



## GREENFIELD PUBLIC SCHOOLS

### Policy & Curriculum Subcommittee Meeting

Wednesday, April 21, 2021 at 1:00pm

**This meeting is being held fully remotely in accordance with the Governor of Massachusetts' March 12, 2020 Order Suspending Certain Provisions of the Open Meeting Law G.L. c. 30A, Section 20**

**Live conference line: 1-408-418-9388 and enter code: 132 107 0607**

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<https://greenfieldma.my.webex.com/webappng/sites/greenfieldma.my/meeting/download/75aeaf8353064574aaec375f85899ec4?siteurl=greenfieldma.my&MTID=mea0d49bf071d42fb5384e2b6f55624fd>

### MINUTES

#### I. Roll Call/Call to Order

Present: Glenn Johnson-Mussad, Subcommittee Chair; Katie Caron, Subcommittee Member

Administration Present: Dr. Judith Houle, Interim Superintendent; Dr. Nadine Ekstrom, TMS

Subcommittee Chair Johnson-Mussad called the meeting to order at 1:03 pm.

#### II. Public Comment – none

#### III. Review of policies pertaining to the student handbook

A. The Chair moved, seconded by Member Caron, to suspend Roberts Rules of Order to allow discussion of proposed policies without a motion.

VOTE: Member Caron, yes; Chair Johnson-Mussad, yes.

B. Dr. Ekstrom presented drafts of policies that would require a first and second reading with the School Committee as they are new policies or could have the first reading waived as they represent updates to current policies.

1. EBC-S: COVID-Related Issues.

DISCUSSION: add some language regarding other pandemics was considered.

MOTION: Member Caron moved, seconded by Chair Johnson-Mussad, to recommend the School Committee hold a first reading on EBC-S: COVID-Related Issues with suggested changes.

VOTE: Member Caron, yes; Chair Johnson-Mussad, yes.

2. IHBHE: Remote Learning  
DISCUSSION: some minor revisions were discussed.  
MOTION: Member Caron moved, seconded by Chair Johnson-Mussad, to recommend the School Committee hold a first reading on IHBHE: Remote Learning Issues with edits made.  
VOTE: Member Caron, yes; Chair Johnson-Mussad, yes.
  
3. JB: Equal Educational Opportunities – suggested revisions are in line with changes in the law.  
MOTION: Member Caron moved, seconded by Chair Johnson-Mussad, to recommend the School Committee waive the first reading on policy JB: Equal Educational Opportunities as revised.  
VOTE: Member Caron, yes; Chair Johnson-Mussad, yes.
  
4. JBB: Educational Equity – not currently in the policy manual  
MOTION: Member Caron moved, seconded by Chair Johnson-Mussad to recommend JBB as a first reading to the School Committee.  
VOTE: Member Caron, yes; Chair Johnson-Mussad, yes.
  
5. JEB: Entrance Age  
The GPS policy was compared to the MASC policy. After discussion, the current GPS Policy will be kept in place.
  
6. JFABD: Homeless Students: Enrollment Rights and Services  
This policy does not exist and it needs to be.  
MOTION: Member Caron moved, seconded by Chair Johnson-Mussad to recommend JFABC as a first reading to the School Committee.  
VOTE: Member Caron, yes; Chair Johnson-Mussad, yes.
  
7. JFABE: Educational Opportunities for Military Children  
MOTION: Member Caron moved, seconded by Chair Johnson-Mussad to recommend JFABE as a first reading to the School Committee and adopting the policy as revised.  
VOTE: Member Caron, yes; Chair Johnson-Mussad, yes.
  
8. JHD: Exclusions and Exemptions of School Attendance  
Recent updates to the law require removal of some text.  
MOTION: Member Caron moved, seconded by Chair Johnson-Mussad to recommend waiving the first reading of JHD to the School Committee and adopting the policy as revised.

VOTE: Member Caron, yes; Chair Johnson-Mussad, yes.

9. JICH: Prohibition of Hazing – the GPS policy adds the definition of hazing, which the MASC version does not have. It was decided to keep as is.

10. JIH: Alcohol, Tobacco, and Drug Use by Students

Changes were recommended, particularly with the addition of vaping/e-cigarettes.

MOTION: Member Caron moved, seconded by Chair Johnson-Mussad to recommend waiving the first reading of JIH to the School Committee and adopting the policy as revised.

VOTE: Member Caron, yes; Chair Johnson-Mussad, yes.

11. JLCB: Immunizations of Students

Revisions were presented to this policy per updates by MASC.

MOTION: Member Caron moved, seconded by Chair Johnson-Mussad to recommend waiving the first reading of JLCB to the School Committee and adopting the policy as revised.

VOTE: Member Caron, yes; Chair Johnson-Mussad, yes.

12. JLCC: Communicable Diseases

Revisions to this policy were presented per updates by MASC.

MOTION: Member Caron moved, seconded by Chair Johnson-Mussad to recommend waiving the first reading of JLCC to the School Committee and adopting the policy as revised.

VOTE: Member Caron, yes; Chair Johnson-Mussad, yes.

The Committee discussed the process for moving forward and set their next meeting for Friday, May 14, 2021 at 10:30 am.

IV. Adjournment

MOTION: Member Caron moved, seconded by Chair Johnson-Mussad to adjourn the meeting at 2:13 pm.

VOTE: Member Caron, yes; Chair Johnson-Mussad, yes.

Respectfully Submitted,  
Dr. Judith Houle  
Interim Superintendent

## Proposal for PreVenture at GPSD

May 21, 2021

Dear Superintendent Houle and the Greenfield Public School District School Committee,

The Communities That Care Coalition (hosted by the Franklin Regional Council of Governments' Partnership for Youth) is pleased to share that we have been granted funding by the Opioid Task Force (through a grant from the Federal Office of Justice Programs) to bring the PreVenture Program to interested schools in the Franklin County and North Quabbin region at no cost to the school districts. Through the PreVenture program, school counselors are trained to deliver workshops which teach skills from cognitive behavioral therapy (CBT) and motivational interviewing (MI) to students whose personalities put them at high risk for alcohol and drug problems as well as mental health challenges. PreVenture is an evidence-based substance use prevention and mental health promotion program that has been proven effective through numerous clinical studies in Australia, the UK, and Canada, but is relatively new to the US. It is listed in the US Surgeon General's plan for reducing addiction in America because of its long-term, population-level effectiveness in reducing youth substance use.

The Communities That Care Coalition's Regional School Health Task Force (which includes representation from all of our local school districts) selected the PreVenture program for several reasons:

- (1) It is incredibly effective.
- (2) It requires minimal student time, and relatively minimal staff time from school counselors.
- (3) It works by improving youth mental health, and we have been seeing depression and anxiety increase among local youth since 2012, reaching epidemically high levels during the pandemic.
- (4) It nicely complements the LifeSkills curriculum (taught in GMS health classes) and the SBIRT program (coordinated by GHS nursing staff) – the two evidence-based youth substance use prevention programs currently in place in GPSD.

We are hoping that the Greenfield Public School District will join us as a key partner in this effort, at no cost to the district. With the support of the Greenfield Safe Schools Safe Streets Coalition (4SC), two GHS counselors (Stacy Page and Deb Potee) participated in the PreVenture two-day facilitator training last summer and both felt the program would be a strong match for the needs and resources at Greenfield High School. In April, Nick Fouche (who replaced Deb Potee) participated in the PreVenture facilitator training, along with counselors from 5 other school districts in Franklin County, and Nick also is excited to bring the program to Greenfield Public School District students. The Partnership for Youth can provide student workbooks, clinical supervision, technical assistance, program evaluation, and positive publicity. While we currently only have 7 more months of funding secured, this will help us pay for the start-up costs

of the program. For ongoing costs, both the Communities That Care Coalition and 4SC are committed to supporting the program in an ongoing way, and will continue to search for funding for workbooks and ongoing training.

Sixteen years ago, when the Communities That Care Coalition first formed, local substance use rates were nearly twice the national average; today they are on a par with national rates. These positive changes have come with the implementation of a wide variety of evidence-based, data-driven strategies identified by the Coalition and implemented by many partners, especially local public schools. These include the LifeSkills program, evidence-based parent education, student and parent social norms campaigns, changes in school policies, compliance checks, shoulder tap surveys, server training, social host liability laws, raising the minimum age for tobacco purchase to 21, Screening Brief Intervention and Referral to Treatment (SBIRT) for all students, and more. The PreVenture program is a very exciting next step, building our school district and community's capacity for prevention.

To participate in the PreVenture program, the Greenfield Public School District will:

- Designate approximately two counselors (or other district professional) to be PreVenture Program workshop facilitators (this would be Stacy Page and Nick Fouche).
- Ensure that all workshop leaders attend a workshop leader training (Stacy and Nick are now trained).
- Implement the program in 8th (or 8th and 9th) grade:
  - Arrange for all students in the chosen grade(s) to take an online screening (the Substance Use Risk Profile or "SURPS" questionnaire) for four personality factors (sensation-seeking, impulsivity, negative-thinking, and anxiety-sensitivity)
  - Recruit students who score high on the screening into the workshop series corresponding to their personality factor (~8-12 students per group)
  - Run two 90-minute workshops for each of the 4 personality factors, (8 sessions total), adhering to the fidelity of the program and including all of the core concepts in each workshop.
- Inform the superintendent, building principal, workshop leader, and staff at the Partnership for Youth by email when adaptations need to be made to the program.

The Partnership for Youth will provide the following support to the Greenfield Public School District:

- Provide basic information about the PreVenture Program to GPSD staff, administrators and School Committee as requested.
- Make workshop leader training available (likely online) at no cost to the school.
- Provide clinical supervision for workshop leader(s), including workshop observations (FRCOG has subcontracted with Clinical and Support Options to provide this).
- Provide manuals and workbooks at no cost to the participating school districts.
- Provide impact-level evaluation of the program's efficacy from annual Teen Health Survey results and report information back to the school team.

- Work to disseminate lessons learned and resources developed from pilot throughout the region, state, and nation.

We are very much looking forward to collaborating with the Greenfield Public School District on this project. Together with the other partners in this grant we are confident that we can be successful in achieving health outcomes and building a sustainable infrastructure for prevention. Please feel free to contact me with any questions.

Sincerely,

A handwritten signature in red ink, appearing to read "Kat Allen", written over a yellow rectangular background.

Kat Allen  
Coalition Coordinator  
Communities That Care Coalition  
Partnership for Youth  
Franklin Regional Council of Governments

# Brief, Personality-Targeted Coping Skills Interventions and Survival as a Non-Drug User Over a 2-Year Period During Adolescence

Patricia J. Conrod, PhD, CPsychol; Natalie Castellanos-Ryan, PhD; John Strang, MBBS, FRCPsych, MD

**Context:** Selective interventions targeting personality risk are showing promise in the prevention of problematic drinking behavior, but their effect on illicit drug use has yet to be evaluated.

**Objective:** To investigate the efficacy of targeted coping skills interventions on illicit drug use in adolescents with personality risk factors for substance misuse.

**Design:** Randomized controlled trial.

**Setting:** Secondary schools in London, United Kingdom.

**Participants:** A total of 5302 students were screened to identify 2028 students aged 13 to 16 years with elevated scores on self-report measures of hopelessness, anxiety sensitivity, impulsivity, and sensation seeking. Seven hundred thirty-two students provided parental consent to participate in this trial.

**Intervention:** Participants were randomly assigned to a control no-intervention condition or a 2-session group coping skills intervention targeting 1 of 4 personality profiles.

**Main Outcome Measures:** The trial was designed and powered to primarily evaluate the effect of the interven-

tion on the onset, prevalence, and frequency of illicit drug use over a 2-year period.

**Results:** Intent-to-treat repeated-measures analyses on continuous measures of drug use revealed time  $\times$  intervention effects on the number of drugs used ( $P < .01$ ) and drug use frequency ( $P < .05$ ), whereby the control group showed significant growth in the number of drugs used as well as more frequent drug use over the 2-year period relative to the intervention group. Survival analysis using logistic regression revealed that the intervention was associated with reduced odds of taking up the use of marijuana ( $\beta = -0.3$ ; robust SE = 0.2;  $P = .09$ ; odds ratio = 0.7; 95% confidence interval, 0.5-1.0), cocaine ( $\beta = -1.4$ ; robust SE = 0.4;  $P < .001$ ; odds ratio = 0.2; 95% confidence interval, 0.1-0.5), and other drugs ( $\beta = -0.7$ ; robust SE = 0.3;  $P = .03$ ; odds ratio = 0.5; 95% confidence interval, 0.3-0.9) over the 24-month period.

**Conclusion:** This study extends the evidence that brief, personality-targeted interventions can prevent the onset and escalation of substance misuse in high-risk adolescents.

**Trial Registration:** clinicaltrials.gov Identifier: NCT00344474

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**Author Affiliations:** Addictions Department, Institute of Psychiatry, King's College London and South London and Maudsley NHS Foundation Trust, London, United Kingdom.

**A**LCOHOL AND DRUG MISUSE by young people is a significant problem in the United States and Europe. A comparative study<sup>1</sup> on rates of alcohol and drug use among high school students in the United States and across Europe estimated that American and British high school students are similar in their illicit drug use patterns and report among the highest rates of lifetime illicit drug use (41% for American students and 35% for British students) relative to all nations surveyed. More recent findings<sup>2</sup> revealed some concerning trends in drug use among American high school students. First, while rates of lifetime marijuana and cocaine use have decreased over

the past 10 years, indicators of more frequent use (eg, past-year, past-month, or daily use) suggest that rates of frequent or repeated use are increasing among high school students. For example, rates of past-month marijuana use increased from 12% in 1992 to 18% in 2006 among high school seniors and from 8% to 14% among 10th graders. Time-trend analyses for British youth suggest similar growth.<sup>1,3,4</sup>

The earlier the age at onset of regular drug use is, the more likely the individual is to develop substance use disorders in adulthood,<sup>5,6</sup> whereby it has been estimated that rates of adult substance abuse and dependence could be reduced by up to 10% with every year that onset of regular alcohol use or illicit drug use is delayed in

adolescence.<sup>5</sup> The school-based approach to drug use prevention is common because it offers a controlled setting for capturing large, culturally unbiased samples of young people and because schools provide an ideal context for early screening and systematic follow-up. However, the evidence base for school-based prevention programs that attempt to delay onset of use or prevent the transition from experimental use to regular substance use is either limited or nonexistent. Three published meta-analyses<sup>7-9</sup> evaluating the overall effect of school-based prevention concluded that the evidence in support of universal programs affecting actual drug uptake or frequency of use is mild. Accordingly, few programs have been sufficiently evaluated to assess effects on actual illicit substance use and fewer show effects beyond the treatment period. Those showing promise tend to be skills-based interventions that involve an interactive component, but they show only mild effects on prevalence of drug use.<sup>7,9</sup> A recent Cochrane review<sup>9</sup> identified only 4 of 29 studies involving randomized controlled trials of school-based prevention that were sufficiently designed and powered to assess effects on actual drug use (many studies evaluated drug attitudes). The 4 studies evaluating 4 different skills-based programs showed a 20% reduction (relative risk ratio=0.80) in uptake of cannabis use and an approximately 50% reduction in rates of cocaine use over a 1-year period relative to a standard curriculum control. However, there was no evidence that these programs had any effect on continuous measures of drug use, suggesting that they are not effective in preventing transition to regular use in experimental users and thus may not be targeting the youth most at risk. Furthermore, number-needed-to-treat (NNT) indices of effect size indicated that only 1 case of cannabis use was prevented for every classroom of children exposed to the intervention (NNT=33). Considering the intensity of these programs (15-30 class sessions), these effects were considered rather mild. Finally, no program was shown to be effective outside the United States, whose unique social context and drug policies might render generalization of findings to other nations problematic. For example, different federal policies toward the illegal classification of cannabis might render prevention more or less difficult.

