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AN OUTCOME STUDY OF
THE COTTAGE MEETING PROGRAM

Report No. 8 - January, 1977
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THE COTTAGE MEETING PROGRAM

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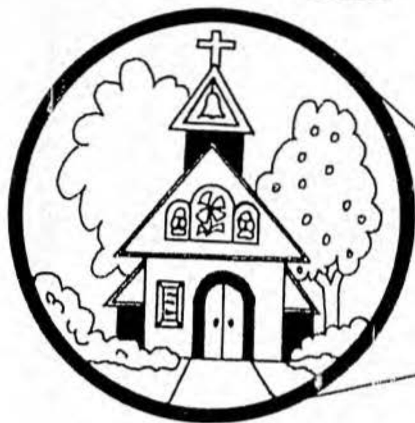

The doorbell rings and you hurry to answer the front door. It is a pleasant-looking woman in her mid-30's –

The Sunday service has just ended and as you reach the door, a friendly-looking, middle-aged woman rests her arm on yours and introduces herself –

The student union lunchroom is crowded and you are looking for a place to sit when you notice a young man with an empty seat beside him beckoning to you –

You are leaving on your afternoon break when the new man in the office joins you –

They are volunteers from the Cottage Program, a private, non-profit group that has been working since 1972 to raise public awareness of the problem of alcoholism.

The basic premise of the program is that the people who can most benefit from education about alcoholism are not the alcoholics but the people affected by the alcoholic's behavior. Cottage workers educate friends, family and community members.

"Would you be willing to hold a Cottage Meeting in your home–to serve as the host for friends and neighbors at an informal get together to learn more about alcoholism?" the volunteer will ask. If you agree, you will be able to set the time and invite your own friends.

It really works something like a house party. The host or hostess provides the setting, guests bring the refreshments. The atmosphere is warm and friendly.

At the time of the meeting, a Cottage volunteer who has been specially trained conducts the meeting. Participants are given handouts which explain the early symptoms of alcoholism and the role that friends and family can play in supporting the unhealthy drinking behavior. The family is regarded as the primary group for treatment. The program is based on the idea that problem drinking is usually reinforced by the environment, and that, through simple re-education, the environment may be changed enough so the drinking behavior is no longer so strongly reinforced.

Hatch Bill Seeks More Emphasis On Family in Alcoholism Therapy

A U.S. Senate hearing on alcohol abuse and alcoholism last summer in Salt Lake City has resulted in a bill from Sen. Orrin G. Hatch, R-Utah, calling for greater emphasis on the effect alcohol misuses has on families.

Bernell N. Boswell, director of the Cottage Program, was advised of the action Monday by Robert P. Hunter, minority counsel to the subcommittee on alcholism and drug abuse, which conducted the hearings at the State Capitol. Sen. Hatch is ranking minority member of the subcommittee.

The Cottage concept parallels that of the measure, the Families with Alcoholism assistance Act of 1977. Mr. Boswell, testifying at the June hearing, advocated the Cottage concept, saying that it is vitally important to provide assistance to the families of alcohol misusers as well as for the drinkers themselves.

Introduces Bill

Sen. Hatch introduced the bill with Sen. William D. Hathaway, D-Maine, chairman of the subcommittee on alcoholism and drug abuse, and Sen. Harrison A. Williams Jr., D-N. J., chairman of the Senate Human Resources Committee.

Sen. Hatch said an identical measure will be submitted to the House by Rep. Majorie S. Holt, R-Md.

He said the Salt Lake City hearing demonstrated "the debilitating effects of alcholism on the family unit."

"I want to make it clear that we are talking about a crisis in our society which exists in every community regardless of size or locale, which, in many cases, is monumental and incalcuable," the Utah senator said on the Senate floor.

The bill would amend the Comprehesive Alcohol Abuse and Alcolism Prevention, Treatment and Rehabilitation Act of 1970 by adding this subsection:

Counseling, Treatment

"Alcohol abuse has a substantial impact on the families of alcohol abusers and alcoholics."

Sen. Hatch calls for inclusion in surveys on the crisis "an identification of the need for prevention and treatment of alcohol abuse and alcoholism by women and by individuals under the age of 18 and for education, counseling and treatment of the families of alcohol abusers and alcoholics (with) assurance that programs within the state will be designed to meet such need."

Sen. Hathaway, also speaking on the Senate floor, said the measure "requires the states to identify the need for education, counseling and treatment of these families and provide assurances that this need will be met."

"In addition," the Maine Democrat said, "it authorizes federal assistance for projects to provide (such) education, counseling and treatment" . . . and "encourages research on the impact of alcohol abuse and alcoholism on the family."

The bill creates a statutory priority within the National Institute on Alcohol Abuse and Alcoholism (NIAAA) "for programs which address the needs of families of alcoholics."

The Cottage volunteer points out that many times family, friends, even employers will "cover" for an alcoholic, rescue him or her or solve the many crises which follow excessive drinking. These people, the volunteer demonstrates, can best help the alcoholic by simply refusing to support the drinking behavior.

Each Cottage Meeting is different, but the same theme runs through each one: The best way to change the behavior of another individual is to change your own behavior.

If an alcohol problem is identified during a meeting or a person asks for help, he or she is referred to a trained counselor. The neighborhood meetings are educational and are not therapy. Often a second meeting is held a week later, to further discuss ways that individuals and the community at large can deal more effectively with the problems of alcoholism.

The Cottage Program's extensive use of volunteers is one of the most unusual aspects of the educational effort. The typical volunteer is a housewife, with children in school and time to donate to a worthy cause. Other volunteers include university students, members of church groups, employees in offices and industries who educate others at their place of work.

Potential volunteers often simply come into or call the Cottage Program. One of the staff members, or a trained volunteer interviews the person to determine the field of interest most suitable to them. The Program is staffed by volunteers at all times. It's rewarding work! Most people are pretty interested once they know you want their opinion on "an important issue." Not all volunteers conduct Cottage Meetings. Some might answer phones or work in the Cottage Program. Those who will participate as community educators, attend weekend training seminars or sessions twice a week and learn how to moderate Cottage Meetings. After 32 hours of training, the volunteer reaches the "graduate level" and may conduct meetings. Eventually, a graduate may reach the "master" volunteer level and begin to train new volunteers.

The Program's long range goal is to change community attitudes about alcoholism—a goal which encourages prevention and early intervention. Stigma and fear keep people from seeking help at a period when something can be done. Alcoholism may be compared to the illness of malaria. Frantically swatting mosquitos while the swamp is still infested will not solve the problem. The problem is the swamp. To treat problem drinking while ignoring the society and family from which it emerges is only a partial solution. We must continue to educate and treat the environm nt.

In several evaluation surveys, Cottage staff members have been able to determine a significant and long term increase in awareness among Cottage Program participants of the problems posed by alcohol misuse and alcoholism. The Program serves as a model prevention effort.

COMPLIMENTS OF:

AN APPROACH TO THE PREVENTION OF ALCOHOLISM

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AN OUTCOME STUDY OF

THE COTTAGE MEETING PROGRAM

Former Cottage Meeting participants and "linked" control subjects were given questionnaires which assessed knowledge, attitudes and opinions, and self-reported behaviors concerning alcohol and other substances of abuse. Significant differences, in favor of participants, were observed on knowledge, in agreement with attitude and opinion items rated by a normative group of alcoholism treatment personnel, and in meanings attributed to selected concepts. Cottage Meeting training in small, high-interaction group sessions, was judged to result in knowledge changes, and to lead to the adoption of desirable attitudes and opinions. Participants were drawn from 7 months to 3 years prior to the study. All participants were similar, however, in their responses to test measures, suggesting that the changes produced were relatively immediate and maintained over the 3 year period.

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I. INTRODUCTION

The Cottage Meeting Program was launched as an experimental pilot program in alcoholism education. It was founded on the challenging premise that concerned and interested citizens, volunteering their time and efforts, can reach out in their neighborhoods in an education and prevention program to alleviate problems related to alcohol.

Since its inception, in February of 1972, the target of the Cottage Meeting Program has been the total community, not just those who were personally affected by alcoholism. Trained volunteers began meeting with small groups of residents in their homes, clubs, and churches to discuss various aspects of alcoholism: how to recognize it, how to deal with it, how to prevent it (Boswell & Wright, 1972a, 1972b, 1973).

The primary activity is the "Cottage Meeting" which is conducted by trained volunteers and supervised by a small professional staff. Cottage Meetings seek to change the patterns of interaction in the family and the sequences of behavior of significant others in relation to the problem drinker. Thus, the emphasis is upon prevention rather than treatment, upon communication rather than remediation, and upon the situation rather than the drinker (Boswell & Wright, 1972a, 1972b; Merrill, Boswell & Finney, 1975; Malouf, Merrill, Itterly & Boswell, 1975).

The value of the Cottage Meeting Program has been demonstrated in four previous studies of the Program. The first study, a mail survey follow-up of about 300 Cottage participants, revealed that participants were highly favorable to the Cottage experience, characterizing it as hekpful, informative, and important (Merrill & Boswell, 1973). The second study focused on high school students who had experienced Cottage Meetings at school. These students evidenced highly significant changes in attitude toward alcohol usage after participating in the meetings (Merrill & Boswell, 1973). The third study found that Cottage participants clearly changed their ideas and attitudes on various aspects of alcohol usage after participating in the meetings. The changes in ideas and attitudes could be described as becoming more tolerant, enlightened, and confident regarding their knowledge of alcohol usage. It was suggested that these changes should help the participants to avoid alcohol problems in the future (Merrill, Boswell & Finney, 1975). The fourth study validated the mail survey findings of the first study through personal interviews with apporximately 100 Cottage participants. The great majority of these participants reported positive feelings toward the Cottage, gains in understanding, and an increased ability to cope with the problems of alcoholism (Boswell & Wright, 1972a, 1972b; Merrill, Boswell & Finney, 1975; Malouf, Merrill, Itterly & Boswell, 1975).

An objective determination of the consequences of the Cottage Meeting Program, however, has not been made. It is the purpose of this study to examine the subsequent effects of the Cottage Meeting Program in the areas of knowledge relative to substances, particularly of alcohol, of opinions and attitudes pertaining to various aspects of substance use, and of alcohol-related behaviors perceived as influenced by the Cottage Meeting Program.

In determining outcome variables to be examined in this study, it was assumed that the Program would establish or strengthen a positive orientation to issues and events relating to alcohol and that participants would grow in ways contributing to desirable perceptions and behaviors concerning substance use. In designing this study, it was recognized additionally that the effects of short-term, education and prevention experiences are difficult to anticipate, much less to pinpoint. It is believed, however, that expeditions into the relatively untraveled areas of assessing outcomes of such programs are needed, if only to begin to define what are and are not appropriate. It is in this spirit that this study was undertaken.

HYPOTHESES

Previous studies of the Cottage Meeting Program have essentially produced subjective assertions of change relative to knowledge of alcohol, ideas and attitudes concerning this substance, and associated behavioral changes. In an attempt to objectify these indications, outcome hypotheses pertaining to these areas were prepared via input by Program staff and considerations of measures available for testing of the hypotheses.

The hypothese formed were organized under the following headings:

Knowledge

1. Cottage participants are expected to show greater general knowledge about alcohol than control individuals.
2. Cottage participants are expected to have greater knowledge concerning Program-derived material than control individuals.
3. Cottage participants are expected to have a greater knowledge of community treatment resources for drug abusers than control individuals.
4. Cottage participants are expected to have greater knowledge of community treatment resources for alcohol abusers than control individuals.

Opinions and Attitudes

5. Cottage participants are expected to show greater agreement with opinion ratings about alcohol made by personnel employed in alcohol treatment agencies than control individuals.
6. Cottage participants are expected to show greater agreement with opinion ratings about drugs made by personnel employed in alcohol treatment agencies than control individuals.
7. The intervention preferences (three levels: "ignore-support", "treat", "punish") of participants for public intoxicants are expected to load in the direction of "ignore-support" and "treat".
8. The intervention preferences (three levels: "ignore-support", "treat", "punish") of participants for users of soft drugs are expected to load in the direction of "ignore-support" and "treat".
9. Control individuals are expected to show agreement with the theoretical distribution of intervention preferences for public intoxicants.
10. Control individuals are expected to show agreement with the theoretical distribution of intervention preferences for users of soft drugs.
11. Cottage participants are expected to rate the concept of Alcohol

Education more positively than control individuals on three dimensions of meaning (evaluative, potency, activity).

12. Cottage participants and control individuals are not expected to differ in their semantic differential ratings of the concept of Alcohol in comparison with controls.
13. Cottage participants anc control individuals are not expected to differ in their semantic differential ratings of the concept of Drugs in comparison with controls.
14. Cottage participants, in comparison with controls, are expected to be more negative in their evaluative ratings of the concept, Alcohol Abuse, but to give higher ratings on the potency and acitivty dimensions of this concept.
15. Cottage participants are more likely to believe that alcohol can be consumed in a non-harmful way than control individuals.
16. No difference between Cottage participants and control individuals is expected in their veiws of the non-harmful use of soft drugs.

Behaviors

17. Cottage participant drinkers are expected to refer to fewer reasons for use of alcohol than control group drinkers.
18. Alcohol use is expected to interfere less with the functioning of Cottage participants who drink than of control individuals who drink.
19. Alcohol use is expected to interfere less with the driving activity of Cottage participants who drink than of control individuals who drink.
20. No difference in the use of health and social services is expected between Cottage participants and control individuals.
21. No difference in need for health and social services is expected between Cottage participants and control individuals.
22. No difference in the referral use of health and social services for family members or friends is expected between Cottage participants and control individuals.
23. Cottage participants who drink are expected to use less alcohol than control individuals who drink.
24. Cottage participant drinkers are expected to self-report fewer problems related to the use of alcohol than control group drinkers.
25. No difference in self-reports of drug use as a problem is expected between Cottage participants and control individuals.

In forming these hypotheses, it was recognized that the Cottage Meeting Program was involved directly only in a few of the activities noted in the hypotheses. On the other hand, it was believed that the Program would stimulate and strengthen, or at least maintain, participant interest in behavior and activities relevant not only to alcohol but to drug use in general.

II. METHOD

SUBJECTS

Cottage Participants

Participant Group 1 (PG1) These participants were contacted and surveyed by an independent research corporation. They were drawn

from three sets of approximately 100, randomly selected, former participants of the Program representing three prior time periods: participants of meetings conducted 7-12 months, 13-24 months and 25-36 months prior to the survey (November, 1976). All participants were residents of Salt Lake County and presumably had participated in the two-session Program experience. If two or more participants drawn for survey were from the same household, only one, randomly determined, was used as a subject.

