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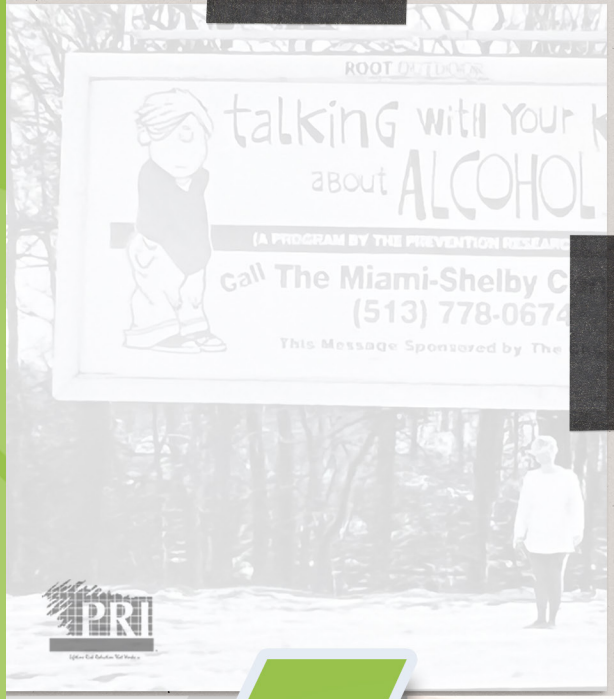
prime

from Prevention Research Institute



40 years

growth happens here™

Prevention Research Institute

40 years...

...of growth, change and perspective.

KAC 1978

1983
Prevention Research Institute

TWYKAA 1985

Delts Talking about Alcohol (DTAA) 1988

David Rosengren, Ph.D, *President, PRI*

"Because science is evolving, what we do and how we do it must also adapt. We must be open to growth, which also requires that we challenge ourselves and our beliefs

It was a big year, 1983.

Motivational Interviewing was born in an article published by Bill Miller, and has since revolutionized how we think about and communicate with people as they consider changes. The Internet was also born that year. While there previously were networks of computers, they did not have a way to communicate with each other until a new communication protocol – Transfer Control Protocol/Interwork Protocol (TCP/IP) – was instituted in 1983. Now we have handheld computers, also known as cell phones, in virtually every part of the world simultaneously accessing the accumulated knowledge through the internet – keeping us connected, and sometimes dividing us. Finally, in 1983 Ray Daugherty decided that prevention of alcohol misuse should be based on science, not on favorite activities or things we simply believed worked, and he left the Kentucky Alcoholism Council and along with Terry O'Bryan, co-developed the curriculum that has become known as Prime For Life. Along the way, Prevention Research Institute was born. All three of these things were unbeknownst to me at the time, a 23-year-old leaving Minnesota to begin my graduate career in clinical psychology at the University of Montana; but they would eventually bring me to these people, this place, and this work. Indeed, 1983 was a big year, and a lot has happened in the 40 years since.

PRI's is a remarkable history characterized by a few things that continue to guide this work. We start with the science. We use practices and information supported by the research. But Ray and Terry noted it's not just what we say, but how we say it that matters. Inviting people into an exploration of their values, their risks, and making informed choices has always been core. From the start we utilized technology to assist us in this process, beginning with overhead transparencies and written manuals and progressing to the Prime For Life App of today. (See Mike O'Bryan's article "$.05 a Sheet" in this edition of Prime for more on the evolution of PRI delivery technology!) Finally, we keep the people we serve centered in this work – be they decision makers, business owners,

agency directors, clinicians, instructors, or the recipients of our programs. Service has been at the heart of what we do, including taking five days to train people to understand prevention, see the model's extant in the world, and discover how Prime For Life differs. PRI also recognizes that if we're to remain true to these things, we need to be looking out to, and over, the horizon to what comes next.

Of course, this means growth and change. Because science is evolving, what we do and how we do it must also adapt. We must be open to growth, which also requires that we challenge ourselves and our beliefs. Over time, we've learned about and incorporated new ideas – Motivational Interviewing, the Transtheoretical Model, Positive Psychology, and Self-Determination Theory to name a few – to enhance this process. We haven't changed for the sake of change, but because the science shows us there is more to know and understand.

