer et al., 2004).

To address this gap in our knowledge and to achieve desired outcomes of reducing negative behavior of youth substance problems and promoting positive development, in this article, I offer a best practice analysis of systematic review regarding community-based preventions, and propose policy changes in the direction of incorporating strengths-based practice. I propose that preventive programs and policy are closely interrelated, and that practices and policies that address youth substance problems will achieve greater effectiveness when they build from best practice wisdom. One fundamental way to address youth substance use prevention is to keep young people on a positive trajectory by engaging them in positive activities from an early age in their childhood.

## BEST PRACTICES

### *Analysis Method*

The term *best practice* refers to programs and strategies that are known to be effective based on research and evaluation (Gibson, Kostecki, & Lucas, 2001). Best practice can be adopted to improve programs and interventions, identifying empirically validated interventions for a given target population and problem. Conventional best practices approaches focus on thorough and systematic reviews of quantitatively empirical research studies (Petr, 2008). Upon extended research and evaluation, science has become more knowledgeable about what works and what does not work. Adopting programs and strategies that are known to work is important to become more cost effective and accountable to meet the needs of today's society.

Community-based preventions were selected for this review because they represent promising approaches to youth substance abuse prevention. Hyndman et al. (1992) emphasize four reasons why a community-based approach should be used in the area of substance abuse prevention: (a) substances are typically prevalent throughout the community and are not restricted to any subgroup, (b) widespread treatments have been shown to be more effective than less broad programming, (c) substance abuse and associated norms are embedded in the community, and (d) community efforts provide the possibility that the underlying community causes related to substance abuse might be addressed.

To do a comprehensive review, extensive search procedures to locate studies have been conducted (Petr & Walter, 2005). The electronic databases of Social Work Abstracts, Social Service Abstracts, and PsycINFO were searched by using the keywords, youth, adolescent, substance abuse, smoking, alcohol, drug, community-based, prevention, and policy. To ensure completeness, additional articles were identified from the citations in most recent systemic reviews that were screened during the course of the search (Gates, McCambridge, Smith, & Foxcroft, 2006; Sowden & Stead, 2003; Thomas, 2006). To provide a timely and reliable review, only the most up-to-date, peer-reviewed studies published in the past 10 years (between June 1996 and May 2006) were searched. This effort yielded 32 programs meeting the selection criteria for the present analysis.

Because best practice inquiry requires evidence-based evaluations to be included in the analysis, several specific selection criteria were additionally applied for the inclusion and exclusion of the articles in the analysis. The articles should be (a) a primary prevention evaluation rather than secondary or tertiary prevention; (b) a community-based program implemented including any age from 10–18; (c) a study on the at-risk youth, though the definitions are very diverse; (d) a study employing either experimental or quasi-experimental research designs that report both pretest and posttest measures; and (e) a study with at least small positive effectiveness results. Accordingly, 12 articles met the criteria and 12 community-based prevention programs were identified.

### *Summaries of Prevention Programs*

The selected prevention programs are as follows: Aban Aya Youth Project (Flay, Graulich, Segawa, Burns, Hollday, 2004), Stopping Them Starting (Gorden, Whitear, & Guthrie, 1997), Woodrock Youth Development Project (LoSciuto et al., 1999), D.A.R.E. (Plus) (Perry et al., 2003), Healthy for Life (Piper, Moberg, & King, 2000), Native American Project (Schinke, Tepavac, & Cole, 2000), Project Towards No Drug (TND; Sun, Skara, Sun, Dent, & Sussman, 2006; Sussman, Dent, Stacy, & Craig, 1998), Project SixTeen (Biglan, Ary, Smolkowski, Duncan, & Black, 2000), Across Age (LoSciuto, Rajala, Townsend, & Taylor, 1996), Project Northland (Perry et al., 1996), and Yunnan Project (Wu, Detels, Zhang, Li, & Li, 2002).

All prevention programs were implemented in the community settings, however, the program focus and main channels used for program delivery were diverse. Considering the program types, all preventions were classified into two categories: school-community incorporated prevention and comprehensive community-wide prevention. The general characteristics of the 12 selected preventions included in the review are listed in Table 1.

As shown in Table 1, a review of all 12 community-based preventions reveals several characteristics of the projects. First, 8 of the 12 projects have school-community incorporated components in the intervention (from Project 1 to 8). In this group, many projects take place in school and community settings and employ skills-development strategies that focus on increasing youth resiliency. Four other projects (from Project 9 to 12) are delivered as comprehensive community-wide projects. Such interventions encourage individuals to reduce their risk behaviors and bring about environmental changes (Aguirre-Molina & Gorman, 1996). Second, the interventions evaluated in the 12 studies are varied in the focus of activity. Some targeted entire communities, but focused on risk behavior reduction, whereas others focused on alcohol, tobacco, and other drug use prevention. In particular, two programs (2 and 12) targeted to the onset of substance use and three projects (3, 7, and 8) conducted to suspend already initiated substance use. In addition, another two projects (6 and 10) focused on the prevention of existing use and resumption of substance use. Third, some studies reported preventions that contained components aimed at youth, but which were part of larger, community-wide programs (1 and 12). Other studies focused on components of mass communication (6), community support (1 and 3), family (5), and other extracurricular or community activities (10 and 11). A detailed analysis of the characteristics of the 12 projects is provided in Table 2.

