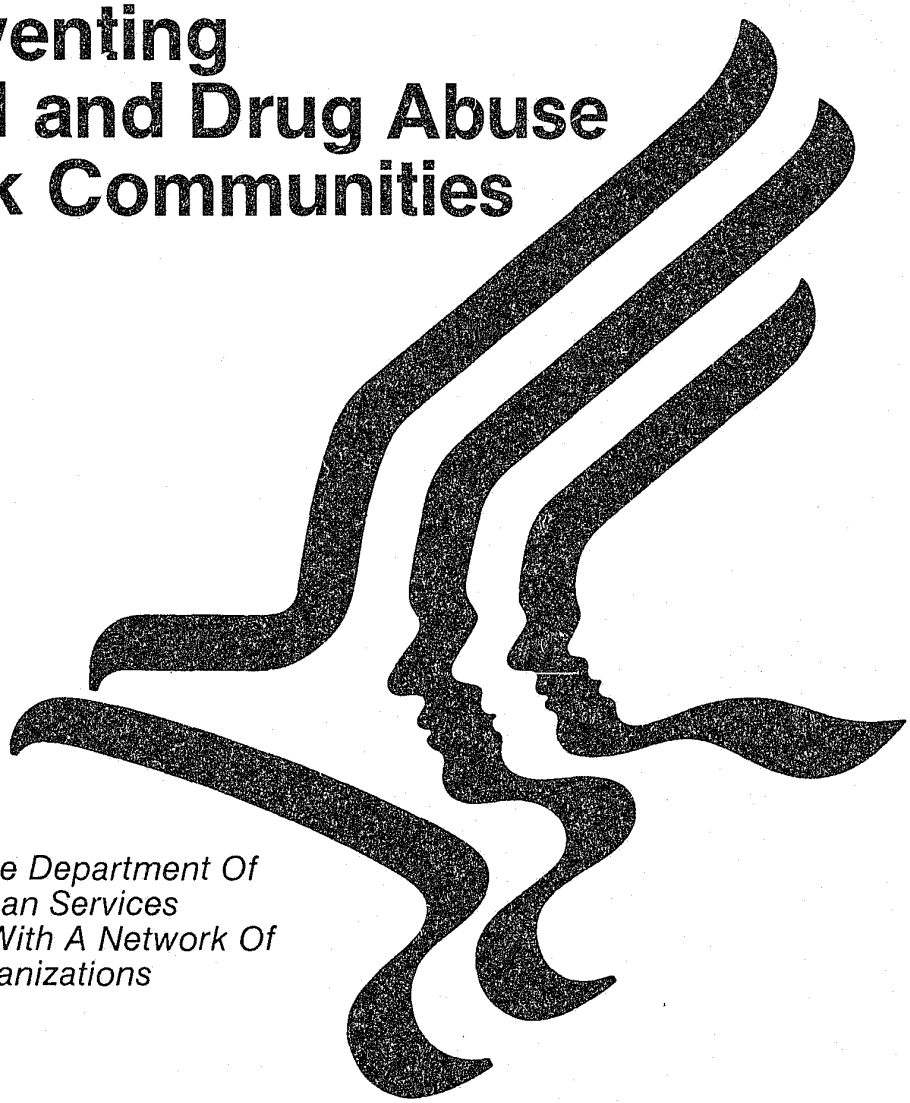
Office for Substance Abuse Prevention
National Institute on Drug Abuse

Proceedings of a National Conference on Preventing Alcohol and Drug Abuse in Black Communities

May 22-24, 1987
Washington, DC



By The Department Of
Human Services
tion With A Network Of
k Organizations

NBAC
NATIONAL BLACK ALCOHOLISM COUNCIL

ARTC
ADDICTION RESEARCH AND TREATMENT CORPORATION

ZETA PHI BETA

Oakland Parents *in Action*
OAKLAND PARENTS IN ACTION

MIBCA
MINNESOTA INSTITUTE ON BLACK CHEMICAL ABUSE

DELTA SIGMA THETA

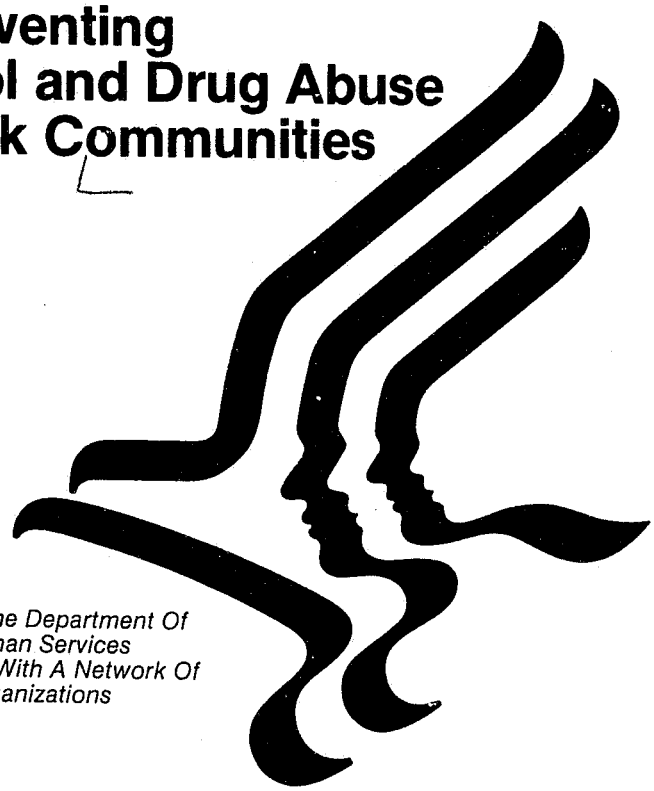
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

Printed by the Office for
Substance Abuse Prevention
and distributed by the
National Clearinghouse for
Alcohol and Drug Information
P.O. Box 2345
Rockville, MD 20852

128810

Proceedings of a National Conference on Preventing Alcohol and Drug Abuse in Black Communities

May 22-24, 1987
Washington, DC



Presented By The Department Of Health And Human Services In Cooperation With A Network Of Major Black Organizations

THE LINKS, INC. | NATIONAL MEDICAL ASSOCIATION | NATIONAL BLACK ALCOHOLISM COUNCIL | ADDICTION RESEARCH AND TREATMENT CORPORATION | ZETA PHI BETA | OAKLAND PARENTS IN ACTION | MINNESOTA INSTITUTE ON BLACK CHEMICAL ABUSE | DELTA SIGMA THETA

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

Office for Substance Abuse Prevention
5600 Fishers Lane
Rockville, MD 20857

These Proceedings are based upon papers and discussions from *A National Conference on Preventing Alcohol and Drug Abuse in Black Communities* held in Washington, DC, in May 1987. The conference was originally funded through contract number 271-85-8401 by the National Institute on Drug Abuse.

Project Manager for the Proceedings was Arnold Mills, Office for Substance Abuse Prevention; Linda Franklin served as Production Manager. The writers were Preston Bright and Clarence Johnson.

The presentations herein are those of the listed authors and may not necessarily reflect the opinions, official policy, or position of the Office for Substance Abuse Prevention, the National Institute on Drug Abuse, the Alcohol, Drug Abuse, and Mental Health Administration, the Public Health Service, or the U.S. Department of Health and Human Services.

DHHS Publication No. (ADM)89-1648
Printed 1990

Foreword

Alcohol and drug abuse has had a devastating effect on communities across the country. Its effect on the lives of our Nation's youth and families is evidenced by high delinquency rates and a myriad of school-related problems, among a number of other social indicators. The Federal Government has long recognized the importance of voluntary groups and professional organizations in the fight against alcohol and other drug abuse. Organizations have already been successfully mobilized to address this very critical problem in communities across the country.

Despite the fact that increased attention has been focused on alcohol and other drug problems in Black America, the community's response has not been commensurate with the gravity of these problems. Black communities are faced with an enormous challenge. New, coordinated approaches to dealing with the growing substance- abuse problem in Black communities are in order. The challenge of organizing a groundswell of support for prevention programming focused on Black communities is urgent. This National Conference on Preventing Alcohol and Drug Abuse in Black Communities was organized to give impetus to the development of alcohol and other drug abuse prevention programs in Black communities and to enlist the help of voluntary, social, professional, health, and mental health organizations, and other groups serving the Black community, in the much-needed and overdue organized fight against drugs.

The planning committee, comprising representatives from the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, the Office of Minority Health, the Office of the Assistant Secretary for Public Affairs, the Office for Substance Abuse Prevention, and the Drug Enforcement Administration, established the following goals for the conference:

- To raise the awareness of the alcohol and other drug abuse problems that exist in Black communities across the Nation and create a broad-based prevention-focused response to that problem
- To share state-of-the-art information on prevention research, evaluation, and resources and knowledge of innovative programs and strategies, as well as to create new or extend existing networks
- To stimulate action by Black communities at the local level to eliminate alcohol and other drug abuse problems

Information from the conference will serve as the foundation for expanding alcohol and other drug abuse prevention initiatives and will provide an impetus for increased involvement of voluntary organizations in alcohol and other drug abuse prevention programming in Black communities across the country.

Elaine M. Johnson, Ph.D.
Director, Office for Substance Abuse Prevention

Acknowledgments

Honorary Chair and Cochairpersons

The conference planning committee is pleased to have had the following persons serve as honorary chairperson and cochairpersons:

Honorary Chairperson

- The Honorable Otis R. Bowen, M.D., Secretary, Department of Health and Human Services

Honorary Cochairpersons

- Mrs. Lonise Bias, Parent, Lanham, MD
- Dr. Dorothy I. Height, President, National Council of Negro Women, Washington, DC
- Dr. William Harvey, Executive Director, Narcotics Service Council, Inc., St. Louis, MO

National Cochairpersons/Coplanners

The conference planning committee acknowledges the special contributions of those private-sector groups and their representatives who served as coplanners and advisors, providing expert guidance and direction throughout the planning of the conference. Special thanks are extended to each of these persons for their time, their technical knowledge and assistance, and their expressions of concern for one of the gravest problems confronting Black America today, alcohol and other drug abuse.

The names and organizational affiliates of those who ably served as national cochairpersons/coplanners and advisors to the conference planning committee are as follows:

- Peter Bell, Executive Director, Minnesota Institute on Black Chemical Abuse, Minneapolis, MN
- Joan A. Brann, Project Director, Oakland Parents in Action, Oakland, CA
- Walter Faggett, M.D., Physician Director, PCP Unit, DC General Hospital, Washington, DC
- Leonard Lawrence, M.D., Board of Trustees, National Medical Association, San Antonio, TX

- Beny Primm, M.D., Executive Director, Addiction Research and Treatment Corporation, Brooklyn, NY
- Jeanne Spurlock, M.D., Deputy Medical Director, American Psychiatric Association, Washington, DC
- Lynette Taylor, Program Director, Delta Sigma Theta Sorority, Inc., Alexandria, VA
- Eunice Thomas, National President, Zeta Phi Beta Sorority, Inc., Washington, DC
- Flavia Walton, Ph.D., National Director of Services to Youth, The LINKS, Inc., Las Vegas, NV
- Maxine Womble, Chairperson, National Black Alcoholism Council, Chicago, IL

Conference Planning Committee

The conference planning committee, consisting of representatives from several agencies and offices within the US Department of Health and Human Services and the Drug Enforcement Administration, represented a unique cooperative arrangement. For the first time, the resources of several offices were joined together to plan and implement a major departmental initiative focused specifically on alcohol and other drug abuse prevention issues and the Black community. The committee members were as follows:

Department of Health and Human Services

- Elaine M. Johnson, Chairperson of the Conference Planning Committee, Deputy Director, National Institute on Drug Abuse

Office of the Secretary

- Stephanie Lee-Miller, Assistant Secretary for Public Affairs
- Madeline Lawson, Special Assistant, Office of the Assistant Secretary for Public Affairs
- Neil Romano, Manager, Special Initiatives, Office of the Assistant Secretary for Public Affairs

Office of Minority Health

- Warren Hewitt, Associate Director for Policy
- Jacqueline Bowles, M.D., Senior Research Advisor
- CloLeeta Simpson, Research Assistant

National Institute on Alcohol Abuse and Alcoholism

- Brenda Hewitt, Special Assistant to the Director
- Fleetwood Roberts, Special Health Advisor, Division of Extramural Research
- Fulton Caldwell, Consumer Affairs Specialist, Office of the Director
- Yvonne Hefley, Consumer Affairs Specialist, Office of the Director

National Institute on Drug Abuse

- Arnold Mills, Public Health Analyst, Division of Clinical Research
- Sheila Gardner, Executive Secretary to the National Advisory Council on Drug Abuse, Office of Science
- Leona Ferguson, Technical Information Specialist, Office for Research Communications
- Troyce Holland, Assistant to the Deputy Director, Office of the Director

Office for Substance Abuse Prevention

- Carl Hampton, Acting Assistant Director for Special Projects, Office of the Director

Drug Enforcement Administration

- Frankie Coates, Chief, Demand Reduction
- Carl L. Jackson, Special Agent in Charge, Washington Field Division
- Robert J. O'Leary, Special Agent, Public Information Officer

Contents

Welcoming Ceremony

Presiding: **The Honorable Stephanie Lee-Miller, Assistant Secretary for Public Affairs, Department of Health and Human Services**

Speakers: **The Honorable Donald Ian Macdonald, M.D., Director, White House Office for Drug Abuse Policy and Special Assistant to the President; Administrator, Alcohol, Drug Abuse, and Mental Health Administration**

Don Quinn, Assistant Administrator, Drug Enforcement Administration

Herbert W. Nickens, M.D., Director, Office of Minority Health, Office of the Assistant Secretary for Health

Charles R. Schuster, Ph.D., Director, National Institute on Drug Abuse

Enoch Gordis, M.D., Director, National Institute on Alcohol Abuse and Alcoholism

Reed Bell, M.D., Director, Office for Substance Abuse Prevention

Dr. Dorothy I. Height, President, National Council of Negro Women, Washington, DC.

Summary of Introductory Remarks by the Honorable Stephanie Lee-Miller

I believe that you in this room really represent the *creme-de-la-creme* of the Black community from around the country committed to finding ways to prevent alcohol and drug abuse and to treat those who have fallen into the hell-hole of alcohol and drug abuse. I am sure you would agree with me that the subject we have come together to discuss for the next 2 days is not a trendy subject. It is not a fad. I have been concerned for some time that on the national landscape, when the war on drugs was declared, the Black community did not get its act together. We have had some excellent efforts

underway and many of you are responsible for those efforts. But you have been in your own communities and your own organizations and there has not been a knitting together of efforts. One of the primary purposes of this meeting is to find a way to form effective coalitions to advance alcohol and drug abuse prevention in Black communities. We must rise above egos; we must rise above organizational identities; we must rise above our organizational rivalries. We must realize that what we are talking about is trying to save our children and our communities.

This conference represents a partnership between the Federal Government and nine national organizations. The organizations got involved on a voluntary basis and have devoted hundreds and hundreds of hours to putting this conference together. They are:

The Addiction Research and Treatment Corporation

The American Psychiatric Association

Delta Sigma Theta Sorority, Inc.

The LINKS, Inc.

The Minnesota Institute on Black Chemical Abuse

The National Black Alcoholism Council

The National Medical Association

Oakland Parents in Action

Zeta Phi Beta Sorority, Inc.

Within the Department of Health and Human Services we have four agencies that have cooperated along with the Drug Enforcement Administration to make this conference happen. They are:

National Institute on Alcohol Abuse and Alcoholism

National Institute on Drug Abuse

Office of Minority Health

Office of the Assistant Secretary for Public Affairs

Summary of Remarks by The Honorable Donald Ian Macdonald, M.D.

I feel in many ways like a latecomer, because I know that most of you have been involved in this longer than I have. One of the things I think I realize in saying that is that there has been some feeling that people like me who come from white, middle-class America were not willing to pay a lot of attention to the problems of drugs because they did not affect us. We did not know that they were affecting us. I did not get involved until the

kids in my practice and neighborhood got involved, and now I am here joining you as a latecomer, but I am here, and in full force.

I think it is important to point out that the death of Len Bias, a Black athlete, was really more than the death of a Black athlete. It was the death of an important, American, young man as seen by people of all races. The tragedy of Dwight Gooden, another person who was not identified by color but as a young man of tremendous potential who played for the championship baseball team, helped us see that the drug problem has become all of our problem. It is not Black, and it is not white. It is not Native American; it is not Hispanic: it is all of ours.

But there are different ways of looking at it. It is important that because of cultural differences and other issues, we approach this problem in as many ways as we can. In my thinking about drugs, I see three different tracks or endemics, and each of them has cultural significance for the way we look at drug use. Let me tell you what I think they are.

There is an underlying opiate problem that this country has had for a long time. There are other problems besides drugs associated with this track. There is the problem of crime. There is the problem of acquired immunodeficiency syndrome (AIDS), which is now moving rapidly to the front of everybody's mind. It is important to point out to people, when they raise concerns about the spread of AIDS to the heterosexual community, that 25 percent of the AIDS victims involve intravenous (IV) drug use; the drug used most often is heroin. When we talk about babies with AIDS we are talking about 75 percent of those babies coming from the union of a partner who is an IV drug user. And when we talk about AIDS and those babies, it is important to point out that a significant number of those babies are Black. When we talk abut AIDS, it is important to say that 25 percent of the people with AIDS today are from the Black community.

There is another track that is also of great concern to the Black community, and that is alcohol use. We must point out that the economic costs of alcohol outweigh the costs of all other drugs. The estimates are that alcohol costs us over $100 billion a year, not counting the human cost. I can remember last year when the Secretary's Task Force on Black and Minority Health released a report on Black health which pointed out that Black people were not living as long as their white counterparts. The report pointed out that there is increased mortality in a number of areas. When you look at what those are, you see that cirrhosis is way up there. You see homicide is way up there; you see infant mortality is way up there. And when you ask what all of those terrible indicators have in common, the answer is alcohol.

There are some other ugly problems that our society has, but this one has been particularly lethal for Black people. There are some who criticize the emphasis that is now being placed on illicit drugs, such as marijuana and cocaine, as missing the point. Alcohol, indeed, is the drug that is responsible for approximately 100,000 deaths a year in this country among whites and Blacks. I do not forget that, but I think that the moves we are making against illicit drugs do carry over into alcohol.

What the President is focusing on, principally, and what the country is most concerned about, is the new endemic—*that is* the third track. We did not really pay a lot of attention to alcohol for maybe 50 years after Prohibition. Something has made us change. Our kids said to us in the 1960s and 1970s that they smoked a little grass and we drank; what was the difference? It got our attention. Indeed, they made a good point: what difference was there between sitting down and having three martinis to relax and having a joint? There are differences, and of course, the kids were lying; they were drinking and smoking.

There is another group of parents who received a different kind of message. These were not parents who thought that alcohol should be banned or removed. Their basic message was that our kids are dying on the highways because of their alcohol use, and we are concerned and want to do something. That got the country's attention. So, indeed, we see a shift in the importance of alcohol.

The newer endemic is the one of the last 25 years, where a whole variety of new drugs appeared: lysergic acid diethylamide (LSD), phencyclidine (PCP), cocaine, and marijuana, drugs that I really did not hear about when I was growing up. Today the President talks about drug-free schools. We did not talk about drug-free schools when I was a kid, because we had drug-free schools. He talks about a drug-free workplace. We did not have a problem with drugs in the workplace. Much of the focus now is on an effort to change for kids and for adults their ambivalence about drugs.

We used to say, and I have said it myself, that the use of alcohol and drugs and sexual experimentation constitute just a normal phase of adolescence. These were things our kids are going to do, and we might as well accept it. We were not willing to take a stand. We, as a society, used to be very strong in saying to our young people: you are going to live in this house; you are going to go to this school; you are going to marry this person; you are going to be in this religion; you are going to vote in this way. And then we said: that is too rigid. What we want to do instead is shift, and for our kids, provide them a message. When you ask parents what they want their children to be, as I do frequently, the answer I get most often is, "I don't really care what my child becomes when he grows up as long as he's happy." Just happy, whatever that means. "I want my children to grow up and feel good about themselves. I want them to live up to their potential. I want them to have spiritual awareness. I want them to make a contribution to the community, and I want them to find happiness in most things." Sometimes happiness involves delayed gratification, it means holding off. We are now willing to say what we could not say 15 years ago to kids: Don't use drugs, period.

It is not a matter of sorting the risks and the benefits in making a decision for yourself or what we used to call a responsible choice. The message now is "just say no." And that is a social message. A very strong message of importance to all the kids and to all of us that we finally take a stand that drug use is a dumb thing to do. We can say they are dumb morally; we can say they are dumb for a lot of reasons. But speaking as a physician, they are not good for your health, and that is what I think you need to say.

The three leading causes of death that the pediatrician knows and that we are not getting a handle on are not related to illnesses we were taught about in medical school. They are not diabetes, leukemia, and infectious disease. They are accidents, homicides, and suicides—all tied into this terrible epidemic of drug use by our young kids.

Another concern that has received increased attention is the workplace. The workplace contains a lot of people who use drugs. They are not, perhaps, shooting drugs, but what we know about drug use, and particularly the ones that are more self-reinforcing, like cocaine, is that people who begin use often do not realize that, for many of them, cocaine use is addictive.

The polls and questions raised by Blacks about workplace testing are interesting. I hear the one argument that if drug testing occurs in the workplace it will be used as a form of discrimination. It would be used as a means of eliminating people from the workforce that somebody does not want. That is an important issue and one that we need to guard against. The flip side of that may be viewed in polls taken of the American people to measure how they feel about drug use in the workplace and testing. In the polls we look at, the Black worker is more concerned and more willing to be involved in efforts for a drug-free workplace than is the white worker. In his wisdom he understands that a drug-free workplace is to his benefit. We have to balance the need for a drug-free workplace and the rights of workers and understand that we all want it, and be sure that in getting it, we do not discriminate in the process. Obviously the program has to be reasonable. The test has to be accurate, the lab choice has to be good, and we have to deal fairly with people who are identified as having tested positive.

Summary of Remarks by Don Quinn

I am pleased to be able to join you this morning on behalf of the Drug Enforcement Administration (DEA) and John Lawn, its administrator. We are the only law enforcement organization represented here today, and we are certainly proud to share our time with you in the mutual mission that we all share.

As a law enforcement organization, DEA's principal responsibility is to enforce the Controlled Substances Act of the United States. We are an international organization. We have almost 200 offices, domestically and around the world. We are in 62 locations overseas. Right now we are 5,500 strong, having grown from a very small organization. Actually we have increased our size by over 40 percent in the last 7 years, and our budget doubled during that period.

We have about 2,800 agents nationwide. We have done a lot over the last several years in stemming the flow of drugs in the United States. You probably all know that the use of heroin in this country has generally leveled off. Marijuana use has actually gone down. Pills—the uppers, the downers—have stabilized. Cocaine is certainly one of our major problems; at present we spend upwards of 60 percent of our investigative resources in

going after the cocaine traffic in the United States and abroad. This morning we are not really here to talk about our role as drug law enforcement. What we really want to dwell on during this conference, from our perspective, is our role in demand reduction.

DEA has had a stepchild role in demand reduction for a number of years. Certainly as long as I have been with DEA, we have had a prevention program. It was a program that over the years has been questioned by the Office of Management and Budget, principally because of the feeling that this is not a DEA role. It was said that our role is law enforcement and that we should not be involved in the area of prevention. DEA has always had strong feelings about that. Law enforcement is important, but law enforcement alone cannot stem the flow or reduce the use of drugs. We have to have demand reduction. We have to have prevention.

The Office of Management and Budget cut the demand reduction function out of our budget, and we continued to fund it internally because we felt so strongly about prevention. It was just a couple of years ago that the White House recognized that DEA did have a role in demand reduction and prevention. Not a principal role, but certainly there was a role for DEA in the demand reduction arena.

Over the last couple of years, we have made a number of strides in the area of demand reduction. Just to mention a few, we trained over 20,000 high school coaches. Over the last 8 months, we have been training college coaches in demand reduction. We placed, or are in the process of placing, demand reduction coordinators in each of our 19 domestic divisions. We are training our country attaches. These are the people who head up our overseas offices in the area of demand reduction. We have been providing expertise to minority business groups on drugs in the workplace. And of course, we have been working with the Boy Scouts, the Girl Scouts, and the Explorers in demand reduction. We are meeting with all the managers and players of all the national sports teams: basketball, football, baseball. The list goes on. As I said, we in law enforcement cannot do it alone. We look at ourselves as just one division in an army, an army that has to act as a fine-tuned network. Network is a key word for us. A network to solve the drug problems we face in this country today.

Summary of Remarks by Herbert W. Nickens, M.D.

Before becoming a bureaucrat, I was a practicing psychiatrist, and often I would be referred alcohol and drug dependent patients. Often these patients would be dragged in by families or law enforcement officials or other people; these patients were not there voluntarily, at least not in the usual sense of the word. Even if people were there voluntarily, their addictions were very difficult to treat. I think often the gratification derived from alcohol and drug dependency is greater than the gratification of improvement or pleasing your family, or getting the cops off your back. Often group treatment

was very effective and the power of the group process was often more powerful than what you could do with somebody one on one. Alcoholics Anonymous I think is a good example of the power of group treatment. I think this conference, therefore, is very important because it is an effort to bring the power of a large group of people to bear on this problem.

I think one of the things that is important about the conference is that alcohol is included. Not only is alcohol a major killer in the country, as was mentioned earlier, but people often combine alcohol and drug use resulting in their developing a dual dependency. People often shift back and forth between alcohol and drugs, sometimes depending on availability, sometimes depending on other factors. It is very important to talk about alcohol in this mix, even though it is a licit drug. The second good thing about this conference is the community concept. The idea of bringing communities together around the issue of alcohol and other drug addiction is really essential to reversing widespread drug use in Black communities.

There is a qualitatively different level of access and power that we have over each other's behavior as a community that is different from what individuals or individuals' families, or individual therapists or doctors can do by themselves. I think we have reason to hope that these kinds of things can change. We have seen changes in our country over time and the way that things get looked at. I often think about cigarettes. I am a fan of old movies, and in old movies smoking was chic. Anybody who wanted to look cool would light up a cigarette. It is not chic anymore to smoke. In fact, people are rather apologetic now; "may I smoke?" is often the prelude, and sometimes if you say "no," they will not even smoke, which is even more surprising.

The second example is that drunkenness is not even funny anymore. It used to be that when you saw somebody, usually in the older movies, get drunk and stumble around, that was comical. That was often the prime bit of every person who had a comedy act. That is not funny anymore, and you do not see it in contemporary movies. Usually drunkenness is seen as something that is sad; somebody's out of control. I think that is a very definite change in attitude.

Marijuana, which only a short time ago was sort of hip, is not hip anymore. We see there can be changes. We really can make a difference; the power is with people.

Summary of Remarks by Charles R. Schuster, Ph.D.

I feel really very pleased to be here this morning because I have witnessed the hard work of my friend and colleague, Elaine Johnson, over the past few months in bringing this conference to fruition today. I think it is an extremely important conference because we are going to be passing on common experiences in prevention activities and attempts

to make them more effective, not only in Black communities but in all communities. As you can see, the program packet is a very rich one. My biggest frustration when I go to meetings is that there is always two or three meetings going on that I want to attend, but I cannot clone myself so I only go to one. I was very pleased to see that the meetings are being repeated so that individuals, including myself, can attend a number of them. I think that this is an important device.

It is safe to say that the need to convene a conference such as this has never been greater. The National Institute on Drug Abuse (NIDA) conducts a number of surveys about the prevalence of drug use. I think it is important to point out that overall, there is really no difference between the prevalence of drug abuse in the white population and in the Black population. However, it is higher in urban areas than in suburban areas. Our 1980 census indicates that Blacks constitute about 11.7 percent of our population. But Blacks comprise about 22.5 percent of the population in urban areas. And to the extent that a disproportionate number of Blacks lives in urban areas, they are at greater risk of drug abuse.

We are particularly concerned about the problem of crack, the smokable form of cocaine, which has had a major impact in Black communities. Because crack is smoked, it is possible, as long as you can breathe, to increase the dose that you can get into your body; hence, it can be very toxic and produce death. In addition, because it is smoked, it very rapidly reaches the brain and its addictive properties are amplified. It is marketed in our major cities in the form that is inexpensive enough so that it is within the reach of any kid who can afford to buy a record album. Thus, we are exposing our children during their most important formative years to a very potent mind-altering and addictive substance.

The second problem that has been alluded to here is the issue of AIDS. NIDA is involved in this because it turns out that 25 percent of the AIDS victims in the United States have probably acquired this disease because of the common practice of sharing needles amongst IV drug users. AIDS was once thought to be a disease that was almost confined to homosexuals and recipients of blood transfusions. We now know that this is not the case. Unfortunately, Black children and adults are greatly over represented amongst the AIDS victims. Fifty-eight percent of the affected children, who, by and large, are the offspring of mothers who have either acquired the AIDS themselves through their own IV drug use or through actual contact with an IV drug abuser, are Black. Also, 25 percent of the adult AIDS victims in this country are Black.

What we are particularly concerned about is the fact that IV drug abusers acquire the AIDS infection through sharing of needles, but subsequently pass it on to the non-IV drug abuser, heterosexual population through sexual contacts. Therefore, particularly in the minority communities in the large urban areas, we are concerned that the heterosexual population is going to have an AIDS epidemic. Because of this, NIDA is sponsoring extensive community demonstration grants in many of the major cities. It is our attempt to prevent, where possible, people from becoming IV drug abusers, and to

try to intervene early and get them into treatment—not only treatment for their IV drug abuse, but to educate them as well regarding safe sexual practices.

It is of utmost importance that we recognize the complexity of the problem and the fact that it is perhaps the major public health problem that we face today. That is why I think you are going to hear about AIDS a lot over and over again at this conference. Although I know that it is going to be spoken about by everyone else, I could not let the opportunity pass to tell you that I think it is such a major problem and that we must address it.

Finally, as has been stated, this is the first conference. I would like to emphasize that I hope that it is just the beginning, not only of conferences, but of dialog. NIDA primarily conducts research; we are not a service organization. But we want to be sensitive to what kind of research we should be conducting. We need input from you in that regard. We need input from the communities to tell us what the important issues are that they are facing so that our research can be more relevant.

Summary of Remarks by Enoch Gordis, M.D.

Let me say how much I understand about the amount of work that goes into putting together a meeting like this. The cooperation among all the organizations and the endless hours of detail that go into this get mine and the National Institute on Alcohol Abuse and Alcoholism's (NIAAA's) congratulations for this effort. The cooperation between organizations is so important. Life is too short for the rivalries and turf battles, whether it is this endeavor or any other. I think this is a wonderful step in getting various segments of the Black community together to achieve such important goals.

Dr. Macdonald refers to the problem of alcohol in our Nation; it is certainly the number one drug of abuse. And the reference to old men sitting drunk next to the alcoholic beverage store is a significant sad part of this problem. I think we have to understand that it goes beyond that very sad image. Most people who are in trouble with alcohol in our country are not skid row folks, they are people who look very much like all of us in this room now. They also include our teenage children. When we talk about the problems of alcohol, we are talking about the whole spectrum, from the occasional drinker among the teenagers who kills somebody on the highway, or gets involved in a drunken fight with injury or death, all the way to the other end of the spectrum, to somebody who has been devoting 40 years of his or her life to drinking and is now sitting on that carton. We have everything from the occasional user who can kill somebody or who can kill himself or herself on one end (this is the alcohol abuser who is not a clinically dependent alcoholic yet) to the adult who depends on alcohol—he is drinking a quart of an alcoholic beverage a day and destroying his life.

You heard Dr. Macdonald refer to the many kinds of troubles that alcohol causes in our community. On one hand we have violence, homicide, injuries, and suicide. Of a special

concern in the Black community, I think, are two very important effects of alcohol: those are first, liver disease and cirrhosis, which are disproportionately high among the Black alcoholics compared to whites, and second, the issue of hypertension. As you know, alcohol is a very great risk factor in high blood pressure. It leads, of course, to strokes and other complications of high blood pressure. Therefore, since we already know the Black community is especially sensitive to that kind of problem, the addition of alcohol as a risk factor for hypertension is a terrifically important element.

Finally, there is the much more subtle issue of the interference with development during the teenage years. You know when you are growing up, you have to go through a lot of things between the ages of 8 and 20. You have to finish your high school education, you have to learn how to talk to adults, you have to learn how to speak to somebody of the opposite sex, you have to learn how to talk when you go on job interviews, and so on. If you are drinking your way through your teenage years, none of these things are accomplished. Even if the person manages to get to adulthood and finally does something about the drinking, these precious years have left a scar or a kind of impairment. Even if we are not talking about full-blown alcoholism, the use of alcohol repeatedly during the teenage years is a terrible sport which really destroys life, not only during those years, but later.

Now in complimenting the various Black organizations that have put together this excellent meeting, we are faced with special problems here. There is no question that alcohol is the leading drug of misuse or abuse or dependency in this country. Dr. Macdonald referred to the tremendous toll in economic as well as in human cost. We are faced especially in the Black community with two problems. One is that it is a legal substance. There is a tendency, because it is legal, to sort of turn away from the fact that alcohol is the leading drug of abuse, with the highest price tag, both in health and economic resources. In doing something about alcohol you are dealing with something you can buy legally without going to jail, without getting involved with the police.

Second, there is obviously a kind of an exaggerated pitch, I think, by the advertising industry to the Black community regarding alcohol. We have a country where free speech is the rule. Therefore, when the Black community gets together and tries to protect its young, especially from alcohol, it is dealing with very powerful forces. I see in one of your sessions on the impact of the media on alcohol and drug use you will be looking at that very important issue in the next couple of days, and I congratulate you for taking that one on.

There are no easy solutions here. The very fact that so many organizations are represented is a reflection of the fact that the audience here recognizes the difficulties in doing something about something that is so subtle, but infiltrates every corner of our life.

Finally, I want to congratulate you for being here. I do hope that this will be the beginning of a cooperative venture among the various organizations, not only for these 2 days, but for a long time to come. We at NIAAA want to thank you for putting together this meeting, and we wish to be responsive to all of your concerns.

Summary of Remarks by Reed Bell, M.D.

It is obvious, in just glancing at the program, you really worked long and hard to ensure that the conference will be a success. We want to do everything that we can to assure the continuance of the momentum started at this conference. Even though we are the new kid on the block, we can play a very vital role in furthering prevention activity in Black communities.

The legislation that was mentioned earlier mandates that the Federal Government step up not only enforcement activities but, equally important, treatment research and efforts aimed at preventing alcohol and other drug use among our young people. That is the purpose of our new office, the Office for Substance Abuse Prevention (OSAP).

There has been a total of almost $42 million earmarked for Federal support of community programs, media efforts, clearinghouse activities, and various other prevention and education activities that are needed to prevent alcohol and drug use among our young people. Congress mandated OSAP to develop programmatic efforts that aid and develop drug-free youth and drug-free communities.

OSAP is more than a Federal program, it is a national resource. We are striving to form a partnership with you, parents, youth, community groups, and other voluntary and professional organizations concerned with substance abuse in this country. Representatives of various groups will be convened in mid-December from across the country at a national strategy conference at the behest of Dr. Macdonald. We will be seeking grassroots input in framing program initiatives to improve the effectiveness of my office and the resources that we will be providing for programs.

Our overall objective is to promote prevention strategies, programs, and services with the goal of achieving drug-free communities throughout the country. We hope to accomplish this goal by working with you in parent groups, youth groups, schools, and neighborhood, civic, and professional organizations. I am instructing my staff to attend and participate fully in every session over the next 2 days. We want to demonstrate our support by our presence. And just as the brochure of the conference indicated, we will seek to help you maintain the momentum generated by this conference.

Lastly, just a personal note, I have been a pediatrician, as has Dr. Macdonald, for the past 30 years or so in Florida. I respect him and regard him as a colleague and a tremendous leader in the drug abuse field. I am new to the Federal Government, Washington, and to you, but I am not new to the harm, or the pain, or the suffering caused by substance abuse as it affects all people. OSAP will continue to do everything it can to help eliminate that harm, that pain, that suffering, by working with you.

Summary of Remarks by Dr. Dorothy I. Height

Madame Assistant Secretary, it is a real pleasure for all of us to be here. I think most of us arrived this morning with an understanding that drugs pose a very critical problem for the Black community. But I think that has been so reinforced that it is very clear to us that the drug problem can best be attacked by our working together. Building coalitions not only will help to deal with the problems of alcohol and drug abuse, but will help us to reinforce one another's efforts.

One of the things that concerns me is the way in which so many Black people today just feel that until they have had a baby, or until they are on something that makes them feel better, that they are nobody. I think all of us here know who we are. As Black people, we have our heritage, our history, our traditional strengths, and the values that we have as a religious community. We have, as a people, always shown a caring for each other. Therefore, it seems to me, a part of what we should be doing now is helping to stimulate in our young people a sense of self-worth. With the knowledge we gain about what each of us is doing, we will be better able to work together. I think that we can take part in creating a generation in which we will be proud.

PLENARY SESSION – MAY 22, 1987

Conference Overview

Speakers: **Elaine M. Johnson, Deputy Director, NIDA, Presiding**

The Honorable Thomas Burke, Chief of Staff, Department of Health and Human Services

Summary of Remarks by Elaine M. Johnson

"Drug and alcohol prevention in the Black community seems to be more complex, as this issue cannot be dealt with in isolation. The drug problem in Black communities is so interwoven with economics, employment, the family, housing, education, teenage pregnancy, mental and emotional problems, crime and delinquency, that additional approaches must be developed and supported. Many good things are happening in the Black community relative to prevention with little support or visibility. These efforts could be significantly enhanced by an increase in support and recognition. The support of a national conference would provide a means to exchange information with other groups that share our concern."

This is an excerpt from a letter written to Administrator Macdonald of the Alcohol, Drug Abuse, and Mental Health Administration, by Dr. Flavia Walton of the Links organization, and it provided the impetus for the planning of this conference.

Early in the planning process it was recognized that all facets of the Black community needed to be involved in the conference. Therefore, we turned to the church, the Black family, our historical Black institutions of higher learning, health and social service organizations, the media, the sports and entertainment world, law enforcement, private industry, and of course, the national voluntary associations. We believe the conference program reflects this broad-based perspective. Moreover, we were cognizant that we must involve our youth, the ultimate beneficiaries of our efforts. Beginning tomorrow, therefore, there will be a Youth Forum, which will run concurrently with the other parts of the conference program.

We are deeply grateful for all of the support provided the conference by the various Federal Agencies that not only provided resources but staff support as well. We especially want to thank the nongovernmental organizations that provided their con-

siderable expertise. And I must express our special appreciation to the National Medical Association and the Zeta Phi Beta Sorority, which provided the facilities of their National Headquarters for our planning meetings. And certainly my deepest appreciation is extended to each of you for being here to participate fully in this momentous occasion.

Summary of Remarks by The Honorable Thomas Burke

My purpose here today is to give you an overview of what the Department of Health and Human Services (DHHS) is doing to fight the pervasive spread of alcohol and drug abuse throughout American society, particularly in the Black and minority communities. President Reagan has described alcohol in America as a national epidemic and has called on every American to do his or her part in fighting the battle. There are two basic components to winning the battle against the scourge of drug and alcohol abuse: reducing the demand and reducing the supply. These two facets are very much interrelated. Demand is induced if you have a flood of drugs on the street, and there is a supply response where there is a demand for the drugs. They go hand in hand.

The Department of Justice (DOJ) has the lead role in the Federal Government's efforts to reduce the supply of illegal drugs in American society. At DHHS, our primary responsibility is to reduce the demand for drugs and alcohol, and, as I speak, Secretary Bowen is at the White House at a meeting of the Drug Policy Board.

Plainly stated, our department is working to do three things: to study the effects of drugs and alcohol on people, to educate people about drugs and alcohol so that misuse can be prevented, and to support effective treatment programs for users. Research continues to form the base upon which successful prevention and treatment modalities are built. Among other things, our researchers at the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) study usage patterns and long-term consequences of drug and alcohol dependency.

Our research activity can be placed in better perspective by looking at the areas of prevention and treatment that we are currently exploring. In the areas of prevention, we are moving aggressively to discourage drug and alcohol use, especially among school-age children. I am sure that many of you have seen our "Cocaine—the Big Lie" campaign featuring such sports stars as Reggie Jackson, Mercury Morris, and Mark Schmidt. Many of you will soon be seeing our anti-alcohol "Be Smart, Don't Start, Just Say No" public service campaign targeted at preteen children. I am sure that many of you realize that the anti-drug abuse "Just Say No To Drugs" program, sponsored by First Lady Nancy Reagan and now enjoying success nationwide, originated in our department.

In terms of treatment, the block grant concept initiated by the President is now allowing States more flexibility to reach treatment goals with money they receive without any strings from our Department. The Anti-Drug Abuse Act of 1986, signed by the President, increased funds to be channeled directly to the States for prevention and treatment of substance abuse through block grants. The bill enhanced even further our Department's role in the battle against drug and alcohol abuse.

NIAAA received additional funds to carry out the prevention and treatment research under the Anti-Drug Abuse Act of 1986 and plans to use it for the following initiatives: research into the effects of alcohol use on adolescent psychological development and on the sequence of adolescent drug use; development of improved technologies to evaluate rapidly the impact of prevention and intervention efforts; support for a National Alcohol Research Center on the determinants of alcohol consumption; and development of an objective marker of alcohol intake to increase the reliability and value of treatment effectiveness studies in improved alcoholism diagnosis and treatment. Much more is being done and other speakers will talk about more of our various programs. There are others, however, that are often overlooked.

Our Health Care Financing Administration, for example, is involved in anti-drug and alcohol abuse efforts through the Medicare and Medicaid programs. Medicaid provides the services of clinics, rehabilitation centers, physicians, and other practitioners such as psychologists.

Our Indian Health Service continues to study the problem of drug and alcohol dependency by a large number of Native Americans. As one who has toured Indian reservations and seen the devastating impact of the effects of alcoholism there, I can attest to the definite need for continued action and cooperation from our Department and local authorities on this very matter. Our department-wide task force is currently investigating the roots of the problem and developing goals designed to free Native Americans of alcohol and drug dependency.

And finally, there is our Youth 2000 Initiative. Together with the Department of Labor (DOL), our Department has founded the Youth 2000 Initiative to ensure that our country has able-bodied leaders and workers in the year 2000 and beyond. Goals have been set and wheels put in motion for a drug-free youth and work force in the year 2000. Our young Americans and America itself are dependent on the success of our efforts.

I would like to deviate from my prepared remarks now and just share with you some statistics I came across recently on substance abuse. The United States ranks 6th, according to the World Health Organization, in a statistical study of deaths due to alcoholism. There are 100 million persons over the age of 15 in this country who use alcohol, and an estimated 15 million alcoholics and drug abusers in the United States. One alcoholic directly affects the lives of four to five persons and indirectly affects about five others. Some 6.5 million workers are substance abusers. The loss of productivity in America because of this phenomenon is computed at approximately $10 billion a year. Twenty-eight percent of the males in mental hospitals are chronic alcoholics; 49 percent of the police arrests are substance abuse related. The divorce rate is four times higher

in alcoholic marriages. Thirty-one percent of suicidal deaths are by substance abusers. Sixty-three percent of all homicides in the United States are committed by people on drugs or alcohol.

What does all this say? This tells me that we have a big problem in the United States, with which we have to get serious, and not wait a long time doing it. The problems that we are confronting—many of them are traceable right back to the problems you people are addressing here today. Many of these problems occur because of substance abuse. We are not living in a world where we are isolated by oceans anymore. We are losing $10 billion in productivity. We can ill afford that.

In the United States, we are beginning to trade in $14-an-hour jobs for $6-an-hour jobs, and minorities tend to, in many cases, be most adversely impacted by this phenomenon. If we do not get serious about getting our act together soon, we are not going to be competing internationally, which is what we have to do. We either do it or we continue the trend of trading in more expensive jobs for less expensive jobs and a declining standard of living. We will be talking out of Hitachi telephones and driving Japanese cars. The time for action, ladies and gentlemen, is now. The problem is very serious. It is not just a social problem in the sense of the family; it is a social problem in the sense of the economic impact that it is having on our Nation.

Last June, Secretary Bowen made this statement; it applies equally today. He stated, "Government isn't the real answer. Public programs can help repair the damage, but they can't prevent it. Real and fundamental change must come from the people and the community. We need to involve parents, grandparents, relatives, teachers, church and community leaders. We need to forge a grassroots constituency that sees what needs to be done and then does it." Your attendance at this program lets us know that you are concerned about the problem and that you are willing to help. I invite you to pay close attention to the experts that will be speaking here at this conference and to make your voices heard. You can learn from them. More important, they can learn from you.

Drug and alcohol abuse will not go away with more Federal dollars. Yes, our programs are important, but without public support and a society that joins us in saying no to drugs and alcohol, they simply cannot succeed. Unfortunately, while most Americans are against drug use, far too many are willing to accept it as a way of life. With alcohol abuse, the tolerance level is far worse. You can help change that.

As the President requested: Stand up and be counted. In the war on illicit drugs and the war on alcoholism, stand up and be counted. The time for action is now. We will continue to do our part, but we are not going to accomplish much if we do not have you walking hand in hand with us.

Keynote Address

Speaker: **The Honorable Charles B. Rangel, Chairman, Select Committee on Narcotics Abuse and Control, U.S. House of Representatives**

Introduction: **Beny Primm, M.D., Executive Director, Addiction Research and Treatment Corporation, Brooklyn, NY**

Summary of Remarks by The Honorable Charles B. Rangel

Thank you, Dr. Primm. Congratulations, Ms. Johnson, for this successful effort and the support that Director Schuster has given you.

I am overwhelmed with the number and quality of people that have come out this morning to participate in this conference. Quite frankly, I am delighted to see so many people who are interested in the Black community and what I consider to be survival. Seeing such leaders as Dorothy Height, Bill Tatum, and Dr. Wells, who have come from New York, and others who have come from all parts of the country, is gratifying. It is so important, as Dr. Primm said, that we are coming together to understand each other's problems. To me, this is a question of survival.

If we are going to talk about the drug epidemic that is just exploding throughout this country and the associated AIDS epidemic that is hitting our community through intravenous drug use, we have to make certain that we truly understand the problem in all its dimensions. The majority in this country has the luxury to celebrate the 200th anniversary of the Congress, the Declaration of Independence, and all these wonderful things I am privileged to participate in as a member of Congress. All of this has been designed to make certain that this great Nation of ours has a legacy to leave to the generations to follow. No one who is white should get upset that Black folks, as we move toward the recognition of this anniversary, constantly remind ourselves, as we prepare our children and our children's children, that while these great designs were being structured, our people were slaves. And there is no program designed at this time to remove the yoke of slavery.

So having said that, we have to provide a roadmap for the resources in this country so the profit and loss statement will reflect the improvements we have made in our lifetime. We have not just come together to share the fact that when there is a national disaster, we, as Black and minorities in this country, are going to get more than our share of it. That is nothing to be celebrated; that is something to be studied to see how we can stop it.

We have to understand how it is that people can be blinded to such an extent that they think the educational process means slapping a book or a pamphlet on the kid that says "Just Say No," when no one ever checked out whether the kid could read. We have people designing programs that are going to tell our Black teenagers and young Americans not to take drugs because it is going to destroy their lives. Well, if you take a kid who has not got a job, who has no job training, who is living with rats and roaches in a dilapidated house where he cannot see any economic development or improvement, and who has no hopes of ever, ever getting out of the situation in which he finds himself and his parents found themselves as prisoners, you just tell me what he has to "Just Say No" to? What is the sense of being drug free if indeed society is still holding him hostage without any hope of escape from the situation?

I cannot tell you the hurt that I feel, as a public official, when young men say, "Congressman, you are doing the best you can. My brother followed your advice, and he's drug free and he's out of work."

Now, unfortunately, the Administration has to understand that this is not the first Administration that talked about doing something about drugs and has not done it. The reason for our lack of progress in this area is because drug abuse was not perceived to be a national problem. Twenty years ago, drug abuse was perceived to be a Harlem-Puerto Rican problem. No one knew that this epidemic was going to grow and explode and get into the classrooms, or the boardrooms, or the military. The same thing has happened with AIDS. AIDS was said to be a gay disease. Now it is recognized to be a universal problem; it is becoming international, and something has to be done. The question has to be: Who is in charge?

We do not grow opium in the United States anywhere. We do not grow the coca leaves that make cocaine in the United States anywhere. Eighty percent of the marijuana in the United States comes in from foreign countries. This means that if indeed you are growing the tonnage in Burma, Pakistan, Thailand, and Mexico and the coca leaves in Peru, Bolivia, and Columbia; if the drug traffickers have so corrupted the governments of certain of these countries that they are a threat to their own democracies, not to mention a threat to our alliance; if in Columbia the truth is that no drug trafficker will ever go to trial because they have killed most of the judges who have taken a stand and the other judges will not take a case; if the military has been stopped by the Supreme Court of Columbia from trying narcotic cases; and if the extradition treaty that we had with that country to bring the scoundrels to this country has now been declared unconstitutional, then we are confronted with a serious international problem. Should we continue to give economic, military, and technical assistance to countries growing poison that is destroying life in the free world?

It would seem to me that, if we are to make certain that these people are not dependent on these crops, we should have crop eradication and crop substitution programs. When we hear about foreign policy, these issues should be on the agenda. When you watch your national leaders who are talking about a declaration of war, you should be hearing about the war you are waging, not only the one in Central America, but the war being fought around the world as we battle the scourges of AIDS and drug addiction.

Let us talk about our borders. If we are conducting war, we have to protect our borders; we are stopping only 15 percent of the cocaine, opium, and marijuana coming into the United States. And that is with all the interdiction we have. We have talked about the resources, but it was interesting to hear Tom Burke talk about prevention. I think we all agree that it is a matter of supply and demand. If you stop the demand, there is no need for the supply. If you are not doing anything with the supply, let us swiftly move over to the demand side and determine a national strategy.

I share this with you since this is not just an ordinary group of citizens, but people who reach out to find out where the national resources and national leaders are. How many people would know that since 1981, in the White House, there was a Special Assistant Advisor to the President, dealing just with narcotic matters? How many? Not too many, I see. That does not say much for you troops who are in the front lines fighting this war. You know that you cannot pick up the phone and call the President, but the Special Advisor must have been in touch with you in the 6 years that he was there. How many people heard from the Special Advisor to the President on narcotic matters? I asked this of an assistant attorney general, and he did not know. I told him not to be embarrassed, half the Congress does not know either.

I am suggesting to you, then, that we are not going to win this war just staying on the sidelines thinking that somebody is going to fight this war for us. This epidemic of AIDS and narcotics addiction has hit our community harder than it has hit any other community. I thank God for those of you, including Dr. Primm, that have had the wisdom to say that you are going to combine your intelligence and resources to make certain that this land that was left to us by our forefathers does right by our children. Life certainly has been easier for us than it was for our forefathers. That is what has made this Nation so great—not how much gold and silver we leave in the legacy, but how much hope we leave for the next generation. This chain has not been broken for 200 years. No matter how poor or wealthy our parents were, life has always been a little bit better, the road has been made a little bit smoother, education a little bit higher, job opportunities a little bit better for the generation that followed.

Brothers and sisters, it frightens me that in our time we cannot say that we left the world a little bit better for those who are going to follow us. We have left an explosion of AIDS and drug availability. Education is less attainable; escaping poverty is less likely. Yet we have an opportunity to turn all that around. We can turn it around by just saying, "no". Just say "no" to indifference. Just say "no" to people who believe that you are not willing to come together, to work together, to register together, to vote together, and to do everything that it is possible to do politically for survival and for the next generation.

Included in the 1986 anti-narcotic legislation, we, the Congress, said to the White House that since we do not have the answer to this terrible epidemic and clearly you do not, why not have a White House conference? Bring together the best minds that we have in international affairs, former secretaries of state, and former presidents to discuss what we can do in the international arena; bring together those in law enforcement, health, education, and prevention to confer to see what we can do in Congress to respond to this national crisis. We hope that when this conference is called, you are included as participants. If you can see who is adversely affected by the spread of this drug epidemic—it is people who look like you and me, and if the White House is going to deal with it, it would seem to me that they ought to at least check with us to get the benefit of our experiences. Let us share our failures so that we can stop them, and share our successes so that we can repeat them.

The good news is that the Congress is going to provide funds even at the risk of asking for additional revenue through taxes, funds for new or expanded programs in education, in drug education, in law enforcement, in interdiction, and in international affairs will be restored by the Senate. Ideally, we should have programs that you have designed, not just to throw money to the cities and States, but to be able to say that we have an accountability as to what is working and what is not working. I feel better today about this struggle than I have ever felt. We may not need a lot of generals to win this war. I am talking to those of you who are on the front lines of this fight, and I am there with you. You will not have to look back for any generals, because your Congress will be supporting your efforts. And I will see you at the White House conference where we will plan a drug-free America.

Alcohol and Drug Abuse: Exemplary Prevention Models

Moderator: Roy W. Pickens, Ph.D., Director, Division of Clinical Research, NIDA, Rockville, MD

Panelists: Bennie Crayton, Senior Health Educator, Center for Drug Problems, Ventura, CA

Bettina Scott, Ph.D., Project Manager, University Research Corporation, Chevy Chase, MD

Claude Mayberry, Ph.D., Editor, *Science Weekly Magazine*, Washington, DC

Avery Carter, Community Organizer, Oakland Parents in Action, Oakland, CA

Ken Ellis, Sports World Ministries, New Tazewell, TN

Summary of Introductory Remarks by Roy W. Pickens, Ph.D.

Treatment is one of those things with which it is very difficult to deal. People admitted into treatment programs do not always do well in those programs. They certainly do better than if they do not go into treatment. However, what we would like to do is avoid the problem in the first place. Obviously, if you can avoid the problem then you do not have anything to treat later, and you do not have the disruption that would occur in the person's life, in the family, and in society.

The area that I represent at NIDA is the area of clinical research. Clinical research includes a number of different areas, one of which is treatment. Clinical researchers try to understand more about drugs and how they affect behavior. Another area is prevention, and that is one of our most active areas of research at the present time—trying to develop strategies that are effective in terms of preventing drug abuse. It is one of the highest priorities we have at NIDA, to develop and test strategies that would keep young adults, middle-aged adults, and older adults away from using drugs and alcohol.

As times change, prevention becomes even more important than ever before. I say that because of AIDS and the association between AIDS and IV drug abuse. This is a fatal disease that is being spread rapidly now among individuals who use drugs intravenously. Sometimes intravenous drug abuse is preceded by using drugs non-intravenously, by smoking, and so forth, or by taking pills that eventually lead to intravenous drug abuse. I cannot think of another time in our history when it was more important to know how to prevent drug abuse than the present.

When we come up with these effective strategies for preventing drug abuse, not only are we preventing drug abuse, but we also are preventing so many other diseases that run along with drug abuse. One of the most obvious of these is AIDS, but there are a lot of other diseases also that are associated. It is not just drug abuse that causes the problems for the individual and for the family; it is also these other diseases that are associated with drug abuse. I cannot think of anything more important right now than to apply prevention efforts in the community and within the family, to decrease the use of drugs, because in so doing, not only are we decreasing drug abuse, but we also are decreasing the risk that an individual runs for AIDS and other diseases.

Summary of Remarks by Bennie Crayton

It is very frustrating to try to share with you some ideas on what prevention is, or what it ought to be, particularly in communities of color. But I hope that I can say something that will interest you, and perhaps you will be interested in pursuing further what I have said.

We know in the area of prevention that perhaps the most important thing is the question of self-esteem. We do not always know exactly what that is or how you go about instilling it or enhancing it or reinforcing it. Many of our efforts over the past 20 years have been directed at experimenting with ways to do that. We have not always been effective.

Most of our efforts, practically all of them, have been directed at the individual. In addition to directing emphasis on the individual, you need to look at the cultural aspects, the cultural determinants, and start directing your efforts toward some of the stressors that are associated with cultural experiences. In order to set that up, we should really ask the question in prevention, and particularly in communities of color, "Can we really talk about drugs?" I do not think we have really talked about drugs the way we should talk about them. This is where I would like to see the communities take the lead, particularly communities of color, by helping us all to understand that this is not the first time—we have been here before. According to Dr. Musto at Yale University, we have been here five times in the last 120 years. We need to understand that we are dealing with a pernicious disease.

There is a method to the illness, and we have watched over and over again as this scenario unfolds. We have the discovery or rediscovery of basically the same two drugs:

cocaine and morphine, or some derivative or morphine. Those two have been important in each of the five cycles. We need to understand that the discovery or rediscovery occurs among a small elite group of people, and gradually the media and word of mouth picks it up and spreads it around, and more people become interested and try it.

If we can understand this as a developmental stage of a disease, then I would think that we would be more interested in finding out what specific efforts can be targeted at each of these developmental stages that might have a more long-lasting impact. What also happens is that the medical research on each phase comes out and discovers new addictive potential and health hazards. Policymakers then express indignation and they get new drug laws. This is precisely where we are in the cycle this time. We are not really paying too much attention to the historical evidence that the cycle develops in this way, and we do not even notice that by the time it gets here, the actual experience of a user is that this initial titillation has turned to horror.

The reason that the cycle keeps coming over and over again is that the public memory fades. We forget what happened 20 years before. Dr. Musto says that it takes each of these cycles about 20 to 30 years, and we keep responding in the same old tired ways. We keep responding as if each new episode occurs in a vacuum. I would like to see more of our efforts directed toward understanding the historical cultural role of drugs.

If you look at it, the ancient Aztecs used opium about 2,000 years ago. It is not a new drug. Each time we respond to it as if it is. The Aztecs used peyote and marijuana. In the Middle Ages, so-called witches used to anoint themselves with lysogenic ointment. George Washington grew plantations of marijuana that he called hemp. Ulysses S. Grant, at the urging or General Cummings, used cocaine to write his memoirs. The Victorian ladies who traveled from Boston to Los Angeles could not wait to meet the medicine men to get their goodies. What I am trying to say is that the problem has been here before. We do not seem to have learned an awful lot about how to deal with it.

We need to understand how it is that racism gets enveloped into this whole issue. I am going to offer a prediction that we will really begin to understand the problem when we examine cultural stressors that make people vulnerable to self-destruction. We need to direct more of our efforts toward gathering our resources to understand those recurring facts and make sure that our strategies are tailored to fit them so that we do not have to repeat the cycle a seventh time.

We need people to help us create an atmosphere where we can really look at the problem and deal with it wherever it leads. We need a prevention prescription that is strong on people. I am suggesting that we do that from a very scientific base. One of the first things we need to do, particularly in our communities, is to identify the enemies—known and assumed.

We really need to take a hard look in our communities at the real enemy. Because we know from our scientific base that in order for any disease to take place you must have the environment and the experiences within the environment that make the individual

vulnerable. It is no accident that people of color tend to be much more vulnerable as a result of their experiences in this culture. We need to work harder at understanding the cultural stressors that set us up to self-destruct. When these human beings with those experiences in the environment come in contact with the drugs, of course, the chemistry is there and the disease takes place.

We have created in the whole of American culture hoards of empty people who have no self-respect. You cannot just talk about that. We have to find some creative ways of helping them. There is no positive sense of identity. You cannot just shout that I am Black and I am proud and act from it. You have to have experienced that being Black makes you feel proud.

If we are serious in prevention, if we are serious about constructing and understanding programs in communities of color that can have some impact, I would suggest that we spend some serious time investigating these kinds of questions and developing a programmatic response to the questions they raise.

Summary of Remarks by Bettina Scott, Ph.D.

Not a lot is known about what works and what does not work in prevention. Over the last 20 or so years, many people have been spending a lot of time with projects in which they were trying to come up with at least some concrete findings about things that would work with young people, with high risk youngsters, with minority youngsters, in the area of alcohol and drug use prevention. So much of the work that has gone on in prevention has taken place within the last 20 years, but now we have come truly into our own as a field. I was very happy when the President pushed for the bill on prevention that passed last fall. In the past, in the area of alcohol and drug abuse, prevention has been the stepchild. It was not the area where you could actually count numbers of successes as you could in treatment. Most of us who have been in prevention for the last 15 or so years, tried to tag prevention onto treatment. If we could be a part of a treatment program and say we were doing prevention, we always got the least amount of money and nobody paid any attention to us because we could not say what we were preventing, and how many people we were preventing from that thing we could not define. It is within the last 5 years that we can say that there are some things that we know that will work in prevention.

We do know by talking to youngsters, themselves, that what they want in a prevention program is information on alcohol and drug problems that is factual and devoid of scare tactics. In the past, we thought that we could prevent people from drinking alcohol or taking drugs if we showed them all of the horrible things that happen to you if you took drugs or indulged in alcohol. We found that this did not work, because what youngsters want is for you to tell them what is going to happen to them now. They do not want to see a cirrhotic liver and be told that 20 years from now this is what will happen to them if they drink. They are a now-generation people. We have been able to come up with

some ideas about things that we can say to youngsters about what alcohol will do to them right now—what drugs will do to them as far as damaging their bodies and affecting their everyday lives, right now.

We also know we have to provide some attention to building skills in the areas of social competence. We give assertiveness training and classes in regular communication skills. This helps youngsters to express themselves in order to say those things that they like and dislike and to be able to communicate and develop rapport in relationships with people, including their parents, teachers, and other adults.

We also know that it is very important to teach youngsters how to go about making decisions. Decisionmaking becomes a very important part of any kind of prevention program. This is because it also helps youngsters to develop skills, not just in the area of making a decision about whether or not to drink alcohol or take drugs, but a whole array of other kinds of activities that they will encounter as adults.

As has been said earlier, improving self-esteem is very important. It is particularly important for Black youngsters. Any way that we can help them to improve their image about who they are and to believe that they are important is a positive activity for anyone working with Black youths. Such positive image building helps them improve their grades in school and gives them attention as young people. Those of us who are in programs in which we work with youth know it is really important to give them opportunities to make their own plans. It is also important to get them involved with some kind of role model. Role models are very important as we know from psychology. It is important in our programs that we provide some kind of role models.

Zeta Phi Beta's Baltimore, MD, chapter tried to consider all of those things when we were developing our prevention program 5 years ago. It was the idea of 4 or 5 people in the chapter of 150 women who work in the area of alcohol and drug abuse, professionally, that if we want a community involvement project, we ought to try to prevent alcohol and drug use among youngsters in our communities. Although the 5 or 6 of us who work in alcohol and drug abuse prevention thought it was a good idea, we had about 140 other members in the chapter who said that was not their bailiwick. We had to spend almost 3 years trying to develop an awareness on the part of the members in the chapter about the importance of our community involvement project and that alcohol and drug abuse prevention was relevant to our community. We conducted workshops for the membership to help them see what alcohol and drug abuse prevention actually entails.

A mechanism was already in place to assist the Baltimore schools, so we adopted one school. We had a kick-off program where we presented to the student body our idea of developing a Just Say No club. To assist the school further, we also wanted to provide them with resources to get started so that they could have things to identify the youngsters in the program. We provided the T-shirts and buttons and a number of other things.

In addition, we convinced some retired teachers that this was a good project. They were motivated and wanted to get into the schools to do some of the things they had been doing while they were teachers. Many of them set up bulletin boards for the regular teachers and assisted them in other ways. The first adopted school program went for about a year, and then other schools noticed the program and asked for our participation in their schools. At the end of the first year, we had requests from 10 schools to adopt their schools also and set up Just Say No clubs.

Let me say a word about Just Say No clubs. Everybody thinks that the Just Say No project originated with Nancy Reagan. I, however, always give the credit to the Oakland Parents in Action who really began this concept, and it began in a Black community. It began in Oakland, CA. Oakland is similar to Baltimore City, where we were working, so our group thought that we could perhaps replicate that program in Baltimore.

Having 1 school adopted is one thing; working with 10 is quite another. We had to meet with the superintendent and the principal of each of the schools, and then we had to recruit the volunteers. The key to the success of this project was to have willing teachers who wanted to volunteer their time to do something extra. Our success has occurred because there were committed teachers who felt that there was something that needed to be done as far as alcohol and drug use prevention was concerned within their own schools. They volunteered to have this extracurricular activity and to be trained and to take on the responsibility for 30 or 40 extra kids at the school, for Saturday hours, and for a number of other things that they were not paid to do. We started with 3 clubs and now have 27 throughout Baltimore.

As volunteers, we could not go in the schools during school hours to do the needed work. We had to get commitments from each school coordinator to allow the volunteers in the school buildings after normal hours.

The function of the youth clubs is to make decisions. We did not decide for them. All we decided is that we would give them T-shirts and buttons. The club members decided what kind of program or activity they wanted to have. Remember I said that you have to get kids actually involved in making the decisions and planning the programs that they want. That means that each of our 27 programs is unique. Some have contests; some just have classes on alcohol and drug use. Others perform skits and play games designed to heighten awareness and influence positive peer involvement within the schools. There are other Just Say No programs in which they want to do things in the community. Some have developed community cleanup campaigns, elderly assistance programs, and innovative projects, all thought up by the club participants and assisted by the adults we recruited to work with them.

Because we were so successful on the local level in developing these Just Say No clubs, our national chapter decided that they should join us in developing national programs in alcohol and drug abuse prevention. Our national president, who is participating in this conference, decided that they would have a program called Project Zeta. The goal of this program is for Zetas to serve as a vital force in the community to prevent alcohol

and drug abuse among all age groups, with a major emphasis on high risk youth. Those of you who have read the legislation know whom they define as high risk youth. If you look at that high risk youth list, you know a large number come from our communities.

We also have decided that there are places in neighborhoods, in addition to the local schools, where there can be alcohol and drug abuse prevention programs. We have undergraduate chapters at colleges and universities, and we have a national conference with our undergraduates to show them how they can have an impact on their campuses on alcohol and drug use issues. The issue of AIDS has become pertinent for our college-level programs.

One of the things that happened to us in the Baltimore chapter is that many of the churches wanted to do something in alcohol and drug abuse prevention and asked us if we also would help them to develop some programs within the religious institutions. Religious institutions are really good places to go, because you get free meeting space and you have a lot of willing volunteers. We are just beginning, at the end of this year, to develop some consortia programs for churches that are within walking distance. Our first project will involve four churches, all of different denominations, in the Lafayette Square area of Baltimore.

Summary of Remarks by Claude Mayberry, Ph.D.

As I listened this morning and talked to some of you as you approached this conference, it became quickly apparent that you are in the business of trying to develop preventive measures that do something about the culture or the victims of the culture.

In 1981, I was provost of Colgate University and came down to Washington for what I thought would be a short time to be a special advisor in math and science and to look at the Title III program. I never returned to the university; in fact, in 1983, I resigned from both the university and the Government and decided to change my approach in the way I gave my services.