Statistical analyses of participants from the three time periods revealed no differences in their responses to the measures administered. The groups were combined, therefore, to form a single group. It was learned that a small number of participants claimed not to have been involved in the Program. Discussion with the Program Director indicated that an error of this nature was possible, albeit rare. In view of this possibility, however, persons who disclaimed knowledge of the Program were excluded.

The discovery of persons erroneously listed as participants was accompanied by indications (e.g., comments of PG1 subjects contacted, and comments by Program staff concerning identified PG1 subjects) that this group included persons who were involved in large group presentations of the Program, a procedure initiated by the Program for information-giving and mass education purposes. Such participants were not involved in the small group, interactive process characteristic of the Program. Secondly, this group included individuals who sometimes attended one but not both Program sessions. Since names were not attached to the survey forms, except in instances where subjects signed a release form (this feature is discussed in a later section), a clear accounting of the number of participants involved in one or both sessions, and of the nature of this participation (i.e., small, interactive groups vs large, less interactive groups) was not possible.

Thirty-four participants were in PG1. Table 1 presents demographic and background information relevant to this group. This group was acknowledged as a "mixed" group of former Program participants.

Participant Group 2 (PG2) The "mixed" nature of PG1 indicated that as a whole, this group could not be treated as representative of the Program. A second pool of participants were drawn, therefore, from the appropriate prior Program periods. These participants were identified by staff as having attended both sessions, and as having engaged in the small, interactive group characteristic of the Cottage Program. Participants obtained from this pool were considered to adequately represent the Program.

Because of time and budget constraints, Cottage staff were used to contact, solicit cooperation, and survey subjects from this pool of participants. The use of staff to gather measures from former participants, however, introduced a potential for unwanted examiner influence (Rosenthal, 1966).

There were 37 PG2 subjects. Table 1 presents background and demographic information about this group. Similar to PG1, time of Program involvement did not affect the measures obtained from PG2. PG2 subjects from the three Program periods were combined, therefore, into a single group.

TABLE 1

DEMOGRAPHIC AND BACKGROUND DATA

	Characteristics	GROUPS			
		Participants		Controls	
		PG1 (N=34)	PG 2 (N=37)	Control (N=37)	Cooperative (N=12)
		%	%	%	%
1.	Sex Distribution: Male	35.3	37.8	29.7	16.7
	Female	64.7	62.2	70.3	83.3
		%	%	%	%
2.	Mean Age	45.8	35.1	42.5	38.6
3.	Ethnic Group:	%	%	%	%
	a. White	97.1	94.4	91.9	100.0
	b. Black	--	--	--	--
	c. Mexican/American	--	2.8	5.4	--
	d. Asian	--	--	--	--
	e. American Indian	2.9	2.8	--	--
	f. Other	--	--	2.7	--
4.	Marital Status:	%	%	%	%
	a. Married	85.3	62.8	57.1	66.7
	b. Widowed	--	--	5.7	--
	c. Divorced	5.9	8.5	--	--
	d. Separated	8.8	--	8.6	--
	e. Single	--	28.6	28.6	33.3
5.	Median Monthly Household Income	$ 1,114.0	$ 1,511.0	$ 1,359.0	$1,000.0
6.	Employment:	%	%	%	%
	a. Full time	38.2	40.5	54.1	41.7
	b. Part time	8.8	24.3	10.8	16.7
	c. Currently unemployed	44.1	35.1	32.4	41.7
	d. Did not report	8.8	--	2.7	--
7.	Education:	%	%	%	%
	a. Less than High School	14.7	18.9	12.0	--
	b. High School, GED	20.6	21.6	29.0	25.0
	c. 1-3 years college	20.6	16.2	24.0	25.0
	d. College Degree	38.2	27.0	29.0	33.3
	e. Advanced Academic Degree	2.9	5.4	--	--
	f. Other	2.9	10.8	6.0	16.7
		%	%	%	%
8.	Number of people in the home, including self (median)	3.2	3.8	3.0	3.0
		%	%	%	%
9.	Drinkers	29.4	40.5	40.5	50.0
10.	Religion:	%	%	%	%
	a. Protestant	26.5	16.1	15.0	9.1
	b. Catholic	--	12.9	12.0	9.1
	c. Jewish	--	3.2	3.0	9.1
	d. L.D.S.	58.8	48.3	55.0	63.6
	e. Other	14.7	19.4	15.0	9.1

NB - The number of subjects involved in the determination of percentages was sometimes / number of subjects in the group because of missing data. Missing data, when it occurred, was generally negligible.

Control Subjects Two groups of controls were involved in this study. In both groups, the controls were "linked" to prior Cottage participants. No attempt was made to govern age or sex, only that the controls live in the immediate neighborhood of Cottage participants. The immediate neighborhood was defined as a 4-block area, in any direction, from the "home" block (the block containing the Cottage participant). Surveyors also were instructed to approach only control homes/residences which were equivalent in value, in their judgement, to the homes/residences of Cottage participants to whom the controls were "linked". The control groups included:

Cooperative Control Group (CC) The subjects in this group were individuals who, following testing and a presentation of what the Cottage Meeting Program offered, expressed a desire to participate in the Program. This group of "cooperatives" was presumed to represent a group similar to Cottage participants prior to exposure to Program sessions. This group was perceived as important inasmuch as interest and motivation factors were seen as possibly interacting with the measures gathered in this study.

There were 12 individuals in this group. Table 1 presents demographic and background information concerning this group.

Control Group (C) These subjects were selected in the same fachion as CC subjects, except that they expressed no interest in the Cottage Meeting Program following a presentation of what is offered.

There were 37 individuals in this group. Background and demographic information concerning C are presented in Table 1.

MEASURES

The dependent variable measures used in this study were obtained from the following three questionnaires.

Questionnaire I This questionnaire includes: (a) a 36-item, T - F set of knowledge questions developed and standardized by Engh (1975); (b) 14, T - F items derived from Cottage Meeting Program materials; (c) an item designed to measure knowledge of local resources available for persons with problems related to alcohol and to other drugs; (d) an item assessing knowledge of the purpose of the Cottage Meeting Program; and (e) the number of Cottage Meetings arranged by participants following their Cottage experience.

Questionnaire II This questionnaire includes: (a) a 24-item set of statements concerning alcohol which subjects rated, using a 5-point strongly-agree to strongly-disagree scale. Contained among the 24 items are 12 key statements, i.e., items with 70% or greater directional agreement by 24 representatives of alcohol service agencies located in Salt Lake County; (b) a 20-item set of statements concerning drugs, rated with a 5-point, strongly-agree to strongly-disagree, scale. Among these statements are 15 key items, i.e., items with 70% or greater directional agreement by the alcohol treatment norm group; (c) items designed to assess intervention preferences with consumers of small amounts of illegal drugs, and with public intoxicants; (d) items concerning the non-harmful use of alcohol or soft-drugs (marijuana, hashish); (e) four concepts (Alcohol Education/Cottage Training,

Alcohol, Drugs (illegal, not prescribed), Alcohol Abuse) to be rated using the semantic differential format; (f) an item assessing rationale (reasons) for the use of alcohol; (g) an item assessing functional interferences "caused" by or related to alcohol use; and (h) items modified from questions predictive of unsafe driving by persons who drink (Pelz-Schuman, 1968).

Questionnaire III This questionnaire includes: (a) items pertaining to a variety of demographic and background data; (b) items which examine need and use, for self and others, of a variety of health and social services; (c) items assessing patterns of alcohol use; (d) an item which examines the mixing of alcohol with other drugs; (e) an item pertaining to prescribed drugs; and (f) two self-report items concerning alcohol or drug involvement as problems.

ADMINISTRATION OF QUESTIONNAIRES

Subjects approached were given a presentation of the purposes of the study, including assurances of anonymity and confidentiality, a brief explanation of the selection procedure (controls were informed that they were randomly picked from residential addresses in selected parts of the area, rather than informed of the linked selection method), a subsequent solicitation for cooperation and, for those volunteering to complete the measures, release forms to sign describing the treatment and use of the information gathered. Signing was optional.

Subject names were not attached to the questionnaires. Identification of questionnaires was possible only if the subject signed the release form. If the subject signed, the signed form was attached to the questionnaires.

Participants were contacted at their homes or by telephone. Controls were typically contacted at their homes. Controls were generally tested in their homes, whereas participants had the option of being tested at home or at one of the Cottage locations. The majority of Cottage participants were tested in their homes.

The questionnaires were self-administrable although instructions prior to filling the questionnaires were necessary. Two modes of questionnaire administration were used:

MODE 1: "Face-to-Face". Following an explanation of how to complete the questionnaires, the surveyor presented the subject with the questionnaires and waited as the latter responded. The surveyor offered supportive statements to maintain subject test-taking behaviors. The surveyor also was available to answer questions concerning questionnaire items.

MODE 2: "Drop-off". Following the explanation of how to complete the questionnaires, the surveyor informed the subject that he/she would be back "in a few hours" to pick up the completed questionnaires. A methodological crisis was precipitated by the fact that questionniares administered by the independent research corporation were done almost entirely by the "drop-off" method, contrary to expectations that surveys would be conducted "face-to-face". Although the questionnaires were designed to be self-administered, the length of the questionnaires (each set required approximately 50 minutes to complete) and relative complexity of some of the items were of concern to the investigators. The questionnaires were intended, therefore, to be administered "face-to-face". Ostensibly, this concern was inadequately communicated to the research corporation contacted to conduct the survey.

Time and budget considerations necessitated the acceptance of all questionnaires completed by the research corporation. The subjects of both control groups and of PG1 were examined by surveyors associated with the research corporation. Of those subjects, 95% were surveyed by the "drop-off" method. In contrast, 70% of the subjects in PG2, surveyed by Cottage staff, were done "face-to-face" and 30% by "drop-off".

DATA ANALYSIS

Data analyses were performed primarily by using the Statistical Package for the Social Sciences (SPSS), Version 6.02, available on the University of Utah Univac 1108 computer (Nie et al, 1975). The SPSS routines for calculating T's also calculate an F-test for homogeniety of variance. If the F-test was significant at the 0.05 level or greater, the T-test was performed using a "separate variance estimate" (Nie et al, 1975) to evaluate the hypothesis. If the assumption of the homogeniety of variance was accepted, the "pooled variance estimate" was used to conduct the T-test. Other analyses were performed using X^2 tests of significance.

The signigicance level for tests conducted was set at alpha = .10. An alpha at this level admittedly runs a greater risk of letting through unwarranted chance differences. The Program, however, is a short-term, intensive effort which attracts a broad social range of individuals (Merrill, Boswell & Finney, 1975), who ostensibly represent an equally broad range of persons with varying levels of interest in, and knowledge of, alcohol. There was considerable concern, therefore, about screening out genuine differences by selecting a stringent alpha level. Additionally, this research on short-term, education and prevention outcomes is regarded as an exploratory search for promising measures. Overall, these considerations led to the selection of alpha = .10.

III. RESULTS

Dependent Variables

A. Knowledge Assessment Items

Although the dependent variables were briefly referred to in the Method Section, the complete descriptions of these measures and scoring conventions are noted below.

Engh Alcohol Knowledge Questions. Engh (1975) standardized a 36-item, true and false knowledge test about alcohol and its use on a sample of 121 college students who participated in a controlled study to assess the effects of a brief alcohol education program. The mean number correct on pretest administration for the experimental and control groups were 20.29 (standard deviation = 5.00) and 20.18 (standard deviation 5.47) respectively. Following exposure to the experimental conditions, both groups were administered an alternative form of the knowledge test. The mean number correct for the experimental and control groups were respectively, 28.21 (s.d. = 4.77) and 20.00 (s.d. = 5.75).

Program Knowledge Items. Fourteen true and false questions were derived from the Cottage Program and other alcohol reference materials. It was anticipated that the items taken from Program materials would have high face validity and hence be useful for determining retention

of Cottage specific concepts and also be sensitive to the method of Cottage training. Items derived from other general alcohol references were added to probe breadth and depth of knowledge.

Knowledge of Community Alcohol and Drug Abuse Resources. Knowledge of community resources available for people with alcohol and drug problems was measured by asking persons to name from 1 to 5 alcohol and from 1 to 5 drug abuse agencies. Each response was assigned a quality rating according to the scheme:

5 = The names of programs, individuals, or agencies specifically serving alcohol and drug involved clients in Salt Lake County.
4 = Established, licensed "helping" professionals available in Salt Lake County. For example: physicians, psychologists, psychiatrists, social workers. The name of a specific person was not required.
3 = AA, Al-Anon, Alateen and related services.
2 = School counselors, clergy or church related organizations or a mental health center. The name of a specific person or agency was not required.
1 = Hospitals available in Salt Lake County including general, non-specific naming of emergency hospital services and psychiatric wards.
0 = No response.

The scores for each response were then summed to form variables with minimum and maximum values equal to 0 and 25 respectively.

B. Opinions and Attitudes

Opinions about Alcohol. Subjects rated 24 statements pertaining to alcohol on a 5-point, strongly-agree to strongly-disagree scale. Among these statements were 12 on which a group of alcohol program treatment personnel (n = 24) demonstrated a 70% agreement/disagreement. The score for each subject was the number of items rated (i.e., agree or disagree) in the direction established by the norm (i.e., treatment) group. The maximum score for a subject on this measure was 12.

Opinions about Drugs. Subjects rated 20 statements pertaining to drugs on a 5-point, strongly-agree to strongly-disagree scale. Among these statements were 15 on which a norm group of alcohol program treatment personnel (n = 24) demonstrated 70% agreement/disagreement. The score for each subject was the number of items rated in the direction established by the norm group. The maximum score on this measure was 15.

Intervention Preferences for Public Intoxicants. Subjects were asked how they would intervene if confronted with a "drunk". Five alternatives, forming three intervention categories, were employed: an "ignore-support" category (i.e., "left alone", "taken home"); a "treat" category (i.e., "taken to a treatment center", "arrested and taken to a treatment center"); and a "punish" category (i.e., "arrested and prosecuted"). The categorical preference selected by a subject (i.e., "ignore-support, "treat", "punish") was the dependent variable.

Intervention Preferences for Persons in Possession of Small Amounts of Illegal Drugs for Personal Use. Sujbects were asked how they would intervene if confronted with a person possessing small amounts of illegal drugs for personal use. Three categories of intervention were employed: an "ignore-support" category (i.e., "ignored", "have drugs confiscated and otherwise ignored"); a "treat" category (i.e.,

"taken to a treatment center"); and a "punish" category (i.e., "arrested and prosecuted"). The categorical preference selected by a subject was the dependent variable.