Over the last three years we transformed how we deliver training and now offer a broader range of continuing education topics without being limited to geographic localities. Together we've learned how to train instructors and deliver the programs virtually, and have also taken advantage of self-directed methods for people to experience the PFL concepts. We can do these things more efficiently, in a manner convenient for learners, and see each other more regularly. We also learned that some things were missing, and have continued to make changes and improvements. For example, we now require individual coaching and feedback because implementation science taught us this was essential for skill development and maintenance, and we developed a method that worked for new instructors.

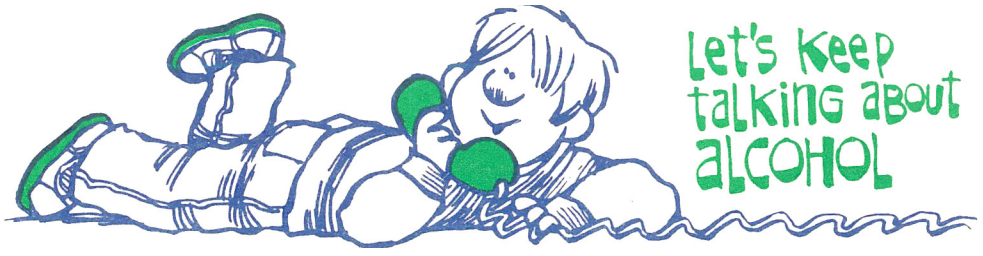
Operations behind the scenes at PRI are more streamlined. We've made it easier to register for training, access certificates for your training experiences, and in the future expect to have the capacity to pay for training and workbooks online.

Support remains a high priority. Even though our staff is spread across the country in places like Kentucky, Georgia, Pennsylvania, Texas, Iowa, Oklahoma, North Carolina, and Washington State, we continue to make it a value that you reach a person and not a phone tree when you call PRI. We bucked the growing business trend that seems to use this technology to frustrate efforts to reach a real person. Instead, we use the technology to direct you quickly to the right person – wherever that person might be located. We have also begun offering chat support for those who prefer that method. Email support is also available at support@primeforlife.org. Our Support Team set an expectation of responding to all requests within 24 hours, with an aim of responding much more quickly than that.

The PRI Research and Media Teams combined forces to make data gathering easier for everyone when we are doing evaluations. QR codes and hyperlinks will be embedded in programs and participants will simply need to scan the image or follow the link to complete an assessment prior to and at the completion of their programs. We'll begin rolling this out in 2023, with much more information coming soon.

Some tantalizing possibilities exist for where the future might take us, though none are certainties. We've been working with the Lyssn organization testing ChatBots to help people refine listening skills. In the next 40 years, perhaps we'll discover new ways for Artificial Intelligence (AI) applications to improve our learning, refine our skills, and aid us in delivering training and programs. We may continue to refine our understanding of what learning is best done in-person and which can be done remotely or in a self-directed manner. Or perhaps we'll discover that allowing the learner to choose their course of learning is the critical factor. Perhaps we move away from paper products and instead people receive an App that accompanies the work they do in Prime For Life. Perhaps AI will help the Support Team aid more effectively, efficiently, and quickly. Maybe there will be a dashboard where our partners can access outcome information for their systems in real time and print reports as needed. While none of these things are certain, we look forward to exploring these options, and others unknown at the moment that will undoubtedly arise.

We have come a long way since it was just Ray, Terry and a half-time administrative assistant bringing the program to the world. And I wonder, How will we evolve toward the future? One thing remains certain to me: If there are substances that can alter people's perceptions, then there will be a need for programs and people that help them avoid getting into trouble with high-risk use. Where and how we deliver those things may change.



Something about an Apple and a Tree

Jamee Smith,
Communications Director, PRI

“I’ve been able to watch a lot of people get clean, change their lives, get their license back – which makes their whole life better.

