

# Library Watch on prevention

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## **Are anti-smoking parenting practices related to adolescent smoking cognitions and behavior?**

Huver RME; Engels RCME; de Vries H. *Health Education Research* 21(1): 66-77, 2006. (41 refs.)

The aim of this study was to explain the effects of anti-smoking parenting practices on adolescent smoking cognitions and behavior by showing the mediating effects of cognitions. Data were gathered among Dutch high school students in the control condition of the European Smoking prevention Framework Approach (ESFA). Anti-smoking parenting practices were measured by parental reactions to smoking, house rules, and frequency and content of communication about smoking. Attitudes, perceived social influences and self-efficacy made up for smoking cognitions. Additionally, intention to smoke was measured. Relations between practices and cognitions were mostly significant. While some practices were associated with less smoking (communication about health risks of smoking, health risks of breathing in smoke, addictive qualities of smoking and attention for smoking in school), others were related to increased chances of smoking (rewards for not smoking, frequency of communication about smoking, communication about being allowed to smoke, price of cigarettes and friends smoking). The effects of parenting hardly varied by parental smoking status or adolescent gender. Several practices operated through cognitions, which was more pronounced in older adolescents. Counter-productive effects of practices and the few effects in the longitudinal analyses indicate that the order in which parents and adolescents influence each other should be examined more closely. Copyright 2006, Oxford University Press.

## **Coercive use of vaccines against drug addiction: Is it permissible and is it good public policy?**

Ridgely MS; Iguchi MY. *Virginia Journal of Social Policy & the Law* 12(2): 260-329, 2005. (310 refs.)

Vaccines against drug addiction may represent the hope of the future for many addicted individuals who are eager to access state-of-the-art treatment. They may also be a promising solution for a society seeking to lower the social and economic costs of addiction among populations such as recidivist drug offenders. Given the medical and socio-economic benefits, this

Article explores the legal and public policy aspects of a potential use of vaccines to fight drug addiction. The following is the core question: Will current law support the coercive use of vaccines against drug addiction? Following a brief introduction, Section II provides a context for the discussion by briefly describing the problem of addiction, the relationship of addiction to social problems such as crime and homelessness, the current approaches to treatment for addiction, and new immunotherapies under development. Although immunotherapies are still under development, the analysis in the remainder of the paper assumes, *arguendo*, the production of a vaccine against addiction that is approved by the FDA as safe and effective and has no significant adverse side effect profile. Section III summarizes the law on an individual's right to self-determination and asks whether addicted individuals can give voluntary consent to receive/refuse addiction treatment. This section also outlines the law on the "right to refuse" treatment and addresses the role courts have accorded to parents in medical decision-making for their children. Section IV discusses the circumstances under which the government has the right to compel treatment against the wishes of a competent individual by asserting its *parens patriae* and police powers to act in the best interest of society. Section IV also identifies when compulsory treatment is available for specific vulnerable populations under current law and discusses the limits of the state's power to impose treatment on such populations. Courts have generally allowed mandated addiction treatments in a variety of contexts, civil and criminal, and there is little to suggest that immunotherapies would be treated differently than other forms of pharmacological intervention. Finally, Section V considers whether the coercive use of vaccines is legally permissible and whether it is consistent with good public policy. The conclusion is that there are situations where coercion is arguably necessary, and likely to be effective, in reducing recidivism and the negative impacts of addiction on both the individual and society. In terms of the negative effects of coercion, legal due process protections may be particularly important in facilitating the ethical use of immunotherapies, especially in the first few years after FDA approval.

Furthermore, research on the experience of coercion in the mental health context suggests that the clinicians could go a long way toward minimizing the negative effects of coercion if they are committed to acting in good faith, treating patients with respect, taking what patients say seriously, and giving their patients a voice in the process. Authority to coerce treatment is derived from the state's *parens patriae* and police powers, but is constrained by the countervailing right to self-determination in medical treatment. That right typically assumes the competence of the individuals making the self-determination. Even given competence, however, the interests of the state may prevail over the rights of individuals within certain classes in society. This Article reviews pertinent statutes and case law bearing on the state's ability to justify the use of coercion. Assuming a situation in which immunotherapy may be legally coerced, this Article concludes by offering some reflections for policy makers and clinicians on fairness in implementing a policy of coercion. Copyright 2005, University of Virginia School of Law.

#### **Employer coverage of clinical preventive services in the United States.**

Bondi MA; Harris JR; Atkins D; French ME; Umland B. *American Journal of Health Promotion* 20(3): 214-222, 2006. (24 refs.)

