DRUG PREVENTION WITH YOUTH

TRAINING CURRICULUM

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of Youth and family Services

NRC YOUTH SERVICES

Drug Prevention with Youth

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TABLE OF CONTENTS

INTRODUCTION

The Network's Drug Prevention Project is designed to reach youth who are dealing with alcohol and drug problems. They may have problems themselves, they may have family members with problems, or their friends may have problems. No matter who has the problem, it becomes the youth's problem when it affects their lives.

Definition of Drugs

Drugs are defined, throughout this curriculum, as chemical substances which alter the user's perception, mood or consciousness. That includes: alcohol, caffeine, and nicotine, as well as marijuana, cocaine, heroin, and other subtances more commonly referred to as "drugs."

Peer Education

. . . youth-led groups are more likely to be effective . . . than are adult-led groups

This curriculum, developed as a part of the Network's Drug Prevention Project, was designed for use by youth leaders. Research into the effectiveness of peer education indicates that youth-led groups are more likely to be effective in reaching youth with drug-related information and skills than are adult-led groups. If your agency has no existing peer education program, you may want to consider initiating one using this curriculum as a beginning focus for the peer educators' activities. The chapter on peer education will provide some tips on developing such a program.

Overview of the Curriculum

The curriculum attempts to provide information and to assist youth in developing the skills they will need to understand their own or others' alcohol and drug problems. They will learn why people use, the effects of use and abuse, how best to intervene in someone's alcohol or drug use, and how to find treatment for those with alcohol and drug problems.

The videos, role plays and group exercises are designed to be used in small group settings: in youth service programs, in after-school programs, in community centers. The vignettes on the video are three- to six-minute pieces that depict a scene in a young person's life. They are provided as a way to get discussion moving. They are not designed to stand alone. They only make sense when used with the exercises provided.

Each of the four sessions—the video vignettes and exercises—runs about an hour. The sessions could be offered every day, every other day, or twice a week for two weeks. The optimal schedule depends upon your program's needs and existing activity schedule.

Leading Groups

Leaders can't make the group do something it isn't ready to do

Group leaders are to guide the discussion and exercises, making sure everyone gets to speak and participate and gently moving the group toward the goals outlined in each session. Leaders have a lot of power in a group, but they can't make the group do something it doesn't want to or isn't ready to do.

While we would like everyone participating in the group to leave each session with a renewed zest for life and a commitment to lead a drug-free life, such a turn around is unlikely. Instead, we hope that group members will leave with a few new thoughts, some new skills, and a commitment to helping those with drug and alcohol problems. The group leader is the key to making this happen. We are offering group members a chance to explore their own ideas, feelings and concerns. This means group leaders will be incredibly challenged: to prod and push just enough to keep the feelings and thoughts coming out, but not so much that group members clam up or say only what they believe they are expected to say.

Good luck.

USING THE CURRICULUM: BEFORE YOU START

There are a few things you need to do before you actually sit down with a group of young people. Each of the steps listed below is important to complete to insure youth are served well.

- Become comfortable with the curriculum.
  Read through the materials several times. Make notes to yourself if that helps you. Highlight key words and phrases in the text to help you move smoothly from one section to another.
- Prepare local information sheets.
  An outline is provided (on the following page). Check with your local information and referral service for all the alcohol and drug programs in your area. Divide up the list and call for the information outlined on the sheet. Put the completed sheets in a resource book or in this curriculum manual.
- Cue up the tape with the video machine you will be using.
  Set your video counter to "0" when directed to do so at the beginning of the tape. Then note on the following page the counter number at the beginning of each session. This will help you find individual vignettes as you go through the session.
- Be prepared to field questions about your own use of alcohol and drugs.
  It is likely that, at some point, youth in the groups will question you about your use. You can simply respond that your use (or their use, for that matter) is not what we're talking about in these sessions. However, you should be prepared for the question and rehearse in your own mind what you will say.

LOCAL ALCOHOL AND DRUG TREATMENT SERVICES

NAME OF PROGRAM

ADDRESS

TELEPHONE

ELIGIBILITY

- age limits
- is participation by others required?
- is parent permission for minors required?
- is insurance required?
- can a client refer him/herself?