What I mean is that, in 1981, the President appointed the National Commission on Excellence in Education. One of my responsibilities was to make sure that those commissioners had an understanding of the state of the art of mathematics and science in high schools in the country. All of my research and publishing had been in developmental mathematics. Whereas the interest of the commission was in high schools, my interest was always in elementary schools. When we would go across the country setting up forums for the commission to look at high schools, I would run over to elementary schools and talk to elementary school principals and teachers to find out what was going on. I wanted to see what was happening in science and mathematics. In 2 years' time, while we were putting that report together, I found a startling statistic that said in this

country, on average, less than 20 minutes a week was being spent on science in our elementary classrooms. That meant that in the course of a year our students in elementary school were spending about 12 hours on science.

In 1967, we were complaining about the people who were governing education, and found that we had Black school board members and Black superintendents in many of the school districts in the country. We had approximately 100 Black superintendents across the country, and hundreds of Black principals and supervisors who had control over the funds and the curricula for schools.

In 1987, 20 years later, we find that we have a generation coming out of high school who will not be prepared at all to be productive citizens. Many will not even be trainable. I remember when I was going to school they talked about "the basics." The basics, as I remember, meant that if you could read well, write well, and speak well, you could probably make it in some kind of career ladder, even if you were Black. You did not have to know how to balance your checkbook; those skills were not pertinent to the basics at that time.

Today, back-to-the-basics movements are going to wipe out a lot of people in this country. The difference is in the numbers. We might lose 30 million whites in this country in the back-to-basics program, but they have 50 million more to carry on. You lose 20 million Hispanics, data tells me they might have 20 million or so left. But if we lose 10 million Blacks through this movement, our future goes with it, because we do not have 10 million more to help us hold our own.

My focus is on the elementary school. If we look for preventive models that deal with the problem at hand, we also have to look simultaneously at what is creating the problem. There are a lot of things that create it, but I know for sure, from my own experiences, that we all have the skills to become productive citizens who can produce and make a living for ourselves. You can create an environment that forces one to develop the kinds of skills to be able to survive in the culture, and that is the thing that leads to the fear of death, fear of prison, or combinations of both.

Many people ask me how I dropped out of high school and ended up with a Ph.D. in mathematics? If I knew all the things that made that happen I would write a book, because a lot of people out there could benefit from it. Our family was split up because of a fire. Five of us continued our rearing in one house and the others in another house. All eight of us had to drop out of school. The five of us that went back to school were reared in a poor white community where we were the only Black family. The other three were left in a poor Black community.

As I look back over the eight of us, what the five had over our three siblings was a stronger elementary education. When I decided to go back to high school, you had to know something about math and science. Fortunately, the background I got in elementary school prepared me to a point that when I took the Scholastic Aptitude Test I got 800 on the test in math and 450 on the verbal test. What those scores indicate is that,

when I got ready to go to Purdue University, here was a person who could count but could not read. That was at a time when it really was not as important to read as it was to count. The other four that were raised in the house with me also were able to go back to high school because they too had a very strong elementary school background.

The three who remained in the old neighborhood went back also, but did not make it. They all dropped out again. The reasons were—and we talked about it: one was lost to alcohol; one was lost to a kind of welfare mentality, and is still on welfare; and one became a kind of underworld character. One of the brothers who dropped out of high school could not read. How he ever got through elementary school and 2 years of high school without being able to read, we do not know today. Those who did go back to high school encountered an enormous gap because they did not have reading or arithmetic skills. To have a decent chance they should have returned to elementary school, but can you imagine trying to tell someone already 18 or older to return to elementary school before they can go to high school to develop the skills necessary for a job?

I point that out to you because what is happening today is a back-to-the-basics program that may create a lot of victims. If we create that kind of environment, we will be creating a permanent job for all of us who are involved in fighting drug abuse. I say that because back in the early 1970s, when universities were trying to get Blacks into the schools, they started what they call supportive service programs. The purpose of these programs was to provide some supportive services for freshmen minority students. Fifteen years later, we now have a national association of supportive services administrators who lobby here in Washington for money for those programs. What has happened over the past 15 years? The program itself has perpetuated a problem to the point where you find people involved in trying to preserve those programs, and even after 15 years, you will still have minority students on white campuses not acquiring the necessary competitive skills.

Let us go back to the 20 minutes a week spent on science. If we look at what is happening with that 20 minutes, we see that in fourth to sixth grade, in this country, teachers are less prepared to teach science and mathematics than they are in kindergarten to third grade. The reason is that at that stage the curriculum covers intermediate concepts in science and mathematics, which means having a little depth, and they are not trained for it. At universities right now, we cannot find Blacks in the country who can take the jobs that are opening up in the areas of hard science and mathematics. If we stay on the track we are on now, in 10 or 15 years we will not have Black teachers in this country teaching Black kids. This is because they are not going to college. And those who are going to college are not majoring in education. And those who are majoring in education are coming out in the lower 25 percent of those students graduating. It gives you some idea of what is happening in the elementary school, which I think is the core of the development of a human being in this country. Having skills in technology, in science, and in mathematics, is going to make the difference.

In 1960, most of the people in this country who had jobs were semiskilled or skilled. "Semiskilled" meant that you could read some, you could write some, you could speak

some, and you could hear and understand some; thus you could get a job. Some of these people could speak very well, could write very well, and could do a whole lot of other things very well. The point I am trying to make is that the skills they had to have then did not require fluency in applications of mathematics. It was not necessary for you to be able to do that. You could learn basic arithmetic to count, multiply, add, and divide, and maybe learn a little bit about percentages. But to be able to take mathematics and be able to manipulate the environment takes an understanding of concepts, the things around them, and an understanding of enough mathematics to manipulate those things. One did not have to have that then. We were still just on the edge of what we call industrial development. We mostly were dealing with industrial kinds of jobs; we had very little research and design going on. There also were those who did not have any skills at all—illiterates who could not write, could not speak well, and those who we perceived as being unable to learn.

But in the year 2000, although people might be able to read, count, do arithmetic, and speak some, they will need to be able to balance a checkbook. Now, when I say balance their checkbook, I mean the concepts behind that. They have to know how to apply mathematics. I did not learn that until I went to college. I majored in physics and mathematics. Science is so important; mathematics by itself is no good. To be able to really understand science, though, you have to understand mathematics. You have to be able to manipulate concepts. People need strong backgrounds in mathematics, not arithmetic; strong backgrounds in science or a strong background in technology with an understanding of both. Most of the people with these backgrounds will not be Americans.

In any large, urban district, check the classified ads, and you will see how long jobs are posted before they are filled. Sometimes when I put an ad in the paper, I get 50 to 75 people who apply for the job. But I have to put another ad in the paper because the 50 to 75 people who applied for the job are not competent. That is what is happening in this country. If you look at the universities, you will see it.

The people being trained to handle the kinds of things that are going on in this country right now are going to be few in number. We are now what we call an engineering science and design society. The corporations in this country talk about trade deficits, but what is meant by trade deficit is that the quality of American products is going down and the quality of foreign products is going up. Big industries in this country say that it is too expensive for us to continue to produce the products in this country because of labor costs. So the industry has turned to engineering and design and wordprocessing and information processing, which call for the kind of skills I am talking about.

If we do not focus very heavily on elementary schools in this country, we are in trouble. When I was in California, I saw in the schools how the Hispanics, in terms of numbers, are beginning to move ahead of Blacks. It makes me think about the Native Americans, how they were moved away and became the invisible people. We are about to become the invisible people in this country. Ten years from now you are going to find out that we are not going to be the majority minority in this country.

When I was in Oakland, I saw that we had a Hispanic superintendent, and I would imagine that that person must be doing a good job. When I look at the people who are becoming superintendents, where you have 70 and 80 percent Black students in the schools, it makes me wonder why we cannot look across this country and find a quality, competent Black to set up a system to give those students an education. When we become the minority of the minorities, nobody is going to reach out and put us in charge of their children. I do not care how competent you are. We need to think about it. If we lose the next generation of students, we are in trouble.

When the students who are entering kindergarten and the elementary grades get out of high school, they will have to have an equivalent of a 2-year associate degree in some area of science, math, or technology. If they do not have it, then they will be relegated to service-oriented kinds of jobs. It is going to be another culture out there grabbing them up; not just alcohol and drugs. They will be subject to those cultures because they will not be prepared.

We have to take an interest in those young kids who are not receiving the appropriate education and make sure that nobody can tell them that mathematics is not as important as reading and that science is not as important as reading.

I came here to tell you what I am doing. I am a publisher. When I discovered what was going on in the elementary schools in this country, and since my research focus is elementary schools, I decided to start publishing at the elementary school level. I remember when I was in elementary school they had something called the *Weekly Reader.* I can remember many times the teacher told us to read that when she had a headache. It was the only fun piece I can remember in school. Most of the time I had to stay after school to do homework I had not done on time.

When I was traveling around the country I heard all kinds of things that we should do for the curriculum. We talked about an integrated curriculum, integrating science, math, arithmetic, and social science. I thought it would be nice if maybe we could develop something that included science to augment the reading and writing and arithmetic, something that could in a subliminal way teach students science while they were studying math and reading. So I came up with *Science Weekly.* It is four pages long and comes out twice a month; it is very similar to a *Weekly Reader.* The key behind this is that it is based on skills, not content; the content is insignificant. Regardless of the curriculum—reading, writing, arithmetic, social studies—the publication can be blended into the course of study. It is designed for teachers who are not trained to teach science. We put out an issue on drug abuse in November 1986.

Summary of Remarks by Avery Carter

I have traveled around the country working with the Just Say No project and with the concepts of Oakland Parents in Action to assist other organizations in either developing

funding or in organizing. There are basic questions that you have to deal with in the community if you are going to start an organization. Oakland Parents in Action and Joan Brann, its director, really dealt with those questions in some very significant ways that were not traditional for Black organizations.

The number one thing that was done was a needs assessment by the individuals who were considering creating an organization. There was also a recognition of the fact that while there are many things going on in the community, many of them were not directed solely at one particular issue or really dealt with any issue in depth. Basically, what happened in our community was we reacted to issues as they emerged. After a period of 2 to 3 weeks, if that long, an issue was no longer important, and there was no more attention devoted to it. What we did in our communities, and still do to a certain extent, is "jaw-jaw." Joan wanted to get away from the idea that our children were going to be involved in those things that would cause us to demonstrate and agitate and get a little offering and then simply go away—and the problem would remain, particularly as it related to drugs and alcohol.

Oakland is about 49 percent Black; the remainder of the population consists of whites and other minorities such as Filipinos, Indonesians, Taiwanese, Cambodians, Bengalese, Hawaiians, Samoans, and Fujians. We have a tremendously varied population, viewed from a minority standpoint. In developing Oakland Parents in Action, the first thing we wanted to define was a focus. Joan decided that prevention was the area of focus and the arena in which we were going to try to develop some awareness by the people in our community.

Most people dismiss prevention as something that is insignificant and unimportant. Our attitude was that attention would be devoted to elementary school children. We would work with the children in our community as they moved not only through elementary school but into junior high. This would allow for a continuing prevention program, not a program in which we would simply work with an individual for 1 year in one grade for 6 months and simply drop them. We would continue the process as they matured and learned; we would also mature and learn and also try to answer and resolve many of the problems that these children would encounter during this period.

In the meantime, one thing that we felt had to happen if we were going to have an effective prevention program was participation by the children in the planning process. We would have them develop some of the research, have them develop a speakers bureau, have them get involved in some things that traditionally were left up to high school students and junior high school students. We found students in elementary school—in fourth, fifth, and sixth grades—who were articulate on almost any subject. And those students essentially became the leaders. During this period, we were talking to parents about the idea of a new parent organization in the community where we have 30 to 40 different organizations, all of which have their traditional turfs.

We were trying to figure out how we could affect them and cause them to change some of the ways in which they had addressed the prevention problem over the last 20 years.

Obviously, they believed in the notion that the prevention focus should be on individuals who were already involved in drugs and alcohol, and we were basically focused on individuals who were 10 to 15 years old.

In focusing on elementary school children, we had to get teachers, parents, and other citizens to believe in long-range prevention. There were some initial problems in getting other organizations involved. Those problems were overcome through persistence and by the fact that 90 percent of the time, the representatives of the organizations with whom we were dealing were students and parents. As a consequence, the whole idea of prevention in Oakland began to catch on. Many different organizations, religious institutions, and places with which we had worked began to develop their own methodologies for dealing with the problem.

From that standpoint, Oakland Parents in Action has done its job. Joan Brann had achieved her purpose in trying to get something done in the community where she grew up, and Oakland Parents in Action was now beginning to make an impact on the community.

One of the concepts that we were working with is Just Say No. How did the concept come about? I want to tell you a story about how it started so everybody understands that it was not Nancy Reagan's concept. We are not upset that Nancy Reagan gets credit for starting the Just Say No program. What does upset us, however, is the fact that many Black people do not know how the program actually started; this has not really been effectively communicated in all the literature that has been developed by some agencies. This program was really the idea of a young child, 10-year-old Norma Martini, and other children who attend Palo Alto Elementary School.

When we visited the school to talk to the kids about drugs and alcohol, one of the kids had a question: "What about those of us who don't do drugs? What do we do? Where do we go?" One of the children said, "Well, maybe we could form a club and call that club Just Say No." We agreed with the concept, and Joan gave the child some material and he went and signed up 120 students in the school who wanted to join a drug-free club. The oath and only obligation was to remain drug free. That is how Just Say No began and how it grew. It grew because children were migrating to something that was drug free and was offering something that basically was not available, not in school, at home, in religious institutions, and in various other places that they were going. So through that mechanism, we were able to develop some other projects, including the World of Work project, which is a mentor program. The program works with students in elementary school and continues to work with them in junior high and high school.

We have two students who accelerated once they got out of elementary school. One of them is now in high school. He was a slow speaker and a slow learner, but the person that we got for him was a perfect mentor. The student had an ambition and a dream. In elementary school he wanted to be a writer, but he could hardly spell. His mentor, who started working with him in the fifth and sixth grades, has helped the student, and he is now striving to get a good education. Mentor programs do work.

Now, how do we get our money? Oakland Parents in Action was not funded by any Federal Agency. There are several reasons why funds were not requested. Joan wanted to develop a program with parents without being restricted by guidelines from the various Agencies. Thus, funding was sought from minority businesses in the community, of which Oakland has many; Oakland is not a rich city. With monies from foundations and other fundraising activities, Oakland Parents in Action has been able to function on a very limited budget for nearly 4 years. Oakland Parents in Action, along with community workers, obtains the necessary resources from the community. In many instances, these resources are not necessarily funds but are people—people who are able to get their organizations to contribute to a program for children. We have never focused primarily on money, as though money would produce all the other things we need. The ideas have focused on producing the program, and as a consequence, we have been able to generate funds.

There are also some other things we were able to do. We have bowling leagues. Bowling is a very precise game in a number of different ways. For a child to get an 8-pound ball down a 60- x 4-foot runway, at about 10 miles per hour, and get it into a pocket that is 1 foot wide, is a major accomplishment. It is a major accomplishment for adults. But to get a child who is 6, 7, or 8 years old to do that is very easy when you take the time and provide the motivation, and you make it possible for them to do something that they have never had the opportunity to do. We were able to use the only bowling alley in Oakland; it happens that the owner is Black. She let us use the lanes at cost.

We were subsequently able to get a couple of Black organizations to fund 100 children for a program that would run year-round. We then set up the program for those children. One of the things that we did in applying the prevention mechanism of having the students do things themselves was to set up the program so that the children who bowled together were from 6 to 18 years old. We did not put the 6-year-olds together; we did not put the 10-year-olds together. We mixed them on purpose. We gave the older children responsibilities in leadership, we developed some chains of command, and we got them involved in things they would have to encounter as time passed.

Simultaneously, we were trying to do some things in our community that had not really been done before: to get children to understand the necessity of being on time, in place, and concentrating on what they were doing. We wanted to make sure that they understood the necessity of functioning as an individual and also as a group. The program enabled us to put boys and girls together, which is a problem that we have in our community, particularly in terms of child abuse and wife beating. We wanted to put boys and girls of different ages together and have them be able to set goals for themselves.

"Today, I bowled 15, Mr. Carter, and that's the best I've ever done; but next week I'm going to bowl 30."

"Don't you think you're setting your goal a little too high?"

"No, I'm going to bowl 30."

"Well, let's talk about your goal from a different standpoint. Let's set it at 25 next week, and if you get 18, you're doing fine. And say at the end of the season you bowl 30, that's your goal."

Well, bingo! Next week comes and the kid bowls 21. But 21 is a real accomplishment for that kid, and before you know it that kid has reached his or her goal of 30. Now, new goals have to be set: "Well, what are you going to bowl next year?" Not only are they already thinking of completing this year, they are thinking about next year. So they are setting their goals; they are looking at the future, and they are beginning to understand what they need.

"Next year, I'm going to need a larger ball, Mr. Carter. Next year, I'm going to need a pair of shoes."

"How are you going to get the shoes?"

"Well, our club's going to raise funds so we can all buy shoes."

We are talking about children who are 6, 7, and up to 18 years old working together to learn some things that basically involve economics, will, and determination. It involves the primary thing we all talk about: self-esteem, self-motivation, pride, success. One of the things we try to tell children all the time is that success is a journey; it is not a destination.

So, we have done a lot of different things; the children designed and painted billboards themselves. We convinced a company that we had a group of students who could come in and paint a billboard and make it look just as good as any in the area. We convinced the students that they could do it and they painted a 14 x 18 foot billboard. We wanted to deal with media messages. We wanted to enable the students to understand the makeup and psychology behind preparing that billboard: what has to be done to get that message across to those driving by in 7 to 15 seconds. We were able to get them to do that in designing the billboard. The billboard resulted not only in pride in that school, but it mobilized the community. The school was proud because it read, "Oakland High Wildcats just say no to drugs and alcohol." This generated interest among all the other schools in the city in being able to do the same sort of thing.

School children were coming up with prevention messages and understanding prevention. A couple of the students were so good that they got jobs, which is one of the other aims of the project. The project from that standpoint was very successful. Now the students at that high school, sophomores and juniors, are already designing and creating the mechanisms they will use for next year because they have seen the success, and they have seen the benefit of that success and dedication to doing a good job.

So, with regard to prevention messages and prevention programs, you have to have students do it. And they have to do it in a fashion which shows that they own it, it is theirs, and it works.

Summary of Remarks by Ken Ellis

I am a former professional athlete with the Green Bay Packers; I retired 7 years ago. Thank God, I was able to play for 10 years and get out with my health and sanity. I want to give you the address and toll-free number for Sports World Ministries, in case you might be interested in having a speaker from the organization speak in your particular area. The address is Sports World Ministries, Box 500, New Tazewell, TN 37825, and the number is 1-800-TEAMLINE.

We approach the drug and alcohol abuse prevention situation from a perspective different from that of the panelists who have spoken thus far, in that we are a Christian organization, and we believe in dealing with the total person: body, soul, and more important, spirit. My career as an athlete spanned a 17-year period: 3 years of high school, 4 years of college, and 10 years in the professional ranks. I grew up in the southern part of Georgia in a small town called Woodbind. I am the oldest of eight children; I have six brothers and one sister. My mother was 15 years old when I was born, and my grandparents ended up raising me. My grandparents' home was in the front, and my parents' home was behind us. We lived on the main street, Highway 17, which still runs through Woodbind. It is almost like a ghost town now because of the interstate highway system.

I was always interested in athletics, and I went to Southern University in Baton Rouge, LA, on an athletic scholarship. I went there to play football, but I also knew that I had to get an education. That was not my intention when I first went to college.

I look back on my childhood, and I am very grateful and thankful to my parents because there were some things that they taught me that stuck with me. Being raised in the South and being a Black man, I had a lot of things that I could have been bitter about. But my grandmother always taught me to respect people, regardless of the color of their skin, and to treat people as I would like them to treat me. I was not able to do that when I was growing up. I had a hatred and bitterness in my heart, especially toward white people. My grandmother used to clean people's houses, and I remember those days when they would come to pick her up. She would politely get in the back of the car, and the little kids would call her by her first name. She would answer them, "Yes, Ma'am" or "Yes, Sir." That upset me tremendously. But she always said, "Son, respect people, and treat them the way you would like them to treat you." That stuck with me.

I was raised in the church, but I went to college and I kind of got away from that. And when I entered professional football, I got completely away from it. I met my wife-to-be as a sophomore in college, and we married my first year in professional football. We have three children.

I saw a lot of things happening in professional sports. Cocaine use was not one of them. I have seen cocaine on television and read about it, but I have never seen cocaine with

my own eyes. At the time that I entered professional football, it was marijuana, uppers and downers, and, of course, alcohol. In fact, whenever we would play an away game, they would provide the alcohol for us. And it is sad to say, a lot of people abused it. I do not know if they are still doing that today.

As a rookie in the National Football League (NFL) in 1970, I met a man that everybody called Doc. About 20 years ago he started Sports World Ministries. Raymond Berry and Don Schnick approached him about starting a service for players—something that players would be able to attend prior to their games. So Doc did that about 20 years ago, and now every team in the NFL, the Canadian Football League, in baseball, and the National Basketball Association has a chapel service before playing. Before an NFL game, players have the opportunity to sit in a small room and hear someone stand up and share some of their experiences, but more important, share their relationship with the Lord and how that relationship has helped them.

Since I had been raised in the church, I knew the right thing to do; so I started attending those chapel services. I really enjoyed them because that was my church service and that was something to which I had grown accustomed. At the end of that first year, I went to a pro athletes outreach conference in Dallas, TX. It was at that time that I realized that after all those years of growing up in the church, God was not at the center of my life, he was not in control of my life. I was doing my own thing; I was living my own life the way that I wanted to live it, and God was on the outside of my life. Because of that, I had gotten involved in a lot of things. I was not happy with my life at that time. So I decided to make God the head of my life, to put him at the center of my life. And I have not regretted a moment of it.

That is how my work with Sports World Ministries got started. For the past 8 or 9 years, the organization has made available former professional athletes—and particularly football players—who have committed their lives to the Lord to travel around the country during the spring and fall speaking mainly to junior high and senior high school students. This past spring, we spoke at about 750 schools. We only go into those areas where we are invited. We do not force what we have to share with people on anybody. We let them know that it is available to them, and if they would like to have us come in and speak, we go. When we visit schools, naturally the kids want to hear about our careers as athletes, so we talk about sports, and about our backgrounds. The administrators want to hear something about drugs, so we share our belief about drugs. Maybe drugs played a part in our lives at one time, and we may have had a problem with them, but we are there as an organization to share the love of God with them. We believe that if you do not deal with the spirit of a man, you are just wasting your time. If a man's heart is not changed, he is not going to change. That is basically what we share. We speak to a wide variety of audiences. They have been all Black, all white, and both Black and white. So we are not limiting ourselves to just one particular group of people—we will go wherever we are invited, wherever someone wants to hear what we have to share with them.

Attending those chapel services and then having experienced firsthand what God had done in my life, I saw the impact that He could have on someone else's life. That is why

I got involved in Sports World Ministries. The more I think about it, the more I realize that I was an entertainer, and I probably entertained many of you over the years. Because of that, young people will listen to what we have to say.

I have talked to many young people over the past several years who have told me that they know it is wrong to do drugs. They know it is wrong to get involved in premarital sex, to rebel against their parents, to steal, and to do the other things in which they are getting involved. But for some reason, they cannot seem to say "no." I have been to many schools where they have the Just Say No clubs, and I see the effect that they have had on a lot of young people. But then there are others who do not have the strength to just say "no."

Let me share with you some statistics that we share with the students in the schools. Every 78 seconds, an adolescent in this country attempts suicide. About 400,000 of them each year attempt suicide. Every 90 minutes, one succeeds. About 7,000 teenagers every year will be successful at taking their own lives. Peer pressure is something that is so prevalent among teenagers today. About 85 percent of teenagers do not like themselves. Every 20 minutes, an adolescent is killed in a crash, often involving alcohol use, and about 10,000 teenagers will die every year from alcohol-related traffic crashes. I believe a lot of it has to do with what they are seeing on television. Some of the most popular commercials involve former professional athletes and coaches advertising light beer—"It tastes great," or "It's less filling." Well, it is not the calories that are causing the problem, it is the alcohol. And it is killing. Every 80 seconds, an adolescent is murdered.

Every 31 seconds, an adolescent becomes pregnant—1 million every year. About 300,000 will have an abortion. I have had opportunities to counsel some of the young ladies who have had abortions. Some have gotten involved in premarital sex and have seen the mental and physical scars. Some have since gotten their lives together, have married and want to start a family—but they cannot because of the number of abortions they have had.

Nearly half of all high school seniors have used an illegal drug at least once; almost 90 percent have used alcohol. It is acceptable in our society; it is a way of life for so many people. There are 5.3 million 14- to 17-year-old problem drinkers. Over half of the teenagers who have used drugs buy them at school. More people are believing that using alcohol and marijuana are normal behaviors for teenagers. Sexual intercourse is almost considered normal behavior for teenagers, and teenage pregnancy has become almost the norm.

When I was growing up, a young lady was proud to be a virgin. My wife is a high school guidance counselor in one of the larger high schools in Baton Rouge. She came home one day and just broke down and began to weep. It turned out that a young lady had been in her office that day and was upset because her friends were teasing her about being a virgin. That shows you where we have been, where we are now, and where we are headed, and it is not getting any better. It is going to get worse.

A divorce occurs every 30 seconds in our society. According to a recent study, the typical teenager spends an average of only 10 minutes alone each day with his or her father. Only 10 minutes! All they want is someone to say to them, "I love you," and many of them are not being told that at home. Many are raising themselves, since mom and dad work. Many children are being raised in single-parent homes. They just want to be loved; they want to know that they are appreciated.

I remember a couple of years ago, I was in Terre Haute, IN, and I had an opportunity to minister to a young lady who was a high school junior at the time. She was having all kinds of problems; in fact, at the time that I was talking with her, she was high on speed. She had had several abortions and had tried every kind of drug on the market. She lost two sisters—a younger one overdosed on drugs, and an older one was killed in a drug deal. This high school junior said she could not deal with life and had to be high every day to make it at school. I shared the love of God with her. I told her that God loved her, that He had a purpose for her life. That young lady prayed with me to receive Christ as her Lord and Savior. Several months later, I received a letter from her. She had graduated from high school as a senior with honors, and she was going to UCLA.

Just recently, I was speaking at a school in Jackson, MS, and there was this young girl in the audience who, I could tell, was disturbed about something. As it turned out, she had been molested by her father, and her friends were encouraging her to get involved with drugs. I started corresponding with her, and I got a letter from her just the other day. She has begun to ask me questions about the Lord and the meaning of certain passages in the Bible.

We believe at Sports World Ministries as the Bible says, "If you would train up a child in the way he should go, when he's old, he won't depart from it." I believe that we as a Nation have lost the vision. And the Bible says that where there is no vision, the people perish. When I was in school, there was not a problem talking about the Bible, about God, or reading the Bible. But we have taken God completely out of our schools, and if we let it happen, they will try to take it off of our currency. We have "In God We Trust" on our currency, but I wonder if it is really in God we are trusting or is it in the almighty dollar?

I am not saying that we did not have problems when I was in school, but they were nothing like they are today. I heard this gentleman talk about how drugs were around back in B.C., and I forgot the year that he mentioned. That may be true. But even back then, God dealt with the people—He destroyed a Nation because of the kind of lifestyle they were living. Remember Sodom and Gomorrah?

What God has done for me in my life is what I share with the kids in the schools. He has put a love in my heart for mankind. That is the same love that my grandmother was trying to instill in me; but it did not happen until God became a reality in my life. Before that, I had knowledge of God, but He was not real because He was not in my heart. But once He became real in my heart, He put that love in my heart. That is the same love that my grandmother would always talk to me about—loving people regardless of the color of their skin, no matter how they treated you.

I believe that is what it is going to take if we are going to deal with the drug problem in our society. It is not just affecting Black people. Drugs are colorblind; they can destroy anyone. At Sports World Ministries, we are about reaching people to let them know that God has a purpose and a plan for their lives. And if people will just allow God, through Christ, to show them what the purpose and plan are, God will be able to help them with their problems.

I hope I have said something that has encouraged you. At Sports World Ministries, we are reaching man and his spirit. And when Jesus Christ comes into a person's heart and changes his heart, we are going to see this thing whipped.

How to Gain Access: Where, When, How, and Why

Moderator: Walter Faggett, M.D., Physician Director, PCP Unit, DC General Hospital, Washington, DC

Panelists: Bradford Nichols, Assistant Director, Bureau of Substance Abuse, Detroit Department of Health, Detroit, MI

John Bland, Director, Alcoholism Control Administration, Maryland Department of Health and Mental Health Hygiene, Baltimore, MD

Lionel R. Collins, Staff Member, Senate Committee on Banking, Housing, and Urban Affairs; former Legislative Assistant to Senator Long (D-LA)

Summary of Introductory Remarks by Walter Faggett, M.D.

The purpose of this workshop is to let participants know: how to influence Federal, State, and local policies on alcohol and drug abuse; how policies are formulated; and how organizations can gain access to the decisionmaking process. The National Medical Association (NMA) is an organization of Black physicians that believes that health care is an undeniable human right and that has a long history of patient advocacy. NMA, through its local affiliates and effective individuals, is able to gain access to the political system on a national, regional, and local level. The organization ensures that its members are knowledgeable about the process and how they can affect the system. NMA endorses a health education program to increase public knowledge about AIDS. Expert members of the organization will be asked to be available to testify before Congress to defend NMA's position on the issue. Organizations can call on the NMA for its expertise to assist in gaining access to resources on the Federal, State, and regional levels.

Summary of Remarks by Bradford Nichols

To gain access to the delivery system that provides public funds for alcohol and drug treatment and prevention programs, you must have knowledge of the administrative structure of State and local governments. You must be aware of how dollars flow into the State from the Federal Government. The agency responsible for this differs from State to State. There are also Governors' commissions, departments of health, and public or private nonprofit corporations that do the planning and distribution of funds. You must know the decisionmakers. You must have knowledge of how priorities are set and knowledge of the priorities and needs of the people in your communities.

The methodology is political pressure. Volunteer at an agency and indirectly apply pressure. Encourage people to be interested in your service. Pressure can be overt or subtly applied. The notion of political pressure began with the funding of substance abuse programs in 1970 when Federal law established the National Institute on Alcohol Abuse and Alcoholism and the local agency apparatus. In 1972, the National Institute on Drug Abuse (NIDA) was established. Throughout the 1970s, local communities could receive grants from the Federal Government to fund community drug abuse programs.

In 1981, the block grant funding mechanism began; the States were awarded grants by the Federal Government to address alcohol, drug, and mental health problems, with the States making awards to programs. State legislators began deciding how money would be spent in the State, ensuring a fair share for constituents. Some State funds flow to regional levels where priorities are set for spending for cities. To have any impact, one must go through the State system. Most States contract with single or multiple counties. The Detroit Department of Health has been designated as a regional coordinating agency for the City of Detroit. Outside of Detroit in Wayne County, there are 26 mayors responsible for overseeing the funds for that county. Three of the mayors represent predominantly Black communities, and they have to work hard politically to get funding for substance abuse programs in their cities. To my knowledge, in those three cities, there are no substance abuse treatment or prevention programs.

To affect the system, find out who the decisionmakers are, develop strategies for influencing them, and know what the needs are in the Black community. This takes data collection. To stem the tide of alcohol and drug use, we forsook treatment programs and established in Detroit a prevention task force. We met for a year to establish a 3-year plan. The result of the effort was the Detroit Youth Report.

We found that there are certain risk factors which influence substance abuse: a family history of alcohol and drug use; family history of management problems; poor parenting; low value on academic achievement; low value on relationships; and friends and parents who use drugs. The neighborhood factors include: weak, inconsistent norms regarding chemical use; proliferation of retail alcohol outlets; weak, inconsistent law enforcement

regarding drug dealing and juvenile crime; and ineffectual community institutions, including the school system, religions institutions, and recreation facilities. There are also larger community problems, including: the lack of employment opportunities; factors encouraging dependency on a welfare system; tax rules favoring the low or decreasing cost of alcoholic beverages; financing of public schools related to community worth—rich schools get more money, poor schools get less; and media promotion of hedonistic values of drug use.

These risk factors lead to problems regarding teenage pregnancy, chemical dependency, infant mortality, unemployability, juvenile delinquency, under-class economic status, and school dropouts. No single risk factor or cluster of risk factors was found to cause drug problems. Thus, a holistic approach is needed to solve the alcohol and drug problem. It needs to be dealt with on a coalition basis.

With this data, we forced officials of the Department of Health to begin to examine their own department, which has 21 divisions to deal with a variety of problems. We began by setting up an interdepartmental task force to deal with prevention. In the next phase, we will go to the police, recreation, and housing departments and work with them. Then we will reach out to religious institutions and the school system to see how they can become involved in the process.

Detroit Youth Report statistics:

- Homicide—the leading cause of death for those age 15 to 24.
- Venereal disease (VD)—43.5 percent are gonorrhea cases; 50 percent of the VD cases involve persons in their mid-teens through early twenties.
- Teenage pregnancy—begins at age 12, increases sixfold at 14, doubles from 15 to 16, and is 50 percent more by age 17.
- Alcohol and drug use—youths age 13 to 15 are requiring treatment; it is not until age 25 or older that youths come in for treatment.
- School attrition—for the class of 1981 entering 9th grade, there were 20,404 students; by 10th grade, the figure was 13,853; 11th grade, 10,302; 12th grade, 7,131; those graduated, 6,146; those who received diplomas, 4,458.

The goal is to make Detroit aware of the problem and find out how we can work on a coalition basis to solve it. You can get the same data for your communities to see what the needs are. Identify the decisionmakers on the community, State, and Federal level to talk to specifically about needs and the things that need to be done to help.

Summary of Remarks by John Bland

The Omnibus Reconciliation Budget Act effectively ended the flow of formula grant funds from the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)

directly to cities and counties. The legislation brought into existence block grants through which ADAMHA funnels funds directly to the State Governors and legislators. The primary responsibility has shifted from local control to State Governors and legislators. In many States, Black areas became a major problem because there had been little communication between local Black communities and the State capital prior to the legislation. And there has not been a great deal of increased activity since the passage of the act. Thus, many people are not aware of the changes and are on the periphery and not in the power equation.

Access has become extremely important. To gain access to something, you need to come up with ways to permeate the barrier between you and the individuals or institutions that control resources which you need to combat alcohol and drug abuse. No matter where you stand on alcohol and drug issues, you need to know how to alter the equation to bring about a shift in resources as they are being distributed so that the Black community can secure its fair share.

If you are in the position of allocating resources and implementing policies, you have power. In Maryland, the legislature cannot add to the budget. The power lies with the Governor, who must balance and approve the budget along with the general assembly. The Governor also chairs the Board of Public Works (which also includes the comptroller and secretary of state), which rules on contracts and other expenditures over $10,000. The board is the fiscal gatekeeper of the State, and the Governor's office is the locus of power. You influence the Governor's office by getting key coalition people appointed to executive positions. Get appointments to gubernatorial councils, committees, or task forces; gain membership in advocacy groups with statewide influence; and exert influence on or gain access to the State alcoholism authority.

The Department of Health and Mental Health Hygiene (DHMHH) has a fiscal year 1988 budget of $2 billion and 20,000 employees. Government Board, task force, and council representatives have influence on what DHMHH does. So, if you have access to these representatives, you are at or near the seat of power in the State.

Councils, committees, and task forces are established by decree, and their members are multiyear appointees. Members of the Governor's Advisory Council on Alcoholism Control are appointees; they are responsive to the needs of DHMHH and are willing to expand services. There is also a Drinking and Driving Task Force, which was instrumental in shaping Maryland's comprehensive driving while intoxicated (DWI) program. It has a broad representation, with much input from groups such as Mothers Against Drunk Driving (MADD) and Students Against Drunk Driving (SADD).

The Black community must become aware of the infrastructure. My department is the last on the access level. We implement—put into motion—the services that are at the end of the power equation. My budget is set; my priorities are approved by a higher authority. Representatives should review what departments do, then go to the beginning of the power equation to demand what is required to meet needs.

A vignette that illustrates principles of access: In 1979, the budget pattern was not changing, and DHMHH seldom got an increase that exceeded 5 percent or $18 million, which was not enough to address needs. We started a needs assessment across treatment components and got information from providers, regional councils, and other groups. The data showed that $12 million was needed to expand services for, in order of priority, detoxification, adolescent and youth education and training programs, and a comprehensive DWI program. The figures were presented to the Governor's Advisory Council. The Governor did not accept the priority ranking of the programs, with DWI last. Instead, he selected the DWI program as the most important—because of the influence of MADD and because it was a major issue in his re-election campaign—and funded it at a rate 2½ times more than recommended by the Task Force on Drinking and Driving.

The lesson to be learned from this is that since MADD came into existence, it has been able to establish a basis for enhancing alcohol and drug abuse services; a group was selected to get the Governor's ear; there was serendipitous fallout—the Governor considered DWI a part of his re-election campaign; and advocates were precise and persistent with selected data. These are ingredients that would help those in communities to bring about change.

When I was appointed in 1979, I was the only Black State alcoholism authority in the country. Now, I am one of only two State directors (Nebraska has the other; and there is the District of Columbia.) As you gain access to the locus of power, where you do not have a friendly face, your efforts must be more precise, more specific. You have to develop coalitions that begin to be seen clearly by legislatures and Governors as irresistible forces.

Summary of Remarks by Lionel R. Collins

My discussion will cover the difference between personal staff and committee staff, block grants, and the budgeting process.

I worked for 3½ years on the personal staff of Senator Long, who is the ranking member of the Finance Committee. As a personal staff member, I assisted in getting as much Federal funding for Louisiana as possible. Secondly, I handled health issues for the Senator. I kept abreast of and kept health professionals in Louisiana up to date on legislation and took note of what changes they wanted. I often tried to get amendments attached to adverse legislation.

I now work with the Housing and Urban Affairs Subcommittee, and my boss is Senator Alan Cranston (D-CA). The committee staff is responsible for writing legislation concerning California. The committee has jurisdiction over housing, community development, and mass transit.

[At this point, Mr. Collins went on to explain the details of the budget process. Bills are formulated in the House and Senate at the committee level. If House and Senate bills differ, the committees on both sides confer to develop a compromise for approval of both Houses and Presidential signature. He also cited the Appropriations Committee, which can appropriate less money than agreed upon in the Senate-House compromise.]

The Housing Subcommittee is in the process of drafting a major housing and community development bill to be introduced, we hope, in 1988. I am contacting people in the field involved in economic development to find out the problems and issues to conduct oversight hearings to bring out the issues so that the public will be made aware of what the problems are. We hope legislation will be drafted to address the problems.

An organization must be involved with (Congressional) committees at an early point when the issues are identified, before a bill is introduced. If you are not involved, your problems may not be brought up at the oversight hearings, because they are not known: no one has mentioned them.

In the old boy network, issues are identified by calling the major trade organizations, who refer you to people in the States. These people, in turn, refer you to friends, who may give you information on the problem. We structure hearings around the point we want to make. If X is identified as a problem, then the hearings are centered around X. Because funds are being cut, it is so important now that people in your group identify those on the committees in the Senate and House. For example, regarding block grant programs, it is important that you contact members on the responsible committee. You should be contacting State senators, Congressional members—to see who is responsible. You have to have a working relationship with members. Get to know presidents of organizations, and write to members of, for example, the American Medical Association. You should also keep in touch with committee staff members who craft legislation.

The National Association of State Drug and Alcohol Directors, a national prevention network, is another important point of entry. The National Medical Association is important because it is viewed as having the financial wherewithal. People involved with medical organizations write letters. When in Washington, visit Congressmen; see them when you do not need them. Pick up the telephone and call them.

Major Discussion Points

Does a State Appropriations Committee function in the same way as the national (Congressional) committee? My programs were formulated in 1980 by Black officials and funded through set-aside funds. Since Blacks get money from one set of funds, the State does not appear willing to supplement them from another program area. How can we get more funding?

The States have run into budgetary problems, the same as the Federal Government.

The appropriations process is essentially the same in the State and Federal Governments. You must make a presentation each year to both money committees, in the House and Senate. State General Assemblies do not consider it appropriate to supplement Federal funds. However, if you know that by the end of fiscal year 1989 your program will be terminating, your responsibility is to push for resources for your constituency in the same way that white groups are now advocating for comprehensive funding for homeless people in Maryland.

With regard to legislation being introduced next year, call your city officials and ask what they have been doing as Federal funds have been cut. Community pressure has to be applied at the local level and regional and State levels. I am not saying that people should not go directly to legislatures, but the greatest results can be achieved through a coalition effort. If you cannot get groups to go with you, you have an uphill battle.

I am a psychiatric technician at the Washington Hospital Center and an ordained minister. I work with alcohol and drug patients. As a minister, I have the facilities, but there is a problem, because of the laws governing the separation of church and State, in getting money to develop community-based programs.

We fund Catholic social services and Lutheran social services. I am very interested in Detroit's Baptist and Methodist churches. Baptist and Methodist ministers perceive themselves as shepherds of the flock. If the flock has problems, they personalize them, saying, "I'm not a good shepherd." There may be difficulty in working with them to operate alcohol and drug programs out of their churches.

We passed a homeless bill, and the issue came up: Can you give money to religious institutions? Can you use the basement of a place of worship to help the homeless? The religious group may use money to fix up and improve the facility. You have to know the regulations. Money is limited, but it is out there. When you find a program that fits the needs of the community, you have to go to the agencies involved. Find out the regulations and work creatively around them.

Three years ago, the coordinating agency for Detroit received $7.5 million from the State. We developed a program with Tabernacle Baptist Church which operated a community center attached to the church. The project's purpose was to provide alcohol and drug treatment counseling. There was no problem in funding the project because the services were being provided under contract. We have begun a contract with a Lutheran coalition on the east side of Detroit to do intervention. We are providing funds for an intervention specialist to work with the group.

The problem is that Black churches are very independent. They are not hierarchial like the Catholic Church, which has independent entities that are connected by Catholicism. Baptist and Pentecostal churches are very independent. You can have religious institutions set up community organizations that will adopt a religious group's name but have a different administrative apparatus.

Bases of Networking and Coalition Building

Panelists: **Dr. Crystal Kuykendall, Director of Marketing, Roy Littlejohn Associates, Washington, DC .**

Erma J. Wright, Ph.D., Assistant Professor, Department of Applied Health Sciences, Tulane University, New Orleans, LA

Summary of Introductory Remarks by Dr. Crystal Kuykendall

We are going to try to give you an overview and some detail on why networking is so important and how to do it. We also are going to talk about some of the obstacles you will run into in networking and coalition building. Very often we may have an idea about what we ought to do and how we ought to do it, but, if you are not aware of the obstacles and the things that are going to get in your way, then it may not work.

Summary of Remarks by Erma J. Wright, Ph.D.

Let me start by saying that as a community health educator, I am primarily concerned about community development. I do that work both domestically in this country and internationally in West Africa. What I would like to share with you today, given my experiences in the substance abuse field, as well as in public health, are some of the issues, factors, and dimensions one must consider when we talk about networking. You hear the terms "networking" and "coalition building" all the time, and they mean different things to different people.

I believe very strongly that there is no monopoly on the knowledge of networking and coalition building. Probably everyone in this room is involved in some kind of network or some kind of coalition, and there are collective experiences here with regard to that process and what goes on in it.

I would like you to take out a blank sheet of paper to get into this whole discussion of networking and what it is all about. What I would like you to do is draw a circle in the middle of that sheet of paper and put your name in it. As I talk I am going to ask you to draw other circles and put other names surrounding that initial circle. Now think about people with whom you have the strongest and closest bonds or affiliations and put their first names in circles around the circle with your name in it. In another set of circles, I want you to put people who have been supportive of you throughout your life and those who are presently supportive of you and what you do. Make sure these are people that you can go to for advice if you need it. In the next set of circles, I want you to think of all the people with whom you would enjoy sharing amour, or from whom you would enjoy receiving a letter, or who would take care of you if you were sick, people you call on in case of an emergency. Who could you borrow money from?

In the next set—and these are new people that you will be adding—think of places that you have lived and different friends you have made, or relatives or people along that line, that you would also include in circles around you—from either social, political, or religious groups in which you are involved. Finally, include anybody else that you did not include in the first few things I talked about who is important to you. Take a minute and reflect upon the names that are on that particular sheet of paper for you and let us talk about that. Think about what the relationships are to you, what they do for you, or do not do for you, and what you do for them. If you had to summarize that list for yourself, what would you say about it?

What you are looking at is a social network. There is a lot of literature that talks about social networks and how, in terms of social support, they help out with stresses and issues and things that we face in life. When we talk about professional networking we look at it in much the same way. You put people in the circles that are close to you. In a sense, it is ego-centered, it is based around you. What kinds of support are in those networks? What kinds of things, what kinds of support, are they providing you? Direction? Mentorship? Encouragement? All these things could probably be summarized in three major types of support: instrumental support, cognitive support, and affective support.

The reason we have social networks is that they serve a function. That function is instrumental support. It is something tangible, something that we may need, a resource. It can be money. It can be tools. It can be a car. It can be where a job can be found. When we talk about cognitive support we are talking about information. We are talking about how we find out about certain kinds of things—specific data. Affective support is made up of the feeling things—encouragement, motivation, inspiration, those kinds of feelings. All of us need that, and when you talk about social networking, we put people in those little circles who help us meet those kinds of things. Is it mutual? If they do that for you, do you have a responsibility of a network to give that back to some of those members? What happens if you do not? Do members in your network have to know and interact with each other? We are talking about social networks in the personal sense. We are looking at it only from the perspective of the individual. So some of those names that you have on your list may or may not do any of the things that you identified for other people in the network. The more they do, the more likely we talk about it as being

an enmeshed network. That can be very supportive, but it can make it very difficult to get information from the outside in.

So we find ourselves personally in networks. This session, however, is about professional networking. The reality is, though, that even in professional networking and coalition building we are looking for the same three types of things—instrumental support, cognitive support, and affective support. We make networks and we make coalitions with people with whom we can feel some sort of affiliation. You do not generally talk about networking with people who are totally opposite from you, that have views and opinions and ideologies that totally differ from your own. There is some commonality, some bond.

When we talk about professional networking, we talk about tangible support. We talk about what resource skills that one agency has that another one does not, about what kind of combination of membership that one group has that another one does not. What kind of information does one organization have that another one does not, that one can compare, that one can share? So we are looking at the same kind of phenomena when we talk about professional networking. But what is the difference? What is the difference between a professional network and your personal/social network?

The difference is that you have some other kind of unifying theme that pulls you together. You have some other kinds of things other than yourself. You become an instrument. It is you, your agency, or whomever else you represent that is then trying to make that linkage. So if I were to ask each of you to take your program, look at yourself in the context of your job, and then talk about your network, you may or may not have some of the same names. What we probably would see on there are more organizations, more agencies, and other kinds of groups that you have worked with to try to figure out what you have in common that you can use to work together. So we are talking about the same concept. It is just that when we talk about it in the context of preventing substance abuse, and in the context of involvement in communities, we are spanning out what we could potentially see.

There are times you will want your social network and your professional network to be one and the same. And given other kinds of circumstances, they may be totally different. And yet, you are really functioning in two networks at the same time. We all do that. The one that we have connected with at work and the one that is connected with that other part of us—both of them are very important to our own functioning and our own ability to deliver whatever the services we want to deliver as a person and as part of a larger system.

Why would you form a coalition or network? What would you do it for? We have talked about these kinds of supports but when we talk about coalitions, we are talking about bringing together networks. So it is expanding on the concept. Coalition building is: I come with my organization and all the network around me, and I meet with you and interact with you and all the network around you.

Why would you try to form a coalition? Strength. Strength in numbers, and what that gives you is power. You must understand power, the nature of power, and how it is used. Networking and coalition building is about gaining strength through numbers in order to obtain power. A lot of us come from smaller programs. You have maybe one or two on staff, and you have a lot of work to do. You are trying to impact communities which may or may not want to hear the message that you have to give. We are talking about impacting communities that have other priorities. Substance abuse may or may not be the number one issue. It may be putting food on the table. It may be getting housing. It may be any number of things.

Not only do you derive strength and power from numbers, but also, when you talk about numbers, you broaden the membership. You broaden your constituency. Our programs have a core group of people who respond to us. When you do coalition building and larger networking, however, it opens up the way to people to whom you would not normally have access. Because you then have the membership base of another organization or another network. So the numbers thing is not just about power; it is also the availability of a larger membership, a larger constituency. A lot of us have very small constituencies. We end up being advocates for people, but we have not been given the mandate from the people. That is an awkward position in which to be. That is why we try to expand out.

The other issue is credibility. Very often when you talk about impacting on people, they may or may not hear or want to hear what you have to say or they may have other agenda. You may have a good program, a very solid approach, but you do not have the credibility. People do not know you. You may be known in alcohol abuse; you may be known in substance abuse. But you are not known in mental health. You are not known in public health. You are not known in AIDS. So, you generally talk about coalition building when you have goals to attain that you, as an organization, cannot reach by yourself. That you yourself cannot reach, that will require, in order for you to meet those goals, something broader. That is really when you see people trying to do networking and coalition building.

Very often what you hear from hard core coalition type people is that if the organization can do it itself, it does not need a coalition or network. You generally see people moving out and trying to bring in other resources when they cannot do it by themselves. They are going for the resource skills. They are going for the broader constituency. They are going for the power. If I have it all myself, you will not see me reaching out to you. You may reach out to me, but I will not reach out to you.

Coalition building and networking sound great. We are going to talk about some techniques in a minute, some strategies and some things you need to think about when you decide who it is you want to pull in and have work with you. But are there any problems with networking and coalition building? What do you think? Your agenda is alcohol abuse or substance abuse, and, say you hook up with public health. Their issue may be sexually transmitted diseases, and then you have to work out what is going to be mutually agreeable between the two of you. Or, you go to a university because they have

access to resources—say computers (we are going to talk about the use of computers in networking), they have access to research, they have access oftentimes to some money sources out there that as an independent agency you would not have. But universities have their own agendas. So when we talk about reaching out to people, we each have to figure out: Am I willing to pay the price? How far can I go? What am I willing to give up?

So when we talk about coalition building and we talk about networking, there are some very critical questions that have to be asked. Very often people will come to us and say they want to join with us, but you may have to pay more than you may get back. You need to be really clear, from an agency point of view, as well as from an ethical-personal point of view, on what it is you can compromise and on what it is you can not compromise. There are real, critical issues here when we talk about networking and coalition building.

Let us look at some points in terms of: What do you need to know to even think about coalition building from a professional sense if you are looking at networking at that level? One of the first things that you want to consider if you are thinking about professional networking and coalition building is the issue of community support. Who are the people in your communities who are the formal and informal leaders? Can you come up with names? Do you know where to find them? How accessible are they? Are there people in leadership positions who have a direct interest in substance abuse-related issues or activities?

Most of us can always identify our leaders. We will come up with the mayor, a principal, or somebody like that. But we seldom stop to ask the next question: Are they either directly or indirectly involved in substance abuse-related activities? A lot of times they may be and do not even know it yet, and that is where your education comes in. You are going to help make the link of how what they are doing with students is related to what you may be trying to do with substance abuse, and of where you can find those people who already have a vested interest—either they have a long history of working in this area, or maybe they have had a personal tragedy themselves, or they know of people in their constituency that have to deal with those issues. Then those are the people you are going to begin to look at. That does not mean you rule out the others, but you do want to pay attention to those people that potentially have a vested interest in what you want to talk about.

Why would you want to do that? You want to have people who are potentially interested in the area. They may come from mental health. They may come from public health. They may come from housing. They may come from some other totally different field. But given whatever experience they have had, make sure they want the involvement. And you want to look at how those leaders can involve other community members in the network or coalition you are interested in building. We are talking about sanction here. You may find that very often leaders are not interested themselves. But if you do not at least pay attention to them, they can block your ability to involve others. We see that very often in the political arena. You did not pay your dues. You did not give me my due. So what happens is that when I hear you coming, I will send my word out. So what happens? You do not get the movement, or people send you chasing. So it is important to understand the leadership role in the context in which you are involved.

So we are talking about organization, group, and individual support. We are not particular when we talk about coalition building and networking. It can be an organization. It can be a community-based group. It can be another agency or maybe one person. Again, we are looking at some of the same kinds of issues. What people, groups, or agencies are out there in your area, either locally, regionally, statewide, or nationally that are interested in substance abuse prevention and related activities?

You spend a lot of time exchanging business cards, which is all a part of networking. You are finding out: Who is out there? What is that program doing that I may or may not be able to do with my program? How can I go about doing some things that do not get me involved in duplicating an effort that is happening in Oakland or New York? If I had known, I could have called out there before I spent all that time developing the same brochure in 6 months that I could have gotten from them and modified in 2.

Are there individuals, groups, or agencies that may be opposed to your efforts? That is very important. We may all see ourselves as helping the community, but there are private agenda. And we have turf issues. For example, there may be this great substance abuse program idea, but it is the health department's responsibility. You make an effort to implement the program and the health department comes down on you because you are on their turf. You need to know things like that because some of the agenda, given all the things that are happening statewide, regionally, and nationally, are sometimes at odds with each other. It is a matter of trying to figure out who is out there and who is for us and who is against us. That changes. It is not consistent. In 1987, you may have one list, and in 1988 the rules of the game change and there is a whole different crew of people with whom you will have to deal. So what I am saying is that you have to be vigilant. They change all the time. Coalitions do not last forever. That is not their function. We come together around a common interest, a common goal, generally for a specific period of time. When that common interest or that common goal has been met, we disband.

Another question in coalition building is: Are there any groups that might not have access to the benefits that result from the coalition's efforts? We often make the assumption that, in our effort to do good and to organize with other people to do good, everybody benefits. That is not true. Generally, somebody gets left out. It is important to at least think about who that might be and what might be the long-range implications of that. If today I focus on Black males in substance abuse and I pull in people from other agencies, what does it mean down the line for Black families or Black women? Is there a fallout effect? Is there an unanticipated side effect? These are very important questions that do not often get asked. We get so involved in the process only to find out we have created a monster out there that is ready to eat us up, because we had not thought about it. Or we have developed a group of people who are fighting us even harder than our other agencies.

Again, we are talking about human resources. That is the other major dimension. What are the resources? Who has the skills? Who has the training? When we plan and implement programs, we also have to evaluate them. Most of the time, most of our

programs get shot down because, as practitioners, we do not know how to evaluate what we do. Other people come in and evaluate our programs and we are upset because they do not understand our language and we do not understand their language. It is very easy to miscommunicate about a program that "does not have the impact that it said it was going to have." We as practitioners have the responsibility for building the capability of assessing ourselves and what we are doing, rather than constantly farming it out to other people who may come in with other agenda or different understandings or interpretations of what we are trying to do. That is what I am looking at in terms of resources here. We have the skills to do the planning, skills to do the implementation—we tend to do that part well. We just tend to be weak on the evaluation, the self-assessment. You ought to be able to assess what you have done more quickly than somebody coming from the outside. The more you can do self-assessment and evaluation, the better and more effective you can be as a planner. You can do corrective changing as needed. You will understand who to pull in and the timing of pulling them in and getting them involved in what you want.

The other major issue, I think, in terms of networking and coalition building, is the whole issue of communication. That is what networks are all about. You can put people out there. But if you do not talk to them, if you do not interact with them, so what? You have people in circles that do not do anything. A large part of what we do in networking and coalition building is around communication. There are cultural factors here that we need to pay attention to, given the populations very often we are serving, and given the kinds of issues we are trying to address.

First of all, we need to examine what types of social situations are most appropriate for exchanging what types of information. A lot of us make the assumption that we can just go out and obtain media coverage—go on TV, go on the radio—or go to the religious institutions, and that these are all good ways to reach the community. What we fail to realize is that some people may not accept one or more of these media forums. They may be effective communication media, but not for what we want to talk about. If we want to talk about AIDS and substance abuse, religious institutions may not be the appropriate setting for that. Yes, we can talk about families. We can talk about networking within families. But we cannot talk about AIDS, sexual relationships, or sex education. It is understanding, given the array of things available to us, which ones make the most sense for us to utilize around which topics. Most programs get burned very easily. People have gone to Black places of worship for everything. The assumption is if we take it there and we talk to folks there, we are going to get the community. Half the folks you want to reach are in places of worship; the other half are not. So that was not the appropriate medium. We did not take enough time to figure out what was.

How does information spread in your community, or in the organizations in which you are involved? Do people get their information from each other? Do they get it from the media, from printed sources? Are they looking to some other particular agencies? It is important for us to know how that is done. We all know that information can be powerful if used in the right way. So we are trying to figure out what makes sense to do as we are looking at not only its impact on the community, but how we are going to communicate

among ourselves. Does it make sense to have a newsletter? Does it make sense to get on computers and work with a computer bulletin board? That is a great technique, but a lot of programs do not even have a computer, so even going to that strategy may not be appropriate. Keeping that in mind, what are the possible means of communication that can be used to involve community members in a network? I believe very strongly that in anything one does in terms of networking or coalition building, there has to be community involvement. It keeps us honest. It is very easy as professionals to get into a mind set that says, "We know what needs to be done for them." Community involvement keeps us grounded. We may not always have our hands on the pulse of what really is happening; it changes too quickly.

What makes sense? How do you bring people in? Is a religious institution the best place? Is it a fraternity? Is it a sorority? Is it some other service organization? Which one? Which way? Which combinations of things are the best ways to bring in the people we think might be willing to work with us and what we are trying to do? Clearly understand the means of communication that are traditionally used to help us answer that question. It is going to vary from community to community, neighborhood to neighborhood, and locality to locality. What works in New Orleans may not work in Washington, DC. I need to understand culturally what is happening in the community with which I am dealing. What is culturally acceptable? We professionals form our own culture after awhile. We use our own jargon and we talk the talk, and a lot of times the people we are working with look at us like we have lost our minds. What is culturally acceptable? I think that is critical, if we are to stay grounded in the realities of what the folks are trying to address or help and must constantly face.

Again, following up on the use of traditionally acceptable communication modes: Which ones are appropriate to use with which people? Some things just cannot be used. Some things are appropriate sometimes for some people; those same things are sometimes not appropriate for others. I remember an instance when I was working with a group and we were dealing with American Indians. We were sitting in a circle talking about certain kinds of things and generally having fun. Inadvertently, we had insulted the American Indian member of the group. In his cultural context, circle meant a certain kind of thing. One only went into that circle around very spiritual and important issues. We did not understand that. We must pay attention to traditional modes of communication. What is culturally acceptable? When is it used? For what kinds of things? —are very, very important.

Finally, another issue when you are thinking about networking or coalition building, what should be always foremost in our minds, is the question: Are there alternate ways of dealing with it? The answer may be yes, or the answer may be no. But whatever happens, it forces you then to consider whether or not you need to do this. These are major questions to think about in terms of coalition building and networking, issues for which you need to obtain answers.

Now let us talk about the nitty gritty—selecting people with whom to actually coalesce. The bottom line is that there are some things we want to be able to answer for ourselves.

We can get all that wonderful information and we can tell each other that we have this in our community and we have that, but we have to answer some other kinds of questions. There are some hard questions that have to be answered within the organization itself. What are those questions when you are talking about selecting with whom you will be involved? Remember, we are talking about power. We are talking about credibility. We are talking about reach. Who you link up with becomes very, very important. If you do it with the wrong people, you end up with negative achievement or some of the things you thought you were striving for go in the opposite direction. What are some of the things one needs to ask about?

First, does the organization with which I want to affiliate have the credibility? Hooking up with the university just to link up with the university in and of itself is not enough. If you are trying to work in a Black community and you are talking about a university that everybody knows has been traditionally segregationist in its orientation, hires no Black faculty, and flunks out all the Black students, that may not be the group with which you want to link. They have credibility in terms of academia, but they do not have credibility in the community you are trying to serve. The big question is: Do they have the credibility that I need from an organizational point of view as I look at what our program is trying to do?

The other issue that one must address focuses around vested interest. Vested interest simply stated means: What is in it for me? Do not fool yourselves, there are always vested interests—on your part and on the part of everybody else in the network and coalition. What is in it for me if I make this link, if I give this time and energy to this particular project? What are we going to get out of it? You try to figure that out for yourself and you also try to figure out how that would be answered by the other organizations with which you are dealing. Does the group or groups in which you are interested have potential allies and influences you want? Who are their allies and the influentials to whom they have access? A lot of us say we know Joe or we know this or that organization, but we really do not have access to them. We have the names, the numbers, and the addresses, but what you really want to look at when you do coalition building is: Who do they really know? Do they really have the mayor's ear? and so forth. In a coalition or professional network, when you bring in new groups or special individuals, you also adopt their liabilities and their assets, their negatives and their positives. So whatever credibility, whatever issues they bring to it, you have it now too, and you need to know what you are letting yourself in for.

Media Accountability and Responsibility

Moderator: **Brenda Otis, Producer, Black Entertainment Television, Alexandria, VA**

Panelists: **George Hacker, Director of Alcohol Policies, The Center for Science in the Public Interest, Washington, DC**

Rosalyn Schram, Director, Community Relations, NBC, New York, NY

Wilbert Tatum, Chairman of the Board, New York Amsterdam News, New York, NY

Summary of Remarks by Brenda Otis

We Black people have never had the commodity of time on our side to debate persons who deal with problems in our neighborhood. All we ever needed to do was look at the statistics at any given moment, especially the ones that relate to our youth, our Black kids. According to the April 27 edition of *Newsweek*, 328 homicides occurred as a result of over 5000 gang-related violent crimes last year in the city and county of Los Angeles. Most of these killings were the result of Black youth gangs that make millions of dollars a year selling crack. In Detroit, young Blacks are killing each other at an alarming rate. Around 15 children have died this year as a consequence of over 150 shooting incidents. Much of this violence is related to the substance use problem.

Drug use among teens in the United States is higher than in any industrialized nation in the world. One-third of all Americans over the age of 12 have tried marijuana, hallucinogens, cocaine, heroin, or psychotherapeutic drugs for nonmedical purposes. According to the 1985 National Household Survey on Drug Abuse, another 44 percent of the youth between 12 and 17 years of age who have ever used cocaine have smoked a drug. And, according to NIAAA, some 10,000 young Americans between the ages of 16 and 24 die each year from alcohol-related traffic injuries.

The mainstream media merchants, those who really make the top decisions—the presidents, the general managers, the managing editors—have proven to be Johnny-

come-latelies in the substance abuse world. According to *Chicago Tribune* editor James Squire, in the October 6, 1986 edition of *Time Magazine*, "Washington discovered the problem when Len Bias [University of Maryland basketball player] died of an overdose. The rest of the country had the concern for a long time." His viewpoint is a matter of debate. But even if it is true, most of us will agree that now more forces—I am talking of the media, Federal Government, religious community, private corporate sector, volunteer agencies—have come together to address and attempt to fight substance abuse in all communities. The Black community has automatically become the beneficiary of much of this activity. This comprehensive and cooperative effort is unprecedented. How can we accommodate survivors on this substance abuse bandwagon and accelerate the speed of the bandwagon's journey?

First, let us distinguish between reality and gossip. Let us not get too engrossed in the allegations, and I emphasize allegations, of civil rights leader Julian Bond's involvement or lack thereof with cocaine, or with whether or not other Atlanta officials are users. As I gave you evidence earlier, we have some hard, cold facts or statistics in our hands, and especially as it relates to teenagers, the young people. There will always be gossip and rumors going around. But let us just deal with the facts. There are enough true cases on which to focus.

On dealing with substance-abuse in our communities, here is a suggestion. The Black media merchants need to try to effect changes in the types of programs that air on television. For instance, we need to de-glamorize alcohol and drug use by shifting those emphases on such shows as *Miami Vice*, *Dynasty*, and *Dallas*. Let us find ways of telling young people that all those glamourous cars that the TV drug dealers are driving were bought, in most instances, with blood money. This is also true in real life drug dealings. Let us tell them that the triple round of cocktails consumed each night on shows such as *Dallas* and *Dynasty* will make you feel and look lousy in the morning. Let us take every opportunity to show or tell the tragic consequences of substance use among our young people. Let us not worry about being too graphic or too detailed in our work. In times of war, sensitivities are often sacrificed. Let us never lose the opportunity to get a TV camera crew, or radio or newspaper reporter to the site of a substance abuse conference such as we have here, a seminar, school plays, a rap contest focused on anti-abuse messages, or whatever positive or educational event the community is staging. And let us push our executive producers and city editors to make sure these stories are not deleted from the shows or the next edition of the paper. Let us fight for more hard-hitting editorial commentaries on ways to fight the increased infatuation with popular drugs. Let us challenge the erroneous assumptions about the safety of advertising the gateway drugs—cigarettes and alcohol. In the case of radio and television programming, let us request those continuity supervisors to allow more substance abuse public service announcements (PSAs).

What has Black Entertainment Television's (BET) public affairs department done on behalf of getting the news out about the substance abuse world? Of course now, this is a little bit of personal horn tooting. But just 2 days ago, our public affairs show *On the Line* invited Elaine Johnson, who is Deputy Director of NIDA, to talk about this very

conference. She raised a number of pertinent issues about alcohol and drug abuse in the community, and she talked with viewers over our toll-free, nationwide telephone. Prior to that, *BET News*, which I produce, covered and aired the preconference briefing in March. We have a reporter and camera crew here today to cover the conference and talk with some of the participants, and this will air over our weekly news show which reaches over 700 cable markets in about 14 million cable homes in the United States and the Virgin Islands. We have offered two reports—and I say reports, complete with photo packages—on the murders of teenagers by teens in the city of Detroit. And BET has consistently reported on the substance use problems around the country. We jumped right into investigating and reporting on drug use allegations among our more prominent citizens, and we have looked into the problem of spreading the AIDS virus through IV drug use. This is a particularly important issue in the Black community.

There are many ways that we, as media merchants can make a difference in the world against substance abuse in our communities. Our personal commitment and creative energies may prove contagious to a forum of passive citizens just waiting on an invitation for involvement. And our lack of commitment? Well, it could mean the loss of a sizable number of our youth to the degradation and futility of drug and alcohol dependency. If a generation of Black youth fall victim to this societal cancer, life in the Black community around the year 2000 will be dismal and dangerous. It will mean for the secondary victims, the nuclear family, an existence much like that of the inhabitants of a Palestine refugee camp as described in the book, *A Woman of Nazareth*. The author, Hala D. Jabbour, says the circumstances of life can become so tragic that laughter is rare, smiles are occasional, talk is concise, drama is always hovering above the horizon, sadness is a must, pleasure is an unaffordable luxury, and everything but the daily task of life is postponed. If this alcohol and drug epidemic is allowed to become a permanent beachhead in the Black community, those of us clean but nevertheless victimized by the epidemic may be driven in droves from our community. We, too, may be relegated to refugee status.

Summary of Remarks by George Hacker

Let me give you just a couple of minutes' background on our interest in these issues. The Center for Science in the Public Interest, a health advocacy organization based here in Washington, DC, works primarily on nutrition issues. We have had a project on alcohol policy, and we have been looking at a number of measures that are designed to help reduce alcohol consumption and reduce alcohol problems. We have examined the potential impact of increasing alcohol excise taxes, improving the labeling of alcoholic beverages with warnings about calories and other ingredients, as well as reforming advertising and marketing for alcoholic beverages.