The research results vary across the projects. As indicated in Table 1, out of 12 studies, the Woodrock Project (3), Project TND (7), Across Age (10), and Project

**Table 1. General Characteristics of the Prevention Projects**

Type	#	Projects <sup>a</sup>	Target	Population	Goals	Sites	Effect
S-C	1	Aban Aya Youth Project Flay et al. (2004)	B	11-14, African American	O, S	School	MO
	2	Stopping Them Starting (Gorden et al., 1997)	T	11-12, Ethnicity not stated	O	School & community	SM
	3	Woodrock YD (LoSciuto et al., 1999)	A,T,D	6-14, Latino 45%	S	4 Schools	ST
	4	D.A.R.E. (Plus) (Perry et al., 2003)	D	7th grade White 67%	O, S	24 Schools	SM
	5	Healthy for Life (Piper et al., 2000)	B	11-15, White 92%	O, S	Cities & towns	SM
	6	Native American Project <sup>b</sup> (Schinke et al., 2000)	A,T,D	10 year, Native American	S, R	10 Regions	SM
	7	Project TND (Sun et al., 2006)	D	14-19, Hispanic 49%	S	21 Schools	ST
	8	Project TND (Sussman et al., 1998)	D	14-19, White 37%	S	5 Counties	MO
C-W	9	Project SixTeen (Biglan et al., 2000)	T	Age 11-13, All ethnicity	O, S	16 Community	MO
	10	Across Age (LoSciuto et al., 1996)	D	12 year, African American 56%	S, R	3 Schools	ST
	11	Project Northland (Perry et al., 1996)	A	6th grade, White 94%	O, S	Community, 24 Schools	ST
	12	Yunnan Project <sup>b</sup> (Wu et al., 2002)	D	15-19 Chinese males	O	38 Villages	MO

Note. B = Substance related behavior problems; A = alcohol; T = tobacco; D = drug; M = marijuana; O = onset of substance use; S = suspending already initiated use; R = resumption of use prevention. ST = strong effectiveness; MO = moderate effectiveness; SM = small effectiveness. Projects listed in alphabetical order of first author of the studies by two program types of school-community incorporated (S-C) and community-wide prevention (C-W).

<sup>a</sup>Authors and years of studies published.

<sup>b</sup>No name stated in the studies. Named by author for analysis purpose.

**Table 2. Programmatic Characteristics of the Prevention Programs**

<i>Program names (publication)</i>	<i>Objective/substance</i>	<i>Site/settings</i>	<i>Intervention components</i>	<i>Duration</i>
1. Aban Aya Youth Project (Flay et al., 2004)	School & community, behaviors	12 Schools, Chicago, IL	Social development class, parental support, community components	1 Year
2. Stopping Them Starting (Gorden et al., 1997)	School and community, smoking	School & communities, Wales, UK	Booklet and workbook, anti-smoking displays, retailer-law reminded	6 Months
3. Woodrock YD Project (LoSciuto et al., 1999)	School & community, substance use	4 Schools, Pennsylvania	In school classes, family, community support, peer mentoring, activities	2 Years
4. D.A.R.E. (Plus) (Perry et al., 2003)	School & community, marijuana use	24 Schools, Minnesota	Classroom session, extracurricular activities, neighborhood action	1 Year
5. Healthy for Life (Piper et al., 2000)	School-family-community, behavior	Cities & towns, Wisconsin	Age appropriate, education sessions, community participation	12 Weeks or 4 years
6. Native American Project <sup>a</sup> (Schinke et al., 2000)	School & Community, Substance use	10 Reservations, in 5 states	Skill training, emphasis on cultural tradition, media, mural painting	3.5 years
7. Project TND (Sun et al., 2006)	School-as-community, drug abuse	21 Schools, California	Classroom program, school-as-community program, newsletters	Up to 5 years
8. Project TND (Sussman et al., 1998)	School-as-community, drug abuse	Five Counties, California	Classroom program, school-as-community program, newsletters	3 Weeks up 1 year
9. Project Six Teen (Biglan et al., 2000)	Community-wide, tobacco use	16 Communities, Oregon	School sessions, family, media advocacy, youth antitobacco activities	3 Years
10. Across Age (LoSciuto et al., 1996)	Community, mentoring, drug abuse	3 Schools, City, Pennsylvania	Mentoring, community service, classroom life skill, parents workshops	3 Years
11. Project Northland (Perry et al., 1996)	Community-wide, alcohol use	24 Schools & communities, Minnesota	Parental involvement/education, behavioral curricular, community task force activities	3 Years
12. Yunnan Project <sup>a</sup> (Wu et al., 2002)	Community-based trial, drug use	38 Villages, rural areas, Yunnan, China	Multidimensional, community activities, family, school education	17 Months

<sup>a</sup>No name stated in the studies. Named by author for analysis purpose.

Northland (11) have produced strong, positive effectiveness. However, in other projects, moderately effective results (1, 8, 9, and 12) and small effective results (2, 4, 5, and 6) were shown.

To be a strong result and to document prevention, the program needs to follow the young participants for some time after the program implementation. Strong effectiveness is defined as statistically significant reductions in substance use at the time of follow-up study compared with the baseline study. For instance, results of Project TND revealed significant positive long-term program effects for hard drug use at year 4 or 5 for the program interventions ( $p = .02$ ) among 1,578 baseline subjects (Sun et al., 2006). The results of Project Northland indicate that at the end of 3 years, students in the intervention school districts report less onset and prevalence of alcohol use than students in the reference districts (Perry et al., 1996).

### ***Critical Review of Prevention Projects***

Although program effectiveness varies across studies, it is necessary to evaluate prevention efficacy and methodological issues associated with each of the four strongly effective studies (3, 7, 10, and 11). First, all four effective studies used experimental design with random sampling procedures. Some studies chose areas specifically to target particular groups of youth; for example, rural, lower middle class to middle class communities in Minnesota (Perry et al., 1996) and public schools in an economically depressed community (LoSciuto et al., 1999). Second, the samples were large, but still varied in size across studies, ranging from 718 in Woodrock Project to 2,351 in Project Northland. Third, prevention attrition was considerable in most preventions, ranging from 12.6% (LoSciuto et al., 1999) to 57% (Sun et al., 2006). Fourth, outcomes were measured 2 years later (LoSciuto et al., 1999), and 4–5 years after the intervention (Sun et al., 2006). The detailed methodological comparison of the four effective prevention projects as well as the other eight moderate or small effective projects is provided in Table 3.