DESCRIPTION OF PROGRAM

- program description
- average length of care
- type of treatment services offered
  - individual counseling
  - group counseling
  - family counseling
  - AA-type meetings
  - detoxification
  - residential care
  - aftercare

COST

- sliding scale
- insurance or Medicaid accepted
- payment plan available

DRUGS AND ALCOHOL: WHAT'S THE BIG DEAL?

SESSION I: WHY DO PEOPLE USE? VCR COUNTER NUMBER

Numbers _____

Backstage _____

Wallflower _____

SESSION II: WHO'S AFFECTED?

Bright Lights _____

Cocaine Mama _____

The Fact Is: Parent Use _____

I Want to Be Just Like You _____

The Fact Is: Not Everyone Uses _____

SESSION III: WHAT CAN YOU DO ABOUT IT?

Cocaine Baby _____

Pick Up _____

DUI _____

The Fact Is: Alcohol and Accidents _____

SESSION IV: WHERE DO YOU TURN?

That's What Friends Are For _____

The Fact Is: No One Seeks Help Alone _____

Acid Blues _____

Breaking the Cycle _____

USING THE CURRICULUM

LEADING GROUPS

Structure of the Groups

The curriculum is designed to be delivered in four sessions at least one day apart. Each of the sessions is intensive and lasts an hour to an hour and a half. Do not attempt to do more than one session a day with youth. They will lose interest and you will be exhausted.

You should open each session with a brief statement about its purpose and content. A brief paragraph is provided at the beginning of each section as an example for you to use. After the introduction, follow the session outline provided—doing the exercises and showing the vignettes in the order suggested. When you have finished the last exercise of a session, summarize the session as outlined on the summary sheet provided and thank the youth for participating.

Group Leaders: Peer Educators and Adult Leaders

As a group leader, you have several very important jobs. You are a **tone-setter.** Your attitude will set the tone of the group. If you are serious, but are enjoying yourself, so will the group. If you are angry and hostile, the group will mirror that back to you. Try to keep your attitude open, interested, and upbeat.

You are an **evaluator.** You can help us in improving this curriculum by providing us with written feedback on each of the groups you lead. By filling out log sheets after each session describing what you did and how it went, you can help us determine what changes we need to make in the curriculum. An example of the log sheet follows on the next page.

You are a **model.** Youth will look to you as an example of how they might be. Think about how you present yourself to them. Put your best foot forward.

LOG SHEETS

You will find, as you conduct these sessions, that some things seem to work better than others. Some exercises work better in some situations than others.

Keeping a log of which exercises you did and how they went will serve as a reminder for you of what you've done and will provide other group leaders with the benefit of your experience. The information on these log sheets will also help the Network redesign the exercises and videos to make them work even better.

Please complete a two-page log sheet after each session. File them in the group leader's manual.

LOG SHEET

AGENCY NAME: _____

DATE OF SESSION: _____

NAME OF GROUP LEADER(S): _____

WHICH SESSION WAS THIS (circle one):

Session I: Why Do People Use?

Session II: Who's Affected?

Session III: What Can You Do?

Session IV: Where Do You Turn?

EXERCISES USED (circle all used):

Session I:
The Facts
Why Do They Do It?
The Pressure Is On

Session II:
No One Is an Island
Who's in Charge Here?

Session III:
The Best and the Worst
Risky Business
The Key

Session I V:
Help!
Where To Turn
What's Needed

GROUP INFORMATION:

How many youth attended this session? ___

Gender of participants (#) Male _____ Female _____

Race of participants (#) White _____ Black _____

Hispanic _____ Other _____

YOUTH RESPONSE (circle the number):

	not at all		some		very much
attentive	1	2	3	4	5
distracting behavior	1	2	3	4	5
interested	1	2	3	4	5
uncomfortable	1	2	3	4	5

STAFF EVALUATION (circle the number):

	not at all		some		very much
I felt prepared	1	2	3	4	5
The session was difficult	1	2	3	4	5
The session achieved goals	1	2	3	4	5
I felt confident	1	2	3	4	5

QUESTIONS ASKED/ADDITIONAL TOPICS DISCUSSED:

PROBLEMS ENCOUNTERED:

HOW DID YOU COPE WITH PROBLEMS? DID IT WORK?