In 1983, we published a book called *The Booze Merchant*, which details numerous efforts that the alcoholic beverage industry uses to increase consumption of their products in this country and measures that against the serious problems that result from alcohol in

this society. One of the critiques to that first report came from Peter Bell of the Minnesota Institute on Black Chemical Abuse. Peter, at that time, criticized our book, *The Booze Merchant*, because it did not focus on the severe problems of alcohol abuse in the Black community and the very specialized targeting of Black consumers by advertisers. To clear up that omission, The Center for Science in the Public Interest published a report called *Marketing Booze to Blacks* and released it at a press conference at which Representative John Conyers of Michigan and representatives of the Black Congress on Health, Law, and Economics spoke. They called for a dialog primarily in the Black community, but throughout the society at large, about the relationship of alcohol marketing and health in the Black community.

To start us off, I would like to share with you some of the things that we are talking about. There are some TV ads that are aired frequently. One of them, featuring Billy Dee Williams, sponsored a showing of *The Jeffersons* in New York city. It aired at 7:00 p.m. and had a viewership of about 300,000 kids under the age of 18. The ad is really a mockery in that the message is: A way to get a lady in the sack is to get her high on malt liquor. As you well know, most of us know that the problem with unwed mothers among younger people, particularly in the Black community, is a severe one. I would doubt if any of us would think that that is an acceptable message to be sending in the Black community.

Alcoholic beverage producers spend over $2 billion a year promoting the sale of their products. If their goods were as innocuous as skim milk or bran flakes, no one would care how much they spent to increase sales. However, alcohol happens to be a special case. It is America's favorite, though legal, drug—a potentially addictive drug that is responsible each year for over 100,000 deaths, more than $100 billion in economic harm, and incalculable human suffering. This harsh reality leaves one to investigate the scope of the industry's marketing programs.

Large alcoholic beverage producers have enough money to exploit every niche in the marketplace. One that they pursue with particular zeal is the Black consumer. For alcohol marketers, breaking into this population means creating new drinkers. In recent surveys, Blacks reported higher rates of abstention than whites; young Black men are far less likely to drink than their white counterparts. Alcohol marketers would like to change these drinking patterns—and that change spells trouble. Increased drinking poses special dangers to the Black population because a large fraction of that population has inadequate access to health care and lives in poverty—in poor housing conditions and with high unemployment. These are among the reasons Black men have 10 times the rate of esophageal cancer and twice the mortality rate from liver cirrhosis than that of white men. Government reports also document that Blacks suffer disproportionately from other alcohol-related consequences, including hypertension, obstructive pulmonary disease, severe malnutrition, and birth defects, to name just a few.

According to NIAAA, alcohol abuse is the leading health and safety problem in Black America. Yet, thanks to the alcoholic beverage industry, Blacks get a double dose of encouragement to drink. They are exposed, not only to ads aimed at the general

population but, in addition, to the concentration of advertising ploys directed specifically at them. Urban Black neighborhoods are peppered by billboards promoting alcoholic beverages. Billboards are perhaps the most invasive of all advertising media. Unlike TV and magazines, there is no on or off switch, no page to turn. Children as well as adults are part of a captive audience. These billboards appear almost anywhere, looming over homes, schools, places of worship, parks, playgrounds, and health centers.

Black-oriented magazines and many Black radio stations carry a high proportion of ads on alcoholic beverages. Respected Black celebrities, ranging from Wilt Chamberlain to Tina Turner to *Roots* author Alex Haley, rent their images to the alcoholic beverage merchants. One side effect of this enormous advertising investment is that Black ad agencies, broadcasters, and publishers are held hostage by alcoholic beverage industry money and are unable to participate fully in alcohol abuse prevention and education efforts. This situation is, of course, no different among the mainstream media. Compared to Black and white media efforts to help stem the use of illicit drugs, their record of addressing alcohol problems—the leading drug problem in the Black community—is dismal.

Such deference to the alcoholic beverage industry is hardly necessary, as Barbara Proctor, who was to be on this panel today, would attest. Recognizing her profession's power to persuade and to generate a need in the consumer that only the advertised product can fulfill, she refuses to hype products she believes to be detrimental, such as cigarettes or alcohol. Alcohol companies, like tobacco companies, complement their advertisement efforts with public relations campaigns that endear and indebt a multitude of Black organizations to them. Anheuser Busch, Seagrams, Coors, and many other companies have an impressive record of involvement in Black community affairs. They support programs like Black history month and make contributions to mainstream Black organizations like the United Negro College Fund and groups combating sickle cell anemia. Major alcohol producers sponsor a staggering, wide array of Black cultural entertainment, sports, and social events. Just one company, Adolf Coors, foots the bills for rodeos, Black collegiate football game broadcasts, tennis tournaments, rock concerts, boxing matches, college interview fairs, and film workshops, not to mention airplanes for the Contras, too. These public relations efforts, as former Congresswoman Barbara Jordan of Texas noted in her preface to our report *Marketing Booze to Blacks*, are beneficent but shallow gestures when compared to massive advertisement campaigns that promote drinking. They are carefully staged and publicized to maximize goodwill and forestall inquiry into prevention policies to reduce the harm from alcohol abuse.

One further issue deserves careful attention. Alcohol producers target certain products specifically at Black consumers. The most prominent of these is malt liquor. I have three examples of the leading malt liquors in this country. Blacks are prime consumers of this beverage. Consequently, Black actors, singers, and other characters are featured in almost all the ads. Malt liquors are sold like beer, but they contain from 15 to 50 percent more alcohol than regular beers. One must certainly question the ethics of pitching

high-alcohol drinks deliberately to that segment of the population which endures the greatest alcohol-related harm.

Our report proposes a number of reforms to help stem alcohol abuse in the Black community. We recommend that alcohol companies, particularly brewers, stop marketing high-alcohol products almost exclusively to Blacks. One solution would be to put a 5 percent alcohol by volume limit on all malt beverages. Alcoholic beverage producers should contribute major funding to independent programs to prevent alcohol abuse, especially among Black youths. The general business community should greatly increase contributions to Black civic organizations and expand advertising in Black media to make Black organizations and Black media less dependent on revenues from alcoholic beverage and tobacco sources. Black civic groups, advertisement agencies, publishers, and broadcasters, and their white counterparts as well, should review the possible impact of contributions from alcohol and tobacco companies on their objectivity and on their programs.

The generous contributions made by alcoholic beverage producers to Black economic development projects, to community and major Black civil rights organizations, to educational activities, and even to the Congressional Black Caucus, must now be reassessed. Collectively, we must try to break the yoke of dependence upon financial support from alcohol and cigarette producers. We, as organizations, legislators, magazine editors, advertising agencies, and media concerned about Black people, must demand that alcohol producers do more to balance the messages directed at the Black community and that they join us at full throttle in efforts to combat alcohol abuse.

In addition to our specific recommendations relating to marketing in the Black community, we have a number of general recommendations that also will help stem alcohol abuse throughout the entire society. We believe that Congress should enact legislation to require health warnings, calories, and ingredients in alcoholic beverages on containers and labels. Congress should require broadcasters to balance alcohol ads with health and safety messages about alcohol, and raise alcohol excise taxes.

Summary of Remarks by Rosalyn Schram

One of the things that I want to talk to you about today is not only broadcaster's accountability and responsibility, but for many of us in broadcasting, what we see as an opportunity. Clearly we reach a mass audience. An audience that has diverse demographics, including the Black population, as well as other minority groups. To that extent, it is a welcome opportunity to be able to use our air time to create awareness about issues such as alcohol and drug abuse. I can only represent NBC, and not the other networks. I am going to go through some of the things that we are doing.

One of the decisions we made at NBC which is not unlike some of our network counterparts, is that we would not make a distinction between alcohol abuse and drug

abuse. In working with many people at NIDA and in other parts of DHHS, informed concerned people have told us that so many are involved with both alcohol and drugs. And to that extent, all of our messages, all of our programming that deals with the topic of abuse, specify both alcohol and drugs.

Air time is very valuable, whether it is used as commercial time, programming air time, or public service. Basically, we split our campaign into two different areas, programming time and public service time. In terms of programming, substance abuse was the topic and the subject of reports as well as entertainment and sports programming in over 700 NBC programs last year. These ranged from news programs such as the *Today Show* to nightly news shows that focused on specific issues and news reports dealing with substance abuse to evening sports programming. *Sports World* as well as some of our other shows have taken a look at the enormous price that is paid by athletes in this country who find themselves in difficulties because of their substance abuse. During last year's Wimbledon tennis matches, Just Say No messages were broadcast. More and more, we are trying to advertise anti-drug messages during our day programs.

In terms of entertainment programming, we have had major story lines on programs as diverse as the *Cosby Show* and *Hill Street Blues*. There is a running story dealing with a nurse on *St. Elsewhere*. Last year, I asked that the *Cosby Show*, which is such a popular show with wonderful role models, to come up with a program specifically dealing with drug abuse and they did. It was not as effective as the show they came up with on their own the year before.

One of the messages that we have learned is we need to be doing a lot of consciousness raising with our producers. Members of the production community—creative talents, writers, producers, and directors—need to have their consciousnesses raised so that they can deliver programs that do not simply make network executives happy because they delivered a show on a particular topic. They need to understand enough and have enough enlightenment and education so that they can handle it in an effective way. Many of our lead characters specifically have story lines involving drug and alcohol abuse. Furillo on *Hill Street Blues* is an alcoholic; Sam Malone on *Cheers* is an alcoholic. They are in the story. Tubbs is one of our crime fighters on *Miami Vice*. I must say that while I think *Miami Vice* takes a lot of beating based on some of the studies that are done, it is clear that the drug abusers are the bad guys. Yes, some of them look as though they have great cars, but at the end they usually blow up.

One of the things that I can speak to you about in a very positive way is that the networks, unlike cable and unlike independent stations, do have broadcast standards and policies in effect. George mentioned that there was an episode of *The Jeffersons* broadcast at seven o'clock in the evening that had a malt liquor commercial. That was not on a network. One of the problems that we face at the networks that I can tell you about is the fact that you have one TV and everything is popping out at you. It is not all coming from the same place. The guidelines that are used at the three networks not only vary from network to network, but they sure are a lot different from the guidelines used by

cable and independents; for example, the ads or story lines you may see at particular times of the day.

Broadcast standards departments at NBC include 40 people working out of the east coast and west coast offices. We have very strong policies. Two lines are real important to us, specifically about drug abuse: (1) narcotic addiction shall be presented only as a destructive habit and (2) the use of illegal drugs or the abuse of legal drugs shall not be encouraged or shown as socially acceptable. I can tell you that we have come a long way. I think many of you in the mental health profession have an understanding of the issues. Our policies have evolved and are getting better. There are things which went on the air in 1978 that cannot get on the air anymore. Several years ago, Bob Hope presented the network with a script for one of his specials that included 20 jokes dealing with drug and alcohol abuse. The broadcast standards division stood firm, which is not too easy to do. There are only about four guys at NBC who basically can do what they want and they are Johnny Carson, Bill Cosby, Bob Hope, and maybe David Letterman. They stood tough. Bob Hope actually took out an ad in the *Hollywood Reporter*, one of our industry's trade magazines, congratulating NBC for being tough and commending us for having made the right decision although it was not easy to say "no." We are continually moving in the direction of being more careful about the kinds of messages that we are giving kids. Also, we are careful to make sure that we are presenting appropriate messages, particularly in the Black community with Tubbs, the Cosby kids, and people who are clearly Black leaders and role models that can have students responding to them.

The other area that I want to talk about is even closer to home for me and that is public service. Since 1979, NBC has launched major public service campaigns dealing with substance abuse. Our partners have always been very clean—basically NIDA and other agencies within DHHS. We take an awful lot of guidance, and really rely on the wisdom, the experience, and the research information to give us direction on what kinds of messages need to be put out through the media.

Our campaign for the past couple of years has involved us with the promotion of the Just Say No message. This past year, we decided to update that campaign and came up with Help Someone To Just Say No, based on all the research and advice we had from our friends at DHHS. Instead of targeting messages to abusers who are frequently already self-destructive and basically tuning out, we target our messages to the friends, the teachers, the parents, and in some cases the kids of abusers to get their help. Each year our campaign is targeted to a particular age group. This past year, it was high school students; the year before, we focused specifically on elementary school students. Our PSAs always include NBC talent and a referral number where people can call to get help for themselves and their friends. Two of our spots use two kids who have performed as role models for the Black community—Malcolm Jamal Warner and Tempest Bledsoe.

The on-air elements, of course, are very important, and these spots were seen on all of the NBC television stations and affiliates. We also feel that in order to take a larger, broader approach, we need to put other things into the community. We have put together public service kits that have been useful to schools. In this past year's campaign,

as well as in the year prior to that, we sent out guides for teachers to every public and private elementary school in the country. The year before, we targeted high schools and sent guides out to every public and private high school in the country. They have lots of information about referral. They have lots of information about data. They also have reproducible masters for teachers to use in developing peer counseling programs and providing advice to youngsters. In addition, posters are sent out to civic and youth organizations, such as the Girl Scouts and the Boy Scouts.

One of the things that we have learned is that we need to send out more educational kits. We keep going back to press. It is sort of the bad news-good news thing in my office because the bills are getting higher, but it is one of those things for which it is worth picking up the tab. Teachers are using it, and we are delighted to be able to send them out.

Another part of our campaign always includes programming. For this year's campaign, we had a special *Cosby Show* episode. We try to highlight one of the shows and make sure we get as much coverage as possible.

One of the other features of the public service campaign, which we have learned is crucial, takes place at the community level. We work with our stations to give them direction, guidance, and advice on how best to form coalitions in their own communities with youth-serving agencies, religious organizations, all of the local political and community leaders, as well as with the schools. Many stations across the country are actually doing admirable jobs in taking the leadership to combat substance abuse.

One of the areas of difficulty for us is always assessment. I ask myself, and sometimes I am asked by others: How much of an impact do you think you are making? It is almost impossible to quantify. The only kinds of quantitative data I have are things like the numbers of Just Say No clubs that have grown and grown. We are getting a lot of information and feedback that NBC's participation in the campaign was a major part of that growth. We have quantitative data when we know that we send out 70,000 posters and study kits to the schools and we get requests for another 30,000. Beyond that, it is basically qualitative.

We do not believe that the media is as powerful as we would like ourselves to be. However, we feel that we are making the best use of the air time and we hope we are working in partnership—not only on the local level, but for many of us nationally—with organizations as well. I think the basic feeling is that we are very sophisticated and know that a 10-second spot is not going to make sure a kid stays out of trouble. What we are hoping, by having an approach that involves community-based activities, as well as the actual messages on air time, is that some information will get into the schools. We think that all of these things can work together to create a synergy that will change the norms and change some of the messages in the environment.

Summary of Remarks by Wilbert Tatum

In many ways, I resent one of the presentations that was made here. But resentment alone is not enough. I want to tell you about the world in which I live. It is a very, very real world. I had read the speech that Charlie Rangel had this morning, called "What Shall I Tell My Children?" Those of you who are older, that is, my age, will remember that in 1945 or thereabouts, there was a train they called The Freedom Train. Langston Hughes wrote a poem about it, and he said, "What shall I tell my children?/You tell me./For freedom ain't freedom/when a man ain't free." We were not free in 1945. And we were not freed in 1954 with the Supreme Court decision. And we are not free today.

Running a Black newspaper, being committed to the idea that there must be change is a must, no matter the cost. When I come to something such as this conference—and I always accept because not only are the kids in school my children, so are you—I am overjoyed to hear a keynote address such as the one Rangel made this morning because he focused where it is.

I want to go to the media for a minute. I am not going to defend Black media at all. But I want to give you some facts to help your perspective on the Black media. There are 250 Black newspapers in the United States. There are fewer than 50 Black magazines. The advertising budget for alcoholic beverages and cigarettes is about $2 billion. All Black media combined, given the last figures I saw, got less than 3 percent of this. Now, let me tell you why. I have a friend who works on the editorial pages of the *New York Times* who is death on cigarettes. You see an editorial or an opinion piece every week or every month against cigarettes. I was in a meeting with him, and he talked to me about cigarette ads and my newspaper. And I allowed that, yes, we do accept cigarette advertising. And I also allowed that when the Nation decided that it was going to ban it and make it illegal, I would stop. But it goes beyond that. Two days later, I saw a four page ad in his newspaper advertising cigarettes. Now, that ad in that newspaper cost $19,000. In my newspaper, the same ad, that I did not carry incidentally, would have cost $1,800. There is your fact for a different perspective.

A spot on television during the Super Bowl can go for $75,000 a minute. A spot on a Black radio station in New York City—WLIB, goes for $1,100. And there is no Black television station in New York City.

I recently won a suit against GENCOR. They were selling WOR, channel 9 in New York, and I felt that images for Black people were important. And it goes back a long time again to a Black poet who wondered why Black women did not know they were beautiful. The poet answered himself by saying that Black women did not walk the banks of the Tigress, the Nile, and the Euphrates when dawns were young. And that there were no palm trees on Lenox Avenue, and the dishwater gave back no images. That is why I am in the image business. I want to make certain that 100 years from now, when the time comes to take that 100-year-old time capsule out of the ground in which you

have all the white newspapers, magazines, and television programs listed, that Black newspapers are found, too. Because, if you were a Martian looking at a time capsule of mainstream, white media, you would have to conclude that Black people and Hispanics ran like the wind. It would suggest that those very tall persons could jump up and shove a basketball through a hoop, that they could take their fist and beat someone to death, and that they could toss a football 100 yards. According to the pages of the white newspapers, we Blacks should never have gotten married. We never had children who became Ph.D.s, and we were a lot of people who were narcotics abusers, wife abusers, criminals, and all manner of things. I am so glad the Black press exists because at least a piece of the record will be straight.

To NIDA and this conference on Blacks, I am glad that it happened. And I think that there must be a focus and an insistence that we be participants in the process to take care of our own and that we want to say yes to the resources to get rid of this poison in our society and put the blame where it squarely belongs—on the kinds of entrepreneurism generated when you can take soda, capsule, pipe, and cigarette lighter—all legal—and become what is called an American dreamer.

Major Discussion Points

There are some misconceptions, particularly in the area of sports—sports advertising. Many people I know have made remarks about youth being influenced by advertising during sports shows. The truth is that only 8 percent of the people who watch sports are youngsters. The alcohol advertising on sports-related programs is really not geared toward youngsters, if for no other reason than the fact that that is not the demographic segment of the population that is watching. One of the things that I can assure you of is our own guidelines. One of the guidelines specifies that the people who are seen in the commercial not look like they are youth. So, in some cases there have even been models who have been rejected, who have been older than drinking age who simply have a youthful appearance who were not allowed on that commercial.

The larger question in terms of what kinds of guidelines we have for talent is one that I think Mr. Tatum may be able to appreciate. Basically, it is an entrepreneurial market. We cannot tell talent, for example, that they cannot be in any kind of advertisement, whether it is an alcohol ad, a pantyhose ad, or a sexist advertisement. What we can do, as carefully as possible, is choose those particular people who we want to have involved with substance abuse messages. For example, we felt that it was very important for our posters that we display Malcolm Jamal Warner and Tempest Bledsoe, rather than the 20 or so other stars we have involved in the campaign, specifically because they are young and Black and we felt that they could have the greatest impact. One of my private fears is that someday I will have an NBC talent who I will ask to participate in a campaign, and the next morning I will wake up and see that they were busted. We do the best that we can do: we ask for enough involvement so that we are personally assured that these are people who are solid, who are not abusers, who are taking this very, very seriously. I will tell you that there have been people who have wanted to participate in

campaigns, and we turned them down. I think one way to be safe is to ask those particular celebrities in what things they are involved outside their own programs. But beyond that, in terms of actual contract, to the best of my knowledge, there is no way to stipulate that particular actors involve themselves or stay out of involvements with particular products.

There is enormous debate, and no consensus in the scientific community, on whether or not alcohol advertising has an affect on youngsters. That is a real big debate.

Black newspapers are not only in a catch-22; we live in a racist society as well. Let me give you an example. If you go to Bloomingdale's in New York City on any given day, you will see those pretty Black sisters and brothers walking out of that store like there is no tomorrow. Yet, Bloomingdale's refuses to advertise in Black newspapers. Gimble's, for years, refused to advertise in Black newspapers, though their base was Black. They went out of business. And there was no organized effort to put them out of business; they simply went out of business for any number of reasons. The *Daily News* in New York has just been convicted of discriminating against its people. And almost 50 percent of their readership is Black. You see what is happening here with your catch-22. We go to an advertising agency. You cannot go directly to the product person or the product manager. If you do, you do so at your peril if you are in the advertising business. They place their obligation on the advertising agency. The advertising agency could give less than a damn about social responsibility.

If you get a hamburger—well, they know visually how many Black persons eat hamburgers and junk food. The junk food industry has recognized the Black market and they give us a small piece. But if you look at tombstone ads (ads about offerings on Wall Street) in newspapers (*The New York Times*, *The Wall Street Journal*)... We have never had a tombstone ad. I submit to you that Black people buy stocks and bonds, but you cannot get an ad.

Advertise a big co-op in New York City, a big co-op. Black folks have money. You could not get an ad on one of these for anything. There are categories that they simply will not allow us to get into. I will tell you when it is going to change. New York City today, according to the census clock, has just become the city of the majority of minorities, Blacks, Hispanics, and Asians represent 54 percent of the population in New York City. First comes the miracle power, then comes political power, and finally comes economic power. And you must relate political power to economic power. Because with a budget of $22 billion in New York City, those who are closely connected to government (and it has happened traditionally, with the Irish, the Italians, the Jews, every group who has hit majority status) will be able to partial out that budget to their own. Now they want to change the rules of the game when Blacks and Puerto Ricans are about to get into a majority status. I will tell you something, we must not allow that to happen. When we become the majority, politically and numerically, the advertising agencies, at least in New York, will begin to look and say they have to change their policies.

I do not want to lose the Black newspapers in this country. I do not want to lose the Black magazines. *Ebony* lives on a precipice. There have been articles on alcoholism in *Ebony*, though not as many as you would wish to see. I think I have attended many meetings where we as publishers have knocked this around. We say to those folks who

criticized us, "Come with us to the real estate people who will not advertise in our newspapers, to the people who simply refuse because we are Black or Hispanics." It indeed is a catch-22, and I am not about to boycott John Johnson (Chief Executive Officer, *Ebony Magazine*). I will say to him publicly, "John, you got 30 percent." But I am not going to criticize John, because John is getting what John can get. And those who look at the enormous dollars that go into advertising and the paltry amounts that go to Black media . . . It is mind boggling when you know that we spend $200 billion in this country a year.

I do not know about the other newspapers, but I try to educate my readers about how advertising works. In my newspaper, and many other Black newspapers, we deal with things that would never make the front page of a white newspaper.

What we do in terms of handling the campaign is the following. First of all, we usually have about 20 different stories involved in the campaign. We try to get as much of a representation of all demographics. So, we have stories from the *Golden Girls*, who are senior citizens. We have stories from *St. Elsewhere*. We have stories from all the different shows. It was my decision to have the Cosby kids really highlighted.

We work nationally with several different and major groups. I work very closely with the National Urban League, for example, as well as the Children's Defense Fund. We take lots of direction from many different groups. As far as I am concerned, the only way to do coalition building, whether it is at the national or local level, is to bring in as many partners as you can. For example, I discovered the National Collaboration for Youth which puts together 14 of the major groups: Girl Scouts, Boy Scouts, Boys' Clubs, 4Hs, Optimists, and so forth. This national collaboration, which serves 14 million youth, has been instrumental in helping us come up with designs for the curriculum as well as for the reproducible masters.

One of the things that I try to do is work with each of the affiliates. We have 206 stations across the country. As far as I am concerned, those affiliated stations are grassroots chapters. What I need to be able to do is give them material that they can localize. For example, the spots that they receive can have a local tag placed on them. Each of our stations receives between 100 and 200 copies of each poster and other material developed by NBC headquarters that they can send out. For example, if my office is doing a mailing to every single high school, we will suggest to the affiliates that they go out and mail to the junior high schools. Or, if we are not reaching the religious institutions, we will ask the affiliates to reach out to them. When we work with national-level organizations (e.g., the National Urban League), we encourage them to tell their State-level people to call their NBC affiliate to work with them to become part of the coalition. So we work with lots of different groups to get input into the community.

Even in terms of programming, I could tell you that, aside from involvement with different individual people and callers on our shows, we also work very closely on many of our programs, even in terms of pre-training them, with lots of groups to get some advice from them about whether they think we are getting the message right or not.

We have a condition that is real; it is as real as anything can be. There are things that we can do that I do on my pages. I am not going to go down the tubes because I refuse to accept a legitimate piece of advertising while every other newspaper in the country does not. I said, and I will say it again, I wish that the Government would be

genuine and say: Since smoking cigarettes kills you, we are not going to allow you to do it anymore. Then there would be a bigger black market in cigarettes. There is the education process in which I and many of my people are personally involved. And you will see an anti-cigarette piece along side a cigarette ad. But I will tell you that if my newspaper and all the Black newspapers in the world rejected cigarette and alcoholic beverage advertising, there would just be more for the white advertisers who are not going to reject it. Now, it is a catch-22, and I am not sanctioning anything. I am simply saying that there is a world we live in called a world of competition, and I am going to compete just so long as it is legal.

Voluntary Associations: The Backbone of Community Involvement

Moderator: **Flavia Walton, Ph.D., National Director of Services to Youth, The LINKS, Inc., Las Vegas, NV**

Panelists: **Lynette Taylor, Program Director, Delta Sigma Theta Sorority, Inc., Alexandria, VA**

Aaron O. Wells, M.D., Imperial Medical Director, AEAONMS-The Shriners, New York, NY

Dr. James B. Abram, Chairman of the Guideright Commission, Kappa Alpha Psi Fraternity, Inc., Virginia Beach, VA

Eunice Thomas, International Grand Basilius, Zeta Phi Beta Sorority, Inc., Washington, DC

Summary of Remarks by Lynette Taylor

Delta Sigma Theta Sorority, Inc., at 74 years old, has 800 chapters on 382 campuses with graduate and undergraduate membership. The undergraduates have taken the leadership in the fight against alcohol and drug abuse, organizing prevention programs in local communities to help youngsters aged 8-12. An example of the undergraduates' commitment is their participation in the Teen Lift program involving nine high schools in Winston-Salem, NC, where a public meeting was held that focused on health issues, including candid discussions and a call for parent involvement. The highlight of the meeting was a 3-mile Just Say No to drugs walk in downtown and east Winston-Salem.

The organizational structure of a volunteer organization must have a philosophy, a purpose, a commitment, and a capability of establishing goals. In addition, it must have accountability, credibility, and the willingness to give time, energy, and financial resources.

What does a volunteer do? A volunteer must be willing to be trained to do the job effectively and be a part of a reporting mechanism. The volunteer must have measurable short-term, interim, and long-term goals.

There are 150,000 volunteers in Delta. Members have an "orbit" of 50 to 500 people, a kind of family committed to doing social and public service.

The attitude of a volunteer should be one of sharing the program with other well-meaning people—sharing ideas, things to do, knowledge, information, publications, and so forth.

The kinds of assistance that Delta provides include direct, hands-on help and aid in assessing the system. Unless the system changes, unless the policy is effective, unless the pushers get off the street, unless the young people get into training centers, unless the system—whether it is city, county, State, or Federal—is accessed and willing to join with voluntary organizations, we will just be floundering in the wind. Volunteers must be a catalyst for changing the system and must seek to get others' help in bringing about change.

With regard to alcohol and drug abuse, agenda setting is important. Delta has made alcohol and drug abuse prevention its number one priority. With the focus on getting the message across to 8- to 12-year-olds, undergraduate pilot groups in 34 cities, through the use of videotapes at cluster meetings and area conferences, reached thousands of people in seven areas across the country.

Delta also started a model single-heads-of-household program in 42 cities. Several chapters became concerned when it was recognized that teenagers in these households were using drugs heavily. That model was picked up by seven area groups, and we now have 235 single-heads-of-household programs. The program model was used by Delta in Nairobi, Kenya, where one out of three women are single-heads-of-household and drug and alcohol abuse was a problem for them as they raised their children.

Delta will be sponsoring a drug abuse and AIDS conference in Nassau, the Bahamas, for women around the world to dramatize the number one problem—economics, and the number two problem—health, drug abuse, and AIDS.

Summary of Remarks by Aaron O. Wells, M.D.

Established in 1893, the Shriners is one of the oldest Black organizations in the country. Activities of the organization, which held its first convention in 1901, include health and medical research; screening for hypertension, cancer, diabetes, and sickle cell anemia; donating to colleges, universities, and hospitals—including Howard University, Meharry Medical College, and Tuskegee Institute—for medical research; maintaining a grants program for people age 17-24; providing educational grants to colleges; aiding youth to fight drug abuse, juvenile delinquency, and crime; and assisting with voter registration.

A major part of the Shriners' annual convention is its youth program, in which up to 3,000 youth as young as 7 are involved in a wide range of activities, encompassing parades, slide programs, and bugle corps activities, that encourage positive, healthful behavior.

Also part of the convention is the organization's health component composed of 20 doctors and 40 nurses who provide health services. Programs on health highlight convention proceedings, beginning with the subject of drug addiction several years ago. The convention addressed in 1985 several major health problems affecting the Black community: the high death rate from AIDS, the rate of functional illiteracy (25 percent among Blacks), and teenage pregnancy (70 percent of youngsters born out of wedlock are Black).

The 1986 program covered child abuse and what every teenager should know about it, including sexual abuse. Youngsters attending the 1986 convention were asked to complete a questionnaire that asked what other things they wanted to know about sex. They responded that more time should be spent on the subject and that they wanted to know how they could talk to their parents about sex. Youth were told that sex abuse occurs within and outside the family. They were urged, if they were abused, to seek counseling from someone like a minister or school nurse and to not be afraid to speak out. Children are abused in other ways: they are kept out of school, given inadequate food and poor housing, and inflicted with emotional punishment.

The 1987 program, to be held at the convention in Atlanta, GA, will host a Teens Speak Out forum in which youth will discuss topics such as alcohol, AIDS, and teenage pregnancy. Health Watch, a network of physicians, will participate. Prizes will be awarded to youth for the best responses to essays written by them on such topics as teenage pregnancy and drugs. The essays will be read beforehand and distributed to youths at the convention.

Summary of Remarks by Dr. James B. Abram

Kappa's Guideright Commission, established in 1923 in St. Louis, gives educational and vocational direction to youth, including assistance in obtaining jobs and going to college. In addition, the commission addresses myriad problems in its attempt to help youngsters develop self-esteem and build their confidence. Programs focus on expanding educational, career, and employment opportunities for young people. The Kappa Instructional Leadership League, National Student of the Year Pageant, the Ebony Awareness Bowl, Live A Day, and tutorial and guidance programs are all examples of services provided under Kappa's Guideright Commission. Incorporated within these programs are ways to deal with alcohol and other drug abuse, teenage pregnancy, and venereal diseases.

With regard to educational opportunities, Kappa provides information on colleges, sponsors college nights and visits to campuses, holds financial-aid workshops, and offers information on vocational schools and on life in the military.

The Leadership League, established in 1975, operates like a boys' club; it teaches parliamentary procedures and holds essay and speaking contests in which donated cash prizes are awarded. The contests start on the local level, move through the regional level, and culminate at a national conference where students vie for National Student of the Year honors. Last year, Kappa donated $20,000 in prizes to 20 students in both high school and college categories for participation in the Student of the Year pageant. The program is in 200 cities across the country. In Oklahoma City, 98 percent of the students who participated in the program (at Douglas High School) went on to college.

The Ebony Awareness Bowl, modeled after the college bowls, originated in Oklahoma City, the capstone of Kappa activities. Eight churches participate in a competition in which questions are asked about the Black community. The competition ends after three to four weekends, when the church that is able to answer the most questions correctly wins.

The Live A Day program, which originated in Berkeley, CA, involves pairing an adult mentor and a Guideright youth who have common vocational interests. The pair spends several structured days together during which the youth learns about the mentor's profession, and the two also engage in activities like lunch and bowling where they can discuss issues involving the profession in a less formal setting. Based upon the role-model concept, the program has proven to be very successful in attracting and motivating young people to pursue professional careers.

Kappa covers 12 geographical regions, each having a Guideright coordinator who is a member of a task force on alcohol and substance abuse. The task force is presently writing a manual about the problem of substance abuse, which is to be distributed to 600-plus Kappa chapters. The manual lists authorities in the alcohol and drug abuse field who can be used as resources to present lectures and seminars. The task force will also present film strips and slides on an ongoing basis; in some areas this has been going on for several years.

Summary of Remarks by Eunice Thomas

The Zeta Phi Beta sorority became interested in drug abuse prevention after examining several issues affecting the Black community. We looked at illiteracy. There are 23 million illiterates; 700,000 high school graduates cannot read. We looked at economic development, including what types of jobs would be available in the year 2000. We looked at poverty and health care for the poor. We concluded that drugs are behind all of this. Thus, the sorority embarked on Project Zeta.

Let me first describe Zeta Phi Beta. The sorority began at Howard University in 1920. It has undergraduate and graduate members in 600 chapters throughout the United States, Africa, and Germany. In its first 45 years, Zeta sponsored the National Juvenile Delinquency Project, which continues today. Other programs include education, social service, and housing and economic development projects; parent and child-care training programs; welfare, education, and health service projects; and pregnancy, women, and small children programs, including stress and prenatal care programs. In 1966, Zeta organized programs in Africa—Project Food Production and a project in Liberia in conjunction with CARE.

Zeta's membership—professionals, mothers, grandmothers—is its greatest resource. These are women of courage, dedication, commitment, and determination.

Project Zeta is an integrative approach to problem resolution in the Black community. It encompasses the Stork Nest program, in which clients are educated about AIDS, drug abuse, and how to care for children; and a juvenile delinquency program, in which members work with prisoners and prisoners' children. Drug awareness programs have been developed by Zeta chapters in different parts of the country, with each chapter involved with its community in implementing its drug abuse prevention program.

Project Zeta uses a combined approach in which existing projects are expanded as new programs are initiated. Project Zeta is integrating drug abuse prevention programs in its economic services, illiteracy, and health services programs. The project is viewed as an investment in people and, in particular, the future of our youth.

Other programs include Building Blocks in Belgrade, GA, where the Black community is working with adolescent pregnant mothers. A pal system is being developed in which a Zeta member works with a pregnant teen throughout her pregnancy. Zeta holds seminars on drug and alcohol abuse, preaching no smoking, no drinking, no drugs.

We have a drug abuse program in Fort Valley, GA, where residents have joined with police in a crime-reduction community program.

Zeta is working with the churches in Ashville, GA. In Baltimore, MD, Zeta has 27 Just Say No clubs that provide an alternative for children in teaching them ways of resisting pressure from their peers to use drugs. And in 10 counties in Georgia, Zeta is working with churches and holds town meetings with legislators who work with the churches.

Summary of Remarks by Flavia Walton, Ph.D.

Middle-class organizations are getting involved in preventing the use of drugs by our children. We cannot keep our heads in the sand anymore. Drug use is a lifestyle. Pushers are using children, and children are being shot on playgrounds. Houses are being ripped off. The organizations represented on this panel provide effective examples of what can be done in the community.

We must do something about drugs, alcohol, and AIDS to ensure a future for our kids. We have to work together. Carry these concepts back to your communities. Start coordinating councils or groups to replicate what we have here. Affecting policymaking institutions in the community must be a priority. Each of us is a role model. Unlike yesteryear, we are not giving our children clear messages on what is acceptable, what is not acceptable, and the consequences of certain behaviors. The message is: help teach values again—how to be mommies and daddies. Teenagers are having babies. They especially do not know how to be mommies and daddies. We have to deal with the new problem creatively, innovatively, sincerely, and committedly. Do it in your own personal and organizational orbit.

Major Discussion Points

Drinking parents are observed by children. Parents must set an example for children. Parents beating on each other creates violent situations that are unacceptable in teaching children. We need more how-to-do conferences: how to help with children—even at the prekindergarten level; how to discuss sex through the proper framework. We must learn to treat each other with self-respect.

Middle-class organizations are reaching out into low-income housing areas or reaching the unemployed. The Links has a program for the homeless in Atlanta. The homeless are certainly a population with which, historically, very few Black organizations would have dealt. It is a learning process. We definitely have some skills that allow us to help each other and other Black folks, because the orbit is not necessarily a socioeconomic one anymore, it is more of an environmental one.

Things begin with you and include all those in the community. We must be able to deal with people who say, "I want to get out." Being middle class is one payday away.

I am one of the founders of the National Association of Black Social Workers. The question is how to connect the low-income individuals with middle-class professionals. Organizations have not had the reaching out they need. There is a big gap between services provided to working-class children and those provided to kids who are not in school or those in the housing projects—places much farther removed from us than our general orbit.

Some organizations, or at least some chapters, have identified the leadership in particular communities and have attempted to work with this leadership. The bottom line: How people read you is part of the question.

Statistics show that in 1975, 10 percent of educators were African Americans; in 1978, 8 percent; in 1983, 6.5 percent. We cannot allow other people to teach our children. Half the children do not know Martin Luther King or know why we should celebrate Negro History Week. There is no rite of passage for 13-year-olds. Blacks must find a rite of passage, not the rite of passage of having a baby, going to jail, using drugs. We

must find a way to get African-Americans who can talk to and teach children. We must get children early. By kindergarten, they have been destroyed. They are what they have learned from 0 to 4 years old. When we talk about preventing drug and alcohol abuse, we are talking about closing the barn door after the horse is out—doing something after they have reached the age of majority. We have to start at the age of minority.

In the 1960s, I was chief social worker at the University of Maryland Hospital. Creativity is the key. There was a housing project near the hospital. Tenants using the hospital could not communicate with the doctors, so I started a citizens council to bridge the gap between the hospital and the community. It succeeded, and the people from the surrounding community ran the program. They got educated about medical services. Tenants shared information with other tenants. Communications between the hospital staff and the community was greatly improved.

Playing the Game: The Athletics/ Substance Abuse Connection

Moderator: **Robert O'Leary, Special Agent, Public Information, Drug Enforcement Administration**

Panelists: **Brig Owens, Partner, Bennett & Owens, Sports Management Team; former Washington Redskins player; and President of Super Teams, a drug prevention program for adolescents**

Ken Johnson, Sports World Ministries, Inc., New Tazewell, TN; former Cincinnati Bengals player

Darrell Green, Defensive Back, Washington Redskins

Summary of Introductory Remarks by Robert O'Leary

The DEA has allocated resources and manpower for a demand reduction program. DEA has joined with a group of professional athletes in establishing a sports drug awareness program. Things changed with the death of Len Bias; athletes do not want to create a bad image. Dave Winfield, of the New York Yankees, has formed the Winfield Foundation, an organization aimed at helping youth, and has worked with the DEA to produce a 17-minute film that exhorts youth to Just Say No to drugs. Narrated by Winfield, the film discusses prescription and illegal drugs and kids' ignorance about drug effects, and presents comments by doctors, addicts, and athletes.

Summary of Remarks by Brig Owens

Drugs are the most frightening thing we are dealing with in our lifetime because drugs are the only thing for which a person will give up everything. People will sell themselves and steal from the family. People across the Nation are concerned because youth are

becoming more involved with drugs—9-year-old dealers and users with beepers on their hips are in evidence in cities in different parts of the country. It is frightening because we are tampering with the lifeblood of our Nation. It took the deaths of Len Bias and Don Rogers, of the Cleveland Browns, to wake up the world. Big business, government, and law enforcement agents cannot do it alone. Individuals cannot do it alone. But working together, we can put a dent in the drug abuse problem.

Athletes are involved with drugs because, like others in society, they have problems. Teams do not want to be tested. They are not saying that they are against drug testing, but they are saying that what is needed is a strong educational system. If something is wrong, confront the individual with the problem, even if it is a superstar. The problem in sports is that the name of the game is to win. Coaches do anything to win. Urinalysis is not the cure-all. Only 65 percent of the tests are correct. Companies do not want to spend money for a high-quality test. Over-the-counter drugs can make a test positive.

Parents and groups are not educated about drug problems. We must open lines of communication to children because of the peer pressure. In 1981, the Super (Students United with Pros to Encourage Responsibility) Teams were started. The program involves professional football, basketball, and baseball athletes who work with 20-25 high school kids in a 5-day residential setting. The youth learn about the importance of family structure, how to deal with peer pressure (it is okay to say no), and academics. The youth are asked to take what they have learned back to the high schools, junior highs, and elementary schools. Nine schools in the Washington, DC, area are involved in the program.

The program has been successful: 30 percent of the students involved are on the honor roll; drug use has decreased in schools where the program has been implemented; and students who were trained helped to reduce suicide in their schools. In addition, "rap" rooms have been developed to deal with students experiencing problems. The program also deals with teenage pregnancy.

Before children enter the program, a 5-hour meeting is held with parents and a 3-hour meeting is held with school administrators and teachers to inform them about the program, because a lot of parents have alcohol and drug problems. We have had students who have gotten help for their families because they knew where the support systems were.

Athletes' involvement in the program, which continues to grow, is an added incentive for kids to participate. Many of the program participants did not realize that athletes care. They are telling young people that they do care by taking time out of their training. No matter how much we talk, it is the peers out there that can have them go one way or the other.

Summary of Remarks by Ken Johnson

I was attracted by the lifestyle and money in athletics. I thought that would fall into place if I became a pro, but it was a false assurance. Many athletes today are also deceived, and this can open the door to drugs.

Legal drugs are used all the time in football to stop injury pain and swelling. Then drugs are given to athletes to speed up the healing process. The drug influence is there all the time. Coaches and management are more interested in an athlete's performance. There is pressure on the athletes to play; they must produce or risk losing their jobs to other players.

With respect to illegal drugs, the Black athlete is the key target of drug dealers because of his finances and his visibility. Because athletes have no counseling and education about drugs, they are easy prey for dealers. Also, athletes think they must live up to a macho image.

Careers have been wiped out by drugs, and the drug problem is on the increase. I was helped by the Chapel Services Program, started in the National Football League in the early 1970s. It gave me a purpose in life beyond the football field. It helped to channel my problems, frustrations, and stress in a positive direction. It gave me a game plan for life. Athletes do not have a game plan for life; they have a game plan for a season, but not for a lifetime.

Sports World Ministries is an organization of 15 retired athletes who speak to high school students, sharing their experiences, telling how they have dealt with the drug problem and what helped them to overcome adversities. Young people are receptive to the message.

Summary of Remarks by Darrell Green

Only God will bring us out of this problem. As it is stated in Romans, Chapter 12: "For just as we have in one body many members, but the members do not all have the same function." We are all members of the same body—teachers, doctors, athletes—and we must pull together.

I have never had problems myself, but have witnessed people with drug problems. I have worked with programs whose goals were to prevent drug use among young people. There are many such groups—MADD, SADD, Super Teams. Athletes can only contribute to solving the problem; the real solution rests with the user. We are not going to conquer this problem overnight. But we must not give up; a quitter never wins.

I only deal with the drug problem outside of the world of sports. There are teammates with problems, but these are not the people with whom I work. The problems are so plentiful that it is as if they are coming in through the front door and the back door. It is mind-boggling sometimes, but as long as we have athletes who are interested and who care enough, we will have someone working on this problem. The Redskins, in some cases, have done a lot; in other cases, they are really doing nothing at all. I can get three or four guys out of 60; my job is to get the guys out. Kids are receptive.

The Government does a lot for kids. I have worked with the Department of Transportation in a program challenging kids to do well in academics, to stay out of drugs, and to do community service—work at old folks' homes and cleaning parks—to be a complete person.

My purpose for being here is to ask you to stay on the road. If we all quit, we are doomed. The kids are the lifeblood of society. I have two daughters, and it is scary to think that someone would offer them drugs. By God's grace, I did not get into drugs. I realized that a 140-pound defensive back cannot afford to get involved in drugs. There is no need for me to create hurdles for myself by doing drugs.

I get my message over by being honest. When speaking to kids at schools, you go into a room and get right to the point; other times, you go easy. Sometimes, you give medical information. Be open-minded, be willing to learn as much about the problem as possible. Some people help just to get personal credit. You should plan to be in the battle for the long haul. If you are not honest, open-minded, and sincere, kids will see right through you.

Major Discussion Points

I have worked in the prevention/education field for 14 years. I have mixed feelings about recovering athletes speaking to young people. Some of them look nice, macho. Young people say, "If athletes use drugs, why can't I, too."

It can be a problem sometimes. Recently, at a program for rehabilitating drug abusers, I wanted a speaker that had been involved and had gotten over the hump. You cannot eliminate those recovering from drugs; they are important. A recovering guy's message is just as strong as one from someone who was not involved.

A fully recovered person, who has experienced drug abuse, is a good example because there are so many people on drugs who do not have hope. When they see a recovered person, it gives them hope. Young people need hope.

It is the athlete's responsibility to screen the person and check on the time that he has been off drugs. I did not go with John Lucas (professional basketball player) even though I wanted him as part of the program.

People in the community can help fortify Black athletes against drug dealers by educating kids in elementary school. The problem is that the family structure is broken down; people are needed to help out, to be committed. Athletes are working with kids in the inner city, where positive role models are in great demand; kids need encouragement and support.

Showcasing Effective Networking Models

Moderator: **Dr. John Robertson, Chairman, Organizational Development Committee, National Black Alcoholism Council, Utica, NY**

Panelists: **Dr. Janice Stevenson, Chairperson, Black Mental Health Alliance, Baltimore, MD**

Avery Carter, Community Organizer, Oakland Parents in Action, Oakland, CA

Dr. Andrew B. James, Chairman, Black Congress on Health, Law, and Economics, Houston, TX

Maxine Womble, Chairperson, National Black Alcoholism Council, Chicago, IL

Summary of Remarks by Dr. John Robertson

The title of the Workshop is: Showcasing Effective Networking Models. I mentioned to our presenters earlier that I would like to modify the direction from that of perhaps showcasing, which I always think of in a very static and a very sedentary fashion, to one of talking about development, talking about progression, and talking about sharing of several of these models. I intend to just talk informally with you, to purely share, to say to you, "these are things that do work." Some of our presenters may talk also about things that have been tried that do not work, and therefore, save you some time and wear and tear. With that as an introduction, let us talk about the most effective methods.

I believe that our presentation will focus on models that will show the capabilities of individuals and organizations that are often underfunded and overworked. Many of them are unpaid for the efforts they make, but, despite that, are able to remain effective, creative, and viable in finding solutions that work.

Summary of Remarks by Dr. Janice Stevenson

The Black Mental Health Alliance came into existence in 1982. It was the idea of a social worker from Ethiopia who practices in the Veterans Administration Hospital in Baltimore. His name is Secor Wiltner. He had an idea about cooperation among Black mental health and minority mental health service providers. He went to a guy named Maxi Collier with that idea. Maxi is a Black psychiatrist in Baltimore. Maxi works in the health department, and the two of them thought that this was a good idea and presented it to other minority mental health professionals in the area. Baltimore City Health Department awarded us a grant for $70,000. We pulled together about 12 other minority mental health providers in Baltimore. In 1984, we hired Walter Wilson, who is our director and one of the most compulsive people I have ever met in my life. Walter puts in 18-hour days working on board-related activities and the Alliance, and we are very impressed with him. He just completed his Master's degree in Business Administration, which is his second Master's, and got accepted for law school. He starts law school in September in the evenings. He speaks five languages, went to college in Switzerland and England, and he is an overachiever. He has one person who works with him—our administrative assistant.

The board has several functions that are mandates of the Alliance. The Alliance has four main charges. The first is to take a decisive role in preserving the integrity of the Black family, which has traditionally been a wholesome and sustaining force in our community. Our organization must spearhead the community initiative that will revitalize the Black family.

Advocacy is our second goal. Our organization must become aware of and guard against past misconceptions and stereotypes which have been an integral part of certain criminal protocols in the misdiagnosis and treatment of our community. The Alliance has done this in many ways. One of the ways is through my radio show. The purpose of that show is to present mental health information to the general public. Another way is by promoting other Black and minority mental health professionals in the city to do as much public presentation of information as they can. One of the stereotypes in our community is that if you walk into a mental health clinic, it automatically means that you are crazy. Therefore, as Blacks, we will not utilize mental health clinics because we do not wish for anyone to call us crazy. One of the myths in the community is that we do not know who the Black providers are because once you guys get educated, you leave our community, you forget that we are here, and there is no one to serve us. If they see us as visible, viable people working in the community, then possibly that would make it easier for them to recognize that there is a problem that can be helped without them having to live with themselves as crazy.

Some of the board members are involved in various tasks. One of our board members directs the city division for Springfield State Hospital, another one is medical director for Spring Grove State Hospital, two of the primary State hospital facilities in Maryland.

Another one is presenting a concurrent workshop today; that is Nollie Wood, who is presenting on violence and substance abuse. He is working at the Centers for Disease Control, but before that he was coming out of the MPH program at Johns Hopkins University. Shirley Pulliam is a nurse at Liberty Medical Center, which used to be Provident Hospital, one of the main medical facilities in our city. Another board member is community director for one of the units at the Walter P. Carter Center in Baltimore, which is the third primary State mental health facility. Our board members are spread throughout the primary mental health system in the State and they work very hard on our board. Another board member is in private practice, spearheading a plan to set up a mentoring program for Black students in the private schools in the City of Baltimore.

We have worked very hard to make the work of our board members visible to the community, so that they will know we are alive, we are workable, and we have not left the community. Even if we do not live directly in the community, we are working hard. Part of that is the advocacy for education. We must advocate for the education of the Black community members who will specialize in the field of mental health in order to overcome the chronic shortage of professional Black personnel. We also must acquire the necessary expertise, either through additional education or by consulting established Black professionals familiar with Black family dynamics, so that we can assist and advise other mental health care providers in the delivery of culturally relevant treatment modalities. In that light, we have used our $70,000 a year for the past 3 years to conduct a number of training experiences throughout the State of Maryland.

Our last mission is to develop a viable research program that will enhance our understanding of Black psychopathology—delving deeply into causes and treatment possibilities available—and suggest new and more appropriate treatment modalities. To this end, we need to engage Black researchers with firsthand experience about Black family dynamics. That was our original charge—certainly an easy, achievable task, and I am sure we can do it with no problem.

What do we do? The Black Minority Mental Health Education Program is, at present, the one funded program administered by the Alliance. Its mission is to provide inservice education, through staff development programs, at various facilities that deliver mental health services in metropolitan Baltimore and southern Maryland. Our catchment area includes Anne Arundel County, Baltimore City, Baltimore County, Carroll County, Harford County, Howard County, Montgomery County, and Prince George's County, the primary urban areas in the State of Maryland. Our exposure through the training events is widespread.

The educational seminars that the program sponsors focus on cross-cultural issues that influence the effectiveness of minority mental health service delivery. This training is geared to psychiatrists, psychologists, clinical social workers, nurses, counselors, and other mental health care providers. The program engages the expertise of highly trained and experienced consultants to conduct specialized workshops aimed at sensitizing mental health professionals to the diverse and special needs of their minority clients. In that light, we have put on workshops about being Black, about being Asian American,

about being American Indian, and we put on several about being female. And we had absolutely no trouble finding speakers or topics for any of those categories.

Prior to scheduling an inservice training program at a treatment facility, the program director is required to complete a needs assessment questionnaire to identify issues of current interest to the staff based on the facility's target population. The survey is then followed up with an on-site visit to further tailor the educational program for the specific needs of the facility by making it as relevant to the staff as possible. The module, consisting of a workshop and symposium or a series of seminars, can then be developed for presentation. The presentations are designed to enhance the clinician's ability to understand and integrate cultural heritage and ethnic values into effective diagnostic treatment interventions. At the conclusion of each session or series, participants assess the overall quality of the module by evaluating its relativity to their educational needs as well as its adequacy regarding the depth and scope of coverage.

Part of our needs assessment and part of our evaluation process ask the facility about the number of minority staff they have, the identification of job categories occupied by minority staff, the number of minority clients served, the training of minority service providers, as well as the training of the majority service providers. As a result of the needs assessment, we are able to break down our evaluation based on whether or not it is effective for the minority providers and for the majority providers. We also have an idea of the demographics for minority and majority providers at all of the State facilities. We know how many Blacks, Asian Americans, American Indians, or in total they have hired—how many male, how many female—and we have an estimate about the composition of the client population. We know which agencies serve a lot of Black, Asian, or Hispanic clients, and so forth. We are able to use this information in the other mission that we have accepted, which is to lobby for the service needs of minority clients in the State of Maryland.

With the exception of major conferences, all the inservice training is conducted at the work site of the clinicians for whom it is intended. Many of the facilities are able to grant credits for continuing education. Also upon request, the Black Mental Health Alliance provides certificates for attendance. In addition to the small on-site workshops and seminars, which are overall staff development programs for the various facilities served, the Alliance sponsors at least two major, all-day, training events each year. One of these events is usually geared toward the entire public mental health delivery system within a particular jurisdiction. The other is usually regional or statewide in scope. The Minority Mental Health Education Program of the Alliance has exceeded its objective for each year of its existence.

Our goal for the current year is to provide 40 training programs for a total of 1,000 participants. As of December 1986, 19 programs have been attended by 330 participants. These include 16 on-site seminars and 3 full-day conferences. Not included in this list is a major 2-day conference that we sponsored in September that addressed the topic of Black-on-Black homicide. That workshop was attended by about 100 people. This year the Black Mental Health Alliance will focus much of its attention on mental health

issues affecting children or adolescents. In the coming year, 1987-88, we will target the topic, the quality of Black life.

One additional activity that we have undertaken this current year, resulting from a networking effort in which the Alliance was involved, is called Strategies Against the Violence Epidemic or Project SAVE. The Alliance received funding from the National Center for Neighborhood Enterprise to implement this program on a pilot basis. The program is a demonstration project consisting of a series of activities and programs designed to prevent violence in Baltimore City public schools. The goal of the project is to reduce the severity and frequency of violence that occurs in the schools and, ultimately, in the communities they serve. The participating school is located in southwest Baltimore where the project is expected to be conducted over a period of 6 months. It involves teachers, students, community organizations, and, particularly, students who are predisposed to violent behavior. A total of 88 staff members, 4 guidance counselors, and 1,500 students will be affected by this program. This represents the potential for sizable impact.

The Alliance and the Maryland Institute for Planning and Public Policy, a cosponsoring agency, intend to incorporate the results of the pilot project into plans for extending the program to other schools in Baltimore City. The goal of this project is to affect 15,000 adolescent students and 1,000 staff members (i.e., teachers, guidance counselors, and school psychologists).

This current year, the Alliance was able to implement two other goals that we had, one of which was the establishment of a dues-paying membership structure as one means of diversifying our fiscal base. Right now, we are at the whim of political smiles. We were almost wiped out a year and a half ago when somebody did not smile. This year, the board started a membership program. We now have four subcategories of membership; each contains its own fee structure and benefits. When we started advertising the membership plan, within 2 weeks we had 15 responses for membership. We have not launched a membership campaign, so most people do not know that we have memberships. And we are getting responses to it already; we like that.

The other project that we were able to complete successfully this year was the establishment of a newsletter called *Visions*. Its purpose is to provide up-to-date information deemed to be useful to mental health service providers, consumers, and community residents interested in the quality of service delivery to Blacks, other minorities, and special populations. The newsletter serves as a vehicle to stimulate community awareness of major issues affecting the mental health status of minorities throughout Maryland. The Alliance hopes to deliver vital information to the public, which will result in boosting the number of membership subscribers. The membership structure is expected to provide the organization with a core of volunteers that will enable the Alliance to broaden its impact in the larger community.

That is sort of who we are and what we do. We are a 15-member board, have a 2-person staff, and provide training throughout the State of Maryland. Our board currently has

active liaison relationships with the Institute of Public Policy and Planning and with the Black Congress on Health, Education, and Law. We also have active liaison relationships with the Baltimore Urban League, the Maryland Psychological Association, and the Institute for Urban Research in Baltimore City. We are actively working with the Institute for Urban Research at Morgan State University and the Urban League to develop a grant program for a center for minority research. We are a busy group.

How did we accomplish this? The attitude for the board is cooperation, not competition. There is enough work for all of us to be busy, we do not have to compete with each other. And we try to keep ourselves distracted from the fact that we work for the dollar. We try to work for the good of the community. It is up to me as board chair to set that tone and to make sure that it is followed through, and not sabotaged, within the rest of the Alliance. We have established relationships with viable agencies and persons within the community who have multiple agendas so that we can offer something for them as well as get something for ourselves.

My approach is very direct, very honest, and very open. People know that when I say something they can pretty much count on it. I set a tone in the board meeting that says, "We can talk about anything." For example, when we had our first white person join the board, that person expressed concern in private about being the token white and I was aware of that. When this person met with the board for the first time, I introduced him as our token white so that we could get that over with and out of the way. Then we were able to talk about it. Fortunately, he is a friend of mine, so he was not really offended by it. He was able to say that he resented being the only white on the board. That was important.

Another issue that I hope I have been able to model appropriately for the board through being honest, open, and direct is the ability to talk about how we carry out our own racism. We are real good at working down to our stereotypes. We must fight constantly against crabbiness and being inflexible, because we may buy into a pronouncement of ourselves that we do not like. If the majority culture says that we as Blacks must act in the following ways, on the Alliance board we try hard not to accept that, but to make sure that we have defined for ourselves how we will act and who we are. That takes a lot of work because a lot of times we are not aware of what we have internalized. We try to make sure that our agendas are met to our mutual benefit and that we are really clear about what needs to be done.

More than anything else, the Black Mental Health Alliance exists and survives out of luck. We have had people at the right place at the right time to get us a location, to get us monies, and to get us people who can do the job. We have been very lucky about getting people who have a shared purpose in doing our work. The Director of the Alliance and our administrative assistant put on all those workshops, they get all the speakers, they meet every deadline that the State and city health departments ask of us, and they are able to accomplish everything that board members ask of them.

I have stated some of the problems that we have already. One of them is that this is a working board, so when people come onto our board they know that. We have four committees in place: an education committee, which oversees the educational process; a finance committee; a community affairs committee; and a political committee. Shirley Pulliam is vice chair of the board and president of the Black Congress on Health, Law, and Economics, in Baltimore. It is a problem sometimes keeping the board members involved in an active, working way. We have a problem with lack of knowledge and expertise. We do not always know how to work the system as well as we can or as well as we need to. We try not to learn by error—sometimes we have no choice, but we try not to. That means that we on the board have to put a lot of energy into doing our homework and making sure we know who is out in the mental hygiene administration, for example, or who the Governor is holding in particular favor or disfavor when we may need some political information. We need to know who is being moved out of what part of what system within the State mental health delivery system so we can know who to access to help, or to not hinder, or to at least not get in our way.

At the State level, we need to have all of the people who are in positions of clout get together so that we can coordinate the work that we do. The Alliance is already trying to do that by making sure that we know, for example, that Sharon Jones is Medical Director at Spring Grove State Hospital and that she just got married and decided that she wants to stay home. That means then that the one Black medical director in a major State facility is leaving, and we want to make sure that she is replaced by someone Black. That takes work, and it is tiring. A lot of people do not like to do work outside of work. The biggest problem that we have is getting someone for the Alliance to write grants. We have people on our board who write grants as a part of their job. But getting them to write grants after hours, for our purposes, is a struggle. We have a problem with our evolution, we are growing and we are sort of building the skills as we go along. We are trying to find out what other systems in the Nation have already accomplished so we do not have to re-invent the wheel.

I mentioned overcoming our own racism and not accepting our own stereotypes. One mistake that we make, and I think we probably will remake, although we try not to make this one over and over again, occurs when members come on to our board. We have to make sure that we do the relationship-building work. One of the things that we learned is that, with Black people in particular, we have to do relationship-building work so we can do task-oriented work. I have seen people do it the other way around because they were socialized to be more task-oriented. But, with us, we have to ask how the kids are doing, have some continental breakfasts, shake hands, make sure we know who each other is before we can have any credibility at all with each other. We lost three board members by not doing that kind of work. They did not feel like they belonged. They were not part of the system, even though they were acclimated and given tasks to do. We had not bothered to let them know that we need them, that we like them, that we want them, that they have credibility. That is an important learning, because if we do not know our own information, about which we are teaching the rest of the State, then we will not integrate, and that was important for us to know.

We need to be flexible with people with full schedules, who are not quite sure who they are and what they are about as Blacks, to make sure that we allow them spaces to work that are nontraditional. Two of our board members are in law school in the evening so they cannot attend our board meetings. Attendance at board meetings is mandatory. So we have worked out ways that they can do committee work or other things for the office that are not part of active board work, and they still feel a part of the system.

Our board members are interested. They like what we do; they see it as an important mission. We have demonstrated that we have clout within the system. When we did the Black-on-Black homicide conference, we got a call from the Governor's office asking for the transcript of our tape. We did not realize someone had notified the television people; they came with their cameras to tape our speakers and to do a big thing about it. We needed to try to get the Black professionals there to hear the information, and now our transcript has gone to the Governor's office and has been incorporated into the Governor's Task Force on Violence in the State of Maryland. We have had several politicians come to us and ask for our endorsement. We do have openness and honesty throughout our system as much as we can control that. I think I helped set the tone for that.

For our future, we wish to set up the clearinghouse functions at the Institute for Urban Research at Morgan State so that we can continue to track who works where, if they are well trained, and if they have done a good job. People coming out of the graduate schools in the State of Maryland, or wherever, who enter the State of Maryland, can see us as a resource to find out where the jobs are. The people who hire minorities can see us as a resource to identify who is available for work. We already have professionals in the State letting us know when they are ready to change a job, because we already have systems in the State letting us know when they have openings. We need to formalize that.

We want to develop our indirect service system so that our speakers bureau is more effective. Right now it is workable, but there are a couple of holes in it. We need to upgrade our training program, and we need to expand our internship/externship program. Each year we get at least two students from Morgan's mental health program. We want to experiment so that we have one person for an entire year, possibly someone enrolled in a graduate program, maybe in business administration. We are trying to work that out to see what we can do with it. We have one far-flung goal that we do not know how to fit into place yet. We want to add an international perspective so that we can link up with the World Health Organization and with mental health service systems in the Caribbean and Africa. We already have board members who are from the Caribbean and from Africa. We have not quite determined how yet, but we will because we are motivated.

That is the Black Mental Health Alliance, and it is in existence because of networking. Its life is maintained because of networking. And its survival is assured because of networking.

Summary of Remarks by Avery Carter

Oakland Parents in Action is an organization that deals with drug use prevention and works primarily in elementary and secondary schools. It is primarily interested in mobilizing parents in North Oakland, as well as in trying to demonstrate how the principles promulgated by Oakland Parents in Action can be applied in other communities. We recognized that one of the ways of getting parents involved in what we are doing is through working with their children. Organizing their children, getting things that are interesting to their children, and getting things that their children want to do is an objective of ours and a means of reaching parents.

One of the other things that we wanted to make sure of is that we stayed away from politics. We did not want to involve ourselves in politics, and, as a consequence, we have not applied for Federal or State money. We have sought private funds to support the project. We stayed away from developing a board, basically because we wanted to avoid the little petty fights that occur. At the same time, there is no ending date established, if you will, for Oakland Parents in Action. There was no grand design set for the project that states that we are going to be in existence 2 years, 5 years, 10 years, or 3 years. Oakland Parents in Action will exist for as long as people support it and as long as we can generate funds and interest in the things that are going on in the community. The organization will continually change to meet the needs of the community, as it has changed over the course of the last 3 years.

The thing that has made us work, probably more effectively than most organizations in our city—and there are many organizations within Oakland—has been the ability of the individuals who work with the project to generate parents who support it—parents who develop effective networks and effective communications with all the other agencies and organizations within the city. We have been able to establish linkages with organizations in Oakland, San Francisco, and the surrounding counties, even up to Sacramento. Through our networking efforts we are able to share ideas on how to mobilize or organize communities. As a result, we have had individuals come and help us and we have gone and helped them to do various projects.

Our networking efforts also have extended outside of the State. For example, I got to go back home to Houston, for the first time since I was graduated from school—and I was graduated from school in 1962. I went back in 1986 to help an organization called Community Interaction organize its Just Say No program. I appeared on several TV programs as well to talk about organizing parent groups. I also established communications with people with whom I grew up, who are now sitting on various community boards, to get them to lend their support to prevention projects that were getting underway in Houston. Similar assistance has been provided in Arizona and Minnesota.

There are only two other staff people on Oakland Parents in Action. Each of us is able to work with people at all levels. We fit well together. We are able to work as a cohesive

group and are always mindful of the need to keep lines of communication open and information flowing to the communities we serve. If you are going to assemble a staff, their skills should complement one another and blend in such a way that will enable you to maximize the abilities of everybody.

The parents for whom we work have been able to assess when and where volunteers are needed. They pitch in—the teachers have pitched in, researchers have pitched in—to do many of the jobs that need to be done. We have worked with a number of different people who volunteered their services as the need arose. If a community organization is going to accomplish its objectives, its leadership has to be able to network effectively and involve the people that it is attempting to serve. You should generate trust with the community and avoid pursuing hidden agendas.

Because we do not have a board, we do not have the problem of finances and the fights that go with how the money is going to be spent. When we raise money for a specific project, it goes for that project. We do not have the kind of fights that would ordinarily take place within an organization around funds. Obviously, when we sit down and design a project on which we want to work and for which we want to raise funds, we strive for unanimity of opinion among the parents, the children, and the staff in terms of what we are raising the funds for and how they are to be spent.

There are organizations that have existed in Oakland for well over 20 years that evolved out of the 1960s. They grew up with a mentality that says, "We were the first here. It is our territory. We are going to be here to represent the community." And, basically, they have not changed their philosophy. To avoid conflict with those organizations, what we have typically done is work with them and let them decide in which ways they can contribute to the thing that we want to do in a particular area or part of the community. We do not do the same things in every community. We do not do the same thing in West Oakland that we do in East Oakland. We do not do the same thing in North Oakland that we do in West Oakland. The designs of the various projects have come about as the result of our ability to network with the people in different communities.

When looking at prevention, and establishing an organization on the sole basis of addressing prevention issues there, a number of problems are likely to be encountered. Some of the problems involve the very important issue of funds. How do you fund a prevention project? How long will it last? What will you do with your organization? Some of these questions were not really answered for us. We knew from where the initial funds would come; we knew where we would be able to raise some funds. But, then again, there were no definitive answers to the questions of how long the project was going to go, how much funding was going to be needed over X period of time, and how large the organization was going to be.

If you want to talk about doing something in the areas of prevention—working in schools and working with parents—you have to look at the fact that some organizations have a very limited focus. They can only focus on an issue for a set period of time after which they are going to have to change. Oakland Parents in Action is changing, and I

am sure that many of you will face those kinds of problems as your organizations begin to flourish and mature. You are going to have to evaluate what you have accomplished and chart your future direction based on past performance and future needs of the community. You are going to have to make some adjustments, or the organization will die.