Semantic Differential Ratings on Three Attitudinal Dimensions. Four concepts were rated by the subjects: Alcohol Education, Alcohol, Drugs (illegal, not prescribed), and Alcohol Abuse. Each concept was rated on three dimensions (i.e., evaluative, potency, activity), using pairs of polar adjectives relevant to the dimensions. Four pairs of polar adjectives were employed to measure each of the attitudinal dimensions. A 7-point scale anchored by the polar adjective pair was used to measure the three dimensions of each concept. The individual scale positions were converted to a numerical scale (1 = negative, weak, inactive, through 7 = positive, strong, active). The sum of the subject's responses to the four polar adjective pairs (maximum score = 28) pertaining to a dimension was the dependent variable. Each subject produced three measures (i.e., for the evaluative, potency and activity dimensions) for each concept rated.

Non-Harmful Use of Alcohol. Subjects were asked to rate a statement concerning the non-harmful use of alcohol, using a 5-point, strongly-agree to strongly-disagree scale. Each of the points on the scale was converted to a numerical quantity (1 = strongly-agree, to 5 = strongly disagree), and treated as the dependent variable produced by each subject.

Non-Harmful Use of "Soft Drugs". Subjects were asked to rate a statement concerning the non-harmful use of "soft drugs", using a 5-point, strongly-agree to strongly-disagree scale. Each of the points on the scale was converted to a numerical quantity (1 = strongly-agree to 5 = strongly-disagree), and treated as the dependent variable produced by each subject.

C. Behavioral Self-Report Measures

Reasons for Alcohol Use. Participants and controls completed eleven items which asked them to indicate on a 5-point scale ("not at all" through "always") how frequently they drank for certain reasons, e.g., sociability, enjoyment of taste (see questionnaire II, Item 51). The scores for each response were added to form a constructed summary variable with a minimum of 0 and a maximum of 44. Only data for those individuals who reported that they drank alcohol were included in the analyses.

Interference with Functioning by Alcohol. Participants and controls completed ten items which asked them to rate on a 5-point scale ("not at all" through "always") how frequently their drinking disrupted classes of behavior and caused negative outcomes to occur in certain situations (e.g., interfered with work or study, caused conflict with spouse/family). The scores for each response were added to form a constructed summary variable with a minimum of 0 and a maximum of 40. Only data from individuals who reported that they drank alcohol were included in the analyses.

Unsafe Driver Items. The Pelz-Schuman (1968) items were combined into a constructed summary variable with a minimum score of 0 and a maximum score of 16. Only data for individuals who reported that they drank alcohol were included in the analyses.

Use of Health and Social Services. Participants and controls completed a question which asked them to report their frequency of use for 9

different categories of health and social services during the past 12 months. The frequencies for the individual categories were summed to derive a constructed variable with a minimum score of 0 and an unspecified maximum.

Need for Health and Social Services. Controls and participants were asked to rate on a scale from 1 (no need) to 4 (great need) the degree to which they judged themselves to be in need of 9 classes of health and social services. The scores for each category were added to construct a summary variable of total need for service with a minimum score of 9 and a maximum score of 36.

Referral of Family or Friends for Health and Social Services. Participants and controls were next asked to indicate whether they had referred a family member or friend for any of 9 classes of health and social services during the last year. The rating for each class of services was added to form a summary variable with a minimum of 0 and a maximum of 9.

Average Amount of Alcohol Consumed. Participants and controls were asked to report the current average frequency and amount of beer, wine, and spirits that they consumed. The frequency of use of each class of beverage was multiplied by the average amount of that beverage consumed to generate a class score with a minimum of 0 (no use) and a maximum of 30 (daily use of an amount equal to or greater than 6 drinks). The consumption scores for each class of beverage were then added to form a summary variable for the total amount of alcohol drunk with a minimum of 0 and a maximum of 90. Only data for those individuals who drank were included in the analyses.

Self-Report of Alcohol as a Problem. Controls and participants were asked to rate their use of alcohol as a problem on a 4-point scale (1 = no problem; 4 = severe problem). Only data for those individuals who drank were included in the analyses.

Self-Report of Drug Use as a Problem. Participants and controls rated their use of drugs as a problem on a scale identical to the alcohol problem scale. Data from all participants were included in this analysis.

Demographic Background & Characteristics

In general the characteristics of the groups examined indicate that the Cottage Program has been presented to a diverse group of individuals (see Table 1). A modal description of the Cottage Participant in the present study would be white, female, housewife, high-school graduate with some college, from a middle-income household of 3.2 persons, Protestant (largely L.D.S.) and in the late 30's. This description is consistent with previous descriptions of "typical participants" (Merrill et al, 1975; Malouf et al, 1975).

The subjects in PG1, PG2 and C were similar in sex distribution. The CC group, however, shows a greater percentage of females. The large unemployment factor shown in the table is primarily due to the high percentage of females who were housewives, and therefore usually unemployed or empolyed part-time. The Program appears to attract a substantial proportion of individuals who use alcoholic beverages, although PG1 contained fewer drinkers (29.4%) than PG2, C and CC (40.5%, 40.5% and 50.0% respectively).

Within Group Comparisons

The groups involved in this study are presented in Table 2. Two participant groups were included because subjects in PG1 were not always recipients of the small interactive group process, i.e., PG1 represented a "mixed" population of former participants while PG2 participants experienced the Program as designed.

The *a priori* consideration that PG1 may have been different from PG2 was supported. Group comparisons on measures relevant to the experimental hypotheses (1 through 25), stated in null form, revealed signigicant differences between these groups on: alcohol knowledge, program knowledge, knowledge of drug resources, knowledge of alcohol resources, alcohol education - evaluative and activity dimensions, alcohol - potency dimension, alcohol abuse - potency dimension, unsafe driver, non-harmful use of drugs (see Table 3 for details).

The differences found, with one exception, generally suggest that PG2 subjects are more in agreement with Program expectations concerning knowledge, opinions and attitudes, and behaviors related to alcohol use than PG1 subjects. Comparatively, PG2 subjects were more knowledgeable about alcohol and about general Program concepts, knew of more drug and alcohol treatment resources, rated alcohol education higher on the evaluative and activity dimensions, perceived alcohol abuse as more potent, and were more tolerant of the use of soft drugs. PG2 subjects also rated alcohol as more potent than subjects in PG1. However, subjects in PG2 who use alcohol were more at risk as drivers than similar drivers in PG1.

No difference was observed in the nature of interventions preferred for public intoxicants (see Table 4). PG1 and PG2 minimized the use of "punish" and clearly preferred the "treat" and "ignore-support" alternatives. Concerning a comparison of persons in possession of small amounts of illegal drugs, the observed and expected frequencies for the three modes of intervention by PG2 revealed no difference. For PG1, however, signigicance was obtained ($X^2 = 6.81$, $df = 2$ $P < .04$). PG1 and PG2 appear equivalent in their use of the punitive approach. On the other hand, PG1 clearly preferred treatment interventions with the user, while PG2 equally selected the "ignore-support" and "treat" alternatives (see Table 4).

Because PG2 subjects completed the questionnaires under both modes of administration, PG2 subjects tested by the two modes were compared employing null hypotheses. PG2 subjects tested "face-to-face" were more productive in listing drug resources ($t = 3.16$, $df = 35$, $p < .01$) and alcohol resources ($t = 2.38$, $df = 35$, $p < .05$), rated alcohol education higher on the evaluative ($t = 2.35$, $df = 35$, $p < .05$) and activity ($t = 2.3$, $df = 35$, $p < .05$) dimensions and were more accepting of the non-harmful use of alcohol ($t = 1.93$, $df = 34.87$, $p < .10$).

The above findings suggest that "face-to-face" testing conditions can facilitate performance. Overall, however, PG2 subjects appear more alike than unlike each other, regardless of mode of questionnaire administration. The effect of the mode of amininistration, unfortunately, is not evaluable given the design of this study. Since mode is confounded with examiner conditions (i.e., PG2 subjects were tested only by Cottage staff; other groups only by the research corporation), caution is indicated in interpreting comparisons involving PG2.

Table 2 also presents the control groups, C and CC. The CC group was included to examine whether interest or motivation for involvement in the

TABLE 2

COMPARISON GROUPS

Group	n	Distinguishing Characteristics
I. Participant Group 1 (PG1)	34	Mixed group: includes participants trained in either large - typically didactic, or small - interactive groups and/or participants attending one or both Program sessions.
II. Participant Group 2 (PG2)	37	Participants known to have attended both small interactive Program sessions.
III. Cooperative Controls (CC)	12	Controls who completed the questionnaires and subsequently reported an interest in the Program.
IV. Controls (C)	37	Controls who completed the questionnaires, but rejected the solicitation for Program participation.

TABLE 3

Descriptive and Inferential Statistics for Participant Group I (PG1) and Participant Group 2 (PG2)

Hypo-thesis	Measure	Group				Inferential Statistic		
		PG1		PG2		t value	df	p
		Mean	Standard Deviation	Mean	Standard Deviation			
1.	General Alcohol knowledge Test	24.35	2.55	26.05	3.34	-2.39	69	.020*
2.	Program knowledge Test	9.88	1.90	11.03	1.85	-2.57	69	.012*
3.	Knowledge of Drug Resources	4.74	5.92	7.19	5.86	-1.75	69	.084*
4.	Knowledge of Alcohol Resources	7.53	4.86	9.95	6.81	-1.71	69	.092*
5.	Opinion Ratings About Alcohol	8.59	1.78	9.08	1.40	-1.30	69	.197
6.	Opinion Ratings About Drugs	10.68	2.84	11.59	1.89	-1.59	58.61	.117
11.	Meaning of Alcohol Education							
	1. Evaluative	20.62	4.19	22.97	3.85	-2.47	69	.016*
	2. Potency	17.47	3.55	18.33	3.23	-1.13	69	.263
	3. Activity	17.56	3.58	19.84	3.57	-2.68	69	.009*
12	Meaning of Alcohol							
	1. Evaluative	12.35	4.92	13.32	5.81	-.76	69	.452
	2. Potency	17.85	3.99	19.65	4.34	-1.81	69	.075*
	3. Activity	16.79	3.29	17.24	3.79	-.53	69	.596
13.	Meaning of Drugs (Illegal/not prescribed)							
	1. Evaluative	10.68	4.98	11.89	5.60	-.96	69	.339
	2. Potency	19.79	5.01	20.32	4.84	-.45	69	.651
	3. Activity	17.00	4.49	18.51	4.65	-1.39	69	.168
14.	Meaning of Alcohol Abuse							
	1. Evaluative	10.35	5.05	9.65	5.25	.58	69	.567
	2. Potency	19.12	5.09	21.57	4.40	-2.17	69	.033*
	3. Activity	17.82	5.79	18.89	5.39	-.81	69	.423
15.	Opinion Rating about the potential for the non-harmful use of alcohol	2.76	.89	2.73	1.52	.12	58.89	.905
16.	Opinion Rating about the potential for the non-harmful use of "soft" drugs.	3.35	1.04	2.89	1.22	1.71	69	.093*

(cont.)

TABLE 4

Descriptive and Inferential Statistics for Participant Group 1 (PG1) Participant Group 2 (PG2) and Combined Control Groups (C): Intervention Preferences

Group	Hypothesis	Intervention Preferences			Test		
		Catagory	Expected[a]	Observed[b]	$\underline{X}^2$	df	p
PG1	7. Public Intoxication	a. Ignore-Support	13.6	21			
		b. Treat	13.6	11			
		c. Punish	6.8	2			
					7.91	2	<.02*
	8. Soft Drug Use	a. Ignore-Support	13.6	8			
		b. Treat	13.6	21			
		c. Punish	6.8	5			
					6.81	2	<.04*
PG2	7. Public Intoxication	a. Ignore-Support	14.0	19			
		b. Treat	14.0	15			
		c. Punish	7.0	1			
					7.00	2	<.04*
	8. Soft Drug Use	a. Ignore-Support	13.6	14			
		b. Treat	13.6	16			
		c. Punish	6.8	4			
					1.59	2	N.S.
C	9. Public Intoxication	a. Ignore-Support	19.2	31			
		b. Treat	19.2	3			
		c. Punish	9.6	4			
					12.52	2	<.01*
	10. Soft Drug Use	a. Ignore-Support	18.0	17			
		b. Treat	18.0	20			
		c. Punish	9.0	8			
					0.39	2	N.S.

[a]The "expected frequencies were based on the assumption of equal use of intervention responses relevant to the three categories. Five preferences were available, two each for "ignore-support" and "treat", and one for "punish".

[b]The minor differences in frequency counts for PG2 and C are due to missing

*Difference is significant

Program interacted signigicantly with the measures gathered in this investigation. It was presumed that CC subjects would be similar to Program participants prior to the Program experience and would serve as a useful comparison group to assess Program effects.

Null comparisons of the control groups on measures relevant to the experimental hypotheses were generally accepted. Ostensibly, interest in the Program does not interact with the experimental measures obtained. A signigicant difference involving one of the comparisons made was found: this deviation from null, however, is interpreted as a chance occurrence rather than a "real" one. These two groups were combined, therefore, to form a single control group (also referred to as C) for comparison with the two participant groups (PG1 and PG2).

Between Group Comparisons

Data analyses* allowing evaluation of the twenty-five hypotheses are presented in the sections that follow. Table 5 contains the means, standard deviations and significance tests for comparisons of PG1 vs C on hypotheses 1 through 6 and 11 through 25. Table 6 contains similar data for comparisons involving PG2 vs C. The analyses for evaluation of hypotheses 7 through 10 for PG1, PG2 and C are found in Table 4.

A. Knowledge Assessment

PG1 vs C. According to expectations (hypothesis 1, Table 5) PG1 answered signigicantly more questions correct than C on Engh's test of general knowledge about alcohol. In comparison to the experimental group mean of 28.21 from Engh"s study (1976) PG1 answered an average of 3.86 fewer items correct. The control subjects in the present study, however, answered 3.04 more questions correct than Engh's controls (1976).

The mean number correct for PG1 on the Program Knowledge Questions (hypothesis 2, Table 5) was not significantly different from the control group mean. PG1 was signigicantly more knowledgeable, however, about alcohol treatment resources (hypothsis 4, Table 5), recalling more specific agencies and individuals from whom help could be sought. Comparisons of the groups on knowledge of drug treatment agencies (hypothesis 3, Table 5) were not significant although the mean for PG1 was slightly higher than the control group score.

PG2 vs C. PG2 scored significantly higher than C on all knowledge items (measures 1 through 4). PG2 was more knowledgeable about general alcohol information (Engh's Questions); knew more Cottage Program concepts, and could name more alcohol and drug specific "helping" resources. In

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*Analyses comparing knowledge, and attitude and opinion scores for drinkers vs non-drinkers within and between groups were nonsignificant. Apparently the impact of the program is independent of alcohol use. It appears, therefore, that experience with drinking does not necessarily lead to greater knowledge about alcohol or to perceptible differences in attitudes and opinions.