A recent shift toward more targeted approaches to drug prevention has led to the development of brief, selected, skills-based interventions targeting personality risk factors for substance use.<sup>10-12</sup> Personality factors such as hopelessness, anxiety sensitivity, impulsivity, and sensation seeking have been shown to be concurrent or predictive risk factors for substance misuse in adulthood<sup>13</sup> and adolescence.<sup>11,14-19</sup>

Anxiety sensitivity and hopelessness have been shown to be related to alcohol consumption as a response to managing anxiety<sup>20</sup> or as means of stemming depressed feelings.<sup>17,19</sup> Impulsive personality traits have been robustly associated with antisocial behavior in childhood and adolescence<sup>21</sup> and found to be predictive of alcohol and substance misuse in adulthood.<sup>22</sup> In contrast, sensation or excitement seeking is directly associated with heavy alcohol consumption and binge drinking<sup>14,15</sup> for enhancement reasons.<sup>20</sup>

Three randomized trials have shown that targeting personality in brief coping skills interventions is effective

in reducing alcohol and illicit substance use in substance-dependent individuals<sup>10</sup> and in reducing drinking quantity, drinking frequency, and drinking problems in high school- and college-aged drinkers.<sup>11,12</sup> The current Preventure Study is a fourth randomized controlled trial evaluating a school-based, personality-targeted prevention program delivered to younger secondary school students (mean age, 14 years) who for the most part had not yet initiated substance use. The 6- and 12-month drinking outcomes of the first wave of this trial were reported by Conrod et al.<sup>15</sup> The study revealed robust effects on drinking rates, drinking quantity, and frequency and growth in drinking as well as a reduction in psychiatric symptoms to which each personality profile was most susceptible.<sup>15,16</sup> The NNTs were as low as 2, suggesting that for every 2 interventions delivered, 1 case of alcohol misuse was prevented. We now report the primary outcomes of the full Preventure Trial, which involved 2 waves of recruitment, randomization, and assessment of illicit substance use at 6, 12, 18, and 24 months after intervention to provide the necessary statistical power to detect moderate intervention effects on illicit drug behaviors that have a lower prevalence and later onset relative to alcohol use. The current investigation, involving the full Preventure Trial sample of 732 high-risk adolescents randomized to receive a 2-session personality-targeted group intervention or the standard school drug education curriculum, examines the effects of personality-targeted interventions on survival as a non-drug user over a 2-year period and the effects on frequency measures of drug use. We hypothesized that the intervention would significantly extend the time to onset of drug use, that certain personality variables would be more strongly associated with drug use onset (impulsivity specifically), and that stronger intervention effects would be shown for individuals with those personality traits associated with faster progression to drug use.

## METHODS

### PARTICIPANTS AND PROCEDURE

Twenty-four state-administered secondary schools in London, United Kingdom, were recruited to participate in this study, in which students attending years 9 to 11 (aged 13-16 years; median age, 14 years) were surveyed during class time. Secondary schools in 11 of the 33 London boroughs were sent information on the project. Boroughs were selected based on proximity to the Institute of Psychiatry, King's College London, where the research team was based.

Students were surveyed and invited to participate in personality-targeted interventions if they scored 1 SD above the school mean on 1 of the 4 subscales of the Substance Use Risk Profile Scale<sup>17</sup>: hopelessness, anxiety sensitivity, impulsivity, and sensation seeking. In a minority of cases (<25%), students scored at least 1 SD above the school mean on more than 1 subscale, whereby they were assigned to the personality-targeted intervention for which they showed the most deviance according to z scores. Participation in both the survey and intervention phases of the study was voluntary and required both parental consent and student assent. The randomization procedure involved inviting all interested and eligible youth (who met personality criteria and provided signed parental con-

sent) to an information meeting at which they were guided in reviewing the contents of the consent forms. Principles of voluntary participation, confidentiality, and random assignment were explicitly explained, and then youth were asked to pick a piece of paper from a hat containing either the letter *x* or the letter *y* to specify assignment to the control or intervention conditions in a transparent way.<sup>11</sup>

A total of 732 high-risk students were randomized according to a 1:1 randomization scheme to intervention (*n*=395) or control (*n*=337) conditions. **Figure 1** shows participant eligibility, randomization, and follow-up attrition. Figure 1 also shows that while 85% of the eligible sample volunteered to participate in the interventions, only half provided parental consent. There were no exclusion criteria other than reporting unreliable data (responding inconsistently across the survey or positively to a sham drug item) at baseline assessment and not providing parental consent. Forty-one adolescents provided unreliable data at 1 of the follow-up assessments and were thus excluded from analyses for that time only or had their data imputed for intent-to-treat (ITT) analyses. **Table 1** provides information on personality scores and drug use rates in the overall screened sample, the subset of participants deemed eligible for the trial based on personality criteria, and the smaller subset of participants who volunteered and provided signed parental consent to participate. Independent samples *t* tests and  $\chi^2$  analyses showed that relative to their low-risk counterparts, the adolescents who were selected based on personality criteria reported significantly higher rates of drug use at baseline, confirming the personality selection criteria. While there were small differences between eligible youth who were and were not recruited, there was no evidence of a systematic bias toward recruiting youth with lower risk profiles.

## FOLLOW-UP ASSESSMENTS

Follow-up assessments were conducted in school at 6, 12, 18, and 24 months after intervention by research assistants blind to the treatment condition. When participants could not be reached at school, a questionnaire booklet was mailed to their home and they returned the completed booklet by mail. Book vouchers were offered as incentives for returning the questionnaires. Follow-up rates for 6-, 12-, 18-, and 24-month follow-up assessments were 83%, 73%, 62%, and 53%, respectively. A total of 638 participants (87%) were assessed at least once over the 2-year follow-up period, 510 (80%) were assessed at least twice, and 396 (62%) were assessed at least 3 times after intervention. Survival data (drug use uptake) were available for 81% of the baseline non-drug using sample because drug use was most often initiated prior to the adolescent becoming unavailable for follow-up.

## MEASURES

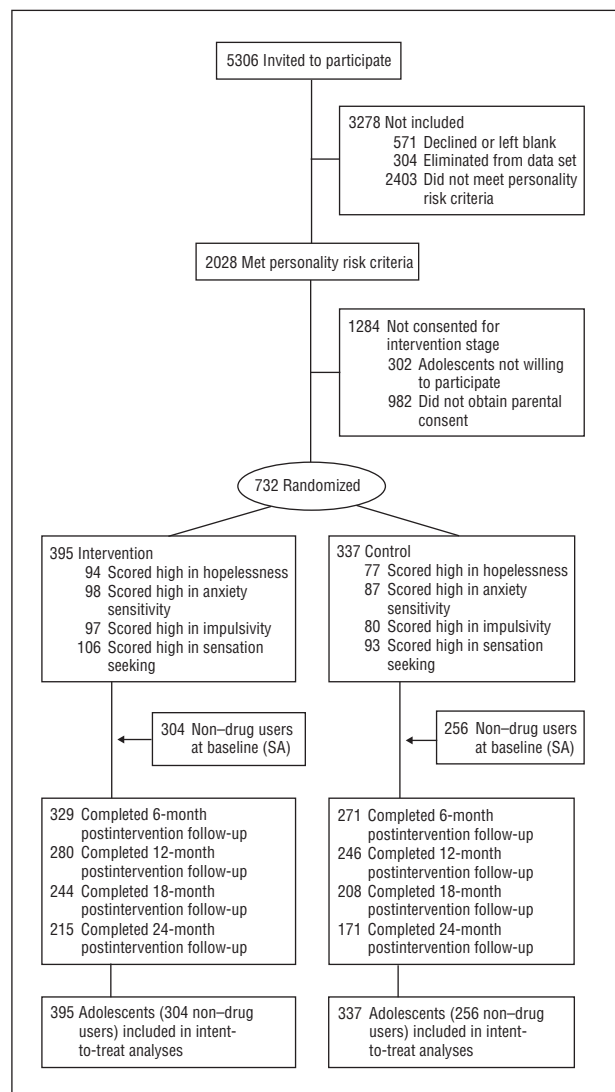
The following measures were all included in baseline and follow-up assessments.

### Demographic Characteristics

Using a questionnaire similar to one used by Stewart and Devine<sup>18</sup> and by Conrod et al,<sup>11,15</sup> adolescents were asked to provide information on sex, age, grade, and ethnicity using a forced-choice answering procedure.

### Personality Risk

The Substance Use Risk Profile Scale<sup>17</sup> is a 23-item questionnaire that assesses levels of several personality risk factors for



**Figure 1.** Participant eligibility, randomization, and follow-up procedure. SA indicates survival analysis.

substance abuse or dependence, including hopelessness, anxiety sensitivity, impulsivity, and sensation seeking.<sup>19</sup> This scale has been shown to be sensitive to personality-based individual differences in response to acute alcohol challenge<sup>23</sup> and stress challenge<sup>24</sup> and has been shown to have good concurrent, predictive, and incremental validity (relative to other personality measures) with respect to differentiating individuals prone to reinforcement-specific patterns of drug use.<sup>15,19</sup> In the present sample, each of the subscales appeared to have good internal reliability for short scales, with Cronbach  $\alpha$  coefficients ranging from .67 to .77 ( $\alpha$  = .77 for hopelessness [7 items];  $\alpha$  = .67 for anxiety sensitivity [5 items];  $\alpha$  = .67 for impulsivity [5 items]; and  $\alpha$  = .69 for sensation seeking [6 items]).

### Drug Use

Drug use was assessed using the Reckless Behavior Questionnaire,<sup>25</sup> a 10-item measure that asks participants to report how often they have engaged in various risky behaviors over the past 6 months. Three Reckless Behavior Questionnaire items were used to assess the frequency of illicit drug use ("How many times in the last 6 months have you used marijuana [never to >10 times], cocaine [never to >10 times], and other drugs that are

**Table 1. Drug Use Rates and Personality Scores for Adolescents<sup>a</sup>**

Drug Use or Personality Subscale Score	Sample Surveyed (n=4431) <sup>b</sup>			Eligible Sample (n=2028) <sup>c</sup>	
	Full Sample (n=4431)	Low Risk (n=2403)	Eligible (n=2028)	Declined (n=1296)	Participated (n=732)
Drug use, No. (%)					
Marijuana	714 (16)	<b>288 (12)</b>	<b>432 (21)</b>	272 (21)	160 (22)
Cocaine	85 (2)	<b>24 (1)</b>	<b>68 (3)</b>	<b>52 (4)</b>	<b>16 (2)</b>
Other	214 (5)	<b>72 (3)</b>	<b>142 (7)</b>	91 (7)	51 (7)
Any	799 (18)	<b>312 (13)</b>	<b>477 (24)</b>	311 (24)	166 (23)
Subscale score, mean (SD)					
Hopelessness	13.0 (3.5)	<b>12.1 (2.5)</b>	<b>14.0 (4.1)</b>	14.2 (4.2)	13.9 (4.0)
Anxiety sensitivity	11.5 (2.8)	<b>10.9 (2.1)</b>	<b>12.2 (3.3)</b>	12.1 (3.3)	12.2 (3.2)
Impulsivity	11.8 (2.8)	<b>10.9 (2.1)</b>	<b>12.9 (3.1)</b>	<b>12.7 (3.1)</b>	<b>13.1 (3.0)</b>
Sensation seeking	15.3 (3.4)	<b>14.4 (2.7)</b>	<b>16.4 (3.8)</b>	<b>16.1 (3.9)</b>	<b>16.9 (3.7)</b>

<sup>a</sup> Boldface indicates significant group differences.

<sup>b</sup> Results from  $\chi^2$  analyses of drug use comparing low-risk vs eligible youth were as follows: marijuana,  $\chi^2 = 67.40$ ,  $P < .001$ ; cocaine,  $\chi^2 = 14.63$ ,  $P < .001$ ; other,  $\chi^2 = 55.54$ ,  $P < .001$ ; and any,  $\chi^2 = 77.37$ ,  $P < .001$ . Results from independent samples  $t$  tests on personality measures were as follows: hopelessness,  $t_{4429} = 19.4$ ,  $P < .001$ ; anxiety sensitivity,  $t_{4429} = 15.4$ ,  $P < .001$ ; impulsivity,  $t_{4429} = 24.9$ ,  $P < .001$ ; and sensation seeking,  $t_{4429} = 19.7$ ,  $P < .001$ .

<sup>c</sup> Results from  $\chi^2$  analyses of drug use comparing those who declined participation vs those who participated were as follows: marijuana,  $\chi^2 = 0.21$ ,  $P = .65$ ; cocaine,  $\chi^2 = 4.86$ ,  $P = .03$ ; other,  $\chi^2 = 0.02$ ,  $P = .91$ ; and any,  $\chi^2 = 0.04$ ,  $P = .84$ . Results from independent samples  $t$  tests on personality measures were as follows: hopelessness,  $t_{2026} = 1.4$ ,  $P = .18$ ; anxiety sensitivity,  $t_{2026} = 0.9$ ,  $P = .37$ ; impulsivity,  $t_{2026} = 2.5$ ,  $P = .01$ ; and sensation seeking,  $t_{2026} = 4.2$ ,  $P < .001$ .

not marijuana or cocaine [never to >10 times]?"). The 3 drug-related items were then combined to create a drug use frequency score, dichotomized into yes or no variables, and then added to create a variable of the number of drugs used—a scoring strategy for which there is established validity, particularly with respect to measuring personality-specific aspects of drug use behavior.<sup>26</sup> Finally, we included an additional sham drug item in the Reckless Behavior Questionnaire to detect unreliable self-report. All participants who responded positively on this item were presumed to be overreporting and were excluded from analyses ( $n = 41$ ). Participants responded to all drug-related items in reference to the 6-month period prior to the assessment date. Several studies have found that adolescent self-reports of substance-related symptoms have excellent discriminant validity<sup>27</sup> and predictive validity.<sup>28</sup> This, together with guaranteed confidentiality to participants and the inclusion of the reliability check (sham drug item) in the questionnaire, should contribute to the reliability of these data.