We have to understand that when we talk about prevention, the students we are working with now are the future parents. When we talk prevention to someone in elementary school—that is where we started primarily—and we talk in junior high school, and we show them how to do things and we work with them to do it, we are teaching the next generation of parents. We are giving them some tools and some mechanisms with which to work. We also are developing a network among the students. There are two students with whom we work who now have formed a business. There have been a number of positive things that have developed out of our having brought a number of young people together. A network has developed among students which typically did not or would not exist. When you talk about networking, you have to look at a number of different things that are going on in your community.

I want to refer you to the guide that was developed based on the experience of Oakland Parents in Action. One of the odd things about organizing a community is you really do not think about what you do, you just do it. You do what is necessary and consistent with sound principles of community organization. This guide gives you plenty of information on how to set up a program such as ours for your community.

Summary of Remarks by Dr. Andrew B. James

Networking has probably been a part of all of our lives. This conference makes you focus on the word itself. I suspect that I as well as others are a product of networking. It has been a very big part of the Black community. In my own case, as far as I can remember, even as a child, my forefathers and some of my family who were older than I was at the time got in trouble, I guess, in Alabama. There was a network setup in getting that person out of Alabama, to Tennessee, and then to Kentucky and points north. Many times, as a child, I would awaken to the prayers, and the collection of monies, that were given to the individual who had a need to be somewhere else. That was real networking for a very immediate type of priority.

When I was standing in the back of the ballroom, talking with Dr. Stevenson, it was mentioned that she is from Texas, also. I happened to go to Texas. A colleague and friend of mine walked through the door and the first thing out of my mouth was, "What are you doing here?" Being a psychologist, he understood that that did not really mean anything but that I was really glad to see him. And I was. That person was Dr. Baylis Walker, who happens to be the President of the American Public Health Association, which is the largest association of public health people in this country. That was networking. Baylis and I go back a long way. When I came out of Central State . . . (It

is really a small world for us. The speaker at the luncheon tomorrow is Art Thomas who is now the President of Central State, from where I was graduated.) I would never have been graduated from that institution unless we had a networking program there. That was one place that did not mind letting you stay in college if you did not have any money. I never had any money until the end of the term. I went to college on an installment basis. I have earned several other degrees since then. None of them would have occurred unless I was able to get the first one. I got it because there was somebody in a position of authority and power who was willing to will it on my behalf. I said all that to say that about Baylis—and I am glad to see him. Baylis was the first to work in environmental health in the city of Dayton. I kind of looked up to him at that point. We all started by talking with each other and by going out for each other. That is the real networking and somehow we have to extend that personal networking to the community at large.

I recently saw a report by the U.S. Census Bureau that indicated Blacks are now living longer. In fact, the life expectancy for Black males, in 1981, averaged 66 years, and for Black females, 75 years. Whites still are expected to live about 4 years longer than Blacks; for males it is 71 years, and for females it is 79. So if we look at just being alive, we are doing better.

The health status of all Americans has improved. As I said before, life expectancy has increased. And this increase can be attributed, in part, to major advances in health and medical research, improved social and economic status, and major advances in general health delivery services and technology.

According to another colleague of mine, who is Dean of the Department of Public Health at the University of Massachusetts, these improvements are not consistent and equally distributed within the Black community. He presents a concept that he calls "a differential deficit ratio." I am going to use that concept without trying to explain it fully, for it overlaps the health and social indices for different population subgroups. Having an understanding of this concept, one can better analyze the impact of public health and other programs on subpopulations within a group. Black Americans particularly, who have suffered and continue to suffer disproportionately, according to my colleague, manifest an inordinately high negative differential ratio. This is the percentage of deficit absorbed between the Black population and white population. What it points out is that, though there are decreases in the existing rates of mortality or morbidity, there is still a difference.

In 1950, the death rate from all causes was 841.5 for 100,000 residents, and in 1980, 585.8 for 100,000—a 30.4-percent decrease for the overall population. At the same time, in 1950, the rate for Black males was 1,373.1 per 100,000 Black residents and for white males 745.3. In 1980, the death rate for Black males was 1,112.8 per 100,000 and for white males 745.3 per 100,000, for a difference of 367.5 per 100,000. You will note that even though the difference had decreased, the differential ratio built from all causes between Black and white males had increased from 42.6 percent to 49.3 percent, resulting in a 6.7 def[illegible]he 40-year period. For Black females, the death rate from all causes in 1950 was 1,106.7 per 100,000 residents, and for white females, 650 per

100,000 residents, with a difference of 456.7 and a differential ratio of 70.3 percent. By 1980, this gap had decreased to 56.3 percent for a decrease of 17.1 percent.

In a recent article, Barbara Jordan, who is a former Congresswoman from Houston, TX, and George Hacker, who is the director of alcohol policy at the Center for Science in the Public Interest in Washington, DC, painted a critical picture on the victimization of Blacks by the alcohol industry. Paraphrasing the article, it stated that despite the health and safety goals of the total community relative to alcohol-related fatalities, alcohol and alcoholism are still major problems—social and health problems—in Black America. The rate of cirrhosis is nearly two times higher among Black males than it is among white males. In some urban areas, the article pointed out, it was 3 to 12 times as high. The leading causes of excess death in the Black community—homicides, accidents, and cancer—indicate a correlation between these deaths and drinking and smoking. The rate of cancer of the esophagus (the cause of which is directly related to smoking and drinking) among Black males 35 to 49 years of age is 10 times that of their white counterparts. And to think of this disproportionate suffering, it would appear that the Black community is then targeted by alcohol producers for an intense sales and marketing program, primarily to increase their profits.

In Houston, the Black Caucus of Health Workers is monitoring a pilot program in 29 middle schools to induce young Black and other children to just say "no" to alcohol and drugs, which is part of the national program that we are talking about. We are convinced that, unless we can intervene at an early age, those values are already deformed, and we will be trying to repair the damage that has taken place.

Recently, I had an opportunity to attend an educational conference on cancer in the Black community in Houston, TX. A recurring theme of many of the papers presented was that the incidence of cancer was associated with race. That went for many cancers—your risk level increased if you happened to be Black. But oddly enough, this risk, while correlated with race, also varied with poverty. It appeared then that poverty is a heavy contributor to the cancer phenomenon. I want to paraphrase Dr. Walker again, who said this before I did: Poverty does not appear on the death certificate as a cause of death, but I suspect that it is a major contributor to Black mortality and Black morbidity.

In 1980, the population of the United States was enumerated by the Census Bureau to be approximately 226 million people. Of this total population, 76.7 percent were white Americans, 11.7 percent were Black Americans, 6.4 percent were Hispanic Americans, 1.5 percent were Asian Americans, 0.6 percent were Native Americans, and the rest were classified as other races. Comparing the population to the incidence of poverty based on 1980 data, of the total population of whites, 9.6 percent were at the poverty level, while in the Black population, 29.4 percent were in poverty. The rate of poverty prevailing in the Black community is about three times higher than that in the white community.

Now, most of us in health generally, and public health specifically, recognize that the indicator of physical, socioeconomic, and political well-being in the community often-

times used is the infant mortality rate. We use the infant mortality rate because we recognize that even though it has some limitations, it is universally accepted as a health indicator. The premise is that most civilized populations and societies will make an effort to preserve the life and well-being of their young. In the United States, the infant mortality rate has been decreasing for the overall population, and that is good. The overall parity between the Black population and the white population has been widening. In other words, the differential ratio does not portend parity in infant mortality between the Black and white community. And it does not portend that in the near future. The point being, we are not really closing the gap in infant mortality, which is such a sensitive indicator to health in the community. In fact, it has been widening for the last 30 years. The data are a clear indication of an inadequate distribution of health resources based on need in the Black community.

Why does the Black population infant mortality rate remain twice that of the white population? Do these data reflect a concerted effort to improve the overall socioeconomic, environmental, and physical well-being of Black Americans at the community level? This and related questions provided a genesis for organizing the Black Congress on Health, Law, and Economics.

The Black Congress on Health, Law, and Economics, referred to as BCHLE, is a growing federation of national organizations, over 10,000 members strong. It provides a forum for Black professionals to participate and shape national policy. It was the infant mortality rate, then, that brought BCHLE into existence. The simple idea was even though the rates were coming down, they were coming down with a bridge still between the populations. We want to see some convergence in those rates, and we have not yet seen that. Maybe what we need, then, is an excess of access to health so that we can converge those two areas.

The purpose of the Black Congress is to promote the educational, social, political, economic, and physical well-being of Black people by identifying and addressing issues that have an impact on their livelihood, and to effect the legal implementation of policies that will ensure improvement. We want to ensure greater cooperative effort among Black people and professionals in dealing with the health problems of the poor, to encourage Black health professionals to increase their knowledge by presenting the latest hard data on minority health matters, and to introduce, and then support as a collective body, resolutions addressing conclusions drawn from existing health data. Our charge is to raise the level of consciousness among our sponsoring organizations, Black professionals, and the national and world community in general on the need for Black professionals and for Black consumers of all income levels to help improve our educational, social, political, and economic status and to provide an ongoing process for legal implementation of the above objectives.

BCHLE is sponsored by six major Black organizations and supported by the following five participating Black organizations: the National Pharmaceutical Association, the National Bar Association, the Black Caucus of Health Workers of the American Public Health Association, the National Podiatry Association, and the National Optometric

Association. I want to point out that BCHLE is not a super policy board for its member organizations. It is, however, made up of some of the more powerful Black professional organizations in this country. They are not about to allow a board to decide what they are going to do, so what we do is just the opposite. It is a federation; it is not a super board. They tell us what it is they will commit themselves to do. I want to tell you that opinions are very sharp and that there is a lot of debate. But even though the opinions are sharp and the discussions sometimes spirited, when pulled into the subset of the Congress' agenda, each sponsoring organization's board of directors must approve the action of its representatives. While this may appear less than expedient, the mutuality of the sponsoring organizations when completed is an exceedingly powerful tool. Congressmen will listen to us. Heads of agencies will listen to us. State government will listen to us.

The Black Congress' Operation Taking Charge is an example of such a collaborative process. Only the sponsoring organizations that you see sitting around there can vote. But we have extended our presence into the community so that we have relationships not only with sponsoring organizations, but with participating organizations as well. Among those are the Black Psychologists, the BCHLE in Maryland, and the BCHLE in Mississippi. They are supporting members and we value their input, but they cannot vote. It is almost a moot point because by the time we have dealt with an issue, they have already helped to forge the policy.

Operation Taking Charge is the major program thrust for the Congress this year. It was adopted in response to Margaret Heckler's (DHHS) report on Black and minority health. The object of Operation Taking Charge is to help eliminate the more than 60,000 excess deaths the task force said occurred each year among minorities in six disease areas.

So how do we do that? We do that by having each one of the sponsoring organizations take one of the disease areas. For instance, the National Pharmaceutical Association decided it would take the area of chemical dependence. They are very active in that. One of the things they are doing is putting together a program that can be used in public schools all over the country. We are hoping to pilot test projects on several of the area's large school districts. The National Black Nurses Association, which is also a sponsoring member, is very active in health fairs around this country. They do a lot of screening and they have about five major programs going on.

The idea is to generate awareness in the six disease areas that were mentioned in the report, to communicate to the Black community that action is being taken to prevent occurrences of these health problems, to disseminate health information and educational materials, and to develop programs/strategies for dealing with these health problems.

We identified States that had a population of Blacks of 150,000 or more, and we targeted those States. We identified cities that had a Black population of 28,000 or more. We are establishing advisory committees for each of the identified health areas at the Federal

level. This committee will consist of members of the various health disciplines, M.D.s, D.D.S.s, R.N.s, and so forth. We have arranged to meet with the Office of Minority Health at least twice a year and report back what we have found all over the Nation in the various health areas. We follow the 10 Federal regions for dealing with health problems among Black Americans and assign one of our sponsoring organizations to each region.

The Black community in the United States has carried an inordinately heavy burden in terms of socioeconomic problems. Notwithstanding constitutional safeguards intended to remove the badges of slavery, statistics show that Black Americans are disproportionately represented in poor physical, social, and economic health. BCHLE, the Black Congressional Caucus, and other major Black professional groups are working together with their collective memberships to provide the needed leadership and to support legal action to address these problems. We can join with the Urban League, the National Association for the Advancement of Colored People (NAACP), and Black sororities and fraternities that are making an effort to address these problems. We have got to plan, organize, and work together to solve the problems that are really so crucial and critical to the survival of the Black community in this great Nation of ours.

Summary of Remarks by Maxine Womble

I would like to give you a brief history of the National Black Alcoholism Council (NBAC) and bring you up to date in terms of where we are today.

In 1978, a number of organizations were thinking and plotting and trying to get together to start a national organization. We had people in New York, California, Kansas, and Washington, DC, trying to start different organizations. Among the people attending Rutgers University's School of Alcohol Studies, were John Robertson and myself. In 1977, after hearing John Bland, who taught the only course in Black studies at the school, we began talking about forming an organization. We recognized that alcoholism is a severe problem in the Black community, the most serious in terms of its relationship to other health and social issues. We were unable to identify a single organization focused on the relationship between alcoholism and health and social issues in the Black community.

In 1978, John Robertson and Rose Cole brought together several organizations that had expressed an interest in forming a national federation to advocate for Black issues in regard to alcoholism in the Black community. Five organizations came to Howard University for a mini-conference, at which time the seeds of the organization were sown. We had a 2-day session, on October 7 and 8, to kind of battle it out. We talked about territorial ownership issues, and who was going to be the head of this organization, and all those things that go into the birthing of a new group. It was a very difficult 2 days of trying to come to grips with the fact that a national federation was needed to serve as

one voice. The groups assembled all agreed to join together and develop an organization.

As a result of considerable discussions, we merged our egos into one and came up with a steering committee, which was to lay the foundation for the organization. Peter Bell and Rev. R.B. Holmes were asked to cochair the organization. The steering committee's efforts, which were continued for 1 year, developed a set of bylaws and incorporated the group as a 501-C-3 organization. During this interim period, we established relationships with national and Federal organizations, including NIAAA and NIDA. We also developed relationships with Black congressional leaders. In short, we set the process in motion for the first board to be elected, and we planned the first national conference.

That first conference was held in Washington, DC, at the Skyline Inn. It is interesting, when you first start an organization, no one will have you in their hotel. The only hotel that would take us in was the Skyline Inn. We were very close at the time, and we brought in over 100 people. We had a great time.

People came back to Washington, DC, and we had most of the original people who were involved in the mini-conference. We established a membership fee of $35, which still has not been increased. We adopted our constitution and elected our first board of directors. At that time, it represented some 28 States. Carl Bontops from Massachusetts was elected the first chairperson of the National Black Alcoholism Council, which was the official adopted name of the organization. We included State chapters as part of our organizational structure. The organization, in terms of getting to the national board, is a bottom-up operation. If there is a State chapter, one must join the State chapter to be eligible to serve on the national board. If there is no State chapter, then individuals can join the national directly. State chapters hold annual meetings; during these meetings, two delegates are elected to serve on the national board. The national board then elects the executive committee, which consists of 12 people who carry out the business of the organization.

There are three at-large members on the national board, and four standing committees: research, education, and training; organizational development; public policy; and the national conference committee. There is also a chair—me. The vice-chair is Frances Brisbane. The treasurer is Tommy Kid. The secretary is Betty Fletcher.

It is through the State chapters that we begin our process of networking. We expect State chapters to adopt the national agenda and to carry it out on a community basis, where possible. Our State chapters have been very effective in terms of what they have been able to accomplish. We have, at the State level, begun to address the issue of advertising and its impact on drinking. In Ohio and Massachusetts, the State chapters took on Coors. That company was correlating its advertising expenditures to the increase in drinking among Blacks and Hispanics. Unfortunately, in Ohio, we did not have much success because we could not get support from the NAACP, the Urban League, and other Black organizations. In Massachusetts, however, they were a bit more

successful because they did network with other organizations who supported their efforts.

The chapters are also engaged in other activities. The New York State chapter hosts a breakfast each year for Black and Hispanic legislators to let them know their agenda. In Illinois, we have been very involved in counselor training. New York has also sponsored a number of training workshops to train counselors for certifications, a prerequisite to become qualified counselors. The certification exam is a wave of the future. And if Blacks cannot pass these exams then they cannot practice; they cannot be reimbursed for services rendered. Therefore, agencies will not hire them. We must reach out to people in our community to help prepare them for work in the field. This gives you an idea of how our State chapters are working.

As a means of communicating with our membership and the public, we established a newsletter in 1983. We wanted people to know who we are, where we are, and the kinds of things that we are doing. The newsletter also provided an opportunity for NBAC to publish articles. There is a dearth of information available on Blacks and alcohol. We encourage people to write articles that can be published in the newsletter.

The Institute is another one of our efforts that also was initiated in 1983. Our first class was offered in October 1983; it was a 3-day session. The Institute is now held in June of each year in cooperation with Howard University's School of Social Work. It is 1 week in duration and designed to increase the number of competent trained persons who are working with Black people. We have found that far more white people than Blacks work with Blacks in the alcohol field. It is important that we reach out and encourage them to come to the Institute so that they can learn more about how to work with a Black population. We have been able to sponsor the Institute with absolutely no money. We have been fortunate to have people volunteer their time to teach at the Institute an average of 10 hours a week, during the weekly session, and at least 5 hours during the 3-day session.

So we have been very fortunate and able to carry out our agenda through the use of volunteers who are also our friends—they are not always members of NBAC. They are, for example, Jay Chung, who is the President of Medgar Evers College and who was instrumental in helping us establish the relationship that we have with the Howard University School of Social Work. We have professors like Dr. Meyers from South Carolina and Dr. Edwin Nichols, who someone referenced earlier, who teach in our Institute. We have a number of other contacts, like Dr. Barr who is with the Black Psychologists. We are constantly networking. We pool our resources and ask people to volunteer.

In 1984, we started our Blacks Against Drunk Driving (BADD) campaign. At that time, drunk driving became a national issue, everybody was saying we need to stop drinking and driving. We developed a policy statement in support of the national effort and instituted a program that could be carried out at the State level. We had asked State chapters to conduct a series of community forums that included not only people working

in the alcoholism field, but religious groups, court officials, and other organizations, bringing them together to talk about the issue of alcohol-impaired driving. The ultimate purpose of the forums was to develop plans with community input to prevent alcohol abuse and alcohol-impaired driving. As part of our marketing strategy, we have developed novelty items like T-shirts with messages and key chains that have engraved on them the slogan, "Be Wise, Don't Drink and Drive." The proceeds from the sale of these little items are used to help support the organization. We suggest that you consider implementing some of the same strategies in your local communities that we have proven to be successful in getting local organizations and leaders involved in prevention programming efforts.

Conferences are another way in which we educated the public about alcohol abuse in the Black community. Our first conference, as I said, was in Washington, DC; the second one in Chicago; and the third, in New York. We try to select very timely topics and address some of the major issues. We call on people from across the country to come in and talk. They are not only NBAC members; we have people like Barr and Nichols. And anyone who has something of value that we need to hear is requested to present at the conference. Our next conference will be in Atlanta. We had originally planned to have our conference in Scottsdale, AZ, but in view of the Governor's position on Dr. Martin Luther King's birthday, we decided to move the conference to Atlanta. We also decided that we will not be going to any other State that does not recognize Martin Luther King's birthday as a State or National holiday.

In terms of our linkages with other organizations, we officially are members of the National Black Leadership Roundtable, headed by Congressman Fauntroy of Washington, DC. A member of NBAC serves as a liaison representative to the Advisory Council of NIAAA. We serve on the board of directors and the executive committee of the National Commission on Credentialing and in a number of other organizations on the State level.

Our areas of involvement include public policy, and we do that, as you have seen, through our BADD campaign and our public policy statement of opposing random drug testing and through a number of other ways, such as taking a stand on alcoholic beverage advertisements.

We are an advocacy group; we try to advocate for increased or effective services for Black people. One of our major tasks involves the dissemination of information about alcohol use in Black communities. We are trying, without any funds, to gather information and articles about alcohol use in Black communities so that we may serve as a clearinghouse for people needing to know how to combat alcohol abuse. This information is sent out at no charge. We have gotten numerous calls for information about the treatment of Black alcoholics and the daughters of alcoholics since the appearance of an article in *Essence* magazine about NBAC. If anyone has any articles, or if you know of any, please give them to us; we will be glad to get them out to people. Because of the lack of information, Frances Brisbane and I coedited a book called *The Treatment of*

Black Alcoholics. This book was published in 1985. All funds derived from the sale of the book go directly to support NBAC.

That basically is what we are all about. We are a voluntary organization without a funding base. We survive primarily on volunteerism. We have been in existence for 9 years, and I hope that we will be able to continue for a while longer. We plan to be around for a long time.

AIDS: Its Impact on All Segments of the Black Community

Moderator: **Beny Primm, M.D., Executive Director, Addiction Research and Treatment Corporation, Brooklyn, NY**

Panelists: **Harry Haverkos, M.D., Chief, Clinical Medicine Branch, Division of Clinical Research, NIDA, Rockville, MD**

Wayne Greaves, M.D., Chief, Division of Infectious Diseases, Howard University Hospital, Washington, DC

Rudolph Jackson, M.D., Professor and Chairman of the Department of Pediatrics, Morehouse School of Medicine, Atlanta, GA

Suki Ports, Director, Minority Task Force on AIDS, New York, NY

Summary of Introductory Remarks by Beny Primm, M.D.

The Centers for Disease Control (CDC) estimate that the number of AIDS cases among heterosexuals is about 4 percent nationally, 12 percent among Blacks, 1 percent among whites, and 4 percent among Hispanics. If it had been reported that 12 percent of white heterosexuals have AIDS, there would be an incredible focus by the media on education. We have to do the same thing. We must look at the AIDS statistics from a global perspective and a Black, minority perspective.

The media has tended to underreport the impact of AIDS among Blacks when compared to studies of urban populations that show a rise in the number of 18- to 30-year-old Blacks testing positive for the AIDS virus. The CDC does not want to hide this fact, but is sensitive to the problem with regard to race. The CDC thinks that it would be called racist if it called attention to the problem. But I want them to report the facts even at the risk of being called racists. I want them to save Black lives. You must encourage whites to be truthful and report facts. In 5 years, when deaths are occurring, they (whites) will be called genocidal, conspiratorial. It is better to be called racists now.

Summary of Remarks by Harry Haverkos, M.D.

In 1981, before AIDS became a problem, people began showing up with unusual cancers or infections as a result of a virus infection—human immunodeficiency virus (HIV). The national statistics show that those with AIDS are likely to die within 6 months to a year because of the unusual infections or cancers. Study of the military population shows that those who are healthy have less severe illnesses but have the infection and potentially can infect others who may develop AIDS, and, therefore, become carriers. AIDS represents the severe form of the infection. The number of people infected by the AIDS virus in the United States is estimated to be about 2 million. Of the 30,000 cases reported to the CDC between 1981 and 1987, more than 50 percent of the people have died; 80 to 90 percent of the survivors will be dead in the next year. In the last 3 months, 5,000 new cases have been identified, bringing the total to 35,000 as of spring 1987. Europe, Africa, Australia, and Asia also have had dramatic increases in AIDS cases in recent months.

In the United States, whites make up the majority of cases, but Blacks and Hispanics make up a sizable number of AIDS patients. AIDS is an urban disease—30 percent of the cases are in New York City—and Blacks and Hispanics make up much of the urban population. Blacks make up 22 percent of the AIDS cases in cities; 11 to 12 percent are Hispanics.

Gay men make up 90 percent of the white cases. Less than 50 percent of the Black cases are gay men, and just about 50 percent of Hispanic cases are gay men. IV drug users who are heterosexual and have heterosexual partners make up 12 percent of the AIDS cases. About 74 percent of the gay men with AIDS are white, 16 percent are Black, and 11 percent are Hispanic. But for IV drug users with AIDS, more than 50 percent are Black and 30 percent are Hispanic. It appears that the heterosexual spread of AIDS in the United States is arising from IV drug users, some of whom are prostitutes and sexually active heterosexuals.

Regarding the heterosexual contact breakdown with respect to race: for Haitians, not surprisingly, a strong percentage of AIDS cases are Black; for non-Haitians, of the American-born cases attributed to sexual contact, over 50 percent in the United States are Black, and a larger percent are Hispanic than white. So heterosexual contact and spread of AIDS in the United States appear to be happening more rapidly or sooner in Black populations than in white ones. This can be confirmed by pediatricians who see that children contracting AIDS through heterosexual transmission are likely to be Black and Hispanic.

NIDA has been working on the problem of AIDS and drug abuse among Blacks and Hispanics for the last few years. The budget to work on this problem has increased dramatically over 2 years. Two years ago, it was $500,000. Last year, it was about $7 million. This year it is $31 million. And next year (fiscal year 1988), we expect it to be

between $60 million and $70 million to institute a three-pronged approach primarily focusing on reducing IV drug abuse. The program includes support for: (1) research to learn more about drug abuse and AIDS—how to prevent the spread of the virus among drug abusers, encouraging them not to share needles—and to learn more about heterosexual and perinatal transmission; (2) sero prevalence monitoring studies to try to measure the rates of HIV infection among drug users in several cities to learn more about the extent of the problem; (3) demonstration projects involving community outreach activities in which community leaders are recruited to encourage IV drug users to enter treatment and to encourage the testing of their sexual partners; (4) information and education programs—educating counselors, developing adolescent outreach training, providing training for women drug abusers; and (5) communications—dealing with publications and videotapes for dissemination through drug treatment programs and other groups.

Summary of Remarks by Wayne Greaves, M.D.

There is a disproportionate number of AIDS cases among Blacks, who constitute about 25 percent of the total number of cases nationally. But this is not true in every locality. In the District of Columbia, Blacks are not disproportionately represented among the reported cases, but they are in Baltimore—this is related to IV drug use. In the DC area, gay people represent 91 percent of the cases; only 7 to 8 percent are IV drug users. Persons can be infected but have no symptoms.

Some have AIDS-related complex (ARC); then there is AIDS. Most reported AIDS cases in DC are in the gay population. At Howard University Hospital, 90 percent of the AIDS cases are homosexuals, not IV users. There is a concern because, in the outpatient clinics, 200 people have been infected with the virus but have not developed the disease; 90 percent of these are IV users. The next wave of cases is going to be IV users.

More than 50 percent of all women with AIDS are Black. Also, 58 percent of the children with AIDS are Black. If this trend continues, there will be a decrease or negative population growth in the Black community. This may affect all people—the hospitals who must care for patients, plus those who provide the care for patients. We need more Black medical professionals in the community to become more involved to form a cohesive unit—not only doctors and other health care people, but also leaders in the community. Even if you are biased against homosexual men, you will be touched by caring for someone young who was productive but whose life ebbs away and he dies. That kind of picture unfolding before your eyes will soften even the hardest heart among you.

With regard to the differences in patient populations, at Howard, the median survival time is 6 to 7 months from diagnosis, as compared to 14 to 18 months nationally. We see very little karposi sarcoma (skin cancer). Other factors regarding patients include their

poor access to health care, the lack of medical insurance (typical among Black and Hispanic patients), which may cause the AIDS patient to postpone seeking care, unemployment, and poor nutrition—the infection is likely to attack a poor immune system weakened by disease. Trying to find medical assistance is an enormous problem.

All these issues demand time and economic support. The disease has been particularly burdensome to the Black community. With regard to education and research, more money has been allocated for research. The press needs to report data and other information concerning the spread of the disease that are more relevant to the Black community. There is so much homophobia in the Black community that relatives of patients who die from AIDS often tell others that they got AIDS from IV drug use to hide the fact that they were gay. This is going to allow the disease to spread more and more. We do not have a formal education program at Howard focused on the community, but we are developing a comprehensive hospitalwide approach to educate patients and relatives. We, however, do have an ongoing program for staff. We want to initiate a broader effort to include a toll-free number for persons who have a need for information about the disease; and we would mail materials to persons requesting information about AIDS and how to reduce one's risk of contracting the disease.

With respect to research, we are caught in a vicious circle as a minority institution. To get research grants, we need to demonstrate a track record. If you do not have resources in the first place, and the university does not have enough money, you cannot demonstrate a track record. Tell your supervisor that when writing grants or requests for proposals, not only should they say study the transmission or epidemiology in the Black community, but they should start thinking of being more specific in asking minority institutions to look at this and other problems. They do it for minority businesses; why can't they start doing it for minority institutions? We should be the ones telling people in the Black community what is happening in the Black community. At least we should get a share of the pie.

Several projects are underway at Howard University, including:

- a prospective study of health care workers inadvertently exposed to the virus
- a study of infants born to pregnant mothers who have tested positive for the virus (The ongoing study involves 50 women, and there has been a high infection rate in the infants.)
- a study of prostitutes in the DC area (Fifty percent tested positive for the antibody, but publicity about the study has had a negative impact, and very few prostitutes have enrolled in the study since the story broke.)

Additional Remarks by Beny Primm, M.D.

In New York, once a minority IV user has been diagnosed as having AIDS, he or she lives for 13-18 weeks, compared to whites who may live up to 1 year, 18 months, or even 2 years. Homosexuals may live up to 4 or 5 years. The importance of this is that

in-the-closet IV users could be infected and infectious and be with a significant other sexually, and transmit the virus to that person. Sometimes a person can be in the closet for as long as 2 years, hiding drug use. The community has to be educated about this. The other thing is in-the-closet bisexual males, among whom are a great number of Blacks. Married men with families leading dual sexual lives can become infected with the virus and get AIDS.

In addition, at Harlem Hospital, a number of people have been diagnosed as having tuberculosis (TB). In Harlem, the incidence of TB is second only to that in Haiti in the western hemisphere, and Haiti is the poorest country in the world. Many people die of a weakened and impaired system before AIDS is diagnosed. They die of other diseases that might not be diagnosed as ARC or AIDS. Thus, the number of people who have died from causes secondary to the virus is grossly underreported.

Summary of Remarks by Rudolph Jackson, M.D.

We were saying a year ago that a disproportionate number of minority persons is involved in AIDS. No one took us up on this. Dr. Primm and I agreed to continue efforts as hard as we could because people did not want the fact to get out that a disproportionate number of Blacks are being reported to the CDC as having AIDS. The Public Health Service had been burned by the Haitian experience. Also, too much talk about minorities would turn off folks; there would be less funding available for research and other projects aimed at preventing the spread of AIDS. We agreed that it would be criminal to have those disproportionately affected by the epidemic unaware of the fact that AIDS affects all of us, particularly Blacks, Hispanics, and other minorities.

As of February 2, 1987, there were 30,000 AIDS cases in the United States; now (spring 1987), there are 35,600. States with the highest number of cases include New York, New Jersey, Florida, Texas, and California. In the Standard Metropolitan Statistical Areas of those States, the cities with the highest number of cases include New York, Newark, Miami, Houston, San Francisco, and Los Angeles. Together, they account for 60 percent of all cases. The "hot spots," as reported by *U.S. News and World Report*, include these cities (100,000 population) and several others—Atlanta, Ft. Lauderdale, and Dallas. Males represent 92 to 93 percent of all AIDS cases. The greatest number of these cases are men within the ages of 20 and 49. Of this age group, 50 percent of cases are men aged 30-39. For women, the greatest number of cases is for ages 20-29. Seventy percent of women who have contracted AIDS have been in the childbearing age group—defined in this case as being between 15 and 40 years of age. This has implications for a large number of children contracting AIDS. Of the cases reported to the CDC (there may be a 20- to 30-percent underreporting of cases), 60 percent are in the white community and 40 percent are in the minority community, with 25 percent Black, 14 percent Hispanic, and 1 percent others.

The AIDS virus is transmitted through sexual contact, sharing of needles, and through a transfusion in which a recipient receives contaminated blood. As of March 1985, when blood testing began, the blood supply has been 99 percent clean. But there is still a window in which one could register a negative antibody test, but still have the virus present. AIDS also is transmitted from an infected mother to her infant before or around the time of birth. Other statistics: 64 percent of males with AIDS are white; 21 percent are Black; 14 percent are Hispanic. Of the white males, 80 percent are homosexual, 12 percent bisexual. Of the Black males, 40 percent are homosexual or bisexual. Of Hispanic males, 49 percent are homosexual or bisexual. About 11 or 12 percent of the AIDS cases in males fall into the bisexual category. Thirteen percent of Black males with AIDS are bisexual. It is most difficult to get true bisexual figures because very few admit to being bisexual. With regard to IV drug use, 23 percent of American men have contracted AIDS this way. Blacks comprise 44 percent of this figure and Hispanics, 42 percent.

In comparing modes of transmission in the Black community, IV drug use is more prevalent than the other two methods. For Black women, IV drug abuse as it relates to contracting AIDS is the big problem. Women make up about 6.7 percent of AIDS cases; 50 percent of the cases are Black, 29 percent are white, and about 21 percent are Hispanic. Of the women who have contracted AIDS, the most frequent mode of transmission has been the IV-drug/contaminated-needle route. Of the Black women who have AIDS, 61 percent got it through this method. When you combine this percentage with that of the Black males, the greatest problem becomes clear—IV drug abuse.

About 23 percent of the women contracted AIDS through heterosexual involvement. Whites make up 19 percent of the total, Blacks 21 to 22 percent, and Hispanics 32 percent. It is important to recognize that IV drug abuse and heterosexual contact are the two major ways by which women have contracted the AIDS virus. Most infants—80 percent—have gotten AIDS from mothers, or there has been a parent who has been at risk for AIDS. The projection for the AIDS epidemic through 1991 is 270,000 total cases and 179,000 deaths.

In summary, minorities (Blacks and Hispanics) make up 40 percent of the adult/adolescent AIDS cases reported to the CDC. About 73 percent of the female cases reported are minorities—52 percent Black, 21 percent Hispanic. Of the heterosexual cases, 75 percent are minorities—up to 54 percent Black, the remainder Hispanic. Of the pediatric cases, 80 percent are minorities—60 percent Black, 20 percent Hispanic.

Since we do not have a cure for AIDS, providing information and education on risk-reduction measures seems to be the best way to deal with the problem. IV drug abuse is at the top of the list of modes for transmitting the virus, followed by sexual contact. Blacks constitute more than 50 percent of the females who are contracting AIDS. As a result, 60 percent of pediatric AIDS cases reported involve Blacks. We must be careful with statistics, but we must be mindful of the fact that we do have a problem in the minority community. And when it comes to IV drug abuse in the Black community, we have a major problem.

Summary of Remarks by Suki Ports

The Minority Task Force on AIDS was formed in January 1986. The upshot of a New York Council of Churches conference, it is the only community organization in New York to provide services to minority persons with AIDS and their families without regard for race, sexual preference, origin of AIDS, or age. The organization started with volunteers who worked in the evenings. It trained buddies to provide services to minorities with AIDS and provided emergency referral services and housing, bedding, food, and clothing. Volunteers moved furniture, baby sat, and paid light and phone bills. The organization has developed a brochure and is working on a script for a street theatre and on a picture book. Free meals and car fare also are provided.

New York has about one-third of the total AIDS cases in the country and the majority of pediatric cases. As of April 1987, 4,575 men in the city have AIDS, of which 2,305 are IV drug users. Of the 866 minority women with AIDS, 533 are IV users, another 188 are sex partners of men at risk. The 3,026 total cases—that is, men and women IV drug users and women who are sex partners of men at risk—are more than the total cases reported to the World Health Organization by any single nation in the world.

The Centers for Disease Control and New York statistics ignore Asians or Native Americans; they are categorized as "other" and "unknown." How can we awaken people to their vulnerability to AIDS if we classify them as "other"? It is truly someone else's disease then. Haitians are euphemistically categorized as "persons from countries where risks are unclear," primarily as a political response. There are an estimated 200,000 drug addicts in the United States. Of those, less than one-sixth are in methadone programs. Ninety percent of the infants with AIDS were born to Black or Hispanic women. The majority are drug users or sex partners of drug users. What do these high statistics mean and why are there so many addicts in New York City? New York City has more AIDS, TB, and drug abuse cases than any other city in the Nation. The State and city are playing catch up with the disease and the effects of the disease. We have indulged our abilities to politically ignore groups and to religiously rationalize and blame others instead of ourselves. We have been caught, by a tiny, relatively fragile virus, in the crisis that may mean the destruction of our financial ability to sustain a program in New York City. Let us look at what it means for thousands of youths to drop out of school each year. Public schools in New York City are primarily the point of entry and indoctrination of the poor and those with no choice. Dropouts end up in dead-end jobs, have limited reading ability, or may even be illiterate. Many have turned to drugs or crime-related activity. New York State incarceration figures show that most deaths during incarceration stem from AIDS or the drug-related crimes for which the prisoners were arrested in the first place.

Many minority youth, because they cannot do well in the community, wind up in the Job Corps or military—two places with mandatory HIV antibody testing. They come back with the stigma of having the virus or AIDS without any emotional counseling or any support program. They are also often homeless.

The disenfranchisement from families, due to the growing number of addicts and those who are gay or bisexual, has created a greater need for support groups, buddies, sensitive counseling, and education of families, none of which exist in proportion to the need. There is racism and the lack of sensitivity directed at persons who do not speak English well. If we care about what is going to happen to young people in this country who have AIDS, we have to develop an "AIDS Care Corps"—widows, people with grown children, experienced women who know what to do.

AIDS devastates individuals and families. For example, a grandmother had to spend 7 months in a hospital because there was not one nursing home bed for someone with AIDS in New York City. And there is a mother with AIDS who worries about her kids at home. There are women who desperately need respite care, somebody to help them. It is not true that we do not care. The numbers are too great, and the officials are not recognizing the AIDS crisis with the degree of seriousness demanded by the situation. We are going to see in New York City a wipeout of some of our youngsters; a wipeout of whole segments of the population because we are not looking at long-range goals regarding what we really want for society. Youngsters who are 12, 13, and 14 years old and experimenting with sex and drugs are going to be exposed to the virus. Six years from now, when they want to have a healthy baby, they are going to end up with a baby with AIDS.

Violence and Homicide: Another Facet of Substance Abuse

Moderator: **Garry Mendez, Director, Administration of Justice, National Urban League, Washington, DC**

Panelists: **Wali Shabazz, Crime Prevention Specialist, Tampa Urban League, Tampa, FL**

Dr. Nollie P. Wood, Division of Injury Epidemiology and Control, Centers for Disease Control, Atlanta, GA

Jeanne Spurlock, M.D., Deputy Medical Director, American Psychiatric Association, Washington, DC

Rudolph Sutton, Administrator, Philadelphia Injury Prevention Program, Department of Public Health, Philadelphia, PA

Summary of Remarks by Garry Mendez

We are going to look at violence, homicide, and substance abuse from an Afrocentric view of the world. We are talking about looking at it from our perspective. By Afrocentric, I mean us, African Americans. We want to put our collective African-American brains to work. So, turn off your European brains, and click on your African brains. There is a reason for this. We have had a long history of being able to solve our problems by coming together collectively as a people. We have moved away from that, and as we have moved away, we have had more and more problems. Now, what we are talking about is not a problem of white folks. This is not a session to come in and talk about what is wrong with white folks and what the white folks need to do. This is not about what the Federal Government needs to do. This is about what we need to do. We need to lead ourselves out of wherever we are. This is not up to anybody else. And I think one of our problems now is that we have been waiting for somebody else to lead us out, to show us the way. And so what I want us to do when we are in here today, at least for this 2 hours, is to think of ourselves as our own leaders and we will take ourselves out. Because we have had a rich—understand this, a long, rich history of solving problems in our community. It has not required that we go outside and ask someone else. Therefore, I know we can get back to that and we can do it again, if we decide to come together.

We will identify the problem from our view of the world and also come up with a solution from our view of the world, and the solution has to be what we can do. It has to be what we can do. It is not about "we need a new President of the United States" or anything like that. It is about what we as a people can do. I define this as a family affair. And I want you to think of us as a family. And if you go back and think about how your family dealt with problems when you were younger, they did not go outside, you know that. And you were told not to take the family business outside. Keep that business in the family and the family will solve the problems. The only thing that I request of the panelists is to tell us what we need to do. Do not tell us how bad it is. Everybody tells us how bad it is in our communities. We do not need to keep rehashing how bad it is, we agree.

Summary of Remarks by Wali Shabazz

I work at the Tampa Urban League as a crime prevention specialist. I go out into the high crime areas. You may have heard about a lot of the problems that have existed in the city of Tampa the past several months, and the riots that have occurred down there. I have been working in those areas for the past 3 years. It is my responsibility to work with the dope dealers, the parents, and the police department, to establish crime watches, and to serve as a buffer between local law enforcement and the Black community. I have had bricks thrown at me. I go into the prisons; I talk to young kids who are locked up in the institutions and who will come right back into the same neighborhoods in which I work.

Our theme is: Crime is not a part of our Black heritage. Crime is not a part of our Black heritage. As a race of people, African-American people, this is something that we all must keep in mind. We are not criminals by tradition. Ten percent of the people in our community commit 100 percent of the crime. I tell this to the white community repeatedly: We are not criminals; only 10 percent of the people in our community commit 100 percent of the crime in our community.

Traditionally, the Afro-American community is very religious. The Afro-American community is a hard-working community. Those of you 40 and over know that your parents always told you that you had to work harder than whites in order to be successful. We always had to work hard in order for us to come from slavery to dignity. That is not uncommon for us in America. We are very religious, very moral (at least we used to be) in what we consider right from wrong. We are very God fearing and peace loving, and we love America. So we are really the moral majority. As a matter of fact, we are really the original American people. Everybody else came here with a culture, ours was stripped from us and we have developed one that is strictly, purely American. The American Indian is not the original American, you are. Keep those points in mind.

There is a plot—whether you want to accept it or not; I am not being paranoid. There is a plot to destroy our young Black males, particularly. If you look at our movement

from 1555 to 1987, you will see that in the 400 years of slavery we experienced here in America, or the 300 and some odd years of chattel slavery we experienced here in America, the Black male—if this is a white, male-oriented society—the Black male is the number one enemy—potential enemy.

So we were emasculated, stripped of all sense of dignity, and not allowed to be successful in America. It only has been since the mid 1950s that you and I, as a race of people, really have begun to acquire dignity, collectively, through the civil rights movement. And I do not like to use the term "civil rights movement," because it is not really a civil rights movement. It is a struggle for human dignity, for civil rights you get through the courts when you want to be accepted as a human being. Those are not civil rights; those are human rights. Those are God-given rights, given to all human beings on the face of the planet earth. We need to stop allowing other people to dictate to us what we do, what we should be called, and where we should go. We need to come into rooms like this, do for ourselves, and come out with solutions to our problems. Once we do this, we will have more respect from the White House, the Black house, and every other house. But until we can collectively begin doing something for ourselves, we will continue to be looked at as boys and girls. No matter how many doctorate degrees there are on this podium, or how much money you have, or where you live, if you are not working collectively to improve the condition of the worst amongst you, you are still considered a boy or a girl.

We came through that era. In the 1950s, there was very little drug use in the African-American community. Drugs became more prevalent in the 1960s as we began to discard the robe of docility and began to fight back. Many of the young people running in the streets, throwing rocks and bricks, were rejecting—this is a very important point—the value system of their parents. Now, you reject one value system and do not replace it with another value system, and you are subject to every whim and emotion that blows in the environment. So, what was the whim and emotion blowing in the environment from which American society is still suffering? The ME-ology. The me generation—the immediate self-gratification: "I will do anything so that I can feel good right now."

Kids today do not realize that it is not uncommon to wake up in the morning feeling bad. We are not promised a good day every day of our lives. When we wake up in the morning, sometimes we feel bad. If they wake up in the morning and feel bad, they have to get something to feel good. Where did they get this idea? We gave it to them—you and I. When we were getting high and acting crazy, when we were out in the streets doing those kinds of things that we were doing in that era and rejecting the value system of our parents, we did not replace the value system of our parents with another value system. Consequently, you have a generation and a half right now that has grown up without a sense of values, morality, dignity, respect, or knowledge of who they are or where they are going. This is what we are confronted with today.

I am from Harlem, USA. We do not own anything there, except the drugs deposited in our community. DC—where you are now, drugs are sold in your community. It is not by accident. It is by design. It is by design because you and I do not have the courage to stand up and say, "hell, no, I am not going to allow people to come into my neighborhoods and do this."

What we are going to do is this. We have a program with the theme: Crime is not a part of our Black heritage. In our program, we take successful African Americans, like yourselves, especially African-American males who represent positive role models, back into these high-crime areas to share their experiences, to let some of these kids—who, for the most part, previously have not—experience a positive male image in their lives. We also take college students from the University of South Florida into these high-crime areas to talk to the young kids in terms of career planning.

We had a session last week in which we dealt with sex education. You would be surprised how ignorant a lot of the young boys and girls are in our poor communities. A girl told me that if she had sex with a person now she cannot get pregnant. These kids have way-out ideas about birth control and sex education. They do not have an understanding about what it means not to engage in the sexual act until they are ready to take on the responsibility that is implied by the act. We teach what it means to be responsible also. We took a premed student from the University of South Florida—an Afro-American, female, premed student—to teach the young girls sex education from the perspective of abstinence first.

We talk about male responsibility. We take professional athletes from the Tampa Bay Buccaneers to work with the young males. Even though the Buccaneers are a losing team, we have winners in terms of the athletes that participate in our projects. They will come and tell the kids, "I am a professional football player now; I make $400,000 a year. I'm also working on my MBA (Master of Business Administration degree). That should tell you young brothers that professional football is not the end. I am looking beyond professional football. Do not think that you are going to make it as a professional athlete."

We also take hard-working men that have dirt underneath their fingernails back to work with the young males. They do not always have a good grasp of the workings of the society, but they are hard-working, honest men. These are positive role models that we bring into the community to talk to the young kids.

We teach Black history, culture, art, and development because most of our children do not know the simple facts that Cleopatra was a woman of color, that Egyptians are people who look like us, that all Africans are not in the Tarzan syndrome, and that most of us—a lot of us—came from a great civilization in Africa. We need to teach our children a sense of dignity and pride so that we can combat the influences that they are experiencing in society.

Summary of Remarks by Dr. Nollie P. Wood

I am going to share some information about homicides—from a national perspective and from a local point of view—and end with a discussion of the Black family and the concept of networking.

In Detroit, a Black teenager, carrying a beeper, is involved in a fight over some bad drugs.

In Savannah, GA, a Black woman shoots and stabs her husband in an argument following a card game during which they had been drinking.

In Washington, a youth, hanging out with two other friends, kills another youth over a brand-name jacket, a hat, and a pair of Adidas tennis shoes.

In a Los Angeles bar, a fight erupts between two Black men following an argument over a baseball game.

These are all realistic pictures of Black homicide today. Although we make great strides nationally, the burden of Black homicide continues to be a problem of paramount concern to the Black community. Homicide is the leading cause of death for Blacks between 15 and 34 years of age. It is the third leading cause of premature death, and ranks fifth in all causes of death for Blacks overall. For Black males, it is the second leading cause of premature death. Approximately 50 percent of homicide victims are involved with alcohol. In a national survey conducted by Research Triangle Institute, approximately 10 percent of all homicides were drug related. But let me first show you what the national homicide picture looks like.

From 1970 through 1985, the homicide rate for Blacks was much higher than it was for whites. Recently, it has begun to drop. In 1981, the probability of becoming a murder victim for a Black male was 1 out of 28. Anytime you go down the street and see 28 Black males, you can figure that one of them has an excellent chance of becoming a homicide victim. Whether you are Black, white, male, or female, you are more likely to become a homicide victim between the ages of 20 and 34. However, Black males are at a sixfold risk and Black females are at a fourfold risk when compared with their white counterparts. The highest homicide rates are mostly in the south and west—the parts of the country where large numbers of Hispanics and Blacks are located. The weapon of choice is a gun, specifically a handgun. More Blacks use handguns than use any other weapon to kill each other. The majority of homicide victims, whether they are Black or white, know each other; they knew each other prior to the homicide.

There is a belief that most homicides are related to the commission of a felonious crime such as a robbery or burglary. This is not true. Most homicides evolve from arguments. The national data clearly show that alcohol and drug use account for a small percentage of the homicides.

If we look at Baltimore, we can see that Blacks in comparison to whites are at a greater risk for homicide. However, when you look at the rates of Blacks versus whites with regard to homicide victimization, Blacks are more likely to be involved in both felony offenses—robbery and burglary—and drug-related events that led to their deaths.

In New York, Blacks and Latinos have the greatest risk of homicidal death. Both Blacks and Latinos are also at higher risk for homicidal death due to drugs. They are also at high risk in regard to being involved in arguments and disputes.

Again, in Los Angeles, there is a discrepancy between risks among Blacks and whites. When examining the percentages of those whose blood-alcohol level was found to be over 100 milligrams, you see clearly that Blacks had higher amounts of alcohol in their blood than other homicide victims. Large numbers of Blacks who wind up being homicide victims in Los Angeles have alcohol in their blood; a large number of them are intoxicated at the time of the homicide.

Homicides occur in bars, in restaurants, in the streets, and at home. Alcohol is involved in a large percent of the incidents. Interestingly, it is not gang warfare that creates the homicide situation. It is physical fights or verbal arguments. The instruments used in these alcohol-related homicides are most often knives or something with a cutting nature.

Blacks who commit homicides have higher rates of alcohol use than other groups; they also have higher rates of substance use in regard to barbiturates. Blacks, aged 15 to 34, are more likely to have barbiturates—sleeping and other types of drugs—in their bodies.

In summary, we know that Black males between the ages of 15 and 34 are more likely to die from a homicide than any other cause, and that they are usually killed following an argument by someone they know. Though the national picture seems to indicate that most homicides are not drug related, clearly many of them are—alcohol and other substances are involved.

Frequently, white-run institutions, of which I am a part, control the collection and dissemination of information relating to circumstances in Black communities. We need to become more aware of the kinds of information available and utilize it to fit our needs. We also need to participate in the collection and assessment of data used to define the parameters of our environment. The challenge for us is to involve institutions, such as the Urban League and traditional Black colleges, in this process. We need to involve them in interpreting information and developing strategies focused on preventing drug use, homicide, and assaults in our communities.

A recent study indicates that there is not much difference in the profiles of people usually involved in fights. Of those who are likely to fight, 30 percent are Black and about 30 percent are white. The preliminary data indicate that the difference is Blacks are more likely to carry weapons and use them during fights than are whites. Now, what is that? Is there something cultural about carrying weapons? What is this sense of macho? What is it about? How can we intervene?

The challenge is to extend the concept of Black family and to engage Black institutions, such as the Urban League, similar organizations, and traditional Black colleges, in defining the situation for the Black community and in developing strategies that will make a difference in our community. We want to develop local problemsolving and extend our network so that we can share our successes with others. Frequently, we do not know what works and needlessly spend our resources reinventing the wheel. We can do so much better.

Summary of Remarks by Jeanne Spurlock, M.D.

The American Psychiatric Association is a membership organization of some 30,000-plus psychiatrists in this country. I am one of the deputy medical directors and director of the Office of National and Minority Affairs. My thesis is that a negative sense of self has a decided bearing on Black violence, as well as on self-destructiveness. I refer to the substance abuse and suicide that appears to be out of control in many parts of the Black community. My thesis is based on my professional experience and my observations as a child psychiatrist as well as an observer of children and their parents in public settings. I make particular reference to what I see about the relationships between Black parents and their children on the street, on public conveyances, and particularly in grocery stores. Following is a thumbnail sketch of my thesis and some suggestions about how we can go about remedying some of our problems.

First, I would like to stress that it is not my intention to suggest that a positive sense of self does not exist among many people in the Black community. I am going to skip over numerous illustrations to support this; however, I am sure you are aware of much that has been in the behavioral science literature to support this point of view. However, for any one of several reasons, some Black families have not provided an adequate head start, or a good start, or a healthy start for children. There is a downside to childrearing practices in parts of our community, a side that we can no longer ignore or afford to respond to by saying that that is a racist attitude of some investigator. Separate illustrations of the downside will be cited, and suggestions for modification in child care will be offered.

There is no one point at which we direct corrective measures toward the resolution of our problems. Rather, it is important to elicit support from various groups of interested and concerned people in our communities—lay people, professional people, and people from a broad age range. It is important for each group to address a particular segment of our problem.

Too many Black children are born in a poor state of physical health, which in turn is likely to mar or impair their psychological development. Too often, being born at risk stems from inadequate or poor prenatal care, which results from any one of a number of factors. The psychological immaturity of many of our adolescent mothers-to-be serves as a barrier to adequate prenatal care. The lack of concern for or disinterest in the growing fetus is not uncommon among pregnant women who are substance abusers. Thus, their babies are born with symptoms of withdrawal and often a too-poor physical and psychological start.

There are too many adolescents who long for motherhood, which many say they want because it will provide them with someone to love and someone to love them. These adolescents, too frequently, tire quickly of parenting responsibilities. This reference

however, is not to suggest my absence of empathy for these child mothers who have not had their own dependency needs met. It is not to suggest that I am unaware of the various external stresses, such as limited financial resources and poor and unsafe housing. However, we Black people cannot afford to disregard the child neglect and/or child abuse that so often becomes companion to parenthood of the very young and the very troubled. For example, a harsh demand—hush your mouth, child—is possibly the least damaging of insults to healthy psychological development, but even so we are aware that this measure of chastisement cuts off or impairs the healthy drive to question, to be curious. Far too often, untold results of the inhibition of the drive to question are compounded when coupled with rewards for normal inhibitory behavior, rather than safe exploratory behavior. I have seen this much, much too often in the projects, in unsafe housing conditions, where mothers, to protect their child's safety, inhibit any kind of curiosity. And this subsequently impairs their children's academic learning.

These two aspects of our overall problem can be resolved through sustained attention to "educating" the total of Black communities to the emotional needs of children and through massive efforts to make the home environment safe so Black children can explore without undue fear for their physical and psychological safety. The fundamentals of sexual education, parenting responsibilities, and healthy growth and development need to begin in the grade school years and continue at appropriate doses through the high school years. The responsibility should be broad, rather than limited to parents and teachers; we should seek assistance from the religious leadership, from the music industry—especially the lyricists—from the television producers and script writers, and from the comic strip authors. I recognize that I have suggested seeking assistance from those outside of the Black community, but let me remind you that the majority of the individuals and groups that I have mentioned do indeed exist within the Black community. If all the child's immediate environment can and will foster the development of the Black child's positive sense of self, we will have made giant steps.

I have not excluded Black teachers. Very often, as we become more educated and more middle class, we tend to separate ourselves from the growing underclass. Black teachers need to be reminded frequently that because kids live in the projects does not mean that they are not upwardly mobile. They must be reminded of their responsibility to foster positive self-esteem among Black children. That also is true of Black physicians, other health care professionals, and Black policymakers, especially those who work in the arena of public housing. We need to further emphasize the value of discipline. We have, in the Black community, tended to, especially since the 1960s, equate freedom with license or lack of discipline. We need to go back to the old ways.

Discipline is essential in developing self-confidence and self-respect. Children need discipline to grow and feel secure. This does not mean that the kids have to be beaten; it does not mean that kids have to be verbally abused—verbal abuse really impairs a child's positive self-esteem. I think of the mothers that I have seen—and some fathers—who shout at kids, verbally abuse them, call them negative names, and sometimes smack them around in public settings. Perhaps I have failed in doing anything about this, and maybe all of us need to get up a little bit of nerve to interfere, at least to say something, when we see this going on. If, perhaps, no more than to say, "It looks to me like you are

really having a lot of stress; is there any way I can help?" But be prepared to be cursed out.

A modification of Father Clement's (a Roman Catholic priest in Chicago) program might be useful. That is, religious and other community organizations should adopt single parents who have no extended family support and provide a respite from the stresses of parenting. Help as simple as babysitting children while mother shops for groceries has been of considerable support for more than a few families I have known.

I want to say one word about socialization through television, because we Black folks, adults as well as children, tend to rely on television as our source of entertainment to a greater extent than the majority of the community. Two programs, *Webster* and *Different Strokes*, have received broad acclaim in many pockets of the Black community. Certainly both boys in these two programs are smart. I think it is important, particularly for Black boys, to be smart. However, my personal opinion is that they are also smart alecky. But there is also another message that is given to many Black children. That is, if something, and God forbid, should happen to a Black child's parents, there is nobody in the Black community who gives a damn; a white couple or a white family will have to take care of these kids. This is the downside, and I think it impairs the positive self-image of youngsters. I have often recommended to parents that instead of television, they give their children tapes. There are audio tapes by Black actors. I think, particularly, of one by Brock Peters and Diana Sands of African folklore. These tapes have been very entertaining to many Black youngsters that I have known and have been used to deemphasize their interest in television.

I suggest that we, particularly those of us who are researchers or are in any way involved in research, and lay people, too, foster and promote research in the Black communities that relate to positive aspects, rather than pathology. There are many of us who came from poor backgrounds who have "made it." But nobody studies this. I think that we would be in a better position to resolve our problems if we could find out how it is that so many Black people escape the hazards and cruelty of the ghetto without becoming suicidal, being killed by their best friend, or dying of an overdose. These are things that I think all of us, lay and professional alike, have to promote, endorse, and get going so that we can correct the problems—not only correct the problems, but prevent the problems that face us.

Summary of Remarks by Rudolph Sutton

I am from the city of Philadelphia and, at the present time, I am the administrator for our Injury Prevention Program, which gives me an opportunity to take a look at all kinds of injuries, including those resulting from violence. We are trying right now to determine why it takes so long for people who are injured to be served, not only by the police and by the emergency medical service system, but at the hospital once they get there.

Last year, in north Philadelphia, a 22-year-old Black man was stabbed to death by another 26-year-old Black man. The 22-year-old man was the right age, because homicide for Black Philadelphians between the ages of 15 and 34 was the leading cause of death in 1984. The fact that these two men were brothers supports the claim that homicide most commonly occurs between people who know each other. There are tragedies like this one throughout our Black community. Reports have indicated that homicide and violence are so common in Black communities that very little or sometimes no newspaper coverage is allotted to them. This homicide, like the other approximately 23,000 per year, only shows the tip of the iceberg. Nonlethal violence takes a severe toll in the Black community in terms of injury, disability, economic loss, and disrupted home and community life.

The perpetrator in this case had exhibited signs of violence since his childhood, yet nothing had been done during his life to try to help him. The victim had sought help from a community mental health agency because he felt his life was out of control, and he was helpless to do anything about it. In this one case alone, the mother had to bury one son and attend the trial of the second. This was after losing another son 8 years earlier who was stabbed in the chest by an acquaintance during an argument.

Violence and homicide have long been addressed by various disciplines, which include sociology, psychology, and especially the criminal justice system. Understandably, perpetrators who commit fatal violence carry the wrath of society for justice and punishment. However, it is clear that the efforts of the law enforcement, judicial, and penal systems have not reduced or prevented homicides from being a leading cause of death. There exists, at best, only a minimum of prevention-oriented research. It is apparent that violence is in need of control. Society needs to change its concept of violence. It needs to dramatically reduce the level of violence and needs to decide how much violence is enough.

In addition to treating violence and homicide as crimes, they can and should be treated as diseases. The same three elements that are necessary for disease are necessary for violence and homicide. Namely, you need an agent, a host, and the environment. The public health community has begun to address violence because of its severe threat to the health of individual communities across the country. Victims of violence—the husbands, wives, children, friends, and neighbors—await the development of intervention strategies by researchers of the various disciplines, which now includes public health. If the public health community would put into violence, the same efforts it put into small pox, and recently into AIDS, we probably would soon see some control. However, the public health community is not batting a thousand in terms of improving the health of the disadvantaged. It is not enough to say that violence and homicide are as much public health issues as VD, TB, heart disease, or any other health threat, because Blacks are still being short-changed in every category of health.

Violence and homicide should be given top priority, even before the 1990 objectives for the Nation. Public health must join hands with every available discipline to develop integrated interventions. The community must see evidence of interagency coordination, cooperation, and communication, and that something is being done about the

issues now. The eradication of small pox is indicative of what can be done through dedication and service.

Homicide is a disease. In Black communities, it represents a devastating waste of young Black males in terms of many years of productive life lost. The cultivation of this disease, which threatens the health of all Black Americans, must be dealt with by applying existing public health concepts to prevent its occurrence. There is clearly a need for a multidisciplinary effort by public health professionals in collaboration with criminal justice and social service professionals. Homicide in the inner cities or urban Black areas with low socioeconomic conditions is symbolic of the numerous other health and social needs of these communities. TB, social disease, visual impairments, mental illness, unintentional and intentional injuries, alcohol and drug addiction, psychosis, and divorce are all important and need to be addressed by the public health community.

A goal of this conference is to stimulate action by Black communities at the grassroots level to eliminate alcohol and drug use problems. It is hoped that lessons have been learned from other Black community programs, such as free health care, drug abuse prevention and treatment, crime control, infant care, model cities, rat control, and many, many other programs for the people. It is impossible to develop any worthwhile injury prevention program without dealing with the institutions of poverty and racism. The availability of alcohol and drugs in the poor communities just may be by design. Federal, State, and local health agencies know about these problems and the lack of services and resources to combat them.

Community-based services, like shelters for battered women and rape crisis centers as well as other agency services, are needed throughout our communities. Many neighborhood facilities provide free services, such as those just mentioned, to residents who reside in a particular catchment area. But are these services free? Does anyone pay? Is there a cost?

Unfortunately, free programs are not free. They cost consumers a lot more in some instances than they are willing to pay. Some are so used to paying that they are not aware they do not have anything else left to give. Their dignity was taken by the system before they were born. Their pride or reasonable self-respect was taken during their youth and adult life. For those who have managed to survive to reach their older years, all they have left is time. Time to reflect on the promises for a better life. Time to continue to wait for better housing. Time to wait for providers to ask, "What do you think, or how should we do this?" Time to wait for surveys, interviews, and reports to verify that they have more heart disease, TB, VD, visual impairment, obesity, flat feet, bad teeth, bad attitudes, bad morals, and even bad breath. During their youth, they were convinced that they were less educated, less productive, less likely to succeed, and less likely to survive. In their waiting years, they have been convinced that they are less needed and less wanted. They have been lied to, promised much, cheated a lot, betrayed, and dehumanized, all in the name of programs.

I say, as the president of the American Public Health Association said all the way back in 1968, "Something is wrong when despite medical care, Medicare, and Medicaid, and

a variety of medical and hospital insurance plans, we still have two systems of medical care—one for those of preferred socioeconomic status, and one for the poor—and despite all of the great advances this country has made in medical technology, millions of people are not receiving the benefits of these advances."

In 1985, according to *Nation's Health* magazine, the national health expenditure was $425 billion. The American poor have been x rayed, surveyed, and studied more than rats, roaches, and flies. We know that something is wrong. We know that we want to do something about homicides and violence in the Black community. Let us do it.

Major Discussion Points

We talk about homicide as being a disease; I think self-hate is a disease. There is a program in Detroit that we refer to as an athletic enrichment program. We place kids into a situation in which they play basketball on the court and then put them in workshops for enrichment. One of the things that I noticed with these kids is when they get out on the court with each other and one of them does something good, the others pat him on the back. But when they get up in the classroom and one of them stands up to respond to a question or make a comment, they laugh at him. Why do kids laugh at each other when they are trying to do something like that? It makes me think that they do not like themselves, and they do not like each other. Until we begin to learn to love ourselves and love each other, we are going to have this problem of fighting among ourselves and trying to hurt each other.

We need to find a way to help kids see intellectual achievement as being part of our Black heritage. Too many Black kids today see being smart academically as being white, or acting white, or not being one of us. One way to show our kids that being smart is part of being Black is to let our kids know something about Black history. It should be a part of Sunday school lessons. It should be a part of dinner conversations. We need to instill this into our kids any way that we can.

Years ago, when I was growing up, the doctor lived in my neighborhood. I knew the lawyer. I knew the doctor. I knew the businessmen. Now these people live somewhere else.

There are Black models in the Black communities that maybe you and I, as professionals, do not see as positive role models. In Alice Children's book, called *A Hero Ain't Nothing But a Sandwich*, she talks about a stepfather's conversation with a well-trained counselor in which he admonishes the counselor to relate to him and not to some football player or movie star that the counselor is suggesting the parents should have as their role model for their kids. There are janitors and garbage collectors who can and do serve as effective role models. There are all kinds of people in the community. In some of the work that James Comer has done in the public school system in New Haven, CT, he has noted that there are a lot of positive Black role models that we often disregard since we have become so educated. In the book by James Comer, *American*

Violence in Public Policy, there is a whole chapter on Black-on-Black crime and self-esteem.

How children deal with rage is a real issue in relation to children growing up and learning how to resolve difficulties and differences and at the same time being able to be friends. Some studies have been done at the Prevention and Intervention Research Center out at the National Institute on Mental Health (NIMH); those are the centers that frequently target young children. Specifically, one of the things that can be done to help children deal with their rage is to have local civic groups, religious groups, and community organizations have community workshops. For instance, you talk about academics and so forth, and you begin to discuss the importance of structuring the home environment with regard to that. There is a designated time and place to study, and it is encouraged around that. You also begin to train kids through the use of stories and pictures. You need to demonstrate to them how to resolve conflicts within themselves. You bring siblings together and you talk about conflict resolution. It also involves training kids as early as possible in good-neighbor games, teaching each other how to be good neighbors and how to develop alternatives. You are developing two types of skills; one is decisionmaking and the other may be classified as social competence and conflict resolution. You think of it just like a booster shot. You get a booster shot when you need it. Think of these kids in their first grade; they need a shot of how to resolve conflicts, how to deal with peers, how to share, and how to be friends and be supportive. You develop these skills early. You develop them at home, at school, and in the community.

One of the things that we do in Tampa is have a cadre of volunteers. (It is very important that we encourage volunteerism in our communities, because we do not have unlimited financial resources or an economic base, but we do have people resources.) We network with Black social workers in Tampa, and they teach parenting skills to the parents in the high crime areas. Parenting is probably the most difficult role that any woman can have. The way we were raised as kids and how kids are raised today cannot be compared. We are so technical today; it is a very complicated world, and the stress factors are much higher. We need to be more sophisticated in how we raise our children.

There is a lot of good parenting in the Black, crime-ridden communities. We have to look at that. Many of the mothers who live in these communities are going to suburbia to raise children. Let us not forget about that. One of the issues that we have to address is how to relieve the stress that many parents in inner city, crime-ridden communities are experiencing. We can do that through building support systems. I do not mean to disregard or to say that social workers or other professionals cannot be a part of those support systems. But one of the things is to relieve the stress that very often culminates in rage.

The more we talk about this, the bigger the problem becomes. As I said earlier, it is like an iceberg with just the tip sticking up. I have always felt that our kids belong to all of us. I know that my mother and father did not raise me; every adult raised me. I think we need to get back to that concept. There were some things that were said today which indicate to me that Black men at one time had joy in their hearts. It sounds strange to

have joy and pride in your heart even in chains and shackles, but we had that. We had something that we have lost. Our problem today is that you do not feel like you are a successful Black person unless you can get that Mercedes Benz or that Rolls Royce. Those things are important, but there are basic things that we need first. We have lost our perspective on those basic things.

We talked previously about the issue of AIDS. What is the main concern about the issues of AIDS? The concern is the notion of spread. Let us apply that notion to interpersonal problems in our Black community. It is known that children who are exposed to violence on TV—and we know that our rate of exposure to TV violence is higher than is whites'—who have witnessed or been a part of violence early in their lives, are more likely to wind up being victims of violence or homicide later in life.