**Purpose.** To characterize employers' coverage of clinical preventive services. **Design.** Mercer Human Resource Consulting Inc. included questions on clinical preventive services as part of its National Survey of Employer-Sponsored Health Plans, 2001. **Setting.** A national sample of employers of a large, medium, and small number of employees, including governments. **Subjects.** Respondents self-identified as most knowledgeable about the organization's health benefits. **Measures.** Weighted analyses of responses to eight survey questions on health promotion. **Results.** The survey was completed by 2180 employers, and the response rate was 21%. More than 90% of employers included increased productivity and decreased health care costs among their most important reasons for coverage of clinical preventive services. Within health insurance, coverage of physical examinations, immunizations, and screenings generally exceeded 50%, but coverage of lifestyle modification services was less than 20%. Only 20% of employers covered tobacco cessation services, and only 4% of employers provided an "optimal" benefit. We compared employers' offerings with a published ranking, by impact and value, of clinical preventive services. We found the biggest discrepancy in tobacco cessation services and alcohol problem prevention, which

ranked high in terms of impact and value but are offered by only 20% and 18% of employers, respectively. **Conclusions.** Employers seek financial return from their offerings of clinical preventive services to employees, but they are least likely to offer the services most likely to provide this return. Copyright 2006, American Journal of Health Promotion, Inc.

#### **A multihealth behavior intervention integrating physical activity and substance use prevention for adolescents.**

Werch CC; Moore MJ; DiClemente CC; Bledsoe R; Jobli E. *Prevention Science* 6(3): 213-226, 2005. (61 refs.)

The primary purpose of this study was to test the efficacy of a brief, multi-health behavior intervention integrating physical activity and alcohol use prevention messages for high school-aged adolescents. A total of 604 participants, 335 9th and 269 11th grade students from a suburban high school in northeast Florida participated in this study. A randomized control trial was conducted with participants randomly assigned within grade levels to receive either a brief consultation and prescription with a mailed reinforcing follow-up flyer (Project SPORT) or a minimal intervention control consisting of a wellness brochure provided in school and a pamphlet about teen health and fitness mailed to the home. Differences between intervention groups were evaluated with a series of MANCOVA tests. Project SPORT participants demonstrated significant positive effects at 3-months postintervention for alcohol consumption, alcohol initiation behaviors, alcohol use risk and protective factors, drug use behaviors, and exercise habits, and at 12-months for alcohol use risk and protective factors, cigarette use, and cigarette initiation ( $p$ 's < 0.05). A post hoc analysis examining interactions between past 30-day use of marijuana and/or cigarettes by treatment group indicates significant positive effects for drug use among adolescents who received Project SPORT on alcohol consumption, drug use behaviors, and drug use initiation at 3-months, and for drug use behaviors and exercise habits at 12-months ( $p$ 's < 0.05). A brief, 12-min one-on-one consultation integrating alcohol avoidance messages within those promoting fitness and other positive health behaviors holds promise for influencing adolescent alcohol and cigarette use and other health behaviors at posttreatment and 1 year later. Long-term sustained effects for cigarette and marijuana use, and both vigorous and moderate physical activity, were found among adolescents using marijuana and/or cigarettes prior to intervention. Copyright 2005, Society for Prevention Research.

### **Parental monitoring: Can it continue to be protective among high-risk adolescents?**

Shillington AM; Lehman S; Clapp J; Hovell MF; Sipan C; Blumberg EJ. *Journal of Child & Adolescent Substance Abuse* 15(1): 1-15, 2005. (33 refs.)

Adolescence is a developmental period during which many youth experiment with risk practices. This paper examined the association of parental monitoring with a range of alcohol and other drug (AOD) use behaviors among high-risk Youth, while controlling for other demographic and environmental variables previously found to be associated with AOD use. Participants were recruited as part of a longitudinal evaluation study of four youth drop-in centers located in Southern California. These centers served at-risk youth, including Hispanic, Lesbian/Gay/Bisexual/Questioning (LGBQ), and homeless and runaway youth. Participants were aged 14 to 24 and were new attendees at the drop-in centers. Results from logistic regression analyses revealed that while controlling for demographic and environmental variables, adolescents who reported less parental monitoring were more likely to report lifetime use of cigarettes, marijuana, and methamphetamine, and in the past three months, use of alcohol and binge drinking. The findings thus indicate that, even among high-risk youth, those who reported low parental monitoring were significantly more likely to use a variety of substances. Implications of these findings are discussed as they pertain to AOD prevention and interventions for children and their families. Copyright 2005, Haworth Press Inc.

### **Prevention of adolescent smoking: A prospective test of three models of intervention.**

Byrne DG; Mazanov J. *Journal of Substance Use* 10(6): 363-374, 2005. (56 refs.)