TABLE 5

Descriptive and Inferential Statistics for Participant Group I (PG1) and Combined Control Groups (C)

Hypothesis	Measure	Group				Inferential Statistic		
		PG1		C				
		Mean	Standard Deviation	Mean	Standard Deviation	t value	df	p
1.	General Alcohol Knowledge Test	24.35	2.55	23.64	5.10	1.55	74.68	.063*
2.	Program Knowledge Test	9.88	1.90	9.67	2.51	.41	81	.341
3.	Knowledge of Drug Resources	4.74	5.92	4.14	4.21	.50	55.59	.309
4.	Knowledge of Alcohol Resources	7.53	4.86	5.76	5.01	1.59	81	.058*
5.	Opinion Ratings about Alcohol	8.59	1.78	8.49	1.79	.25	81	.403
6.	Opinion Ratings about Drugs	10.68	2.84	9.55	2.97	1.73	81	.043*
11.	Meaning of Alcohol Education							
	1. Evaluative	20.62	4.19	20.04	3.57	.67	81	.251
	2. Potency	17.47	3.55	15.94	3.24	2.04	81	.023*
	3. Activity	17.56	3.58	16.37	2.38	1.70	52.91	.047*
12.	Meaning of Alcohol							
	1. Evaluative	12.35	4.92	13.25	4.99	-.80	81	.423
	2. Potency	17.85	3.99	17.49	4.42	.38	81	.703
	3. Activity	16.79	3.26	16.94	4.00	-.17	81	.862
13.	Meaning of Drugs (illegal/not prescribed							
	1. Evaluative	10.68	4.98	11.92	5.25	-1.08	81	.282
	2. Potency	19.79	5.01	18.18	5.51	1.36	81	.178
	3. Activity	17.00	4.49	16.27	4.73	.71	81	.480
14.	Meaning of Alcohol Abuse							
	1. Evaluative	10.35	5.05	10.59	4.80	-.22	81	.414
	2. Potency	19.12	5.09	18.73	5.06	.34	81	.368
	3. Activity	17.82	5.79	17.49	4.37	.30	81	.388
15.	Opinion Rating about the potential for the non-harmful use of alcohol	2.76	.89	3.08	1.80	-1.06	74.33	.146

(cont.)

TABLE 5 (cont.)

Descriptive and Inferential Statistics for Participant Group I (PG1) and Combined Control Groups (C)

Hypothesis	Measure	Group				Inferential Statistic		
		PG1		C				
		Mean	Standard Deviation	Mean	Standard Deviation	t value	df	p
16.	Opinion Rating about the potential for the non-harmful use of "soft" drugs.	3.35	1.04	3.43	1.72	-.25	79.74	.804
17.	Reasons for Alcohol Use. (Drinkers only)	10.05	4.81	11.33	5.70	-.40	29	.346
18.	Interference of Function by Alcohol. (Drinkers only)	1.60	1.78	3.24	4.12	-1.54	28.88	.066*
19.	Unsafe Driver questions (Drinkers only)	1.00	.94	1.76	1.97	-1.46	28.97	.078*
20.	Use of Health and Social Services	9.04	8.71	8.40	15.98	.22	66.95	.829
21.	Need for Health and Social Services	11.19	3.19	10.04	2.76	1.69	81	.095*
23.	Referral of Family or friends for Health and Social Services	1.35	1.63	.82	1.19	1.64	56.39	.106
23.	Average amount of alcohol consumed (Drinkers only)	19.00	6.85	22.33	11.11	-.87	29	.196
24.	Self-Report of Alcohol Problem Status (Drinkers only)	1.30	.675	1.10	.30	.92	1.074	.379
25.	Self-Report of Drug Problem Status	1.00	0.00	1.00	0.00	0.00	81	1.00

*Significant difference

TABLE 6

Descriptive and Inferential Statistics for Participant Group 2 (PG2) and Combined Control Groups (C)

Hypothesis	Measure	Group				Inferential Statistic		
		PG2		C		t value	df	p
		Mean	Standard Deviation	Mean	Standard Deviation			
1.	General Alcohol Knowledge Test	26.05	3.34	23.04	5.10	3.30	82.64	.0005*
2.	Program Knowledge Test	11.03	1.85	9.67	2.51	2.76	84	.0035*
3.	Knowledge of Drug Resources	7.19	5.85	4.14	4.21	2.68	62.43	.0045*
4.	Knowledge of Alcohol Resources	9.95	6.81	5.76	5.01	3.14	63.44	.0015*
5.	Opinion Ratings about Alcohol	9.08	1.40	8.49	1.79	1.66	84	.055*
6.	Opinion Ratings about drugs	11.59	1.89	9.55	2.97	3.89	81.95	.0001
11.	Meaning of Alcohol Education							
	1. Evaluative	22.97	3.25	20.04	3.57	3.65	84	.0001*
	2. Potency	18.33	3.23	15.94	3.24	3.47	84	.0005*
	3. Activity	19.84	3.57	16.37	2.38	5.12	59.17	.0001*
12.	Meaning of Alcohol							
	1. Evaluative	13.32	5.81	13.25	4.99	.07	84	.946
	2. Potency	19.65	4.34	17.49	4.42	2.26	84	.026*
	3. Activity	17.24	3.79	16.94	4.00	.36	84	.722
13.	Meaning of Drugs (Illegal/not prescribed)							
	1. Evaluative	11.89	5.60	11.92	5.25	-.02	84	.982
	2. Potency	20.32	4.84	18.18	5.51	1.88	84	.064*
	3. Activity	18.51	4.65	16.27	4.73	2.20	84	.031*
14.	Meaning of Alcohol Abuse							
	1. Evaluative	9.65	5.25	10.59	4.80	-.87	84	.194
	2. Potency	21.57	4.40	18.73	5.06	2.72	84	.004*
	3. Activity	18.89	5.39	17.49	4.37	1.33	84	.095*
15.	Opinion Rating about the potential for the non-harmful use of alcohol	2.73	1.52	3.08	1.80	-.96	84	.170
16.	Opinion Rating about the potential for the non-harmful use of "soft" drugs.	2.89	1.22	3.43	1.72	-1.69	83.72	.094*

(cont.)

TABLE 6 (cont.)

Descriptive and Inferential Statistics for Participant Group 2 (PG2) and Combined Control Groups (C)

Hypothesis	Measure	Group				Inferential Statistic		
		PG2		C		t value	df	p
		Mean	Standard Deviation	Mean	Standard Deviation			
17.	Reasons for Alcohol use. (Drinkers only)	12.47	9.63	11.33	5.70	.41	20.96	.344
18.	Interference of function by alcohol (Drinkers only)	4.33	7.34	3.24	4.12	.52	20.30	.304
19.	Unsafe Driver questions (Drinkers only)	2.20	2.01	1.76	1.97	.65	34	.259
20.	Use of Health and Social Services	16.97	35.47	8.40	15.98	1.34	46.79	.186
21.	Need for Health and Social Services	11.35	5.16	10.04	2.76	1.34	46.84	.185
22.	Referral of Family or friends for Health and Social Services	1.86	2.34	.82	1.19	2.50	49.93	.016*
23.	Average amount of alcohol consumed (Drinkers only)	20.40	7.93	22.33	11.11	-.58	34	.284
24.	Self Report of Alcohol Problem Status (Drinkers only)	1.53	1.13	1.10	.30	1.47	15.44	.081*
25.	Self-Report of Drug Problems Status	1.08	3.63	1.00	.00	1.56	84	.121

* Significant difference

comparison to the experimental group from Engh's study, PG2 answered 2.16 fewer items correct. Hypothesis 1 through 4 were accepted for PG2 (see Table 6).

B. Opinions and Attitudes

PG1 vs C. Consistent with expectation, PG1 demonstrated greater agreement with opinions established by a relevant norm group (alcohol treatment personnel) concerning drugs and drug treatments (see Table 5, Hypothesis 6) than the control group. A similar level of agreement with opinions pertaining to alcohol and alcohol treatment was not obtained, although the difference between groups was in the predicted direction (see Table 4, Hypothesis 5).

The intervention perferences of PG1 and controls for persons publically intoxicated (see Table 4, Hypothesis 7) were similar. On this measure, three response categories were involved: "ignore-support", "treat", and "punish". Both groups minimized use of the "punish" category, and preferred the "ignore-support" approach for public intoxicants. Concerning persons in possession of small amounts of illegal drugs, the observed distribution of alternatives selected by control subjects was equal to the expected distribution. PG1 subjects, however, differed signigicantly from expected, clearly preferring use of the "treat" alternative (see Table 4, Hypothesis 8).

On the semantic differential, PG1 subjects significantly rated the concept, Alcohol Education, as expected (i.e., higher) on two (potency, activity) of the three dimensions (see Table 5, Hypothesis 11). Participants were higher also on the evaluative dimension ratings; the difference, however, was not significant. As anticipated, no differences were obtained in the semantic differential ratings of the concepts of Alcohol and Drugs (see Table 5, Hypothesis 12 and 13). Dimensional differences, on the other hand, were expected in group ratings of the concept, Alcohol Abuse. The expectations, however, were not supported (see Table 5, Hypothesis 14).

Lastly, it was expected that PG1 subjects would be more inclined to believe that alcohol could be used in a non-harmful fashion than control subjects and that both gorups would not differ in opinions about the non-harmful use of drugs. The latter (null) hypothesis was supported (see Table 5, Hypothesis 16). However, contrary to expectation about the non-harmful use of alcohol (see Table 5, Hypothesis 15) both groups were essentially neutral in their opinions about the non-harmful use of alcohol.

PG2 vs C. Congruent with experimental expectation, participants in PG2 showed significantly greater agreement with normed opinions concerning alcohol and drug statements (see Table 6, Hypotheses 5 and 6) than the control group. The intervention preferences of PG2 and control subjects for public intoxicants did not differ, although both groups deviated significantly from the expected distribution of intervention preferences (see Table 4). Both groups minimized the use of "punish". However, while PG2 subjects were approximately equal in their use of "ignore-support" and "treat" alternatives, control subjects preferred the "ignore-support" alternative over the other choices ($X^2 = 9.25$, $df = 1$, $P < .01$). No differences between expected and observed frequencies were found in the intervention preferences of PG2 and controls for users of soft drugs (see Table 4).

On the semantic differential, the expectation that PG2 subjects would rate Alcohol Education higher on the three dimensions was upheld (see Table 6, Hypothesis 11). Expectations concerning Alcohol Abuse for PG2 subjects in comparison with controls were partially supported. Differences in the expected directions were obtained on the potency and activity dimensions, but not on the evaluative dimension (see Table 6, Hypothesis 14). For the concepts, Alcohol and Drugs (the hypotheses were stated in null form), PG2 subjects rated the potency dimension significantly higher than control subjects on both concepts (see Table 5, Hypothesis 12 and 13). PG2 subjects also rated the activity dimension on Drugs higher than the controls.

PG2 subjects did not differ from controls in their opinions about the non-harmful use of alcohol, although the difference obtained was in the expected direction (see Table 6, Hypothesis 15). No differences in opinion about the non-harmful use of soft drugs was expected between participants and controls. PG2 subjects were found, nevertheless, to be significantly supportive of the non-harmful use of soft drugs (see Table 6, Hypothesis 16).

C. Behavioral Assessment

PG1 vs C. Of the nine behavior related hypotheses (see Table 5, Hypotheses 17 through 25) evaluated for PG1 vs C, three were accepted. There were significant differences between PG1 and C on measures of "Interference With Function by Alcohol" (Hypothesis 18), "Unsafe Driver Status" (Hypothesis 19), and "Need for Health and Social Services" (Hypothesis 21). Reports by PG1 drinkers indicate less functional interference due to alcohol use than reports by C drinkers. Similarly, PG1 scores on the Pelz-Schuman scale indicated they engaged in fewer unsafe driving practices than C. However, PG1 saw themselves as being in greater "Need of Health and Social Services" than C. While the remaining comparisons were not statistically significant, measures relevant to Hypotheses 22 and 23 tended toward significance. That is, PG1 tended to make more "Referrals for Health and Social Services" ($p = .106$) and reported drinking less ($p - .196$) than C.

Considering the absolute level of scores on variables for the two groups, it is noted that most tended toward minimum values. For the significant comparison, "Interference with Function by Alcohol", the means were extremely low indicating that individuals in both groups drink in a way that rarely causes them unpleasant effects. Similarly, the absolute level of scores for the Pelz-Schuman "Unsafe Driver" items, although significantly different tended toward minimum values, denoting that both groups would be considered "safe drivers". The "Need for Health and Social Services" variable shows the same trend, with both groups scoring slightly above the minimum value of 9.

For the nonsignificant comparison "Reasons for Alcohol Use", neither group admit that they drink for socially inappropriate reasons, nor do they rationalize their drinking by indicating that they "always" drink for any one reason. Regarding the variable "Use of Health and Social Services", both groups indicated an average frequency of use of about 9 services per year or less than one per month. A similar trend is seen for "Referral of Family or Friends for Health and Social Services" with both groups tending toward a minimum number of referrals of approximately one per year.

The scores for the groups on the "Average Amount of Alcohol Consumed" are more difficult to interpret because of the relatively large variability of the scores and because the scores were a composite generated by combining frequency of drinking three types of beverages. The mean scores would indicate that individuals who drink are moderate consumers, consuming 3 to 4 drinks on about three days per week (9 to 12 drinks per week). The higher variability for the control group indicates some individuals tended toward heavy and perhaps problem drinking. Mean ratings of alcohol as a problem by drinkers in both groups were low, tending toward the minimum. When compared to the absolute amounts of alcohol consumed by the groups, the problem ratings would appear to be contradictory. That is, C had a higher absolute amount of consumption than PG1, and yet saw themselves as having fewer problems with alcohol than PG1.

Ratings by the groups of "Drug Use as a Problem" were at the minimum 1 (no problem). Attempts to correlate reports of use with problem ratings were unsuccessful since most participants either did not answer the frequency of drug use items or rated their use at zero.

PG2 vs C. Comparisons of PG2 and C on the nine behavioral measures revealed significant differences on the number of "Referrals of Family or Friends for Health and Social Services" (Hypothesis 22) and on the self ratings of "Alcohol as a Problem" (Hypothesis 24). PG2 made more referrals of "Family and Friends for Health and Social Services" than C subjects. Similarly, PG2 drinkers rated themselves as having more of an alcohol problem than C drinkers. While comparisons on the remaining seven behavioral measures were not statistically significant, "Use of Health and Social Services" (Hypothesis 25) and "Need for Health and Social Services" (Hypothesis 21) tended toward significance ($p=.186$ and $p = .185$, respectively).