What are some communities doing? They are getting together. They are making sure that police departments, local health departments, and their traditional Black colleges work together. Those are some things we need to do to make sure our community, our agencies, and our legislators are responsive so that we can provide that kind of networking. We network here; let us network our organizations.

I am the director of a program that deals with perpetrators of some of these crimes that we talked about today in Harrisburg, PA. The agency I work with—Help House, Inc.—is a small, private facility for pre-release offenders. Many of the people we see in the program are young, Black males. We have a strong counseling component which deals with how they got into these kinds of troubles in the first place. Most of them indicate they were using alcohol or drugs.

Many of our children and youth get into double binds; we tell them one thing and then they see another. One of the issues is that we do not teach our children—or we have not been taught—how to use alcohol. It is interesting, for example, that in many of our denominations there is a lot of alcohol use among those who are supposed to abstain. There are some real issues we need to address related to alcohol and other substances. We need to be very clear and open about that, and be very honest with our children and talk with them about it.

We must initiate a Black family reconstruction process. We have to put the Black family back together; no one else can do that. And the most irresponsible people in the country are Black males. I know it looks bad for me saying that since you know I am a substance abuser from the past and you might think I am still there, but the bottom line is, until Black males take responsibility for the Black community, nothing is going to happen. If that is the focus, all other things will fall in line.

We cannot leave the Black female off the hook. I want to say this in regard to girls: we have to help our girl children understand that being beaten is not equated with love. Let me give you one example. On a playground in a grammar school, the teacher intervened in a fight. A boy was hitting a girl. The girl said to the teacher, "He didn't mean any harm, Mrs. Jones, he did that because he loves me. I shouldn't have been

talking to the other boy." I think that this is tied in with the lyrics of some of today's music. We need to involve people at every level in the community to help them—help us—to help our kids understand that you do not have to be beaten, you should not be beaten, to be shown that you are loved. That is another bit of violence that is really overwhelming in the Black community.

If we really understand who we are, we can change the structure of the family. Think of it in these terms, the family is a total family. The problem you are having is trying to get individual families who do not have the strength of the total community, and that is us. The Afro-American people do not provide the strength our individual families need. We can restructure and understand that we are a big family and everybody in the family needs help. If we do not help the people in the family, do not expect those individual families to be able to make it. That is why it is important for us to open that family up. Our task then, is to reconstruct the family.

Alcohol and Drug Abuse in the Workplace

Moderator: J. Michael Walsh, Ph.D., Director, Office of Workplace Initiatives, NIDA, Rockville, MD

Panelists: David R. Burmaster, Physician Assistant, Office of Medical Services, Ashland Petroleum, Ashland, KY

Dr. Murriel Gray, Employee Assistance Programs, United Airlines, Washington, DC

Melva Daniels, Director, Employee Assistance Program, Amtrak, Washington, DC

Summary of Remarks by J. Michael Walsh, Ph.D.

The problem of drug abuse has gained considerable visibility in the last year. Congress passed the 1986 Anti-Drug Abuse Act in October. The President signed an Executive order in September calling for a drug-free workplace. An outcome of this activity has been the establishment of the office that I direct to coordinate Federal activities regarding the Government's policies about drug use in the workplace and to assist the Department of Labor and the private sector in providing technical assistance to business and industry across the country.

A consensus has developed among business, labor, and industry that the workplace is an appropriate place to begin to deal with individual substance abusers. The issue is how to implement substance abuse programs in an effective way that is fair to the employee. At the same time, there is an intensity surrounding the issue of drug testing, reaching hysteria in some cases. Wild accusations on both sides have led to ill-conceived company policies and the proposal of some bad legislation. My office has tried to go around the country and provide technical assistance to business and labor to try to achieve fair policies that respect the individual's privacy and rights.

The workplace programs are probably the Nation's best prospect at turning around the problem of drug abuse in this country. But to be effective, they must be carried out intelligently. This panel is unique in that it represents companies that have developed programs and policies and have gone through a very difficult process of bringing

together all of the resources of the company—security, medical, employee assistance—and getting them to agree on how to deal with substance abuse in the workplace. When you bring the various groups within a company together, believe me, you must exercise good judgment, have a good grasp of issues, and be an astute organizer. The security guy has his own opinion, which is different from that of the medical department and employee assistance program personnel. For the corporate officer, the bottom line is the thing—what is cost-effective. These difficult issues require a delicate balancing act.

Summary of Remarks by David R. Burmaster

Drug abuse costs industry from $40 billion to $100 billion a year. But it really does not cost industry anything. It costs you and I, the consumer, through increase in costs of consumer goods and services.

The problem of substance abuse is that for many years it has been treated with the ostrich approach—put your head in the sand, and it will go away. But it does not; for example, within recent years, there has been an increase in the use of cocaine in the workplace.

Industry has to face the problem of dealing with the corporate drug pusher, the individual who can supply drugs to the workforce on company time, the individual who enjoys company benefits—paid vacation, stock option plans, and even unemployment insurance if he is terminated. It is difficult to identify these people; they blend into the workforce. They have many different jobs, many different faces. But if they are identified, the worst that happens is that they are terminated. Many companies are so embarrassed when this happens in the workplace that they permit these people to draw unemployment benefits, and sometimes almost pay them to leave the area. Industry suffers losses through such things as theft, poor productivity, poor quality of work, and poor attitude and morale. The individual in the workplace can exchange computer hardware and software directly for drugs. It is convenient for employees. It almost encourages company theft to have these people in the workplace.

Industry has tried to curb drug abuse by implementing drug screening or substance abuse programs. There is a definite difference between the two. Drug screening, by itself, does not mean that a substance abuse program has been implemented. Many times, industry, upon discovering the existence of a drug problem, overreacts and puts in drug screening procedures. Much to their chagrin, after testing employees, they find out that there is an over 35-percent positive rate. You cannot eliminate 35 percent of your workforce. So something has to be done.

A substance abuse program, first and foremost, must be established as a matter of policy—a policy that is fair and just for the employer and the employee. The program should ensure the health, safety, and well-being of the worker in the workplace. Also, the program should guarantee that the employer, who is paying for 100 percent of the employee's capability, is getting a fair shake for his dollar. The policy must not dis-

criminate against anyone; what goes in the board room, goes in the tool room. It has to apply to everyone, even contract personnel who may be in your workplace. Secondly, there should be provisions for drug testing or screening. Thirdly, an adequate employee assistance program should be implemented. The program should be able to handle financial, marital, family, and other such problems, as well as substance abuse problems. Lastly, there should be a provision for retesting and followup. Employers tell me that if they are going to invest from $7,000 to $25,000 to put someone through a detoxification program and a rehabilitation program, they want to make sure that their money is well spent. They need some sort of insurance that the employees are at least following their end of the bargain.

Testing is a hot item. There are many, many categories of testing. Testing can be broken down into private-sector testing and public-sector testing, that is, Federal, State, and local government. Individuals who have private companies have the freedom to do what they want with regard to setting up drug testing and substance abuse programs. They may only want to implement a drug screening program, and their solution to the problem of substance abuse in the workplace may be termination. They still have to implement a program fairly, but they do not have to follow through with rehabilitation.

In the private sector, testing is usually broken down into four categories. Pre-employment testing is being used more than the other three. Many employers, once an individual has been evaluated by personnel or human resources, will have the prospective employee evaluated by the medical department, which administers drug screening as part of the medical evaluation. If the individual tests positive, more often than not, the person will not be hired. Occasionally, however, a company will allow an individual to reapply and be hired within 6 weeks to 6 months. Many times, individuals who pass the pre-employment drug screening have better attendance at work, have better merit reviews at 6- and 12- month intervals, and tend to be better producers.

The second type of screening is for cause. Cause testing is for absenteeism, Monday and Friday absence problems, reoccurring illness and injuries, poor production, poor morale and attitude, change of personality, and fighting at work. An important part of cause testing is the implementation of supervisory training. The supervisor is usually the person who has to document an employee who may be tested for cause. It is important that supervisory personnel are trained appropriately to correctly recognize substance abuse problems among employees.

The third type of drug screening—and I am absolutely not in favor of this type—is incident testing, testing after an accident or incident. It is like closing the barn door after the horse is out. Someone runs another person over with a front loader; something gets dropped on someone's head. You test the persons responsible for the accident, and they are positive for drugs. The man is still dead; the company is still liable. It really does not benefit anyone, in my opinion.

Last is the most controversial of all drug screening—random testing. It is an insurance that the work force can remain drug free. There are questions about such issues as discrimination and the right to privacy. Proper random testing means that you test the entire shift, the entire department, an entire day's workers, what have you, but you test

an entire group. Also, if you are going to implement random testing procedures, I recommend that everybody be tested randomly sooner or later. Do it by lottery. Random testing is not being used widely.

We are seeing some positive things about drug screening and drug abuse programs. Companies benefit from the drug screening, the time, and the rehabilitation costs that they have invested in an employee by getting the employee back in the workforce—a person who is already trained. This improves the morale of the workforce. In addition, the person who has been given a second chance will many times be more productive than before he became a drug abuser. He becomes a role model, an example in the workforce. People who might have been afraid to come out are now coming out and saying, "Hey, if he can beat it; I can beat it." It can have a domino effect.

Also, new meaning is given to the family. A rehabilitated father becomes a role model to the family. Assuming he was a cocaine user, he now has more money to spend at home. The family unit, we hope, can come together and support him after rehabilitation. The community benefits; the individual is off the street. He has more money, and maybe he is going to take better care of himself, his family, and his home.

The individual benefits the most. His self-confidence and self-respect have been restored. He knows that he can return to the workplace and have a productive life.

From my experience, with respect to Blacks and minorities undergoing pre-employment testing, Blacks have had no higher incidence rates of positive drug screens than have nonminorities. The same applies to random testing and other facets of drug screening. From 10 to 50 percent of Black individuals tested during pre-employment screening will test positive. The same percentage holds for the nonminority community. Many times, the major companies on the west coast have to do 50 pre-employment screenings just to hire 25 people. The rates of abuse are that high.

As far as substance abuse being an issue pertaining only to minorities, that simply is not true. The problem is not just an urban problem, a ghetto problem, a suburban problem, or a rural problem. All communities are involved in substance abuse in one way or the other. Industry, by itself, cannot combat the problem of substance abuse. It has to be a joint effort involving the family, the community, religious groups, the workplace, and government at all levels.

Summary of Remarks by Dr. Murriel Gray

I came prepared to talk about designing employee assistance programs (EAPs) to meet the needs of Black clients. Black clients are not a homogeneous group. There are differences as well as similarities. Some of those differences get to be barriers. The differences may be socioeconomic, cultural, historical, or ancestral. There are differences related to the degree of acculturation and, more important, to the desire to acculturate. It is important to view Black clients on all of these levels.

There are barriers that Black clients might bring to the program.

- Reluctance to self-disclose. This is not unique to Blacks, but the degree to which this tendency exists is greater among Blacks. When Blacks have admitted to having a substance abuse problem in the past, for the most part, it has gotten them into trouble. So, it is understandable that someone would not self-disclose, particularly if they are with an organization that is predominantly white. But the issue is not only for Black clients. Others are concerned about the issue because there is a desire to separate one's work from one's personal life.
- Perception. When you are dealing with a white organization, and if the primary counselor is not Black, there is the perception of the organization as being insensitive. For the most part, the Black client is going to expect the counselor to be insensitive, and, unfortunately, too often, the counselor may be.

The EAPs set up barriers, too. They inadvertently set up barriers for all people, but especially for Black clients.

- Lack of recognition. This is particularly true if the counselor is not Black. Counselors do not attempt to really learn the background of the Black person, or to recognize that this Black person is different from that Black person. Sometimes, in an attempt to demonstrate sensitivity to Blacks, companies end up displaying even more insensitivity because all Blacks get clumped together. An EAP person might pick up the differences but might lack the knowledge of what the differences mean. Companies need to seek consultation to help in that regard.
- Untimely referral. Black clients, for the most part, are not referred when they should be, although most other clients are. Perhaps people have some stereotypical notion of normal behavior for Blacks, and of normal coping skills for Blacks. People, therefore, assume that a certain behavior that they see is normal for someone who is Black, which, of course, is quite racist. By contrast, people may be afraid of being called racists and, therefore, they encourage, allow, and tolerate more unacceptable behavior than they should.
- Insensitivity. (See discussion under Perception.)

These barriers have implications for program design—program development, staff selection, outreach strategies, and use of community resources. In the program development stage, it is important that you have the option of an extended assessment period, especially for anyone who has trouble self-disclosing. There should be flexible program schedules, and perhaps even some flexible locations, where employees can be counseled. There should be an option for on-site and off-site delivery of services; a lot of people prefer to be off-site, others want the convenience of on-site.

It is important to be sensitive to cultural differences when it comes to staff selection. I do not assume that a Black staff can necessarily meet the needs of Black clients. The program should look for someone who can communicate and establish a rapport with Blacks of diverse backgrounds, from the street person to the professional. The person should be able to understand the community in which the Black client lives—wherever that might be—as well as the fact that many Blacks are bicultural.

It is important for the counselor to understand that Black clients may have multiple problems that need immediate solutions. The counselor must deal with an urgent sense of timing, some of which is largely due to the initial untimely referral. Counselors are also dealing with an EAP client. Once clients have gotten the nerve to acknowledge the existence of a problem, they want help right away. The staff has to be made available for these immediate solutions.

Some outreach strategies are particularly helpful. One is meeting Black clients face to face in what might be considered an unorthodox setting. Being at the worksite means that people can ask me questions about the EAP and about me, and get a feel for me. They need to know who I am before they will come to the program. They are deciding right then and there if they can trust me or not. They are not going to come to the office to ask those questions; but if I am there, they will. Also, because you are dealing with employees who have families in which both parents work, or who are single parents, they are not always able to come to the office. You have to build in some flexibility when it comes to seeing people outside the worksite and the traditional office.

With respect to using community resources, I use nontraditional referrals in working with Black clients. These are not the same kinds of referrals that I would necessarily make with white clients, especially as they relate to some of the religious institutions and their activities. I do not think that religious groups are automatically thought of as a part of that network; in working with Blacks, I find that they are more and more a part of the network. Also, there are some social organizations to which I will refer people, especially youngsters, like the Girl Scouts and Boy Scouts. Other predominantly Black organizations have been of great value, especially to many adolescents.

An EAP that meets the needs of Black clients will not be limited to serving Blacks. If you can develop a program that will attract this group, you have actually developed a program that will attract the majority of your employees.

Summary of Remarks by Melva Daniels

Historically, railroads and alcohol use went hand in hand. When the engineer stepped into the cabin, so did his bottle—in his back pocket. This has been going on for years and years. The results of an alcoholism study on the seven major railroads showed that a lot of employees got drunk during working hours—a violation of Rule G. The rule specifies that if employees are caught with drugs or alcohol on the job, they can be dismissed. In 1985, the Federal Railroad Administration (FRA) developed a set of policies governing drug and alcohol use on the railroads, and a number of the railroads, including mine, decided to embrace them. Last year, they implemented a policy for those who run the trains, calling for pre-employment testing, reasonable cause and suspicion testing, and a return to work physical and periodic physicals for employees.

We have had an employee assistance program at Amtrak since 1978. And there is Operation Red Block, a joint effort by the FRA and the railroads to put a coworker,

peer prevention program in place. It gets the employees involved in preventing drug and alcohol abuse. It has philosophies that can reach out to management—you know an employee is drinking or using drugs on the job, so you need to prevent or stop it. Operation Red Block calls for the formation of peer prevention teams of three to seven members in various locations. The teams are trained in recognizing drug and alcohol problems and in what their roles and responsibilities are. They are not counselors, diagnosticians, or members of the safety committee; they confront an employee who has a drug or alcohol problem. It has been implemented by a number of railroads, and Amtrak is currently looking into including Operation Red Block in its EAP by the end of September.

Peer prevention team members confront substance-abusing employees and give them the option of stopping the behavior or seeing the EAP counselor. If the employees elect not to go to the EAP counselor, and team members know that these persons are impaired to the point that they are going to be a safety hazard in the workplace, they will put them out of service and call in the EAP counselor for assessment and referral to treatment resources. The program gets employees involved in preventing drug and alcohol abuse in the workplace. As long as you have a strong EAP in operation, impaired personnel have a resource to go to when help is needed.

Amtrak is subsidized by Federal funds. Knowing that every fiscal year, jobs could just be abolished, can create low morale among employees within the corporation. The thinking may be that the company is not going to be around, so why not take that drink. The railroad industry, especially Amtrak, has a lot of real problems.

When the employee is assigned to the EAP, he is monitored by the program for 2 years. The employee has the option of being assessed for inpatient treatment, outpatient treatment, or drug education. Also, there is a strong family component to the program. We tie in the family, and employees must participate in the family portion of any treatment. Employee spouses and children having problems can come into the program.

It is strictly confidential. The coworker is not jeopardized under the peer prevention program. If I turn someone in to a peer prevention team, I will not be brought up if disciplinary action is taken against the person. I remain anonymous. The program protects the employee who is trying to get these people assistance.

Major Discussion Points

We have, in conjunction with our training program, a supervisory training program that is mandatory. Supervisors attend a 2-day session on drug and alcohol issues in the workplace. Participants learn how to get reluctant employees out of the workforce and into the EAP office. Employees come into the program either voluntarily or through Rule G—an employee has been charged with a violation, admits it, and elects to come into the EAP.

Tending the Flock: The Role of the Church

Moderator: **Edward Dixon, Attorney and Assistant to the President, National Baptist Convention of America, Shreveport, LA**

Panelists: **Joseph Eaglin, Executive Director, Congress of National Black Churches, Washington, DC**

Sister Helena Teresa Stanislaus, Teacher, St. Frances-Charles Hall High School, Baltimore, MD

Summary of Remarks by Joseph Eaglin

The Congress of National Black Churches is the association of the leadership of the seven main line Black denominations: the three Baptist denominations—the National Convention Baptist U.S., the National Baptist Convention of America, and the Progressive National Baptist Convention; the three historical Methodist denominations—the African Methodist Episcopal Church, the African Methodist Episcopal Zion Church, and the Christian Methodist Episcopal Church; and the major Pentecostal group—the Church of God and Christ. That leadership represents some 65,000 churches in the United States, and between 16 million and 18 million members. The primary concerns of this group are evangelism and theological education. The leadership is to look more closely at the mission of the Black church: what it has been, where it is, and what it will be for the rest of this century.

We will conduct executive training sessions for some 250 of the leadership of these denominations—for the bishops, the denominational secretaries, and so forth. We do promotions of the seminaries and recruitment to the ministry. (Thirty years ago, the ministry was one of the primary professions for Black people, particularly Black men. A lot has changed, and we are concerned about the quality of persons entering our seminaries.) We also conduct programs with the Black family. We have a major national initiative in four different cities around the country that involves local churches in exploring how to conduct parenting education programs, afterschool programs, and Saturday tutorial and coping skills training programs for children aged 6-12. We also are doing extensive training of pastors, focusing on how to deal with the problems of

contemporary Black families. We have designed an extensive, 18-week training program for Black pastors targeted for the inner-city area. It is called Project Spirit, and it is in its pilot stage. We are expanding it next fall; eventually, we intend to institutionalize it throughout the denominations in as many Black churches as possible. In addition, we are involved with the management of church resources—developing model programs in cash management. We have a national insurance agency to manage insurance functions. We perform activities in collective purchasing and work with churches regarding community development, housing, and so forth.

Last December, the Congress' executive board decided that the Black church should take a very strong role in providing some leadership coordination regarding the problem of drug abuse. We are experiencing horror stories in our communities. Many of you know the horrors, I need not run down them. And the pastor is being asked to aid, to assist in some way. The question is, to whom do we turn? There is just simply a lack of centralized information on or understanding of how to deal with the range of problems associated with drug abuse. But there is even a bigger problem, and it is the problem of crime and drugs—drug trafficking right in the middle of our community.

In Oakland, a couple of months ago, one of our church groups, with the police surrounding them, moved their Sunday morning services to the intersection outside their church, just to stop the drug trafficking. People who do street ministries are basically saying, "We don't even feel safe anymore, because they made it very clear they don't want us interfering with their traffic." This is a problem of major crime. And it is the kind of crime that we perceive as eating up not only the basic structure of the community, but also the family itself. And there is a certain percentage of the police force that is either on drugs or involved in the trafficking. So whom can you trust?

The question further compounds itself when we look at the large percentage of young Black youth who are caught up in the drug dealing activities. They are often the first persons to be arrested, and the real drug dealers stay behind the lines. These are 14- to 18-year-old youngsters who are running crack houses, pushing marijuana, or performing various kinds of drug dealings. They cannot go back home because then the drug machines terrorize their families. They cannot go to the police because they do not feel that the police would understand or be able to help them, or that they can trust the police, anyway. So they are caught.

Until the community itself mobilizes to attack both the drug abuse and drug-related crime, neither the social services agencies nor the police will have any effective way of limiting this problem. As a matter of fact, as police resources and activities increase, so does the drug trafficking in the community.

What can the church do? It can do what it traditionally has done, which is to mobilize and to provide leadership. Basically, it is something that nobody else can do—not social service agencies, the police, or the school system. The church can bring to bear its religious role as well as its social/political/ethical role. Even more importantly, it can bring about some accountability for the resolution of the problems.

The question might be asked, "How did these drugs get into these communities?" It is obviously an organized effort, and it must be combated in an organized way. We are then concerned about developing a new kind of collaboration between the various forces in the community. You have forces battling one another for funds, turf, and authority. Thus, the church must mobilize the community as a single entity and then draw upon these agencies—the police and the school system and all the service agencies serving the community. To that end, we began to design in the organization a $2^1/_2$-year anti-drug and anti-drug-related crime campaign.

We recognized that there are many risks involved. Many pastors have been dealing with the drug issue for a long time. You stand the risk of being eliminated. Some pastors have been killed, hurt, and had their families hurt because they decided to step between the drug dealers and those families. We are equally concerned about the activities of the law enforcement groups in these communities. In their zealousness to go after the drug dealers, many innocent people in the community may be hurt. Thus, we feel that in this collaboration, the police department and the State's attorney general's office must be involved.

We want to put a different message out in the community. First, that it is necessary that the community itself assume responsibility for resolving this problem, not the police, not the social service agencies. The community should work with and draw upon the services of these agencies and the educational system. Secondly, this is as much of an economic problem as it is a social-psychological problem. How are we going to tell a kid—a high school dropout—who is making $2,500 a week, and who has just paid up his mother's back rent and bought her some living room furniture she has never had—that drugs are going to destroy his life. He was convinced, before he started dealing drugs, by a negligent, indifferent school system and general environment, that he had no future. Now he has importance. Now he is running a game, and he has money and power. That is what we are up against.

We have said that the only way to deal with that young man is through relationships in his life—a mother, sister, or brother. And it is through these relationships that we feel we can begin to work with that young man or young woman. Starting in October, we will be launching this campaign in conjunction with the Justice Department. Unless we have the cooperation of the police department in this campaign, it is not going to be effective. We have targeted some 25 different communities: the Bedford-Stuyvesant section, Queens, Jamaica, and possibly Brooklyn, NY; northern New Jersey; Philadelphia; Baltimore; Washington, DC; the Norfolk Tidewater area of Virginia; the Research Triangle area near Raleigh-Durham, NC, and the Fayetteville, NC area; Charleston, SC; Memphis; Birmingham; Atlanta; Freeport, Grand Bahama; Dallas and Houston; Jacksonville, FL; St. Louis and Kansas City; Chicago; Detroit; Seattle; and two areas each in San Francisco and Los Angeles.

Our attempt is to forge different kinds of messages into the community. It is one that deals with accountability, ethics, morality, and a cultural context in regard to drugs and drug-related crime. Crime is not a part of our Black heritage. At the end of September, about 700 church leaders will convene at a national conference called Somebody's Got to Say Something.

We will be putting out a new message. And that message has to go to the mother who takes the money from her son. It is a message that must speak to people who are responsible for administering programs and who are enforcing the law. We are concerned about both groups. It is also a message to the political leadership regarding accountability to that community and the necessity of that leadership to join in with all persons of goodwill and attempt to resolve this problem now.

We can design a message that we can get across to 65,000 churches. In 25 communities, we have already started the process of identifying what we call the 10 "lead pastors" in those churches. We will be working with what we call the "recognized church leadership" across these member denominations. That leadership then calls upon the mayor, asking the mayor to join us. We will convene folks who have claim on this community—the attorney general, the head of police, the head of the school system, the social service agencies, the drug treatment agencies, lawyers, people in medical professions, social workers, the media, and so forth.

It is important also that we turn around some of the accountability on the families themselves, and say, "Let us find a way as family groups to work together to resolve this." This way, we begin to develop our own support network groups. Ours is to bring some accountability to this issue, even if it means we have to create some new ordinances and change some existing programs. If we have to get it out that there is one single number that a family can call, then we promote that hot line number. There is a role the media can play. There are a lot of messages, and we have to somehow make those messages uniform, and make very clear the nature of the service being provided.

We will go through a period of 5 months of organizing communities, of assigning a local coordinator and regional coordinators to work with these groups and provide technical assistance. Starting in February or March of next year, we are going to link up the 25 communities by satellite and try to pull off something of a Black town meeting on the air for 3 hours in the evening. We will pack these churches with a couple thousand people. Our resource committee, the mayor and/or his representatives, representatives from the police department, and from all those agencies will be there. And we will review these strategies. It is a technological sharing of information.

It does another thing—simply let these community groups know that they are not isolated, that they are not alone. That often kills most organizational efforts. They become isolated. Ours is to make sure these communities sustain this sense of uniform effort and some sense that they themselves have the leadership in solving the problem. NIMH, the Department of Justice, and the Department of Education have a lot of strategies. Let us determine how effective they are in our communities. Let us hear from the people whom these programs are intended to serve.

You have, in the communities, the vehicle for addressing this issue—the church. It has been the vehicle throughout Black history. By the turn of the century, the Black church had already organized into major denominations and subdivisions. It was a haven for those without clothes; it was a schoolhouse. It was a vehicle by which the Black community survived throughout the depression and the whole migration north. Continuing as an education focus, the church remained the primary advocate of school

integration and, eventually, civil rights. And for the last 15 or 16 years, the church has been the primary vehicle in our communities for dealing with programs, the aged, all kinds of youth education programs, and drug abuse programs. In facing this crisis, the church leadership says, "We must merely continue what we have always done."

Summary of Remarks by Sister Helena Teresa Stanislaus

I am a Sister with the Obligate Sisters of Providence, one of the oldest, Black Catholic communities of religious women. I teach English, French, and math at St. Frances-Charles Hill High School, in Baltimore, MD. My presentation is two-pronged, aimed toward the ministers of the church—in particular what is happening in the Catholic church and in some other denominations, and also toward the laity. It is about the problem of alcoholism, especially concerning memories of my own life.

Alcoholism is no respecter of age, race, or creed. I walk among several who actively deal with the problem of alcoholism and drug abuse on a daily basis. Unwittingly, in the Black community, alcoholism and drug abuse have become as acceptable as water, particularly alcoholism. We take for granted the drunks who hang out on our corners or in the tavern. We have become used to the domestic fights, the yelling and the screaming, in which alcoholism is indeed the problem. Then there is the wife who has to wait for the husband or boyfriend for money because the paycheck has been spent on alcoholic beverages before anything else. And in our hospitals, lines are long where men and women have complications that have been aggravated by alcoholism.

I come from a home where alcoholism is a problem; so I understand from firsthand experience. Several of my friends had alcoholic parents or have brothers and sisters who they actively have to deal with today. So, in my own life, I have observed and grown up with the very real phenomenon.

In our Black neighborhoods, you can count sometimes two or three or four alcoholic beverage stores and/or bars within a two- to three-block radius. Using alcohol and drugs seems to be a mark of maturity. A young boy is supposed to grow up when he takes his first drink, a myth that often seems to be perpetuated. And single parents that we meet in school, the parents of many of our children, very often drown their problems through the use of alcohol and/or drugs. Celibate men and women in our religious community also fall prey to the same problem. Some find emptiness in the mid-life crisis, which they try to fill through drinking.

Alcoholism is a disease, but in the Black community we do not talk about it as a disease. In fact, we have difficulty talking about it at all. Alcohol keeps individuals from being alert. It destroys the whole person and adds to the feelings of inferiority. And it does not allow people to love themselves as they are and to reach their greatest potential. Alcoholism tends to destroy and degrade. We, as ministers, in particular, must see it as

a disease. Jesus brought healing to his broken followers. And through the members of his church today, He still brings healing to broken individuals. And that is still the role of the church—to bring healing. The task of the church is to bring holistic health to each and every individual as much as possible.

I am a teacher and minister. If I, as a minister, am going to be effective, I have to be knowledgeable in an area. I have to be able to really read a publication and be informed about different organizations. I also have to be sensitive to alcoholism regarding my own life. How do I view alcoholism? How do I use it in my own life? Is alcoholism prevalent in my own family? Are there patterns in my life that are the result of having lived in an alcoholic environment? There is no shame behind that. The point is to use that and go from there. And we as ministers have to see our own brokenness to help others.

There are vehicles available for help: Alcoholics Anonymous (AA), Al-Anon, Adult Children of Alcoholics (ACOA), and therapy—either psychotherapy or the other therapeutic models. However, we just are not aware of these vehicles. When I attend Al-Anon meetings, there are very few Blacks present. It is not due to lack of interest, but lack of awareness. I have been in religious life for almost 20 years, and I did not know about the Al-Anon or ACOA organizations until at least 3 years ago.

Therefore, as ministers, I feel that it is imperative—if you know very little about what is behind AA or Al-Anon—that you attend meetings. Find out where they are held. Visit treatment and rehabilitation centers. Allow your churches to be opened for AA, Al-Anon, and ACOA meetings. In your sermons, address the topic in a nonthreatening way, but bring it to the level of consciousness. In the Black community, the church is powerful. An effective minister can at least raise the consciousness, promote awareness, and push for action in a very sensitive, caring way. I am a product of two churches. That is the beauty of being a Black Catholic. A Black Catholic often comes out of the Baptist tradition and, therefore, has the feel for both. Have speakers from organizations address the matter. You would be surprised how many members of our church are members of AA. And how in some sensitive way, they will come forward if encouraged. Keep literature and references and phone numbers available for members who do come for counseling or help that is readily available. If, as a minister, I am informed and sensitized, and I have firsthand knowledge of organizations, then I can indeed address others and lead or guide them where they need to be guided.

As for the laity, we first need to feel important. Often the bottle and drugs have been used as a form of self-esteem or as a mask for problems. The fact is, alcoholism is a disease and one needs help with it.

The social habits of our churches—are they really effective? Is our social atmosphere a deterrent, so that students and young people will not take drugs or get into another scene that is not the best? What makes you happy? What constitutes partying? Are there enough social events that could be synonymous with a partying atmosphere in our churches? What are the social patterns that we bring about there? Do we try to expand the horizons in our churches to include something for every group? Is our church family really a family setting?

My point is that you should use the vehicles available and, in the Black community, be really sensitive toward organizations that are available. Urge others to attend AA, Al-Anon, and ACOA meetings.

Major Discussion Points

An attorney and treatment counselor, I am enrolled in divinity school. I have been through a treatment center and a lot of restoration programs at various foundations for enhancement purposes and applications. I have met a lot of Catholics, recovering priests, brothers, fathers, and so forth. I never met one Black, Baptist alcoholic. I would like to see one Black minister go through a 28-day program. I do not believe anyone can understand. I have been under either the influence of somebody under the influence or under the influence myself for 40 something years. And my reason for going to the divinity school is I have represented a lot of people in criminal matters who had drug abuse problems that the courts do not understand, legislators do not understand, and the ministers do not understand. I hope in the course of your conferences you will inspire somebody to get them training, or come out of the closet.

Between 1971 and 1976, there was listed through a number of Federal and State Agencies, a series of programs that had over 400 alcohol- and drug abuse-related training programs that were located in religious institutions. Along with that came some of the State Bible schools with a series of programs that dealt with the ministers and drug abuse and alcoholism. Yes, this is a very real problem among the clergy. They could not treat their people or run or sponsor programs unless they themselves got involved and looked among their own brethren who are involved with it. There is a whole body of training and knowledge that deals with clergy and alcoholism, and now it is even extended to substance abuse. Why are they not a part of Al-Anon and the other movements? I cannot answer that directly. I do know that there are programs within various clergy settings that do deal with ministers.

I am an ordained Baptist minister and a minister through the Church of God and Christ. I am also a substance abuse counselor at Washington Hospital Center. The problem that you have involves the church discipline. In the Baptist church, which has local autonomy, the personality of the church usually reflects the personality of the pastor. So a pastor's belief that a person should be put out who has alcohol or drug problems becomes the philosophy and bylaw of the church. Therefore, those members who have these problems do not confess. Some of the young people that I work with in the church came to me very early on; they smoke "reefers" (marijuana cigarettes). Where do I go with that information? You cannot go to a pastor who is going to throw them out—which is the worst thing to do. The church today is no longer, per se, family. On our unit, we had three generations of drug addicts—a woman, her daughter, and her oldest grandson; they were all supposed to be Baptist. Are the people refusing to accept the discipline of the church, or has the church failed in its outreach to the people? You can understand why ministers and deacons and people who have prominent positions in the church do

not admit their alcoholism and drug addiction to the church; it would mean they were going to be out of a job.

I am a licensed Baptist minister, and I work with the Circle of Love Christian Counseling Service in Oklahoma City. I am having a problem that is very similar to that. Here is a resource program; we are willing to go into any religious institution in the State of Oklahoma—even out of the State—with information on prevention and intervention. I have run into a lot of resistance in the Baptist church in the larger cities. The rural communities were glad we came; they wanted to know what to do because the alcohol and drug problem is prevalent in the rural community as well as in the big cities. That is where I go with my ministry. But we must open up so we can have the resources available and receive these things that are there for us. And if they are there, utilize them.

I am an ordained Lutheran minister, and the director of the Council of Churches—the Bronx Division for New York City—and director of the center for the city's substance abuse program. We tend to look at alcoholism as a bad situation that has to be made good. If the church takes the point of view that alcohol use is a sin and to deal with it you have to become good, an alcoholic is always going to fail. And he is going to excommunicate himself because he never feels he is ever going to measure up. If we believe that Jesus came to bring healing, then people can deal with that because people can see stages of healing, but they cannot see stages of good and evil.

Another observation has to deal with the whole "say no" mentality. When people say "no"—when those mothers who are using the rent money that their kids got selling crack or dope say "no" to that rent money—something has to be put in its place. We have lost our concept of the holistic ministries in which the churches come together as the people of God and begin meeting some of those other needs to fill the void when that parent has to say "no."

There is the treatment approach. When we talk about the inability to get into churches and to do something in a community, we are talking about a system problem with the church and the community. Primarily because there is no singleness of mind, there is no single focus as to what to do about the problem. Institutions are run by rules and regulations. To that end, it is necessary that we look at the systemic problem and understand from an institutional point of view what we can do and what we should do. This does not necessarily address the treatment issues. We have placed up front that this is an ethical issue and an economic issue. There is another aspect that deals with the positive elements of the community. When you say "no" to drugs, you are, in fact, saying "yes" to us as a people; we are saying "yes" to the community. That is the only real defense; that is the only real offering that we have. And out of that comes, we hope, some new sense of economic accountability.

When pastors say, "We are going to evict you because you are alcoholic, and that is sin," that is a theological issue. That is where we have to change our mindset and see the theology in other veins.

That is not a theological thing; it is doctrinal. You have many religious institutions running all sorts of drug programs. It is a doctrinal issue that calls for clarification.

I am in the U.S. State Department, and I worked as a substance abuse counselor in Syracuse, NY. We are struggling with looking at alcoholism as an addiction. The place in which the Black church has been lacking is in opening up the doors to AA and Al-Anon and encouraging people. I do not think that we have to get a coalition together to do that. Alcoholism is a disease that brings us in touch. There is a spiritual aspect, but there is more to it than that. I cannot just deal with it as a sin. It really needs to be dealt with as a disease, and it is not done that way in church.

Since 1971, when the Federal Government began its funding, churches have been involved. When we first raised the issue back with the denominations, we felt we were involved to the hilt in providing these various services. But a lot of churches are not involved. The doctrinal and theological issues were raised. Their response was that when you deal with an institution as enormous as a religious organization, you must deal with it from its institutional structures. And that is the approach we are taking. All the concerns that you have are addressed within that institutional approach. We will have them look at the whole alcohol or substance abuse issue from a different prospective than we did 10 or 15 years ago. Then it was merely a community service; now it is a family necessity. That is a big approach.

The seven denominations of the Congress of National Black Churches came together in 1978. They are the mainline Black, historical denominations. They came together for very specific purposes. Ours was not in any way to put down the Black caucuses of the predominately white denominations. The problem was that we were trying to create a decisionmaking, political structure that could act. The major problem with Black religious institutions is their inability to act in some uniform manner. If we were able to pull together seven of those denominations, the Congress thought that was sufficient. There is also the problem of how to incorporate the Black caucuses of the predominately white denominations into the second layer of the organization. The Congress was composed of national, Black church organizations with membership in excess of a half million people, with churches in at least three or four geographical areas.

Invite the Black people from AA and Al-Anon to come to the places of worship to talk. See if they will violate their anonymity to get the folks out of the closet and be a healing agent for them. I do not think we can expect too much from pastors.

Part of the problem exists within the church leadership. A lot of ministers are dealing in drugs themselves. More commitment from the churches is needed in serving the communities. The church needs to start channeling some of the money back into the community for programs. The church is doing very little. I commend you for your intended effort, but the results, in terms of commitment, are the bottom line.

Look at the number of prison ministries that are in every city and the number of pastors who work out of hospitals and crisis centers. Not every pastor drives a Mercedes; a very small percentage of them do. One of the worst things you can do, particularly those who are working in programs, is to walk up to someone who is a leader in a religious institution and present that kind of narrow-mindedness and prejudice. If you sit in any legitimate pastor's office from 9 to 12 any morning, you will hear a whole range of calls that deal with the problems of the community. But, yes, there are abuses. In any large

religious institution there are abuses. But the key thing is to use the vehicle, the religious institution, which is ours. Accountability is natural; it does not have to be commanded.

You all are committed and believe in the things that you do. But you are going to be anti-us, and we are going to be anti-you, because we are seeing transgressions. We both have valued points. It is an issue of public relations and the kinds of breaches of trusting relationships that we have had within our own ranks. I think it is really counter-productive.

In looking at our churches historically, we have a tendency to deny some of the issues that are in our midst. There is crime in our communities. The Black churches need to begin to articulate and formulate a statement of intention regarding how we are going to try to help prevent some of these things from occurring. We have not talked at all about prevention. I do not think the church will accept, especially Catholics, the issue of condoms and AIDS. You have got to look at the real issues regarding denial in our communities and churches, and we need to look more to the proactive means whereby we can begin to address problems before they occur.

The first step of this whole campaign is developing the message. The meeting planned for the end of September will have about 500-700 religious leaders to ratify that message in a statement that deals with the doctrinal issue as well as the social responsibility and accountability issue.

Regarding the issue of AIDS, I wish we would keep that separate for now. This summer a coalition of religious groups will begin addressing the issue of where the church should stand and what the church should be saying in regard to AIDS. What the speaker says is true: AIDS should be encompassed in a total picture of the drug abuse situation. If those things emerge, you have to walk it through the process, an institutional process, a doctrinal process, a social and accountability process.

I am an associate superintendent at a big rich school system in northwest Washington, DC, but I am also an ordained Baptist minister in the American Baptist Church. I definitely would like to commend you for that very unthankful job that you have to try to perform. We can decide that what we have heard today is unworthy. We can decide that it is not worth our while. We have our own agendas, and we are looking for what we want. If the group of seven churches wants to go ahead and do their thing over there, and they do not want to deal with the AIDS issue right now, let someone else deal with the AIDS issue. We have all kinds of problems in the Black community. Wherever we find somebody who is pushing in the right direction, bless them and let them go on, and let us continue to do our thing.

I came from one of the big churches in Alabama—National Baptist. Give us some kind of training package so that these ministers who have not been willing to join up can study it themselves, and maybe they may just help somebody. We just cannot say, "Be warm and be clothed." We have to feed them, clothe them, and then preach to them.

Substance Abuse and Black Families

Moderator: **Dr. Frances Brisbane, Associate Professor, School of Social Welfare, Health Science Center, Stony Brook, NY**

Panelists: **Dr. Wade Nobles, The Institute for Advanced Study of Black Family Life and Culture, Oakland, CA**

Dr. Joycelyn Whiten, Director, Addiction Research Center, King-Drew Medical Center, Los Angeles, CA

Marilyn Marigna, Program Coordinator, The Center for the Improvement of Child Caring, Inc., Studio City, CA

Summary of Remarks by Dr. Wade Nobles

The model of the Black family is related to our culture. When you talk about Black culture, you are talking about African culture. Rituals are an important part in reclaiming the culture base of the African people. Analysis of substance abuse is really an analysis of people's aberrant human functions. The theoretical model to be discussed for remediation and rejuvenation of the Black family has to be a normal model and not an abnormal model. Too often, we see the Black family in an abnormal cast, and see an abnormal cast of what the Black family is about. What is the African family form, the impact of drug abuse on it, and how do we remediate it? The problem is not only chemical, but is also our addiction in the adoption of an alien culture. We are internalizing an alien culture form and reflecting its aberrant behavior, as well as its aspirations.

Society has defined Black culture in this way: Black folks have no culture, or Black culture is a deviant culture. So we move away from it. There can be no African-American culture family without more education and an African culture base. The African culture is the base for the Black family. We must define the family—this definition is important—and define drug abuse in the family process, the structures and functional components.

The African-American family is a group of people who are historically, culturally, biologically, and spiritually bonded, and whose relationships are governed by particular

cultural beliefs. But we unconsciously take someone else's cultural base to develop the Black family. The purpose of the family is centered in children, who are critical when we look to the future. And drugs impact children. The social organization of the family represents a living organism moving according to pressure that could lead to a broken home. We must recognize that the alien culture is just as abusive as the drugs we take into our veins. Drug abuse is a structural, societal problem. We must define our own interpersonal relationships. The family model is being impacted by concrete conditions such as racism, which attributes negative ideas to Blacks and feeds these ideas into the Black consciousness because the African experiences are not in their consciousness.

In the biology of Blackness, high-intensity melanin is a critical variable in the central nervous system. To be human is to be Black. How does melanin affect drug addiction? Does more melanin mean that one gets addicted quickly and it is more difficult to get off of drugs?

What are the community ideas that precipitate drug use? What is the social climate that changes ideas to change behavior? Just Say No must be consistent with concrete structures, concrete conditions in the community.

In a 1-year Oakland, CA, study of Black families, in which the emerging drug culture and the issue of drug trafficking were studied systematically, an attempt was made to interview 500 families to find out how drugs were affecting their lives. One out of two people were afraid to talk about drug abuse because they were fearful of the dealers, saying that higher-ups—the police, legislators, judges—know about drug dealing and were benefiting. Thus, the community has one view of drug abuse, and officials have another. Ultimately, only 200 families were interviewed about the impact of drugs on their lifestyle. In terms of awareness of drug activity, 64 percent of the adults said that they had a personal awareness, and an equal percentage of children knew, too. About 81 percent of the families felt that their children were attracted to the lifestyle of the drug dealer.

We tried to assess the psychological stress and trauma that children experienced to look at the consequences of drug use in terms of physiological (pain) and psychological (nightmares) effects. About 50 percent of the children reported always having trouble sleeping; the majority said that they felt socially out of step with the community and their peers, bored, and entrapped. Couple this with the imaging the child has of drug trafficking and drug lifestyles as being the thing, and you have children choosing excitement and glamour over being entrapped and bored. We found that four out of five parents were under constant tension; 65 percent of them experienced headaches and backaches and had to get prescription medicine for relief. How can one be a responsible parent in this situation? There is a possibility that in using prescription drugs for pain, people move up to illegal drugs—something stronger—when prescription drugs do not work.

There is a shift that we think we have documented concerning traditional values in the Black family and the values of the drug culture system. It documents the real change in our communities in terms of an alien cultural orientation being abusive. In traditional

African culture, role relations were defined by the appropriateness of your conduct. There was a theme in the Black culture of a sense of excellence. Parents encouraged a model of excellence—be the best that you can be. This contrasts with the drug scene which says anything is permissible, as long as you have ability, which is defined by material possessions. There is no trust—trust nobody but the dollar. It is the traditional culture with its emphasis on responsibility, cooperativeness, mutual aid, respect, and restraint versus the drug culture—socially defined as the American way with the values of corporate business, and the values, when clinically interpreted, equal to that of a psychopath.

The question of drug abuse is one of substance abuse, and substance can be defined as ideas just as it can be defined as chemicals. Just as chemicals addict us, alien folks' ideas about what is good and bad equally can addict us.

Summary of Remarks by Dr. Joycelyn Whiten

I am a neuroscientist involved with the biochemistry of behavior, and it is from this standpoint that my interest in substance abuse springs.

There are many different kinds of Black families. Children must be carefully taught values consciously, or undesirable values will be absorbed unconsciously. Studies show that Americans born since 1945 are more mentally unstable and require more psychotherapy than predecessors. Why? A Yale study notes that there are high risks for depression, and that there is an ominous trend toward depression and associated illnesses.

The media says that all situations can be solved. I see a correlation between the decline in reading and the upswing of the visual concept. Everything is advertised, and television has an answer for everything; nobody gets permanently hurt on TV. In TV's emergency room, death is not a fearsome thing. In the child's construct, he rises and you rise, so no harm is done. Values must be taught consciously. We still respect age in the Black community.

We must teach by precept and example. "Don't drink and drive"—few target groups are affected by such social service ads. Say "no," and "yes" to life. In speaking to kids, how do we tell them how to make distinctions? There was a 7-year-old child who knew about methadone because his mother was an addict. How can we combat this?

In 1980, 25 percent of families said alcohol problems adversely affected them. It would be a higher percentage today, and the Black family would be disproportionately affected. The Black family has to be more flexible and resilient.

Venereal diseases follow an increase in drug use. The numbers are staggering regarding AIDS cases and the "old diseases," syphilis and gonorrhea; there are penicillin-resistant strains.

Drug abuse has corroded the Black family, first in the 1960s and 1970s. In the 1980s, television and the person on the street mainly determine the standards in the Black community. We are more tolerant of the aberrant than any other communities. We care for our own, and others come along; Blacks care for the homeless in Los Angeles. Tolerance has made the family vulnerable.

Black families must consider what family means; communities must come together as family, become politically aware and say, "Stop the proliferation of alcoholic beverage stores." Alcohol is the gateway to drugs. We have 8-year-old alcoholics; 12-year-olds are dying of cirrhosis. Children are looking for the happy hour. TV cartoons show that children are greedy to learn about our culture. The police have given up on junior high school students. We must recognize and understand what is meant by family, and it must be carefully taught.

There is a genetic predisposition for alcoholism, a genetic deficiency passed down through grandfathers and fathers which make people vulnerable to the psychological problems. Get out the message: This is the destruction running through our ethnic group. We must look out for the children. NAACP Director Benjamin Hooks said of the Black man, "By the year 2000, 25 percent will be dead, 25 percent will be in jail, and 25 percent will be addicted."

Summary of Remarks by Marilyn Marigna

We have had to make parenting adjustments to survive since slavery. I hope we can still make adjustments today. Ineffective parenting is seen as the cause of substance abuse in children. Our program gives parents a different method of parenting.

In the last 10 years, the Center for the Improvement of Child Caring has collected information on Black parents and parenting. The center has done research with Black parenting experts to come up with a refinement of curriculum that incorporates basic values—values that need to be put back in communities. The basis of the program is a pyramid of success for Black children, including quality education, a good job, and ways to resist street pressure, improve the Black community, and have loving relationships with the family and other community members. Characteristics needed to achieve these goals include high self-esteem, pride in Blackness, self-discipline, healthy physical habits, and good school skills and study habits.

It is a behaviorally based program of 15 weeks with 3-hour sessions. Parents are taught to use corrective and positive consequences, to praise positive behavior and eradicate negative behavior. Praise is the most powerful means of child management through family rules. The program also includes a special, two-session, instructional unit on what parents can do to resist street pressure.

The project is funded by the Prevention Research Branch of NIDA and carried out by three groups: the Center for Improvement of Child Caring, Inc., the Los Angeles

Unified School District (Region C, the Watts area), and the Charles Drew Postgraduate Medical School. Parents have been involved from 13 elementary schools; only the first and second grades were included. Four schools were selected at random as controls, while the other 9 were treatment schools. About 1,500 parents were available for study; 196 were interviewed. Some 58 parents graduated the first year, and 55 are expected to graduate the second year. (Graduates have included grandmothers, great-grandmothers, and teenagers—but no fathers.)

The most significant result of the program has been the reduction in the use of corporal punishment and in parental depression and compulsion for control and order. There also has been an increase in praise, and positive effects on other family relationships have emerged. These are only preliminary results. A more detailed study is needed to see the long-term stability of the positive effects, to test the generalizability of the results to other Black families, and to determine which subset of the program is most effective.

Major Discussion Points

Parent-effectiveness training is one way to give children values. It is the easiest. People have not been taught to care, to love. We must carefully teach what we want the child to know. The concept of community as Blackness must be taught.

As an African, I would like to reinforce Dr. Noble's presentation. We are impressed by our parents. They take care of us; then, when our parents get old, we care for them. We perform libations and obey the father. Principally because of the economy, we stay home. Children here are out of the house when they are 15.

The media, especially the negative impact from television, is conveying a cultural frame of reference. The time spent in front of the television takes the place of reading and spelling. Drugs are needed to evoke imagination. There is a lack of communication, a loosening of skills. When an athlete—a positive role model—gets $5 million to $6 million a year, kids translate this into selling drugs to get that kind of money. We need a national campaign to burn televisions, then kids would learn to play games. Television has replaced talking and doing things with the family. The fallout is that children lack imagination; they cannot make imaginary characters.

We at the Center for Improving Child Caring encourage mothers to teach sons to be responsible. This is done in teaching Black children, not just sons, to take responsibility for behavior.

Black males are an endangered species. It is a matter of reclaiming our culture. Even when men are not in the house, it is men's responsibility to participate in raising kids. It is not a man or woman's responsibility; it was the tribe's and community's responsibility.

Alcoholism in the home has not been specifically addressed. It is a community problem, and it is being overlooked by society because those affected are poor.

We are teaching people to help themselves. We make ourselves available to people. We have an underground network and volunteers to help. Someone has to take the leadership role.

With regard to self-esteem, kids have never heard of Malcolm X. We do not have to go back and teach these children from the beginning. There must be things we can do now. We need to generate alternatives for them.

Culture is not going back; it is a process that gives people a design for living. We must know our culture to develop confidence and competence in conscious Black children. Culture is rule-governed propositions. We must know the technical specifications of our own culture. If we do not know, we will keep talking about what is Black and not know what it means. Culture is the basis of information children use to learn. Some of it is historical; some is how you deal with the future.

Getting Out the Messages: Accessing the Media

Moderator: **Angela Robinson, Host, Panorama, Fox Television, Washington, DC**

Panelists: **Sheila Douglas, News Assignment Editor, WJLA-TV, Washington, DC**

Cheryl Mattox-Berry, National Reporter, USA Today, Washington, DC

Summary of Remarks by Sheila Douglas

There are several key things that I want to emphasize that people should do to obtain coverage, whether it be on television or in the newspaper or any of the magazines. One of the most important things is to familiarize yourself with the newsmakers, the people who are deciding what goes in the newspaper or the news broadcast. Most people are familiar with anchors and reporters. We remember the people on camera, but we do not know the people behind the scenes. How many people know what an assignment editor or a managing editor is? Or your desk editor? That is the person you should really pinpoint and establish a rapport with, because that person is looking at all the possible stories that come through the station or the newspapers. The assignment editor and the managing editor, those are the people who are editing out, editing in, the news and the information. Those are the people you should contact whenever you have something you want covered. After a while, you know certain reporters cover certain stories. One reporter is going to cover crime. One reporter covers health. One reporter does features. That person should be the second person you contact. The more contacts you make, the better your chances are of getting covered.

In the television business, there is also the public affairs department, which is different from the news department. Not everyone necessarily realizes that public affairs is different from the news department. The news department is churning out news and information every day, five times a day, for the morning show, the noon show, and the shows at 5, 6, and 11. The public affairs department has the time to work with community-based organizations and government agencies to develop a theme or a spot

that they want to get on the television. That includes public service announcements (PSAs)—which do not cost anything, which are different from advertisements and commercials for which you do have to pay.

The public affairs department is underutilized at most television stations. Only a select few know who the PSA director is in their television market. That person will work with you. They have a separate crew, which can be sent out to shoot your community seminar on alcohol or drug abuse. It will not cost you anything, and it will get more air time. You will see that spot—a 30-second or 60-second spot—throughout the day and night. Whereas, in news, it is a one time only shot, most often. If it is in the 5 o'clock show, it will not be in the 6 o'clock show, and it will not be in the 11 o'clock show. Most of the people in the public affairs department have more time to spend with you, and they have more air time to offer for programs that necessarily are not going to make the news on a particular day.

News is exactly that; it has to be new. It has to be timely; it has to be accurate. And you have to incorporate that with what people like, what their interests are. You have to capitalize on trends. There is a tendency for us to do things that people have done before. You call the TV station, and we do not come. You wonder why. It is because you are not doing anything new or different. Capitalize on trends like videos. Everybody does a telethon. There is one group that is doing a sitathon; that is new. We went out and covered that. Hot lines are not new, but a hot line operated by teens for teens is new and different. You have to be creative and get that sort of energy in coming up with new ideas, because people are doing it everyday.

If you say we are going to have a meeting and we are going to come up with plans to help solve the problem of alcohol and drugs in the Black community, you are not likely to get a response. Calling people into a room and sitting down is not new, and for TV, it is not visual. We need to be stimulated visually. We need the color, we need the action, because it is a visual medium. That is basically what it is. So, you need to think of things that are going to attract us, that are going to attract viewers, because most viewers watch television news twice a week. While they are watching it they are cooking dinner or playing with their children. So they are really not paying attention, so you really want to have something to catch people's eye and keep their attention so they will learn something. Ultimately, you want some type of reaction. You want the community, the public, to get involved with a specific cause.

As I said, most people watch TV news twice a week and it may not be the same station. One day it might be channel 4, the next day at 11 o'clock it might be channel 9. So they do not even know from day to day what is going on, whereas the people in the news business do, because they are keeping track. We are always watching for new, and different, and creative, and visual ways of telling the story.

The advent of crack was new. That happened about the time when everyone seemed to be jumping on the war on drugs bandwagon. I read in the newspaper that we had a war on drugs 20 years ago. What placed it on the tips of everybody's tongue this time? Probably because there was a new element and everyone could spin into it and that is

the advent of crack. Cocaine, and marijuana, and heroin, we have talked about all that stuff before. Crack sort of gave it a new twist. I am sure that helped fuel the recent war on drugs once again. If you have chronicled some of the news shows over the last couple of weeks or months, you may recall that whole story sort of disappeared. It is here today, gone tomorrow. We have an ongoing joke in our newsroom: That was a great story; you had all the elements, you told the story well, you had visuals of the people; but that was yesterday. What have you done for me lately? Every day we are looking for something new and different.

I want to talk about press releases. You should call the assignment editors, the editors, and let them know about your event. More importantly, you should write them a press release—and it does not have to be extensive, it does not have to be in depth. Assignment editors do not have much time to read through packets. We just do not have time to read all this information. We need to know who is doing what, when, where, why, and how long you are going to do it. When you are thinking about sending press releases, remember a lot of them get tossed.

When I found that I was going to come here and speak before you, I did a survey of the mail I had received. From April 27 through May 1st, I got 100 press releases; 60 of them I did not use. I just did not. They did not apply; they were not timely. I do not need to know that someone from this corporation is being moved over to another corporation. That is the sort of stuff I get. I do not need that. We have a day system file to alert us about upcoming events. We consult our file folders to see all the events that are going to happen on a given day. I filed 30 of the press releases; 8 of them I used. I could tell you that day that I was going to use that press release, that information, at some point in time. Two of them really did not apply to my business, per se. But I got something that I said I am going to keep because I think that is interesting and I am going to use it personally. What does that say? That says of the press releases sent to me, I do not use half of them. I do not use two-thirds of them. I use maybe one-tenth of all the press releases I get.

Information for the press people or the public relations people—intentions are well and good, but they are not timely. They are not new. Information coming from ice cream companies, the circus, book authors, school systems, congressmen, other corporations' communications divisions, and so forth, I am just not going to use. So, when you have a message that you want to get covered, you have to attract our attention. But you have to keep in mind, too, that we are getting in a whole lot of materials, a lot of information that we are not going to use unless there is some reason that makes it stand out. You have to follow up; you have to give us a call to make certain that we got the press release. Do not ask us a month in advance if we are going to cover your story. A week before your event you should call to check or correct the release in case there are changes.

In addition to press releases, we are going through papers, because TV, for the most part, has a symbiotic relationship with the print media. We are glancing through magazines and newspapers—*USA Today*, *The Washington Times*, the local *Journals*, the *Washington Observer* papers, *The Washington Post*, *The Wall Street Journal*, and *The New York Times*, because we are always in a quest for new story ideas. So, keep that in mind.

Everyone is always converging on us trying to get their story covered. It is important for you to follow up.

One of the other things I want to implore you to do is to compliment us when you see a story that you thought was good. Call us and tell us that. When you see a story that you think was terrible, that stinks, was discriminatory, whatever, you should call us. Some people do that regularly. Every telephone call we get we equate with 300 people! For every one phone call we get we know that there are probably 300 other people out there thinking the same way. That helps us editorialize, expand our coverage, treat stories better, and become more sensitive to what our viewing public is watching, to what they expect of us. For instance, during the snow storms here in February we got a lot of calls from the suburbs asking us why we were concentrating our coverage on the city's plight and hounding the mayor. They said their plight was equal to the city's. That prompted us to check out the situation in the suburbs. We do not always know what is going on out there; we are in our newsrooms. You have to call us and let us know.

Make it easy for us. When you call us, have all of your information together. We need contact phone numbers. We need to know who the point person is, who is in charge, and who is going to be there to answer the questions. We want to know addresses. We are like dispatchers; we cannot get to a place if you give us vague information. If you hand us everything on a silver platter, you stand a better chance of getting your news covered.

Summary of Remarks by Cheryl Mattox-Berry

USA Today is still considered the new kid on the block, although it will be 5 years old in September. Although we were criticized quite a bit for our product, I am sure in your own home towns you will find that a lot of the things *USA Today* does, local papers are copying.

There are four sections to the paper: News, Money, Sports, and Life; there is occasionally a fifth section which is called the Bonus Section. In the Bonus Section, we cover specific topics. We have one coming up on the Constitution. Now, the Constitution celebration in most people's minds is a dead event, but we have done a number of innovative things to kind of bring the Constitution alive.

I mainly write for page 3 of *USA Today*. Down the left-hand side we have "Nationline", which is a column of mini-stories from all parts of the country. Some people take a look at that and they say, "Well, apparently these stories must not have been that important to be relegated to just a little space." But, if you look at most *USA Today* stories, they are not very long stories. We give some of these stories in the left-hand column just as much weight as we do some of the other stories. Often my stories will end up in this column; these are stories that I have spent a lot time researching and reporting. I am a little disheartened when I look in the paper and see them there, but I have done this

column and I know these stories are just as interesting as the ones on the right side. When you look at this page you wonder where we got these stories? We got these ideas from several sources.

The wires. Associated Press. United Press International. We have access to every State wire in the country. We have a pretty vast computer system, so we are able to look at the wires and see what news event is happening, what is the most important thing out of that State. Then we decide how we will use it in the paper.

Some of our reporters have beats. One of my many beats right now is AIDS. We have a medical reporter in the Life section who does lifestyle type stories on AIDS as well as medical advances. Often we will team up to do special projects.

Newspaper clips. We pour over tons and tons of newspapers each day, trying to find out what is going on in local communities across the country. Last summer, I worked as planning editor for about 3 or 4 months; I must have had about 20 newspapers that I went through every day. This was in addition to getting phone calls from people to ask me about news releases that had come in the mail.

Press releases. Perhaps about a tenth of our story ideas come from press releases. I receive hundreds of news releases every day because people from all across the country are sending me their story ideas, telling me I should send a stringer or reporter from our headquarters to their city (wherever) to cover this or that because they thought it important.

When you are sitting down to write your news release, think of it as selling a product. If you have some innovative thing to do, how would you pitch that? If you were the buyer, what would attract you to this product? As Sheila said, we are looking for something new and different—something to catch our eye. At *USA Today* we have this saying: This is *USA Today*, not yesterday, not last week; this is *USA Today*. When you do your news release and you send it to *USA Today*, the person you should send it to is the planning editor. It varies from paper to paper or TV station to TV station, but there is an assignment editor or a planning editor. You should find out who that person is. Direct your mail to that person. When you call *USA Today* you will likely get the national desk and you will probably talk to a news assistant. Tell the news assistant that you want to talk to the planning editor or the assignment editor. Do not waste your time talking to the wrong people. Do not waste your time with elaborate packages. A simple, cleanly typed, double-spaced news release is just as good as a high-priced, slick production. The slick production will catch our eye, but if it is not about something new or important it will not get anywhere.

Timing is also important. If you are going to have a press conference, do not have it on a Friday because *USA Today* will not cover it—we do not publish on Saturday. Do not have it at 5 o'clock in the evening or 6 o'clock, because the news is on. Granted there are night crews, but if you want to get the maximum amount of exposure for your activity, try to schedule it early or mid-morning or early afternoon during the week.

Let me talk about the different departments. We have four departments. If you have something you want to pitch to the newspaper, there are two departments to which you can send your information: one is the news department; the other is Life. Now, the news department is mainly looking for trends. If you have some new idea or something new that you are doing in alcohol or drug treatment, we could use that as an angle to look at, say, the overall problem. Now granted, your story may not get a lot of play on 3a, but it is being highlighted as the hook to look at the larger problem. Also, if there is one person who is spearheading some fantastic program that you would like to have get attention, try to sell it to 2a, the newsmakers' page. Newsmakers are people in the news today for some newsworthy activity. Say somebody has done a report or some research that this conference is highlighting, that research could go on 3a or we could spotlight the person on 2a and still get in the content of the report, even though 2a is more about personality.

The other section that has done a lot vis a vis alcohol and drug abuse is our Life section. Alcohol and drugs are big stories as far as *USA Today* is concerned. The Life section stories are short, tight, and bright, but you will find all kinds of information on the latest reports, the latest trends, and statistics. It is chock-full of what we call fact toys. It contains a lot of information that you can use for your own purposes.

Also, there is a section of the paper that we call Close-Up where we take an issue and explore it. We bring it home and talk about it in human terms. We will go out and interview people. *USA Today* has a policy of not using anonymous sources; that cuts down on problems of plagiarism, making up stories, what have you. In these Close-Up stories, most times people will give us their names. We respect the fact that you might not want your name used, but most often people do not mind. On these Close-Up pages, we really do use real people with real problems and talk about how they can solve their problems. We run the names of organizations, places where they can go for help, and we often have hot lines where people who have problems can call in and talk to experts. We also do followup stories on these kinds of calls. Stories on who called in to say what kind of problem they had and what kind of information we suggested.

After you have done your news release and sent it in, about a week before the event is to occur, it is a good idea to call, because we operate a week in advance. On Wednesdays, we have our planning meeting. We look at what stories we are going to cover for the next week. We go through this file that we have each day of the week. We look at the news releases, we talk to the reporters who are covering beats to find out what is going on on their beat next week. So everybody, all the editors, get together in this big planning meeting and decide what stories we are going to pursue and how we are going to do the stories. So, it is a good idea to call and check with us to see if your story will be running. Also, just ask if there is any other information we need. The chances are, if there is any missing information, we will have a news assistant call you back.

For your event it would be helpful if you had a prepared statement. It is helpful for the media to have a copy. This cuts down on people saying they were misquoted or the reporter got it wrong. Have a copy of the statement ready; include a biography of the person, which will be quite helpful.

If you have done all of that, then you have pretty much done your job of notifying the media about your activity. Often people will call and say that they have sent their press release, they have done the telephone call, and so forth, yet no one showed up. What can you do about that? There are lots of things going on everyday. We may have plans to run your story; however, something more emergent may knock your story out of the paper. But do not give up; the next time you have something, go through the same process that I have outlined.

Major Discussion Points

Hypothetical case: Attempted promotion of Just Say No activities on May 15 (citywide project). Sent out information via information services of the city, professionally prepared, to 35 media specialists. Received only two TV stations for coverage. Got only a 5-second blurb despite parade and host of other activities. Another city's march was promoted over our activity. No newspaper coverage. Our activity coincided with the national march.

The media is tired of Just Say No. We have gone through the administration hyping it and at the same time cutting funds for education and treatment. The media is sort of between and betwixt watching them say one thing and do another. The community organizations are still jumping on the bandwagon; but we have already covered that. What is new? What is different?

Probably, because the city that received the coverage is in the same market area as your city, the TV stations just grouped their coverage. Additionally, something else could have influenced the degree of coverage. I am surprised that you did not get newspaper coverage; newspapers have larger staffs. Did you call after the event to determine the reason for the lack of coverage?

Let us look at other approaches different from the hard news route. What are the alternatives? Cheryl spoke about the lifestyles department. Perhaps it would be easier to get some media coverage on the lifestyles section—with a different approach. It is not so much that we are having a march today and everybody around the country is doing it—and unfortunately, it appears that the media around the country are not really concerned that the march was on that given day. Lifestyles, in terms of the newspaper, scheduled TV, public affairs—those are alternatives to the day-to-day news grind. There is another alternative: have you thought about producing your own message? Producing your own video is an alternative. Most major programs have the funding. You have the audience. You should gear your particular message to a specific audience and market your own video production. You do not have to go to TV.

It is amazing that the small, local newspapers did not give coverage. When you reach into the community newspapers, you have alternatives; it is a lot easier to get the smaller newspapers out.

Always think of a hook; you are selling your event. The media is looking for the next step after Just Say No.

If you want to get air time for, say a 15-minute, regularly scheduled, radio program about alcohol and drugs and their affect on the Black community, probably the easiest way would be through the public affairs department. Each TV/radio station, because they are licensed through the Federal Communications Commission, has a requirement to produce public affairs programs. Target your public affairs person, establish a rapport, and present a proposal. Another route is to find a local business or merchant to sponsor the program.

Remember timeliness. For example, the hoopla around crack—when something like that comes along, make sure that all of your resources are in place so that your organization is looked upon as a source for local expertise.

College sponsored radio/TV programs are probably more receptive to these kind of topics. Also listener-supported programs are often looking for people to come on and do a talk on such subjects—periodically.

The call-in shows are a good, free way to get your message out there. You also have access to cable channels. They are either free or involve minimal cost. Most areas are developing extensive cable services; they have a lot of air time to fill. There is a mandate that the cable carry municipal issues. Learn about the cable channels.