COMMENTS, IDEAS, AND SUGGESTIONS FOR CHANGE:

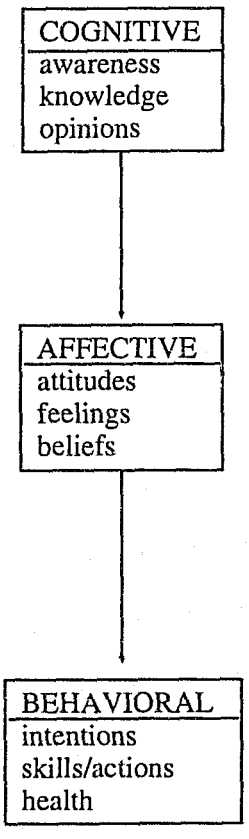
RATIONALE FOR THE DESIGN

The curriculum has been designed for use with runaway, homeless, and other high-risk youth in a variety of settings. It is intended to provide these youth an opportunity to do the following:

- learn about drugs and drug abuse
- develop the skills needed to help someone else deal with a drug problem
- practice the interpersonal skills necessary for resisting drug use.

It uses an indirect approach, putting more emphasis on helping others deal with their drug problems than on dealing with one's own problems. The topics covered in the sessions and the manner in which they are covered are grounded in basic health education and learning theory. The overall design of the curriculum was built upon social learning theory and problem behavior theory, using a social skills training model.

An Indirect Approach



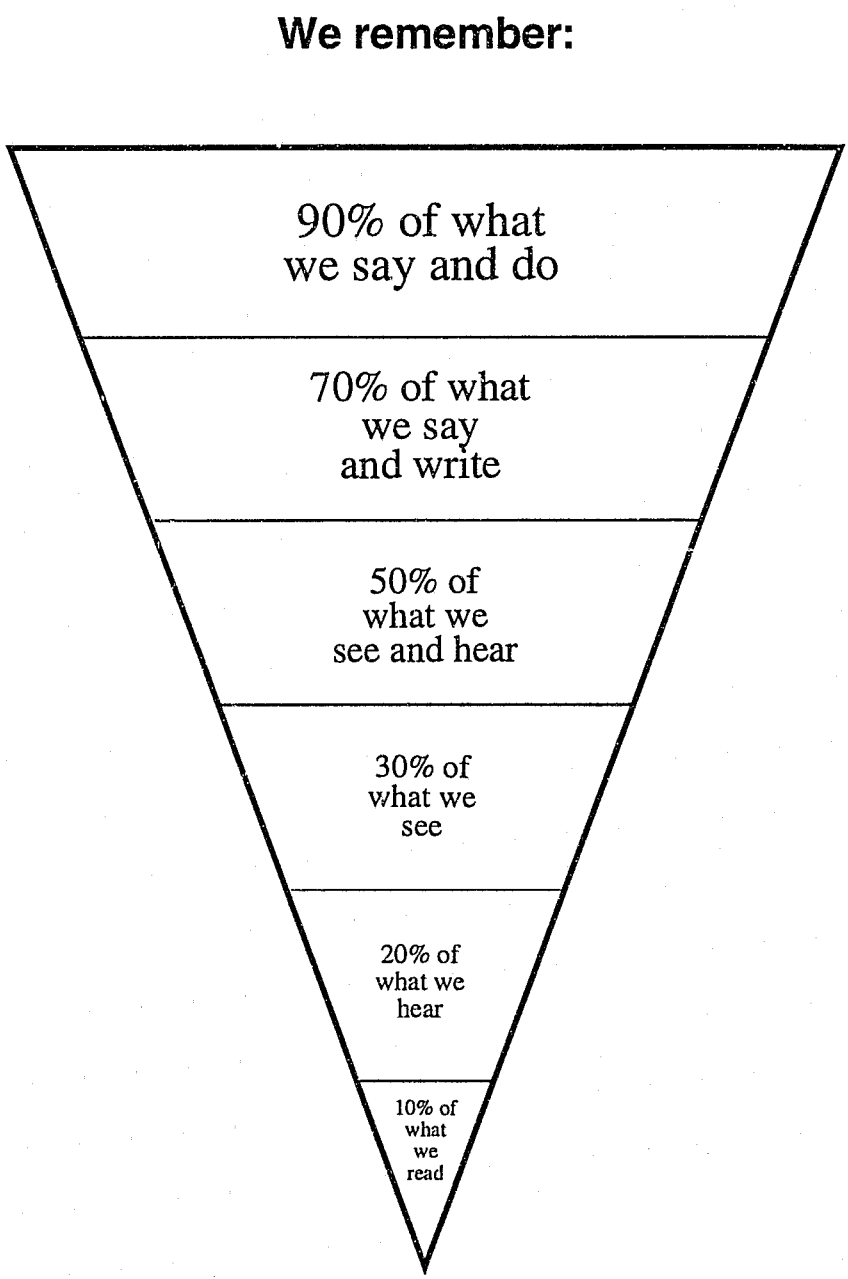
Runaway, homeless, and other high-risk youth experiment with and regularly use drugs at a higher rate and are more socially and emotionally isolated than are their in-school counterparts. Although they live in an environment in which family and friends are using alcohol and drugs and are able to identify the negative consequences of others' use, they deny their own problems with use. Most youth have strong allegiances to their peers. They feel connected to the youth subculture, in general, and to their friends, in particular. When they see friends who are having problems—whether it is with family, with boyfriends or girlfriends, with school, or with drugs—they want to help.