Objective: The onset of smoking in adolescence leads to significant health problems in later life and so adolescent smoking prevention is a crucial concern of health psychology. Yet the evidence on smoking prevention in adolescence is not encouraging. The objective of this study was to examine the relative long-term efficacy of three specifically focused prevention strategies (health-oriented, fitness-oriented and social skills/stress management-oriented) directed at the onset of adolescent smoking. Design: A longitudinal intervention study. Method: A large sample of adolescents aged 11-17 years was assessed for smoking behaviour and then assigned through group randomization to one of the three intervention programmes listed above. Following intervention, based on four standard classroom sessions, smoking behaviour was then reassessed immediately after intervention. Final follow-up of smoking behaviour at

12 months after intake yielded completed data for n=1,694 (62.3%) of the intake cohort. Data on smoking behaviour were then compared both across intervention strategies and with another large "control" cohort of adolescents who had been identically assessed in a previous study by DGB. Results: Application of a health-oriented strategy was significantly better than the other two strategies in controlling smoking behaviour immediately following intervention. The intervention strategy emphasizing social skills and stress management in the face of peer pressure to smoke was, however, superior to either the health- or fitness-oriented strategies, or to the "control" group in controlling smoking behaviour at 12-month follow-up. Conclusions: While the health message cannot be dismissed as a focus for adolescent smoking prevention, a strategy that assists young people to resist the effects of peer pressure through social skills and stress management seems to provide the most enduring means of controlling smoking behaviour in adolescence. Copyright 2005, Taylor & Francis.

### **Prevention programmes for children of problem drinkers: A review.**

Cuijpers P. *Drugs: Education, Prevention and Policy* 12(6): 465-475, 2005. (40 refs.)

It is well established that children of problem drinkers have an increased risk of developing mental health problems, including drinking and drug misuse problems, depression, eating disorders, conduct disorders, and delinquency. However, compared to the hundreds of studies that have examined the effects of parental problem drinking on their children, the genetics of problem drinking, and the physical and mental problems of these children, it is disappointing that so few studies have explored the possibilities of prevention. Despite all the research on children of problem drinkers, we have no usable operationalizations of what problem drinking is, or when a child can be defined as a child of a problem drinker. Furthermore, no valid screening or severity assessment instruments are available; there is no solution for the ethical dilemma of the need to involve parents while these parents are at the same time the problem; very few theory-driven prevention programmes have been developed; very little is known about protective factors that could be the focus of prevention programmes; and we have no programmes that can be considered to be 'evidence based'. This paper describes these problems, presents an overview of the prevention research in this area, and gives some directions for future research. Copyright 2005, Taylor and Francis Ltd.

**Secondary prevention services for clients who are low risk in drug court: A conceptual model.**

DeMatteo DS; Marlowe DB; Festinger DS. *Crime & Delinquency* 52(1): 114-134, 2006. (55 refs.)

offenders are addicts, and that drug use fuels other criminal activity. As a result, drug court clients must satisfy an intensive regimen of treatment and supervisory obligations. However, research suggests that roughly one third of drug court clients do not have a clinically significant substance use disorder. For these clients, standard drug court services may be ineffective or even contraindicated. Instead, these clients may be best suited for a secondary prevention approach directed at interrupting the acquisition of addictive behaviors. Unfortunately, there are no established secondary prevention packages for adults in criminal justice settings. This article presents a conceptual framework for developing and administering secondary prevention services in drug courts and proposes a platform of prevention techniques that can be tailored in a clinically relevant manner for the sizeable population of drug court clients who are low risk. Copyright 2006, Sage Publications.

**Standards of evidence: Criteria for efficacy, effectiveness and dissemination. (review).**

Flay BR; Biglan A; Boruch RF; Castro FG; Gottfredson D; Kellam S et al. *Prevention Science* 6(3): 151-175, 2005. (121 refs.)

Ever increasing demands for accountability, together with the proliferation of lists of evidence-based prevention programs and policies, led the Society for Prevention Research to charge a committee with establishing standards for identifying effective prevention programs and policies. Recognizing that interventions that are effective and ready for dissemination are a subset of effective programs and policies, and that effective programs and policies are a subset of efficacious interventions, SPR's Standards Committee developed overlapping sets of standards. We designed these Standards to assist practitioners, policy makers, and administrators to determine which interventions are efficacious, which are effective, and which are ready for dissemination. Under these Standards, an efficacious intervention will have been tested in at least two rigorous trials that (1) involved defined samples from defined populations, (2) used psychometrically sound measures and data collection procedures; (3) analyzed their data with rigorous statistical approaches; (4) showed consistent positive effects (without serious iatrogenic effects); and (5) reported at least one significant long-term follow-up. An effective intervention under these Standards will not only meet all standards for efficacious