In addition to the methodological characteristics, a review of the aforementioned four strongly effective community-based programs (3, 7, 10, and 11) also reveals several substantive characteristics of the projects. First, the participants varied across studies. However, all studies targeted youth in specific high-risk groups. In two studies youth thought to be at-risk of substance misuse were targeted (LoSciuto et al., 1999; Sun et al., 2006), and in another, youth living in an area of high rates of alcohol-related problems in the state (Perry et al., 1996). Second, the age of participants ranged from 6 to 18 years across the four effective studies. Because this study concerns at-risk youth aged 10 to 18 years, the targeted youth and their ages of the studies are consistent with this study and other research findings. Although the term *at-risk* has been used in a number of different contexts, *at-risk youth* refers primarily to youth who are in danger of negative events including alcohol and drug use (Keating, Tomishima, Foster, & Alessandri, 2002). It is also during the time between age 10 and 18 that most people start to use alcohol, tobacco, and other drugs. Third, all prevention programs emphasized community components as its core of effectiveness. Although the four projects differ with respect to content and target substances, they include some combination of classroom life-skill education, family involvement, and community support. The community components of these effective programs emphasize changing community and personal norms to promote healthy lifestyles.

**Table 3. Methodological Comparison of the Prevention Programs**

<i>Programs (Publication)</i>	<i>Participants/age/ethnicity</i>	<i>Designs/analysis</i>	<i>Attrition</i>	<i>Outcomes</i>
1. Aban Aya Youth Project (Flay et al., 2004)	11–14, African American, parents/teachers	Cluster randomized trial	Not applicable	Boys: Reduced by 32% (SDC) and 34% (SCD); no significant effect for girls
2. Stopping Them Starting (Gorden et al., 1997)	11–12, M/F, Ethnicity not stated	Experimental	Not applicable	Some influence on attitudes and intention to smoke in the short term
3. Woodrock YD Project (LoSciuto et al., 1999)	718, 6–14, Latino 45%, White 19%	Experimental, ANCOVA	12.6%	Improvements in race relations, significant reduction in substance
4. D.A.R.E. (Plus) (Perry et al., 2003)	6,237, 7 <sup>th</sup> grade White 67.3%	Growth curve analysis	Loss to follow-up: 16%	Multiple drug behavior: 21-item range, 21–102. Boys, $p = .16$ ; girls, $p = .20$
5. Healthy for Life (Piper et al., 2000)	2,483 students 11–15, M/F White 92%	Experimental, ANCOVA, MRA	8%–14% loss by grades 14,1%	Small positive results on cigarettes and marijuana
6. Native American Project <sup>a</sup> (Schinke et al., 2000)	1,396, 10 years, M/F, all Native American	Experimental, ANOVA	14,1%	Follow-up rates of substance use were lower
7. Project TND (Sun et al., 2006)	1578, 14–19, White 31.6%, Hispanic 49.5%	Experimental	29%–57% by terms/programs 43%	Significant positive long-term effect for hard drug use, $p < .02$
8. Project TND (Sussman et al., 1998)	1,074 students, 14–19, M/F, White 37%	Experimental, ANCOVA	Not applicable	Preventive effects found on alcohol & hard drug use
9. Project SixTeen (Biglan et al., 2000)	4,438 Students, 11–13, parents, all ethnicity	Experimental	Not applicable	Decreased from 13.8% to 9.7% in year 2, $p < .04$
10. Across Age (LoSciuto et al., 1996)	729, 12 year, African American 52%	Experimental, ANCOVA	22%–25% by groups 19% lost	More positive changes in knowledge, attitudes, behavior, and life skills
11. Project Northland (Perry et al., 1996)	2,351, 6 <sup>th</sup> grade, White 94%	Experimental	Not applicable	Less onset and prevalence of alcohol use
12. Yunnan Project <sup>a</sup> (Wu et al., 2002)	Number unclear, 15–19, Chinese males	Experimental	Not applicable	2.7-fold greater reduction; highest among males 15–19.

<sup>a</sup>No name stated in the studies. Named by author for analysis purpose.

Thus, findings from the methodological and substantive review indicate that 4 of the 12 interventions are probably efficacious preventions, and thus have the best evidence to date. Best practices inferred from these projects are as follows: clearly articulated goals, at-risk youth targeted, age and developmental level appropriate intervention, community-wide or community-school incorporated settings, structured alternative activities, social-behavior education, peer leadership and mentoring, family involvement and community mobilization, and media advocacy.

However, this methodological and substantive analysis is not enough to determine the state of evidence-based practice. One more step is necessary to critique and to advance the state-of-the-art of best practice analysis (Petr & Walter, 2005). The step is a systematic way to incorporate values into the inquiry, specifically the analysis of current best practices. Accordingly, four value criteria were chosen to judge the overall quality of best practices. A way of assessing the strengths of the best practices is to examine their fit with specific value criteria. Values help determine how good a practice is, whether it is indeed best. The criteria of the best practice are expected to provide a useful framework for creating a quality experience in the process of reviewing substance prevention programs. Although there are a number of values that the best practices could be weighed against, the following values are seen as critical in evaluating the best practices for preventing adolescent substance use. The following four values have been discussed in the substance prevention literatures and best practice studies as important consideration (Hawkins et al., 1992; Loeber & Farrington, 1998; Petr, 2004; Petr & Walter, 2005; Springer et al., 2004; Tyas & Pederson, 1998).

The first value criterion considered is *ecological understanding of functioning*. With this ecological perspective, service providers should consider the personal, cultural, and community-based elements of the population (Swick & Williams, 2006). As identified in the aforementioned methodological and substantial reviews of the four efficacious preventions, the best practices of community settings, structured alternative activities, family involvement and community mobilization, and media advocacy were specifically ecological. The second criterion is *client-centered perspective*, which is a value principle that is highly relevant to services for children and their families. Several best practices inferred from the four prevention projects are consistent with the value of client-centered perspective. These include the practices of clearly articulated goals, at-risk youth targeted, age and developmental level appropriate intervention, social-behavior education and life skill development, and peer leadership and mentoring.