## INTERVENTIONS

The brief interventions, which involved two 90-minute group sessions, were manualized and were carried out at the participants' schools. The manuals incorporated a psychoeducational component, a motivational component, and a cognitive behavioral therapy component and included real-life scenarios shared by high-personality-risk British youth in specifically organized focus groups. The interventions were facilitated by chartered counseling psychologists (MSc in counseling psychology) or experienced special needs teachers (postgraduate diploma in education with specialization) and cofacilitators (masters-level research assistants). The interventions were not intended to change personality. Rather, they were designed with the intention to change how individuals with specific personality risk factors cope with their vulnerability. The first sections of the manual involved guiding participants through a goal-setting exercise to increase motivation for behavior change. Psychoeducational strategies were then used to teach participants about the target personality variable (hopelessness, anxiety sensitivity, impulsivity, or sensation seeking) and associated problematic, personality-specific coping behaviors like avoidance, interpersonal dependence, aggression, risky behaviors, and substance misuse. The adoles-

cents were then introduced to the cognitive behavioral therapy model and guided in breaking down a personal experience according to the cognitive behavioral therapy components of an emotional response. All exercises discussed thoughts, emotions, and behaviors in a personality-specific way. The last section of the manuals encouraged participants to identify and challenge personality-specific cognitive distortions that lead to problematic behaviors. For information on treatment integrity, refer to the articles by Conrod et al.<sup>11,15</sup> Most adolescents assigned to the intervention condition (91%) completed both intervention sessions.

## DATA ANALYSIS

Sample size was calculated to detect a moderate effect on drug use outcomes, assuming that drug use would be prevalent in 20% to 30% of high-risk youth by the 24-month follow-up. For primary continuous outcome measures, analyses of covariance controlling for baseline demographic variables were used to assess intervention effects on the full ITT sample, which included users and nonusers at baseline ( $n = 732$ ). Interactions between intervention and personality group as well as intervention and baseline drug use status were also investigated. Effect sizes were calculated on log-transformed data for time-specific group differences and within-group change from baseline to each follow-up assessment using the Cohen  $d$  formula and standard deviation of baseline scores as the standardizing unit.<sup>29</sup> The ITT analyses included all participants initially randomized to intervention or control conditions, whereby missing information for continuous variables was imputed using a full-information maximum likelihood estimation method (SPSS statistical software version 15; SPSS Inc, Chicago, Illinois). This was considered appropriate because attrition rates were comparable across treatment condition, primary substance use outcomes, and demographic characteristics except sex. The drug frequency score and number of drugs used were log transformed to correct for positive skew.

To evaluate the preventive effect of the intervention on drug use onset, survival analyses were conducted on the full ITT sample of baseline non-drug users ( $n = 560$ ), in which missing cases were censored at the time of final nonmissing follow-up based on the assumption that cases were missing at random.

Logistic models with time as a discrete variable and age, sex, ethnicity, and drinking onset as covariates were used to estimate proportional odds and risk factor coefficients for onset of drug use as recommended by Abbott.<sup>30</sup> In a second step, main effects of personality were examined. Then, individual logistic regression analyses were performed to evaluate effects of the intervention on the probability of a drug use event up until each time point using data from the subsample of baseline non-users who were followed up until onset of drug use or until they were no longer available for follow-up (81%). Odds ratios (ORs) based on logistic regression or survival function models and NNTs based on raw percentages were used as effect size indices for categorical data, with the NNT representing the number of participants needed to be treated in order to prevent 1 additional negative outcome.<sup>31</sup>

## RESULTS

Participants' baseline demographic information by treatment condition is presented in **Table 2**. There were no significant baseline differences revealed between the control and intervention groups. The  $\chi^2$  analyses and analyses of variance showed that attrition from the study did not differ by treatment condition, drug use, or demographic characteristics, except that girls participated in more follow-up interviews than boys ( $\chi^2_4=48.41$ ;  $P<.001$ )—5% of girls and 11% of boys were not followed up at any time during the 2-year follow-up period.

### CONTINUOUS MEASURES OF DRUG USE

The ITT analyses on the drug use frequency composite and number of drugs used repeated over baseline, 6-, 12-, 18-, and 24-month assessments involved a repeated-measures analysis of covariance with intervention condition, personality group, and baseline drug use status as between-subject factors and sex, age, and ethnicity as covariates. The primary analyses of interest were time  $\times$  intervention interactions, which were significant for both drug use measures. **Table 3** shows *F* scores and log-transformed estimated means for drug use frequency and number of drugs used in the past 6 months. Analyses of simple time effects within the intervention and control groups indicated that the intervention group showed a significant decrease in drug use frequency scores from baseline to 6 months ( $P<.001$ ;  $d=0.50$ ) and 24 months ( $P=.001$ ;  $d=0.37$ ) (**Figure 2**) and a significant reduction in the number of drugs used from baseline to 6 months ( $P<.001$ ;  $d=0.67$ ) and 24 months ( $P=.02$ ;  $d=0.60$ ). In contrast, the control group showed no change in the frequency of drug use and significant increases in the number of drugs tried from baseline to 12 months ( $P=.03$ ;  $d=0.60$ ), 18 months ( $P=.02$ ;  $d=0.61$ ), and 24 months ( $P=.049$ ;  $d=0.60$ ). Table 3 also presents significance levels for simple group comparisons and effect size calculations for any significant group differences comparing the intervention and control groups at each time. Small effects of intervention on drug use measures were revealed at each follow-up. Three- and four-way interaction effects were not significant, suggesting that the interventions were not differentially effective for specific

**Table 2. Demographic Characteristics by Treatment Condition<sup>a</sup>**

Characteristic	Participants, No. (%)	
	Intervention (n=376)	Control (n=315)
Age, y		
13	93 (25)	82 (26)
14	193 (51)	153 (49)
15	88 (23)	79 (25)
16	2 (1)	1 (0)
Female (n=471)	249 (66)	222 (71)
In secondary school year 9 (n=394)	226 (60)	168 (53)
Ethnicity		
White (n=277)	153 (41)	124 (39)
South Asian (n=69)	37 (10)	32 (10)
Afro-Caribbean (n=208)	113 (30)	95 (30)
Mixed (n=80)	45 (12)	35 (11)
Other (n=57)	28 (8)	29 (9)
Substance use		
Marijuana	81 (22)	64 (20)
Cocaine	9 (2)	5 (2)
Other	25 (7)	17 (5)
Any	82 (22)	68 (22)
Alcohol	215 (57)	163 (52)

<sup>a</sup>No significant group differences were found for any of the measures at baseline.

personality types or for those who had already initiated drug use at baseline.

### SURVIVAL ANALYSIS

#### Marijuana Use

We used ITT logistic regression to estimate the effect of the intervention on the probability of a marijuana use event up to the 24-month follow-up period. Results indicated that over and above the effect of demographic variables and baseline drinking status ( $\beta=0.9$ ; robust SE=0.2;  $P=.001$ ; OR=2.5; 95% confidence interval [CI], 1.7-3.7), the intervention was associated with a nonsignificant trend for reduced odds of taking up marijuana use ( $\beta=-0.3$ ; robust SE=0.2;  $P=.09$ ; OR=0.7; 95% CI, 0.5-1.0). The second step revealed a main effect of impulsive personality on marijuana use uptake ( $\beta=0.3$ ; robust SE=0.1;  $P=.002$ ; OR=1.3; 95% CI, 1.1-1.6). Then, logistic regression analyses on onset of marijuana use by each follow-up period were conducted to investigate time-specific effects of the intervention. Analyses including the same covariates as earlier indicated nonsignificant trends for intervention effects on marijuana use uptake at 18 months ( $\beta=-0.3$ ; SE=0.2;  $P=.12$ ) and 24 months ( $\beta=-0.3$ ; SE=0.2;  $P=.12$ ) (**Table 4**). The NNT calculations on rates of marijuana use uptake by the final 24-month follow-up indicated that for every 18 adolescents who took part in an intervention, 1 case of marijuana use was prevented.

#### Cocaine Use

The effect of intervention on the probability of a cocaine use event over the 24-month period was inves-

**Table 3. Log-Transformed Changes in Drug Use From Baseline to 6, 12, 18, and 24 Months After Intervention<sup>a</sup>**

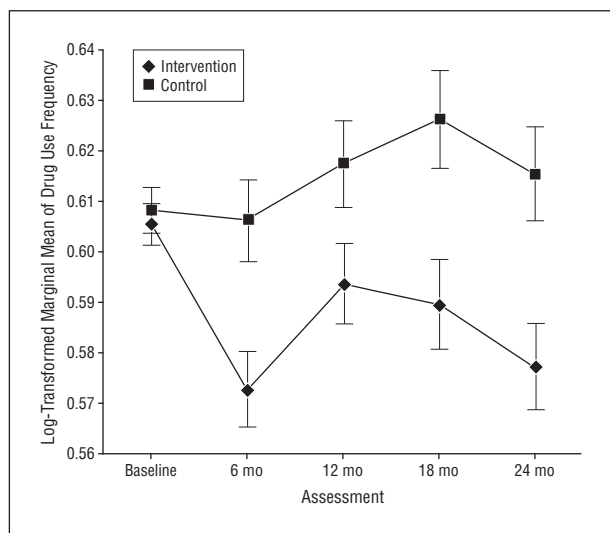
Drug Use	Log-Transformed Change, Mean (SD)					Time × Intervention		Effect of Time Within Group	
	Baseline	6 mo	12 mo	18 mo	24 mo	F Score	P Value	F Score	P Value
Frequency						$F_{4,669} = 2.86$	<.05		
Intervention (n=376)	0.61 (0.08)	0.57 (0.14) <sup>b,c</sup>	0.59 (0.16) <sup>d</sup>	0.59 (0.17) <sup>b</sup>	0.58 (0.16) <sup>b,c</sup>			$F_{4,362} = 1.82$	.13
Control (n=315)	0.61 (0.07)	0.61 (0.14) <sup>b</sup>	0.62 (0.16) <sup>d</sup>	0.63 (0.18) <sup>b</sup>	0.62 (0.16) <sup>b</sup>			$F_{4,301} = 0.43$	.78
Cohen <i>d</i>		0.29	0.19	0.23	0.25				
No. of drugs used						$F_{4,669} = 3.84$	<.01		
Intervention (n=376)	0.18 (0.06) <sup>d</sup>	0.14 (0.19) <sup>c</sup>	0.17 (0.19) <sup>d</sup>	0.17 (0.23)	0.16 (0.23) <sup>c,d</sup>			$F_{4,362} = 2.74$	.03
Control (n=315)	0.17 (0.05) <sup>d</sup>	0.17 (0.20)	0.20 (0.20) <sup>c,d</sup>	0.20 (0.25) <sup>c</sup>	0.20 (0.23) <sup>c,d</sup>			$F_{4,301} = 0.48$	.75
Cohen <i>d</i>	0.18		0.16		0.18				

<sup>a</sup>The means (SDs) are log-transformed total scores, which were estimated with demographic variables (sex, age, and ethnicity). All effects (*F* scores, Cohen *d* values, and *P* values) were calculated on log-transformed variables. In covariate analysis, a significant main effect for ethnicity was found for both drug use frequency ( $F_{1,672} = 9.68$ ;  $P < .01$ ) and number of drugs used ( $F_{1,672} = 18.77$ ;  $P < .001$ ) and a significant time × ethnicity interaction was found for both drug use frequency ( $F_{4,669} = 4.91$ ;  $P < .01$ ) and number of drugs used ( $F_{4,669} = 5.30$ ;  $P < .001$ ), indicating that white adolescents showed increased drug use at baseline and increasing drug use scores across time. Significant time × baseline drug use interactions for drug use frequency ( $F_{4,669} = 43.23$ ;  $P < .001$ ) and number of drugs used ( $F_{4,669} = 58.15$ ;  $P < .001$ ) indicated that adolescents who reported drug use at baseline showed elevated drug use scores across time and that non-drug users at baseline showed increasing scores over time.

<sup>b</sup>Group difference significant at  $P < .01$ .

<sup>c</sup>Change from the baseline score was significant at  $P < .05$ .

<sup>d</sup>Group difference significant at  $P < .05$ .



**Figure 2.** Illicit drug use frequency scores in adolescents randomized to control or intervention conditions.

tigated with survival analysis using logistic regression models in the full ITT sample. Results indicated a significant effect of age ( $\beta = 0.5$ ; robust SE=0.2;  $P = .03$ ; OR=1.6; 95% CI, 1.0-2.6), being male ( $\beta = 1.0$ ; robust SE=0.4;  $P = .005$ ; OR=2.8; 95% CI, 1.3-5.7), and intervention ( $\beta = -1.4$ ; robust SE=0.4;  $P < .001$ ; OR=0.2; 95% CI, 0.1-0.5) on probability of a cocaine use event over this period. Again, impulsivity scores were shown to be significantly related to shorter time to onset of cocaine use in the second step of the analysis ( $\beta = 0.4$ ; robust SE=0.2;  $P = .02$ ; OR=1.5; 95% CI, 1.1-2.1). Time-specific logistic regression analyses (Table 4) indicated significant intervention effects on cocaine use uptake at 6 months ( $\beta = -1.6$ ; SE=0.7;  $P = .001$ ), 12 months ( $\beta = -1.6$ ; SE=0.5;  $P = .001$ ), 18 months ( $\beta = -1.6$ ; SE=0.5;  $P = .001$ ), and 24 months ( $\beta = -1.4$ ; SE=0.4;  $P < .001$ ). The NNT indicated that for every 10

interventions provided, 1 case of cocaine use was prevented over the 24-month period.

### Other Drug Use

Survival analyses using logistic regression models indicated that the probability of an event of other drug use was significantly associated with drinking status ( $\beta = 0.7$ ; robust SE=0.4;  $P = .047$ ; OR=2.0; 95% CI, 1.0-4.1) and intervention ( $\beta = -0.7$ ; robust SE=0.3;  $P = .03$ ; OR=0.5; 95% CI, 0.3-0.9). The second step in this analysis showed that impulsivity scores were related to outcome ( $\beta = 0.3$ ; robust SE=0.2;  $P = .05$ ; OR=1.4; 95% CI, 1.0-1.9). Logistic regression analyses revealed significant intervention effects on other drug use at 12 months ( $\beta = -0.6$ ; SE=0.4;  $P = .06$ ), 18 months ( $\beta = -0.6$ ; SE=0.3;  $P = .03$ ), and 24 months ( $\beta = -0.6$ ; SE=0.3;  $P = .03$ ). The NNT for other drug use over the 24-month period was 16.