Cost depends on the market area in which you are interested. There are other variables too, like what day and what time. You have to call the sales departments of the stations you are interested in using for your messages.

My institute put out a large document. In it was a kind of "man bites dog" item, and that was what the news media emphasized.

If you do not want it in the media, do not say it—or make it clear that you are talking background and off the record. If you feel that you have been misquoted or that the reporter has completely missed the story or point you were making, contact the general manager or the publisher. There usually is an ombudsman that handles that sort of thing. You should demand a correction and/or clarification to any error. Not doing so runs the risk of an error being repeated; the error can go into the file and possibly be used again.

Most radio and TV have certain time blocks for PSAs; you do not really have a lot of choice. Each station is unique.

Speak Out (TV commentaries) is WJLA's version of alloting time for public service. That is just one way we do that. If you have an opinion on any topic, you should be able to get your point of view on the air.

Summary of Remarks by Angela Robinson

I want to remind you to be diligent in your calls. You have to worry them—and I know Sheila and Cheryl would rather not hear this—but I can tell you that you have to worry the media to death. They are used to it; it does not really bother them. They expect it, and, as long as you offer something that is contemporary, something that is a cause, something that affects a wide group of people, then you have a pretty good chance of getting your message across. But call them, write letters, send press releases; then start the process all over again. Then it is likely that you will get yourself some degree of media attention. And again, do remember the alternatives: think of cable TV, think about the very small community newspapers—you get more coverage and you are likely to get it more often.

Drug Enforcement: Old Problem, New Ideas

Moderator: **Carl L. Jackson, Special Agent in Charge, Washington Field Division, Drug Enforcement Administration, Washington, DC**

Panelists: **William D. Quarles, Attorney, Venable, Baetjer, Howard, and Civiletti, Washington, DC; former Assistant U.S. Attorney in Baltimore, MD**

Captain Michael J. Fannon, Commanding Officer, Drug Enforcement Section, Criminal Investigation Division, Baltimore City Police Department, Baltimore, MD

Summary of Introductory Remarks by Carl Hampton

Carl Jackson, your moderator, is a graduate of Prairie View University. He has more than 25 years experience in law enforcement, and is the senior Black law enforcement official in the Federal Government, and also in DEA. Formerly, he was chief of the Dangerous Drugs Division in DEA. He also has served in several regional offices, including as deputy director of the region office in the greater metropolitan New York area. He is currently involved with NOBLE, the National Organization of Black Law Enforcement Executives—yet another effort at self-help collaboration aimed at mobilizing Black professionals in the law enforcement field.

Summary of Remarks by Carl Jackson

The title of this seminar suggests where we have been, and where we might try to go. I do not think we have a panacea for this problem. The drug problem is one that is going to take more effort on the part of all of us to resolve. Some of the things that actually never get mentioned and that maybe, as a free society—a democratic society, a capitalist

society, we may have to drop back and start thinking about are where we are as a society and what we really want to do. We cannot have it both ways. We have a lot of freedoms in this country—I am proud of that; I would not want that to change. But with a lot of freedoms, there are a lot of abuses. And law enforcement really cannot deal with a social problem. And drug abuse is a social problem.

I have been in law enforcement for about 26 years. We have locked up a number of people, and we will continue to lock up people. But that is not going to resolve the problem. And I do not think anybody here today is going to tell you that. We, as a society, need to decide what we want to do. Legalizing drugs is not the answer; we have enough problems. We need to take a look at our values, at what is important to us. There was a time I would not have talked like this, because in law enforcement, we did not talk about values. We did not talk about where society is going or what we ought to do. We talked about locking up people. And that is all we talked about; that was our only interest. But law enforcement has become somewhat more sophisticated and has gotten on board with current thinking.

Many of the problems that we have—the criminal activity that goes on, the anti-social conduct—can be traced directly to poverty, discrimination, unfair housing, poor education, and any number of things that were mentioned by George Napper, Commissioner of Public Safety in Atlanta. But as people—and I do not mean just Black people, I mean as people, period—we have to start taking some responsibility for the things that we do. And many of us do not do that. Many of us feel that it is appropriate and it is okay to talk about criminal conduct and to talk about criminal activity as long as it does not relate to us. It is quite appropriate to lock up somebody and to jail someone if it is the person down the street. I am not so sure we would feel the same way if it was our 13-year-old, 15-year-old, or 20-year-old. We might think differently then.

I am from Omaha, NE—not many Black people in Omaha. When I was 5 years old, my parents moved us to Greenville, TX. I often wish that my kids could have had some of the experiences that I had in a segregated society. I know that sounds strange. But some of the values that I got in that segregated society, I do not get today. My kids do not get today. In Greenville, TX, we only had one Black doctor, but he was the doctor for everybody. He was not just a doctor; he was a teacher, a friend, everything. And so was the principal. So was everybody else.

Well, it is a little different now. My little boy goes to an integrated school in Fairfax County, one of the better school systems in the country. I think that is great; I like it. But I get so many phone calls from the principal about my little boy's attitude. You know, I do not even know what an attitude is anymore. Sometimes I wonder if it means that you cannot deal with me or if it means that you do not want to hear the truth from me. Does it mean I am not conforming to what you think I should do; or is it you just do not like me? Sometimes it is a lack of communication, but I have adjusted, I think.

Law enforcement to me has been very important. And over the years it has become very progressive. I am glad of some of the things that I have seen in law enforcement. We

have some topflight police departments around the country and some topflight law enforcement agencies, Federal and State. I think they are doing a good job. It tells me something, however, when we have to explain our successes in terms of how many people we are locking up. I do not think that is success. It seems to me it should be the reverse. If we are successful, then we should not have so many people to lock up. That seems logical to me; that makes sense. But we do just the opposite. I am not so sure that is what we want to do, but we have been put into that mode. And, of course, that is how we get our budgets. The more people we lock up and the more seizures we make, the more money we get. We can say we are being successful—maybe we are being successful, but it should be put into some kind of perspective. There are a lot of drugs out there on the street. If we seize 10 percent of what we think is coming into the country, maybe that is success. But 10 percent of 100 is not a lot. So we have a tremendous amount of work to do.

In the last 10 to 15 years, law enforcement has started to employ a number of different kinds of techniques to accomplish this task—a lot of reverse, undercover, sting operations. A number of things have been very successful in getting to the criminal elements and, of course, to the drug dealers. We will continue to do that.

I am sure we are going to have more success at that. I just wish there was some way that I could impart to you—some way that we, as law enforcement people, could get it over to the public that they have got to do more. The kids that you see out there running the streets, using drugs, and being locked up, they are not my kids. But they are human beings and we care about them. There has to be greater cooperation, and more coordination on the part of law enforcement. We need to see more evidence of a genuine interest in doing something about the problem.

Our values are at the heart of all of this—BMWs, Mercedes, things like that. I am not denigrating them; I am not suggesting they are bad. I think that anybody who can afford a car from Mercedes Benz or BMW or Mazarati or whatever it is, should get one. They are certainly good automobiles and they will last a long time. But I do not think we ought to be wrapped up in things like that. We are too oriented toward material things. It is very difficult not to be when you turn on the television and see these things.

As parents we have to reassess our values. We just have to do something about it. I do not really know what the answer is. I do not know what we have to do; I really cannot tell you that. But I think the country, to some extent, is going in the wrong direction; and that has to be turned around. That is up to us, as voters. We have to get people thinking about the things that are important to us—our future, our kids' future.

As parents we have to take a look at programming on television—what kids look at, what they see. Some of the television shows are really bad, I mean, truly not good. Some of them, though too few, are pretty good. I did not realize that *Fat Albert* was so good until about a year ago when my little boy turned it on in the morning. There are some tremendous things in that show that really just get you. It is a very educational program.

I wish they could show *Fat Albert* every day of the week. It is the only show that teaches decent living lessons that I have seen on television.

I am a little tired of some of these programs that take the male as being dumb and unable to do anything. He is made to be a clown for the family to laugh at. If you look at all these comedies, these routines, I think that they really hurt the male image in our communities. The father is depicted as a bumbling clown who cannot do anything right and everybody laughs at him. No wonder kids really do not listen to their fathers half of the time. They see him on TV as being an idiot. It is funny; I know that. We always get a big laugh out of that. I think Bill Cosby's show is one of the few shows that puts things in perspective. You see the male image on that show as being something we can respect and something we like. But most of the shows do a tremendous injustice to the male image.

The Drug Enforcement Administration was created back in 1930. As a matter of fact, it was not the Drug Enforcement Administration; it was the Federal Bureau of Narcotics at the time. In 1968, there was a reorganization. We changed the name from the Federal Bureau of Narcotics to the Bureau of Narcotics and Dangerous Drugs. We had another reorganization in 1973 when we became the Drug Enforcement Administration. We are a single mission agency. We only deal with law enforcement in terms of drugs—whether they are legal or illegal. The agency has grown from about 100 people back in the 1930s, to about 2,600 agents now, and it is still growing. We have offices in every State of the Union and in most of the territories. We have offices in about 50 foreign countries.

We have the National Eradication Program, in which we try to eradicate the poppy and marijuana plants in foreign countries. We are trying also to do something about the coca leaf. We have a number of ongoing programs right now in some of the South American countries in which we are doing just that. We are getting very good cooperation from those countries.

We do not have the staff to interdict or stop people from bringing drugs across our border. There are so many clandestine airstrips between here and West Virginia on which planes can land with all kinds of drugs and you would not even know anything about it. Last year we seized two cocaine laboratories in Orange, VA. These laboratories were capable of producing 125 kilograms of cocaine a day. They were sophisticated and contained all kinds of equipment—some we do not have in our own offices. These were labs we knew about and were able to close down. That is why it is tremendously important that we have cooperation from Federal, State, and local agencies, to get that job done.

Not only are drug dealers sophisticated in terms of the equipment that they have, but they are vicious. They are well-armed. As a matter of fact, in the laboratory that we seized in Orange, VA, we confiscated about 15 to 20 machine guns. Now, I do not know what they were getting ready to do, but that is a lot of firepower. We did not even have machine guns at the time. We do now. We felt that since they have them, maybe we better get some.

That is why it is very important as a society for us to really do something about this. Too many lives are being lost—not just from using drugs, but also from trying to enforce the law. There are too many law enforcement people that are losing their lives over this nonsense. Police officers are forced to put their lives on the line every day.

I am assigned to the Washington Field Division, which covers the States of Maryland, Virginia, and West Virginia, as well as the District of Columbia. We just recently opened an office in Annapolis. We have offices in Baltimore, MD; Charleston, WV; Richmond, VA; and Roanoke, VA. We work very closely with the Maryland State Police, the Virginia State Police, the Baltimore City Police Department, the Baltimore County Police, the DC Metropolitan Police Department, the police departments of Fairfax, Montgomery, and Prince Georges counties. We have been very successful on operations in which DEA worked together with local law enforcement agencies. I am putting success in the context of what we were trying to do. I am not suggesting that we have been successful in stopping the problem—we have not, but we are working on that.

The drugs of abuse in the DC metropolitan area range from anything to everything that you could think about. Unfortunately, PCP is still a serious problem and the drug of choice among a lot of young Blacks. It is a very dangerous drug. Cocaine is all over the place. Heroin is still available. But marijuana seems to be declining, along with methamphetamines. There is a lot of money being made by drug dealers. As a matter of fact, I think the figure last year was about $90 billion. That is a lot of money. Just think what could be done with $90 billion if it was spent for the right reasons. We could build hospitals, schools, all kinds of things.

We also have in our office two task forces. We have a PCP Task Force, which comprises police officers from the Metropolitan Police Department, the Virginia Police, and the police departments of Montgomery, Prince Georges, Charles, and Manassas counties. We have another task force comprising 22 police officers and a lieutenant. These operations have been very successful. People who serve on the task forces have the same authority as I do because they have been deputized, which means that they can travel across State lines. They are not prohibited from following criminals from Virginia into Maryland, from Maryland into Virginia, or from Maryland into Delaware. They can go up to New York, or they can go out of the country—with permission. They can go any place in the United States to make an arrest—the same as I can, with that deputization. I think that was one of the more important tools that was provided to law enforcement and the Federal Government, to be able to deputize State and local officers. This is also being done in specific instances with prosecutors—with State prosecutors, bringing them in to allow them to handle Federal cases.

Some things that we are doing in law enforcement are certainly progressive. The taxpayers are getting their money's worth. Unfortunately, I do not think that we can solve the problem. For the most part, we are doing our jobs and we are doing our jobs well. Of course, we probably need more people. You can be proud of the people—I am not talking about the politicians, I am not talking about those people who come and go, I am talking about those people who have 15 or 20 years in police departments—who are working and putting their lives on the line.

We have to support our local police departments more, too. Over the years, there have been some tremendous misunderstandings between police departments and local communities. I never see anybody visiting the police department. There is a police station behind my office, and I never see people go in there to visit that district station, to talk to their captain or his commander. Usually, when people go in, it is about something that happened the night before, or somebody might have been arrested, or they were looking for somebody, or something like that. But I do not see people go in to ask the commander what he is doing, or tell the commander they really like what he is doing and can he do some other things for them in the community.

These are the kinds of things that need to be done, rather than whining and complaining all the time about the police department not doing this or that. As citizens, we have an obligation to do some things, too. I do not think we are living up to our obligation sometimes. My office has been located at 400 6th Street since 1970, and I can count the times that citizens have come in to visit to see what we are doing. You ought to know that, you have an obligation. Come in and ask these people what they are doing in these communities. Someone would be glad to tell you what they are doing, maybe show you. It will give you a different perspective on what goes on in law enforcement.

Policemen have a reluctance sometimes to open up to the public. There is a real reluctance to deal with the press for fear of being misquoted, or somebody saying something that is incorrect. I do not think that people in law enforcement should be concerned about that. If you are doing what is right and you are trying to do the job, there is really no reason not to talk to the press. Certainly there is no reason not to allow people in the community to come in to see your office and to see what you are doing and talk with you. I encourage that; I think it is a good idea.

Summary of Remarks by William D. Quarles

Often citizens get a feeling of some distance from the police department. But I think that it is a two-way street, and you ought to consider a couple of things when you think about how you relate to the police department. First of all, a lot of the feelings that you have about police departments is based on the fact that, historically, police departments have had lousy relationships with Black communities. It has been a rather small, poor, powerless community versus them. The police have often been, again historically, a sort of occupation army within the Black community. A lot of the attitudes, particularly of the people of our generation, who are now assuming leadership positions in our community, were formed from that experience. But you cannot have those attitudes blind you to the fact that now, in many cities, we control the police department. In the City of Baltimore, there is a Black police commissioner. In the State of Maryland, the former, Black police commissioner is now head of public safety, which runs the State police and other law enforcement agencies in the State. There is also a substantial minority population in Baltimore, and it is well represented in the police force.

I am now a resident of the District of Columbia. I know that not only is the police chief in the District of Columbia Black, but the majority of the police department is, in fact, Black. So a lot of the attitudes that we have had in growing up from being a poor, powerless, occupied community, we have to change. Because that is not the position we are in anymore. In many urban areas, because of our political importance, we now control those institutions.

Even though I am not an active prosecutor anymore, I do a number of these types of presentations, because I think drug abuse is a pretty serious problem. It is something that still concerns me. The Black community, back in the old days, was in fact a community made up of several classes. My family was a poor family in Baltimore, but on one side of us lived a physician and on the other side of us lived a school teacher. I was a poor kid—my dad was a longshoreman; but I got the advantages of the doctor's kid and the teacher's kid because I happened to live close to them. The physical closeness presented role-models and provided other sorts of benefits. Because of those benefits—it seems strange singing the glories of housing segregation—our communities were whole communities; they had social classes and role models. They had all sorts of informal institutions, such as our church and the social groups that provided a number of the services that are provided in the larger communities by formal institutions.

We have lost that, and there is now in the Black community a special separation. There are Black upper-class communities, and Black middle-class communities, and Black poor communities because of changes in residential patterns. That does not mean that we have to lose the advantages of segregated communities. Again, you have to realize that because of our political influence in cities, we now control many of the formal institutions that were formerly all white. In the past, enforcement within the Black community was something that was done by parents because they were aware of their children's activities. They were aware when a kid showed up with $10 for which he could not account. A lot of the enforcement activity was done informally. Well, the fact of the matter is, we now have control of the formal institutions. We have to make those institutions responsive to us, just as we had informal institutions that were responsive when there was stronger residential segregation.

Summary of Remarks by Captain Michael J. Fannon

The City of Baltimore comprises 760,000 people who are spread over 86 square miles. Fifty-nine percent of the population in the City of Baltimore is Black. The average income is $16,700. We have about 3,000 sworn police officers and 500 civilian employees. Stress is a very important consideration for all of the commanders in the police department, particularly in the drug enforcement section. There are a variety of hazards that impact on the individual officer's ability to cope, and stress does affect his family and how he deals with his peers. We have established programs and a monitoring

system so that when individuals come under stress there are in-house programs that he can use to get counseling, to get help. In the Baltimore Police Department, we also have a rotation policy for our drug enforcement officers, that is, we limit the tour of duty to 3 years—with certain exceptions. We recognize that doing this narcotic enforcement work over an extended period of time can have an adverse impact that we do not want to see. We recognize the stress of police work, and we continually monitor the officers. We have a medical section in the police department with nine police physicians, who are also available for counseling and who make referrals to programs.

During my 18 years on the Baltimore City Police Department, we have had 15 police officers killed in the line of duty—some white, some Black, some by white perpetrators, some by Black. During all of these incidents—some of which I was very close to, some of which were farther away in other districts, I do not think that there was an impact that showed a disparity between whether it was a white officer or a Black officer, or whether a Black person or white person committed the act. When that happens, we are sort of all blue at the time. We are not white or Black; we are all officers in uniform. And we all feel a sad loss; a tremendous tragedy like that affects us all.

Major Discussion Points

You need to differentiate between an open door policy in police departments giving me access as an individual to you, and a group of people coming together to talk to someone in charge in the department. I know the workload; I work closely with police officers also and I know the workload down there. They are all about the place; they are on call all the time. Someone wants them somewhere all the time. So, it is not reasonable to believe that I can walk in individually and speak to the captain at my leisure. I doubt seriously if the captain would want to spend an hour with me on something I want to talk about. I think he would be more inclined if I came from the homeowners association with an issue that impacts a broader spectrum of people. I think maybe what we are being presented is the illusion of an open door policy, which in fact you do not find in a bureaucracy of any nature.

Obviously, groups always get more attention than individuals. If you say you represent a group when you go to the station, you obviously are going to be higher on the list of people to whom the police officer is going to allocate his time. But do not forget, there are other things. I know the DC Police Department, for example, offers Ride-Alongs, which I encourage everyone to take if you have not done it before. You can go in and schedule to spend 4 hours in a police car with a police officer to see what he or she does during half of a shift. Their public information office will schedule it for anyone. If you really want to be educated about what a cop does during the day, take a ride with a cop. That is something you do not have to be a group member to do—you do not have to represent 50 or 60 people to do—it is done one on one.

In the Drug Enforcement Administration, we have created another unit, called the Demand Reduction Unit. It speaks to the demand side of drug use, not the supply side. Actually, it is looking at doing something to prevent people from using drugs. This program is relatively new. It was set up last year, but it has been expanded to include a Demand Reduction officer in each division. We have 19 field divisions throughout the country, and there will be a Demand Reduction officer in each division. His primary function will be to go around and talk to the public, to show movies, to make himself part of that community, and to do whatever is needed to help do something about the demand side of drugs. Now, I do not know that that is going to end the problem, but I think that we are taking a more realistic approach in recognizing the fact that we do have people that are using drugs. We are beginning to see some interest in these new programs. One, you have to enforce the law. Two, you have got to treat the people who have drug problems. And three, you have to prevent drug use.

It is probably unrealistic to expect law enforcement officers to have a major impact on demand reduction. The hunger for drugs is social in nature. It is a lot of things; it is the fact that drugs are cool—I think that is a word that kids are still using these days. The fact that the media—the movies, the TV shows—show that drugs are fine contributes to the demand for drugs. In the movies and literature, drug use is associated with glamour, fun, joy, and the good life. It is unrealistic to expect law enforcement people, who have a hard enough time as it is getting rid of that 10 percent it is estimated that we take out of the drug supply, to do anything about the hunger or the demand from drugs. It is going to require a much broader social response from people who are not tolerant of people who pull out a marijuana cigarette in front of you or use cocaine at a party. Drug use has got to be made unpopular. That is something that cops cannot do. You cannot have a cop on every corner or a cop in every bedroom. And I do not think you want to live in a society that has a cop on every corner.

There are precincts in the neighborhoods that really do not want you in them. They make it known that you are not welcome, even to inquire or report something happening in your neighborhood. I recently went to my local precinct to report drug dealing on my street and barely got a response. They were, in fact, hostile to me.

I do not think there is anything more important in law enforcement than sensitizing the police officers to the needs of the community. The type of treatment you get has a lot to do with leadership. I have been to districts in the City of Baltimore in which I knew right away what their commander's philosophy was as it related to the community—just by walking into that district's station house. When you have individual commanders who are caring and concerned about the community, who deal with the community on a regular basis, and who know how officers are treating the citizens when they come into that station house, you are more than likely going to have a good station. You are going to have a station where you can come in and feel welcome.

There are also some variables that work against you that sometimes you do not even realize. It could be simply the physical layout of the particular district. If, for security reasons, for example, you have one entrance and that entrance causes you to have to pass the cell block and the desk sergeant's area and he has prisoners lined up with officers—watching the prisoners, searching them, and booking them—you are going to have a much rougher time than if you had a normal, daytime entrance in the

front of the station house which led you to a community relations sergeant or some other officer to greet you.

Again, I must emphasize that it is a matter of leadership. I do not think you should give up or turn around when you meet resistance from some law enforcement officers. Yes, they are under individual stress and there is a lot going on in the station house, but they are not going to get anything done without you. They are not going to get anything done without your assistance.

I am a correction officer at the Indiana Girls' School, and I have seen 14- and 15-year-olds arrested for possession. They come to the Girls' School and spend 6 to 9 months learning social skills; and the day they get out that same disorder is there waiting on them. Because of that, this 15-year-old becomes a repeat offender three or four times before she is 18.

I cannot say that law enforcement officials actually stop any problems or that we are having any tremendous success. We are doing the best that we can to remove drug sources from the communities. We try, particularly the Drug Enforcement Administration, to put our resources at the highest levels of the traffic. We try to get the most important people that we feel are having an impact in the community. That might not say much to or help the person who sees the guy on the corner every day who is dealing, but we do not work low-level cases. However, I know the police department here has been working a lot of different kinds of things. They have Operation Clean Sweep and a lot of other things that are fairly successful to get drug dealers off the street. Of course, sometimes they get them off the street today, but they are back on tomorrow—though often in a different area.

I will tell you one thing, I live in Virginia and I do not see any people hanging on the streets. Those people out there will not have it. I do not see anybody hanging on the corners and staying around and smoking grass and things like that. Now, they do that at the schools sometimes, or they might go down to the mall and hang around in the mall, but you do not go in these communities out in Montgomery County, and probably Prince Georges County, and certainly not in Frederick County, MD, and see people hanging on the street. The people will not have it.

We have done one thing in Indiana. Historically, the Department of Corrections has insisted that people coming out of the correctional system be screened when they leave the institution, and they have referred them to services, including substance abuse services. For the first time, this year we are trying to work with the Department of Corrections to get these people when they first come out. Although they do not have any problem now—they may not be using drugs—it is obvious that when they go back to the community, they are going to be involved with the people that were there before. So, if we can catch them before they get back into the community, we can send them to a treatment program or some kind of service where they can get some more skills to help them to deal with their attitudes and, we hope, modify their behavior. This approach might prevent them from being repeat offenders.

Perspectives From a Commissioner of Public Health

Speaker: **Reed Tuckson, M.D., Commissioner of Public Health for the District of Columbia**

I realize exactly where I come in the program, and I know exactly what you have been through, and I know that this is Friday evening at 6:00 o'clock, so I promise to be mercifully brief. It is a pleasure to be here, and I am surprised that this many people are here at this hour. It shows me that this is an audience committed to trying not only to increase your own fund of knowledge, but to gather and develop ideas that will be transplanted and nurtured around the country. It is difficult for me to speak to you, because I think that most of you in the audience are probably more expert in this particular facet of the health field than I am. So I want to be very careful that I do not misrepresent myself as an expert, but I think as I was introduced, I am somebody who is on the front line trying to struggle through some very difficult issues from a community and a city perspective.

The District of Columbia is quite typical, I would imagine, of most urban municipalities around the country. We probably are confronted by similar kinds of statistics. We probably suffer from the same difficulty with resources, the same community pressures, and the same difficult political issues. I imagine also that we have the same kinds of social and demographic issues to work through. So perhaps I speak to you as somebody with a little larger or broader perspective than someone who is managing or running a program. I find myself trying to share with you ideas that may be a little more global, a little more sociological, or societal, a little more related to institutions than related to a specific treatment modality. I hope that you will accept that.

We in DC are not proud of the statistics. I do not want to go through a numbers exercise, but I think it is important that you have a sense of the scale of the problems we face. This is a city of some 630,000 persons, 75 percent of whom are Black or other minority. In our city, 85,000 of my neighbors and friends are alcoholics, 16,000 are heroin addicts, and almost 60,000 are probably drug abusers—primarily cocaine and PCP. We are considered not only the Nation's capital, but the PCP capital of the country as well. We have the highest per capita PCP usage rate in the country. In addition, available data on cocaine usage reflect a consistent pattern of increase in use.

Over the past 4 years, we have noticed an 82-percent increase in the number of patients admitted for drug treatment services. This pattern is exacerbated by the escalating numbers of adult and juvenile referrals from the criminal justice system. The city's arrest procedures include urinalysis tests of all who are arrested and charged with major offenses. Tests are conducted for opiates, cocaine, amphetamines, methadone, and PCP. What we find is that 73 percent of all adults arrested and 15 percent of all juveniles arrested test positive for one or more drugs. Seventy-three percent of all adults arrested test positive for one and, so often, more drugs. During March of 1987, the latest month for which I was able to get statistics, 42 percent of all adults arrested and 30 percent of all juveniles arrested tested positive for PCP. Forty-six percent of all adults arrested tested positive for opiates, and 10 percent of all juveniles arrested tested positive for marijuana. Those numbers just give you a sense of dismay.

We have a very aggressive police department. We have an operation called "Operation Sweep" in our city, in which the police literally go out and clean the streets of the drug-abusing population. What that has done is send a very dramatic message throughout the city about what will not be tolerated from a supply perspective. What it does for me is to create incredible waiting lists and lines of people that need treatment services, numbers that are straining the very roots of our treatment system. That says that when we try to look at the major issues affecting our city, we need to create treatment slots and finance them and be able to manage the programs in a cost-effective way. Perhaps the most critical step for us is to convince the community that we are all in this together and that you cannot treat people if you cannot open up a treatment center and, especially, that you cannot play the usual game of "but not in my neighborhood."

We have in our city a very aggressive deinstitutionalization movement to get people out of mental institutions for long-term care. We also have youths who need special housing and we have prisoners who need to get out of an overcrowded prison system. We have a very dramatic increase in demand for a very limited supply of essential services. You get a city like Washington, DC, which historically has had residents over 20 or 30 years who have fought their way through discrimination and housing bias and redlining and all of that to finally get to become middle-class citizens and to live in a neighborhood that has green grass and trees that are pretty, and having gotten there, finally, find a government saying they are going to establish an outpatient drug treatment center down the block from them. Naturally you hear, "Oh, no! That is not what the last 20 years were all about." What one begins to understand is that the critical thing becomes the fostering of an attitude in our city that says, "If we are to save the very life of this city, we ought to be able to save the young people who are diseased and ill and need our services." We have to begin to understand that we have to open our doors in our communities and make these kinds of facilities available.

I have a waiting list, depending on the month and depending on the activity of the police department, that ranges between 300 and 600 people. That is unconscionable! That is unconscionable! The community rails and complains and says, "You have to do something." They say that in all parts of the city. So the issue is how do you make that happen? Well, one of the ways that it has to happen is that we have to become very skilled in how

we run our facilities from a management perspective. I have now learned that one of the most critical jobs in our Alcohol and Drug Abuse Administration is that of the person who drives around to every treatment facility we have to see whether or not cups have been thrown on the sidewalk, whether or not people are loitering, whether cars are parked and people are putting needles in their arms in front of the treatment centers. Managing the facility in a way that is not intrusive to the community becomes the most critical activity. If I cannot run them well, I am surely not going to get any others.

This community also suffered, about a year or so ago, a very significant tragedy. It was also, from a drug abuse prevention and treatment perspective, a very significant opportunity. We suffered the terrible death of a young man who was loved, revered, cared about, and watched in our community; that was Len Bias. The death of Len Bias did something for this community that a million dollars worth of preventive advertisement and commercials and all that sort of thing would never have been able to buy. It is unfortunate that it took the life of a genius, a physical genius, to have that kind of dramatic impact; it was unfortunate, but real. What we understood in our community was that all the drug treatment facilities in the world would not have saved Len Bias. It is in fact always prevention that is the key. Prevention is the key.

So as we are about to undergo the next NBA draft, our community is going to remember very carefully that we have to come together as a family and continue to address the issue. We understand that the statistics that I gave were statistics about individuals who are impaired—numbers, yes, but numbers that are real people. What those statistics also tell us is that drug use has an unbelievable impact on our family structure, in our neighborhoods, and in our society as a whole. What we have been undergoing is some kind of dialog, and I think that is what you too have been doing in your own neighborhoods. I think we all understand this.

It is in fact the family, the neighborhood, and the society as a whole, from which the keys to success must ultimately spring. It is not methadone; it is not the new therapeutic drugs. It is not the therapeutic community as a single treatment modality that will make a difference. What will make a difference is a community that comes together and says we are prepared to create an environment and an attitude that says a few things to all of our people. It says that the young people in our midst will be allowed to exist and develop into whole persons. Our kids must begin to internalize a concept that is foreign to many of them now, and that is the idea of the possibility of a future.

We must stop thinking that it will not work. None of what we do, I think, will work if you only think that you are going to survive up to the age of 15. If the world ends at 15, then all the preaching and teaching and cajoling that we do does not mean a thing, because you are going to have as much fun up until 15 as you can, and then it is all over. You are not going to college, and more of us are in jail than are in college anyway, and there is no hope, so why bother? We must change that kind of thinking.

The most important therapeutic modality I have is religious institutions. Others are the civic associations, the Area Neighborhood Councils, the fraternities and the sororities.

Without them I have nothing. Without them we go no place. We have to find a way. I am into "four wallism." That means I go around and try to find four walls that capture people. Wherever you can capture people, perhaps you can get an opportunity to speak to them. Maybe, if you are good at how you speak to them, and you speak to them in the right way with the right words and coming from the right direction, maybe they will begin to listen. The people that we have to put four walls around first, I think, are all the adults, the parents. What we are beginning to know and what our data have suggested to us is that the majority, not the minority, of our young people are first introduced to illegal substances by watching their parents. It is the adults who have to recognize that they have to change their behavior if the young people are going to change theirs. "Whatcha gonna do?" becomes a fundamental challenge for our adults. I think that once you get parents involved and once you get the religious institutions involved, you have then begun to move.

I spent some time with fraternity groups—the Omega Psi Phi fraternity, the people with the "Q" designation on them. I went to Howard University as an undergraduate. The Omega Psi Phi was the hippest partying fraternity on our campus at the time. I did not belong to it; I was not hip enough. We made a challenge to them. I had 300 of them in a room one day, and I said, "Listen, when you go to your next hotel suite and you order the biggest suite and you have Dom Perignon and Martel and the other alcoholic beverages, and then you reach into your pocket—because you all are the hip people and you know what is happening—and somebody pulls out that white powder," I challenged them, saying, "the most significant thing that you can do at that point is to sneeze." It seems to me that when the people who are setting the standards for what is cool, for what is hip, for what is desirable, they have to be the ones to begin to then create the environment, the attitude, in our community that says this is unacceptable behavior. The people who really are cool are the people who, in fact, have their eyes screwed in straight, have their wits about them, and have a sense of who they are. That is what we want to transmit to the young people.

The same thing goes for the sisters—the Deltas. So what I fundamentally come back to, without belaboring the point, is this: get involved. I know that this is hard to accomplish and sounds nebulous, but this is what must be done. I try to spend my time—I am talking about my Saturdays and evenings—trying to find a way to create an environment that says to our young people, "We care about you." A simple, plain message: "We care about you." To assist us with that message we have created something called PARADE—Parents Rally Against Drug Epidemic. We are trying to find ways of organizing parents. You probably have better ideas on it than I do, but we think our most valuable resource is involved parents.

But how parents do talk! Right now, in our city, I am going through a major fight around health centers based in schools. Those of you who have been through those fights in other communities know the difficulty. You have people saying, "But you're not going to talk about sexuality or give contraceptives to my kids—not in a school." And, "That bad Dr. Tuckson is trying to bring these issues in our schools." What I have said to them—regardless of how we work this thing out in our pluralistic democratic com-

munity, and that kind of process is important—is that I am not going to do anything in these areas without parental consent. Then the traditional public health people say that parents are not involved with their children, so if you demand parental consent you are going to miss some kids. I understand both arguments. However, I am not prepared to write off the parents' responsibility to the young people. What that says is that before I can give up and before I can say nothing works, I have to start teaching parents about how to talk to kids about different issues.

When it comes to sexuality, if you cannot talk to kids about sex, think about how difficult it is to talk to your kid about a baby. It is much easier to talk about condoms than it is to talk about a 7-pound screaming, crying kid. We have to help our parents talk to their children about drug abuse and other unacceptable behaviors. We have to talk about making decisions. It does not matter which drug it is. If I get caught in a trap talking about PCP and doing a heavy intense PCP thing and then the next designer drug comes along and they call it something different, I will just be chasing my tail about this drug one day and another drug the next day. What it comes to is very fundamental—whether it is teenage sexuality or whether they rob or steal, it ultimately has to do with how do you make decisions. It is values; it is principles. Is there a sense of a possibility of a future? Is there a sense of a community that cares? The kind of people needed for the fight is important. I am looking not just for psychologists, but psychologists who are experts in decisionmaking.

The other thing then, of course, is that once you have created the environment, then you have to start practicing the technique of saying no. Just saying no is not the end of it. We understand that there is a learned skill to that, and you who deal with the prevention field every day know that there is a science to it. I do not know all that science, but at least I am strong enough to realize that effectiveness in any skill requires practice. How you deal with the situational psychodynamics that reinforce the student's ability to say no is important. We have tried to combine the two. I happen to believe in the arts. You have to use your artists. If you get good artists who can challenge young people, if you can get artists who can show young people that there is something called an imagination, which, if used and exercised, can be as powerful and exciting and entertaining an experience as any drug, and cheaper and much more reliable and always available, then, perhaps, you can get young people to say that they do not need the artificial thing, that they can get into their own imaginations and discover new and exciting possibilities. We have tried to put that together.

We have an exciting theater company in our city called the Living Stage. The Living Stage is a group of committed, prepared artists who are willing and able to work with youths who are caught up in drug abuse. They took 20 youths who had PCP problems and worked with them for a year. They went through the entire milieu of what it takes to train an actor. They gave them a camera and told them to go out into our city streets, into the socioeconomically deprived parts of our city, and take pictures of love, pictures of hate, pictures of despair. What those young people came back with was fascinating. They began to develop a sense of creativity, a sense of belief in themselves, a certain

sense that they, in fact, had talent they had not conceived of that made a very dramatic impact on who they were. We found that to be an extremely useful intervention.

If anyone has other ideas like that, we would like to hear from you. If you would like to steal this idea, we think it would be lovely, and we would be happy to give it to you.

We also understand the role of the athlete. We are very fortunate in our city that we have some committed professional athletes that are prepared to do more than give lip service. They are prepared to do more than come by and rap to the kids for a day. They are prepared to get involved for the long run. We have developed a concept called "Super Teams," in which the professional athletes develop a cadre of young people to help them mold positive images. These young people are the athletes and stars of the high school world. They pass on their experiences and use their influence in the elementary and the junior high school.

Last year, shortly before Len Bias died, I came up with the idea of a "Drug Free DC Day." We stopped everything for a day in our city and said let us decide as a community that July 1 is going to be Drug Free DC Day and this is what the city will talk about. We went to the media. We went to our public broadcasting station. We did an 18-hour radio show and took every celebrity, expert, theoretician, and academician, including Ron Clark from RAP, and put them on the radio all day long. We got every celebrity that came through town for about a month before that to tape a promo. We had people saying, "This is Mohammed Ali, and I'm saying this is Drug Free DC Day: Don't do drugs." We did that on the stations the kids listen to, the ones they tune in on their ghetto blasters. We got them to program all through the day: special spots, announcements, commentaries, editorials, and all that sort of thing. Even the old folks' stations had it. We went out to the senior citizens centers and talked to them about prescription drug abuse, because we also understand, although we do not ever talk about it, the abuse of prescription drugs leads to more deaths and illness than all illicit drugs combined in this country, and we sometimes forget that.

The issue was everywhere you went in DC that day; you got "This is Drug Free DC Day." We asked the police to give us the worst drug corridor in the city for that month—where everybody congregates—and took the recreation department's band shell and parked it right in the middle where everybody sits. We parked it in the middle of the street and then brought in the most significant cultural movers and educators of our young people in this city. We did not bring in the teachers; we brought in the musicians. We brought in the go-go musicians. Go-go is their music.

Go-go is a muscular, energetic, vigorous music that comes out of the heart and soul of this city. It is in my genetic structure, so that when I hear it, I have to stop what I am doing and move to its rhythm and beat. It has a visceral impact on the folks in our town. The go-go scene is what our youth are addicted to. It was associated historically with the abuse of PCP. That concerned the go-go community, not only because some of them are actually rational people, but also because, from an economic perspective, it threatened to wipe them out. It was in their financial best interest to try to disassociate

themselves from this activity. It became very convenient to us, from a market perspective, from a financial, capitalism perspective, to induce these folk to get involved in anti-PCP messages. It was a win-win situation because the kids were listening to them, and they needed to get the kids to stop doing PCP.

We got the people who were role models to come forward on this. We had Chuck Brown, who is the king of go-go, to stand in the middle of our band shell, in the middle of the drug community, and say, "This is a new song, don't do that 'Love Boat.'" It was tremendously powerful, because as soon as Chuck Brown walked down the street, it was like the Pied Piper—one million kids followed along behind him. Then we brought in Mohammed Ali. Mohammed Ali walked down the street, and the other million kids that were not with Chuck Brown went with Ali. Every member of the City Council came; all the news media came. The only thing on the news that day was Drug Free DC Day. We had a riot because we did not have enough T-shirts! The T-Shirts became the T-Shirts for DC for the whole summer. I now understand that T-Shirts are very important.

We were able to get an innovative film company to come in and do a video for us on "PCP is not for me." They got the go-go bands and other celebrities to come in and do a very dramatic piece for us, which was done very well for almost no money. We showed it on our public broadcasting station and the Howard University station. We marketed it on every bus and every tree. What we did was to basically take a giant poster that had all the prevention health information that you could imagine on it and made it an advertisement. You go outside, and you will see the sign.

We followed up on our TV show by showing the film all around, with a live call-in. The kinds of questions that were asked and the number of people that tuned in were really incredible. We intend to take the film and convert it to 16-millimeter format and promote it to schools. The athletes who serve as role models will take the film into the schools, show it to junior high and elementary school kids, and answer their questions using the film as an aid. We will combine all of our films into one package for use by the community.

I will conclude by saying that it is these kinds of programs that will have the greatest impact. I may not be able to measure the impact, but I do know they made a difference. I hope that we will be able to create, ultimately, in our city an environment, an attitude, that just says that drug abuse is not to be tolerated. Drug use is not what is hip. There is no one who is rational, cool, hip, a role model or symbol, who will support such activity. That, in fact, we will nurture the young people. We will say that we care. We will make sure that you will have a chance to grow. Ultimately in the District of Columbia, for our youth, there is a genuine possibility of a future.

Alcohol and Drug Abuse: Impact on the Black Community

Moderator: Peter Bell, Executive Director, Minnesota Institute on Black Chemical Abuse, Minneapolis, MN

Panelists: Dr. Terra Thomas, Assistant Executive Director, Human Resources Development Institute, Inc., Chicago, IL

William Haskins, Director of Training Department, National Urban League, New York, NY

Bettye Ward Fletcher, Associate Director of Research and Training, Alcohol and Drug Studies Center, Jackson State University, Jackson, MS

Dr. Jay Carrington Chun, II, President, Medgar Evers College, Brooklyn, NY

George Napper, Commissioner of Public Safety, City of Atlanta, Atlanta, GA

Introductory Remarks by Elaine M. Johnson

Welcome to the second day of this very historic conference. We want to extend special greetings to those of you who are joining us for the first time today. You will find that the energy level of conference participants is very high and the dedication to purpose is strong. Anyone coming to this hotel today or yesterday would find it apparent that we are very serious about the business of the conference. So let us continue.

I have just a couple of reminders. One, today is our special luncheon, and we also have a tremendously important plenary session. As I sat through many of the workshops yesterday, I heard many of you say, "Where do we go from here, and what are the next steps?" To answer these questions, we've designed this morning's plenary session. We also have asked some of the leaders of national Black organizations to come together as discussants and begin to look at where we should go from here and what types of

postconference activities we should have. I strongly encourage all of you to come and fully participate in this session. Also, I think that it is very important that we leave here with a commitment to act on the ideas discussed during the conference. So, without further ado, I would like to turn you over to Dr. Jacqueline Bowles from the Office of Minority Health, who helped put this workshop together and will introduce the plenary session.

Summary of Remarks by Jacqueline Bowles, M.D.

It is a pleasure for me to introduce my plenary panel, "Alcohol and Drug Abuse: Impact on the Black Community." I would like to introduce our moderator, who is probably well known to many of you, Mr. Peter Bell. Mr. Bell is currently the Executive Director of the Minnesota Institute on Black Chemical Abuse located in Minneapolis, MN. He cofounded this organization and has led it through its more than 10-year history.

Mr. Bell has written numerous articles and is also the coauthor of a book entitled *Counseling the Black Client: Alcohol Use and Abuse in Black America*. He has provided technical assistance and training to numerous organizations in over 40 states and to NIDA, NIAAA, the National Football League, and Rutgers University. He has appeared on several television shows such as NBC's *Alcohol, Kids, and Drugs* and PBS's *The Chemical People*. He currently serves on the boards of directors of several organizations that are interested in substance abuse.

Summary of Remarks by Peter Bell

When people introduce me, often I am met with a kind of quizzical look. They say, "The Minnesota Institute on Black Chemical Abuse? I didn't know there were any Black people in Minnesota. What happened, did all five of you get together to work with the sixth rascal or what?" Well, I am here to set the record straight: all ten of us are doing quite nicely, thank you. Seven of us are here!

It is really a pleasure and an honor and fulfillment of a dream to see the great turnout that we have for this conference. I am particularly pleased by the large number of folks here who do not work in the alcohol and drug abuse field. Too often I feel somewhat incestuous when we only talk to one another. This has truly provided me an opportunity to have a dialog with people who do not work on alcohol and drug addiction professionally.

The focus of this morning's plenary session, Alcohol and Drug Abuse: Impact on the Black Community, is a topic in which I am particularly interested. Too often the leadership in the Black community addresses the problems of education, quality of health care, crime, jobs, economic development, and housing. They often raise the question of whether the alcohol and drug abuse problem will dissipate. My response, unfortunately, is no. The simple fact is, if you give an alcoholic a job, all you will have is a drunken employee. I believe that solving these problems would be of some use in preventing persons from developing alcohol and drug abuse problems, but we would still be faced with the problem of active and practicing addicts and alcoholics.

We must never forget, as a Black community, that the demographic trends of alcoholism and drug addiction have moved rapidly from communities and cultures that do not necessarily suffer from racism, oppression, and the lack of opportunity to full access to all of society. We must always remember and understand, as a Black community, that quality education will not be achieved in the Black community as long as many of our children go to school stoned or return home to intoxicated parents. Thirty-one percent of high school students are considered to be alcohol users. Fifteen percent of high school students are heavy drinkers. What is tragic about these statistics is they do not include dropouts, who are disproportionately Black.

Thirty to forty percent of all delinquent crimes are committed by people who come from alcoholic homes. About 7 million Americans under the age of 20 have at least 1 alcoholic parent. That is something I have not heard discussed to the extent that I think appropriate at this conference, the thorny issue of children of alcoholics.

The divorce rate among alcoholics and drug addicts is seven times as high as among nonaddicts and nonalcoholics. Two-thirds of all runaway children in this country have alcoholic parents. Alcoholics constitute 35 percent of both spouse and child abusers, while constituting 10 percent of the population. It is the third leading cause of birth defects in this country. The fetal alcohol syndrome disproportionately affects Black Americans.

Many experts, myself included, believe that alcoholism and drug addiction, when their effects are combined, constitute the leading cause of death for Black Americans. We have twice the rate of cirrhosis and 10 times the rate of cancer of the esophagus when compared with the overall population. If we look at the mortality and morbidity rate for adult alcoholics and compare it with Black Americans, the risks are virtually identical.

Our chances of significantly reducing crime in our community are slim until we recognize and address the fact that there is a clear and undeniable connection between crime prevention and alcohol and drug abuse prevention. In 50 percent of all homicide and rape cases, alcohol is a contributing factor. Up to 60 percent of all our prison population consists of those under the influence of alcohol or drugs during the commission of the crime that caused them to be incarcerated.

Expanded job opportunities in the Black community will have little significance until we, as a community, meet the challenge of the alcohol and drug problem of the unemployed and underemployed. Sixty to eighty percent of addicts and alcoholics who enter treatment recover, but the recovery rate drops significantly for those persons who have lost their jobs. We all know who is disproportionately unemployed in this country—Blacks.

Quality housing in large part depends upon the character of the surrounding neighborhoods. A quick and significant step we can take to improve the character of our neighborhoods is to look at and challenge public drinking and particularly destructive media messages that bombard our community from the alcoholic beverage industry. We recently conducted a study comparing *Jet Magazine* with *People Magazine* and found that *Jet* had twice as many alcoholic beverage ads as *People Magazine*. Looking at *Ebony* versus *Life*, we saw 27 percent more alcoholic beverage ads. Black radio stations have 360 percent more alcoholic beverage ads than white stations. We need to take control of some of the messages that are coming into our community.

Our panel this morning is well suited to address the issues I have raised and to significantly expand upon them. Our first presenter is Dr. Terra Thomas, Assistant Executive Director of Human Resources Development, Inc., Chicago, IL.

Summary of Remarks by Dr. Terra Thomas

I was asked to talk about housing and the effects of substance abuse on housing. I started thinking about the neighborhoods in major cities across this country. If you think about homes in neighborhoods that are decaying—where there are abandoned buildings, where there are buildings that are not well kept and are falling down—that is where you will find alcohol and drug abuse rampant.

Substance abuse is especially devastating to the Black community. The family is the number one unit in the community, and when the family is destroyed, the leadership in the community is destroyed. As the leadership begins to die, institutions deteriorate. We know about the degrading effect that alcoholism and drug addiction has on the individual. We know how, over time, the person's hygiene becomes very poor; his or her physical health deteriorates. If you think about the long process of addiction in terms of the toll it takes on the individual and how it effects the family, sometimes in terms of sexual abuse, child abuse, and domestic violence, there is a parallel process that also happens as far as housing is concerned. The physical edifice that people live in, the way it looks, the way it is kept, is sometimes a manifestation of the social habits of the people who live within it. As the people who live in some communities begin to lose control over their ability to drink, over their ability to make decisions for themselves, a subculture begins to develop. A subculture develops that accepts deteriorating conditions, human and environmental.

Black people often operate on the premise of an extended family. In Africa, the whole community becomes your family. The alcohol problem in this country is not confined to one's household. It reaches out and affects the entire neighborhood. And, if a subculture develops where people accept substance abuse as a way of life, then we begin to see the physical manifestations of substance abuse throughout the community.

I live in Chicago. In 1985, the National Black Alcoholism Council (NBAC) did an analysis of alcoholism and drug abuse within Chicago public housing. Chicago's public housing is a prime example of substance abuse in poor housing conditions. People who live in public housing are probably no more susceptible to alcoholism and drug abuse than other populations. We use this as an example because we can look at public housing all across the country and see the rampant effect of alcoholism on the condition of units in which people live. We believe that if an individual does not take care of himself, he is not likely to take care of the property in which he lives. If someone is in a drunken stupor, then his ability to pay attention to holes in the walls, to roaches crawling around, or to rats in his environment is impaired. He is not likely even to notice these things.

Across the nation, there are 1.2 million public housing units. I am defining a housing unit as a dwelling that is used to provide shelter for a family—whether that family has one or eight persons in it. In Chicago alone, there are 70,000 units that house families. NBAC's study showed in Chicago, among 145,000 public housing residents (Chicago has the second largest public housing development in this Nation, after New York. If you took public housing out of Chicago, it would be the second largest city in Illinois.), approximately 40,000 had problems with alcohol and drugs. That is a combination of youth and adults. About 17,000 alone had problems with drug addiction and drug use.

I did a quick analysis and divided the number of units into the number of people who are affected, and I found that in Chicago housing alone—and I do not think Chicago's public housing is dissimilar from other housing developments around this Nation—one in two households, on the average, is affected by alcoholism. One in five households is affected by other drugs of abuse. So, we are talking about 50 percent of the households being affected. We are talking about a culture that develops around the use of drugs. Substance abuse first engulfs the individual; it reaches out and engulfs the family, and it reaches out and eventually engulfs the entire community. If we are going to be able to reverse this trend, then we have to be able to address the leadership in a community. And, the leadership has to come from within, not from without.

I believe the remedy for the problem of substance abuse is to help people help themselves. We see communities across the Nation in a gradual state of decline. We begin to see bottles appearing on the streets, yet people do not notice what is occurring. Then we begin to see more and more bottles, and people hanging on corners. The corners give way to bottle gangs, then empty buildings, and, before long, shooting galleries. The corridors, especially in high-rise buildings, become centers for the exchange of drugs. This is what our youth and our kids and our babies are witnessing every day. Because we accept this kind of behavior, it becomes a way of life. This is what too

many of our children grow up with. This becomes a norm. Too soon it becomes normal to live in this kind of an environment.

We have to deal with the leadership to effect positive change at the individual and community level. We turn to leadership and prepare them to change the people who live around them. The way we do that is not any different from the approach we would use in organizing a prevention program, using the five strategies for prevention. We talk about education, we talk about social policy and alternatives. We talk about providing people with social competency skills. That is what we do in the community. In Chicago, we are doing some unique things. We are training public housing residents to be prevention specialists. We take people who may not be working, who may be on welfare, who are living under the kinds of conditions just described. Many of them come from substance abusing homes; we sensitize them to the affects of substance abuse on themselves, on their families, and on their communities. At the end of the training program, we present them with a State certificate—the Prevention Specialist Certificate. We have 19 housing developments. We take 3 representatives from each of those 19 developments, and we teach them prevention strategies. We teach them how to have an impact on substance abuse in those communities.

We provide community forums so that, on a regular basis, the people of the community can engage in the repetitive process of learning about substance abuse, learning about alternatives, and getting people involved in their own health and well-being. We bring in professionals, not to preach, but to prepare the indigenous leadership in the community to teach themselves and to teach other people.

The biggest thing we have to concentrate on is social policy. We have to start challenging people in the community not to accept the culture that has developed, not to accept the exchange of drugs in their homes, not to accept abandoned buildings being used as shooting galleries. We have to teach people how to take control over themselves. We do that by bringing the leadership of the community together with the policymakers, with their aldermen, with their State representatives, with their congressmen, to talk about the things that they can do in their community to reverse the process.

Right now what we find is that the decaying process takes place over a 20-year period. Instead of the people in the community being able to rebuild themselves, what happens? They are displaced. We have massive rehabilitation, but rather than that rehabilitation taking place with the people living in that community, we have urban development, or more accurately, urban upheaval. With urban development comes a very different change. The complexion of the neighborhood begins to change and the people move out. So you do not have a remedying of the problem. We just move the people who need rehabilitation to some place else, and that neighborhood begins decaying.

There are some definite things that we can do. When you go back to your homes and you ride through different neighborhoods, think about the deterioration process and what can be done. Substance abuse has a devastating effect on the community, and the

deterioration that you see is simply a manifestation of what is happening to the people who live there.

Summary of Remarks by William Haskins

It is a pleasure for me to have the opportunity to address you on such a very vital subject. I am unhappy to report to you that the news that I bring you today will not be good. It may be interesting, but it certainly will not be good. I think we are at a point in time where each of us has to make a judgment about the kind of action we are going to take to improve the lot of some of Black America. I would urge all of you to read the 1987 edition of *The State of Black America*.

The topic I will talk to you about today is economics and unemployment, particularly in the Black community. A recent U.S. Department of Commerce report stated that almost 35 million Americans were officially poor in 1986, a rise of 4 million since 1980. Twenty percent of American children are poor, and for Black youngsters, the rate is 50 percent. The typical white family has a net worth 12 times as great as that of the typical Black family. Almost a third of Black families in America have no assets at all. Most standard indicators of economic life continue to record the highest level of racial inequity since the mid-1960s.

National data on poverty rates and labor market status show the extent of economic distress in the Black family and in the Black community. In the last year, Black Americans have suffered a decline in well-being, as conditions went from bad to worse. While the Nation's overall unemployment rate stabilized at about 7 percent, Black unemployment continues at a staggering 16 percent, and Black teenage unemployment is over 40 percent. Only 42 percent of Black workers displaced between 1979 and 1984 found new jobs, and those who did typically earn 80 percent of what they used to earn. The accompanying erosion in Black purchasing power is having a devastating impact on the pocketbooks of Blacks wherever they live. While Blacks are 12 percent of the population, Black incomes amount to only 7.4 percent of the money in this country. Black men in this country are an endangered species—1.2 million unemployed, 700,000 incarcerated in prisons and jails and detention facilities across this country; another million are unaccounted for and show up in nobody's statistics.

Let me remind you that in this country, where we live and work, it is estimated that within the next decade 85 percent of the jobs available will involve high technology in the areas of commerce, communications, information exchange, world trade, and research and development. The few manufacturing jobs that remain will be primarily in companies manufacturing products related to high technology. The ability to get a job will be based on whether young people develop some skills in the areas of communications and computations. Skills in English, mathematics, and science will be necessary to obtain an entry-level job, just as the ability to read and write one's own name was the criterion 25 years ago. Being Black will have little to do with obtaining a job, except

possibly to require that Black people be better trained in these skills than their white counterparts. These are precisely the skills that urban minority youth do not have.

We are spending hundreds of millions of dollars a year to produce an unemployable workforce. Dr. Beny Primm, a Black physician renowned for his research on drugs, believes drug abuse to be the most serious and perplexing problem facing Black Americans today. He reminds us of studies that clearly show that the statistics on drug dependency establish an inverse correlation to the availability of employment. In other words, as employment goes up, drug dependency goes down. Persistent high levels of unemployment, the stresses of poverty, the changing labor market from manufacturing to high technology, combined with the ever-present humiliation of racism, all contribute to putting low-income Black families at high risk of becoming drug users and finally drug dependent.

The most righteous and simplistic among us are often heard suggesting that if we had the money for drug treatment centers, we could cure the drug problem. Wouldn't that be nice? If it were just that simple. People who are legitimately drug dependent—the real addicts—cannot stop even when they know that their lives depend on it. The drug epidemic confronting our community is a function of bad housing, few jobs, poor schools, negative self-images, and racial discrimination. Drug rehabilitation programs are necessary and important, but they are overwhelmed, underfunded, and after the fact. Until we develop a national policy to address the fundamental quality-of-life issue, we have programs that are but fingers in the dike.

Now we have AIDS, and AIDS does not make you feel bad, it kills. And there is no rehabilitation program. AIDS is a family disease. It kills men, women, and children. AIDS is in the area of the highest drug use. One of the major vectors for transmitting AIDS is through IV drug use.

The fundamental question for young Black people is not how to avoid using drugs and alcohol, but who they are and what they are, individually. One important aspect of self-perception among Black people is their educational, occupational, and family expectations. For young Black people with clearly formulated expectations and high aspirations, the perceptions of the risk of drug addiction and alcoholism—when measured against their perceptions of future potential—are quite high. Many other young people, however, do not perceive the risk as great enough to abstain from drugs and alcohol. Our major task is to see to it that our Black children have and know that they have an opportunity for a decent, fulfilling life. We have to help them understand that, to a far greater extent than many of them imagine, they have the capacity to create their own success. What they need most is not merely the means for avoiding alcohol but a reason for avoiding it.

Poor people and Black poor people want clean, healthful environments as do other people. Yet low-income communities across the Nation are deteriorating physically, esthetically, and socially. Much of the deterioration can be traced to the economically displaced young people who have never had the opportunity to develop marketable

skills. Youth unemployment is an acute social as well as economic problem because a generation of young people is approaching maturity lacking social skills, a work ethic, a sense of community, and national pride. The absence of work opportunities, particularly among low-income, minority youth, underlies many of the social and environmental deficits of the Black community.

My challenge, my appeal to you and to Black America is to confront, with no more delay, those issues in our own community that nobody can handle and solve but us. It is time for us to hold ourselves accountable for our own set of circumstances. We must get control of our own communities and our lives. We must set the national standards for our children and ourselves.

Summary of Remarks by Bettye Ward Fletcher

My chore this morning is to talk about the impact of drug abuse on the Black community within the area of education. While I attempt to do this, the majority of my comments will be focused on postsecondary institutions, and the reason for this is simply because that is the area in which I have been involved.

Substance abuse has been identified as one of the major concerns that affects the social well-being of the Black community. The destructive forces of alcohol and drug abuse are evident within the institutions of education, just as in all other segments of the community. Prevalence data on the use of drugs and alcohol by Blacks are limited and oftentimes inconclusive. While prevalence data on alcohol and drugs suggest that Black youth use some chemicals less frequently than their white counterparts, I think it is very important that we view prevalence data in a very cautious manner. First of all, such data quite frequently are based on in-school youth, thereby excluding significant portions of the at-risk youth population. Second, the prevalence data do not tell the whole story. The consequences in the form of health problems, encounters with the law, and other social problems are grave. Such consequences are in many ways directly related to the social conditions of Blacks. Given that reality, it is, therefore, imperative that these environmental factors as well as the cultural attitudes, values, and beliefs that shape behavior be included in the development of prevention programs.

If the funding agencies can be used as a barometer of the target group in vogue, then minorities and high-risk youth are the current buzz words. While the need for prevention programming for these target groups is past due, it is imperative that we recognize that schools are not the only focal point and are not necessarily the most expedient ones. For many high-risk youths, the schools are no longer a primary contact point. The very kid who needs it the most is often not in school. He has dropped out, or he has been pushed out. Consequently, high-risk youth prevention programs must be administered by those agencies and institutions, including health, social welfare, vocational training, and law enforcement, that make contact with such groups.

In many ways, our schools have accelerated the movement of Blacks into the high-risk groups through their handling of students using or abusing chemical substances. Educators must reevaluate their ideological orientation toward alcohol and drug abuse, and particularly their role in the process. One of the most frequently adopted stances is being punitive and takes the form of applying consequences when a student does not apprehend or adhere to the standards regarding alcohol and drug use.

The traditional modes of handling alcohol and drug use in secondary school settings often have been the least effective and actually counterproductive for Black youth. There are essentially five philosophical models, in terms of discipline. The first one is vindictive and is characterized by revenge on the part of the punisher. The second model is retributive, based on the premise that people must suffer the consequences of their behavior. Deterrence is the third model and is predicated on preventing negative behavior in the future by imposing unpleasant consequences. A somewhat more progressive approach is remedial, which is reactive and attempts to restore the individual to a normative behavior. The most promising model, however, is prevention, and it is based on a proactive stance that seeks to remove the causes of antisocial behavior, thereby preventing its occurrence.

Suspensions and expulsions are frequently used modes of dealing with alcohol and drug problems among youth. However, such methods are frequently ineffective and, in fact, counterproductive. These measures have particular significance for Black youths, who are more likely to be suspended at a rate significantly disproportionate to the percentage of the enrollment. Further, suspensions or expulsions are often counterproductive to the extent that they result in students getting into more trouble by being in an unsupervised environment. Lastly, prescribed action merely addresses the offense with no attention given to the underlying factors. Disciplinary actions often place the student, the parent, and the school in an adversarial relationship that minimizes the possibility for collaborative intervention.

While historical racism and oppression are not justifications for drug abuse and delinquent behavior, the recognition of the profound influence of this history on the individual and the culture of the individual is very important. A significant prevention strategy is to provide our youth with positive and self-actualizing experiences that counter the propensity toward drug abuse. While we encourage our youth to just say no, we have a greater responsibility to provide self-fulfilling and self-affirming opportunities to which they can say yes. How do we do this? The first step is to confer with the person that we see in the mirror—ourselves. If each of us, as an individual, makes an action-oriented commitment to mentor one youth, that is a beginning.

When we consider substance abuse at the postsecondary level, the problem does not disappear. Black postsecondary education is at a very critical juncture, and its problems are compounded by the use of alcohol and drugs.

In 1979, Blacks were almost comparable to whites in number of years of schooling completed. On closer examination, however, there are profound disparities. Blacks, age

25 and older, are underrepresented among those completing 4 years of college. Furthermore, Black college graduates tend to earn less than white graduates. More alarming is the fact that more Blacks between the ages of 18 and 24 drop out of high school than enroll in college. Further, Blacks in postsecondary education tend, to a disproportionate extent, to be enrolled in 2-year community colleges.

Given the current administration's policy on financial assistance, an appreciable drop in Black postsecondary enrollment is an imminent possibility. However, for those students who survive the financial aid crunch, there are other hurdles they must overcome. One of those hurdles is the use of chemical substances. College students are learning to become responsible adults. One significant issue they must address is the decision to abstain or to use mind-altering substances. In the midst of contemplating this most important decision, collegians are overridden with all kinds of inducements, advertising, and promotion encouraging the use of alcohol and drugs.

Student organizations, and particularly Greek letter organizations, are essential mechanisms for campus-based prevention. While alcohol and drug use transcend all groups and boundaries, if we get really honest with ourselves, we must admit that the extensive use of alcohol is hastily becoming the trademark of some of our student organizations. I am encouraged by the fact that we are beginning to see some change in this area.

In a 1985 study conducted at Jackson State, the use of alcohol and marijuana among Greek and non-Greek students was compared. The results revealed that while the percentage of drinkers and nondrinkers did not differ significantly, there were significant differences in the extent of use among the users. Specifically, those students affiliated with Greek letter organizations consumed all three types of alcohol beverages cited in the study more frequently and in larger quantities than their non-Greek counterparts. A similar pattern was evident for marijuana use. Two times as many Greeks as non-Greeks reported that they used marijuana at least once a day. The impact of heavier use by students affiliated with Greek letter organizations is far-reaching. On most campuses, Greekdom is viewed as a social status symbol, and Greek organizations provide much of the student leadership. Further, Greek affiliation is closely tied to academic performance. Consequently, heavier use by Greeks often involved those students who are in leadership roles.

I hasten to add, at this point, that the involvement of sororities and fraternities and volunteer organizations in the prevention movement at the national level is a welcome and very needed addition in this area. These organizations are to be applauded for their leadership in this area.

When we look at Black postsecondary institutions, we see that historically Black colleges and universities and particulary United Negro College Fund institutions have strong historical ties to the Black community. They are more than just academic institutions that happen to be in Tuskegee, AL, or in Tougaloo, MS. They stand as majestic symbols of the strength, the fortitude, and the resilience of Black people. They have served collectively as the cornerstone for Black leadership. Given the unique history of Black

colleges and universities, the role of these institutions exceeds academics. Black parents send their sons and daughters to these institutions with the expectations that in addition to getting an education, they will receive the nurturing that is an extension of the family. Consequently, colleges become a system for the furtherance of the socialization process, including image enhancement and exposure to positive role models. Given this reality, faculty in such institutions are more than just teachers; instead, they wear multiple hats including those of confidants, tutors, counselors, and, in some instances, surrogate parents.

A 1977 study of racial differences in student drug use and a comparison of patterns of drug use among Black students in predominantly Black institutions and Black students attending predominantly white institutions found that a significantly higher incidence of use existed among those students attending predominantly white institutions. Fulfillment of the nurturing role might very well be a contributing factor for historical Black institutions. In order for our institutions to effectively address the issue of alcohol and drug use prevention, it is imperative that we confront certain institutional as well as attitudinal barriers that impede this process.

The first one is what I call institutional denial. This is the refusal to recognize, accept, and act on the realization that alcohol and drug use are problems on our campuses. Much of this denial is embedded in a belief that action constitutes a confession to having an alcohol problem that exceeds that of other campuses. I think that is very important, because our experience at Jackson State has been one of really having to educate our administration and convince them that there is a concern, that there is a need for campus-based prevention programs, and that if you develop one, it does not mean that you are saying your problems are worse than anyone else's. But we know that we all have problems on our campuses, so somebody has to take the leadership role in that area. I might add, however, with the recent request for proposal (RFP) that came out from the Department of Education for the development of substance abuse programs in postsecondary institutions, we have been inundated with calls from across the country asking what can be done. We are asked what kind of ideas we have for the development of campus-based programs. So it is interesting how RFPs can convince us that we need to act on some things.

The second barrier that I think we have to address—I could call it "institutional enabling"—is the see-and-do-not-see orientation toward excessive alcohol use and illicit drug use. Such an orientation is often based on a tolerance for inappropriate use and minimization of the problem as the zealous and rebellious nature of a few deviant students. Oftentimes, institutions unfortunately sweep the problems under the rug, and what that does is allow students to continue to behave in an irresponsible manner without having to face the consequences of their behavior.

The third and probably one of the most important barriers that we have to overcome is adult role modeling. Standards and policies regarding alcohol and drugs must include faculty and staff. The inappropriate use on campus and during institutional events by staff, faculty, and alumni must not be condoned. Homecoming, athletic events, and

other social functions must not be occasions for us to indulge in irresponsible behavior. In fact, we must have policies that govern such behaviors, and they must be applied consistently to our students as well as to adults within the institution.

Our sororities, our fraternities, and our volunteer organizations have an obligation to be responsible role models. To do that, we have to start with ourselves, in terms of our behavior. So when you go back home and you go to those events at your alma mater, make sure that your behavior is consistent with the kind of behavior you would like to see in the students at that institution.

The fourth area has to do with the deglamorization of alcohol and drugs. Part of any campus-based prevention program is to foster attitudes that respect the rights and choices of students to be drug free. This entails chiseling away at the notion that fun equals alcohol and drug use. We can enjoy ourselves without resorting to alcohol and drug use. I think it is important to really become advocates for those students who choose to abstain. On many of our campuses, students are so inundated with the pressures to use chemical substances that oftentimes their choices to be abstinent are choices that they cannot be open about or very comfortable with. I think that we have a responsibility to recognize and advocate abstinence as an acceptable and very appropriate choice for our students.