The third criterion is the *strengths perspective* and this was assessed by positive youth development components in the prevention projects as it incorporates aspects of the strengths perspective. The strengths perspective assumes that all consumers have positive capabilities and the capacity for success. Youth development components can offer opportunities for personal growth and a positive outlet. Thus, the best practices of clearly articulated goals and structured alternative activities are consistent with this value criterion. The fourth criterion is *respects for diversity and difference* source, which includes gender, age, race, and sexual orientation with multicultural and urban/rural related emphases. Therefore, the best practices of at-risk youth targeted, age and developmentally appropriate intervention, and media advocacy would be commensurate with the value criterion of respects for diversity and difference.

A value-critical analysis of the best practices is implemented by applying the four criteria to the four strong effective preventions. Value-critical analysis is a term and method of analysis elucidated by Donald Chambers (2000), who based much of this

**Table 4. Value-Critical Analysis of the Four Effective Prevention Projects**

<i>Best practices/value criteria</i>	<i>E-P</i>	<i>C-C</i>	<i>S-P</i>	<i>D-D</i>
Clearly articulated goals		7,10,11	3, 10	
At-risk youth targeted		3,7,10		3,7,10
Age/developmentally appropriate		3,7,11		3,7,11
Community settings	3,7,10,11			
Structured alternative activities	3,7,10		3,7,10	
Social-behavior education		3,7,10		
Peer leadership and mentoring		3,7,10		
Family/community involvement	3,10,11			
Media advocacy	7,11			7,11

*Note.* E-P = Ecological perspective; C-C = client-centered perspective; S-P = strengths perspective with youth development components; D-D = respects for diversity and difference; 3 = Woodrock Youth Development Project; 7 = Project Towards No Drug Abuse; 10 = Across Ages; 11 = Project Northland.

thinking on the ideas of policy analyst Martin Rein (1976). The value-critical approach uses evaluative criteria to identify gaps and shortcomings in policies and programs. Thus, the purpose of a value-critical analysis is to create an outline or blueprint for something that might work better than the existing policy (Chambers, 2000; Petr, 2008).

Table 4 indicates the results of this value-critical analysis. In view of the criteria, the ecological perspective and criterion of client-centered perspective are the most emphasized. For example, the best practice of community setting is utilized in the Woodrock Project (3), Project TND (7), Across Age (10), and Project Northland (11) as it relates to ecological perspective. Media advocacy practice with ecological perspective is included as a program component in the Project TND (7) and Project Northland (11). The criterion of respects for diversity and difference appears as an important value for the prevention projects. However, the criteria of the strengths perspective is the least employed in the four prevention studies. The practice of structured alternative activities is employed in the Woodrock Project (3), Project TND (7), and Across Age (10).

### ***Strengths-Based Component as a Needed Improvement***

The result of a value-based critical analysis of the prevention projects reveals strengths-based component as a needed improvement in best practice. Although all value perspectives need to be emphasized, the lack of the strengths perspective as a critical value component is particularly important because it supports other value perspectives. Petr (2004) states that “the strengths perspective is integral to combating adultcentrism, engaging in family-centered practice, and respecting diversity and difference” (p. 155). The strengths perspective is also important because this is consistently associated with the principle of positive youth development among the young participants. In particular, the strengths perspective has laid a foundation on which the youth development principle can be resurrected and built (Morrison, Alcorn, & Nelums, 1997).

The strengths perspective builds interventions on strengths and deemphasizes pathology (Rapp, 1998; Saleebey, 2005). Positive youth development also emphasizes the values, strengths, and potential of children and youth, while shrinking the focus on

pathology. An important feature of the youth development settings is that they provide youth with a sense of belonging, being valued, as well as promoting perceptions of caring and connectedness, and allow opportunities for meaningful engagement (Delgado, 2002). In general, the youth development component includes youth activities at schools or communities, promotion of self-determination, community youth participation, and community services.

Thus, the improvement of the strengths-based components in the best practice can be implemented by practitioners by incorporating positive youth development activities in their prevention efforts. In fact, none of the four programs has a youth development component as a core component of the preventions. Although two projects (Woodrock Project and Across Age) employ alternative activities and community service, these components were utilized as subsidiary interventions. The main components of these two projects were in-school human relations, life skills classes, and peer-mentoring interventions.

Research is supportive of the strengths-based positive development programs. Benard (2004) acknowledges, “the most effective, efficient, and even rewarding and joyful approach to problem prevention is through supporting healthy youth development” (p. 2). Programs that adopt positive prevention principles are significantly more likely to be effective in reducing substance use than other programs among high-risk youth and these effects are long lasting (Springer et al., 2004). For example, in a nonexperimental study, students who spend 1–4 h per week in extracurricular activities are 49% less likely to use drugs and 37% less likely to become teen parents than students who do not participate in extracurricular activities (Kahne et al., 2001).

## **INTEGRATION OF POLICIES AND BEST PRACTICES**

The specified needed improvements of strengths-based positive development perspectives require policy changes to be implemented. To complement gaps or problems that exist in current practices, it is logical to change subsequent policies in the direction of incorporating the identified best practice wisdom. In this section, current prevention policies to reduce youth substance problems are identified and summarized, followed by an analysis of the supports and problems of the current policies to change toward the strengths-based youth development approach in the substance prevention practices. The extent and level of possible policy changes are proposed, along with a discussion of the ways that these proposed policy changes help build on youth and community strengths. Finally, specific strategies for accomplishing these proposed policy changes are suggested.

### ***Policies on Youth Substance Prevention***

A policy is understood as “any established process, priority, or structure that is purposefully sustained over time” (Holder, 2000, p. 845). It consists of laws, rules, regulations, and requirements as well as informal guidelines and directions for action (Pentz, Bonnie, & Shopland, 1996). At the community level, policy refers “collectively to any voting decisions, referenda, ordinances, written regulations, licensing requirements, funding agreements, or statements that represent public agreement about a course of action for drug abuse prevention” (Pentz, 2000, p. 258).