The curriculum builds upon that concern for others and tries to avoid pointing fingers at youth in the group as having drug problems themselves. Rather, the project works to help youth recognize their own problems with alcohol and drug use through an indirect approach. Youth are given opportunities to learn the skills necessary to identify others' abuse of drugs and to intervene in that abuse in a caring and compassionate manner. In learning to help others, youth can learn to help themselves as well.

Health Education and Learning Theory

Health educators identify three basic areas of competence necessary for engaging in healthy behaviors: cognitive, affective, and behavioral. Within each of those three areas are identifiable steps that people typically move through. The exercises and information in the curriculum are designed to give youth an opportunity to be involved in all three areas by providing information; exploring opinions, attitudes, and feelings; and practicing skills and behaviors.

The curriculum is a "hands-on" design which actively involves youth in each session. This is because people learn better by doing than by hearing or seeing. This can be best illustrated by Dale's Learning Cone pictured below.



By allowing youth an opportunity to hear, see, say, and do things in each session, we are insuring the information and skills they gain will have greater staying power.

Theoretical Base

The project builds upon social learning theory (Bandura 1977) and problem behavior theory (Jessor and Jessor 1977), incorporating a social skills training model (Botvin 1986). **Social learning theory** proposes that individuals will have an increased likelihood of changing behavior if they have an opportunity to see the desired behavior modeled, if they can practice it, and if there are supports within the environment for the new behavior.

The curriculum provides youth the opportunity to view some of the desired behaviors (through the video vignettes). They have an opportunity to practice the behaviors through structured role plays in a small group setting.

Involving peers as group leaders and creating an atmosphere in which drug abuse and intervention in others' abuse is explored helps to build a supportive environment for youth in the groups.

Problem behavior theory views alcohol and drug abuse as a functional behavior that is socially learned and that serves a purpose. This behavior results from an interplay of social and personal forces in the individual's life. Social skills training attempts to counterbalance these forces and the behaviors they foster by development of personal and social skills. Social skills training typically focuss on two or more of the following areas:

- problem-solving and decision-making
- cognitive skills to resist interpersonal or media influences
- increasing self-control and self-esteem
- relieving stress
- building interpersonal skills
- assertiveness training.

Evaluations of **social skills training** approaches have demonstrated significant behavioral effects among participants. Studies suggest that more intensive formats (several times a week) may be more effective than only weekly sessions (Botvin 1984).

The curriculum incorporates some aspects of each of the six areas of social skills training listed above in an intensive format (two or more sessions per week). It uses video vignettes of teens in various realistic settings followed by discussions and role plays of desired new behaviors.

CULTURAL SENSITIVITY

Our own cultures and backgrounds—our gender, class, race, ethnic group, religion, age, and political beliefs—influence how we relate to those we perceive as different. The values we grew up with and the experiences we have had contribute to the attitudes we now have about certain groups or types of people.

Even those of us who feel we are generally accepting of others have buttons that can get pushed by different people. That's okay. What's not okay is to pretend to be totally open and accepting of everyone. It's simply not true. People can see through these pretenses. Perhaps most importantly, until we face our own biases and address them, we can never outgrow them.

Developing a sensitivity to those from other cultures and backgrounds is a lifelong process. Two articles from the National Institute on Drug Abuse are included to provide an overview of two groups and a summary of the particular aspects of their culture that may affect drug use and abuse.