### COMMENT

This study is the first of its kind to demonstrate that brief school-based targeted interventions can prolong survival as a non-drug user over a 2-year period. The success of this program is likely due to its selective nature in that only high-risk youth with known personal risk factors for early-onset substance use were targeted. This selective approach allowed us to deliver interventions that were brief, personally relevant, and focused on risk factors directly related to the individual's risk for substance use. As such, the personality-targeted interventions were found to be effective in preventing escalation in the frequency of drug use and preventing experimentation with new illicit substances over a 24-month period relative to a no-intervention control condition. The ORs representing the effect of the intervention probability of drug use events over the

**Table 4. Time-Specific Intervention Effects on the Percentage of Adolescents Reporting Drug Use (Nonsurvival)<sup>a</sup>**

Drug Use	6 mo	12 mo	18 mo	24 mo
Marijuana				
Intervention	19.0	24.7	26.2	29.7
Control	17.2	26.0	31.2 <sup>b</sup>	35.3 <sup>b</sup>
OR (95% CI)	1.1 (0.6-1.8)	0.9 (0.6-1.4)	0.7 (0.5-1.1)	0.7 (0.5-1.1)
Cocaine				
Intervention	1.2	2.4	2.8	4.0
Control	5.9 <sup>c</sup>	10.3 <sup>c</sup>	10.2 <sup>c</sup>	13.5 <sup>c</sup>
OR (95% CI)	0.2 (0.05-0.7)	0.2 (0.1-0.5)	0.2 (0.1-0.5)	0.2 (0.1-0.5)
Other drugs				
Intervention	4.1	6.9	7.7	10.0
Control	6.1	11.8 <sup>b</sup>	13.2 <sup>c</sup>	16.4 <sup>c</sup>
OR (95% CI)	0.7 (0.3-1.5)	0.5 (0.3-1.0)	0.5 (0.3-0.9)	0.5 (0.3-0.9)

Abbreviations: CI, confidence interval; OR, odds ratio.

<sup>a</sup>Values for the intervention and control groups are reported as the percentage of adolescents. Intervention effects on drug use status were assessed using logistic regression analyses including sex, age, ethnicity, and drinking status at baseline as covariates. The ORs indicate the odds of reporting a drug use event at that time in the intervention group relative to the odds in the control condition, controlling for baseline covariates. An OR of 0.2 indicates 80% reduction in cocaine use rates in the intervention condition, and an OR of 0.5 indicates 50% reduction in other drug use in the intervention condition.

<sup>b</sup> $P < .10$ .

<sup>c</sup> $P < .05$ .

2-year follow-up were very similar to 1-year outcomes from the most well-established, more intensive, universal school-based drug prevention programs.<sup>9</sup> However, the NNT indices suggest that the approach may be more efficient in producing these effects in that fewer and briefer interventions can be delivered to a subsample of high-risk youth, requiring that only half to one-third the number of students be targeted to prevent a case of drug use (NNT = 10-18).

While another promising approach in targeted drug prevention is brief motivational interviewing with young drug users,<sup>32-35</sup> there is some evidence that this latter approach may be more effective for heavier users<sup>35</sup> and is likely limited in its ability to produce primary prevention of onset or escalation to frequent use such as is demonstrated here for the personality-targeted approach. An important advantage of the personality-targeted approach is that high-risk youth can be selected and targeted before they have initiated substance use, and they can be assisted in preventing onset and escalation to regular and problematic use by managing early behavioral risk profiles. The fact that some of the intervention effects reported in this study were delayed until 18- and 24-month outcomes (ie, marijuana and other drug use) lends support for this interpretation.

#### STRENGTH OF THE EVIDENCE

The current study represents the fourth reported randomized controlled trial in which personality-targeted interventions were shown to be more effective than no-intervention control<sup>11,15</sup> or placebo control<sup>10,12</sup> conditions in preventing or reducing substance-related behavior. These findings have been reported by 2 independent research groups and involve large samples of youth ranging across a variety of demographic variables in different countries; taken together, they indicate real substantial benefit from the personality-targeted approach for youth drinking behavior.<sup>36,37</sup> The current re-

sults also provide, to our knowledge for the first time, promising evidence in favor of the efficacy of this intervention approach for preventing onset and escalation of illicit drug use.

The small effect of the intervention with respect to preventing marijuana use might be related to the fact that adolescents tend to underplay the risks associated with marijuana use relative to use of other drugs<sup>3</sup>; also, it might imply that a drug education component should be added to this targeted intervention approach to additionally address problematic drug attitudes toward this relatively normative behavior. However, all adolescents in this trial were exposed to substantial drug education through the UK standard curriculum and additional boroughwide Drug Education Services, which suggests that future efforts to combine drug education with interventions targeting individual risk factors should consider a more integrated approach in which drug education is also delivered in a personality-targeted way.

#### LIMITATIONS

This trial did not include a placebo control condition, which would have strengthened the methodological quality of the trial as the intervention was evaluated only relative to a treatment-as-usual control group where all youth are exposed to some form of drug education and generic coping skills information through the standard school curriculum. Two previous placebo-controlled trials involving adult participants showed that personality-targeted interventions result in significantly greater reduction in alcohol and drug use relative to 2 active psychotherapy placebo conditions<sup>10</sup> and relative to 2 non-therapeutic group sessions.<sup>12</sup> Furthermore, despite their prevalence, very few alternative intervention programs have been shown to be effective in preventing substance-related behaviors in youth. This suggests that there is little evidence for a placebo effect on adolescent drug-related behavior produced by adolescents attending generic group sessions.<sup>9</sup>

Another problematic feature of the study was the high rate of attrition, which happened in 2 stages: (1) when parents were asked to actively consent to their child's participation in the trial, and (2) when children were followed up for 2 years after intervention. However, data presented in Table 1 on how the ITT sample differed from all eligible participants showed that there was no systematic bias present in the recruited sample relative to the eligible sample. Furthermore, trial outcomes were evaluated using ITT and non-ITT samples involving at least 3 different ways of managing missing information, including survival analysis, which optimizes the use of all available data (81% in this study). Results were consistent regardless of the method used to evaluate the intervention effect or to manage missing data, suggesting that study attrition did not have a significant effect on the results of this trial.

### FUTURE DIRECTIONS AND CLINICAL IMPLICATIONS

The next steps in further establishing the validity of this intervention approach will be the exploration of treatment utility and effectiveness. The majority (85%) of adolescents identified as eligible for inclusion in this trial volunteered to participate in the intervention sessions, suggesting that the program could be easily adopted by schools if appropriate training and resources were made available. One trial that is currently under way, entitled *Adventure*, will examine the efficacy of personality-targeted interventions when delivered by educational staff and school counselors and involving an opt-out consenting procedure for parents; it will begin to explore more sustainable strategies for implementing this school-based program. Additionally, study of the mechanisms by which this benefit is conferred will enable further refinement of this procedure. Furthermore, it might be worthwhile to investigate whether different selection cut-offs for establishing personality risk will result in more sensitivity with respect to identifying current and future substance users and perhaps those most likely to respond to the intervention. Finally, Castellanos and Conrod<sup>16</sup> previously showed that personality-targeted interventions are effective in reducing psychiatric symptoms to which each personality risk group is most susceptible. It will be important to examine the extent to which interventions targeting younger children with these personality risk factors could also lead to prevention of other mental health problems.

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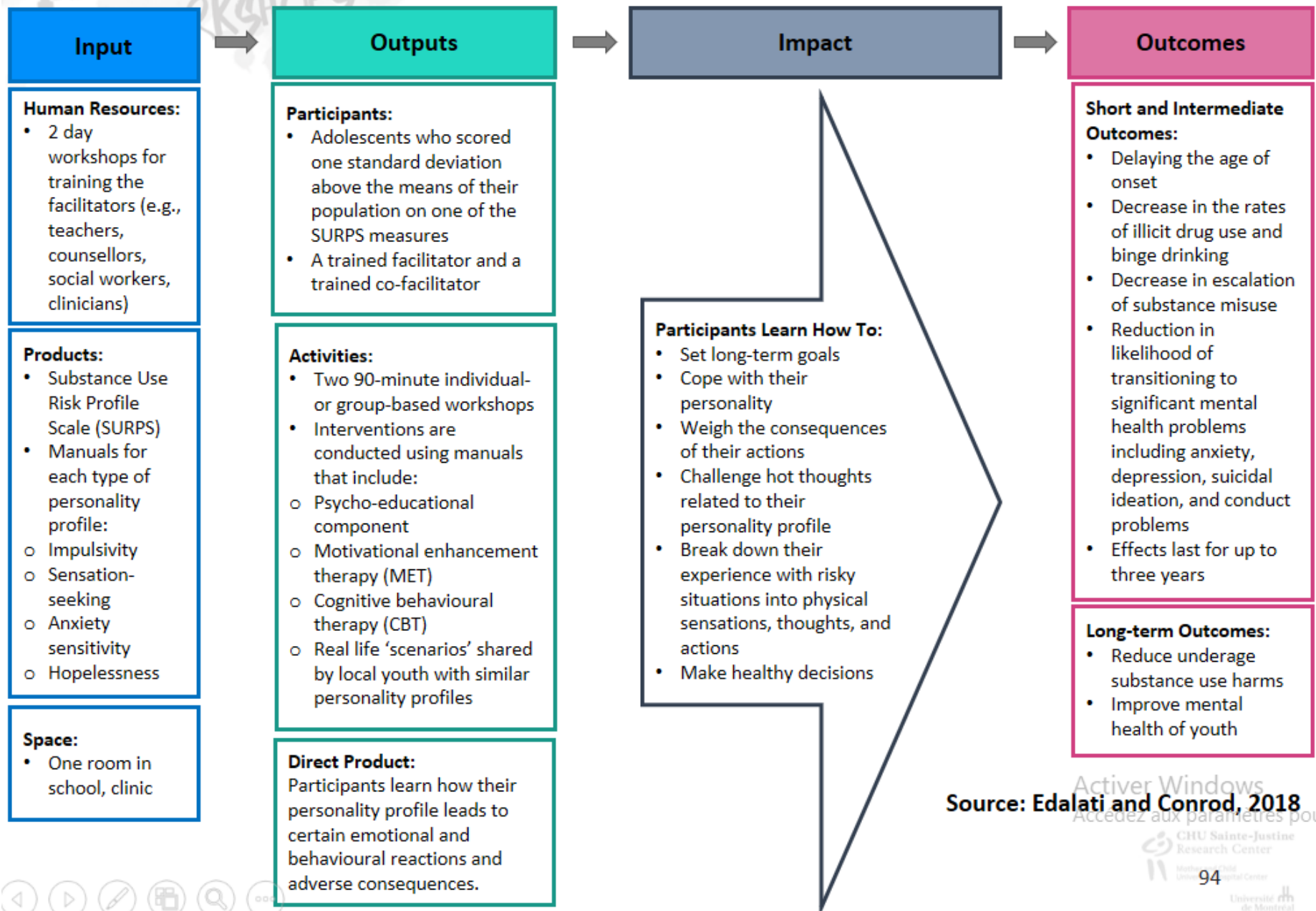
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# Logic Model for Preventure Programme



Source: Edalati and Conrod, 2018

## Brief interventions targeting personality risk factors for adolescent substance misuse reduce depression, panic and risk-taking behaviours

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### Abstract

*Background:* Personality-targeted cognitive-behavioural interventions have been proven to be effective in reducing alcohol-related behaviours in adolescents.

*Aims:* As these interventions target personality traits linked to risk for non-addictive psychopathology, the aim of this study is to examine the extent to which this approach can also prevent the onset or reduce relevant psychological problems in youth.

*Method:* Participants aged 13–16 years ( $n = 423$ ) were randomly assigned to either a personality matched cognitive-behavioural intervention or a no-intervention control. The personality matched interventions targeted four personality risk factors: negative thinking (NT), anxiety sensitivity (AS), impulsivity (IMP), and sensation seeking (SS).

*Results:* Baseline and follow-up data were obtained on depression scores, panic attacks, and reckless behaviour. Results showed a moderate effect of the NT intervention on depression scores, and a similar effect of the AS intervention on panic attack and truancy (i.e., school avoidance). A small but significant intervention effect was found for shoplifting for the entire sample, as well as a moderate intervention effect on this outcome for the IMP intervention group.

*Conclusions:* These intervention effects indicate that personality-targeted interventions designed to prevent alcohol misuse, can concurrently reduce other relevant psychological problems in youth.

**Keywords:** *Adolescents, cognitive behavioural interventions, prevention, personality, panic attacks, depression, reckless behaviour, truancy, substance abuse*

### Introduction

The comorbidity between substance use disorders (SUDs) and other mental disorders is well recognized. In adolescence, such comorbid disorders include depression, anxiety and post-traumatic stress disorders, conduct disorder, and psychosis (Zeitlin, 1999). Through varied research, causal links among disorders have been found, but overall agreement among researchers about the true nature of these causal links is still elusive. Currently, the relationship between SUDs and other psychiatric disorders can be

explained mainly by four different theoretical models. These models are clearly defined in a recent review of dual-focused cognitive-behavioural treatments for comorbid substance use and psychiatric disorders (Conrod & Stewart, 2005). In one model, SUDs and psychiatric disorders are understood as being related through a third or underlying variable. This model suggests that treatment should target this underlying factor in order for it to be effective. There is growing empirical support for this type of model, especially one suggesting personality risk as the common or underlying variable (Caspi et al., 1998; Mueser et al., 1998). In their review, Conrod and Stewart (2005) argued that early interventions targeting personality risk factors for co-occurring SUDs and mental disorders could avoid complications related to comorbidity at later stages of each of the disorders and thus have the potential to have large effects on both sets of symptoms.

This study intends to test the extent to which a novel intervention approach, which has proven to be effective in reducing substance misuse (Conrod et al., 2006; Conrod & Castellanos, 2005), can also prevent the onset or reduce a variety of relevant psychological problems. Conrod et al. (2006), recently reported the results of a randomized controlled trial testing the efficacy of cognitive-behavioural interventions targeting three different personality risk factors for alcohol misuse: anxiety sensitivity (AS), negative thinking (NT), and sensation seeking (SS). In a sample of Canadian high-school students, moderate intervention effects were found on binge drinking, and quantity and frequency of drinking at four-month post-treatment (for comprehensive results on all drinking outcomes, please refer to Conrod et al., 2006). Conrod and Castellanos (2005) recently replicated these effects on drinking behaviour in a younger sample of British high-school students and extended the effect to a fourth personality risk group, namely, an impulsive (IMP) group. Both studies found robust personality by intervention interaction effects indicating that the personality-targeted intervention had effects on individual drinking outcomes, and the effects were specific to the drinking outcomes to which each personality group was most susceptible. For example, SS youth were particularly prone to binge drinking and both studies found that the SS interventions were especially effective in reducing binge drinking rates.

Although these interventions were initially devised to prevent alcohol misuse, they target personality factors that are relevant to other psychological problems that commonly co-occur with alcohol misuse. AS is associated with risk for panic disorder (Maller & Reiss, 1992), NT is an identified risk factor for depression (Joiner, 2000), and IMP and SS have been implicated in antisocial and thrill-seeking behaviour (Arnett, 1994; Zuckerman, 1994). Therefore, it is very likely these interventions will also prove to be effective in preventing or intervening early with a variety of related psychological symptoms.

In addition to examining overall intervention effects on emotional and behavioural outcomes, we were interested in testing several *a priori* hypotheses. Because each of the interventions targeted personality risk factors for specific forms of comorbid psychological disorders, we expected each intervention to have specific effects on only certain symptom clusters. *A priori* hypotheses included the following: relative to their no-intervention, high personality risk counterparts: (i) the NT students who received the NT intervention would have lower depression scores at follow-up, (ii) the AS students who received the AS intervention would report fewer panic attacks at follow-up; and (iii) the IMP and SS students who received personality-matched interventions would report fewer antisocial and risk-taking behaviours at follow-up.