In general, it is designed to reflect societal values by governing benefits and services and by specifying actions for social improvement. Thus, substance policy is an environmental or structural response to alcohol, tobacco, and other drug problems. Although some policies on substance problems apply to those who are using and in need of treatment or have violated a law or regulation, prevention policy intends to reduce substance supply and demand among youth who have not yet tried alcohol, tobacco, or other drugs. Substance problem prevention policies are also designed to affect all individuals in a specified area, such as a state, county, or community, regardless of their participation in a related prevention program (Pentz, 2003).

Substance abuse prevention policies are identified at the federal, state, and local community. The federal government has designated the reduction of substance use as a national health and education priority. Many states have drafted laws and commissioned investigations to address the growing public concern about youth substance use. Local communities established the priorities for community action to reduce risky behavior involving substance use. School districts across the country have voluntarily initiated a variety of school-based substance prevention programs and district-wide antidrug policies. Various agencies have been working to develop and implement intervention strategies to reduce the number of substance-involved problems.

At the federal level, policy consists of the overall national drug control strategy and legislation that applies to all states. Federal prevention policies are supported by several laws, including the Drug Abuse Office and Treatment Act, Omnibus Budget Reconciliation Act, Anti-Drug Abuse Act, and Drug-Free Schools and Communities Act (Bukoski, 1990; Pentz, 2003). Recently, the No Child Left Behind Act (P.L. 107-110) amended the Safe and Drug-Free Schools and Communities Act (SDFSCA). Through the program authorized by SDFSCA, funds are disbursed first to states, and then to local communities and educational agencies by formula to create programs deterring drug use among elementary and secondary students (U.S. Department of Education, 2005).

More specific laws and regulations for substance prevention are legislated at the state level and implemented at the community level. This includes allocated funds for prevention, minimum age drinking laws, prevention program planning, tobacco and alcohol tax legislation, and penalties for possession of tobacco (Pentz, 2003). For example, many state laws have passed smoke-free air (SFA) laws to protect nonsmokers from secondhand smoke at public places, work sites, and schools. Currently, 46 states have SFA laws covering public schools and 28 states cover private schools. Moreover, seven states have passed the most comprehensive SFA laws, which cover private work places, restaurants, and bars (Tauras & Chaloupka, 2004). As for the possession, use, and purchase (PUP) laws, the number of states with PUP laws has increased dramatically since 1988 (Alciati et al., 1998).

For the prevention of youth substance abuse, many local formal and informal policies were established and implemented. Examples relevant to alcohol use include drinking and driving enforcement by the local police, mandating server training for bars, pubs, and restaurants, and enforcement resources allocation to prevent alcohol sales to minors (Holder, 2000). Local tobacco control policies include possession, use and purchase (PUP) laws and tobacco control policies. Most policies at community levels appear to focus on supply reduction than demand reduction (Pentz et al., 1996; Pentz, 2000).

In particular, local areas have increasingly enacted PUP ordinances in recent years. For example, the state of New Jersey does not currently have any state laws that prohibit the possession, use, and purchase of tobacco products by minors, but 48 municipalities in the state of New Jersey had passed ordinances prohibiting minor use and purchase of tobacco products. (Hrwna, Adler, Delnevo, & Slade, 2004). Local regulations regarding alcohol and tobacco price, consumption, and use significantly influence youth substance problems. Research has shown that restricting youth access by enforcing ordinances regulating retail sales to youth can reduce youth smoking rates. Clean Indoor Air ordinances that restrict the places where tobacco may be smoked, particularly those that target public places, have been shown to reduce cigarette demand (Hays, Hays, & Mulhall, 2003).

### ***Policy Change for Strengths-Based Positive Development***

As identified and summarized above, existing national and state or local laws and regulations provide the legal basis for substance abuse prevention policies. This enables states or local communities to prioritize use of existing resources within legal frameworks to achieve specific objectives. However, it is recognized that most policies are limited as to the types of restrictions and training/education at whatever level it is implemented. Although effective prevention programming and community coalitions are emphasized at the federal policy, few policies have focused on strengthening young people's positive development. Little attention goes to preventing the onset of those problems of substance use from a strengths-based positive youth development perspective.

It is not surprising that dominant policy response to youth substance use problems has been to adopt regulatory and programmatic policies. Regulatory policies include law enforcement, restriction of access, and alcohol taxes; programmatic policies take the form of mandating funds, requiring standardized implementation, and creating nonprofit organizations to establish and operate programs. As Pentz (2000) found, the effects of regulatory policy and programmatic policy are paramount in bringing about significant reductions. However, it should be emphasized that the improvement of the strengths-based positive development perspective is more effective and fundamental to reduce substance abuse problems among youth. An analysis of best practice wisdom also indicates that current substance abuse prevention policy needs to move toward a strengths-based positive development policy.

To improve current trends in substance prevention programs, more policies need to strengthen the community programs that focus on how well young people will be prepared or how fully they will be engaged in positive activities outside of the formal education system. Zeldin (2004) states that, "prevention does not occur only through the delivery of targeted interventions. Prevention also occurs naturally through youths' daily experiences, formal and informal, within neighborhoods, community youth organizations, and other grassroots entities" (p. 627).

Thus, substance problem prevention policy needs to provide youths with positive developmental opportunities and supports. The policy and program activities need to redesign to promote the development of positive behaviors in youth and to protect against the development of substance abuse. As stated in the earlier section, strengths-based youth development policy can be implemented by employing community youth participation components in the related laws, regulations, or ordinances.

Although prevailing policies and institutional practices are not supportive, this can be promoted by creating incentives for youth participation in community development and decision-making processes of youth-related issues. According to Pentz (2000), policy studies in the substance prevention field suggest that, “restricted access policies that involve youth in enforcement, for example, through youth activism or youth involvement in sting operations, have an effect on decreasing tobacco sales and purchases, and may decrease alcohol consumption” (p. 263). This kind of youth participation is increasingly viewed as an essential component of youth development perspectives.