Developing a sensitivity to those from other cultures and backgrounds is a life long process

In reviewing these articles and attempting to apply them to work with youth, try to avoid the pitfalls of stereotyping by keeping a few key points in mind.

- Don't form impressions too soon.
  Stay open to additional information that may provide a clearer picture of an individual and his/her situation.
- Understand others' viewpoints before drawing conclusions about them.
  Give others a chance to fully express themselves and their ideas before categorizing them.
- Don't generalize from a non-typical group to the whole community.
  Every community has its own subgroups that represent a wide variation in attitudes and behaviors. Don't assume a group is typical of other groups within a community.
- Remember, individual variations occur with groups and within the community.
  Even though they may be of the same background, individuals are each different. What one does may not predict the attitudes or behaviors of another.

DRUGS AND DRUG ABUSE

We live in a drug-using society. We are deluged with images of people using cigarettes or alcohol and having a terrific time on billboards, television, and in print. We are led to believe from a very early age that no one should have to experience pain or discomfort—there is always a drug that will make it feel better.

It's no wonder that young people respond to that influence. They use drugs for as many different reasons as adults use to make their pain or discomfort go away, to attempt to have as much fun as others who use seem to have, or just to escape.

This section will provide some basic information about drugs and drug abuse: How much young people are really using, why they might be using, the link to HIV/AIDS, the process of addiction, types and effects of drugs, and modes of treatment. It's a lot of information in a few pages. Use it as a reference in your work with youth.

Alcohol and Drug Use among Runaway and Homeless Youth

BACKGROUND: ALCOHOL AND DRUG USE AMONG YOUTH

Use of alcohol and other drugs among teenagers as measured in the High School Senior Survey (Johnston et al., 1988) is declining. The 1987 survey found the following among high school seniors:

- a sharp downturn for the first time in the use of cocaine
- a leveling off of the use of crack cocaine
- the lowest annual prevalence level of marijuana since the initiation of the study in 1975
- a significant drop in daily marijuana use
- no corresponding increase in alcohol use to offset the reduction in use of other drugs.

This is doubtless the result of many factors. Changing public attitudes and messages about the desirability and acceptability of alcohol and drug use may have contributed to the downturn. Drug education offered through schools may have had an impact. The decline may also have resulted from a growing awareness among youth of the negative health effects of use, especially heavy and frequent use.

Although this general decline in use is a positive sign, there is still cause for concern—especially for high-risk youth. The Senior Survey collects data in public and private high schools from youth currently completing their senior

year. Many high-risk youth are missed by such a sampling technique. They have either dropped out or are chronically truant and unlikely to have been present to complete the survey. These out-of-school youth represent a more disadvantaged population and tend to have higher rates of use than in-school youth (US Public Health Service, 1989).

The downturn in drug and alcohol use among high school seniors, is, at least in part, a result of the prevention efforts of the last five years. Unfortunately, that decline in use among in-school youth will not necessarily translate into reduced usage rates among out-of-school youth. In-school youth are more likely than out-of-school youth to be responsive to suggestions about self-care (e.g., improving health and avoiding legal and school problems by staying drug free) and responsibility for self and others (e.g., avoiding driving while intoxicated). Preventing and reducing use by high-risk, out-of-school youth may well present more problematic and challenging problems (US Public Health Service, 1989).

The downturn in drug and alcohol use among high school seniors will not necessarily translate into reduced usage rates among out-of-school youth.

Risk Factors for Alcohol and Drug Use

The majority of adults in this country drink alcoholic beverages at least once a year. By their mid-twenties, nearly 80% of young adults have tried an illicit drug and 60% have tried an illicit drug other than marijuana (Johnston, et al., 1988). The fact that the majority of these youth and adults experience no drug- or alcohol-related problems indicates the existence of factors which put some individuals and/or groups at higher risk for developing such problems than others.

Although no clear causal relationships can be drawn between specific variables and development of alcohol- and drug-related problems, there are a number of risk factors believed to be correlated with such problems. Generally, a youth's drive toward drug and alcohol use is thought to be a function of the convergence of several factors rather than a single overriding factor. High-risk youth are, by definition, youth who embody and/or encounter several of these risk factors. Identified risk factors for alcohol and drug use occur at different levels including the following:

- social and cultural context
- community setting
- family history and environment
- school experience
- peers
- individual characteristics.

Children from families with poor parenting skills, family conflict, and poor family communications have a disproportionately high risk of using alcohol.