At PRI, we do a lot of talking and a lot of listening…like a lot, a lot. And somehow, sometimes we are still surprised by what we hear. That was certainly the case when, in a Continuing Education Session, I saw an instructor casually mention in a chat that she was a third generation Prime For Life Provider – as if that was **NO BIG DEAL?!**

I had to know more. So I gave Caroline Swain a call the next day, and here is what she told me about her Prime For Life-loving family.

After struggling with substance abuse, Caroline’s grandfather Glynn Melton made a huge change in 1983, and knew he wanted to help others do the same. In the early 1990s, Glynn opened Melton’s Driving School in Dublin, Georgia – still the only driving school in this part of the world. His wife, Yvonne “MeMe” Melton, helped him run it, plus their insurance business, and they raised a family in between Prime For Life sessions. These sessions were taught using film slides at first. We’ve shipped a lot of different materials and resources to Melton’s over the years!

In 1997, Caroline’s father, John Ivey, joined the fray, teaching Prime For Life and eventually becoming the driving school’s owner and director. Like Glynn, John raised his family in the office around the program. Caroline was there almost every day after school and some of her earliest memories are pieces of the program, like the “Brothers of Brothers” discussion that was included in early Prime For Life versions.

In 2007 (you guessed it!), Caroline became a Prime For Life instructor, teaching alongside her father for the first few years in her position. “We have a pretty good balance, between work and home,” she says, a balance that makes their family business successful. Now, she teaches Prime For Life a few times per month, spending her weekends “with Allan and Ejna” who she loves to see at Continuing Education Conferences.

Caroline, like others in her family, views her work as an honor and privilege. “I’ve been able to watch a lot of people get clean, change their lives, get their license back – which makes their whole life better,” she says. One participant in her program still drops by the office to visit after he made

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changes to protect his values, moving from deep in the Red Phase to a whole different life.

I loved hearing this story and can't wait to see what the future holds – rumor has it Caroline's daughter, niece, and nephew spend a lot of time around the office just like she did growing up. Maybe we will have the honor of training a fourth generation Prime For Life Instructor one day?

$.05 a sheet

Mike O'Bryan
Creative Director, PRI

Done! I was finally done with middle school. It was summer and I couldn't wait to sleep late, hang out with friends at the pool and savor my last free days before starting high school! Unfortunately the **summer of 1983** didn't quite pan out the way I had envisioned. As PRI was formally incorporated and my mother (Terry O'Bryan) was full steam ahead with training and spreading the TWYKAA message, I was recruited to start making large quantities of overhead transparencies....UGH!! At least I could earn some spending money for the summer. Not sure if it was actually legal to employ me, but I managed to negotiate $.05 a sheet!

Fast forward 40 years, and while I'm still making images for PRI, the technology used to deliver Prime For Life has changed dramatically. After having to lug around that heavy transparency projector for too long, instructors were finally able to deliver the program using slide projectors. What an improvement right? Maybe not, but it was a more compact case at least! Slide projectors finally gave way to the cutting-edge technology of CDi (Compact Disc Interactive) which proved to be the predecessor of DVD. It was exciting tech, but was short-lived. It did, however get PRI thinking about using technology to **enhance** the program **rather than just deliver** it. Video and animation became a new part of the program, allowing instructors to illustrate concepts and share personal stories. As DVD technology overtook CDi, PRI again shifted gears and adopted DVD as the standard delivery method in classrooms. It was portable (mostly) and relatively affordable. DVD made it easier to navigate to places in the program and delivered a high quality video experience.

I still get a chuckle when I see CDs plastered to the sun visor of some cars, and I think about where we are today and the humble beginnings of PRI. The ubiquity of fast internet has paved the way for delivery of PFL in ways we might not have imagined 40 years ago. From the Prime For Life App and e-Manual to the NITO e-Learning platform, PRI has embraced technology that enhances both the instructor and the participant experience.

Rest assured, we will continue to look for ways to provide a better teaching and learning experience by leveraging technology in the years to come...hopefully another 40 and beyond!

> **"The ubiquity of fast internet has paved the way for delivery of PRI programs in ways we might not have imagined 40 years ago.**

Harm Reduction & Lifestyle Risk Reduction

What's the Difference & Are They Compatible?