## Method

### *Participants*

Twelve secondary schools in London were recruited to participate in this study, in which students from years 9 to 11 (aged 13–16) were surveyed during class time. Students were invited to participate in personality-targeted interventions if they scored at least one standard deviation (SD) above the school mean on any one of four personality risk subscales of the Substance Use Risk Profile Scale (SURPS; Conrod & Woicik, 2002): NT, AS, IMP and SS. Because we were interested in preventing the onset of psychiatric symptoms, selection was determined based on a statistical rationale and not clinical cut-offs or psychiatric diagnoses. When participants demonstrated statistically deviant scores on more than one scale, z-scores were used to determine on which dimensions they were most deviant. Although multiple personality-risk elevations were common in high risk students, we did not target more than one personality risk at a time.

Participation in the intervention phase of our study was voluntary. Only those students who had indicated interest in participating in the programme when they completed the survey were invited to take part. The percentage of eligible students who indicated interest in participating in the intervention was 79%. However, only 51% of these eligible and willing students provided parental consent to participate in the next phase of the study.

In total, the intervention phase of the study involved 103 NT adolescents, 108 AS adolescents, 96 SS adolescents and 116 IMP adolescents, of whom 224 were randomly assigned to participate in the relevant personality-targeted intervention, and 199 to participate in the no-intervention control groups. Of those randomized to the intervention groups, 92% attended both intervention sessions and 83% ( $n = 351$ ) were assessed 6 months post-treatment. Intent to treat (ITT) analyses were conducted on all those assigned to treatment, including those who did not complete treatment and who were not available for assessment at follow-up.

### *Consent*

This study was approved by the Joint South London and Maudsley and the Institute of Psychiatry NHS Research Ethics Committee. Parents provided passive consent for their child's participation in the screening by responding to letters asking parents to contact experimenters if they *did not* wish their child to participate. On the day of screening, students were debriefed on the study protocol, which included information on the confidential and voluntary nature of their participation in the study. For the intervention phase of the study, parents provided active informed consent and students themselves provided written assent.

### *Measures*

Initial and six-month post-intervention surveys included personality, emotional, and behavioural symptom inventories that were identical across the two assessments. A total of 2776 students completed the initial assessment questionnaires and only those randomly assigned to the experimental or control intervention completed the six-month post-treatment questionnaires.

*Personality risk.* The Substance Use Risk Profile Scale (SURPS; Conrod & Woicik, 2002) assesses variation in personality risk for substance abuse/dependence and psychopathology along four dimensions: NT, AS, SS, and IMP. The SURPS subscales are designed to have

non-overlapping items to aid in discriminating personality dimensions which are normally highly correlated (e.g., the 7-item SURPS NT subscale assesses NT independent of AS). In the present sample, each of the subscales appeared to have good internal reliability for short scales, with Cronbach alpha coefficients ranging from .66–.76 ( $\alpha = .76$  for NT,  $\alpha = .67$  for AS,  $\alpha = .68$  for IMP, and  $\alpha = .66$  for SS). Previous research on this scale has shown that the scales have good convergent and discriminant validity and adequate two-month test-retest reliability (Conrod & Woicik, 2002).

*Demographics.* A questionnaire assessing demographic information (similar to one used by Stewart & Devine, 2000) asked participants to provide their age, gender, current grade level in school, and their ethnicity according to a forced-choice answering procedure.

*Panic attacks.* The revised Panic Attack Questionnaire (PAQ-R, Cox, Norton & Swinson, 1992) was included to measure panic attacks during the last 6 months. The PAQ-R asks participants whether they have ever experienced a panic attack (using a definition based on the DSM-IV provided at the top of the questionnaire). If so, participants are asked to indicate how many such attacks they have experienced in the past six months. In the present study, the only PAQ-R dependent measure was a dichotomous coding of this last item (i.e., “occurrence of any panic attack in the past six months” – yes or no); 33% of our sample reported having experienced a panic attack in the last 6 months.

*Depression symptoms.* Depression symptoms were measured using the seven-item Depression Subscale from the Brief Symptom Inventory (BSI), a standardized self-report symptom inventory designed to serve as a screen for depression (Derogatis, 1993). The adolescents rated the level of severity of each symptom in the last 6 months on a scale ranging from 1 (“not at all”) to 5 (“often”). Research indicates that the BSI depression scale is comparable to the Beck Depression Inventory with respect to its accuracy in detecting depression symptoms in adolescents (Sahin et al., 2002). In the current study, the internal consistency (Cronbach’s  $\alpha$ ) for the depression subscale was .89.

*Reckless behaviour.* The Reckless Behaviour Questionnaire (RBQ) is a 10-item measure that asks respondents to report how often they engaged in risky behaviour in the past six months (Shaw et al., 1992). The RBQ includes items on drug-taking, reckless driving, risky sex, and antisocial behaviour. Internal consistency (Cronbach’s  $\alpha$ ) for the RBQ was .77 in the current sample. In the present study, only the items on sexual behaviour (2), vandalism (1), and shoplifting (1) were examined as outcomes. The items pertaining to drug-taking (3) are examined elsewhere (Conrod & Castellanos, 2005). The three items on reckless driving were not included because the young age and urban nature of our sample yielded base rates of zero for these items. One item on truancy was added to the survey, which asked participants “how many days of school did they miss, without permission, last term”. Although all items were answered using a five-point scale, variables were dichotomously coded for analyses (i.e., present or absent in the last six months/last term), due to the low variability in responses to these questions.

*Brief intervention.* All interventions were provided by qualified youth workers or counsellors, and a co-facilitator (a Masters level research assistant). Each intervention involved two 90-minute sessions and the number of students per group ranged from 2 to 9.

The NT, AS, IMP, and SS manuals were first designed for Canadian youth (Conrod et al., 2006), but were adapted for a UK sample by including “scenarios” or real life

experiences shared by high personality risk UK youth in specifically organised focus groups (Conrod et al., 2004a,b,c,d).

The interventions included three main components: (a) a psycho-educational component, (b) a motivational intervention component, and (c) a cognitive-behavioural coping skills training component. The psycho-educational component first educated students about the personality variable in question and the problematic coping behaviours associated with that personality style. This was followed by a motivational exercise (weighing the short and long-term positive and negative consequences of a particular behaviour) around the use of problematic behavioural strategies for coping with that particular personality dimension.

The cognitive-behavioural coping skills training involved learning how to identify and challenge personality-specific cognitive distortions taken from previously developed cognitive restructuring interventions for individuals fearful of anxiety (Barlow & Craske, 1988; Conrod et al., 2000), for sensation-seeking individuals (Conrod et al., 2000; Conrod et al., 2006), for depressed individuals (Barlow, 1985; Conrod et al., 2000), and impulsive individuals (Kendall & Braswell, 1985) in the case of the AS, SS, NT and IMP interventions, respectively. In the AS intervention students learned how to better manage their anxiety by challenging thinking errors related to catastrophic cognitions that could lead to avoidance behaviours (e.g., skipping school, drinking) and interpersonal dependence. Although we do not know of any quantitative study indicating a relationship between AS and truancy, qualitative interviews with high AS adolescents revealed that skipping school was a common consequence of anxiety for these youth (Comeau, 2004). Therefore, truancy was directly addressed in the AS intervention manual through an illustrated example of how catastrophic thinking about the pressures at school (in this case giving a presentation), leads to certain problematic coping behaviours like truancy and drinking. In the NT intervention, special emphasis was placed on challenging thinking errors related to internalization, generalization, and negatively-biased cognitions that could lead, for example, to social withdrawal and alcohol misuse and how these coping behaviours, in turn, increase depression. The SS intervention involved challenging cognitive distortions related to reward-seeking and boredom susceptibility, while the IMP intervention focused on aggressive thinking and not thinking things through (i.e., impulsive cognitions). In these latter two interventions, special emphasis was placed on antisocial behaviour: binge-drinking and using fireworks in the SS groups; stealing and reacting aggressively in the IMP group. Truancy was also addressed in the SS and IMP interventions in personality-specific ways. Alcohol and drug use was targeted in all four interventions as a problematic way of coping, but, again, was discussed in a personality-specific context in each of the interventions.

## Results

### *Baseline measures*

The full sample was aged 13–16 years (mean age 14), and came from a variety of ethnic backgrounds (40% white European, 18% black African, 14% black Caribbean, 6% South Asian, 2% East Asian, 20% mixed and other). More than half were girls (64.3%) due to a disproportionate number of girls' schools in one borough.

There were no significant differences between the personality groups or experimental conditions on any of the demographic variables, except for gender; analyses showed that girls were overrepresented in the AS (75.7%) and IMP (77.2%) groups. Analysis of baseline

data revealed no significant differences between the experimental conditions in the whole sample or by personality group on any of the psychological symptom variables. See Table I for baseline and follow-up rates of behaviours by personality group and treatment condition.

#### *Six month follow-up measures*

Attrition rates were comparable across personality groups ( $X^2(6) = 3.90, p < .69$ ) and treatment conditions ( $\chi^2(2) = .79, p < .67$ ).

#### *Statistical analysis*

To conduct intent-to-treat analyses, participants who did not complete the follow-up assessment were assigned outcome scores based on their baseline scores. For non-continuous variables, main effects of intervention and interactions were assessed using Chi-square analyses. Phi was used as an estimate of the effect size from analyses involving dichotomous outcomes and is a chi-square-based statistic that is calculated by first dividing the chi-square statistic by the sample size, and then taking the square root of the result. A value greater than .50 represents a large effect, a value greater than .30 represents a moderate effect, and a value greater than .10 represents a small effect.

Repeated measures analyses of variance (ANOVA) was used for the one continuous variable (i.e., depression scores). Cohen's (1977)  $d$  was used as an estimate of the effect size from ANOVAs and is a number that represents by how many standard deviation units the two groups differ. Values range from 0.80 representing a large effect through to 0.20 representing a small effect, with a value of 0.50 representing a moderate effect (Cohen, 1977).

Finally, on dichotomous measures we also reported number needed to treat (NNT) analyses, which is the number of subjects who need to be treated in order to prevent one additional bad outcome (Laupacis et al., 1988). This index is calculated by taking the reciprocal of the difference in rates of occurrence of the problem in control and experimental groups.

As previously mentioned, in addition to analysing all psychological symptom measures in the entire treatment sample (testing for general intervention and intervention by personality effects), we conducted analyses on symptom measures that were differentially addressed in individual interventions, limited to our *a priori* hypotheses.

#### *Depression scores*

Depression scores in the treatment sample were analysed by using a repeated measures analysis, which did not show intervention or intervention by personality effects on depression scores in the whole treatment sample.

When analyses focused on the NT group only, a trend was revealed for a time by intervention effect ( $F(1,63) = 3.29, p < .07$ ; Figure 1), with the intervention group showing lower depression scores compared to the control group at follow up ( $d = .42$ ). This intervention effect was further confirmed by running a paired sample  $t$ -test of pre and post scores in both the NT groups. Results confirmed that there was a significant reduction in depression scores only in the NT intervention group ( $t(1,35) = 2.55, p < .01$ ;  $p = .82$  for NT controls). In order to establish that this effect was specific to the NT group, we ran a set of 2-way repeated measure analysis on depression scores in each of the other personality groups. Results confirmed that the time by intervention effect was not significant in the AS

Table I. Baseline and follow-up prevalence of psychological symptoms.

	Intervention by Personality																							
	NT				AS				IMP				SS											
	Intervention	Control	NT	AS	AS	Control	AS	Control	AS	Control	IMP	Control	IMP	Control	IMP	Control	SS	Control	SS	Control	SS	Control		
Truancy	% Base	23.3	26.3	20.0 <sup>†</sup>	23.1	34.6	28.6	20.0	17.0	23.1	34.6	28.6	20.0	17.0	23.1	34.6	28.6	20.0	17.0	23.1	34.6	28.6	20.0	17.0
	FU	22.5	20.0	4.7** <sup>†</sup>	21.2**	31.9	34.1	45.7	35.3	25.5	27.9	35.3	45.7	35.3	25.5	27.9	35.3	45.7	35.3	25.5	27.9	35.3	45.7	35.3
Vandalism	% Base	45.2	34.2	17.3	15.0	38.5	51.2	59.2	41.0	39.6	35.9	51.2	59.2	41.0	39.6	35.9	51.2	59.2	41.0	39.6	35.9	51.2	59.2	41.0
	FU	32.5	36.7	23.3	15.2	40.4	50.0	44.4	42.4	34.9	37.1	50.0	44.4	42.4	34.9	37.1	50.0	44.4	42.4	34.9	37.1	50.0	44.4	42.4
Sex without contraception	% Base	11.9	10.5	6.4	15.0	11.5	6.3	12.0	5.0	9.0	7.2	6.3	12.0	5.0	9.0	7.2	6.3	12.0	5.0	9.0	7.2	6.3	12.0	5.0
	FU	2.6	6.7	9.3	6.1	8.5	9.3	11.1	6.1	7.9	7.2	9.3	11.1	6.1	7.9	7.2	9.3	11.1	6.1	7.9	7.2	9.3	11.1	6.1
Sex with someone they don't know well	% Base	15.6	10.8	2.0	7.5	3.8	0.0	10.0	12.5	7.3	7.3	0.0	10.0	12.5	7.3	7.3	0.0	10.0	12.5	7.3	7.3	0.0	10.0	12.5
	FU	7.5	3.3	2.3	6.3	10.6	6.8	13.9	15.2	8.4	7.9	6.8	13.9	15.2	8.4	7.9	6.8	13.9	15.2	8.4	7.9	6.8	13.9	15.2
Shoplifting	% Base	27.8	31.0	22.0	17.5	44.2 <sup>†</sup>	49.0	34.7	22.5	32.7 <sup>†</sup>	31.5	49.0	34.7	22.5	32.7 <sup>†</sup>	31.5	49.0	34.7	22.5	32.7 <sup>†</sup>	31.5	49.0	34.7	22.5
	FU	16.7	17.2	20.0	25.8	26.2** <sup>†</sup>	52.5**	27.8	35.5	24.2** <sup>†</sup>	32.9**	52.5**	27.8	35.5	24.2** <sup>†</sup>	32.9**	52.5**	27.8	35.5	24.2** <sup>†</sup>	32.9**	52.5**	27.8	35.5
Panic attacks	% Base	35.7	42.1	35.7 <sup>†</sup>	48.3	34.0	37.0	24.0	30.8	39.2	39.2	37.0	24.0	30.8	39.2	39.2	37.0	24.0	30.8	39.2	39.2	37.0	24.0	30.8
	6m FU	22.9	26.9	17.5* <sup>†</sup>	35.5*	11.6**	38.5**	27.8	12.9	19.5**	29.1**	38.5**	27.8	12.9	19.5**	29.1**	38.5**	27.8	12.9	19.5**	29.1**	38.5**	27.8	12.9
Depression symptoms	Base mean	16.1 <sup>†</sup>	15.9	16.3	16.5	15.1	16.3	13.8	13.7	15.7	15.7	16.3	13.8	13.7	15.7	15.7	16.3	13.8	13.7	15.7	15.7	16.3	13.8	13.7
	Base SD	8.2	7.9	6.8	5.1	6.4	6.6	5.9	6.2	6.8	6.8	6.6	5.9	6.2	6.8	6.8	6.6	5.9	6.2	6.8	6.8	6.6	5.9	6.2
FU Mean		13.0** <sup>†</sup>	16.3*	15.6	17.4	14.5	16.0	14.2	13.0	15.6	15.6	16.0	14.2	13.0	15.6	15.6	16.0	14.2	13.0	15.6	15.6	16.0	14.2	13.0
	FU SD	7.3	7.9	7.3	7.8	7.6	7.3	6.7	5.8	7.3	7.3	7.3	6.7	5.8	7.3	7.3	7.3	6.7	5.8	7.3	7.3	6.7	5.8	7.3

\*Group difference significant to the level of 0.08. \*\*Group difference significant to the level of 0.05. <sup>†</sup>Change between baseline and follow-up data significant to the level of 0.06 (as measured by paired-sample *t*-test (depression) and McNemar test).