The social and cultural context embodies the influences of the society at large. Such influences are manifested through the media, laws and their level of enforcement, and social norms and expectations. If attitudes relayed through these various modes are seen as favorable and accepting toward use, youth will be more likely to use and to use more frequently and in greater amounts (Kandel et al., 1987; Smith and Fogg, 1978).

A community's overall climate will also affect the use and abuse of alcohol and drugs. Youth living in communities which offer few opportunities for productive involvement, which are economically disadvantaged, which are overcrowded and physically deteriorating, and which are crime- and drug-ridden are at an increased risk for drug and alcohol use and related problems (Bursik and Webb, 1982; Murray, 1983; Wilson and Hernstein, 1985).

Family factors influencing drug and alcohol use by youth include the following:

- attitudes toward and patterns of use by parents
- family conflict and communication patterns
- family bonding.

Evidence that alcoholism may be genetically transmitted, particularly among sons of alcoholic fathers who had an early onset of drinking problems, is mounting (Cloninger et al., 1985; Shuckit, 1980). Parental approval of drinking is a predictor of alcohol consumption by youth and parental use of marijuana is associated with youths' use of illicit drugs (Barnes and Welte, 1986; Hawkins et al., 1986; and Johnston et al., 1984). Actually involving youth in parents' drug-taking behavior is also associated with intentions to use and actual use by youth (Ahmed et al., 1984).

Children from families with poor parenting skills, family conflict, and poor family communications have a disproportionately high risk of using alcohol and drugs (Kumpfer, 1987; Patterson and Dishion, 1985; Penning and Barnes, 1982; Simcha-Fagan and Gersten, 1986). Drug-related problems are also more common among children who have been abused (Dembo et al., 1979).

. . . youth who perceive using alcohol and drugs use to be the norm may use them in an effort to fit in.

Because the family is the major agent for socialization, a lack of bonding or attachment to the family can increase the social and behavioral problems of youth. Strong attachment to family seems to protect youth from drug use, and increased drug use is seen among youth who are not close with parents (Brook et al., 1986; Kandel et al., 1978; Norem-Hebeisen et al., 1984).

Peer influence operates on a number of levels. Young people who use alcohol and drugs tend to associate with others who also use (Dembo et al., 1979; Norem-Hebeisen et al., 1984; Kaplan et al., 1982). Additionally, youths' perceptions about the attitudes and behaviors of peers are powerful influences on their own use patterns (Kandel et al., 1978; Jessor and Jessor, 1978). Most youth use drugs in a group setting (Barret and James-Cairns, 1980), and drug users spend more time with their peer groups than do non-users (Tudor, 1980).

However, it is not clear that "peer pressure" per se is the driving force. Most youth do not report that they have felt pressured by others to use (Bachman et al., 1987; Sheppard et al., 1985). It may be, instead, that peer influence operates in a more indirect way. Given that adolescence is a time of conformity and self-consciousness, youth who perceive using alcohol and drugs to be the norm may use them in an effort to fit in.

. . . truancy and dislike of school are associated with higher levels of drug and alcohol use.

Experiences in and attitudes about school are related to drug and alcohol use by youth. School failure increases the risk of drug-related problems (Anhalt and Klein, 1976), and drug use is more prevalent among school dropouts than among in-school youth (Kandel, 1984). In addition, truancy and dislike of school are associated with higher levels of drug and alcohol use.

Individual characteristics associated with increased use include the following:

- rebelliousness and alienation (Jessor and Jessor, 1978; Johnston, 1973; Kandel, 1982)
- early antisocial behavior (Kandel et al., 1986)
- lack of empathy for others
- easy and frequent lying
- favoring immediate over delayed gratification
- insensitivity to punishment (OSAP, 1989).

Risk Factors and Runaway Youth

Based upon these six risk factors, runaway youth are at high risk for drug- and alcohol-related problems. In a study of youth served by runaway centers in the southeast (Southeastern Network, 1989), at least three of the six factors are clearly in evidence: family history and environment, school experience, and individual characteristics.

Runaway youth reported major family problems, experienced school problems, and experienced problems that put them at risk.

Runaway youth reported major family problems. Over 60% reported emotional conflict and poor communication within their families. Many youth had been abused (48% reported physical abuse, 42% neglect, 37% emotional abuse, and 27% sexual abuse) and reports of domestic violence (16%) were also common. Nearly a fifth (18%) reported parents' alcohol and/or drug use was a problem.