Mark Nason, *Research Analyst, PRI*

Can harm reduction and LRR strategies be compatible? Yes, as long as harm reduction strategies are used in a manner that does not undermine the efforts to promote age-appropriate low-risk Q/F choices.

In the not-too-distant past, harm reduction was viewed very negatively by most professionals in the U.S. Now, it is much more widely accepted and is increasingly being promoted.

Sometimes there is confusion between Lifestyle Risk Reduction (LRR) and harm reduction, since "risk reduction" and "harm reduction" sound so similar. This potential confusion is illustrated by a quote from a NIDA Monograph: "Although they refer to the same general approach or model, Europeans (particularly the Dutch) call it 'harm reduction,' the British refer to 'harm minimization,' and Americans are more likely to prefer the term 'risk reduction.'" [Marlatt, et al, pg. 147] In addition, risk reduction and harm reduction share the same goal of preventing problems. Nevertheless, there are some important differences, so it is important to clarify terms.

"Risk reduction" is a broad term with multiple meanings, while "Lifestyle Risk Reduction" (LRR) is a very specific model of prevention developed by PRI. When applied to substances, LRR says that alcohol and drug problems result from an interaction between our alcohol or drug choices and our individual biology. Low-risk quantity and frequency (Q/F) choices make problems unlikely and high-risk choices make problems likely. Accordingly, LRR focuses on three strategies—increasing abstinence, delaying onset of use, and reducing high-risk use. If an approach implies any other cause or focuses on other prevention strategies, it is not Lifestyle Risk Reduction, even if it uses the term, "risk reduction." [For more details on the LRR model, see this information sheet]

In contrast, the focus of traditional harm reduction is on changing behaviors other than the substance use itself, as illustrated by the following definitions. "The application of methods designed to reduce the harm (and risk of harm) associated with ongoing or active addictive behaviors" [Marlatt et al, p. 147], and "Harm reduction is the policy of preventing the potential harms related to drug use rather than trying to prevent the drug use itself." [Duncan, et al, pp. 281-282]

At times, promoters of traditional harm reduction have mentioned that reduction in substance use is a worthwhile goal, saying there is a continuum of choices, that risk for harm increases as use increases, and that any movement toward lower quantity and frequency is desirable. Nevertheless, Marlatt stated that "...attention is focused on reducing harmful or risky consequences of

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drug use rather than reducing drug use per se." [pg.149] Duncan goes further, stating "the usual prevention goal of abstinence from drug use for young people is unthinking, unobtainable and unacceptable." [p. 284] This is clearly at odds with the prevention goal of increasing abstinence. It suggests this goal is useless and harmful. Duncan adds, "Just as it is a truth that any drug can be abused, it is a truth that any drug can be used without abuse." [p. 284] Duncan is correct that alcohol can be used in a low-risk manner by many people; and in an absolute sense, there likely is a Q/F for any drug which does not increase risk for impairment or health problems, but such a small amount would not create the high that motivates most drug use. So, while different in degree, both Marlatt and Duncan have focused on reducing harmful outcomes with little-to-no focus on reducing high-risk use.

As Duncan presents it, harm reduction seems to adopt an attitude of hopelessness, in effect suggesting that since everyone won't abstain, abstinence is not a useful goal. PRI's concept of influence versus control is important here. We cannot control anyone's Q/F choices, but we ought not abandon our role of influence. We can increase abstinence by promoting non-use of drugs and abstinence as one of the options for alcohol, and by supporting people who abstain.

A common traditional harm reduction strategy for preventing car crashes due to impairment on substances is to promote the use of designated drivers. Using a designated driver is a low-risk driving choice and prevents legal problems and reduces highway injuries and deaths, but without reducing substance use. Thus, it does not help prevent other impairment problems or health problems. As we discuss in PFL, in some cases this approach can even encourage high-risk use when people are not driving. By contrast, LRR works to prevent crashes primarily by recommending abstinence from impairing substances prior to driving. In addition, people are encouraged to always follow the low-risk guidelines so they can reduce their risk of experiencing any substance-related problem.