Similar to the patterns noted for PG1 and C in the previous section, the absolute level of scores on the variables for PG2 tended toward minimum values. For the comparison, :Referral of Family or Friends for Health and Social Services", PG2 made referrals for about two services per year (minimum = 0). Considering that the minimum value for ratings of "Alcohol as a Problem" is 1, no problemm while 2 is a slight problem, PG2 drinkers with a mean score of 1.53 saw themselves as tending toward a slight problem. Comparing the absolute level of alcohol consumption of 20.40 for this group to the level for C of 22.33, a contradiction is noted. Why would PG2 drinkers, while drinking less than C drinkers, rate themselves as tending toward a slight problem?

On the non-significant comparison "Reasons for Alcohol Use", PG2 drinkers tended toward the minimum of 0, indicating that rationalization for drinking occurs at a low level. Similarly, the score for PG2 on "Interference with Function by Alcohol" are at a minimum. It appears that alcohol use rarely causes unpleasant outcomes for PG2

The scores on the Pelz Schuman "Unsafe Driver Items" reflect that PG2 drinkers are on the whole, safe drivers. For the variable "Use of Health and Social Services", PG2, while using more services than PG1 or C, tends toward the minimum, using these services on an average of 16.97 times per year. The large variability for the score reflects the use of weekly counseling services by one individual.

PG2 rated themselves slightly above the minimum value of 9 for "Need for Health and Social Services". Apparently these participants

see themselves as receiving adequate services. Like PG1 and C, the scores on "Average Amount of Alcohol Consumed" would indicate that PG2 drinkers are moderate consumers whose drinking causes them little dysfunction. On the variable "Self Report of Drugs as a Problem", again, PG2 tends toward a minimum, rating themselves as having "No Problem".

Additional Findings

It was noted earlier (see Method Section) that participants of the Cottage Meeting Program were drawn from three different periods: 6-12 months, 13-24 months and 25-36 months prior to the collection of experimental data. Participants from these time periods in both PG1 and PG2 generally were found to respond similarly on the knowledge, opinions and attitudes and behavior-related measures administered. These findings led to the treatment of subjects within PG1 and PG2 as "wholes" since time of Program training did not discriminate among these subjects. In comparing participants with Control subjects, the differences obtained indicate that the Cottage Program clearly impacts upon the pursuit, acquisition and retention of knowledge relevant to alcohol and other drugs. Furthermore, since differences were not shown among participants from the prior Program training periods, it appears that the Program's impact upon knowledge is relatively immediate and enduring.

In opinions and attitudes, fewer differences between participants and controls were obtained. Additonally, the differences obtained largely invovled comparisons between PG2 and C. It appears, therefore, that while prior time of Program trianing is not a determining factor, participation in the two-session, small and interactive group meetings is a factor interacting with the opinion and attitude measures.

Even fewer differences between participant and control subjects were obtained on self-reported behaviors, indicating that Program impact is weakest in the behavioral area. An inspection of the data obtained, however, revealed interesting trends in the reported behaviors of PG1 and PG2 subjects vs control subjects concerning drinking. In particular, drinking participants reported less consumption of alcohol than drinking controls, but rated their use of alcohol as more of a problem than controls (see Table 5 and 6). An aposteriori decision was made, consequently, to examine the strength of relationship between self-report items for drinkers only within the participant and control groups. Because of the interest in Program outcomes on drinking, this examination focused on the relationship of amount of alcohol consumed with each of the following self-report items: self-rating of alcohol use as a problem, at-risk driver score, reasons for alcohol use, and functional interferance due to alcohol use.

Table 7 presents the correlation values generated. Consistent with Hypotheses 17, 18, 19 and 24, it was expected that positive r's would be obtained between amounts of alcohol consumed and each of the other four, drinker only items. The findings obtained are noteworthy. For one, most of the r's calculated were found to be significant, indicating that the behaviors referred to in these items are internally consistent. These findings also provided support for the expectation of a positive relationship between amount of alcohol consumed and other drinking-related activities.

TABLE 7

Pearson Product-Moment r's Between Amount Alcohol Consumed and Each of Four, Drinker-Only, Items.

Group	r with Amount Alcohol Consumed			
	Item			
	Alcohol as Problem	At-Risk Score	Reasons for use	Interfere with Function
Control	-.19	.41*	.74**	.81**
PG1	.02	.61*	.36	.27
PG2	.63**	.37	.67**	.73**

* $\underline{P} \leq .05$
** $\underline{P} \leq .01$

Secondly, the findings suggest that participants trained in small, interactive sessions perform more in accordance with expectations than participants whose training was conducted under unknown or large group conditions. PG2 subjects, those trained *via* small, interactive sessions, are clearly more open about or sensitive to the problem potential of alcohol use and apparently relate use to other drinking-related activities. PG1 subjects did not relate consumption of alcohol to alcohol use as a problem, nor did they see themselves as using alcohol for a variety of reasons or as functionally hampered because of alcohol use. Interestingly, the consumption of PG1 subjects was significantly related to their at-risk driver score. This relationship may have been identified because the at-risk driver score is essentially subtle in its derivation. Thirdly, PG2 subjects show a strong relationship between alcohol consumption and ratings of alcohol use as a problem, while controls show a negative, albeit non-significant, *r*. Controls show no relationship between their use of alcohol and their sensitivity to such use as a problem. Interestingly, controls showed significant *r*'s between amounts consumed and at-risk scores, and, similar to PG2 subjects, significantly related consumption to the number of reasons listed to use alcohol, and to reports of functional interference due to alcohol use.

In the design of this study, a subset of control subjects was identified which the investigators believed would add significantly to an assessment of Program effects. These were the "cooperative" controls, i.e., control subjects who expressed interest in Program training following a brief description of the Cottage Program and an invitation to training. It was believed that such subjects would be especially similar to former Program participants, but without benefit of training. This group was perceived as critical, inasmuch as factors associated with interest and motivation may significantly affect subject response to the questionnaires administered. It was found that control subjects, regardless of interest in the Program, were not different in their responses. All control subjects were combined, therefore, forming a single C group.

Of note, however, is the fact that 24.5% of persons (i.e., "cooperatives") serving as controls were interested in the Program. The substantial number of non-Program individuals found to be interested in alcohol education and prevention (note that these individuals were approached solely *via* "linking" to former participants) is highly supportive of earlier assertions that the basic Cottage Outreach procedure ("knocking on doors") is workable and productive (Boswell & Dinsmore, 1976).

Participants and controls were asked to state their perception of the purpose of the Cottage in an open-ended question. The responses were scored according to quality, using the scheme: 1 = heard of it; 2 = linking the Cottage with alcohol, or changing behavior, attitudes and communication skills with alcohol implied, or providing education, prevention or help for problems with alcohol again implied; 3 = linking the concept of alcohol with education, prevention, training, family problems or helping the family of the alcoholic; and 4 = linking alcohol consistently with the family and connecting this concept with education, prevention, training, changing behavior, attitudes or communication.

Two additional questions asked the participants: (a) "if they had been instrumental in arranging other Cottage Meetings"; and, if yes, (b) "how many Cottage Meetings did they arrange".

The mean scores for the purpose of the Cottage for PG1 and PG2 were

2.94 (S.D. = .814) and 2.93 (S.D. = .840) respectively, indicating that, in general, individuals who experienced the Cottage saw it as an alcohol education, prevention or family intervention program.

Thirty-three individuals in PG1 reported they had not been instrumental in arranging other Cottage Meetings, and one person reported he had been responsible for arranging two meetings.

Eight of the thirty-seven individuals in PG2 reported they had been responsible for arranging other meetings according to the distribution:

Individuals	No. of Meetings Arranged
1	1
1	2
1	3
2	5
2	10
1	72

Considering PG1 and PG2 as a total group, nine people (13% of the total participants interviewed) were responsible for arranging one hundred other Cottage Meetings. Since each Cottage Meeting includes approximately three people, these participants were instrumental in voluntarily spreading the Cottage concept to three hundred other individuals.

IV. DISCUSSION

The Cottage Meeting Program is a brief, highly interactive, small group education and prevention effort which is well received and regarded locally and nationally. Because of the Program's nature, mainly its brevity and content (education and prevention), prior evaluations of the Program have focused upon consumer satisfaction and highly subjective assessments of knowledge, attitudinal and behavioral changes. Those evaluations have generally produced strong support for the Program (Merrill et al, 1975; Malouf et al, 1975). The present study represented an effort to more objectively assess the efforts of the Cottage Program.

In designing this study, it was recognized that an evaulation of an education and prevention program was, at best, a difficult affair. For one, there are no generally accepted criteria concerning the construction, contents or objectives for substance abuse education and prevention. Secondly, methodological problems abound in experimental efforts to measure changes in knowledge, attitudes, and behavior as a result of such training. Relatedly, the measures and controls needed to assess Program effects typically demand evaluation strategies which are longitudinal in nature and which make use of random assignments to treatment and non-treatment groups (Globetti, 1975). It is not surprising, therefore, that evaluations of substance abuse education, particularly of alcohol education, are rarely done. And, if evaluations are done, these typically involve short-term attitudinal assessments (Smart, 1972).

This study was, however, an attempt to objectify attitudinal and subjective claims of Program effect. In defining the areas to be measured, it seemed natural to examine variables likely influenced by Program exposure, i.e., knowledge, opinions and attitudes, and related behaviors. Subjective assertions of Program impact upon these particular areas have been made

(Merrill et al, 1975; Malouf et al, 1975). In defining the measures to be gathered, it was assumed that the brief, small, interactive Cottage Program format would generally sensitize participants to things and events relevant to substance abuse, particularly of alcohol. It was expected that this "set" would lead to more flexible, tolerant, and healthful perceptions, opinions and attitudes about substances, and finally, that this "set" would eventuate in appropriate alcohol-related behaviors.

Needless to say, most of the measures obtained did not relate to specific elements of the Cottage Program. The variety of measures devised did relate, however, to an effort to assess the Program and its effects. The variety of measures involved also permitted an examination of the range and generality of the Program's impact upon participants.

The results show clearly that the knowledge level of individuals who participate in the Cottage Meeting Program is enhanced. In particular, the small group, interactive training procedure is indicated to be superior to the large group procedure for changing knowledge. This observation is primarily supported by the superior performance of PG2 over PG1. Knowledge appears associated to both procedures, but the small group seems to be most efficacious.

Concerning opinions and attitudes, the comparisons made indicate that Program effects are largely contingent upon the method of delivery. Participants trained in the two, small, interactive group sessions performed more in accordance with Program expectations concerning opinions and attitudes than participants whose training experiences were "mixed" (i.e., in terms of attendance or method of delivery), or untrained individuals from similar social environments. These results indicate that the small, interactive training method impacts favorably upon the feelings and opinions of the participants. Such participants appear to become more like alcohol treatment personnel whom, we presume, have personal or professional orientations conducive to rapport-building, understanding, and behavior change activities.

The affective or connotative impact of the Program upon properly trained individuals also is noteworthy. These participants are indicated to conceptualize and interpret substances and substance use as different from individuals who generally do not receive proper training or who receive no training at all. Properly trained individuals reliably attach greater subjective significance to alcohol education, to alcohol and its abuse, and to illegal/non-prescribed drugs. This implication contains much signigicance for prevention inasmuch as one's activities are often groverned more by "affective" or "connotative" meanings attached to these activities than by their "dictionary" meanings.

No differences were found between the groups in their rejection of punishment as a means of dealing with alcohol and soft-drug use, nor in group perceptions about the non-harmful use of alcohol. Depending on training, however, differences were observed in the groups' preference for "ignore-support" and "treat" interventions for users, and in their opinions concerning the non-harmful use of "soft-drugs". Properly trained participants were more tolerant of "soft-drug" use than the other two groups ("mixed" participants and controls), suggesting that well-trained individuals tend to consider "soft-drug" use as less dangerous than alcohol use. Additionally, "mixed" participants and untrained individuals tend to prefer "ignore-support" interventions for the publicly intoxicated person, while properly trained participants equally prefer "treat and "ignore-support interventions.

Of special note concerning opinions and attitudes is the suggestion that participants with unknown or large group training are more like control individuals than properly trained participants. It is suggested, therefore, that while method of Program delivery may be of debatable consequence for the promotion of knowledge, proper delivery (i.e., delivery in small, interactive sessions) is apparently strongly related to the development of desirable attitudes, opinions and "meanings".

Only minor differences were detected between participant groups and controls on the behavioral, self-report measures. The absolute rates of most measures were low, tending toward minimum values. Thus, where the differences were significant, the meaning of the differences found is not entirely clear because of the "flooring" of the measures. It is therefore suggested that other, and more subtle measures need to be developed to adequately assess behavioral changes. The difficulty in changing behaviors is a well documented fact. It is probably "asking too much" that 4 hours of intervention should alter long established and complex behavior patterns.

Despite the poverty of support for hypotheses pertinent to self-reported behaviors, the <u>aposteriori</u> look at relationships involving amount of alcohol consumed with <u>at-risk driver</u> score, ratings of alcohol use as a problem, reasons for using alcohol, and functional interference due to alcohol use, yielded provocative data. The findings provided internal support for self-reports as a data source, and, relatedly, upheld the logical expectation of a reliable, positive relationship between amount consumed and other drinking-related activities. Of particular interest, however, was the finding that properly trained participants, in comparison with untrained persons and participants with unknown or large group Cottage Program training, clearly related amount of alcohol consumed with alcohol use as a problem (see Table 7), while the latter two groups revealed no relationship whatsoever. It would appear that properly trained participants are more willing to admit to the problem potential of alcohol use than do individuals in the other groups. Since change in "denial" or unwillingness to confront an unpleasant reality is a basic objective of intervention/prevention programs, one may surmise that the Cottage Meeting Program, at least with properly trained participants, has shown substantial accomplishment relative to this objective.

Concerning the data shown in Table 7, it is of additional interest that greater agreement is shown between the reports of properly trained participants and of untrained persons than between properly trained participants and those with unknown or large group training. A possible explanation of these differences is that untrained persons may be more open about their involvement with alcohol <u>but</u> engage substantially in denying (or, equally appropriate, are less <u>sensitive</u> to) the potential harm of alcohol use. On the other hand, participants with unknown or large group training, as a group, show a sensitivity suggestive of "guardedness", i.e., they may be downplaying their involvement with alcohol for defensive reasons. If so, this futher underscores the desirability for training to be conducted in small, interactive group sessions.