interventions, but also will have (1) manuals, appropriate training, and technical support available to allow third parties to adopt and implement the intervention; (2) been evaluated under real-world conditions in studies that included sound measurement of the level of implementation and engagement of the target audience (in both the intervention and control conditions); (3) indicated the practical importance of intervention outcome effects; and (4) clearly demonstrated to whom intervention findings can be generalized. An intervention recognized as ready for broad dissemination under these Standards will not only meet all standards for efficacious and effective interventions, but will also provide (1) evidence of the ability to "go to scale"; (2) clear cost information; and (3) monitoring and evaluation tools so that adopting agencies can monitor or evaluate how well the intervention works in their settings. Finally, the Standards Committee identified possible standards desirable for current and future areas of prevention science as the field develops. If successful, these Standards will inform efforts in the field to find prevention programs and policies that are of proven efficacy, effectiveness, or readiness for adoption and will guide prevention scientists as they seek to discover, research, and bring to the field new prevention programs and policies. Copyright 2005, Springer.

**The European Smoking Prevention Framework Approach (ESFA): Effects after 24 and 30 months.**

de Vries H; Dijk F; Wetzels J; Mudde A; Kremers S; Ariza C; Vitoria PD. *Health Education Research* 21(1): 116-132, 2006. (34 refs.)

The European Smoking Prevention Framework Approach (ESFA) study in six countries tested the effects of a comprehensive smoking prevention approach after 24 (T3; N = 10 751) and 30 months (T4; N = 9282). The programme targeted four levels, i.e. adolescents in schools, school policies, parents and the community. In Portugal, 12.4% of the T1 non-smokers in the control group had started smoking at T4 compared to 7.9% of the experimental group. Smoking onset in the experimental group was thus 36% lower. In Finland, 32.4% of the T1 non-smokers started smoking compared to 27.6% of the experimental group, implying a 15% lower onset in the experimental group. In Spain, 33.0% of the T1 non-smokers in the control group had started smoking, compared to 29.1% of the experimental group, implying a 12% lower onset. In The Netherlands, the ESFA programme was effective for non-native adolescents with 11.4% new weekly smokers compared to 19.9% in the control group. An opposite

effect was found in native Dutch adolescents with 19.0% new weekly smokers in the comparison group compared to 24.0% new smokers in the experimental group. Future programmes should use more standardized ways to assess process evaluations and should assess which elements are responsible for behavioral effects. Copyright 2006, Oxford University Press.

**Tobacco outlet density and demographics at the tract level of analysis in Iowa: Implications for environmentally based prevention initiatives.**

Schneider JE; Reid RJ; Peterson NA; Lowe JB; Hughey J. *Prevention Science* 6(4): 319-325, 2005. (45 refs.)

This study assessed the geographic association between tobacco outlet density and three demographic correlates-income, race, and ethnicity-at the tract level of analysis for one county in the Midwestern United States. Data for residential census tracts in a Midwestern U.S. county were derived from year 2003 licenses for 474 tobacco outlets. Demographic variables were based on 2000 census data. Census tracts with lower median household income, higher percent of African American residents, and higher percent of Latinos residents had greater density of tobacco selling retail outlets. Areas characterized by lower income and disproportionately more African Americans and Latinos have greater physical access to tobacco products. Physical access to tobacco is a critical public-health issue because, given that smokers have been shown to be price sensitive, lowering access costs (e.g., reduced travel time) is likely to increase consumption. Findings also suggest the need for structural or environmental interventions, i.e., tobacco

outlet zoning laws, to mitigate the health consequences associated with tobacco use in certain populations and geographic regions. Copyright 2005, Springer.

**The Building Resiliency And Vocational Excellence (BRAVE) program: A violence-prevention and role model program for young, African American males.**

Griffin JP. *Journal of Health Care for the Poor and Underserved* 16(4, Supplement B): 78-88, 2005. (68 refs.)

There are sharp disparities between non-Hispanic Whites and African Americans in mortality and years of potential life lost for numerous health-related conditions, including HIV/AIDS. The Building Resiliency and Vocational Excellence (BRAVE) Program is an intervention using Resiliency Networking designed for use with African American young men to help offset these disparities. Resiliency Networking incorporates coaching, career planning, and re-definition of gender roles to help young men develop a sense of purpose and future and to manage their lifestyles effectively. In addition to fostering a strong link with an older mentor, the program fosters healthy peer-to-peer relationships. The paper reports on preliminary use of the intervention and recommends future applications. [Note: The BRAVE Program is a substance abuse and violence prevention program. It uses standardized ATOD prevention curriculum, two violence prevention curricula, goal setting, vocational mentoring, vocational peer-to-peer support and manhood development training as prevention strategies.] Copyright 2005, Johns Hopkins University Press.