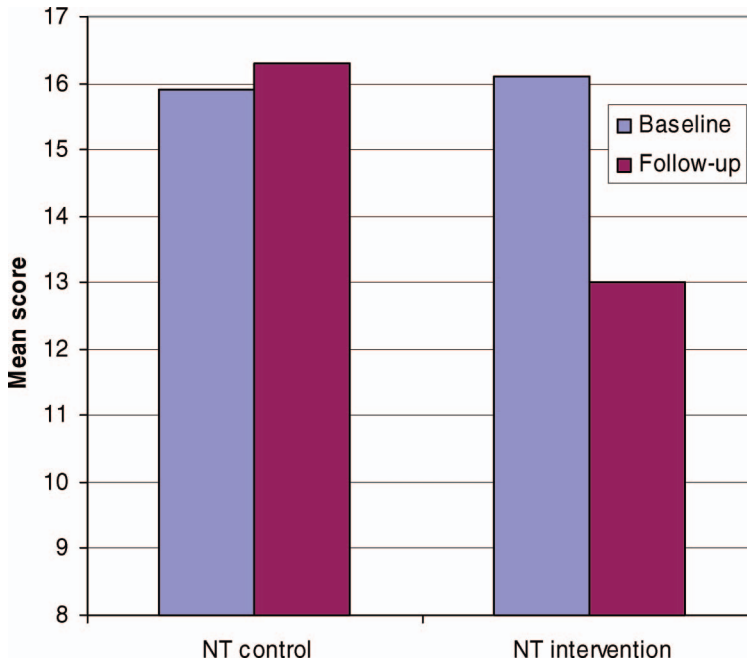


Figure 1. Depression scores in NT students.

group ( $F(1,69) = 1.01, p = .31$ ), the IMP group ( $F(1,81) = 1.04, p = .31$ ), or the SS group ( $F(1,65) = .79, p = .37$ ).

#### Panic attacks

Chi-squared analyses on post-treatment panic attack rates revealed a small but significant overall intervention effect ( $\chi^2(1) = 3.57, p = .04, phi = .11, NNT = 10.4$ ). Chi-squared analyses in each personality group revealed an intervention effect on panic attack rates in the AS group and the IMP group. **In the AS group, the intervention effect was larger but slightly less significant than the effect in the overall sample ( $\chi^2(1) = 3.0, p < .07, phi = .20, NNT = 5.5$ ; Figure 2).** A one-tailed McNemar test for change confirmed a marginally significant reduction of panic attack rates from pre-intervention to follow-up in the AS intervention group only ( $\chi^2(1) = 4.6, p < .06; p = .42$  for AS controls). **A moderate significant intervention effect on panic attack rates was found in the IMP group ( $\chi^2(1) = 7.98, p < .01, phi = .31, NNT = 3.7$ ).** However, one tailed McNemar test showed **no significant changes from pre to post-intervention panic attack rates in the IMP intervention group ( $\chi^2(1) = .44, p = .14; p = 1.0$  controls).** **No intervention effects on panic attack rates at follow-up were found in the NT group ( $\chi^2(1) = .133, p = .47$ ) or the SS group ( $\chi^2(1) = 2.23, p = .12$ ).**

#### Reckless behaviour

Chi-squared analyses were run for dichotomous items on risky sexual behaviour, vandalism, shoplifting and truancy. No intervention effects or intervention by personality effects were found for the risky sexual behaviour and vandalism items at follow-up.

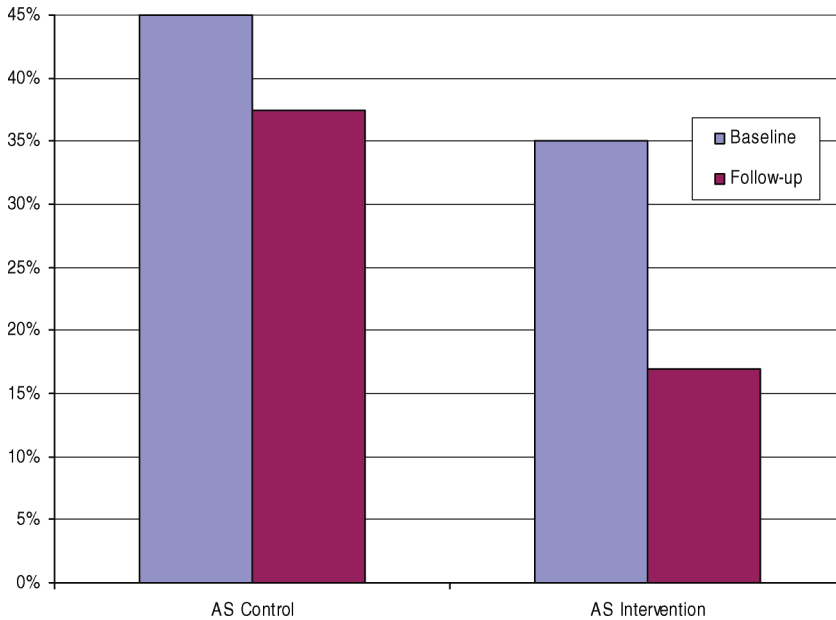


Figure 2. Prevalence of panic attacks in AS students.

An intervention by personality effect was found for the truancy item ( $\chi^2(4) = 18.31, p < .01$ ). Analyses of simple main effects of intervention at each level of personality revealed an intervention effect for the AS group ( $\chi^2(1) = 4.87, p < .03, phi = .24, NNT = 6.0$ ; Figure 3). One tailed McNemar test for change confirmed that there was a significant reduction from pre-intervention to follow-up truancy rates for the AS intervention group only ( $\chi^2(1) = .91, p < .04; p = .62$  for controls). The effect of intervention on follow-up truancy scores was not significant in the NT group ( $\chi^2(1) = .25, p = .42$ ), the IMP group ( $\chi^2(1) = .05, p = .49$ ) or the SS group ( $\chi^2(1) = .71, p = .27$ ).

A significant overall intervention effect was found for the shoplifting item,  $\chi^2(1) = 3.46, p = .05, phi = .10, NNT = 11.4$ . A significant reduction in the proportion of shoplifting from pre-intervention to follow-up was found for the intervention group only as measured by a one-tailed McNemar test for change ( $\chi^2(1) = 20.36, p = .01; p = .32$  for controls). No intervention by personality group interaction was found in the whole sample, but because stealing was specifically targeted in the impulsivity intervention, we ran analyses for shoplifting in the IMP group. We found a significant intervention effect on shoplifting rates at follow-up for the IMP group ( $\chi^2(1) = 5.96, p < .01, phi = .27, NNT = 3.8$ ; Figure 4). A McNemar test for change indicated that, compared to baseline scores, the prevalence of shoplifting decreased significantly in the IMP intervention group only ( $\chi^2(1) = 4.54, p < .05; p = .68$  for controls). No intervention effect on shoplifting rates was found in the NT group ( $\chi^2(1) = .004, p = .60$ ), AS group ( $\chi^2(1) = .33, p = .38$ ), and SS group ( $\chi^2(1) = .46, p = .33$ ).

## Discussion

The aim of this paper was to test the extent to which a personality-targeted intervention approach designed to prevent adolescent alcohol misuse could also reduce or prevent the

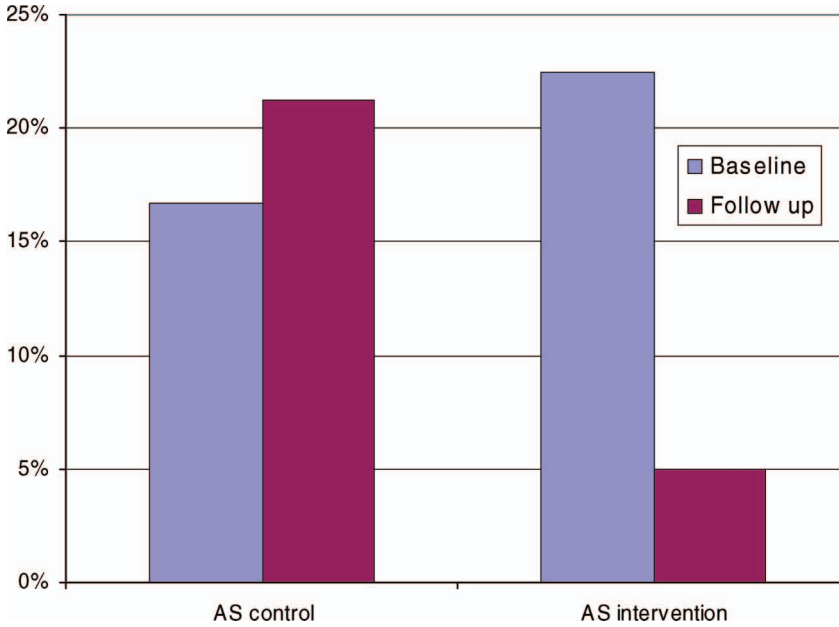


Figure 3. Prevalence of truancy in AS students.

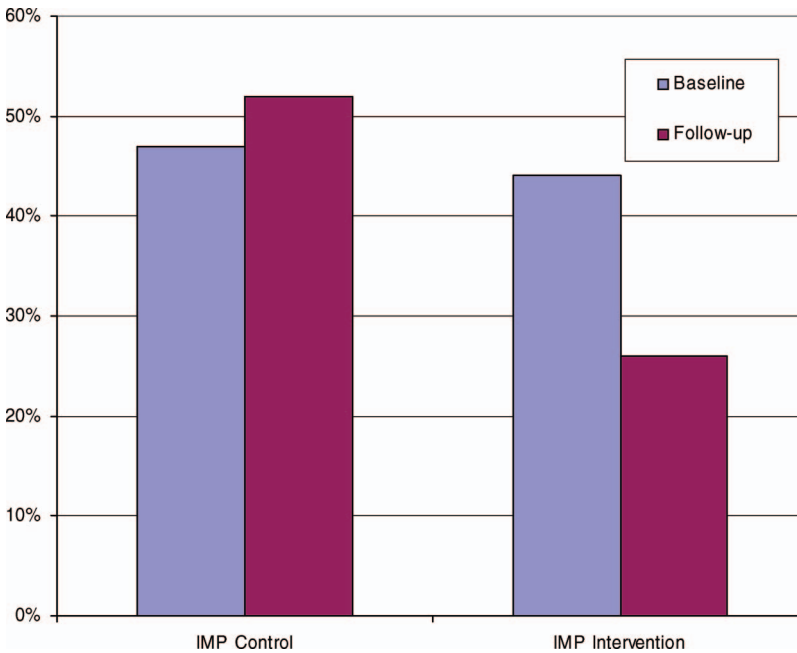


Figure 4. Prevalence of shoplifting in IMP students.

onset of a variety of relevant psychological problems that are commonly comorbid with adolescent alcohol misuse. Our rationale was that, although these interventions were initially devised to prevent alcohol misuse, they were developed based on empirically supported

interventions for childhood and adult psychiatric disorders and may therefore prove efficacious in preventing the onset of these disorders.

In many ways this was achieved. Analyses revealed an overall intervention effect on the prevalence of panic attacks and shoplifting. The effect sizes were small in both cases. But intervention effects became larger when examined in the personality groups most at risk for the target behaviours. A mild-to-moderate intervention effect was found for the AS intervention on prevalence of panic attacks at follow-up. NNT analysis indicated that only five adolescents need to receive the AS intervention in order to prevent one adolescent from experiencing panic anxiety within a six month period. Similarly, a moderate effect was found for the IMP intervention on panic attack rates. Although unexpected, speculatively it is possible that taking part in the IMP intervention contributed to reduced levels of conflict and stress in these students' everyday lives, which in turn reduced their panic anxiety levels. The small intervention effect on shoplifting found in the whole sample, again, became moderate in size when analyses focused on the IMP group. NNT analysis indicated that for every four IMP interventions provided, one case of reported shoplifting was prevented.

Analyses also confirmed our *a priori* hypotheses regarding personality-specific effects in the NT group. Specifically, we found a mild-to-moderate intervention effect on depression scores in the NT group.

In terms of reckless behaviours, aside from the intervention effect on the prevalence of shoplifting, a significant mild-to-moderate intervention effect was found on truancy for the AS group. NNT analyses showed that only six adolescents need to receive the AS intervention in order to prevent one additional case of truancy in this group.

Despite these promising effects on the prevalence of shoplifting and truancy, intervention effects were not found for any of the other reckless behaviours. Also, aside from the large intervention effect obtained on drinking rates reported elsewhere (Conrod & Castellanos, submitted; Conrod et al., 2006), no effects were found on any of the behavioural outcomes for the SS intervention. Previous literature indicates that SS is associated mainly with a propensity to alcohol misuse in the absence of other forms of psychopathology (Conrod et al., 2000). Therefore, our *a priori* hypotheses about the effect of SS interventions on non-substance related behaviours were less clearly defined. It is possible that we did not include the right outcome measures to properly assess change in behaviour in SS individuals. For example, measures that assess the extreme to which youth engage in risky behaviours, rather than just whether they do or not, may reveal more effects in the SS group. It is also possible that because drinking is the most problematic outcome of high SS, the effects of interventions that integrate motivational and cognitive-behavioural techniques will only be limited to the problem areas that are most current and salient to SS individuals (i.e., drinking).

It appears that to some extent effects on outcome behaviours were limited to those behaviours that were directly targeted in the interventions. For example, theft was discussed in the IMP group, whereas risky sexual behaviour and vandalism were not. The IMP intervention was shown to have direct effects on shoplifting behaviour. Truancy was directly targeted in the AS intervention which resulted in significant reductions in truancy rates in this group. However, despite the fact that truancy was discussed in the SS and IMP interventions, no effect of intervention was found on truancy rates in these two groups. This differential effect is interesting because although truancy was discussed in all three interventions, the AS intervention dedicated over six pages of the manual to the discussion of a case that involved contemplating skipping school as a way to avoid anxiety symptoms. In contrast, the IMP and SS interventions only dedicated a page of the manuals to truancy, where skipping school was referred to as an additional example of problematic coping

behaviours but where there was no elaboration on the motivational processes involved in this behaviour for each personality type. These results suggest two things: (i) in order to prevent a specific problematic behaviour, it is important to discuss it explicitly in the intervention, highlighting how this behaviour is a personally relevant, but a problematic, way of coping, and (ii) that even if one problematic behaviour is discussed and prevented, this effect will not necessarily generalize to other similar behaviours that are linked through the same motivational process (e.g., vandalism for the IMP group).