In the initial design of this study, it was intended that participants from three prior training periods would be examined. However, participants from these prior periods produced similar dependent variable scores. Prior training period, therefore, was not kept as an independent variable. Of special interest here is the implication that Program effects on the measures administered are essentially immediate, and that changes attributable to the Program persist with no appreciable loss over time (participants were trained up to three years prior to this study). The complexity of this

implication is not understood, at least from data gathered in this study. What is known, however, is that the Cottage Program is a brief (two sessions), highly interactive training experience which challenges existing attitudes and feelings about substances and which promotes a social-environmental approach to problems of use and misuse.

In keeping with what is known, it would seem inappropriate to directly attribute the knowledge and information findings to Cottage Program participation. Some information is provided during training, but not to the extent measured by the questionnaires employed in this study. It is speculated that the Program impacts primarily upon "meanings", opinions and attitudes, and that given this base, participants become more accepting/responsive to concepts, information, etc., pertinent to alcohol and other substance abuse. To a substantial degree, this speculation is supported by the findings of the present study. Just how information is acquired, however, is unclear. A substantial number of Cottage Program participants apparently seek other alcohol-related experiences (Malouf et al, 1975). It also is known that much alcohol information is freely available through a variety of media (T.V., radio, literature) to interested, motivated individuals.

The problem is presented, therefore, that motivation is crucial to the outcomes observed in this study. An important question here concerns the Cottage Program's relevance to the study's findings. Since the current study is a post-test design, and since participants were not randomly assigned to the PG1, PG2 and control groups, the problem of motivation and how this interacts with the Program is essentially unresolvable via this study. Note, however, that an effort was directly made to generate an appropriate (as near as possible) post-test control group. Thus, when control subjects were obtained from equivalent social-environmental settings (i.e., controls were "linked" to participants on the basis of residence), the procedure included an identification of controls who were interested in Cottage Program training. It was presumed that these control subjects would be similar to participants prior to Cottage Program training.

In analyzing these control subjects' scores from controls not interested in Cottage Program training, no reliable differences were obtained. To a degree, therefore, motivation per se is not sufficient to "explain" change in knowledge level. On the other hand, it may be that given a little more time, interested untrained individuals would show changes in knowledge, etc., even without access to the Cottage Program. A possible test of this would be to re-examine the untrained interested controls in 5-6 months to check for knowledge, attitude and related gains.

There are other study-related conditions which "muddy" the present findings. For one, there were methodological problems around the different interviewing procedures used for PG2 and PG1 and control groups. PG2 interviews were conducted "face-to-face" according to the intended procedure. While PG1 and the controls were to have been interviewed "face-to-face", this seldom occurred. Thus, for PG1 and control subjects, misinterpretations of questions may have occurred in an unsystematic way (note that the instruments were designed to be administered with an interviewer present).

PG1 and control subjects were interviewed by representatives from an independent research corporation. PG2 subjects, on the other hand, were principally interviewed by Cottage staff. This latter procedure may have tended to bias the responses of PG2 in a more favorable direction (Rosenthal, 1966). To determine the extent of these biases, it would be necessary to replicate the study specifically controlling for interviewer effect (Cottage

staff vs unknown interviewer) and interview procedure (face-to-face vs self-administration).

Another potential methodological drawback of the study was the use of unverified self-reports to measure amount drunk, degree of interference with function by alcohol, etc. While the validity of the participants' self-reports is open to question, the internal consistency demonstrated by the significant correlations of amount drunk with the measures of dysfunction caused by alcohol, lends credibility to the accruacy of the data.

The checks of internal consistency were only possible, however, on those participants who admitted they drank. The claims of abstinence by the remainder of the participants is totally unverified. One area that should be pursued in future research by the Program is to determine the veracity of abstinence claims, length of abstinence, reasons for abstinence and the relationship between abstinence and Program impact. Additionally, the inclusion of validity checks on behaviors by "significant others" for all participants in the research sample would be an excellent methodological control.

An extremely important feature of the Cottage Program, alluded to previously, is its "spread of effect". Nine of the participants (13%) from the sample surveyed reported that they had been instrumental in arranging one hundred additional Cottage Meetings. Since the mean number of people trained per meeting is three, these nine people were responsible for the training of over three hundred additional participants. If these findings can be considered as representative of the Cottage Program, then each of the individuals represented in the thirteen percent would be involved in activities leading directly to the training of 33 new participants. Once this cycle is begun, therefore, the numbers of potential participants generated without direct solicitation by Program workers may be self-perpetuating. This principle, as exemplified by the Program, may be useful for blanketing a community with education and prevention training without increasing funding for door-to-door solicitation. This "spin-off" concept is in need of further investigation, not only because of funding implications but also to assess the persistence of this principle to generate new participants.

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The Cottage Prog.

February Twenty-eighth
1 9 7 8

Bernell N. Boswell, Executive Director
The Cottage Program International, Inc.
PO Box 25152
Salt Lake City, Utah 84119

Dear Bernell,

Thank you for your letter of February 23, and for the information regarding The Cottage Program you forwarded to me at the request of David Keyes. I would be happy to meet with and assist Ms. Pibus in anyway possible, however, I will be in Juneau for the Legislative Session until approximately June 1. Therefore, I would appreciate your forwarding to her my Juneau addresss and office telephone (465-4997).

Best Wishes,

Mike Colletta
Senate Floor Leader

MC/das

THE COTTAGE PROGRAM INTERNATIONAL, INC. P. O. Box 25152 Salt Lake City, Utah 84119 Phone (801) 532-6185

February 23, 1978

Senator Michael Coletta
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Coletta:

Two or three months ago, at the request of David Keyes of the Wine Institute, I forwarded to you materials concerning the Cottage Program in Salt Lake City, Utah.

The purpose of this communication is to acquaint you with Ms. Sharley Pikus, who will be living in Anchorage after March 2, 1978. Ms. Pikus has had an excellent background in human services and has demonstrated a unique ability and understanding of the Cottage Program concepts.

I would be indebted to you if you would allow her an audience and hopefully support her in the pursuit of her career.

Respectfully,

Bernell N. Boswell
Executive Director

AN APPROACH TO THE PREVENTION OF ALCOHOLISM

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ANNOUNCING – ALCOHOLISM PREVENTION AND EDUCATION

Over the past five years we have developed an alcoholism prevention program that has achieved national prominence.

We have taken our program to many new communities over the past three years. This has been accomplished by Cottage staff members contracting with other agencies for consulting and training services - usually resulting in a cost to the sponsoring agency of $1,000 to $1,500.

Two years ago we began to record the small group interaction that is characteristic of the Cottage Meeting delivery method. From these recordings we have developed a complete set of twelve fine quality audio cassette recordings covering the complete system of The Cottage Program.

Extemporaneous recordings of groups in Anchorage Alaska, Boise Idaho, U.C.L.A., Lincoln Nebraska, St. Paul Minnesota, New York and many other localities make up the cassette program.

People participating from wide socio-economic and ethnic groups enables the listener to actually become part of the experience, and can quickly internalize the concepts and adapt The Cottage Program principles to their own environment.

Cassette 1, side 1, describes the program content and follows with live Cottage Meetings and delivery to a group of ten people.

Cassette 1, side 2, answers your questions about this prevention program: how it started, how it works in many communities throughout the nation, why volunteers are so attracted to the program, and many other questions by alcoholism workers from around the country.

Cassette 2, side 1, is the transcript of a Cottage Meeting being conducted by a trained volunteer - simple, effective, emotional experience.

The aspect of denial, as it relates to alcoholism is dealt with intensly, actual experiences are shared in an emotional live experience.

The entire program is complete in these twelve, 20-30 minute topics (6 actual cassettes).

Our purpose is to provide a method of enabling other agencies and groups to be able to deliver an effective prevention and early intervention program. As a result of our experience, we have developed this complete training package which includes:

1. Cassette tapes
2. Handsome vinyl binder
3. Alcohol The Crutch That Cripples - 1977 texbook
4. The Cottage Meeting Program - An Approach To The Prevention of Alcoholism.

Originally expected to cost over $200, we are able to provide the complete training package for a total price of $90.00 plus $1.00 postage. In ordering please use a purchase order or check payable to CPI (Cottage Program International).

Once your request has been received we will forward the training package, the instructions, and other materials.

Sincerly,

Bernie Boswell

Bernie Boswell
Co-founder/Director

BB/kao

Hearing Focus on Alcohol, Drug Abuse

Panel Witnesses Say Family Key in 'Curing' Alcoholic

By Dave Jonsson
Tribune Staff Writer

The family of an alcoholic is not only a victim of his disease but also "carries" the malady itself and often unwittingly supports it. Yet the family may be the single most effective tool in the "cure."

This general theme was repeated over and over Monday at a U.S. Senate subcommittee hearing on the impact of alcoholism and drug abuse on the family. The hearing was held in the State Capitol, and conducted by subcommittee members Sen. Orrin Hatch, R-Utah, and Sen. William D. Hathaway, D-Maine.

Efforts to Fight Abuse

More than a dozen witnesses told the lawmakers of their organizations' efforts to control and diminish — or stamp out — alcohol use and abuse.

Several witnesses also described a successful Utah-originated program — The Cottage Program — which stresses the re-education of the family to help it stop the type of behavior that may support an alcoholic's disesase.

Such behavior, said founder and director Bernie Boswell, includes covering up for the alcoholic when he fails in his duties and commitments.

Jewish Tradition

A panel of religious leaders stressed the family as the single most important tool in curing the alcoholic, but one of the three, Rabbi Abner Bergman, Congregation Kol Ami, injected a note of caution that "to make something taboo is to increase its fascination" to those who would try its use.

Jewish tradition calls for the use of wine in moderation, he explained, and the "fact that wine is something that is in itself not negative" has led to a lower than average rate of alcoholics who are Jewish.

He urged "extreme" solutions to the problems of liquor advertising and promotion be shunned.

Elder David B. Haight, Council of the Twelve Apostles, Church of Jesus Christ of Latter-day Saints stated that while the church also believes the family unit to be the key to the alcoholic's rehabilitation, "the church boldly declares that abstinence — not moderation or responsible drinking — is the only sure way to avoid the social and spiritual consequences of alcohol use."

Purposeful, Meaningful

The church projects a "pronounced emphasis that life is purposeful and meaningful and (it) strongly repudiates the beer commercial philosophy 'you only go around once in life'," he said.

The Cottage Program, Mr. Boswell told the subcommittee, stresses that a drinking problem is usually reinforced by the environment. . . that through "re-education" of the family the environment can be changed to knock away supports to the alcoholic's drinking behavior.

Model Program

Rather than covering up the drinker's behavior, the program suggests that friends, family members and employers and co-workers "refuse to support this behavior."

The program has become a model that others are "replicating" — including the LDS Church, which has adopted the methods for use in dealing with members' problems.

Others testifying included Dr. LeClair Bissell, chief, Smithers Alcoholism Treatment and Training Center, Roosevelt Hospital, New York, N.Y.; Mona Mansell, vice president, National Council on Alcoholism; James D. Kazen, director, U.S. Office of Education, Drug and Alcohol Training Center; Father Thomas J. Meersman, Sen. Moroni L. Jensen, D-Salt Lake; Sgt. Don Harman, Salt Lake County Sheriff's Office and Josie Couture, president, The Other Victims of Alcoholism, Inc.

Case Histories

Dr. Bissell presented some case histories of families afflicted by an alcoholic member: an 11-year-old boy who was drowsy in school because he had become accustomed to staying up late nights to "cajole" and "distract" his alcoholic father away from physical attacks on his mother and sister; a

See Page 19, Column 6

Panel's Witnesses Say Family Key Tool in 'Curing' Alcoholic

Continued from Page 17

school teacher mother who collected her children after school every night, took them home for dinner and immediately out for a movie while the father stayed home and drank himself into unconsciousness; a teenager who made sure that either himself or his father was home with his mother, to ensure that she didn't start a fire with an unwatched cigarette or attempt to drive or make endless long distance phone calls to friends while drunk; and an 18-month-old baby, thought retarded because she'd never talked, whose first words to her mother, when she opened another in an endless chain of beer cans, were "Mommy . . . no!"

The stunned mother stopped drinking as a result of that incident, Dr. Bissell added.

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THE COTTAGE PROGRAM INTERNATIONAL, INC. P. O. Box 25152 Salt Lake City, Utah 84119 Phone (801) 532-6185

November 15, 1977

Sen. Michael Coletta
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Sen. Coletta:

On November 12, 1977, I received a letter from David Keyes of the Wine Institute, asking me to forward directly to you, information concerning The Cottage Meeting Program.

From July of 1974, through June of 1977, the NIAAA funded our Program as a community prevention effort. Our Final Report to NIAAA for this demonstration period is enclosed. I believe the report can give the best conceptual understanding of the Program's potential.

Also enclosed is a brief summary of the Outcome Study conducted by our State Authority's Research and Treatment Director, Dr. Bernaldo Garso.

Additionally, I will be forwarding under separate cover, the "Outcome Study" of Program participants, as you may wish more scientific data and exacting information on an effective prevention approach.

I trust this information will be of value to you, and if I can be of further service, please feel free to contact me.

Sincerely yours,

Bernell N. Boswell, Executive Director

BNB:wp

Enclosure

xc: Mr. David Keyes
Wine Institute
165 Post Street
San Francisco, CA 94108

Hatch Bill Seeks More Emphasis On Family in Alcoholism Therapy

A U.S. Senate hearing on alcohol abuse and alcoholism last summer in Salt Lake City has resulted in a bill from Sen. Orrin G. Hatch, R-Utah, calling for greater emphasis on the effect alcohol misuses has on families.

Bernell N. Boswell, director of the Cottage Program, was advised of the action Monday by Robert P. Hunter, minority counsel to the subcommittee on alcholism and drug abuse, which conducted the hearings at the State Capitol. Sen. Hatch is ranking minority member of the subcommittee.

The Cottage concept parallels that of the measure, the Families with Alcoholism assistance Act of 1977. Mr. Boswell, testifying at the June hearing, advocated the Cottage concept, saying that it is vitally important to provide assistance to the families of alcohol misusers as well as for the drinkers themselves.

Introduces Bill

Sen. Hatch introduced the bill with Sen. William D. Hathaway, D-Maine, chairman of the subcommittee on alcoholism and drug abuse, and Sen. Harrison A. Williams Jr., D-N. J., chairman of the Senate Human Resources Committee.

Sen. Hatch said an identical measure will be submitted to the House by Rep. Majorie S. Holt, R-Md.

He said the Salt Lake City hearing demonstrated "the debilitating effects of alcholism on the family unit."

"I want to make it clear that we are talking about a crisis in our society which exists in every community regardless of size or locale, which, in many cases, is monumental and incalcuable," the Utah senator said on the Senate floor.

The bill would amend the Comprehesive Alcohol Abuse and Alcolism Prevention, Treatment and Rehabilitation Act of 1970 by adding this subsection:

Counseling, Treatment

"Alcohol abuse has a substantial impact on the families of alcohol abusers and alcoholics."