The final area has to do with the marketing on our campuses of legal substances such as alcohol and cigarettes. The trafficking of illegal drugs, of course, remains a major issue with which we have to contend. I think it is unfortunate that events, such as the African-American Art Exhibit we had at Jackson State, are often sponsored by beer distributors. I think it is extremely unfortunate that the Medgar Evers Memorial Weekend in Mississippi is sponsored by one of the brewing companies. That should not be the case, and if that is the case, I think we have to seriously contemplate what kind of messages we are sending when we do that. Although the resources of those businesses might have a role to play, I do not think they should be in the forefront of those kinds of events in our community. We had the experience at Jackson State of approaching one of the local beer distributors regarding support of our prevention programs for students on campus, and they said to us, "Well, we don't have any money to give out now, but if you want some beer to sell, to make some money, you're welcome to it." We said, "Thanks, but no thanks."

I think we have to, in terms of direction for prevention education, develop policies that set forth clearly defined codes of behavior, not only for students but for administrators, faculty, staff, and alumni. I think it should include opportunities for the development of networks within the institution whereby we have the benefit of the vantage point of all our faculty and staff in the development of campus-based programs. The involvement of student groups, particularly Greek letter organizations in promoting health and responsible behavior is a significant consideration. I also might point out that one college in Mississippi, a non-Black institution, recently received an endowment in the amount of $250,000 for the development of an alcohol and drug education center on their campus. The Greek letter organizations on that campus made a commitment to

pay $5 per member per semester to support the campus-based program to the tune of $100,000 over a 4-year period. I think that might serve as a model of something we can do on our campuses to raise the funds to do the kind of things we need to do in the area of alcohol and drug abuse prevention.

Curricular offerings that provide students with an opportunity to explore their own values, beliefs, and attitudes toward substance abuse are very important. Also, greater utilization of existing mechanisms for prevention programming is encouraged.

Prevention for students must include recognition of the fact that substance abuse issues involve family as well as friends. As a result of some workshops that we did on our campus regarding children of alcoholics, we found a number of students who came forth to say, "I want to be a part of the support group simply because my mother or my father is having a problem and that's affecting me. I have feelings about going home, because I know what I have to deal with when I get there." The use of alcohol and drugs is not the only issue that concerns college students. Oftentimes, they also are concerned about significant others who are having problems with the abuse of substances, problems that tend to impinge on the students. When we consider the magnitude of drug use on the campuses, the United Negro College Fund slogan, "A mind is a terrible thing to waste," should take on a new meaning for us.

Summary of Remarks by Dr. Jay Carrington Chun

There is an interesting phenomenon occurring in the south, and most us are southerners by birth, if not by migration. You will find that the homicide rate is higher than the suicide rate among Blacks in southern areas, but it will fan out toward the west and toward the north. If you look at those deaths, you will find an alarming degree of alcohol use and drug abuse prior to the homicidal act. Whether it is a precipitant factor or a mitigating factor, we are not certain. I would suggest that we not seek a single causation in trying to understand this from a research perspective, but consider multiple causation by examining seven or eight variables. For example, with modern technology, the use of multiple regression analysis and multiple analyses of various types with computers, we can almost predict the suicide rates among Black youth in certain neighborhoods in certain cities. The problem with coming up with that kind of data is getting that type of research funded.

I was largely unsuccessful in obtaining research funds for prevention efforts and some of the other research ideas I had. The best I could do was to get some seed money to test the feasibility of doing some of the research I was proposing. The whole process of dealing with understanding the problem and preventing its occurrence is something that we have to deal with from a policy perspective.

Let me just say in summary some of the things that I see as very critical for us to do in order to move ahead in problemsolving and seeking solutions to the drug and alcohol abuse problem in our communities. The whole question of our need for better research and a more precise data base is obvious. We are not certain about the degree to which alcohol and drug abuse cause certain behavior. We know that it is a contributing factor, to both homicide and suicide. We know it is a contributing factor to family violence. I passed The House of Ruth, a home for battered wives, on the way in from the airport this morning. You will find, if you interview the wives there, that at least 60 to 70 percent will say that the excessive use of alcohol contributed to their husbands' behavior. You will find that pattern in most other battered shelters. You will find it in other areas as well, and we need to examine the degree to which alcohol and drug abuse contribute to that type of behavior.

We also know that if you look at instances of sexual abuse of children as well as other types of abusive behavior directed toward children, as we did in our studies with the National Council of Black Child Development at the National Institute of Black Child Development, you will find that stress contributes to the abusive behavior of parents. The way Black folk and Black families often deal with stress in our society is either by striking out at each other or through drinking. It is quite unfortunate the so-called Black pathology is turned toward other Blacks and self. In other words, we are our own worst enemies. Our homicide and suicide rate is very high and represents a Black-on-Black crime phenomenon, which of course affects the family. I recommend that we set up survival networks within our community so that we can deal with the question of helping families to survive the ravages of alcohol and drug use.

Not only is it glamorous and fashionable to drink, not only will *Jet* and *Ebony* and publishers of other magazines make it appear to be one of the things you must do to be a he-man or a she-woman, but it is also quite profitable. It is not just the fraternities and the sororities that are pushing drug and alcohol use, it occurs throughout our social functions and in many of the places that we socialize. In dealing with people in networking behavior, alcohol and drugs are usually a part of that process. I would like to recommend, in closing, that we set up a national policy network so that we can deal with the prevention issue and the question of preventing the infiltration of drugs into our communities from a social policy perspective. Change the zoning laws; change the extradition laws. Let us examine local policies passed by the cities. Let us start outlawing behaviors that are destructive to us, rather than encouraging them and then turning around and saying, "That's not right."

Summary of Remarks by George Napper

It is apparent that my role has changed considerably. I think now my primary responsibility is basically to say, "Amen, and I thank you all for coming this morning." Let me commend all of you for being here today. Obviously, it is an expression of your concern about alcohol and drug abuse and the impact that it has on our respective communities.

It is obvious to me that, on a holiday weekend, there are probably more exciting things to do, but I can assure you that there is nothing more important that you could be doing with your time than to be engaged in a discussion about this devastating problem of drugs that affects our lives and our communities.

After having gone through the tumultuous years of being chief of police during the Wayne Williams experience, it was really a relief to me when I was appointed commissioner of public safety by the Honorable Andrew Young. In the years 1982, 1983, and 1984, it was extremely gratifying to be able to report to the mayor and to the city that we had experienced an overall decrease in crime in each of those years. Notwithstanding that this was also the national trend, the fact that we had exceeded the national average suggested that there was something occurring in the city of Atlanta that was not occurring in other cities. I was inclined to take credit for the decreases in crime that we had experienced, as we had always gotten the blame for the increases in crime, but my better judgment prevailed, and I did not assume that posture. It seems that everywhere we went, people were asking, "Why is it that we are experiencing a decrease in crime? What's going on in Atlanta? What is going on nationally that helps us to understand this particular phenomenon?"

I think basically there are two schools of thought that can be used to explain what was going on in the country. One school of thought said that we were experiencing this decrease in crime primarily because of very aggressive law enforcement, certainly by Federal Agencies, but also very aggressive law enforcement at the State and local level. A lot of people were being arrested and the courts were responding by making sure that a lot of people were sent to jails and prisons. These were the primary reasons for the decreases in crime. They also deterred would-be criminals from engaging in criminal activity.

The other school of thought, with which I took issue, said that it was not so much aggressive law enforcement, though that was to be applauded, but more the changing demographics of the country. The country was getting older, according to this school, and therefore, there were fewer people in the age categories that are usually responsible for most of the crime. I could take issue because, by the end of 1984, what had been a decrease began to creep upwards, requiring us to take another look at the crime situation. In 1985 we had an increase in crime, and that trend continued through 1986 and 1987.

The first school said that the people arrested earlier are now back out on the streets. We could not keep them long enough, and they have returned to their criminal ways. The demographers were at a bit of a loss to explain. They had predicted that we would experience a decrease in criminal activity because the society was getting older. They ultimately concluded that the reason for the increase in crime was the drug problem.

It is my judgment, and I think the judgment of a number of my colleagues, and perhaps a number of you as well, that drugs are the single most compelling problem in our community. It is a problem that significantly explains the increases that we are having

both in crimes against property and in crimes against people. I am not talking solely about the issue of cocaine and other illegal drugs, but also about the problems brought on by alcohol abuse. I am referring to problems requiring police intervention, like alcohol-related wife beatings and child abuse.

I think there is something else that is equally devastating, and that is the extent to which this situation has created what I call a drug-saturated environment. A drug-saturated environment is one that lacks the characteristics and factors that make for a civilized community: cooperation, observation, vigilance, and shared values regarding the quality of life. This situation also diminishes the ability and the readiness to be involved in the kind of collective action that is really basic to our ability to remedy these problems. Because of fear, because of demoralization, and, because of despair, increasing numbers of people retreat to the privacy and individualism of their own lives and do not become involved in the kinds of collective action that should characterize each of our communities.

Another factor that is directly related to this drug-induced environment has to do with the fact of handguns. The reality of more than 2,000 deaths a year involving handguns obviously suggests we should be doing something about them.

There is a tendency for citizens to want to blame the law enforcement community and the criminal justice system for many of a community's troubles. If I have learned anything over the past three decades that I have been involved in the criminal justice system as a student, teacher, and practitioner, it is that there are no magic wands, no simple solutions, no—pardon the pun—quick fixes with respect to the issues we are concerned with here.

It is important to understand that the justice system basically reacts. Ours is a system that processes those who are identified as being criminals and houses them in a particular way. It should be apparent then, that when we get involved, it is primarily because other institutions have not been able to carry out their responsibilities. Whether it is the home, the family, the church, or the educational institutions, we become involved when, for whatever reasons, those systems stop working properly. It is obvious to me that we have to reorient our concerns and our efforts to try and strengthen these institutions so that they can do their jobs. Only then can we cut down on the number of people that the criminal justice system has to process.

Let us look at the family for a moment. It is clear to me, and I think to increasing numbers of people, that the family, again, for a number of reasons, is not able to discipline its children. It is not able to give the children the kinds of values we would like to see in this country. If the family cannot do it, we cannot expect the schools to do it.

The schools have pretty much the same situation. I spend a lot of time talking to kids in our school system in Atlanta and in other cities as well. It is apparent that many of our kids really do not see the linkages that exist between school and the real world. Unfortunately, the linkages they do see are very negative ones.

One of the earlier speakers mentioned the youngsters we see in every city—10, 11, and 12 years old—making huge sums of money as lookouts for drug traffickers. You can imagine the difficulty encountered by a teacher, who is underpaid, trying to tell a 12-year-old, who is making so much money, that he or she ought to stay in school. It seems to me that when we talk about 1987, we are thinking about another world from 1957! We may have to do something different in school systems. Many of us recall that when we were 8 or 10 or so, that when school was out, we came home and somebody was there. That is not the case in 1987. And it does not matter whether you are lower class, middle class, or upper class, everybody has to worry. There are 3 or 4 hours of unsupervised time that allows kids to get involved in any and everything. And they do get involved in everything. I think we have to begin to raise the questions about modifying some of our institutions so that they reflect the realities of the present day.

I think that there are ways those 3 or 4 hours can be filled meaningfully to help kids understand the linkages between schooling and the real world. I think we have to get government and the private sector involved in helping us to solve these problems of today's world. We will not be returning to 1957; we have to come to grips with things as they are now.

Let me wrap this up by suggesting the importance of not expecting the law enforcement community and the criminal justice system to be the salvation. That simply will not be the case. As much as I would like 200 more police officers, that would not be the answer for the conditions that are creating the demands on law enforcement. We have to have the courage to stand up and be seen and heard as role models expressing concern for what goes on in our communities. Some of our youngsters' current role models, we do not want, and believe me, we do not need.

Luncheon Address

Speaker: **Arthur E. Thomas, Ed.D., President, Central State University, Wilberforce, OH**

We must look at the potential in our young people if they are going to survive. Let me give you an example of what I am talking about. A young brother at Central State was taking a final examination. The final examination was in community health; it was an essay examination. The teacher asked the question: How important is community health in your community? My man wrote on his paper, "It is so important, I cannot discuss it at this time." I could have sent him home, but I said, "With that kind of insight, you could be a lieutenant colonel—or president!"

Another young brother was looking at someone else's paper in sociology. The teacher asked, was he cheating. He said, "No, sir. I was just checking." We must take that potential and mold it positively.

I watched my grandfather being dehumanized and made to feel like less than a man. I said to myself, "If I ever reach a position of influence, I will fight hard to see to it that no one on the face of the earth—red, white, brown, blue, polka dot, chartreuse—no one would be treated like they treated my grandfather."

One of the things we must do if we are going to save our children is to teach them to respect their mothers. We have to teach our Black males to respect Black women. There was a time when Black women were thrown into the Atlantic ocean because they refused to submit to slave traders. We have to teach them that there was a time when these women submitted to slave traders to keep Black men and Black babies from being thrown into the Atlantic.

Some of us get these degrees and we go crazy. It makes me sick; acting like we are better than everybody else. Further alienating ourselves from the people that we are supposed to be bringing along with us.I learned my most important lesson walking with my mother at the age of 5 to the New Central Baptist Church in Philadelphia, PA. I saw a tall, worn, broken, dirty, filthy Black man; he stood 6 feet, 7 inches tall, and he had rags wrapped around his feet during the month of December. I said, "Mom, look at that old man." My mother said, "My child, your obligation, your responsibility whenever you see someone suffering, in pain, confused, or in need, is to help them. Because," she said, "my child, that could be you, were it not for the grace of God." I did not understand her meaning then, but I understand it now.

We have to teach our children that knowledge is power. We have to teach our children that there is nothing that they cannot do if they make up their minds to do it. We do not realize how brilliant we are. Our children do not realize how brilliant they are. According to a famous Russian psychologist, if we exercised just half of our brain power, we would be able to master the encyclopedia from cover to cover; we would be able to master 40 different languages; we would be able to master the university requirements for 12 different subjects at the same time—if we used just half of our brain power.

Once again, the psychologists tell us that we all function at only 15 percent of our capacity, which means that each and every person can be 85 percent better. You can be 85 percent better at anything you want: 85 percent better at keeping kids off dope; 85 percent better at keeping adults off of alcohol; 85 percent better at registering to vote; 85 percent better at supporting your parents; 85 percent better at putting pressure on the system; 85 percent better at supporting your church; 85 percent better at minding your business; 85 percent better at being 85 percent better at anything you want to improve.

Again, psychologists tell us that we can get into the habit of doing anything in a 90-day period. If we were formerly in the habit of walking with our head down and then we get into the habit of holding our heads high and saying to ourselves that we are the most magnificent individuals on the face of this earth and there is absolutely, positively nothing that we cannot do, and if we do that for 90 days, we will do that for the rest of our lives. I know that the 90-day plan works. You can get in the habit of doing anything over a 90-day period.

We have to get our children into the habit of spending more time in the library. If they cannot read, let them go to the library, sit down, look at the book, pick up something by osmosis, but get them into the library. We did not play football in Africa. We did not play baseball in Africa. We did not play basketball in Africa. They only let Jackie Robinson play 40 years ago, and now we dominate everything. If we make up our minds today that 40 years from now our youngsters will control genetic research, oceanography, urban planning, and transplanting of organs, and if we will get them into the library and let them spend as much time in the library as they spend on the football field or basketball court, then we will dominate and control those areas just as we now do football and baseball. We have to get our youngsters in the library.

We have to teach Black mothers to stop telling Black children that their daddies are no good. We have to stop telling our Black children that they cannot do math, that Black people cannot do math, that they cannot do science. We have to be as positive as we can possibly be with our children. We have to deal with the pregnancy issue.

We have to teach our children to stop being afraid of foreign languages. We must stop calling them foreign languages and start calling them other languages. The fourth largest Spanish-speaking population in the world is in the United States of America; we cannot ignore that many brothers and sisters. We cannot do it. It is important for us to know just as much about Hispanic culture and language and heritage as we know about our

own if we are truly interested in coalitions that are going to result in power and influence. We must do that. If our children would not be confined to the continental boundaries of the United States of America, if our children would be citizens of the world, they must learn the cultures, the politics, and the languages of the world. When I visited the Middle East with the Reverend Jesse Louis Jackson, we talked with 9-year-olds who could speak nine languages fluently. What are our children going to say when they get off the plane in Paris? Parlez vous Anglais?

We have to teach our children about their history. One of the reasons we are having so many problems with our children is their ignorance of their history. We do not know it either, and therefore, we cannot teach it to them. When you know your history, you can feel better about yourself. When you know your history, other folks cannot make you feel bad about yourself. When they know your history, they know you have made a contribution, so they deal with you on another level. We have got to teach our children that there were highly complex civilizations in Africa. We have to teach our children that 5,000 Black folks—women and men—fought in the Revolutionary War. We have to teach them that a Black woman named Phyllis Wheatley, at the age of 13, during the Revolutionary period, wrote magnificent poetry. Teach them about Richard Allen, founding his own African Methodist Episcopal Church, which exists to this day. Teach them about Harriet Tubman, leading 300 brothers and sisters to freedom. We have to teach them.

Frederick Douglass said that if there is no struggle, there is no progress. Men may not get all they pay for in this life, but they most certainly must pay for all they get. Teach them about Sojourner Truth saying, "I hold this Constitution in my hand. Something must be wrong with this Constitution. The boll weevils must have gotten into this Constitution, because I look and look and look into this Constitution, but I don't see any rights for me." Teach them about Booker T. Washington; he left us a school. Teach them about Mary McCloud Bethune and Carter G. Woodson. Teach them about Daniel Hale Williams, and Fannie Lou Hamer saying, "I am sick and tired of being sick and tired . . ." Teach them about Rosa Parks, and teach them about Martin Luther King, Jr. Teach them about Malcolm X—yes, teach them about Malcolm X.

We have to teach our children that we have always had white friends, and we have to teach our children that if we are going to continue to progress, we must continue to have white friends. I am talking about John Brown. He died, he gave his life for us to be free. I am talking about Thaddeus Stevens and Charles Sumner, two white men who dedicated their lives before, during, and after the Civil War to bring about economic justice and reciprocity. I am talking about Viola Liuzzo, a white woman from Detroit who died in Alabama trying to secure for us the right to vote. Teach them about Hubert Humphrey and John F. Kennedy, and teach them about Lyndon Baines Johnson. Lyndon Baines Johnson voted against us during his entire congressional career, but when the time came to do the right thing, Lyndon Baines Johnson got on national TV to garner support for the Voting Rights Act of 1965.

If you do not know what to do with a youngster on dope, if you do not know what to do with a youngster who is mistreating his parents, try this. Tell him that in 1918 in Valdosta, GA, a Black woman named Mary Turner was walking down the street. She was 9 months pregnant. She refused to get out of the street for a member of the Ku Klux Klan, so she was hung from a tree. While she was hanging from that tree, another klansman stepped forward and cut her stomach open, and a baby fell to the ground. Another klansman stepped forward and squashed that baby's skull into the ground. And then another one stepped forward and burned Mary Turner's body to a crisp. Why did she die? Tell him that she did not die for him to take dope. Tell him she did not die for him to steal somebody's pocketbook. Tell him she did not die for him to curse his mother. And tell him she did not die for him to put his books in the locker room in September and leave them there until June. And then you write me and tell me how he responds.

We have to get away from all this negativism. I understand why we mistreat each other, but it has got to stop. I mean, look it up in the dictionary. The English language is a racist language. The English language helps to develop negative feelings of self in our children, not in 1907, but in 1987. Read it. One hundred and thirty-four synonyms for the word Black; 75 percent of them have negative connotations. Then go to white. Seventy-five synonyms for the word white; 75 percent of them have positive connotations. A Black child cannot sit down to a meal without being exposed to racism: the angel food cake is white and the devil's food cake is Black. Reporters get on the air and talk about "a *dark* day for America." Well, we are not in charge of anything. Why can't it be a white day for America?

I used to watch those two cars on the Shell commercial running out of gas—the Black car and the white car. I watched them for 3 years. The Black car always ran out of gas first. Subliminal seduction—they make you think even your car can't do anything right.

When I was a child, my main man was Tarzan. I wanted to be like Tarzan. I rooted for Tarzan for 3 years, and then one day I looked on that screen and Tarzan was chasing a brother that looked just like me. I said, "Wait a minute! Come on, brother, get Tarzan . . ." That is why I am so glad that Dr. Bill Cosby is changing all of that.

Some of you do not want your children to go to Black colleges. We cannot be that bad. We graduated 75 percent of all Black Ph.D.s and 75 percent of all Black officers; 85 percent of all Black Federal judges and 85 percent of all Black physicians. The civil rights struggle came out of North Carolina A&T, not the University of North Carolina. The Supreme Court decision of 1954 came out of Howard University, not Harvard University.

It is not just scholarship; it is also leadership. Jesse Jackson was graduated from a Black school. Adam Clayton Powell was graduated from a Black school. Martin Luther King, Jr., was graduated from a Black school. W.E.B. Dubois was graduated from a Black school. Nicki Giovanni was graduated from a Black school. Barbara Jordan was graduated from a Black school. Leontyne Price was graduated from a Black school. Julian Bond was graduated from a Black school. Jacqueline Jackson, the wife of Reverend Jesse Jackson, was graduated from a Black school. Congressman Walter

Fauntroy was graduated from a Black school. I know the list is much longer so let me say, et cetera, et cetera, et cetera.

For every Harvard there must be a Howard. For every Marquette there must be a Morehouse. For every Tulane there must be a Tuskegee. For every Cincinnati there must be a Southern. For every Duke there must be a Dillard. For every Boston there must be a Bishop. For every Stanford there must be a Spellman. For every Ohio State University there must be a Central State University.

We are going to teach our children. We are going to teach our children to be the best in communications and oceanography and genetic research and urban planning and nuclear fusion and chemistry and physics and business management and computer science and economics and statistics and geology and biology and law. We are going to prepare our children for the world of the future. Read Steven Rosen's *Future Facts*. Read John Naisbitt's *Megatrends*. Read Alvin Toffler's *Third Wave*. Read Lerone Bennett's *Before the Mayflower*. Read my *Like It Is*.

We are going to teach our children to prepare for a world where they will be able to retard aging and keep people from getting old; a world where they will be able to control obesity and keep people from getting fat; a world where they will cook with sunlight, use garbage for power, and alter time—a world where you will be able to get on a train, not a plane, and end up in Los Angeles 1 hour and 37 minutes later.

How do we survive in a world like that? We survive by trusting in God. We survive in a world like that by working harder than anyone else, by spending time in the library, by loving and trusting and respecting each other. We survive by taking and using the examples of our ancestors.

We have gone too far, and we will never turn back. God is our all. God is our all.

Youth Forum

The Youth Forum offered young people, ages 12 to 17, an opportunity to express their ideas and feelings about issues relating to alcohol and drug use. There were workshops focusing on, among other things, self-esteem, dealing with peer pressure, and alternative methods of "coping." Tim Reid, noted TV and movie personality, served as keynote speaker; he and Daphne Maxwell, actress, served as co-leaders for the workshop. The following is a summary of the Youth Forum activities.

Close to 75 young persons from throughout the United States, especially from the metropolitan Washington area, attended the day-long Youth Forum at the Sheraton-Washington Hotel. The Youth Forum was held so that the recommendations on preventing substance abuse in the Black communities would include the perspective, experiences, and concerns of young people. Also, the conference would enable these young people to interact with the leaders in the field.

The program began with opening and introductory remarks by co-conveners Sheila H. Gardner and Warren Hewitt. This was followed by an informative, lively, stimulating, and sincere presentation by Tim Reid, a well-known actor, parent, and leader in the drug prevention campaign, along with Daphne Maxwell, a noted actress. (Mr. Reid is currently starring in *Frank's Place* on national television.)

Mr. Reid provided information and discussed personal and professional experiences that strongly encouraged all those in attendance to avoid drugs. He also stressed the benefits of remaining drug free.

The kids were so enthusiastic about his messages that they even provided examples of their own about the destruction that drugs bring to one's life. The young people asked many frank and direct questions.

The junior high and high school students attended a luncheon, sitting at reserved tables. By lunch time, they were all familiar with one another and enjoyed meeting the others in attendance. The luncheon speaker was Dr. Arthur Thomas, President, Central State University, who gave a fiery speech that electrified the audience, including the students.

In the afternoon session, the students were divided into two discussion groups coordinated by college students who served as facilitators and resource persons. Each group was asked to dialog about issues pertaining to saying no to drugs and serving as possible role models. After their lengthy, lively, and frank discussion, each group developed a

skit around an antidrug theme. Mr. Reid and Ms. Maxwell served as resource persons by joining the discussion from time to time.

A video tape was made of some of the activities of the Youth Forum. Each group did a skit dramatizing antidrug messages. The video tapes were great, given the brief time to prepare and practice and the fact that these young people were not professionally trained. The video tapes are available for use by teen clubs, junior and senior high schools, and local community groups.

Everyone who participated was encouraged by the seriousness and awareness of the junior and senior high school students. They were cooperative, energetic, and articulate in their desire not to use drugs and to encourage others to remain drug free.

The video tapes can be useful with minor editing and should be used whenever possible.

The involvement of young people in the planning and implementation of similar conferences should be encouraged. The participants expressed an interest in continuing their involvement. However, they suggested that we have students come during the week, since most have part-time jobs on Saturday. (A list of all the young participants is available.)

Conference Participants

Mr. Farreed Abdullah
Prevention Consultant
Regional Council on Alcoholism
3101 Euclid Avenue, Suite 707
Cleveland, OH 44115

Ms. Carol H. Abercrombie
Chief, U.S. Army Drug Abuse Program
Building 3241
APG MD

Dr. James B. Abram
Chairman, Guideright Commission
Kappa Alpha Psi Fraternity, Inc.
2320 N. Broad Street
Philadelphia, PA 19312

Sheila Adams
Thomas Jefferson Junior High
3007 S. 13th Street
Arlington, VA 22204

Ms. Camille D. Alexander
Public Health Analyst
Health Resources and Services
Administration
Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20807

Dr. Aris T. Allen
Medical Affairs Advisor
Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

Mr. Miguel Almestica
Health Educator
Prospect House, Inc.
100 Lancaster
Worcester, MA 01609

Dr. Kirby Alvy
Executive Director
Center for the Improvement of Child Caring
11331 Ventura Boulevard, Suite 103
Studio City, CA 91605

Dr. Aniece L. Amos
Clinical Pharmacist Supervisor
King/Drew Medical Center
12021 S. Wilmington Street
Los Angeles, CA 90059

Mr. Omonale Amuleru-Marshall
Director, Cork Institute
Morehouse School of Medicine
720 Westview Drive
Atlanta, GA 30310

Mr. Ival Angel
General Supervisor
Ford Motor Company
Lorain, OH 44035

Mr. Vernice D. Anthony
Health Director, Wayne County, MI
1200 6th Street, M-146
Wayne County, MI 48226

Mr. Rudolph P. Antoine
President, Texas Black Alcoholism Council
P.O. Box 3002
Beaumont, TX 77704

Ms. Jarmalia Arnold
The LINKS, Inc.
3888 Red Rock Street
Las Vegas, NV 89103

Ms. Cheryl Arrington
Chief Clinical Health Care Associates
P.O. Box 27888
Richmond, VA 23261

Ms. Mary Ashley
Program Development Officer
U.S. Information Agency
P/OF 301 4th Street, SW
Washington, DC 20547

Mr. Nathaniel Askia
Executive Director
FIRST, Inc.
34 Intervale Street
Boston, MA 02121

Ms. Leslie Atkinson
Legislative Assistant to
Congressman Louis Stokes
Washington, DC

Mr. Charles Avery
Public Health Analyst
Commissioner of Public Health
Office of Health Planning
425 I Street, NW
Washington, DC 20001

Mr. Tyrone Backers
Executive Director
Community Crusade Against Drugs
P.O. Box 680-174
Miami, FL 33168

Ms. Karla Bailey
National 2nd Vice-President
Delta Sigma Theta Sorority, Inc.
2300 Steuben Avenue
Fort Washington, MD 20744

Mr. C. Vincent Bakeman
President
Human Resources Development Institute,
Inc.
417 S. Dearborn Street, Suite 700
Chicago, IL 60605

Ms. Norma Baker
Executive Director
Northern Education Service, Inc.
622 State Street
Springfield, MA 01109-4182

Ms. Edna R. Baldwin
E.A.P. Counselor
Washington Metro Area Transit Authority
600 5th Street, NW
Washington, DC 20001

Ms. Elizabeth Bamberger
Research Associate
Pacific Institute for Research and Evaluation
7101 Wisconsin Avenue, NW
Suite 805
Bethesda, MD 20814

Ms. Janet Barker
Clinical Social Worker
City Lights School
7 New York Avenue, NE
Washington, DC 20001

Ms. Barbara Baskerville
Assistant Professor
University of the District of Columbia
4200 Connecticut Avenue, NW B44 218F
Washington, DC 20008

Ms. Linda E. Bass
Director, Health Division
National Council of Negro Women
701 N. Fairfax Street
Alexandria, VA 22314

Ms. Mary Battiste
Registered Nurse
St. Joseph's Hospital
127 South Broadway
Yonkers, NY 10701

Ms. Jean Beard
Program Specialist
Montgomery County Public Schools
850 Hungerford Drive
Rockville, MD 20850

Ms. Mary Bebel
Research Associate
Columbia University
622 West 113th Street
New York, NY 10025

Ms. Kathleen R. Beckwith
DCA Volunteers Hand Council
Montgomery County Department of Family Resource
101 Monroe Street
Rockville, MD 20850

Mr. Darnell Bell
Substance Abuse Director
Avalon-Carver Community Center
4920 South Avalon Boulevard
Los Angeles, CA 90011

Ms. Pamela Bell
Social and Scientific Systems
7101 Wisconsin Avenue, Suite 610
Bethesda, MD 20814

Mr. Peter Bell
Executive Director
Minnesota Institute on Black Chemical Abuse
2616 Nicollet Avenue, South
Minneapolis, MN 55408

Mr. Hardy Bennett
Health Program Coordinator
Montgomery County Adult Drug Treatment Services
3719 12th Street, NE, #104-B
Washington, D.C. 20017

Ms. Sylvia Benson
Prevention Specialist
Underage Drinking and Substance Abuse Program
Community College of Beaver County
College Drive
Monaca, PA 15061

Ms. Edna L. Bernard
Delta Sigma Theta Sorority, Inc.
2068 E. 20th Street
Erie, PA 16510

Mr. Willie Bethune
Community Mental Health Services
SC Department of Mental Health
P.O. Box 485, 2414 Bull Street
Columbia, SC 29202

Ms. Eleanor Beverly
Delta Sigma Theta Sorority
3322 Lynne Haven Drive
Baltimore, MD 21207

Ms. Jeanette Bevett
Project Manager
Social and Scientific Systems
7101 Wisconsin Avenue, #610
Bethesda, MD 20814

Dr. Adrienne Bins
Youth 2000
HHS
200 Independence Avenue
Washington, DC 20201

Ms. Juanita Blake
Head Nurse
Temple University Hospital
6558 N. 18th Street
Philadelphia, PA 19126

Mr. John Bland
Director, Alcoholism Control Administration
Maryland Department of Health and Mental Hygiene
Herbert R. O'Conor Building
201 W. Preston Street
Baltimore, MD 21201

Ms. Teddy R. Borum, Jr.
Counselor
Sunrise House
116 E. Alisal Street
Salinas, CA 93901

Mr. Charles Boss
Evening Counselor
Bowling Green Inn, Brandywine
495 Neward Road
Kennett Square, PA 19350

Dr. La Claire Bouknight
Medical Counsultant
Michigan Department of Social Services
1514 Colorado Drive
East Lansing, MI 48823

Ms. Wilhelmina Bowie
Community Leader
Montgomery County Department of
Family Resources
101 Monroe Street
Rockville, MD 20850

Ms. Bettye J. Bowman
Alcohol Services Center
838 North West Street
Jackson, MS 39209

LaSean Nicola Brice
6186 Edsall Road, #746
Alexandria, Va 22304

Ms. Edith Elizabeth Bridges
Director of Treatment Service
Marlboro County Commission on ADA
100 West Main Street
Bennettsville, SC 29512

Dr. Frances Brisbane
Associate Professor
School of Social Welfare
Health Science Center
Level 2, Room 093
SUNY at Stony Brook
Stony Brook, NY 11794

Ms. Delana Brooks
Addictions Counselor
Constant Care Medical Center
1501 Division Street
Baltimore, MD 21217

Ms. Shelia Brooks
Social Worker Counselor
S.A.F.E., Group Service, Inc.
P.O. Box 09342
Milwaukee, WI 53209

Daniel Brown
Arlington Public Schools
3111 South 15th Street
Arlington, VA 22204

Ms. Freda Brown
Counselor, Employee Assistance Program
Social Security Administration
Baltimore, MD 21217

Ms. Jacqueline T. Brown
Assistant Professor
Bowie State College
Bowie, MD 20715

Ms. Rosa T. Brown
Coordinator, Guidance and Counseling
Leon County School Board
2757 W. Pensacola Street
Tallahassee, FL 32304

Ms. Wanda Brown
Nurse
National Education Association
1836 Metzerott Road, #1414
Adelphi, MD 20783

Mr. Edwin T. Brownley
Physician, Internal Medicine
555 Fenchurch Street, Suite 302
Norfolk, VA 23510

Ms. Carol P. Bruce
Chief, Alcohol Drug Control
U.S. Army Chemical Research Development
and Engineering Center
Attn: SMCC-AL
Aberdeen Proving Ground, MD 21010

Ms. Gwendolyn H. Brunson
Chapter Basileus Beta Zeta Chapter
Zeta Phi Beta Sorority, Inc.
1719 Varnum Street, NW
Washington, DC 20011

Ms. Marguerite E. Bryan
Executive Director
New Orleans Education Intervention Center
4725 Freret Street
New Orleans, LA 70115

Mr. Donald L. Bryant
Recreation Counselor
Montgomery County Youth Center
540 Port Indian Road
Norristown, PA 19403

Mr. Benjamin H. Bullett
Substance Abuse Specialist
Daymont West, Inc.
1520 Germantown Street
Dayton, OH 45408

Ms. Reba Bullock
Zeta Phi Beta Sorority, Inc.
3707 Loch Raven Boulevard
Baltimore, MD 21212

Mr. David R. Burmaster
Physician Assistant
Office of Medical Services
Ashland Petroleum
P.O. Box 391
Ashland, KY 41114

Ms. Gina Burney
Director
Alcohol Epidemiological Data System
1400 Eye Street, NW
Suite 600
Washington, DC 20005

Mr. John S. Burrus
Assistant Executive Director
NOW, Inc.
232 Elm Street
Waterbury, CT 06702

Dr. Sydney Bush
Harlem Hospital Center
506 Lenox Avenue
Room WP-541
New York, NY 10037

Ms. Jacqueline P. Butler
Associate Professor of Clinical Psychiatry
University of Cincinnati
3259 Elland Avenue
Cincinnati, OH 45267

Karen Byrd
Washington-Lee High School
2111 N. Key Boulevard
Apt. #984
Arlington, VA 22201

Ms. Lucille Cadiz-Barrow
Registered Nurse
Abraham and Straus
6 St. Charles Place
Brooklyn, NY 11216

Mr. Fulton Caldwell
National Institute on Alcohol Abuse
and Alcoholism
Room 16-95
5600 Fishers Lane
Rockville, MD 20858

Dr. Raymond M. Campbell
Senior Research Fellow
Narcotics and Drug Research, Inc.
55 W. 125th Street
New York, NY 10027

Ms. Jacqueline Carey
Zeta Phi Beta Sorority, Inc.
1517 Valor Drive
Petersburg, VA 23823

Mr. Avery Carter
Community Organizer
Oakland Parents in Action
2852 Pine Street, #B
San Francisco, CA 94115

Ms. Kathleen M. Carter
Social Worker
Private Practice
2500 College Avenue
Baltimore, MD 21214

Ms. Ruth Carter
Chairperson, National Trends
The LINKS, Inc.
19271 Strathcona Drive
Detroit, MI 48203

Ms. Veda Carter
Social and Scientific Systems, Inc.
7101 Wisconsin Avenue, Suite 610
Bethesda, MD 20814

Ms. Shirley Chambers
DC State Director
Zeta Phi Beta Sorority, Inc.
217 Primavera Circle
Sterling, CA 22170

Ms. Robbie Chissell
President, Baltimore Chapter
LINKS, Inc.
3243 Powhatan Avenue
Baltimore, MD 21216

Dr. Jay Carrington Chun, II
President
Megdar Evers College
1150 Carroll Street
Brooklyn, NY 11225

Ms. Elizabeth Clanton
Professor
University of the District of Columbia
3126 Cherry Road, NE
Washington, DC 20018

Ms. Mary E. Clark
Principal
Birch and Davis Associates, Inc.
8905 Fairview Road, Suite 300
Silver Spring, MD 20910

Mr. Mason Clark
Supervisor
Montgomery County Recreation Department
12210 Bushey Drive
Silver Spring, MD 20902

Mr. Ronald Clark
Executive Director
RAP, Inc.
1731 Willard Street, NW
Washington, DC 20009

Ms. Renee E. Clements
Chemical Dependency Clinician
Catherine McAulty Health Center
5301 E. Haron River Drive
P.O. Box 2506
Ann Arbor, MI 48106

Ms. Rosalyn Cofer
Administrative Assistant
Help House, Inc.
644 Muench Street
Harrisburg, PA 17102

Ms. Lavinia Cohen
Administrator, Step One Program
Commonwealth Mental Health Associates
4921 Seminary Road, Suite 107
Alexandria, VA 22311

Ms. Delores Cole
Resident Counselor
Housing Opportunity Commission
824 Bowie Road
Rockville, MD 20852

Ms. Glory Coley
Director of Clinical Services
Family Health Center-NBCU
5361 NW 22nd Avenue
Miami, FL 33142

Ms. Annette Collins
Trainer/Consultant
Prevention Resource Center
417 S. Dearborn, #200
Chicago, IL 60605

Ms. Donna Collins
Christ Hospital
2139 Auburn Avenue
Cincinnati, OH 45219

Monique Colvin
Langley Junior High School
2028 North Capitol Street, NW
Washington, DC 20002

Mr. John C. Coney
Professor
California State University
Division of Social Work
6000 J Street
Sacramento, CA 95819

Mr. William Conyers
Drug Ministry
Ebenezer A.M.E. Church
7806 Allentown Road
Fort Washington, MD 20744

Mr. Otis Corbitt
Community Mental Health Service
SC Department of Mental Health
P.O. Box 485, 2412 Bull Street
Columbia, SC 29202

Ms. Mary Cothran
President
Delta Sigma Theta Sorority, Inc.
Montgomery County
417 Hillsboro Drive
Silver Spring, MD 20902

Ms. Eleanor Cox
Director, Operation Sisters United
National Council of Negro Women
4604 13th Street, NW
Washington, DC 20011

Mr. Bennie Crayton
Senior Health Educator
Center for Drug Problems
4651 Telephone Road, Suite 250
Ventura, CA 93003

Rodney Crayton
Crossland High School
7018 Hastings Drive
Capitol Heights, MD 20743

Ms. Jenny Cree
Montgomery County Department of
Family Resource
101 Monroe Street
Rockville, MD 20850

Dr. James Curtis
Director, Harlem Hospital Center
Department of Psychiatry
506 Lenox Avenue
Room WP541
New York, NY 10037

Ms. Cynthia Dansby
Prevention Specialist
Cleveland Urban Minority Alcholism
Outreach Project
10605 Chester Avenue, Suite 507
Cleveland, OH 44106

Ms. Marcia Davis
Narcotics and Drug Research, Inc.
1501 Broadway, Suite 1914
New York, NY 10036

Ms. Nancy Day
Montgomery County Department of
Family Resource
101 Monroe Street
Rockville, MD 20850

Ms. Clara Dean
129 Keer Avenue
Newark, NJ 07712

Mr. Joe Dear
Consultant-Administrator
Observer/Sutter/SBAC Project
2214 21st Street
Sacramento, CA 95818

Mr. Thomas DeCoster
Clinical Director
Changing Point
P.O. Box 167 College Avenue
Ellicott City, MD 21043

Ms. Mae Demps
Alcohol and Drug Counselor
Milwaukee Council on Alcoholism
2266 N. Prospect Avenue, #324
Milwaukee, WI 53209

Meta E. Dennis
127 Dale Street
Alexandria, VA 22314

Mr. Willard (Bill) Derry
Community Relations Representative
Meadows Recovery Center
730 Maryland Route 3, P.O. Box 521
Gambrills, MD 21054

Mr. J. Mason De Sousa
Grand Board of Directors
Kappa Alpha Psi Fraternity, Inc.
175-07 144th Drive
Jamaica, NY 11434

Ms. Phyllis A. Diggs
Consultant
L.D. Associates
601 N. Eutaw Street, #511
Baltimore, MD 21201

Ms. Patricia Dillard
Drug Education Specialist
Norfolk Public Schools
School Administration Building
800 E. City Hall Avenue
Norfolk, VA 23501

Mr. Dale P. Dirks
Washington Representative
Association of Minority Health Professions
Schools
400 First Street, NW Suite 712
Washington, DC 20001

Ms. Rolyn Dix
Substance Abuse Specialist
Vanderbilt University Medical Center, B2106
Vanderbilt University Medical Center North
Nashville, TN 37232

Mr. Edward Dixon
Attorney and Assistant to the President
National Baptist Convention of America
P.O. Drawer 1150
Jackson, LA 70748

Ms. Wanda Dorm
Guidance Counselor
Delta Sigma Theta Sorority, Inc.
101 West College Avenue
York, PA 17403

Ms. Shelia Douglas
News Assignment Editor
WJLA-TV, Channel 7
4461 Connecticut Avenue, NW
Washington, DC 20008

Ms. Jane Dunckelman
Student Assistance Program
Dayton Public Schools
4280 North Western Avenue
Dayton, OH 45427

Mr. Anthony Dunn
Community Service Specialist
Veterans Administration
10000 Brecksville Road
Brecksville, OH 44141

Rev. Gerald L. Durley
Pulpit Associate
Ebenezer Baptist Church
Assistant to the President, Clark College
2823 Catryn Court
East Point, GA 30344

Mr. James Dyson
Counselor
Mid Atlantic
2037 Kingshouse Road
Silver Spring, MD 20904

Mr. James Dyson, Jr.
Paint Branch High School
2037 Kingshouse Road
Silver Spring, MD 20904

Mr. Joseph Eaglin
Executive Director
Congress of National Black Churches
1919 Pennsylvania Ave, NW
Washington, DC 20006

Ms. Phyllis Eason
Zeta Phi Beta Sorority, Inc.
P.O. Box 11104
Washington, DC 20008

Ms. Austine A. Ellis
Coordinator
Prevent Adolescence Substance Abuse
(RICCA)
P.O. Box 288 Route #2
East Moline, IL 61244

Mr. Ken Ellis
Sports World Ministries, Inc.
National Headquarters
P.O. Box 500
New Tazewell, TN 37825

Mr. John Emery
President
J & E Associates, Inc.
1717 K Street, NW
Suite #803
Washington, DC 20006

Ms. Valetta Evans
Counselor
Employee Assistance Program
Social Security Administration
Baltimore, MD

Captain Michael J. Fannon
Commanding Officer
Drug Enforcement Section
Baltimore City Police Department
601 E. Fayette Street
Baltimore, MD 21202

Nina Farmer
Langley Junior High School
119 Rhode Island Avenue, NE
Washington, DC 20002

Tina Farmer
Langley Junior High School
119 Rhode Island Ave, NE
Washington, DC 20002

Mr. Fred Ferguson
Director, Community Service
Merritt Peralta Medical Center
370 Hawthorne Street
Oakland, CA 94609

Ms. Leona Ferguson
NIDA
5600 Fishers Lane
Rockville, MD 20857

Ms. Marian R. Finney
Chairperson, Health Mental
Health Committee
Delta Sigma Theta Sorority, Inc.
2813 Arlene Circle
Baltimore, MD 21207

Mr. Clarence Foote
Commissioner
Rockford Housing Authority
330 15th Avenue
Rockford, IL 61108

Ms. Cherie Fortes
President, Alpha Chapter
Zeta Phi Beta Sorority, Inc.
1239 Vermont Avenue
Washington, DC 20005

Ms. Madeline H. Forythe
Supervisor
Rehabilitation Services Administration of DC
6459 31st Street, NW
Washington, DC 20015

Ms. Hiawatha Fountain
Associate Superintendent
Special and Alternative Education
Montgomery County Public Schools
850 Hungerford Drive
Rockville, MD 20850

Ms. Erna Foushee
Regional Coordinator, Drug Education
Zeta Phi Beta Sorority, Inc.
1111 35th Street
West Palm Beach, FL 33407

Ms. Marvelyn Scott Fowler
Addictions Counselor/Supervisor
Cheverly Drug Abuse Treatment Clinic
2 Hospital Road
Cheverly, MD 20785

Ms. Regina Jollivette Frazier
National President
The LINKS, Inc.
1200 Massachusetts Avenue, NW
Washington, DC 20005

Ms. Veronica Freeman
Prevention Specialist
National Council on Alcoholism
6155 Oak Street
Kansas City, MO 64113

Ms. Darlene French White
Educational Specialist
Substance Education
1450 NE 2 Avenue, Room 725
Miami, FL 33132

Mr. Mohammed Fullah
Community Mental Health Service
SC Department of Mental Health
P.O. Box 485, 2414 Bull Street
Columbia, SC 29202

Ms. Susan Galbraith
Assistant Washington Representative
National Council on Alcoholism
1511 K Street, NW
Suite 320
Washington, DC 20005

Ms. Macon Gardner
Regional Director
Zeta Phi Beta Sorority, Inc.
Route 2, Box 178
Cameron, SC 29030

Ms. Faith Mary Gault
Counselor
Syracuse Community Health Center
819 South Salina Street
Syracuse, NY 13202

Ms. Sabreena Geddie
Banneker High School
5032 13th Street, NE
Washington, DC 20017

Mr. Michael Gilchrist
Associate Regional Coordinator
D.A.R.E. Archdiocese New York
218 West 108th Street
New York, NY 10025

Ms. Frances Gillen
Senior Associate
Prospect Associates, LTD.
1801 Rockville Pike
Suite 500
Rockville, MD 20852

Mr. Lawford Goddard
Senior Research Associate
Charles R. Drew Post-Graduate Medical School
1621 E. 120th Street
Los Angeles, CA 90059

Ms. Linda R. Godfrey
1st Lt. ANC
Zeta Phi Beta Sorority, Inc.
475th Mash
Frankfort, KY 40601

Mr. David L. Goodlow, Jr.
Associate Director
Turning Point, Inc.
1105 16th Avenue, N
Minneapolis, MN 55411

Ms. Maxine Goodson
Counselor
Delta Sigma Theta Sorority, Inc.–New Haven
74 Yale Street
Stratford, CT 06497

Sean Goodwin
Williamsburg
2025 Cameron Street
Arlington, VA 22207

Ms. Cheryl D. Goosbey
12753 Turquoise Terrace
Silver Spring, MD 20904

Ms. Jamelia Goosby
Prevention Specialist
Illinois Department of Alcoholism/
Substance Abuse
100 W. Randolph, Suite 5-600
Chicago, IL 60601

Ms. Janet E. Gordon
Home School Advisor
Fulton Junior High School
7320 W. 10th Street
Indianapolis, IN 46214

Ms. Ruth Gordon
President
Gordshaw Professional
Health and Development Services, Inc.
301 E. Riding Road
Montgomery, AL 36116

Ms. Sharon Graham
Director of Social Services
Delta Sigma Theta Sorority, Inc.
2802 Pheasant Hollow Drive
Plainsboro, NJ 08536

Mr. David Grant
Information Specialist
Minnesota Institute on Black Chemical Abuse
2616 Nicollet Avenue
Minneapolis, MN 55408

Dr. Murriel Gray
United Airlines
Employee Assistance Program
National Airport, Hangar #3
Washington, DC 20001

Ms. Ruby Gray
Counselor Outpatient Program
New Hope Foundation, Inc.
516 N. Mill Street
Jackson, MS 39202

Dr. Wayne Greaves
Chief, Division of Infectious Diseases
Howard University Hospital
2041 Georgia Avenue
Washington, DC 20060

Ms. Lettie Green
Vice President
Green and Associates
P.O. Box 93754
Cleveland, OH 44101-5754

Mr. Robert L. Green
Coordinator
Joint Center on Applied Research
Cuyaloga Community College
Cleveland, OH

Mr. Terome Green
Executive Director
Health Care Associates
P.O. Box 27888
Richmond, VA 23261

Ms. Mary Griffen
Drug Rehabilitation Counselor
VA Hospital–Allen Park Michigan
Southfield and Outer Drive
Att: #1168
Allen Park, MI 48101

Ms. Shirley A. Gross
Executive Director
Bayview-Hunters Point Foundation
6025 Third Street
San Francisco, CA 94124

Mr. George Hacker
Director of Alcohol Policies
The Center for Science in the Public Interest
1501 16th Street, NW
Washington, DC 20036

Ms. Barbara D. Haley
Psychiatric Nurse
St. Elizabeths Hospital
2700 Martin Luther King Avenue
Washington, DC 20020

Ms. Aundrella Hamed
Vista Volunteer
Informed Families
9725 NW 14th Avenue
Miami, FL 33147

Miss Jerald Hamilton
Program Coordinator
Department of Human Welfare
Board of Church and Society
United Methodist Church
100 Maryland Avenue, NE
Washington, DC 20002

Mr. Carl Hampton
Office for Substance Abuse Prevention
5600 Fishers Lane
Rockville, MD 20857

Mr. Gregory Handen
Graduate Fellow
University of Michigan
Department of Psychology and Social Work
2503 Braeburn Circle
Ann Arbor, MI 48108

Mr. Michael Handon
Vocational Rehab ilitation Center
St. Elizabeths Hospital
1253 U Street, SE
Washington, DC 20020

Ms. Lillian Handy
President
Tresp Associates, Inc.
4900 Seminary Road
Washington, DC 20011

Ms. Clarice Harris
Project Director
Department of Mental Health, Wichita, KS
1457 North Chautauqua Street
Wichita, KS 67214

Ms. Julia Harris
Elementary School Principal
Delta Sigma Theta Sorority, Inc.
335 West Springettsbury Avenue
York, PA 17403

Ariana Harris
St. Jerome's
6743 S. Holt Avenue
Los Angeles, CA 90056

Ms. Dorothy Y. Harris
Summit II Committee Chairman
Delta Sigma Theta Sorority, Inc.
6650 Jordan Drive
Harrisburg, PA 17111

Ms. Yovonne Harris
Art Counselor
St. Luke's Roosevelt Hospital
260 West 136th Street
New York, NY 10021

Mr. William Haskins
Director of Training Department
National Urban League
500 East 63rd Street
New York, NY 10021

Mr. Vincent Hayden
Executive Director
Turning Point, Inc.
1105-16th Avenue
Minneapolis, MN 55411

Mr. James Haye
Program Consultant
Alameda County Health Care
Services/Alcohol & Drugs
499 5th Street
Oakland, CA 94607

Mr. Hugh Haynes
Alcoholism Counselor
Century House
87 E. Front Street
Red Bank, NJ 07107

Collis Heath
Robert E. Lee High School
7046 Brocton Ct
Springfield, VA 22150

Mr. Joseph W. Heath
Project Director
Kora Associates
1156 15th Street, NW
Suite 200
Washington, DC 20005

Ms. Lena Henderson
Brown Memorial A.M.E. Church
14th & Constitution, NE
Washington, DC

Ms. Martha Henderson
Program Administrator
San Francisco Health Department
Substance Abuse Services
170 Fell Street
San Francisco, CA 94102

Ms. Sue Henry
Coordinator
Drug/Alcohol Impact Program
220 S. Main
Bel Air, MD 21014

Ms. Jo Ann Henson
Clinical Supervisor
Constant Care Medical Center
1501 Division Street
Baltimore, MD 21217

Mr. George Hicks
Executive Director
New Well, Addict Rehabilitation
15 Roseville Avenue
Newark, NJ 07107

Ms. Edwina G. Higgins
The LINKS, Inc.
3502 South Parkwood Drive
Houston, TX 77021

Aaron Hill
John Peter Tetard, J.H.S.
2600 Grand Avenue
Bronx, NY 10468

Rev. David Hill
Director
Center for the City
Substance Abuse Program
2427 Morris Avenue
Bronx, NY 10468-6577

Mr. Earl Hill
Program Coordinator
St. Frances Medical Center
45th Street, Off of Pennsylvania Avenue
Pittsburgh, PA 15201

Ms. Karen Hill
Director
Housing & Economic Development
National Urban League, Inc.
500 East 62nd Street, 10th Floor
New York, NY 10021

Ms. Maude Hill
Assistant to the Director
Governor's Office for Recovery Services
170 N. High Street
Columbus, OH 43215

Ms. Gail Hillman
STEAR
10 Ginesi Center
Metuchen, NJ 08840

Ms. Angela Hodges
Residential Advisor
Potomac Job Corps Center
#1 DC Village Lane SW
Washington, DC 20032

Mr. Simon Holiday
Acting Chief
Commissioner of Public Health
Office of Health Planning
425 I Street, NW
Washington, DC 20001

Shawn Holland Phillips
Paint Branch
2042 King House Road
Silver Spring, MD 20904

Mr. Raymond Holloway
Counselor
Adolescent Development Program
Cornell University Medical Center
411 East 69th Street
New York City, NY 10021

Mr. Thomas Hudson
Executive Director
Wildlife Georgia Council on Drugs
538 First Street
Macon, GA 31204

Ms. Joan Hurley
Director
Associate Consultants
9800 Broad Street
Bethesda, MD 20814

Mr. Paul W. Ingram
Executive Director
PBA, Inc.
1425 Beaver Avenue
Pittsburgh, PA 15233

Mr. Ethel Ivory, Jr.
Intervention Specialist
Jackson State University
Alcohol/Drug Studies Center
P.O. Box 17054
Jackson, MS 39217

Mr. Harold Jackson
Residential Advisor
Potomac Job Corps Center
#1 DC Village Lane, SW
Washington, DC 20032

Mr. Lewis Jackson
National Black Alcoholism Council
1225 Vine Street, 2nd Floor
Philadelphia, PA 19107

Ms. Melody V. Jackson
Coordinator of Prevention
Human Resources Development
417 S. Dearborn
Chicago, IL 60605

Dr. Rudolph Jackson
Professor and Chairman
Department of Pediatrics
Morehouse School of Medicine
720 Westview Drive, SW
Atlanta, GA 30310-1495

Mr. James Jacobs
Psychiatric Technician
Washington Hospital Center
5055 Seminary Road, #1207
Alexandria, VA 22311

Dr. Andrew B. James
Chairman, Black Congress on Health, Law,
and Economics
P.O. Box 20828
Houston, TX 77225

Mr. Dennis James
Alcoholism Rehabilitation Tech-CAC
Veterans Administration
Medical Center
3495 Bailey Avenue, Ward 4D
Buffalo, NY 14215

Ms. Jacqueline Jenkins
Supervisor
Potomac Job Corps Center
#1 DC Village Lane, SW
Washington, DC 20032

Mr. Anthony Jerrido
New Horizons Mental Health
1469 NW 36th Street
Miami, FL 33142

Ms. Carole E. Johnson
136 Duvall Lane #301
Gaithersburg, MD 20877

Ms. Diane Johnson
Vice President
Telspan International
4401 Ford Avenue, Suite 405
Alexandria, VA

Ms. Doris Johnson
Zeta Phi Beta Sorority, Inc.
3506 Rosedale Road
Baltimore, MD 21215

Ms. Elaine Johnson
NIDA
5600 Fishers Lane
Rockville, MD 20857

Ms. Frances B. Johnson
President
Zeta Phi Beta Sorority, Inc.
2624 E.N. Bay
Tampa, FL 33610

Mr. Gerald Johnson
Executive Director
Orca House
1905 E-89th
Cleveland, OH 44106

Ms. Joycelyn A. Johnson
Sports World Ministries
P.O. Box 500
New Tazewell, TN 37825

Mr. Ken Johnson
Scheduling Coordinator
Sports World Ministries, Inc.
P.O. Box 500
New Tazewell, TN 37825

Mr. A. Billy S. Jones
Health Educator
Whitman-Walker Clinic
Sunnye Sherman Aids Education
1800 Wyoming Avenue, NW
Washington, DC 20009

Ms. Brenda Jones
Director
Parklands Community Center
3515-21st Street, SE
Washington, DC 20020

Ms. Frances Jones
Prevention Advisor
Alcohol and Drug Abuse Prevention Unit
201 W. Preston Street
Baltimore, MD 21201

Ms. Ida Jones
DCA Volunteers Hand Council
Montgomery County Department of
Family Resource
101 Monroe Street
Rockville, MD 20850

Mr. Henry P. Jones
Associate Director
Central Ohio Regional
Council on Alcoholism
1755 Alum Creek Drive
Columbus, OH 43207

Ms. Mary Frances Jones
Drug Abuse Coordinator
Zeta Phi Beta Sorority, Inc.
5111-B Lahm Court
Andrews AFB, MD 20335

Ms. Delora Jones-Hicks
Programs Coordinator
Urban New Well
15 Roseville Avenue
Newark, NJ 07107

Ms. Pat Joyner
Supervisor of Drug Education
Newark Board of Education
2 Cedar Street
Newark, NJ 07102

Ms. Latifah A. Khidhr
Zeta Phi Beta Sorority, Inc.
200 Rhode Island Avenue, NW #401
Washington, DC 20002

Ms. Johanne Kibbie
Executive Director
Because We Care
3221 Collinsworth
Fort Worth, TX 76107

Mr. Tommie L. Kidd
Inner City Council on Alcoholism
4365 N. 27th Street
Milwaukee, WI 53216

Mr. John Kline
Prevention Coordinator
Detroit Health Department
Bureau of Substance Abuse
9000 E. Jefferson, 5-3
Detroit, MI 48214

Ms. Ann Kovalcik
Prevention Coordinator
St. Mary's County Government
P.O. Box 653
Leonardtown, MD 20650

Dr. Crystal Kuykendall
Director of Marketing
Roy Littlejohn Associates
1848 Columbia Road, NW
Washington, DC 20036

Mr. Lawrence Landry
President
Associate Consultants, Inc.
1726 M Street, NW
Suite 600
Washington, DC 20036

Ms. Sylvia Law
Chairman Service to Youth
LINKS, Inc.
4130 Buckingham Roads
Baltimore, MD 21201

Mr. William P. Lee
Executive Director
New Hope Foundation, Inc.
516 N. Mill Street
Jackson, MD 39209

Mr. Preston D.H. Leonard
Vice President
Pinellas County Awake & Action Council
1820 Walton Street, South
St. Petersburg, FL 33712

Ms. Joan A. Lewis
Housing Manager
Department of Housing and Community Development
1133 North Capitol Street, NE
Washington, DC 20002

Mr. Richard Lewis
Counselor Tech.
Changing Point
P.O. Box 167 College Avenue
Ellicott City, MD 21043

Mr. Russell Lewis
Community Mental Health Service
SC Department of Mental Health
P.O. Box 485, 2414 Bull Street
Columbia, SC 29202

Tracy Lewis
Crossland High School
4415 23rd Place
Marlow Heights, MD 20748

Ms. Karryl Lindsey
Primary Counselor
New Directions
30245 Pettibone Road
Glenwillow, OH 44139

Mr. Pharnell Lindsey
Elmhurst Home, Inc.
12017 Linwood
Detroit, MI 48206

Ms. Ceola Loan
Deputy Director
Children's Hospital National Medical Center
111 Michigan Avenue, NW
Washington, DC 20011

Dr. Raymond Logan
Director of Social Services
PBA, Inc.
1425 Beaver Avenue
Pittsburg, PA 15233

Raymond Lomax
Forestville
3901 Suitland Road
Apt. #514
Suitland, MD 20784

Mr. Vincent B. Love
Property Manager
Syracuse Housing Authority
516 Burt Street
Syracuse, NY 13202

Ms. Gladys Diane Lundy
President
Zeta Phi Beta Sorority, Inc.
1220 Carlton Avenue
Raleigh, NC 27606

Mr. Roland J. Marsh
Contract Program Auditor
Los Angeles County DHS
Office of Alcohol Programs
714 W. Olympic, 10th Floor
Los Angeles, CA 90015

Ms. Brenda Martin
Clinical Coordinator
Residential Care Alternative
617 Book Building
Detroit, MI 48226

Mr. Eddie J. Martin
Resource Mobilizer
Blacks Against Dangerous Drugs, Inc.
1317 15th Street South
St. Petersburg, FL 33705

James Mason
Wakefield
4163 S. Four Mile Run #2
Arlington, VA 22204

Ms. Mae H. Maxey
Registered Nurse
VA Medical Center
7628 Woodmore Trace #709
Indianapolis, IN 46260

Ms. Daphine Maxwell-Reid
Actress
Timalove Ent., Inc.
1901 Avenue of the Stars #585
Los Angeles, CA 90067

Dr. Claude Mayberry
Editor, *Science Weekly* Magazine
P.O. Box 70154
Washington, DC 20088-1054

Mr. Terry Mayfield
Consultant/Program Coordinator
Cork Institute
Morehouse School of Medicine
720 Westview Drive, SW
Atlanta, GA 30310

Ms. Sharon K. Mays
Clincial Social Worker
District of Columbia General Hospital
19th & Mass Avenue, SE
Washington, DC 20002

Ms. Lazette McCants
Director
Narcotic & Drug Research, Inc.
1501 Broadway, Suite 1914
New York, NY 10036

Ms. Gwenda McClain
Prevention Coordinator
Prince Georges Health Department
Directorate of Addictions
6201 Riverdale Road, Room 104
Riverdale, MD 20737

Ms. Cherrie McClelland
Secretary
The LINKS, Inc.
3023 Frontage Road
Vicksburg, MS 39180

Dr. Henry L. McCurtis
Director of Education & Training
Harlem Hospital Center
506 Lenox Avenue
Room WP-541
New York, NY 10037

Ms. Yvette Mceachern
Health Policy Analyst
Maryland Department of Health and
Mental Hygiene
5th Floor, 201 W. Preston Street
Baltimore, MD 21201

Ms. Mary McKnight
Director, Substance Abuse
Community Re-Entry
1468 W. 25th Street
Cleveland, OH 44113

Ms. Evelynee McLaren
Coordinator
NEED/ACTION Council
New Opportunities for Waterbury
232 North Ealm Street
Waterbury, CT 06702

Mr. Ed McMahon
Executive Director
Coalition for Scenic Beauty
218 O Street
Washington, DC 20003

Ms. Patricia McManus
Executive Health Administrator
Milwaukee Comprehensive Community Health, Inc.
1747 North 6th Street
Milwaukee, WI 53212

Ms. Rebekah McPherson
Social & Scientific Systems
7101 Wisconsin Avenue, #610
Bethesda, MD 20814

Mr. Garry Mendez
Director, Administrator of Justice
National Urban League
633 Indiana Avenue, NW
Washington, DC 20531

Ms. Wendy Mettger
National Cancer Institute
9000 Rockville Pike, Building 31
Room 4B-43
Bethesda, MD 20892

Malcolm Miles
Hayfield Secondary
7006 Devereux Circle Drive
Alexandria, VA 22310

Ms. Oval Miller
Executive Director, BASIC
Black Alcohol/Drug Service Information Center
625 N. Euclid-Suite 615
St. Louis, MO 63108

Traci Miller
7033 Longview Road
Columbia, MD 21044

Mr. Arnold Mills
NIDA
5600 Fishers Lane
Rockville, MD 20857

Ms. Audrey Minor
Director
Outpatient Children's Center
101 E. Alexandrine
Detroit, MI 48235

Mr. Clifton Mitchell
Health System Administrator
Alcohol & Drug Abuse Services Administration
1300 First Street, NE
Washington, DC 20010

Ms. Ellen Mitchell
Department of Housing and Community Development
Government of DC
Washington, DC 20002

Ms. Willa Mohamed
Director, Mental Health
East of the River Health Center
5929 E. Capitol Street, SE
Washington, DC 20019

Ms. Barbara C. Moore
South Carolina State Director
Zeta Phi Beta Sorority, Inc.
237 Swandale Drive
Columbia, SC 29203

Mr. Boissan Moore
Assistant Director
Minnesota Institute on Black Chemical Abuse
2616 Nicollet Avenue
Minneapolis, MN 55408

Mr. Gary E. Moore
E.A.P. Ford
2216 Broadway
Lorain, OH 44052

Ms. Julia Moore Foster
National Treasurer
Zeta Phi Beta Sorority, Inc.
P.O. Box 1651
Cincinnati, OH 45201

Ms. Margaret Moore
Administrator
The Consortium
P.O. Box 8076
Philadelphia, PA 19101

Ms. Veronica Moore
Research Social Worker
NIAAA-LCS-DICBR
1312 Edenville Drive
Forestville, MD 20747

Mr. Horace L. Morancie
Chairman, Board of Trustees
Addiction Research and Treatment Corporation
22 Chapel Street
Brooklyn, NY 11201

Ms. Jacqueline Morrison
Senior Community Prevention Consultant
Wayne State University
Department of Community Medical Project
540 E. Canfield, Room 1368
Scott Hall
Detroit, MI 48201

Mr. Sydney S. Moshette, Jr.
Executive Director
Reality House, Inc.
637 W. 125 Street
New York, NY 10027

Ms. Laura A. Mosley
Mental Health Worker
University of VA Medical Center
Jefferson Park Avenue
Charlottesville, VA 22901

Ms. Angela Moss
Senior Counselor
A.L. Nellum and Associates
1900 L Street, NW #405
Washington, DC 20036

Mr. Abdul-Rasheed Muhammed
Substance Abuse Prevention Specialist
Ypsilanti Resource Center
518 Harriet Street
Ypsilanti, MI 48197

Mr. Jonnie Mullins
Frenchbey Job Corps Center
Frenchbey, KY

Ms. Annette Murphy
Prevention Education
Cape Fear Substance Abuse
801 Princess Street
Wilmington, NC 28401

Ms. Mabel Murray
Vice President
Delta Sigma Theta Sorority, Inc.
Baltimore County
P.O. Box 240
Randallstown, MD 21133

Ms. Barbara Musgrove
Program Director
A.L. Nellum & Associates
1900 L Street, NW #405
Washington, DC 20036

Ms. Gloria Myers
Clinician IV
Loudon Mental Health Center
2619 John Milton Drive
Herndon, VA 22071

Mr. James Myricks
Clinical Director
National Council on Alcoholism and Other Dependencies
14320 West McNichols
Detroit, MI 48345

Mr. George Napper
Commissioner of Public Safety
City of Atlanta
Department of Public Safety
120 Ralph McGill Boulevard
Atlanta, GA 30308

Mr. Lee Nattress
Development Officer
Center for the City
593 Park Avenue
New York, NY 10021

Ms. Hyaciath Nelson
Alcohol Services Center
838 North West Street
Jackson, MS 39209

Mr. Bradford Nichols
Assistant Director
Bureau of Substance Abuse
Detroit Department of Health
1151 Taylor Street, Building 1
Detroit, MI 48202