Another possible explanation for the lack of effect of intervention on these other behaviours is their low prevalence in such a young sample (mean age of 14 years). Risky sexual behaviour had a much lower prevalence (~10%) relative to other risky behaviours (~40%) which may mean that the current study was underpowered to detect main and interaction effects on behaviours with a lower prevalence. Similarly, potential *indirect* effects of the intervention on risky behaviours that were not mentioned in the intervention session may also require additional power in order to be detected.

This said, we believe the intervention effects on the emotional and behavioural symptoms described above are sufficiently promising, and illustrate that personality-targeted interventions designed to prevent alcohol misuse, can also effectively prevent other relevant and often comorbid emotional or behavioural problems in youth. While our findings are not novel in terms of demonstrating the preventative efficacy of cognitive-behavioural interventions on depression in youth at risk for depression (Possel et al., 2005), no previously-published study has demonstrated that cognitive-behavioural interventions are effective in preventing anxiety and antisocial symptoms in adolescents showing personality risk for such problems. The second novel, and arguably more exciting, finding is that the interventions concurrently reduce alcohol misuse (Conrod et al., 2006; Conrod & Castellanos, 2005). The success of this brief programme on such a wide variety of problems may be attributable to the fact that it is so targeted with respect to individual and to content of intervention.

Co-morbidity of mental health and addiction is a major challenge to current health systems and the current intervention approach shows much promise with respect to preventing this difficult problem. However, the current study was not without its flaws. It did not examine the efficacy of the personality-targeted approach using a placebo-controlled design. While one previous study with adult substance abusers showed that the personality-targeted approach was more effective than personality-mismatched interventions (i.e., interventions that are theoretically different from participants' motivational/personality profiles) or motivational control interventions (Conrod et al., 2000), future studies may wish to compare the outcome of this targeted approach within a research design that controls for the amount of therapist contact across experimental and control groups. Other limitations are that data were gathered through self-report which is susceptible to bias, and the lack of inclusion of tools to assess clinical outcomes in this study. The BSI depression subscale has been criticised for being non-specific and for measuring general distress rather than depression symptoms (Coyne et al., 2000). Furthermore, Norton et al. (1999) found that the PAQ-R overestimates the number of actual panic attacks, in comparison with those reported in structured interviews. Single-item indicators were used to assess behaviours like vandalism, shoplifting, truancy, and panic attacks, which may not capture the complexity of these behaviours. Unfortunately, due to the range and variety of behaviours and psychological symptoms associated with the personality risk factors of interest, as well as the large sample size needed to detect intervention and interaction effects, longer and more thorough assessment methods could not be used in this study. It will be important to demonstrate that similar intervention effects can be observed on the onset of clinical

disorders, rather than just emotional and behavioural symptoms of such disorders. Finally, it will be important to determine the extent to which changes in psychological symptoms and changes in substance misuse co-vary, and whether change in one cluster of symptoms accounts for changes in another cluster. Such a study would directly feed back to current models of co-morbidity and inform intervention strategies targeted at individuals prone to substance misuse and associated mental health problems.

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## **EBC-S - POLICY ON COVID-RELATED ISSUES**

The School Committee takes note of the COVID-19 emergency; resulting disruption of the traditional school day and year; growing concerns of students, families and the community; and the growing number of issues that will affect public education.

Therefore, the school committee establishes an emergency, interim policy to:

- promote public safety and safety of students and faculty,
- maintain to the extent possible the high and efficient level of educational services,
- ensure support for students in general and in particular for those at highest risk educationally as well as those at social and economic risk, and
- comply with the emergency orders of the governor and adhere to the extent possible, to the guidance of the Department of Elementary and Secondary Education and other agencies of state and federal government and expedite the safest strategy for returning students to school.

The school committee will approve the final plan submitted to DESE which will outline its strategy for returning students to school and will, in collaboration with the superintendent, make such modifications to the "back to school plan," and district policy, and will authorize the superintendent to suspend, revise or create protocols to facilitate the safe return to school.

The superintendent will designate the appropriate staff members to oversee the safe administration of COVID-related policies during the period of the pandemic emergency and shall make such recommendations to the school committee as needed.

The school committee will authorize the superintendent to act expeditiously in executing the "back to school" plan in accordance with current law and regulation and will, where noted, authorize the superintendent to suspend, revise, or recommend policies, rules and protocols as needed to serve the best interests and safety of students, their families, and the community.

The "back to school" plan shall constitute the policy of the school district during the pandemic emergency, and the superintendent shall exercise the authority provided in law to carry out the plan as needed.

- General district goals affected by the pandemic.

The superintendent, with the advice and consent of the school committee, may suspend or modify individual district policies to address the COVID-19 emergency as declared by the governor. Such suspension of policy shall expire upon the end of the emergency as declared by the governor.

The goal of emergency pandemic policies shall be to:

- o ensure the safety and health of students, faculty, staff, and all persons who may come in contact with them;
- o provide the most effective educational services as possible to students under the circumstances;
- o authorize changes to operating protocols as needed to open and operate schools

effectively from various venues or platforms;

- o conduct the district business and operational functions of the district as efficiently as possible;
- o allow the superintendent and staff to act quickly to carry out a "back to school" plan and,
- o facilitate the re-establishment of a safe and productive school day and year.

- Student assignment to schools (File [JCA](#))

Subject to the guidance from the Department of Elementary and Secondary Education, the superintendent may suspend or revise the assignment of students to schools, including the assignment of new students for such a period as the emergency declaration is in force.

- School calendar (File [IC/ICA](#))

Subject to the guidance from the Department of Elementary and Secondary Education and the provisions of collective bargaining agreements, the superintendent may suspend or revise the school calendar with the approval of the school committee.

- Class size (File [IIB](#))

In order to maintain healthy, safe, and effective classrooms, the superintendent may suspend district policy on class size, subject to the provisions of the collective bargaining agreements where applicable.

- Attendance (File [JH](#))

Subject to operative law and regulations, suspend, modify or adapt policies related to student attendance including the link between and absences when appropriate, (including the link between attendance and grades), chronic absence policies, and accommodations for students requiring special placements

- Time on learning (File [IC/ICA](#) and [ID](#))

Subject to the guidance from the Department of Elementary and Secondary Education and the provisions of collective bargaining agreements, the superintendent may suspend or amend requirements for time on learning for the duration of the COVID pandemic.

- Grading and retention (File [IKE](#))

In accordance with guidance from the Department of Elementary and Secondary Education, the superintendent may propose, subject to the approval of the school committee, modifications to the policy of the district for grading and retention of students.

- Local graduation requirements (File [IKF](#))

In accordance with guidance from the Department of Elementary and Secondary Education and modifications to current regulation or law, the superintendent may propose, subject to the approval of the school committee, modifications to the policy of the district regarding graduation requirements. DUPLICATE STATEMENT IN SPECIAL EDUCATION

- Special education (File [IHB](#), [IHBA](#), [IHBAA](#), [IHBFB](#))

The superintendent and school committee should be mindful that attainment of a high school diploma may render certain students ineligible for further services.

- Discipline and Suspension/Expulsion with home schooling rights (File [JIC](#), [JK](#))

The "back to school" plan recommended by the superintendent and subject to the approval of the school committee shall contain protocols for serving students who are disciplined or suspended during the pandemic emergency.

Further, the superintendent shall provide in these "back to school" plans provisions for students were disciplined or suspended or who may elect to remain at home under the provisions of the policies related to home schooling, or who may elect remote learning in the interests of safety or health concerns.

- Exemptions for particular groups of students (i.e., use of masks for youngest children, high risk students) (File [JL](#))

The superintendent shall provide protocols to principals and teachers regarding students who may require special exemptions from health and safety standards during the pandemic emergency. Such protocols may address exemption for utilizing support animals.

- Job descriptions (File [GCA](#))

The superintendent may revise job descriptions for district staff, considering the provisions of current collective bargaining agreements, in order to secure the safety and health of students and staff, establish effective communications between school and community, maintain facilities, transport students as needed, provide food services, and acquire necessary materials to operate schools safely and securely during the pandemic. The superintendent will inform the school committee of any such changes. Any changes to job descriptions shall expire at the end of the declared emergency situation.

- STUDENTS AT RISK ([JIE](#), [JL](#), [JLC](#), [JLCC](#))

During the COVID pandemic, the superintendent or principal of a school may revise or suspend provisions of policy to facilitate the education of students at risk or with special physical needs or their family caregivers, including, but not limited to caring for or educating students with disabilities, illness, pregnancy, childrearing responsibilities, or special education needs consistent with law and regulation.

- Privacy of Students. (File [JRA](#))

During the pandemic, the rights to privacy held by students and their families shall not be abridged by the public schools. Such rights extend to the confidentiality of student academic records, health data, economic status, and other such information as may be considered confidential by law.

Massachusetts law prohibits the recording of individuals without their permission. Similarly, students may not be recorded in classrooms by audio, visual, or remote means without the permission of parents or, if of age, by individual students. During periods of remote learning, the privacy of students participating in on-line classes shall not be violated by recording them without appropriate permissions.

- Pivoting back to remote learning, or back to in-school instruction

The superintendent shall incorporate into the "back to school" plan protocols for modifying these plans including addressing the needs of students who may require reversion from in-school to remote learning modalities because of the pandemic emergency.

- Home schooling File [IHBG](#) (temporary), home-bound instruction File [IHBF](#) (e.g., students with physical disabilities) and remote instruction for students in quarantine

The "back to school" plan shall provide for students who are temporarily homebound due to illness, quarantine, or disability

- Public Safety Officers, including the school resource officer (MOA with the local police.)

Subject to current law or regulation, the superintendent shall report to the school committee of any change in status of the school resource officer. (If the district eliminates visitors to school during the school day, the SRO may be impacted.)

- Eligibility for participation in extra-curricular activities, including sports (File [JJ](#))

Subject to law, regulation and standards established by the appropriate and legitimate regulatory body, the superintendent may propose changes to district protocols for participation in extracurricular activities including sports subject to the rules established by the Massachusetts Interscholastic Athletic Association.

- Attendance vs. participation in events (File [JH](#) and Student/Athletic Handbooks)

Subject to law, regulation or emergency declaration, the superintendent may propose protocols or modifications or suspensions of district policies regarding attendance by students or the public in school events including, but not limited to assemblies, sports events, large gatherings, or other programs.

- Visitors in schools and buildings (File [KI](#))

Subject to current emergency declarations, the superintendent may propose suspension or modification to district policies regarding visitors to school buildings during the school day and after school hours.

- Illness and contact tracing (File [JLCC](#))

Subject to the provisions of the "back to school" plan, the superintendent may establish protocols for tracking student contacts as a means of locating others from whom students may contract or expose other persons to the COVID-19. Such protocols will be consistent with law and regulation and be consistent with standards to protect the privacy of students, their families, and other persons.

- Transportation and busing (File [EEA](#), [EEAA](#), [EEAEC](#), [EEAG](#))

Subject to current law and regulation, the superintendent may suspend or modify policies related to the transportation of students by the school district. Legal requirements relating to IEP's that contain transportation for students shall not be altered without the appropriate family consent. These modifications shall be consistent with the district "back to school" plan.

- Operations and plant maintenance (File [EC](#), [ECA](#))

Subject to the provisions of law, regulation and collective bargaining agreements, the superintendent may suspend or amend current policy to ensure the efficient operation of business functions and maintenance of school buildings and other such offices as the district maintains.

SOURCE: MASC - July 2020

**File: IHBAA - OBSERVATIONS OF SPECIAL EDUCATION PROGRAMS**

1. Parents'/guardian's request to observe their child(ren), current program, or a potential placement must be made at least five days in advance with the Special Education Director or designee and/or Principal.
2. The Special Education Director or designee shall contact the parent(s)/guardian for initial scheduling conversation within five (5) days of receipt of the parents'/guardian's request.
3. When a parent/guardian requests an observation of a special needs student or program, the Special Education Director or designee will seek approval from the Director of Special Education and the building principal before it is processed. Such approval may only be withheld for those reasons outlined within law and DESE regulation.
4. The Special Education Director or designee and/or Principal will work with the classroom teacher and the observer to set up the specifics of the observation (including, but not limited to, scheduling and placement of the observer in the classroom).
5. The number, frequency, and duration of observation periods will be determined on an individual student basis in accordance with law and regulation. The start and end time of observation periods and a schedule of observation periods will be stated in advance. In order to minimize classroom or student disruption, the length of individual observation periods may be limited.
6. If the observer is not the parent/guardian, the parent/guardian must sign a release for the individual to observe.
7. The number of observers at any one time may be limited.
8. The observer will be informed that they are not to interfere with the educational environment of the classroom. If their presence presents a problem, they will be asked to leave. This notice is particularly important, since the presence of parents/guardians can influence both the performance of their child(ren) and those of others.
9. The observer will be asked to submit their report of the observation in advance of any follow-up TEAM meeting.
10. The observer will be informed that they are there to evaluate the appropriateness of a specific educational program to meet the needs of an individual child. They are not there to evaluate a teacher's ability to perform his or her contractual job duties.
11. The observer will be instructed regarding the disclosure of confidential or personally identifiable information relating to other children. Staff must be mindful of removing materials which may be part of students' records from plain view. In the event that removal is not possible the observer may be asked to sign a non-disclosure agreement.

12. A school administrator, or designee, also will observe at the same time and take notes as to what is observed, paying particular attention to note anything that is non-typical concerning the period. This observation summary will be placed in the student's file and provided to the parent(s)/guardian prior to any follow-up TEAM meeting.

LEGAL REF.: MGL [71B:3](#)

Massachusetts Department of Elementary and Secondary Education Technical Assistance Advisory SPED 2009-2 dated January 8, 2009

CROSS REF.: [KI](#), Visitors to Schools

SOURCE: MASC

ADOPTED: September 2009

NOTE: The following quotes from the DESE Advisory are important points of understanding to the implementation of this policy.

"School districts and parents/guardians have reported that, typically, observations are between one and four hours. While useful as a general rule, the Department recommends that district policies and practices specify that the duration and extent of observations will be determined on an individual basis. Districts should avoid rigid adherence to defined time limits regardless of the student's needs and settings to be observed. The complexities of the child's needs, as well as the program or programs to be observed, should determine what the observation will entail and what amount of time is needed to complete it. Discussion between school staff and the parent/guardian or designee is a good starting point for resolving the issue."

"The observation law states that districts may not condition or restrict program observations except when necessary to protect:

- the safety of children in the program during the observation;
- the integrity of the program during the observation;
- and children in the program from disclosure by an observer of confidential or personally identifiable information he or she may obtain while observing the program."