Sen. Hatch calls for inclusion in surveys on the crisis "an identification of the need for prevention and treatment of alcohol abuse and alcoholism by women and by individuals under the age of 18 and for education, counseling and treatment of the families of alcohol abusers and alcoholics (with) assurance that programs within the state will be designed to meet such need."

Sen. Hathaway, also speaking on the Senate floor, said the measure "requires the states to identify the need for education, counseling and treatment of these families and provide assurances that this need will be met."

"In addition," the Maine Democrat said, "it authorizes federal assistance for projects to provide (such) education, counseling and treatment" . . . and "encourages research on the impact of alcohol abuse and alcoholism on the family."

The bill creates a statutory priority within the National Institute on Alcohol Abuse and Alcoholism (NIAAA) "for programs which address the needs of families of alcoholics."

THE COTTAGE PROGRAM INTERNATIONAL, INC. P. O. Box 25152 Salt Lake City, Utah 84119 Phone (801) 532-6185

THE COTTAGE PROGRAM
FINAL REPORT

A Community Education & Prevention Model
Funded by N.I.A.A.A.
Grant Award #1 R18-AA-00958 ARSP

PRESENTED TO:

COMPLEMENTS OF:

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The Cottage Meeting Program was launched as an experimental pilot program in alcoholism education in February of 1972, in Salt Lake City, Utah. It was created and developed by Bernie Boswell and Sandy Wright, and was founded on the challenging premise that concerned and interested citizens volunteering their time and efforts could reach out in their neighborhoods in an educative and preventive program to alleviate problems related to alcohol.

Also instrumental in the early formation of the program was the Church of Jesus Christ of Latter Day Saints (Mormon), who provided the first group of ten lay volunteers who were willing to go out into the community, knock on doors, and discuss problems related to alcohol with community residents. These same volunteers were later willing to learn how to hold Cottage Meetings on alcoholism with the residents who were interested in learning more about it. When the program's designers realized that lay volunteers, with no background in alcoholism, could successfully be trained to help with community education, the Cottage Meeting Program was born. The program evolved out of the efforts of many other people, too, who were willing to take a risk -- to forge a new path into the prevention of alcohol mis-use and the early treatment of alcoholism.

In June of 1972, Mrs. Marty Mann, Founder/Consultant of the National Council on Alcoholism, met with the program developers and began to provide direction and guidance to the program. Her support and assistance through the ensuing years have provided a major contribution to the Cottage Program's development.

In September, 1972, an old home was acquired in Salt Lake City, Utah, at 736 South 5th East. It was appropriately called "The Cottage" and after much redecorating and sprucing up, became the first volunteer training center to function in Salt Lake City. The first Neighborhood Advisory Council was

formed at that time. These individuals, through personal commitment and dedication, and many times through personal contributions, helped to get the project underway. There were many joys and many growing pains, but the concept gradually took hold in the community!

Since its inception, the target of the Cottage Meeting Program has been the total community -- not just those personally affected by alcohol mis-use and alcoholism. Volunteers began meeting with small groups of residents in their homes, clubs, and churches to discuss various aspects of alcoholism: how to recognize it, how to deal with it, how to prevent it. Cottage Meetings seek to change the patterns of interaction in the family and the sequences of behavior of significant others in relation to the problem drinker. Thus, the emphasis is upon prevention rather than treatment, upon communication rather than remediation, and upon the situation rather than the drinker.

The actual Cottage Meeting is a two-session, small, highly intensive, but informal group process aimed at promoting greater knowledge and awareness about alcohol and alcoholism within the community, and at establishing attitudes congruent with a preventive, healthful approach to the problems and challenges of involvement with alcohol.

While the Cottage Program was initiated as a method of bringing education and awareness of alcohol mis-use and alcoholism to the general population, it became evident that the program was reaching individuals with alcohol related problems -- either personally or within their families.

For these individuals, the Cottage Program provides an excellent learning experience for the families. Not only does the family as a whole learn more appropriate responses to the alcohol problem with the family, but also, children living in high-risk environments become exposed to a constructive learning process and can internalize the concepts and content of the Cottage Program.

Thus, Cottage Meetings seek to educate the general population on how patterns of interaction involving families and significant others function to promote or prevent alcohol problems within the family. From this perspective, the main thrust of the program is primary prevention.

The family is regarded as the primary target for the Cottage Program. This concept is based on the idea that unhealthy drinking behavior is usually reinforced by the environment, and that through simple re-education the environment can be changed enough so that destructive drinking behavior is no longer as strongly reinforced.

Specially trained volunteers conduct the Cottage Meetings. The participants in Cottage Meetings are given handouts that explain the early symptoms of alcoholism and the role that friends and families can play in supporting inappropriate drinking behavior.

The Cottage participants are taught that many times families, friends, and employers will cover for an alcoholic -- rescue him or her or solve the many crises that follow excessive drinking. The Cottage volunteers teach that the problem drinker can best be helped by simply refusing to support the drinking behavior.

Each Cottage meeting is different -- but the same theme runs through each one. The only way you can change another person's behavior is to change your own.

On July 1, 1974, the program received funding through the National Institute on Alcohol Abuse and Alcoholism, Division of Community Prevention, for a three-year demonstration grant. At this point, the community of Salt Lake City was divided into four general areas, thus enabling people from all socio-economic settings to be exposed to the Cottage Meeting.

Community Education and Early Intervention
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A continuous neighborhood outreach, door-to-door campaign was implemented to raise the awareness of the community-at-large concerning the effects of alcohol and alcohol abuse on community members. Residents were informed of local resources and how and what to do if they were confronted with alcohol mis-use in their environment.

The youth and student population is the secondary target of the Cottage Program. The student program is designed to facilitate entry into families, thus linking the family and the schools to the community-at-large. A related program, the Youth Alcoholism Council, was implemented specifically for junior high school students. In this program, council members operate as teachers for their classmates. An additional innovative aspect of this program is the requirement for the junior high school student to educate their parents in the learning process.

The Cottage Program's long range goal is to change the community attitude about alcoholism. A goal which will encourage both prevention and early intervention. Alcoholism may be compared to the illness of malaria -- frantically swatting the mosquitoes while the swamp is still infested will not solve the problem. The problem is the swamp. Providing the community with the necessary attitudes and information to combat alcoholism is perceived by the Cottage Program as the "Key" to problems of alcoholism.

To treat problem drinking while ignoring the society and family from which it emerges is only a partial solution. It is essential to educate the community and change the environment.

Community Education and Early Intervention
Grant #1 R18-AA-0095B ARSP

SUMMARY OF COTTAGE MEETING ACTIVITIES

The essential elements of this demonstration Program model have been to:

* Recruit and train volunteers
* Use volunteers to address residents in their homes
* Use volunteers to train other volunteers
* Conduct the small group educational Cottage Meetings
* Outreach -- and to canvas neighborhoods
* Engage media in Program activities
* Utilize alcoholism professionals and specialists in volunteer roles
* Involve civic, religious, educational and other organizations not usually associated with alcohol abuse into the program delivery system
* Develop an Effective Living Skills training program

The intermediate goals of the program are:

1. To stimulate greater awareness of the problem of alcoholism in the community.
2. To change attitudes prevailing in the community regarding alcoholism.
3. To increase the knowledge of residents concerning the onset, identification and treatment of alcoholism.
4. To educate the population as to how the patterns of interaction among the family members and significant others function to promote or prevent alcoholism in the family.
5. To educate and prepare the community for primary prevention models.

The long term goals of the program are to reduce the present level of alcohol abuse and to limit acute alcohol related problems.

STATISTICAL: NUMBERS OF PARTICIPANTS

July 1, 1974 - June 30, 1977

1.	No. of participants	12,960
2.	No. of Cottage Meetings	2,162
3.	No. of Volunteers	424
4.	No. of Volunteer Hours	14,889
5.	No. of People Requesting Information	9,624
6.	No. of People Referred To Other Services	705
*7.	Total No. of People Receiving Services	23,713
**8.	Estimated Total Community Impact (3.2 x No. of people having indirect experience)	75,881

*7. represents the total number of people who have received direct services from the Cottage Program.

**8. is one measure of the number of people who have been affected indirectly by the Cottage Program. It is based on the assumption that every person who receives the program directly will touch the lives of 3.2 other people with this information. Research and evaluation study No. 8 tends to support this assumptic

PARTICIPANT DATA

Beginning July 1, 1974, through June 30, 1977, a total of 12,960 people have experienced the Cottage Meeting groups. The following information on populations served is a randomly selected group of 650 participants that is descriptive of the makeup of participants in Cottage Meetings.

AGE		NUMBER	PERCENT
5 - 10		376	2.9
11 - 15		2,566	19.8
16 - 18		1,374	10.6
19 - 22		1,088	8.4
23 - 50		5,896	45.5
51 - 65		1,205	9.3
65 & over		453	3.5
	TOTAL	12,960	

SEX DISTRIBUTION	PERCENT
Females	57.9
Males	42.1

MARITAL STATUS	PERCENT
Married	42.6
Divorced	7.2
Single	46.6

The number of participants include children in the family context and they are enumerated separately. The highest percentage in age groups (45.5) indicates substantial training to parents.

Community Education and Early Intervention
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MEDIA

Since July 1, 1974, through June 30, 1977, local and national contributions from media sources to the Cottage Program have been at least $184,683.65. Where the Cottage Program is replicated in other communities, the media response has always been favorable, but we are unable to maintain an accurate account of the ongoing dollar value of these services. Accurate records are maintained locally at the Cottage, as broadcasts, television coverage, press releases, etc., are contributed and put out through various agencies.

Unquestionably, the media plays a significant and vital role in the Cottage delivery system, notably in neighborhoods designated for door-to-door outreach efforts. The media can be utilized effectively to prepare the neighborhood for the staff and volunteers who will reach them in such efforts. This kind of media coverage can generate important civic acceptance of the program in advance.

In some instances, civic organization such as Lion's Club, Kiwanis, and Junior League, etc., have used a Saturday morning to implement a successful door-to-door campaign. The media plays a major role in this activity.

The Cottage Program creates the type of activities, human interest stories, action approaches to alcohol mis-use, volunteer movements, etc., that can produce an ongoing media involvement if properly planned and implemented.

VOLUNTEER CONTRIBUTIONS

The 14,889 hours of volunteer contributions from July 1, 1974, through June 30, 1977, represent a total in-kind dollar value of $104,223.00. The many services provided by volunteers range from maintenance and upkeep through the efforts of researchers and professionals who contributed their time and effort addressing all facets of program need.

The following are rates established in order to compute in-kind dollar values.

SERVICES	$ RATES PER. HR.
In Training	4.50
Moderator	4.50
Outreach	4.50
Clerical	3.00
Maintenance & Repair	3.00
Skills Training	6.00
Professional Services	20.00
Research Scientists	25.00
Public Officials	25.00
Professional Planners	25.00
Other	4.50

THE COTTAGE MEETING - CONTENT AND PROCESS

Content:

The Cottage Meeting content is concerned with the delivery of specific services which are directly oriented to prevention. Delivery of the model is totally devoid of treatment modalities or focus. It is rather designed to be adaptable to all group populations, most particularly those without alcohol mis-use or alcoholism related problems.

The specific areas of the prevention focus are directly correlated to the identified primary characteristics of alcoholism and other unhealthy dependencies: low self-esteem, inability to cope, inability to relate, inability to respond, inability to make responsible decisions, unhealthy dependencies, low tolerance for tension, feelings of inadequacy. Skill training focuses on meeting participants conceptualizing and internalizing life skills essential to preventing the deteriorating, downward spiral of unhealthy dependencies in his life environment. In the meeting process the content is also concerned with focusing on the progressive stages in alcoholism: 1) Denial 2) Home Treatment 3) Chaos 4) Control.

The theme of the content throughout the delivery process is the recognition of the importance of self in initiating and sustaining constructive living. The prevention emphasis is consequently accomplished by direct skill training in areas essential to positive personal functioning in relation to self, others and the environment.

The aforementioned 4 stages associated with alcoholism, specifically Denial, are expanded beyond the scope of alcoholism to include all areas of unhealthy functioning in relation to the environment. These patterns of communicating and functioning are thought to be formed early in life and

become manifest in numerous forms of destructive living. The prevention model is itself therefore, expanded to extend beyond the realm of substance abuse and is rather, associated with basic life functioning.

The content also focuses on some identified specific roles inherent in destructive living: Enabler, Provoker, and Victim. The clarification of these roles suggests the possibility that their basic patterns and elements too, are formed in early life and become the basis of communication and relationship dynamics to the extent that they seek out and reinforce compatible associations in order to remain functioning.

The Cottage Meeting content is ultimately aimed at the delivery of secondary prevention services which, in effect, create the environmental and attitudinal changes necessary to the success of any primary prevention model. The premise that all learning takes place from the learner's frame of reference is fundamental to the acknowledgement that the Cottage Meeting content raises that frame of reference to a level permitting integration of primary prevention.

Process:

The Cottage Meeting process is a simple direct skill delivery system. Families, groups or individuals participate in two progressive Cottage Meetings. (For clarification on how they come in contact with the Cottage Program, see Outreach section) The initial meeting, Cottage Meeting I, involves participant response to a measurable attitude questionnaire -- knowledge, skills and opinions -- and the filling out of a locator card for follow-up reference. The content delivery process involves the facilitator distributing and expanding on the material in the handout, "A Key to Prevention: The Cottage Program." The concepts delineated in this handout and their

accompanying skills are trained in an experiential learning framework, with participants actively involved in the learning process.

During the presentation process, participants are given information regarding a variety of available community resources that can respond to their needs for treatment services, higher learning experiences and community involvement. In addition, they are made aware of the advanced skill training models available through the Cottage.

Cottage Meeting II involves an extended learning experience expanding on the concepts internalized in Cottage Meeting I. The facilitator utilizes the handout, "Alcohol . . . Ic or Ism?," as a structural training guide delineating more in-depth analysis of the roles and consequences associated with unhealthy dependencies. Closure to the meeting involves readministering the original attitude questionnaire -- knowledge, opinion, skills and behavior -- for the purpose of measuring change as a result of the Cottage Meeting process.

OUTREACH

The outreach aspect of the Cottage Program is an essential component of the prevention model. Outreach is accomplished through a series of interrelated efforts. The doorknocking model consists of a neighborhood canvass information dissemination method. It is systematically approached through the utilization of city maps with blocked off target areas which are saturated before going on to other areas. Volunteers and staff carry with them specific educational and supportive materials which they leave at each home. In the face to face contact, attempts are made to arrange a cottage meeting for a more detailed overview of the alcohol misuse problem and methods for its prevention.