In particular, Zeldin (2004) stresses the positive influences of youth participation in community decision-making, including risky behaviors such as substance abuse. He suggested several policy directions for integrating youth engagement into local initiatives with the aim being to prevent community problems through the promotion of youth engagement. This policy direction includes (a) broadening public conceptions of youth problem, (b) aligning policies to support youth engagement, and (c) creating local coalitions for community peace. Zeldin (2004) also states that “youth community engagement is best conceptualized as an evidence-based strategy that crosscuts prevention and development models, and that can be embedded within the full spectrum of youth policies and programs” (p. 632).

The policy change into the strengths-based positive development policy is very feasible because a strategy similar to a positive development component already exists in the current substance prevention policies in the form of an enrichment strategy and alternative activity (Adelman & Taylor, 2003; Ellickson, 1995). In fact, while information strategies, affective strategies, and skills development strategies have dominated current prevention, presenting youth with alternative drug-free activities was utilized in part for the last three decades.

Thus, specifically, a mandated participation in community-involved positive development (CIPD) activities can be suggested for the proposed policy change. This proposed strengths-based policy change helps build on youth and community strengths by applying positive youth development principles into community development. As discussed in the best practice analysis of systematic review, the CIPD activities are community-based practices, and thus participation in the CIPD activities provide a promising approach to youth substance abuse prevention. The CIPD activities are strengths-based and also congruent with the four value criteria as reviewed in a value-critical analysis of the best practices in the previous sections. The proposed policy still maintains value dimensions of the strengths perspective, the ecological perspective, the client-centered perspective, and the respect for diversity and difference criterion as it incorporates resources of the strengths, capacities, and adaptive skills of the individual, family, and community.

### ***Strategies for Accomplishing Strengths-Based Development Policy***

The proposed mandated CIPD activities can be accomplished through several strategies. First, states could mandate schools provide their students with CIPD activities. This is similar to the mandated school programs in health education and substance abuse preventions that exist in many states. This proposed strategy asks all youth aged 10 to 18 to participate in some kind of CIPD activities during a school period to prevent substance problems from a strengths-based youth development perspective. Every student in middle school and high school is required to fulfill this community participation as a mandatory requirement for graduation for at least one

semester during a school period, in addition to elective school-based after-school activities or extracurricular activities.

Second, to be included in the CIPD, the activities should employ four required components: (a) after-school hour component—schools and community should support positive activities in the after-school hours; (b) community involvement component—communities can help to fill the gap during the time between when students leave school and their parents finish their workday; (c) structured development activity component—activities should be designed to foster norms against substance problems, promoting personal and social competencies and character development in program contents is also critical; and (d) youth agency administration component—program administration of community-based youth agencies and location of programs outside of schools are recommended for successful programs. This proposed mandated community engagement activity is a proactive approach to provide enriching activities for young students and a way to ensure that every student participates in strengths-based prevention programs.

Third, as a way to ensure this proposed policy change, at the federal level, the current No Child Left Behind Act (P.L. 107–110) needs to reauthorize the Safe and Drug-Free Schools and Community Act (SDFSCA) as Part A of Title IV, 21st Century Schools, in the direction of including the funding streams for the mandated community participation policy change. To accomplish this proposed mandated CIPD community engagement strategy in policy, existing substance prevention policies at state and local community also need to include relevant guidelines, direction of action, and funding stream.

Fourth, although the mandated CIPD activity requires a lot of money, incremental application of the activity participation is suggested to achieve proper funding. Each state and local community receives funding in a block grant format, with the funding level determined by a formula that takes into account how large the 10- to 18-year-old population is, and how many of those young people are eligible for the free and reduced school lunch program. The funds will be allocated to states by developing a formula for conducting community-based development programs that promote youth community involvement and thus prevent substance use problems.

Fifth, the proposed community youth participation policy can also be implemented more effectively at the local and state level by amending or passing relevant federal or state laws. For example, as indicated in the smoke-free air (SFA) laws, tobacco youth possession, use, and purchase (PUP) and drunk driving laws can be amended to support the proposed policy change. In addition, changes should be made in existing school policies. Although most schools support community volunteering, after school programs, and extracurricular activities, these activities are not emphasized as components of the school substance prevention policies. School curricula need to pay attention to substance prevention and thus to the promotion of participation in community-involved positive development (CIPD) activities as a mandated requirement for students, in addition to currently implementing after-school activities for the reduction of students' substance use problems.

## CONCLUSION

This study synthesizes results from community-based substance use prevention evaluations using systematic comprehensive reviews. Best practice inquired here is a

community-based substance prevention approach for at-risk youth aged 10 to 18. The term *at-risk youth* refers to the youth who are in danger of negative events, such as alcohol and drug use. The desired outcome is to promote positive outcomes in the context of broad youth development. All 12 prevention projects were systematically analyzed. Several criteria were applied for the inclusion and exclusion of the articles and four value criteria were adopted for the value-critical review in addition to substantial and methodological analysis. The strengths-based youth development perspective is specified as one feasible needed improvement in best practice.

Existing regulatory policies and programmatic efforts are important and successful in some ways, however, the proposed policy change to positive development strategy is necessary for better substance prevention among youth. The mandated participation in the community-involved positive development (CIPD) activities is suggested as the necessary policy change. This asks all youth aged 10 to 18 to participate in some kind of CIPD activities during a school period. States could mandate schools provide their students with CIPD activities as a requirement for graduation. Through the reauthorization of the Safe and Drug-Free Schools and Communities Act (SDFSCA) by the No Child Left Behind Act, state educational agencies, local youth-serving organizations, and outlying areas are awarded grants by formula. Substance prevention-related laws at the state level and school policies also can be changed to support the proposed policy change.

It is expected to contribute to the reduction of substance problems among young people in an integrative and proactive way. Through the participation in community-involved positive development (CIPD) practices, youth can get educational supports and resources from schools and communities and also can utilize after-school hours more positively. If these proposed policy changes become reality, American youth substance problems would be expected to reduce and thus lead to healthier and safer schools and communities.