## **File: IHBHE - REMOTE LEARNING**

In the event of a district-specific emergency requiring the use of remote learning, the superintendent of schools may declare such emergency and shall, as soon as possible, obtain the approval of the school committee. The remote learning plan below will be applicable in cases of disease, weather emergencies, destruction or damage to schools rendering them inaccessible, or other extraordinary circumstances, including emergencies declared by government officials, the school committee, or the superintendent.

When it becomes necessary for the school district to provide support to students who are unable to attend classes or access appropriate services due to an extended closure, the superintendent shall establish a plan and procedures to ensure that such services are provided. The provision of educational services may include the use of technology and devices, and strategies designed to support student learning away from school.

The remote learning plan will, to the extent possible:

- Ensure the safety of all students and faculty in coordination with appropriate local and state departments and agencies;
- Provide support for student social and emotional wellbeing and address the implications of trauma experienced by students or faculty as a result of the emergency;
- Identify goals and strategies for maintaining standards of student achievement and school improvement plans;
- Ensure instruction and services are delivered by district educators and personnel as much as practicable;
- Utilize the most effective tools and resources available for students and faculty, including the skills and talents of district personnel, in the delivery of instruction and services and share resources as needed;
- Provide resources and services equitably to meet the needs and circumstances of all students;
- Identify remedial strategies necessary after the emergency to advance student achievement (i.e. after-school, extended day, summer school, and contingency scheduling to cancel vacations.);
- Gather information both during and after the period of emergency regarding the most effective means of remote learning to implement as appropriate.

In developing a remote learning plan, the superintendent will:

- Identify and prepare effective means for communicating with faculty, students, parents and community stakeholders.
- Collaborate with municipal agencies that support the schools and community.

- Consult with the school committee to identify any extraordinary actions necessary or authority required to administer emergency and remote learning plans. This includes any changes to district policies on the school calendar, grading, promotions and retentions, local graduation requirements, testing, and standards and accountability.
- Consult with administrators and principals to ensure the continuing education of students at all levels, including:
  - o use of the most appropriate resources, tools and strategies to deliver the curricula given local circumstances and conditions;
  - o equitable access to appropriate content for all students;
  - o specific accommodations for students at high risk, including clients of special education, students with disabilities, English learners, students at economic disadvantage, homeless students, students in foster care and students of military families.
- Utilize available technological resources suitable for serving students at all levels. This inventory will be prepared in advance in anticipation of an emergency.
- Ensure the privacy rights of students, faculty and families are protected, including assessing the security of district technology.
- Consult with bargaining units to determine if modifications to collective bargaining agreements need to be established for the period of the emergency.
- Identify the financial implications of the emergency plan and recommend transfer of funds as may be necessary.

LEGAL REFS.: 20 U.S.C. §1232g Family Education Rights and Privacy Act (FERPA)

15 U.S.C. §§ 6501-6506 Children's Online Privacy Protection Act (COPPA)

CROSS REFS.: [EBCD](#) - Emergency Closings

[IGA](#) - Curriculum Development

[IGB](#) - Support Services Programs

[IHBEA](#) - English Learner Education

[IJND](#) - Access to Digital Resources

[IJNDB](#) - Empowered Digital Use

[IJNDC](#) - Internet Publication

[IJNDD](#) - Policy on Social Media

[IHBEA](#) - English Language Learners

[JB](#) - Equal Educational Opportunities

[JBB](#) - Educational Equity

SOURCE: MASC - May 2020

## **File: IHBHE-E - REMOTE LEARNING ADDENDUM**

Issues to consider when developing remote learning plans:

- Which of these issues requires policy or policy changes?
- What are the policy implications and what should school committees delegate to the superintendent for operating protocols?
- Do we learn anything from earlier experiences in emergencies?
- What can we learn from our current services to students who are unable to attend school because of illness or other disability or for disciplinary reasons?

Specific items to consider in developing a plan:

- When is remote learning appropriate?
- Designating a remote learning point person
- Reviewing the various models for remote learning
- Equity - how to ensure that students have access to tools to learn remotely.
- Internal vs. external resources.
- Collective bargaining implications
- Responsibilities of remote educators
  - Evaluating remote educators and programs
- Who may observe remote instruction
  - Teacher professional development to incorporate various elements of remote learning
  - Common planning time
- Identifying cost implications and approving spending
- Special constituencies:
  - Special education students
  - English Language Learners
  - Physically challenged students
  - Homeless students
  - Students in foster care
  - Students of military families
  - Pregnant and parenting students

- Facilitating collaboration/removing barriers to collaboration.
- Protecting privacy rights of students and parents
  - o FERPA (Federal Educational Rights and Privacy Act and COPPA (Children's On Line Privacy Protection Act)
  - o What privacy protections do vendors and districts/schools have in place.
- Health and nutrition issues that may impact student wellness and/or privacy
- Internet security for students and faculty.
- Protecting educators and others who identify threats to student wellbeing via remote learning.
- Engaging district partners including companies, consultants, media (i.e., public television).
- Impact on decisions to retain or grant professional status educators.
- Academic implications (testing, grading, educator accountability, curriculum adaptations)
- Parental rights (opting in or opting out)
- Data gathered remotely or on-line (who gathers, aggregates, or analyzes).

SOURCE: MASC - May 2020

**File: JBB - EDUCATIONAL EQUITY**

The School Committee's goal is to strive to address the needs of every student in each of our schools, subject to budgetary, space and other limitations.

Educational equity for the purpose of this policy is defined as providing all students, as reasonably practical, the high quality instruction and support they need to reach and exceed a common standard.

To achieve educational equity the district will commit to:

1. Systematically, when appropriate, use districtwide and individual school level data, disaggregated by race/ethnicity, gender/gender identity, national origin, language, special education, socioeconomic status and mobility to inform district decision making.
2. Raise the achievement of all students.
3. Graduate all students ready to succeed in a diverse local, national and global community.

In order to reach the goal of educational equity, as reasonably practical, for each and every student, the District shall:

1. Provide every student with access to high quality curriculum, support, and other educational resources.
2. Seek to promote educational equity as a priority in professional development.
3. Endeavor to create schools with a welcoming and inclusive culture and environment.
4. Provide multiple pathways to success in order to meet the needs of the diverse student body and actively encourage, support and expect high academic achievement for each student.

The Superintendent shall include equity practices in the district's strategic plan and goal strategies to implement this policy. The Superintendent, upon request, will periodically report to the Committee the progress of the implementation of this policy.

SOURCE: MASC

ADOPTED: September 12, 2019

**File: JFABD - HOMELESS STUDENTS: ENROLLMENT RIGHTS AND SERVICES**

To the extent practical and as required by law, the district will work with homeless students and their families to provide stability in school attendance and other services. Special attention will be given to ensuring the enrollment and attendance of homeless students not currently attending school. Homeless students will be provided district services for which they are eligible, including Head Start and comparable pre-school programs, Title I, similar state programs, special education, bilingual education, vocational and technical education programs, gifted and talented programs and school nutrition programs.

Homeless students are defined as lacking a fixed, regular and adequate nighttime residence, including:

1. Sharing the housing of other persons due to loss of housing or economic hardship;
2. Living in motels, hotels, trailer parks or camping grounds due to the lack of alternative adequate accommodations;
3. Living in emergency or transitional shelters;
4. Being abandoned in hospitals;
5. Awaiting foster care placement;
6. Living in public or private places not designed for or ordinarily used as regular sleeping accommodations for human beings;
7. Living in cars, parks, public spaces, abandoned buildings, substandard housing, transportation stations or similar settings;
8. Migratory children living in conditions described in the previous examples.

The superintendent shall designate an appropriate staff person to be the district's liaison for homeless students and their families.

To the extent feasible, homeless students will continue to be enrolled in their school of origin while they remain homeless or until the end of the academic year in which they obtain permanent housing. Instead of remaining in the school of origin, parents or guardians of homeless students may request enrollment in the school in the attendance area in which the student is actually living, or other schools. Attendance

rights by living in attendance areas, other student assignment policies, or intra and inter-district choice options are available to homeless families on the same terms as families resident in the district.

If there is an enrollment dispute, the student shall be immediately enrolled in the school in which enrollment is sought, pending resolution of the dispute. The parent or guardian shall be informed of the district's decision and their appeal rights in writing. The district's liaison will carry out dispute resolution as provided by state rule. Unaccompanied youth will also be enrolled pending resolution of the dispute.

Once the enrollment decision is made, the school shall immediately enroll the student, pursuant to district policies. If the student does not have immediate access to immunization records, the student shall be admitted under a personal exception. Students and families should be encouraged to obtain current immunization records or immunizations as soon as possible, and the district liaison is directed to assist. Records from the student's previous school shall be requested from the previous school pursuant to district policies. Emergency contact information is required at the time of enrollment consistent with district policies, including compliance with the state's address confidentiality program when necessary.

Homeless students are entitled to transportation to their school of origin or the school where they are to be enrolled. If the school of origin is in a different district, or a homeless student is living in another district but will attend his or her school of origin in this district, the districts will coordinate the transportation services necessary for the student, or will divide the costs equally.

The district's liaison for homeless students and their families shall coordinate with local social service agencies that provide services to homeless children and youths and their families; other school districts on issues of transportation and records transfers; and state and local housing agencies responsible for comprehensive housing affordability strategies. This coordination includes providing public notice of the educational rights of homeless students in schools, family shelters and soup kitchens. The district's liaison will also review and recommend amendments to district policies that may act as barriers to the enrollment of homeless students.

LEGAL REFS.: Title I, Part C

No Child Left Behind Act, 2002

## **File: JFABE - EDUCATIONAL OPPORTUNITIES FOR MILITARY CHILDREN**

To facilitate the placement, enrollment, graduation, data collection, and provision of special services for students transferring into or out of the District because of their parents or guardians being on active duty in the U.S. Armed Services, the District supports and will implement its responsibilities as outlined in the Interstate Compact on Educational Opportunity for Military Children. The district believes it is appropriate to remove barriers to educational success imposed on children of military families resulting from frequent moves required by parents' or guardians' military deployment.

### **Definitions**

**Children of military families:** School aged children, enrolled in kindergarten through 12th grade, in the household of an active duty member of the uniformed service of the United States, including members of the National Guard and Reserve serving on active duty.

**Deployment:** The period one month before the service members' departure from their home station on military orders through six months after return to their home station.

**Education(al) records:** Official records, files, and data directly related to a student and maintained by the school including, but not limited to, records encompassing all the material kept in the student's cumulative folder.

Eligible students are children of military families as well as the children of veterans who have been severely injured and medically discharged, and children of active duty personnel who died on active duty. Children of retired active duty personnel are also eligible to receive services for one year following the discharge due to severe injury, or the retirement or death of an active military parent. The Compact does not apply to children of inactive Guard or Reserves, veterans and retired personnel not included above, or U.S. Department of Defense personnel and other federal civil service employees and contract employees.

The District's responsibilities to eligible students include the following:

- Sending schools must send either official or unofficial records with the moving students and District receiving schools must use those records for immediate enrollment and educational placement.
- Upon enrollment of an eligible student, the receiving school must request official records and the sending schools shall respond within 10 days with the records.
- Immunization requirements of the District may be met within 30 days from the date of enrollment (or be in progress).
- Receiving schools must initially honor placement of students in all courses from the sending school. These include, but are not limited to, Honors, International Baccalaureate, Advanced Placement, vocational-technical, and career pathway courses if those courses are offered in the receiving school and space is available. The receiving schools must also initially honor placement of like programs to those of the student in the sending state, including, but not limited to, Gifted and Talented programs, and English as

a Second Language programs. Receiving schools are not precluded from performing subsequent evaluation to ensure the appropriate placement and continued enrollment of the student in courses and programs.

- In compliance with federal law, the district will assume financial and programmatic responsibility for the special education programs of students with existing IEPs drafted in other states.
- As appropriate, the District will exercise the right to waive prerequisites for all courses and programs, while also maintaining its right to re-evaluate the student to ensure continued enrollment, also as deemed appropriate.
- Students of active duty personnel shall have additional excused absences, as necessary, for visitations relative to leave or deployment.
- An eligible student living with a noncustodial parent or other person standing in loco parentis shall be permitted to continue to attend the school in which he or she was enrolled while living with the custodial parent or guardian, without any tuition fee imposed.
- The District high school will accept exit or end-of-year exams required from the sending state, national norm-referenced tests, or alternate testing instead of testing requirements for graduation in the District (receiving state.) If this is not possible, the alternative provision of the Interstate Compact shall be followed to facilitate the on-time graduation of the student in accordance with Compact provisions.

LEGAL REFS: M.G. L. [15E](#);

Interstate Compact on Educational Opportunity for Military Children

SOURCE: MASC October 2019

**DRUG / ALCOHOL USE BY STUDENTS**

In view of the fact that the use of controlled substances and alcohol can endanger the health and safety of the user, and recognizing the deleterious effect the using of controlled substances and alcohol can have on the maintenance of general order and discipline, the School Committee prohibits the use of, serving of, or consumption of any controlled substance or alcohol on school property or at any school function.

Additionally, any student, regardless of age, who has been drinking alcoholic beverages or using controlled substances prior to attendance at, or participation in, a school-sponsored activity, will be barred from that activity and subject to disciplinary action.

SOURCE: MASC

LEGAL REF.: M.G.L. 272:40A

CROSS REF.: IHAMA, Teaching About Drugs, Alcohol, and Tobacco  
GBEC, Drug Free Workplace Policy

## MASC REVISED POLICY

### **File: JICH - ALCOHOL, TOBACCO, AND DRUG USE BY STUDENTS PROHIBITED**

A student shall not, regardless of the quantity, use or consume, possess, buy or sell, or give away any beverage containing alcohol; any tobacco product, including vapor/e-cigarettes; marijuana; steroids; or any controlled substance. The School Committee prohibits the use or consumption by students of alcohol, tobacco products, or drugs on school property or at any school function.

Additionally, any student who is under the influence of drugs or alcoholic beverages prior to, or during, attendance at or participation in a school-sponsored activity, will be barred from that activity and may be subject to disciplinary action.

The school district shall utilize, in accordance with law, a verbal screening tool approved by the Department of Elementary and Secondary Education to screen students for substance abuse disorders. The tool shall be administered by trained staff on an annual basis for grades 7 and 9.

Parents/guardians shall be notified prior to the opening of school each year. Parents/guardians shall have the right to opt out of the screening by written notice prior to or during the screening.

All statements made by a student during a screening are confidential and shall not be disclosed except in the event of immediate medical emergency or in accordance with law. De-identified results shall be reported to the Department of Public Health within 90 days of the completion of the screening process.

This policy shall be posted on the district's website and notice shall be provided to all students and parents of this policy in accordance with state law. Additionally, the district shall file a copy of this policy with DESE in accordance with law in a manner requested by DESE.

SOURCE: MASC February 2018

LEGAL REF.: M.G.L. [71:2A](#); [71:97](#); [71:96](#); [272:40A](#)

CROSS REF.: IHAMB Teaching About Drugs, Alcohol, and Tobacco

[GBEC](#), Drug Free Workplace Policy

Adopted 5-21-18

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Massachusetts Association of School Committees - 2003