Other examples of harm reduction are needle exchange programs and making Narcan readily available. Needle exchange programs have been shown to reduce infection rates but make no effort to change the use of drugs as part of the person's lifestyle. Narcan has proven exceptionally effective in reducing the risk for overdose death, but also does nothing to change use to prevent future problems.

PRI is not suggesting it is wrong to use harm reduction strategies. Who wants to meet an impaired driver on the highway or for their loved ones to die from an overdose? But such strategies are often very different from the primary approach of LRR to promote the adoption of low-risk Q/F choices. Even when focused on impairment or health problems, a strictly traditional harm reduction approach does not address the root cause of all substance-related problems: biology interacting with Q/F choices.

In more recent years, harm reduction has sometimes been redefined to mean any approach to prevention that does not focus solely on abstinence. From this perspective, the 1-2-3 portion of the low-risk guidelines for alcohol could be considered a form of harm reduction. Increasingly, there has been promotion of this type of harm reduction regarding THC use (see, for example Fischer, et al., 2022). This often includes recommendations about when not to use (such as prior to driving or at work) and only using a couple of times per week. Thus, these recommendations include traditional harm reduction as well as a focus on reducing Q/F of use. They do reduce risk for some problems, yet many people who follow these recommendations will lose things that are important to them. Abstinence is currently the only known low-risk choice for THC.

Can harm reduction and LRR strategies be compatible? Yes, as long as harm reduction strategies are used in a manner that does not undermine the efforts to promote age-appropriate low-risk Q/F choices. For example, when promoting the use of designated drivers, it is important to stress that two choices are being made. The preferred message is that if people are going to drink or use drugs, it is recommended they not drive, and if people want to protect what they value, this is best achieved by always making low-risk Q/F choices.

We also believe many other harm reduction strategies do not undermine the promotion of low-risk Q/F choices. For example, it seems highly unlikely that people who have never injected drugs would choose to do so simply because clean needles are available.

In conclusion, we believe the abandonment of a primary focus on reducing use and supporting abstinence is not only unnecessary, it can make some problems more likely to occur. Nevertheless, a comprehensive approach to LRR includes harm reduction strategies to help in the the prevention of problems among people who will make high-risk Q/F choices despite our best efforts to promote low-risk choices.

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Harm Reduction...from page 6

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This article is an update from the May 1996 edition of our newsletter (at that time named, Let's Keep Talking About Alcohol and Drugs).

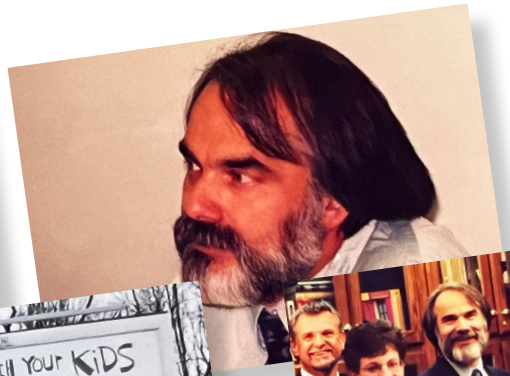
Can you guess the year we put this spotlight on Mark?

(Hint: that little girl is now a mother of her own and 28 years old!)

TWYKAA INSTRUCTOR SPOTLIGHT

Mark Nasan is Prevention Specialist at the Jessamine Counseling and Education Center in Nicholasville. He received his MSW at UK. Mark worked for one year in the Methadone Program at the Comprehensive Care Center in Lexington, and then for four years in the Jessamine County office as a drug and alcohol abuse counselor and educator. For the past two years, Mark has been Prevention Specialist there.

Mark was raised in the Okolona area of Louisville, and is one of seven sons. He is married with a new, 8-month old little girl. Chris, Mark's wife, teaches in the Jessamine County School System. Mark's hobbies include playing with his daughter, and playing basketball, volleyball, and listening to music. He is an active member of the Unitarian Universalists Church in Lexington.



A Brief PRI Timeline