Other outreach methods include presentations to various educational, civic, religious and other groups who request skill training in the Cottage model. Supportive outreach is accomplished through extensive media coverage aimed at information dissemination.

In the three year demonstration grant period, the Cottage received an overwhelming number of requests for increased information and training dissemination services. On the basis of these requests, the Cottage Program has resolved the question of how to effectively respond to these requests by designing a model prevention newsletter for national distribution. This outreach objective will have a multiplier effect on present information dissemination efforts by a projected 33%. It will provide prevention programs on a national scale, the opportunity to receive on-going input regarding Cottage service delivery efforts, findings and training models. It is projected that this effort will have the most significant outreach impact of the models previously used.

REFERRAL

The Cottage Program provides extensive referral services which encompass a broader scope of community resources than are generally utilized by human service related programs. The referral process and purpose is directed toward the objectives of not only providing the individual with access to the desired service, but also, and perhaps even more importantly, the opportunity for increased skill development and growth experience.

The wealth of community resources available to the participant may come in the form of a referral to a potentially wide variety of community services. While this may include referral to an appropriate treatment oriented resource, it is likely to be coupled with a referral to a series of other resources which may include: local Parent Teacher's Association chapters, local Chambers of Commerce, local institutions of higher learning, advanced skill training in the Cottage models, etc. The intent in this multiple referral process is to initiate service delivery to the individual and to simultaneously provide him or her with the opportunity to increase his or her skill level and to deliver services to others.

This system expands the referral concept as it is generally implemented, from merely referring the identified problem to another service delivery modality to now allowing for help with the identified problem while also increasing the individual's skill level and personal contribution to the community as a whole.

The previously indicated advanced training in the Cottage Program through referral provides the individual with an opportunity to acquire multiple life skills enabling him or her to improve his or her life situation and environment measurably. Through this he or she is also given the opportunity to be trained

as a trainer to deliver those same skills to others as a certified Cottage volunteer. This contact also increases his or her on-going access to newly identified community resources and thereby enhances and expands the referral process for future service delivery to himself or herself and others.

VOLUNTEER TRAINING

The Cottage Program has designed and implemented a nationally replicated volunteer training and utilization model. The volunteer component of the Cottage Program is singly, the most crucial area of focus. There is a highly structured volunteer hierarchy which is correlated with comprehensive, on-going training. This volunteer service delivery hierarchy is paralleled to staff positions requiring corresponding skill levels and the delivery of program services.

The volunteer training model itself is concerned with delivering skills which will, in effect, train volunteers to become effective trainers. A great many Cottage trained volunteers consequently, are not involved in direct service delivery within the actual Cottage facility or program structure. Many function as trainers autonomously within there own organization roles; for example: church and civic leaders, educators, management personnel, industrial employees, students, human service delivery specialists and community members at large. Designing and implementing the volunteer training model and program as such, there are multiple community benefits in the expansion of services to a maximum number of community members in a cross section of the total community.

Volunteers who do remain in the service delivery capacity within the Cottage facility are given an opportunity to increase their personal and training skills through experimental learning models and progressively advanced training experiences. Also, formal academic credit is available through several in and out-of-state universities for participation in the Cottage Volunteer Training Workshops. The training is intensive, skill-oriented and on-going throughout the volunteer experience.

EFFECTIVE LIVING SKILLS

The Cottage Program offers a series of progressive skill training models which are available to all program participants, volunteers and interested community people. Effective Living Skills is a culmination of these advanced training models. It provides the learner a simple structured guide or model for effective living while simultaneously illustrating the deficits caused by the lack of any of the skills. This model focuses on the entire life process of the individual and trains him in a methodology to significantly improve his overall level of functioning with regard to self and others.

The premise of the model is that there are specific skills essential to effective living. These skills are: attending, ovserving, listening, responding to feeling, responding to meaning, personalizing, understanding, goal definition, program development and program initiation. The lack of these skills conversely, leads to denial, home treatment, chaos and reacting roles. In order therefore, to remove these deficits the action required is simply to implement the aforementioned skills. In the training process, the primary emphasis is on internalizing and personalizing the model in its entirety. This is an essential aspect to the training process that reaffirms the necessity for focus on self as being the only means of ultimately achieving self directionality and constructive living.

This model provides a basis for primary prevention of destructive living which is illustrated in the myriad of national identified social problems. It is, therefore, applicable to the entire community as prevention modality.

SURVEY RESULTS AND COMMENTS

Accreditation: On October 16, 1976, the Cottage Program was awarded accreditation by the Joint Commission on Accreditation of Hospitals. J.C.A.H. surveyed the Cottage for consultation and education. The following results reflect the surveyors' comments:

"Excellent - could be used as a model for other programs. The consultation and education component has a written plan describing the procedures by which the consultation needs of community groups and/or agencies are assessed and goals and objectives derived and implemented.
For this Service:
Out of a possible 116 points, 116 points were scored (100%)
Surveyor recommendation: substantial compliance."

"Excellent - could be used as model for other programs. The consultation and education component has a written plan describing its philosophy, goals, services, and the procedures by which the community's awaremess and acceptance of alcohol use/abuse is increased."

"Excellent - could be used as a model for other programs. The education service has a written plan which includes documentation verifying accommodation for and participation with relevant organizations, individuals and agencies on a regular and planned basis throughout each year."

"Excellent - could be used as a model for other programs. The education service has documentation of the implementation of measures taken to educate the general public to needs that remain unmet, and to stimulate social action.
For this service:
Out of a possible 177 points, 177 points were scored (100%).
Surveyor recommendation: substantial compliance."

In 1972, the Cottage Program conducted a door-to-door survey based on the Gallup Poll method with a 95% level of confidence that the information received was indicative of the total community. This original survey indicated that 8.1% of the people contacted responded affirmatively to questions regarding an alcohol misuse or alcoholism problem within the family. In 1976, this survey was re-conducted and the results indicated that 31.3% of the people readily admitted the same. This is a direct reflection of the Cottage Program's impact in initiating community awareness of the necessity to confront denial before effective problem resolution can occur. This confrontation of denial reflects a significant attitude change regarding acknowledgement of alcohol related problems. Education Commission of the States: On July 14, 1976, the Cottage Program received the formal endorsement of the ECS. The following statement reflects this endorsement: "We believe that the Cottage Program's direction is in keeping with the recommendations of the ECS Task Force on Responsible Decisions About Alcohol and reflects a standard of excellence that will serve well as a model for other prevention efforts."

Marty Mann, Founder/Consultant, National Council on Alcoholism states: "The Cottage Meeting Program is a unique and extremely important program. I think it addresses the problem of prevention more directly than any other technique I know and I venture to predict that its success will be overwhelming wherever it is undertaken."

Reverend Milton S. Hunt, President of the Gastineau Alaska Council on Alcoholism, after participating in Cottage training on March 21 and 22, 1976, states "The Cottage Meeting Program is the most important contribution to Alcoholism since the founding of the National Council on Alcoholism in 1944."

James Emmert, Executive Director, National Council on Alcoholism, North Carolina, writing of the Cottage Program on May 17, 1977, states: "There are three major factors which make it an excellent program. First, it is demonstrably effective with all age groups. Second, the program model can be easily exported. Third, it is cost effective."

PRIMARY PROGRAM RECOMMENDATION

In spite of all of the Cottage Program's documented success in service delivery, the inherent weakness has been the lack of a rigid well planned comprehensive research and evaluation component. Although the program has had more research and evaluation service than the majority of other human service delivery programs, there is a wealth of research and evaluation possibilities available given the extensive data base collection process implemented since 1972. This base provides an excellent opportunity for the development of relevant longitudinal studies to be conducted.

The original grant award did not provide adequate funds to conduct the research and evaluation as extensive as would have been desired. Since August 1976, however, the State Agency has provided assistance from their research specialists who have a grasp on the program concepts. The Cottage Program would, consequently, urge the expanded continued involvement of the State Agency in this manner.

Although serious consideration has been given to the replication of the program in non-Mormon communities, it would be preferable to first consider the advisability of funding extensive research and evaluation of the operational program and its existing massive data base.

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THE COTTAGE MEETING PROGRAM
(Cited from a summary report to NIAAA, January, 1977)

The Cottage Meeting Program is a two-session, small, highly intensive, but informal group process aimed at promoting greater knowledge and awareness about alcohol and alcoholism within the community and establishing attitudes congruent with a preventive, healthful approach to the problems and challenges of involvement with alcohol. The family is identified as the primary target for training.

The Training of Participants

The Program has been shown to be positively received and valued by a clear majority of participants, by adolescents in Report #2, as well as by adults in Reports #1, 4 and 5, representing a variety of social, educational and employment backgrounds. The principal measures employed to evaluate Program response and attitude change in these studies, however, have been subjective measures allowing ratings relative to perceptions and feelings about alcohol and alcoholism, but providing virtually no substantive data about change in knowledge and attitudes. The principal measure used, however, was shown to be highly reliable, as in Report #3, and, therefore, is seen as effective in assessing shifts in ratings made by participants. Unfortunately, the instrument did not permit assessments of "direction" or desirability of change, nor did it permit assessments other than the "feelings" of participants. It may be noted, however, that the "shifts" demonstrated were interpreted as reflective of greater tolerance and less rigidity, as in Reports #2, 4 and 5, on the part of participants following Program training. The "meaning" attached to the changes, however, was admitted to be "speculative". The absence of control comparisons also raised the spectre of motivation as an uncontrolled factor governing the positive reception and valuations made by participants.

Report #8 was an attempt to objectify the claims made in the reports cited above. The outcomes assessed in this study involved knowledge about alcohol and substances of abuse, opinions and attitudes about such substances and self-reports of behavior relevant to alcohol and other drug use or misuse. A post-test only design was employed, involving: (1) A group of former participants who were exposed to the Program in a "mixed" fashion (such participants did not necessarily attend both Program sessions, nor did they necessarily participate in the small, intensive group process characteristic of the Cottage approach, i.e., a number of participants were involved in large group, less interactive presentations of the Program); (2) a separate group of participants known to have attended two

small group, interactive sessions; and (3) control subjects "linked" to the participants on the basis of residential proximity. The controls were generally seen as "matched" socially and economically. A subset of the controls was identified as wanting to receive Cottage Program training. This group was presumed to be similar to participants prior to Program training and was identified to serve as a "motivational" control group, i.e., a group needed to assess (admittedly "after the fact") the effects of Program training.

A comparison of the "motivational" control subjects with the rest of the controls revealed no differences on the measures gathered, suggesting that "motivation", operationally defined in this study as interest in Program training, did not interact with the measures administered. Consequently, the control subjects were treated as a unit in comparisons with former participants.

The findings of Report #8 clearly indicate that participants in general have greater knowledge about alcohol, about Program-related material and about substance abuse resources than control subjects. Additionally, participants involved in both sessions of the small, interactive group process were superior to participants in the "mixed" group. Pertinent to opinions and attitudes, "mixed" participants were essentially no different from controls. On the other hand, participants involved in the two session, small group process displayed significantly greater agreement with judgements about alcohol and other drug use made by a norm group composed of alcohol treatment personnel, and showed greater affect and reactivity to concepts relating to alcohol education, alcohol, alcohol abuse and drugs than control subjects. Comparing these participants to those in the "mixed" participants group, the few differences obtained were on the semantic differential items, suggesting that affect and reactivity were likely influenced by conditions associated with the two-session, small group process. This implication is offered tentatively.

Differences in self-reports pertaining to behavior were negligible. While this is not surprising, given the nature of the Program (i.e., only two sessions are involved), the measures obtained were generally in expected or desirable directions, suggesting that behavioral changes occur, but require greater experimental control for purposes of detection, more sensitive measures, more subjects to reduce error, or a longer period of observation. Ostensibly, refined replications of this study are needed. Overall, the findings indicate that the Program produces change, and that change is better accomplished via the samll, interactive group training process. The changes are substantial, clearly with regard to knowledge and information gains. Opinion and attitude changes also occur, although apparently requiring small-group training. Concerning behavioral change, the findings present nothing of a reliable nature. Although one is tempted to say that expectations of behavioral changes are possible, it is probably unrealistic to expect such change on the basis of a brief training program.

Additional findings of particular note from Report #8 include:

1. An attempt to assess the "persistance" of Program effects was made by including participants trained 6-12 months, 13-24 months and 25-36 months prior to initiation of the study. Differences among the participants from these three periods were not found, suggesting that Program impact upon knowledge and other informational gains, as

well as upon the attitudes and opinion changes found, occur primarily within six months of the Program training and "persist" at least over a three-year period.

2. Twenty-four and one-half percent of the controls involved in this study expressed a desire for Program training. This finding is seen as lending substance to the basic Cottage outreach procedure, i.e., "knocking on doors". It also indicates that there is a substantial demand for alcohol education and prevention training in the Salt Lake County area.

3. Thirteen percent of the participants on this study arranged one-hundred additional Cottage Meetings. Employing the median size of households in this study, it is estimated that these meetings resulted in the training of three hundred persons. This amount of subsequent Program activity is seen as a highly desireable, behavioral "spin-off" from Program training, an effect which has significant consequences for the "spreading" of education and prevention training into a community.

Volunteer Involvement

A perusal of Report #5 indicates that volunteers may be used effectively as Cottage Program trainers. It was evident, however, that the method of selection, the structuring of activities and the adaptation of program assignments and roles to correlate with volunteer skills and abilities, were variables crucial to the effective use of volunteers. Additionally, the Program was seen as needing to provide supportive experiences designed to maintain volunteer interest and to trigger volunteer activity since high-turnover and low productivity are typically manifested among volunteers.

The current involvement of volunteers is substantially improved, as reflected by a lower turnover rate and greater volunteer activity. Additionally, the Cottage organizational structure has been altered to allow greater administrative, supervisory and training participation by volunteers.

Effective Living Skills

Report #7 introduces an additional education and prevention service provided by the Cottage. The "Effective Living Skills" program is presented as a means to further the education and prevention objectives of the Cottage Program. This program focuses upon four skill areas, basically how individuals deal with self, with others, with the "world", and with drinking in a "drinking society". Report #7 compared Cottage Program participants with participants who received the additional "Effective Living Skills" program. The principal measure involved in this study was the attitude measure earlier alluded to as highly subjective. The results obtained were difficult to assess, primarily because of the subjective measure employed, but also becuase the unique features (i.e., the "Effective Living Skills") were not considered in the comparison of these groups. Motivational differences also appeared to classify subjects who sought the additional training but were not considered in the experimental design employed. Plans are underway to evaluate the Effective Living Skills Program, employing refinements of the more objective measures used in the outcome study of the Cottage Program, and including measures relevant to the unique skills ostensibly imparted by the "Effective Living Skills" program.

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