Although the specified best practice wisdom and the suggested policy changes are important and feasible, the strengths-based approach to practice and policy may be hard to implement in the current regulatory sanctions-dominant practice and policy situation. There are also gaps between short-term outcomes and long-term policy changes. The United States still has a long way to go in its discussions of the strengths-based youth policy on substance problems. Establishing strengths-based youth development policies takes time, patience, and vision, and requires the involvement of a full range of actors.

## REFERENCES

- Adelman, H.S., & Taylor, L. (2003). Creating school and community partnerships for substance abuse prevention programs. *The Journal of Primary Prevention*, 23, 329–369.
- Aguirre-Molina, M., & Gorman, D.M. (1996). Community-based approaches for the prevention of alcohol, tobacco, and other drug use. *Annual Review of Public Health*, 17, 337–358.
- Alciati, M.H., Frosh, M., Green, S.B., Brownson, R.C., Fisher, P.H., Hobart, R., et al. (1998). State laws on youth access to tobacco in the United States: Measuring their extensiveness with a new rating system. *Tobacco Control*, 7, 345–352.
- Austin, A.M., Macgowan, M.J., & Wagner, E.F. (2005). Effective family-based interventions for adolescents with substance use problems: A systematic review. *Research on Social Work Practice*, 15(2), 67–83.

- Benard, B. (2004). *Resiliency: What we have learned*. San Francisco, CA: WestEd.
- Biglan, A., Ary, D., Smolkowski, K., Duncan, T., & Black, C. (2000). A randomized controlled trial of a community intervention to prevent adolescent tobacco use. *Tobacco Control, 9*(1), 24–32.
- Bukoski, W.J. (1990). The federal approach to primary drug abuse prevention and education. In J.A. Inciardi (Ed.), *Handbook of drug control*. Westport, CT: Greenwood Publishing Group, Inc.
- Chambers, D.E. (2000). *Social policy and social programs: A method for the practical public policy analyst* (3rd ed). Boston: Allyn and Bacon.
- Delgado, M. (2002). *New frontiers for youth development in the twenty-first century: Revitalizing and broadening youth development*. New York: Columbia University Press.
- Ellickson, P.L. (1995). Schools. In R.H. Coombs & D.M. Ziedonis (Eds.), *Handbook on drug abuse prevention: A comprehensive strategy to prevent the abuse of alcohol and other drugs* (pp. 93–120). Boston: Allyn and Bacon.
- Flay, B.R., Graumlich, S., Segawa, E., Burns, J.L., Holliday, M.Y., for the Aban Aya Investigators. (2004). Effects of 2 prevention programs on high-risk behaviors among African-American youth: A randomized trial. *Archives of Pediatrics and Adolescent Medicine, 158*, 377–384.
- Gates, S., McCambridge, J., Smith, L.A., & Foxcroft, D.R. (2006). Interventions for prevention of drug use by young people delivered in non-school settings. *The Cochrane Database of Systematic Reviews, Issue 1*, CD005030. Oxford: Wiley.
- Gibson, M.K., Kosteck, M., & Lucas, M.K. (2001). Instituting principles of best practice for service-learning in the communication curriculum. *The Southern Communication Journal, 66*, 187–200.
- Gordon, I., Whitear, B., & Guthrie, D. (1997). Stopping them starting: Evaluation of a community-based project to discourage teenage smoking in Cardiff. *Health Education Journal, 56*, 42–50.
- Hanlon, T.E., Bateman, R.W., Simon, B.D., O'Grady, K.E., & Carwell, S.B. (2002). An early community-based intervention for the prevention of substance abuse and other delinquent behavior. *Journal of Youth and Adolescence, 31*, 459–471.
- Hansen, W. (1992). School-based substance abuse prevention: A review of the state of art in curriculum, 1980–1990. *Health Education Research, 7*, 403–430.
- Hawkins, J.D., Catalano, R.F., & Miller, J.Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin, 112*, 64–105.
- Hays, S.P., Hays, C.E., & Mulhall, P.F. (2003). Community risk and protective factors and adolescent substance use. *Journal of Primary Prevention, 24*, 125–142.
- Holder, H. (2000). Community prevention of alcohol problems. *Addictive Behaviors, 25*, 843–859.
- Hrywna, M., Adler, R.K., Delnevo, C.D., & Slade, J.D. (2004). Content analysis and key informant interviews to examine community response to the purchase, possession, and/or use of tobacco by minors. *Journal of Community Health, 29*, 209–216.
- Hyndman, B., Giesbrecht, D.R., Bernardi, N.C., Dougltas, R.R., Ferrence, R.G., Gliksman, L., et al. (1992). Preventing substance abuse through multicomponent community action research projects: Lessons from past experiences and challenges for future initiative. *Contemporary Drug Problems, 20*, 133–164.
- Johnston, L.D., O'Malley, P.M., & Bachman, J.G. (2003). *Monitoring the Future National Survey results on drug use, 1975–2002: Secondary school students*. Bethesda, MD: National Institute on Drug Abuse.
- Johnston, L.D., O'Malley, P.M., Bachman, J.G., & Schulenberg, J.E. (2007). *Monitoring the Future national results on adolescent drug use: Overview of key findings 2006*. Bethesda, MD: National Institute on Drug Abuse.