Ms. Vanessa Nichols
DCA Volunteers Hand Council
Montgomery County Department of
Family Resource
101 Monroe Street
Rockville, MD 20850

Ms. Jean Nicholson
Registered Nurse
Riverside Hospital
1145 24th Street
Newport News, VA 23607

Ms. Lynn Nicholson
Executive Director
ADAPT, Inc.
435 Warren Street
Boston, MA 02121

Mr. Johnny Noble
Elmhurst Home, Inc.
12017 Linwood
Detroit, MI 48206

Dr. Wade Nobles
Executive Director
The Institute for Advanced Study of Black
Family Life and Culture
155 Filbert Street, Suite 202
Oakland, CA 94607

Ms. Jewell Oates
Program Director
Parkside Medical Services
2951 S. King Drive, #1502
Chicago, IL 60616

Mr. John Oden
Elmhurst Home, Inc.
12017 Lindwood
Detroit, MI 48206

Ms. Beverly Ogletree
Director
Urban Minority Alcoholism Outreach
Program
1323 W. Third Street
Dayton, OH 45407

Ms. Diane O'Neal
Chairman
Seattle Coalition Against Drug Abuse
431-315 Avenue South
Seattle, WA 98144

Mr. Reree C. Orr
Director
E.A.P. Ford
3920 Washington Avenue
Lorain, OH 44052

Ms. Cynthia Osborne
Nurse/Counselor
CAPO Detox Center
842 Hampton Avenue
Newport News, VA 23607

Ms. Brenda Otis
Producer, Black Entertainment Television
4217 Wheeler Avenue
Alexandria, VA 22304

Ms. Charlotte Ottley
President, Board of Directors
Black Alcohol/Drug Information Center
625 N. Euclid, Suite 615
St. Louis, MO 63108

Ms. Jean Owens
The Consultation Center
283 Highland Street
New Haven, CT 06511

Ms. Karen Owens
Director of Family Services
Columbus Urban League
700 Bryden Road, Suite 220
Columbus, OH 43215

Ms. Nicole Owens
283 Highland Street
New Haven, CT 06511

Ms. Jacquline H. Parker
Area Director Chairman
Top Ladies of Distinction, Inc.
254 E. Dennell Drive
Creek, IL 60417

Ms. Phyllis Parker
Student Assistance Counselor
Mercer Council on Alcoholism
408 Bellevue Avenue
Trenton, NJ 08618

Ms. Elizabeth Payne
Administrator
The New York Hospital
701 E. 71st Street
New York, NY 10021

Mr. Frank Peak
Outreach Program Coordinator
N. Omaha Alcohol Counseling Program
1818 Douglas Street
Omaha, NE 68102

Ms. Ursula Pegram
Substance Abuse Counselor
District 19 Women's Day Treatment Program
116 South Adams Street
Petersburg, VA 23803

Ms. Betty J. Penn
Program Analyst
Health Resources & Services Administration
DHHS
5600 Fishers Lane, Room 14A-12
Rockville, MD 20587

Sherlyn Perry
Arlington Public Schools
2000 N. Buchanan
Arlington, VA 22207

Mr. Keith L. Pettigrew
National Institute on Drug Abuse
1722 A Street SE
Washington, DC 20003

Mr. Ronald Pettiway
City Lights Schools
7th New York Avenue
Washington, DC 20002

Mr. Earl Phillips
2037 Kings House Road
Silver Spring, MD 20904

Ms. Grace W. Phillips
National Community Liason
Zeta Phi Beta Sorority, Inc.
1316 Underwood Street, NW
Washington, DC 20009

Anthony Pipes
Smith High School
2406 Dulaire Road
Greensboro, NC 27407

Mr. Robert Pipes
Consultant, Harvard University
Institute for Study of Smoking Behavior
75 East Wayne Avenue, Apt 805
Silver Spring, MD 20901

Ms. Betty Pittman
Prevention Coordinator
Alcohol and Drug Abuse
201 W. Preston Street
Baltimore, MD 21201

Ms. Beverly-Jean Pollard
Minority Outreach Project
Director, Trumbull County Council on
Alcoholism, Inc.
2396 Tod Place, Suite 100
Warren, OH 44485

Ms. Suki Portes
Director, Minority Task Force on AIDS
92 St. Nicholas Avenue
Apt. 1B
New York, NY 10026

Ms. Patricia A. Powell
Certified Nurse
DC General Hospital
19th & Mass Avenue, SE
Washington, DC 20003

Ms. Robin Prichard
Senior Liaison Officer
Office of Liaison Services
Department of Justice, Room 4213
Constitution Avenue & 10th Street, NW
Washington, DC 20530

Dr. Beny Primm
Executive Director
Addiction Research and
Treatment Corporation
22 Chapel Street
Brooklyn, NY 11201

Mr. Paul C. Purnell
Senior Associate
Polaris Research and Development
7201 Wisconsin Avenue, Suite 620
Bethesda, MD 20814

Mr. George Quarles
Outreach Worker
Montgomery County Recreation Department
12210 Bushey Drive
Silver Spring, MD 20902

Mr. William Quarles Esquire
Venable, Raetjer, Howard and Civiletti
1301 Pennsylvania Avenue, NW, Suite 1200
Washington, DC 20004

Ms. Emma C. Redmond
Assistant Administrator
Illinois Department of Alcoholism/Substance
Abuse
100 W. Randolph Suite 5-600
Chicago, IL 60601

Ms. Ester Reed
Zeta Phi Beta Sorority, Inc.
9935 Liberty Road
Randal

Ms. Eva Reed
School Nurse
Newark Board of Education
129 Chestnut Street
Montclair, NJ 07042

Ms. Evelyn Reid
Chairman Lead Program
The LINKS, Inc., Arlington Chapter
1530 South 13th Street
Arlington, VA 22204

Mr. Tim Reid
Actor
Timalove Ent. Inc.
1901 Avenue of the Stars, #585
Los Angeles, CA 90067

LaShawn Rhoades
Largo High School
8940 Congress Place
Landover, MD 20785

Mr. Eugene C. Richardson
Education Coordinator
U.S. Army
Aberdeen Proving Ground
Aberdeen, MD 21005

Ms. Jacqueline Richmond
Senior Associate
Prospect Associates
1801 Rockville Pike, Suite 500
Rockville, MD 20852

Kristi Riggs
Robert E. Lee High School
7839 Belleflower Drive
Springfield, VA 22152

Ms. Louise Ritchie
Director of Substance Abuse Prevention
Detroit Urban League
22223 Hallcroft Lane
Southfield, ME 48034

Dr. Tune Carlotta Rivers
School Principal
Detroit Public Schools
5821 Outer Drive West
Detroit, MI 48235

Ms. Josephine Roberts
Senior Community Specialist
City of Rockville
111 Maryland Avenue
Rockville, MD 20850

Dr. John Robertson
Chairman
Organizational Development Committee
National Black Alcoholism Council
1213 Court Street
Utica, NY 13503

Ms. Shirley Robertson
Program Director
Family Health Center, NBCU
5361 N.W. 22nd Avenue
Miami, FL 33142

Ms. Angela Robinson
Panorama Host
Fox Television
151 Wisconsin Avenue, NW
Washington, DC 20016

Dr. Bobby Ann Robinson
Saginaw–Bay Substance Abuse Commission
1600 North Michigan Avenue, Suite 404
Saginaw, MI 48603

Ms. Grace K. Robinson
Alcohol Counselor
Veterans Medical Center
1481 West 10th Street
Indianapolis, IN 46205

Mr. Lawrence Rodgers
Substance Abuse Director
Avalon-Carver Community Center
4920 South Avalon Boulevard
Los Angeles, CA 90011

Ms. Katherine B. Ross
Zeta Phi Beta Sorority, Inc.
1030 Boxwoor Road
Wilmington, DE 19804

Ms. Betty Rouse
Resource Developer
PA County Board of Assistance
1400 Spring Garden Street
Philadelphia, PA 19130

Ms. Rita Rumbaugh
Parent Group Coordinator
Montgomery County Public Schools
850 Hungerford Drive
Rockville, MD 20850

Mr. Eugene Ruyon
Professor, Psychology Department
North Carolina A&T State University
4302 Kingarthur Place
Greensboro, NC 27405

Ms. Gae-Lauren Schell
AH Training and Development Systems, Inc.
9133 S. ADA
Chicago, IL 60602

Mr. Steven Schinke
Professor
Columbia University
622 West 113th Street
New York, NY 10025

Ms. Rosalyn Schram
Director, Community Relations
NBC, New York
30 Rockefeller Plaza
Room 4811
New York, NY 10020

Ms. Bettina Scott
Project Manager
University Research
Corporation
5530 Wisconsin Avenue, Suite 1600
Chevy Chase, MD 20815

Ms. Deborah L. Scott
Director Patient Care
Management System
Wayne County Health Department
1200 6th Street, Suite M146
Detroit, MI 48226

Ms. Patricia A. Scott
Clinical Social Worker
Cleveland VA Medical Center
1300 E. 276th Suite D
Euclid, OH 44132

Mr. Wali Shabazz
Crime Specialist
Tampa Urban League
1405 Tampa Park Plaza
Tampa, FL 33604

Ms. Ulonda Shamwell
Program Director
A.L. Nellum Associates CADAC
2700 MLK Avenue, S.E.
20032 "P" Building
Washington, DC 20032

Ms. Sharon W. Shaw
President
Nashville Center for Black Family Life
P.O. Box 60205
Nashville, TN 37216

Ms. Bettye Shelling
Georgia State Director
Zeta Phi Beta Sorority, Inc.
3609 Stone Road, SW
Atlanta, GA 30331

Ms. Carol Shepperd
Assistant Director
Syracuse Housing Authoritiy
516 Burt Street
Syracuse, NY 13202

Ms. Juliette Simmons
Board Member
Mental Health Association of DC
235 Rhode Island Avenue, NW
Washington, DC 20001

Mr. Eric Simpson
Mental Health Technician
Brierwood Hospital
209 St. Matthews Lane
Spartanburg, SC 29301

Dr. Cheryl Slaughter Ellis
Director/Professor Health
Delta Sigma Theta Sorority, Inc.
"Just Say No"
Box 545, MTSU
Murfreesboro, TN 37132

Ms. Anita L. Smith Hawkins
Public Health Analyst
DC Department of Human Services
1331 H Street, NW
Washington, DC 20055

Ms. Jean Smith
Community Organizer
Montgomery County Department of
Family Resource
101 Monroe Street
Rockville, MD 20850

Mr. Michael Smith
Drug Ministry
Ebenerzer A.M.E. Church
7806 Allentown Road
Fort Washington, MD 20744

Mr. Robert Smith
Chairman Education Committee
E.A.P. Ford
504 W 21st Street
Lorain, OH 44052

Mr. James L. Snead, Jr.
Housing Manager
Department of Housing
1133 N. Capitol Street, NE
Washington, DC 20032

Mia Snyder
McKinley Senior High School
433 Evarts Street, NE, #4
Washington, DC 20017

Mr. William Sommers
Substance Abuse Counselor
Arlington County Department of
Human Services
3025 South 16th Street
Arlington, VA 22204

Mr. James Spann
Community Mental Health Service
SC Department of Mental Health
P.O. Box 485, 2414 Bull Street
Columbia, SC 29202

Ms. Helen Spicer
Executive Director
Hillvale Education Associates
2516 A. Martin Luther King Boulevard
Dallas, TX 75215

Dr. Jeanne Spurlock
Deputy Medical Director
American Pyschiatric Association
1400 K Street, NW
Washington, DC 20005

Mr. Marshall J. Spurlock
Executive Director
Central Maryland Health Systems Agency
501 S. Paul Place, 10th FL
Baltimore, MD 21201

Sister Helene Terese Stanislaus
High School Teacher
St. Frances-Charles Hall High School
1026 Brentwood Avenue
Baltimore, MD 21202

Ms. Marilyn J. Stanley
Prevention Specialist
Urban Minority Alcoholism Outreach
98 Hamilton Park
Columbus, OH 43203

Mr. Stephen R. Stegall
Executive Director
Intersectional United Advanced Planning
2323 Forest Avenue
Des Moines, IA 50311

Mr. Gunther Stern
3702 Farragut Avenue
Kensington, MD 20895

Dr. Janice Stevenson
Chairperson
Black Mental Health Alliance
1101 North Calvert Street, Suite 211
Baltimore, MD 21203

Dora Stewart
Parkdale High
6914 Elbrook Road
Lanham, MD 20706

Mr. Ben Stinson
Product Manager
Ford Motor Co.
Lorain, OH 44052

Mary Storm
914 1st Street
Alexandria, VA 22314

Ms. Willa Sudduth
Substance Abuse Chair
Coalition of Labor Union/Women
480 Taylor Street, NE, I-14
Washington, DC 20017

Ms. Leona T. Sumpter
Guidance Counselor
Zeta Phi Beta Sorority, Inc.
820 W. Crawford Street
Quincy, FL 32351

Mr. Rudolph Sutton
Administrator
Philadelphia Injury Prevention Program
Department of Public Health
500 South Broad Street
Philadelphia, PA 19146

Ms. Charlene Swann
Drug Rehabilitation Counselor
VA Hospital-Allen Park MI
Southfield & Outer Drive
Attn: #1168
Allen Park, MI 48101

Mr. Ulysses Sweeney
Community Mental Health Service
SC Department of Mental Health
P.O. Box 485, 2414 Bull Street
Columbia, SC 29202

Dr. John Syphax
Psychiatrist
Howard University Hospital
2041 Georgia Avenue, NW
Washington, DC 20060

Mr. Wilbert Tatum
Chairman of the Board
New York Amsterdam News
2340 Frederick Douglass Boulevard
New York, NY 10027

Ms. Lynette Taylor
Program Director
Delta Sigma Theta Sorority, Inc.
203 Yoakum Parkway
Alexandria, VA 22304

Dr. Arthur E. Thomas, Ed.D.
President
Central State University
Wilberforce, OH 45384

Ms. Eunice Thomas
International Grand Basileus
Zeta Phi Beta Sorority, Inc.
201 "Eye" Street
Washington, DC 20024

Mr. Jeffrey Thomas, Supervisor
Potomac Job Corps Center
#1 DC Village Lane, SW
Washington, DC 20032

Mr. Stephen Thomas
Assistant Professor Health Education
University of Maryland
College Park, MD 20742

Dr. Terra Thomas
Assistant Executive Director
Human Resources Development Institution, Inc.
417 South Dearborn
Chicago, IL 60605

Mr. Walter Thomas, Jr.
Interim Director
Elmhurst Home, Incorporated
12017 Linwood
Detroit, MI 48206

Ms. Ella Thompson
Acting Housing Manager
Department of Housing & Community Development
1133 N. Capitol Street, NE
Washington, DC 20002

Ms. Linda Thompson
Executive Director
Zeta Phi Beta Sorority, Inc.
1734 New Hampshire Avenue
Takoma Park, MD 20912

Previs Thompson
High Point High School
6735 New Hampshire Avenue
Takoma Park, MD 20912

Ms. Wanita E. Thompson
Delta Sigma Theta Sorority, Inc.
2231 Castlerock Square, #12C
Reston, VA 20091

Mr. Zachary Thompson
Director of Drug Education & Prevention Program
West Dallas Community Centers
8200 Brookriver Drive #N-614
Dallas, TX 75247

Mr. John Tolber
Substance Abuse Counselor
Neighborhood House, Inc.
1000 Atcheson Street
Columbus, OH 43203

Ms. Ernestine Tolivet
President
Delta Sigma Theta Sorority, Inc.
Baltimore County
P.O. Box 240
Randallstown, MD 21133

Mr. Richard L. Towers
Department Director
Montgomery County Public Schools
850 Hungerford Drive
Rockville, MD 20850

Ms. Laurel Tucker
The LINKS, Inc.
301 Madison
Washington, DC 20011

Dr. Reed Tuckson
Commissioner of Public Health
Washington, DC

Ms. Evelyn Turner
Coordinator-Social Work Program
Bowie State College
Bowie, MD 20715

Ms. Grace E. Turner
Social Worker
Baltimore City Department of Social Services
9721 Mendoza Road
Randallstown, MD 21133

Ms. Johnie Underwood
Program Coordinator
Department of Mental Health
Division of Addiction Service
117 E. Washington Street
Indianapolis, IN 46205

Ms. Judith A. Upshaw
Minority Project Coordinator
Buck County D & A Commission
Doylestown Corporate Center
Doylestown, PA 18901

Mr. Dan D. Vickers
Eagleville Hospital
P.O. Box 1134
Norristown, PA 19401

Mr. Thomas Vinigar
Community Mental Health Service
SC Department of Mental Health
P.O. Box 485, 2414 Bull Street
Columbia, SC 29202

Ms. Joan Walden
Prevention Specialist
Chesterfield Mental Health/
Mental Retardation
Post Office Box 92
Chesterfield, VA 23832

Ballus Walker
Professor-Environmental Health
State University of New York-Albany
Albany, NY 12203

Mr. Benjamin Walker
Chief Executive Officer
Odyssey House
666 Broadway, 10th Floor
New York, NY 10003

James Walker
South Lakes High School
2408 Southgate Square
Reston, VA 22091

Ms. Sybil Walker
Editor
National Federation of Parents for
Drug Free Youth
8730 Georgia Avenue, Suite 200
Silver Spring, MD 20910

Ms. Virgie Walker
Program Coordinator
People Coordinated Services
1221 South Western Avenue
Los Angeles, CA 90006

Ms. E'Lois G. Waller
Executive Director
National Funeral Directors Association
600 Kennedy Street, NW
Washington, DC 20011

Dr. J. Michael Walsh
Director
Office of Workplace Initiatives
NIDA
5600 Fishers Lane
Rockville, MD 20857

Dr. Flavia Walton
National Director
Services to Youth
The LINKS, Inc.
12604 Surrey Circle Drive
Ft. Washington, MD 20744

Ms. Marsha Walton, Director
East Orange Substance Abuse Program
160 Halsted Street
East Orange, NJ 07018

Dr. Bettye Ward Fletcher
Associate Director of Research & Training
Alcohol and Drug Studies Center
Jackson State University
P.O. Box 17054
Jackson, MS 39217

Jonathan Ward
City Lights
635 Powhatan Place
Washington, DC 20011

Mr. Charles Warren
Assistant Program Specialist
NJ Department of Health
CN362
Trenton, NJ 08625-0362

Ms. Juanita Warrick-Williams
Historian-Social Worker
Zeta Phi Beta Sorority, Inc.
2514 Talbot Road
Baltimore, MD 21216

Mr. Elby Washington
Army
Alcohol and Drugs
343 Winterberry Drive
Edgewood, MD 21040

Ms. Robin Ellen Watson
Drug and Alcohol Counselor
Zeta Phi Beta Sorority, Inc.
48 Nye Avenue
Newark, NJ 07112

Dr. Eric Waugh
Medical Coordinator, MMTP&ADU
Harlem Hospital Center
Department of Psychiatry
506 Lenox Avenue (WP4, Room 450)
New York, NY 10037

Dr. Aarron O. Wells
Imperial Medical Director
(AEAONMS) The Shriners
2368 Adam Powell Boulevard
New York, NY 10030

Dave Wharwood
Thomas Jefferson Intermedate
336 N. George Mason Dr., #3
Arlington, VA 22203

Ms. Jean Wheeler Smith
Psychiatrist
Columbia Associates
4451 MacArthur Boulevard, NW
Washington, DC 20009

Dr. Joycelyn Whiten
Director
Addiction Research Center
King-Drew Medical Center
12021 S. Wilmington Avenue
Los Angeles, CA 90059

Ms. Joyce Whitney-Underwood
STEAR
10 Ginesl Center
Metuchen, NJ 08840

Mr. Charles A. Williams
Founder/President
Circle of Love Ministry
3416 N. Spencer Road
Spencer, OK 73084

Dr. Irvin J. Williams
Director, Drug & Alcohol Services
Lakeview Center, Inc.
1221 W. Lakeview
Pensacola, FL 32501

Ms. Joan Williams-Thomas
National Director Employment Opportunities
Zeta Phi Beta Sorority, Inc.
6912 Greenvale Street, NW
Washington, DC 20015

Mr. Michael Williams
Staff
Emanuel Baptist Church
2915 Oxon Park Street
Temple Hills, MD 20748

Mr. Milton Williams
Director Three Quarter House
New Hope Foundation, Inc.
428 Hooker Street
Jackson, MS 39209

Ms. Peggy Williams Smith
602 Tewkesbury Place, NW
Washington, DC 20012

Mr. Robert Williams
Counselor
Potomac Job Corps Center
#1 DC Village Lane SW
Washington, DC 20032

Ms. Thelma Williams
Community Leader
Montgomery County Department of Family Resource
101 Monroe Street
Rockville, MD 20850

Ms. Jacquelyn Wills
Zeta Phi Beta Sorority, Inc.
P.O. Box 11104
Washington, DC 20008

Mr. Charles Wilson
President
Enterprises for New Directions, Inc.
7315 Wisconisin Avenue, Ste 25N
Washington, DC 20814

Ms. Sharon L. Wilson
Prevention Specialist
Bureau of Drug Abuse
Ohio Department of Mental Health
170 N. High Street, Third Floor
Columbus, OH 43215

Ms. Johnnye Witcher
Basileus
Zeta Phi Beta Sorority, Inc.
P.O. Box 4176
Montgomery, AL 36110

Ms. Maxine Womble
Chairperson
National Black Alcoholism Council
417 South Dearborn Street, Suite 700
Chicago, IL 60605

Dr. Nollie P. Wood
Division of Injury, Epidemeology & Control
Centers for Disease Control
1600 Clifton Road, NE, The Koger Center
Atlanta, GA 30333

Mr. Paul L. Woodard
Deputy Director
NYS Division of Substance Abuse Services
55 West 125th Street, 8th Floor
New York, NY 10027

Ms. Sheryl Woodland
Zeta Phi Beta Sorority, Inc.
2432 W. Garrison Avenue
Baltimore, MD 21215

Ms. Ednita Marie Wright
Program Director
Syracuse Community Health Center, Inc.
819 South Salina Street
Syracuse, NY 13202

Dr. Erma J. Wright
Assistant Professor
Tulane University
School of Public Health & Tropical Medicine
212 South Murat Street
New Orleans, LA 70119

Mr. Joseph Wright
ACT Executive Director
Washington Area Council on Alcoholism & Drug Abuse, Inc.
1232 M Street, NW
Washington, DC 20005

Ms. Karen Wright
Hot Line Co-Ordinator
Washington Area Council on Alcoholism & Drug Abuse, Inc.
1232 M Street, NW
Washington, DC 20005

Mr. Moses William Wright
Prevention Coordinator
A.D.A.P.T.S.
Alcohol and Drug Abuse Prevention and Training Services
2924 Chamberlayne Avenue, Suite L
Richmond, VA 23220

Mr. Michael Wynne
KOALA Centers
One Burton Hills Boulevard
Nashville, TN 37215

Mrs. Kay Wyrick
Advisor
Pride
5 Caroline Street
Waterbury, CT 06705

Ms. Darlene Yorkshire
Community Leader
St. Marys County
P.O. Box 653 Government Center
Leonardtown, MD 20650

Ms. Mabel Young
President
AUX, Monumental City Medical Society
4803 Forest Park Avenue
Baltimore, MD

Mr. Elijah Young
Ford Motor Co.
963 Browmwell Avenue
Lorain, OH 44052

The Honorable Larry Young
Delegate
Maryland State Legislature
Lowe Office Building, Room 374
Annapolis, MD 21401

Mr. Lloyd Young, Jr.
Supervisor, Case Management Services
Capitol Area ASAP
5407 Patterson Avenue, Suite 200
Richmond, VA 23226

Participating Programs

Community Research, Inc.

Community Research, Inc., (CRI) is a nonprofit, community-based research and development organization composed of an interdisciplinary team of social scientists and community representatives whose community ties have been demonstrated throughout the team's long history of community service. Established in 1975, CRI has dedicated itself to serving the community's needs and concerns by providing support services, information, and analysis.

CRI's principal approach is to bring information to the community on various social and economic issues that affect the well-being of its citizens, especially minorities and other disadvantaged groups.

Through research, CRI strives to identify, examine, and analyze problem-oriented issues and priorities in such areas as drug abuse, housing, crime, law enforcement, health, and education.

Through monitoring and evaluation, CRI strives to assess the impact and effectiveness of public and private programs targeted on the social and economic problems of minority and other disadvantaged groups.

Through community forums, workshops, and conferences, CRI strives to present factual information to the community on issues and priorities of major concern to the community. The object is to develop, in community-based organizations and individuals, the potential for informed community action.

Drug Abuse Programming

In recent years, CRI has focused much of its program activities in the area of substance abuse prevention. Specific areas of concentration are as follows:

- Training of youth peer leaders
- Providing prevention training for youth and adults
- Providing technical assistance to community groups
- Developing and producing prevention materials
- Distributing prevention materials
- Providing technical assistance to the Alcohol and Drug Abuse Services Administration and other organizations and agencies

Youth Peer Leader Training

On a continuing basis, CRI has incorporated the training of youth peer leaders into its drug prevention and education programs. The use of youth peer leaders in drug abuse prevention represents an effective approach for addressing this problem. Since 1980, this approach has been demonstrated in CRI-sponsored programs such as the Anacostia Drug Abuse Peer Leadership Prevention/Education Project and the Youth for a Drug Free Community.

In 1980 and 1981, CRI conducted the Anacostia Drug Abuse Peer Leadership Prevention/Education Project. The project involved an intensive training program for Anacostia peer leaders. Although the program was school-based, CRI was able to recruit peer leaders not only from the schools but also from the Youth Summer Job Program and community agencies. One major goal of the program was to help the participants become effective leaders and agents of change among their peers.

Prevention Training—Youth and Adults

For the past decade or so, CRI has provided substance abuse prevention training to influential youth and adults, seeing that they obtain adequate knowledge, techniques, skills, and materials to understand and fight the problem in their family and neighborhood.

Using an intensive substance use curriculum, CRI has trained youths in prevention activities through their participation in Youth for a Drug Free Community, the Anacostia Peer Leadership Project, and other training programs as requested by groups and organizations. CRI also has offered courses in adult prevention training. The objective of these courses was to produce effective adult prevention information and techniques to guide youths and help them refrain from substance use.

Technical Assistance

Consistent with its organizational mission to aid grassroots efforts, CRI has offered assistance to community groups in the District of Columbia. Technical assistance includesthe following:

- Organization of community groups to resist drugs in their neighborhoods
- Development and implementation of substance abuse prevention programs
- Development and implementation of demonstration projects on substance abuse, adolescent pregnancy, unemployment, housing, and other areas which affect community development
- Employee assistance programs for substance abuse
- Business development training
- Management consultation and program evaluation
- Proposal preparation
- Fundraising techniques
- Survey research

- Development of promotional concepts and community outreach
- Development and production of prevention materials
- Development, promotion, and management of community rallies, forums, conferences, and workshops

A list of community organizations to which CRI has provided technical assistance includes:

- Bureau of Rehabilitation (DHS)
- Central City Community Corporation
- Community Care Center
- Community Youth and Family Network
- Community Reality Project
- DC Concerned Citizens Caucus
- DC Recreation Department
- DC Public Schools
- Fides Neighborhood House
- Kingmans Boys Club
- Northwest Settlement House
- Operation Sisters United
- Rap, Inc.
- Parklands Community Center
- Peoples Involvement Corporation
- Shaw Community Outreach
- Shaw Project Area Committee
- Shaw Residents Area One
- Southeast Neighborhood House
- Union Temple Baptist Church
- United Planning Organization
- Urban Professional Associates

Development of Prevention Materials

CRI has over 10 years of experience in communications and the use of creative visual expression. In recent years, CRI has increased its emphasis on producing graphic materials that successfully convey a message for a target population. Using a simple and catchy theme, the design and production of T-shirts, buttons, posters, and bumper stickers has been an effective approach in promoting a program. In addition, CRI has been able to expand the substance abuse prevention message through the use of greeting cards, coloring books, and comic books. Brochures and newsletters have been produced to provide the target population with a more detailed explanation of the prevention program, as well as answer questions that the target population may have about the specific health issues.

Recent efforts by CRI have involved the use of video production to record and communicate substance abuse prevention activities. CRI has staff available with extensive experience in video production.

Recently, CRI has produced two handbooks that may be extremely valuable for community education and drug abuse prevention programs. These publications are *What District of Columbia Residents Should Know About Drugs* and *A Substance Abuse Prevention Handbook for District of Columbia Residents*. The first handbook examines the most frequently abused drugs by describing them, how they are used, and their effects on the user. The second handbook lends advice on how to organize substance abuse prevention programs and provides numerous approaches that can be applied for prevention of substance abuse. Both publications can be made available to community groups and organizations as part of CRI's outreach and technical assistance program.

Distribution of Prevention Materials

As a part of its organizational mission, CRI has made available to DC residents relevant information on substance abuse. In addition to the standard drug abuse publications, both government and commercial, CRI has disseminated original and targeted literature and materials, including posters, buttons, T-shirts, comic books, graphic exhibits, and other items.

CRI has used three main vehicles for information dissemination: comprehensive substance abuse library, community outreach Literature Rack Project, and special events.

Substance abuse library

CRI maintains a comprehensive library on substance abuse and related issues. Through word of mouth and referrals from other organizations, the library is made available to community groups and individuals. This library is particularly useful for youths and adults taking substance abuse prevention courses.

Literature Rack Project

As a method of taking substance abuse information directly to the people, CRI has developed and implemented the Literature Rack Project. During the last few years, CRI has gone into high-risk neighborhoods and placed substance abuse and health literature on special racks in barber shops, beauty shops, and similar establishments.

These types of establishments were chosen because the nature of these businesses, that is, those with repeat customers and close personal owner/customer relations, lend themselves to better communication and transfer of drug abuse information. This approach for disseminating information required some training of the proprietors, as well as occasional owner surveys and followup.

Special events

CRI often distributes drug abuse information and other materials at special events such as health fairs, rallies, festivals, drug-free days, and similar occasions. Every year, CRI staff attend numerous events and distribute literature, buttons, T-shirts, balloons, and so forth.

Provide Government and Agency Support

Because of CRI's special designation as a community empowerment group, it has available certain resources and expertise that are useful to government agencies and foundations. Many times, CRI serves as that grassroots link between the community and the government bureaucracy. This is particularly evident in rapid development, organization, and implementation on a community level. Using scarce resources, CRI often pulls together disparate elements to bring about special events, conferences, forums, and similar activities. Recent events for which CRI has provided organizational and technical support include the Citywide Community Initiative on Substance Abuse Prevention and DC Drug Free Days—Taking It to the Street.

Comprehensive Community Initiative

One example of how CRI provided the DC government with technical support was the Citywide Comprehensive Community Initiative against substance abuse. In June 1984, CRI was given the responsibility for helping to develop and implement this program in each of the city's eight wards. The mission of the initiative was to involve the community in the prevention process so that individuals would understand the nature and seriousness of the substance abuse problem in the District of Columbia, its serious health consequences, and the kinds of strategies and techniques that can be developed to deal effectively with the problem. The program involved community officials, business people, civic groups, fraternal organizations, educators, professional groups, and youth organizations.

CRI worked with these individuals and organizations to facilitate the work of the citywide steering committee as well as to plan and monitor workshops and conferences in the eight wards. By October 1984, substance abuse task forces were in place and active in each ward.

Submitted by: Community Research, Inc.
2412 Minnesota Ave., SE
Suite 203A
Washington, DC 20020
(202) 581-0449

The Lonely Black Elderly

Lifestyle and Recommendations

Alcohol is the foremost substance of abuse among the elderly, although illicit drug usage is not unheard of. This fact is explained in part by the maturing of narcotic addicts after age 45 and the inability of the older user to sustain the habit because of cost factors. For these reasons, alcohol becomes the substance of abuse.

The later years in life can be a time of realization when one can enjoy the fruits of one's labor. Yet for some people, aging is an unwelcome process. Entering the golden years may mean:

- living on a fixed income;
- health problems;
- being ignored by youth-oriented culture;
- loneliness as friends and loved ones pass away; and
- increased leisure time.

To cope with these stresses, some find alcohol playing a more important role in their lives. Many older people who have been drinking moderately all their lives begin slipping into patterns of excessive drinking and do not realize it until they become problem drinkers or alcoholics. Friends and physicians may think that alcohol is one of their fears, or remaining pleasures. Elderly people often do not get the help they need.

Factors Contributing to Alcohol Abuse Among Black Elderly

- Stress caused by the widening gap between cost of living and income, along with other sources of hopelessness, often leads to problem drinking.
- Medicaid/Medicare does not adequately address alcoholism as a disease.
- Alcohol problems go undetected for long periods of time.
- The Black elderly are the least informed about alcoholism. They need education before they find themselves needing treatment.
- The elderly are more likely to remain in the closet if they become alcoholic in old age. Their position of authority and respect may be completely lost if they share information about their problem or if they become involved in treatment.
- Black families frequently encourage older relatives to drink, believing it will make older life less burdensome relative to loneliness and illness, but then abandon them if they become drunk and cause embarrassment.
- Black families have the least tolerance for alcoholism among the elderly and women.
- The elderly are at risk of being on medication and of having adverse reactions to prescription drugs and alcohol; they may deny that alcohol is implicated or may be unaware that a relationship exists.

Suggestions

- Blacks who work with Blacks should incorporate a spiritual dimension into the treatment toward promoting therapeutic bonding, which personalizes the professional relationship.
- Involve Black churches that resist establishing programs for elderly alcoholics by appealing for help of family and church members who suffer from addictive parents.
- Self-help groups that respond to race, culture, and gender considerations should be established.

The family religion, church, and spirituality are clues to the essence of treating Blacks. From a Black perspective, Blacks' survival and continued ability to lead satisfying lives are based on a sense of:

- Family—the feeling that we have survived by blood; and
- God—the conviction that we have come this far by faith.

Among the Black elderly, the church is a respected human resource institution and is viewed as a place to which self-referrals are made for problems ranging from alcoholism to sin.

Many common signs attributed to aging can actually be indicative of problem drinking. Some signs and symptoms common to both alcoholism and aging include: confusion, disorientation, clouding of the sensorium, hallucinations, recent memory loss, depression, anxiety, parancia (fear of persecution), hostility, anorexia, tremors, slowed thought process, gastritis, muscle incoordination, hypertension, lies, and improper nutrition.

Submitted by: Helen Postell,Program Director
Youngstown Area Urban Minority Alcoholism
Outreach Program
2311 South Avenue
Youngstown, OH 44507
(216) 743-9082

Alcohol-Impaired Driving and Acceptability of Prevention Strategies: A Comparison Between Black and White Youth

This study represents the second phase of a National Highway Transportation Safety Administration-funded study aimed at developing recommendations to improve strategies to prevent youth from driving while intoxicated (DWI) and riding with an impaired driver (RWID). This phase consisted of three components designed to accomplish the following aims: (1) to assess the influence of stable risk factors on youth DWI/RWID using a large-scale, multisite survey questionnaire; (2) to explore the effects of situational factors on youth DWI/RWID using face-to-face interviews with youths who have actually engaged in DWI or RWID; and (3) to assess the acceptability to youths of 11 popular DWI/RWID prevention strategies using focus group interviews with youths.

Youths in five cities nationwide (Sacramento and Los Angeles, CA; Sante Fe, NM; Omaha, NE; and Washington, DC) took part in each component of the study. Respondents were all students in junior high school, high school, or community college. Sample sizes for the different components were as follows: survey questionnaires, 1,323; DWI interviews, 120; and RWID interviews, 121; and focus groups, 63 youths in 10 groups. For each component, approximately 20 percent of respondents were Black and approximately 30 percent were Hispanic. This discussion focuses on comparisons between Black and white youths.

Results

Stable and Situational Risk Factors

From the survey questionnaire and face-to-face interviews, it was possible to determine the relationship of race to other important demographics, risk factors, alcohol use, DWI, and RWID.

- Black youths are more knowledgeable about alternatives to DWI than whites, but Black youths have less knowledge of the effects of alcohol and less knowledge of laws related to DWI than white youths.
- Blacks are less susceptible to peer influence than other youths and also perceive DWI as more deviant than do other youths.
- Consistent with previous findings, Black youths drink less than white youths, and more Black youths report abstinence.
- Consistent with racial differences in perceived deviance of DWI, Black high school youths report much less DWI than do whites. This fact made it necessary to recruit Black DWI interviewees almost exclusively from the community college-age population.
- More Black youths (15 percent) than white youths (7 percent) report having driven without a license.

- White youths who drive while intoxicated are more likely than Black youths to own their own cars.
- Black youths are more likely to drink in their cars (39 percent) than are white youths (6 percent).

Acceptability of Prevention Strategies

Focus group interviews yielded the following results regarding the acceptability to youth of differing DWI/RWID prevention strategies.

- Three characteristics increase the appeal of anti-DWI programs to all youths: no long-term commitment is required; friends, rather than strangers, parents, or other adults, are involved; youths feel a high sense of personal control in deciding whether or not to use the program or strategy.
- Blacks have more positive attitudes than whites toward structured programs such as school curricula and immersion programs that impart useful information about effects of alcohol and ways to avoid DWI/RWID.
- Black youths also expressed greater approval than other youths for presentations that arouse fear, safe-ride hotlines, and abstinence as a lifestyle.
- Black youths had especially strong feelings against parent intervention strategies, such as taking car keys from youths who drink at parties in the parents' homes.

Implications for Prevention Programming

- There are consistent differences in risk factors and the acceptability of programs between Black and white youths. Therefore, these data confirm the longstanding proposition that alcohol-related prevention programs should be tailored to the target population.
- Although alcohol information programs have not worked well with general population youths, they may be more appealing to Black youths who lack information and find such programs acceptable.
- The acceptability of abstinence as a lifestyle among Black youth increases the feasibility of abstinence-based programming.

Submitted by: Michael D. Klitzner, Ph.D.
and Charles Rossiter, Ph.D.
Center for Advanced Health Studies
Pacific Institute for Research and Evaluation
7101 Wisconsin Ave., Ste. 805
Bethesda, MD 20814

Substance Abuse Prevention in a Historically Black Urban University

The primary mission of the Jackson State University Interdisciplinary Alcohol/Drug Studies Center, founded in 1975, is to provide prevention, education, training, research, and service in the alcohol and drug areas. The Center works to meet this mission by presenting a number of services and programs geared to both students and the community at large. The academic courses offered by the Center are of high quality to help generate well-trained, qualified personnel for the mental health services area—particularly for alcohol and drug abuse program services—and to serve and educate persons from all walks of life. The Center works diligently to conduct and supply needed research and to disseminate the new theories and philosophies that result from the research findings. The primary goal is to develop better skills and more knowledge in the area of alcohol and drug abuse prevention, education, and treatment that will make a definite impact on the survival and well-being of humanity.

SIIP, the Student Intervention/Information Program, is a service component of the Interdisciplinary Alcohol/Drug Studies Center. The program provides information on alcohol and drugs to all university students. It also serves as a helping resource by providing early intervention to those students experiencing substance abuse problems.

The program was launched in November 1983, funded by a grant from the Division of Alcohol and Drug Abuse of the Mississippi Department of Mental Health. Services provided by SIIP are:

- Literature dissemination,
- Information sharing,
- Student interviews,
- Intervention,
- Referral to treatment facilities,
- Group interaction,
- Student progress followups, and
- Speakers bureau.

SIIP personnel are trained and experienced in the varied areas of alcohol and drug problem assistance.

SIIP takes a position that there is a better way through its three-pronged program of intervention, information, and involvement. The program provides pertinent information to enable an individual to make a choice based on timely facts. SIIP maintains a speakers bureau, film library, and literature files for use by any individual or group on campus and within the community.

Early intervention is provided through individual counseling and peer group interaction. Should primary screening indicate the necessity for further action, other human

service agencies are utilized. The SIIP staff maintains a close liaison with community-based service providers and self-help groups.

SIIP takes a nonjudgmental approach to the growing social problem of alcohol and other drug addiction. Student groups and other organizations are encouraged to become involved in SIIP activities. A key to successful intervention is confidentiality. Persons availing themselves of SIIP services are guaranteed complete confidentiality.

SIIP seeks to educate students at Jackson State University concerning the dangers involved in the abuse of alcohol and other drugs. SIIP recognizes that the use of mind-altering substances is ultimately an individual decision and, therefore, seeks to promote (through the informational component) a social and academic atmosphere that engenders responsible decisionmaking. While SIIP recognizes the individual right of adults to drink or abstain, SIIP strongly discourages abuse of alcohol and the use of other drugs because these activities are detrimental to the educational purposes of Jackson State University as well as the social and personal well-being of the students.

SIIP views individual privacy and confidentiality as cornerstones of effective service delivery; therefore, protection of students' rights to private and confidential intervention and information sharing is a major goal.

Submitted by: Dr. Dorothy A. Idleburg
Associate Director for Administration
and Mr. Ethel James Ivory, Jr.
Intervention Specialist
Jackson State University
Interdisciplinary Alcohol/Drug Studies Center
P.O. Box 17054
Jackson, MS 39217
(601) 968-2350

The Prevention of Drug and Alcohol Abuse in Black Communities: What Works?

Despite the unprecedented explosion in scientific knowledge and the phenomenal capacity of medicine to diagnose, treat, and cure disease, Blacks and other minorities have not benefited fully or equitably from the fruits of science or from those systems responsible for translating and using health sciences technology.

Advances in drug and alcohol abuse prevention have used social and behavioral sciences research and methodology to delineate biological, behavioral, and social factors that affect drug abuse patterns. The link among these factors is critical to understanding the behavioral underpinnings of health, identifying effective strategies for drug abuse prevention, maintaining treatment regimens, and suggesting ways to change behavior for more healthful living habits. Unfortunately, in the field of drug and alcohol abuse prevention, there has been a lack of coordinated and systematic assessment of the drug and alcohol abuse situation of Blacks and other minority groups. It is not uncommon for local prevention and treatment planners, administrators, and other decisionmakers to embark upon programs designed to remedy drug and alcohol abuse among Blacks and other minorities without objective data about the efficacy of selected prevention strategies.

In 1985, DHHS completed a landmark report analyzing and synthesizing the present state of knowledge of the major factors that contribute to the health status of Blacks, Hispanics, Asian/Pacific Islanders, and Native Americans. *The Report of the Secretary's Task Force on Black and Minority Health* (DHHS 1985) represented the first time DHHS consolidated minority health issues into one report. Volume 7 of the report is devoted to chemical dependency.

American Blacks and Drugs

The voluminous body of literature on alcohol and drug abuse prevention may cause confusion rather than provide the direction needed to develop and implement effective programs (Technical Paper, NIDA 1980). The U.S. Surgeon General's report *Healthy People* (1979) stated that alcohol misuse is a factor in more than 10 percent of all deaths and may be higher among American Black populations. Unfortunately, data on the prevalence of alcohol and drug abuse for minority populations are limited. Consequently, it is difficult to know the extent of the drug abuse problem and its resultant effect on health status. Most national studies, to date, were designed to elicit baseline data on the general population. As a result, Black and minority samples from these surveys generally are too small to draw definitive statements and conclusions about alcohol use and the nature and extent of alcohol-related problems among minorities (DHHS 1985). Recommendations of the Secretary's Task Force are consistent with the objectives for the Nation in disease prevention and health promotion for the year 1990. Unfortunately, *The 1990 Health Objectives for the Nation: A Midcourse Review* (DHHS 1986) does not clearly delineate progress made toward the prevention of drug and alcohol abuse in Black communities.

Alcohol and drug abuse is a serious social problem as well as an individual behavioral problem in the United States, especially among American Blacks. Individual Blacks in need of alcohol and drug abuse prevention programs may vary by occupation, level of education, socioeconomic status, and selected high-risk behaviors. Subsequently, there may be a need to match alcohol and drug abuse prevention programs with selected demographic characteristics. Additionally, alcohol and drug abuse prevention programs will vary in type. NIDA identified several types of prevention programs in *Drug Abuse and Drug Abuse Research*(NIDA 1984):

- ***Information dissemination***: Based on the assumption that increased knowledge about alcohol and other drugs and the consequences of their use would be an effective deterrent. For example, alcohol and drug education programs primarily attempt to increase student knowledge about legal, pharmacological, and medical aspects of using these substances.
- ***Affective education***: Based on the assumption that substance abuse programs should aim to develop prevention-oriented decisionmaking concerning the use of any licit or illicit drug. Such decisions regarding personal use of drugs should result in fewer negative consequences for the individual. Finally, the most effective way of achieving these goals would be via programs to increase self-esteem, interpersonal skills, and participation in alternative behaviors. This approach would include activities such as communication training, peer counseling, and assertiveness training.
- ***Psychological inoculation and pressure-resistance skills training***: Based on the assumption that peer-pressure-resistance skill development is more effective than the presentation of abstract knowledge about the negative consequences of substance abuse. This approach will involve activities such as role playing, use of peer leaders to deliver prevention programs, and media presentations that include immediate feedback on how to demonstrate specific tactics for resisting peer pressure to use drugs.
- ***Personal and social skills training***: This type of prevention program embodies the broader competence enhancement philosophy found in affective education. It has a conceptual foundation grounded in social learning theory and utilizes many of the empirically validated techniques of cognitive-behavior therapy. In addition to providing students with general life skills, this prevention strategy applies the skills specifically to the problem of alcohol and drug abuse. Students are taught not only a wide range of personal and social skills to improve their personal competence and reduce their potential motivation to use one or more drugs, but also are taught the application of these skills to situations in which they may experience pro-drug use social pressure.

The major problem that continues to exist is the lack of systematic information about which types of prevention programs work with American Blacks. A network of major Black community organizations may serve as the coordinating structure necessary to systematically collect and disseminate the information needed to answer the following questions:

- What types of drug and alcohol abuse interventions have been evaluated on Black and other populations?
- Which drug and alcohol abuse interventions have demonstrated efficacy?
- Do outcome measures of selected drug and alcohol abuse interventions warrant their continued application?
- Under what circumstances do drug and alcohol abuse interventions work best?
- What characteristics best differentiate successful and unsuccessful drug and alcohol abuse interventions?
- What outcome measures have been used to determine effectiveness of drug and alcohol abuse interventions?
- How may drug and alcohol abuse interventions be classified so as best to provide direction for drug and alcohol abuse prevention professionals and policymakers?

National trends on the extent of alcohol and drug abuse among the American population indicate a national crisis. The gap between Black and white Americans, especially among Black youths and Black women, represents an alcohol and drug abuse epidemic in the Black community. One means to close the gap is to conduct drug abuse prevention research on Black persons in the natural setting of the urban and rural community, as opposed to those drug users in the captive setting or clinical institution setting. Innovations in treatment and prevention of alcohol and drug abuse may emerge most naturally from the communities that daily face the tragic results of the failure of previous drug abuse policy. The National Conference on Preventing Alcohol and Drug Abuse in Black Communities represents a positive step in the correct direction.

Submitted by: Stephen B. Thomas, Ph.D.
Assistant Professor of Health Education
University of Maryland
Robert S. Gold, Ph.D., Dr.P.H.
Director of Graduate Studies
Department of Health Education
University of Maryland
Donna Davis, M.P.H.
Minority Health Research Assistant
Department of Health Education
University of Maryland
College Park, MD

Smoking and Alcohol Prevention Strategies Program

The Smoking and Alcohol Prevention Strategies (SAPS) program is a curriculum for smoking and alcohol prevention based on a decisionmaking model for grades 4, 5, and 6. This program was implemented in the 1980-81 academic year in the Norfolk Public Schools in conjunction with the American Lung Association of Virginia, as a part of Virginia's Health Education Risk-Reduction Program under Section 402 of Public Law 95-626 and Section 1703 of the Public Health Service Act. This program operated with Federal funds for 3 years; when these funds were terminated, however, the Ward's Corner Lions Club of Norfolk, VA, provided financial assistance to the program for 1 year, with the Norfolk Public Schools budgeting local funds and making this program a part of the curriculum the following year.

The major objective of the SAPS program is to help young people make responsible decisions about tobacco, marijuana, and alcohol. Since the SAPS program was implemented and up to the present time, it has continued to aim at increasing knowledge and improving attitudes about the *consequences* of smoking tobacco, cocaine use, marijuana use, and alcohol use. Grades 4, 5, and 6 were selected for the SAPS program because national statistics have shown that children start experimenting with smoking cigarettes and marijuana and drinking alcoholic beverages at a very early age. The fourth grade is found to be the average age of early experimentation. Temptation for using these drugs comes from peer pressure to act "grown up" and to become part of the crowd. It was believed that a drug prevention program was needed from a qualified source in the Norfolk elementary schools, since children are not exposed to a comprehensive program until middle school.

There are four phases of the SAPS program: Orientation, Instruction, Evaluation, and Poster contest

In the orientation phase, the health educator meets directly with the school administrator and teachers for an explanation of the curriculum and scheduling of the SAPS program.

The instructional phase involves teaching five 30-minute lessons to fourth grade students on decisionmaking, influences encountered while making decisions, and facts about smoking; five 30-minute lessons to fifth grade students on the effects of tobacco, cocaine, and marijuana on health; and ten 30-minute lessons on the effects of alcohol on health to sixth grade students.

It was realized that sixth grade students need to reinforce their attitudes to make sound decisions about alcohol use based on factual information. Therefore, in these lessons, emphasis is placed on the effects of alcohol on the body, pressure to drink, symptoms of alcohol problems, organizations designed to help alcoholics and their families, and steps toward making sound decisions.

In the evaluation phase of the program, the students are tested prior to the instructional phase and then at the end of the instructional phase for knowledge gained. The fourth phase of the SAPS program is the poster contest. Each year, the Cosmopolitan Club of Norfolk hosts the Norfolk Public School's Health Education Fair. Thirty-seven sponsoring agencies assist in the health fair by judging projects and donating savings bonds to its winners. The health educator of the SAPS program assists the students in grades 4, 5, and 6 toward developing ideas that depict factual information they have assimilated from the program and by expressing these ideas in creative drawings in the health fair. It has been observed that students in nonwhite communities become more open in creating ideas showing physical and mental problems in their illustrations.

Although the same format is used in presenting the SAPS program in the various schools, nonstatistical data have indicated that the presentation of lessons in schools with a low percentage of white students has to be altered and emphasis placed on needs presented by the students. For example, when presenting the sixth grade program in a low socioeconomic area, the students show limited knowledge of the proper functioning of certain body organs, such as the liver, the brain, and the heart; of the definition of the term "drug," and how alcohol falls in the category of drugs; and why alcohol affects young people more than adults. The students demonstrate and express a great deal of misinformation concerning alcohol- and drug-related problems such as heart attacks, stomach and esophageal cancer, ulcers, cirrhosis, mental disorders, and death. Many students believe that alcoholics must drink every day and that children do not become alcoholics. When this same information is presented in a school with predominately white students, the students express a clearer understanding of a healthy body and the proper functioning of its organs. Upon observation, it is believed that adequate emphasis has not been placed on teaching health hazards to the body to nonwhite students; therefore, they have a limited concept of how drugs or alcohol affect the body. It has been observed that students in the nonwhite community are more interested in knowing more about the illnesses and understanding the behavior problems of people who use drugs and alcohol and about treatment and organizations for helping alcoholics, drug users, and their families than they are about the prevention focus of the program.

In presenting the SAPS program, it has become necessary to emphasize the proper functioning of certain body organs, define the term "drug," and show alcohol is a drug by having the students give examples of the observed physical, social, and emotional behavior of individuals who drink alcoholic beverages or who use other drugs.

Once this background information has been fully presented and understood, emphasis is then placed on understanding steps toward making good decisions about alcohol and drugs and knowing that once choices are made, it is the responsibility of the person making the choices to accept the consequences for his or her actions.

Submitted by: Patricia H. Dillard
Drug Education Specialist
Norfolk Public Schools
Department of Health and Physical Education
800 East City Hall Avenue
Norfolk, VA 23501

Action for Youth Project

Prevention Philosophy

According to the *1984 Survey of Drug and Alcohol Among Maryland Adolescents*, over 33.3 percent of Maryland's adolescents use alcohol or other drugs on a regular basis. More importantly, the age at first use of drugs and alcohol is decreasing. It is estimated that up to 20 percent of youth aged 14 to 17 are drinkers or drug users.

By encompassing the concepts of "volunteerism" and "community self-help" into its goals, the Prevention Unit of the Maryland State Alcoholism Control Administration seeks to expand statewide volunteer participation in delivery of prevention services to youth. This has been done, in part, by a Federal grant from ACTION. This grant funds a project called ACTION FOR YOUTH. By establishing a linkage to ACTION, the Maryland prevention system has been able to acquire necessary personnel to organize, develop, and provide necessary leadership to high-risk groups through its current system of peer leader teams and newly trained groups.

Program Purpose and Prevention Philosophy

ACTION FOR YOUTH is funded by a grant from ACTION, the Federal volunteer agency. It is a system of 10 VISTA volunteers assigned to low-income communities throughout the State to work in prevention activities with youth. At present, VISTA volunteers serve in Prince Georges, Charles, Washington, and Worcester counties, as well as the Cherry Hill and Perkins Homes and Upton communities in Baltimore City.

ACTION FOR YOUTH is designed to address the problems of drug and alcohol use among Maryland's low-income, high-risk youth. Its strategy is to use VISTA volunteers to staff the project and to serve as resource aids in low-income communities. The project is administered by the Prevention Unit of the Alcoholism Control Administration with a VISTA supervisor who oversees the operation and implementation of the project goals and objectives.

By Federal mandate, the ACTION FOR YOUTH project must employ VISTA volunteers as trainers and coordinators. Each VISTA volunteer is charged with the responsibility of working with at least two youth groups, with a minimum of 15 in each group. They are responsible for training two youths from each group in leadership skills and chemical dependency. All activities and training are done with parental participation whenever possible. This is viewed as a critical strategy, as it promotes community involvement and leadership in the decisionmaking process. Additionally, this strategy is effective in ensuring that community leaders will be capable of addressing neighborhood needs and concerns with skills and knowledge acquired during the VISTA volunteer's tenure.

The VISTA volunteers are charged also with the responsibility of coordinating prevention activities that are targeted primarily toward high-risk, low-income youth. These

may be either educational and informative or alternative activities. This has been done most successfully by the creation of local Just Say No clubs or similar youth groups. The youths take leadership roles in these clubs and begin to feel good about themselves because they are recognized as leaders by their peers. Thus, they feel a sense of responsibility and empowerment. When the youths feel they can make decisions about their lives through the activities they engage in, they develop a deeper sense of commitment to not only their roles as leaders, but also to the sense of social responsibility.

It should be noted also that the youths and parents served by the project were identified as the target population by two methods. First, local health agencies or community organizations within a particular area identified the community as having high-risk youths. Thus, these agencies had already initiated prevention activities for youth. Then the VISTA supervisor met with staff and leaders in these agencies and organizations to verify that the population to be served would include a majority of the target group as mandated by ACTION. After the process was completed, VISTA volunteers were officially assigned to the site.

Conclusion

ACTION FOR YOUTH, simply stated, works for drug-free youth. This is the mission of this project. It is made operational by a network of 10 VISTA volunteers who work in low-income communities with high-risk youth throughout the State. They serve as resources aides, trainers, and coordinators while providing educational and alternative activities to youths and parents.

Applicability to the Black Community

Inasmuch as an overwhelming number of Black youths are among those at high risk, it is clear that ACTION FOR YOUTH is applicable and adaptable to the Black community. Actually, more than 90 percent of the youths and families served by the project are Black and Hispanic.

Submitted by: Delois L. Newton
VISTA Supervisor
ACTION FOR YOUTH
Maryland Department of Health and
Mental Hygiene
Alcoholism Control Administration
Prevention Unit
201 W. Preston Street
Baltimore, MD 21201
(301) 225-6562

HEALTH WATCH: An Innovative Approach to Black Health Improvement

HEALTH WATCH Information and Promotion Service is an innovative concept in communications targeted at increasing the health and longevity of Black Americans by:

- eliminating the Black/white health information gap;
- motivating more healthful lifestyles and behavior; and
- increasing Black expectations of the Nation's health care delivery system regarding preventive health services.

HEALTH WATCH believes that:

KNOWLEDGE + ACTION = POWER

Funded for research and development by the National Cancer Institute and the New York State Science and Technology Foundation, HEALTH WATCH is a national health information and promotion service conceived and developed by AMRON Management Consultants, Inc., under the direction of its President, Norma J. Goodwin, M.D.

HEALTH WATCH develops and disseminates culturally sensitive, relevant, accurate health information on major Black killers and disablers, using state-of-the-art communication methods. Cancer, hypertension, heart disease, diabetes, and obesity are initial HEALTH WATCH targets. Other HEALTH WATCH concerns include adolescent pregnancy, alcohol and drug abuse, AIDS, infant mortality, homicide, suicide, accidental death, and sickle cell disease.

Key HEALTH WATCH activities for 1987 and 1988 include the following:

- Production and distribution of several brochures, such as the recently published *HEALTH WATCH Cancer Awareness* brochure
- Conducting seminars, conferences, and workshops on disorders targeted by HEALTH WATCH, customized for various population segments
- Production of *HEALTH WATCH News*, a quarterly newsletter

The HEALTH WATCH network includes: national Black flagship organizations, such as the National Medical Association, National Council of Negro Women, NAACP, and the National Urban League; major voluntary health agencies such as the American Lung Association, National Society to Prevent Blindness, and the American Diabetes Association; and corporate sponsors such as the Equitable Life Assurance Society of the United States and the Xerox Foundation.

HEALTH WATCH strongly believes that all Americans have a stake in the health and well-being of the Nation's Black population. As the ethnic market prospers and adopts healthier lifestyles and behavior, everyone benefits. We are convinced that an informed and motivated Black population will expect and demand more responsive health care delivery systems. Medical costs will go down. Memberships in religious, civic, and

political organizations will go up. From the individual to the small business community to corporate America, the increase in productivity and longevity will bring unprecedented opportunities for growth and prosperity.

Finally, the approach used by HEALTH WATCH in addressing the health of Black Americans is transferable to other high-risk disorders and population groups, with appropriate cultural input, involvement, and adaptation.

Submitted by: Norma J. Goodwin, M.D.
Director, HEALTH WATCH
Information and Promotion Service
3020 Glenwood Road
Brooklyn, NY 11210
(718) 434-0986

Sea Island/McClellanville Project

Charleston County is situated in the heart of the South Carolina low country. It has 91 miles of easily accessible seacoast, a large metropolitan port of entry to potential drug traffickers, and millions of annual tourists.

The area is divided and redivided by major rivers and tributaries, which impede easy access from one community to another. There are 294,800 residents who live in the county, with 70,776 living in the Greater Charleston metropolitan area. Many of the residents living outside of the city live in the rural areas, mostly in remote communities miles from major population centers.

Traditionally, residents in these outlying areas have been inadequately served by treatment programs. These areas include the town of McClellanville situated in the northern end of Charleston County and the Sea Islands located south of the city of Charleston. The majority of the residents living in the rural areas are Black and are prevented from participating in treatment programs because of limited incomes, lack of transportation (no public transportation is available in the rural areas), and a lack of knowledge about identifying substance abuse problems. While distance and a lack of material means prevent some residents from participating in programs located in metropolitan areas, there is also a strong cultural factor that tends to inhibit their participation.

For these and other related reasons, the Sea Island/McClellanville Project was developed to provide education, prevention, and intervention services to these areas of Charleston County.

In the rural areas of Charleston County, particularly on the Sea Island, the populations are predominantly Black and comprise large extended families. The social, business, and family life is intermingled, and what happens in one household is generally known in the entire community. As a result of the closeness, residents know a lot about each other's lives. Someone coming into their community is at least noticed and quite often looked upon with suspicion. This is in part because most of the residents on the islands speak the Gullah language and frequently are the target of researchers, filmmakers, and the curious.

Most residents of the islands do not look at alcohol as a drug and feel its consumption is something to be dealt with privately. "Ain't no harm in takin' a drink so long as a man knows his limit or don't bother nobody when he starts to feel it," one local resident said.

The Sea Island/McClellanville Project has several focal points:

- To educate the community to the real dangers of alcohol and drug abuse, dispelling myths and rumors about such
- To get community people actively involved in carrying out programs with an antidrug theme
- To train community people to act as facilitators for various programs

- To provide referral services to the community for problem areas other than drugs
- To establish advisory boards that identify community problems and work toward solutions
- To create community projects that will generate interest in the youth
- To be flexible

The first step in accomplishing these goals began with education presentations in the schools for grades 1 through 12. The aim was to allow the youths to get to know the substance abuse counselors.

Special school projects were then implemented, such as a rap contest where the theme had to have an antidrug posture. Groups were formed according to grade levels, and schools competed against each other for prizes donated by local merchants and radio stations. Informal discussion sessions were formed, where students could talk about drugs and alcohol. For example, teen pregnancy opened the door to discussing fetal alcohol syndrome. Getting into the workforce or joining the military could tie into drug testing and how drugs affect the body and so forth.

Once we were in the schools, the next step was to get into the churches, which have had a long and strong influence in the rural communities. There are a number of groups and clubs in the churches that sponsor various programs. After contacting a group in one of the churches, a presentation was made and requests began coming in from other churches.

Many church members are parents, so they have a tangible interest in the children. This offers an opportunity to harness their energy to become parent volunteers for special projects, such as I'm Special and Just Say No clubs.

Advisory boards made up of community residents identify community needs and look for ways to deal with various issues. Counselors from the Substance Abuse Commission offer support and referral services for these boards. Members of the community advisory boards are recruited from church and PTA members.

In most cases, youths on the islands get into alcohol and drugs because they do not have much to do with their spare time. There are few centers and activities that students can get involved in after school.

One community volunteer began working with a group of girls after school. She found that the girls were interested in drama. A counselor at the Commission had a background in drama and began working with the girls once a week. The group's first play was about their language, Gullah. After performing at neighborhood churches and schools, the group was invited outside the community and, to date, has performed in Atlanta, North Carolina, and Hilton Head. Planned performances include Tennessee and Washington, DC. The girls, who call themselves the Petersfield Rural Women's Project (PROP) Girls, are currently working on a play dealing with drugs and alcohol.

Several of the young men in the community took a cue from the girls and started their own club. They were not interested in drama, so they began taking on repair projects in the community. The J-Team, as they are called, is currently gutting and renovating an old trailer to be used as a community library.

Some of the PROP Girls provide arts and crafts sessions for younger children at the local community center.

In another community, residents saw the need to start Alcoholics Anonymous in their community and, with the leadership of a local pastor and several recovering alcoholics, started a group.

There are a number of problems that still must be faced in some rural areas where treatment and counseling for substance abuse are not readily available, but the involvement of the communities in planning responses is a very important part of dealing with the problem.

Submitted by: Robert Small
Sea Island/McClellanville Project Coordinator
P.O. Box 2635
Charleston, SC 29403
(803) 723-7212, ext. 292.

Children for Prevention—The Winner's Circle

Children should be the primary target of our drug prevention efforts. They are in the process of developing habits, attitudes, and traits of character that can last a lifetime. We will lose the battle if we wait until junior or senior high school to present the true advantages of a healthy, drug-free life to our children. Drug prevention education must begin in the elementary school.

The Winner's Circle is a comprehensive education program used with fourth, fifth, and sixth grade students. In most schools, the basic program is completed within 6 weeks. It uses at least five basic principles that have evolved from working with thousands of students, teachers, school administrators, and parents.

Five Principles for Drug Prevention

- ***Factual information about drugs.*** Children need to know the latest and most interesting scientific facts about drugs and the dangers they pose to their total well-being before they are tempted to experiment and become temporarily satisfied users. In accomplishing this educational process, we must utilize the very best audiovisual materials (films, slide programs, pathology displays, literature, self-discovery activity sheets) and small-group activities. Best results are obtained when these audiovisual materials are used in conjunction with experienced, committed drug prevention educators and teachers who are currently drug free.
- ***Opportunity for commitment to be drug free.*** When the facts have been properly presented and the opportunity is given, most children are eager and willing to take a stand for a healthy, drug-free life. They are asked to make a commitment to be drug free and given The Winner's Circle pledge. Signing the pledge is their own choice.
- ***Reading drug information literature and discussing with parents.*** Children should be encouraged to read carefully selected literature about the dangers of drugs and then discuss that information with their parents or other available adults. By doing so, they can help open up the lines of communication between children and adults regarding the topic of drugs. Parents are encouraged to become involved and to continue discussion in the home.

  Children should also be taught that it is all right to say no to drugs. The Winner's Circle teaches them the confidence and skills to say no. Students must read three special issues of *The Winner* magazine and then discuss one article from each magazine with a parent or other adult.
- ***Participation in drug prevention activities.*** All children should be given the opportunity to participate in the activities that will allow them to utilize the information they have learned from the educational experience and any personal experience relating to drugs. For example, they could construct a poster that depicts the dangers of drugs, write a story expressing their reasons for being

drug free, offer to share with others what they have learned, or start a support group where children can discuss their common concerns. Some of the posters that the students have made were so good that they have been reprinted in *The Winner* magazine.

- ***Positive recognition for drug-free students.*** All too often, it is the child who exhibits negative behavior that receives attention, while children who are striving to live according to the rules go unnoticed. During a special assembly, all students who participated in The Winner's Circle are honored and receive a special program T-shirt. Selected students are honored for outstanding achievements on designated program projects.

Joe Whittaker began developing The Winner's Circle program in the early fall of 1981 with the help of a dedicated school teacher, Mr. Tom Nicely, of Coldwater, MI. He used Mr. Nicely's classroom, and he and the students, in turn, provided technical evaluation of the program's progress.

During the past 5 years, more than 1,100 students in that one school signed The Winner's Circle pledge to be drug-free. Only 1 of those 1,100 students has been disciplined by the school for a problem related to drugs.

In the 1980-81 school year, before the program started, comprehensive school records showed that a total of 148 students had been disciplined for problems related to drugs, including alcohol and tobacco. Starting with the 1981-82 school year, those figures have steadily declined. During the entire 1985-86 school year, a total of only four students had been disciplined by the school because of drugs, and none of the four had signed The Winner's Circle pledge.

In May 1986, The Winner's Circle drug prevention program was awarded Distinguished Honors by the Department of Education of the State of Michigan. It is now being tested more extensively in inner-city schools, and several foundation grants have been requested for the development of materials. One of its present appealing features is its community-based funding program. Businessmen and merchants are proud to be a part of The Winner's Circle and the war on drugs.

The Winner magazine, an acknowledged leader in drug prevention information for the younger set, is a 16-page monthly (September through May). It was first published in 1957 and is in its 30th year of publication.

Submitted by:

D.S. Williams, Ed.D., M.P.H.
Executive Director
Narcotics Education, Inc.
6830 Laurel Street, NW
Washington, DC 20012
(202) 722-6733

Samuel DeShay, M.D., M.P.H.
Medical Director
Family Health Services
Hadley Memorial Hospital
4601 Martin Luther King, Jr. Ave., SW
Washington, DC 20032
(202) 574-5730 or 891-6050

☆ U.S. GOVERNMENT PRINTING OFFICE: 1990—261 - 217/05342