- Kahne, J., Nagaoka, J., Brown, A., O'Brien, J., Quin, T., & Thiede, K. (2001). Assessing after-school programs as contexts for youth development. *Youth & Society, 32*, 421–446.
- Keating, L.M., Tomishima, M.A., Foster, S., & Alessandri, M. (2002). The effects of a mentoring program on at-risk youth. *Adolescence, 37*, 717–734.
- Loeber, R., & Farrington, D. (1998). *Serious and violent juvenile offenders: Risk factors and successful interventions*. Thousand Oaks, CA: Sage.
- LoSciuto, L., Hilbert, S., Fox, M.M., Porcellini, L., & Lanphear, A. (1999). A two-year evaluation of the Woodrock Youth Development Project. *Journal of Early Adolescence, 19*, 488–507.
- LoSciuto, L., Rajala, A., Townsend, T., & Talyor, A. (1996). An outcome evaluation of Across Ages: An intergenerational mentoring approach to drug prevention. *Journal of Adolescent Research, 11*, 116–129.
- Morrison, J.D., Alcorn, S., & Nelums, M. (1997). Empowering community-based programs for youth development: Is social work education interested? *Journal of Social Work Education, 33*, 321–333.
- Pentz, M.A. (2000). Institutionalizing community-based prevention through policy change. *Journal of Community Psychology, 28*, 257–270.
- Pentz, M.A. (2003). Anti-drug abuse policies as prevention strategies. In Z. Sloboda & W.J. Bukoski (Eds.), *Handbook of drug abuse prevention: Theory, science, and practice* (pp. 217–241). New York: Kluwer Academic/Plenum Publishers.
- Pentz, M.A., Bonnie, R.J., & Shopland, D.S. (1996). Integrating supply and demand reduction strategies for drug abuse prevention. *American Behavior Scientists, 39*, 897–910.
- Petr, C.G. (2004). *Social work with children and their families: Pragmatic foundations* (2nd ed.). New York: Oxford University Press.
- Petr, C.G. (2008). *Multidimensional evidence-based practice: Synthesizing knowledge, research and values*. Binghamton, NY: Haworth Press.
- Petr, C.G., & Walter, U.M. (2005). Best practices inquiry: A multidimensional, value-critical framework. *Journal of Social Work Education, 41*, 251–267.
- Perry, C.L., Komro, K.A., Veblen-Mortensen, S., Bosma, L.M., Farbaksh, K., & Munson, K.A. (2003). A randomized controlled trial of the middle and junior high school DARE and DARE plus programs. *Archives of Pediatrics and Adolescent Medicine, 157*, 178–184.
- Perry, C.L., Williams, C.L., Veblen-Mortenson, S., Toomey, T.L., Komro, K.A., Anstine, P.S., et al. (1996). Project Northland: Outcomes of a communitywide alcohol use prevention program during early adolescence. *American Journal of Public Health, 86*, 956–965.
- Piper, D., Moberg, D.P., & King, M. (2000). The Healthy for Life Project: Behavioral outcomes. *The Journal of Primary Prevention, 21*(1), 47–73.
- Rapp, C.A. (1998). *The strengths model: Case management with people suffering from severe and persistent mental illness*. New York: Oxford University Press.
- Rein, M. (1976). *Social science and public policy*. New York: Penguin Education.
- Saleebey, D. (2005). *The strengths perspective in social work practice* (4th ed.). Boston: Pearson Education Inc.
- Schinke, S.P., Tepavac, L., & Cole, K. (2000). Preventing substance use among Native American youth: Three-year results. *Addictive Behaviors, 25*, 387–397.
- Sowden, A., & Stead, L. (2006). Community interventions for preventing smoking in young people. *The Cochrane Database of Systematic Reviews, Issue 1, CD001291*. Oxford: Wiley.
- Springer, J.F., Sale, E., Hermann, J., Sambrano, S., Kasim, R., & Nistler, M. (2004). Characteristics of effective substance abuse prevention programs for high-risk youth. *The Journal of Primary Prevention, 25*, 171–194.
- Stewart, R. (2001). Adolescent self-care: Reviewing the risks. *Families in Society: The Journal of Contemporary Human Services, 82*, 119–126.

- Sun, W., Skara, S., Sun, P., Dent, C.W., & Sussman, S. (2006). Project Towards No Drug Abuse: Long-term substance use outcomes evaluation. *Preventive Medicine, 42*, 188–192.
- Sussman, S., Dent, C., Stacy, A., & Craig, S. (1998). One-year outcomes of Project Towards No Drug Abuse. *Preventive Medicine, 27*, 632–642.
- Swick, K.W., & Williams, R.D. (2006). An analysis of Bronfenbrenner's bio-ecological perspective for early childhood educators: Implications for working with families experiencing stress. *Early Childhood Education Journal, 33*, 371–378.
- Tauras, J.A., & Chaloupka, F.J. (2004). Impact of tobacco control spending and tobacco control policies on adolescents' attitudes and beliefs about cigarette smoking. *Evidence-Based Preventive Medicine, 1*, 111–120.
- Thomas, R., & Perera, R. (2006). School-based programmes for preventing smoking. *The Cochrane Database of Systematic Reviews, Issue 4*. Oxford: Wiley.
- Tobler, N., & Stratton, H. (1997). Effectiveness of school-based drug prevention programs: A meta-analysis of the research. *The Journal of Primary Prevention, 18*, 71–128.
- Tyas, S.L., & Pederson, L.L. (1998). Psychosocial factors related to adolescent smoking: A critical review of the literature. *Tobacco Control, 7*, 409–420.
- U.S. Department of Education. (2005). Safe schools and citizenship education, safe and drug-free schools and communities: State grants, fiscal year 2006: Justifications of appropriation estimates to the congress. Washington, DC: Government Printing Office.
- Wagenaar, A.C., Murray, D.M., Gehan, J.P., Wolfson, M., Foster, J.L., Toomey, T.L., et al. (2000). Communities mobilizing for change on alcohol: Outcomes from a randomized community trial. *Journal of Studies on Alcohol, 61*, 85–94.
- Wu, Z., Detels, R., Zhang, J., Li, V., & Li, J. (2002). Community-based trial to prevent drug use among youth in Yunnan, China. *American Journal of Public Health, 92*, 1952–1957.
- Zeldin, S. (2004). Preventing youth violence through the promotion of community engagement and membership. *Journal of Community Psychology, 32*, 623–641.

Copyright of *Journal of Community Psychology* is the property of John Wiley & Sons Inc. and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.