Over a quarter of youth served had experienced school problems. Thirty percent were underachievers, 28% were chronically truant, 23% had unruly behavior in school, and 21% had trouble with teachers. In fact, only half of the youth were attending school regularly. Nearly half (48%) had failed or repeated a grade in school. Thirty percent had failed once, 14% twice, and 4% three times or more.

Runaway youth also experienced individual problems that put them at risk. Nearly half (43%) reported low self-esteem, and 33% were depressed. Sixteen percent had had problems with law enforcement or the justice system. Nineteen percent identified their own drug and/or alcohol use as a problem. Among runaways, 28% acknowledged use of alcohol and/or drugs prior to running away, and 27% acknowledged use while on the run.

Resiliency Factors

In addition to risk factors, it has been suggested that there are resiliency factors operating as well (Werner, 1987). These are factors which protect youth from negative outcomes, including alcohol- and drug-related problems. These resiliency factors include the following:

- four or fewer children, spaced more than two years apart
- much attention paid to infant during first year
- positive parent-child relationship in early childhood
- additional caregivers besides mother
- care by siblings and grandparents
- steady employment of mother outside of household
- availability of kin and neighbors for emotional support
- structure and rules in household
- shared values
- close peer friends
- availability of counsel by teachers and/or ministers
- access to special services (health, education, social services)

Such factors create situations in which youth have access to caring support systems within their environments—among the nuclear and extended family, other caring adults, and peers.

It is important to consider the presence of such resiliency factors in assessing a youth's risk for alcohol and drug problems. Although youth service agencies cannot change a youth's family history, they can address the last two items listed. They can make themselves available for counsel on an ongoing basis and can insure that needed services are accessible for youth and their families.

Prevention Strategies

Targeted programming activities focus on psychosocial issues through either social influence or social skills

The most effective prevention strategies are designed to decrease the risk factors identified above and to increase the resiliency factors. This can be accomplished through individualized prevention efforts, large scale prevention programming, or targeted prevention programming.

Individualized prevention efforts provide support and structure for particular youth. Efforts typically focus on development of one-to-one relationships as in Big Brothers/Big Sisters programs. Youth service agencies are engaging in such efforts when their staff or volunteers are working on an individual basis over a period of time with a particular youth.

Large-scale programming uses a more generic approach with a large and frequently heterogeneous population. Programming may include mass media campaigns or community or schoolwide programs. Most youth service agencies

are involved in such efforts as partners with other community groups. Community projects such as Chemical People and the Red Ribbon Campaign are examples of joint efforts by a coalition of community groups to address drug and alcohol problems.

Targeted programming identifies a particular group of youth and engages them in a specific set of activities. Typically, such activities focus on psychosocial issues through either social influence or social skills training (Botvin, 1986). Many youth service agencies already offer such activities as an ongoing part of their programming for youth.

The social influence approach is based on the assumption that youth can be "inoculated" against social influences to use by progressively exposing them to more intense pro-use social influences. The components of this approach involve making youth aware of the influences they may be exposed to, teaching them specific skills with which to resist those influences, and correcting misperceptions about social norms of use. Older or same-aged peer leaders are often used in such programs.

The social skills training approach incorporates many components of the social influence approach, but expands and emphasizes the development of generic personal and social skills. Such approaches typically include two or more of the following components:

- general problem-solving and decision-making skills
- general cognitive skills for resisting media and interpersonal influences
- skills for increasing self-control and self-esteem
- adaptive coping strategies for relieving stress and anxiety
- general interpersonal skills
- general assertiveness skills

Within each of the three modes—individual, large-scale, and targeted programming—prevention activities can be classified as primary, secondary, or tertiary. Primary prevention activities are targeted for youth who have not yet used and they are designed to prevent that initial use of alcohol and drugs. Secondary prevention—sometimes referred to as intervention—is targeted for youth who are at high risk for using or who have already used, but who are seen as capable of stopping. Tertiary prevention is, essentially, treatment and is focused on ameliorating the effects of abuse on the youth.

Prevention activities must also be developmentally specific.

Runaway youth may be found at each level. Some have never used, some are experimenting, and others are already in need of treatment. Agencies serving these youth must recognize the diversity of this population in their design of prevention efforts.

Prevention activities must also be developmentally specific and responsive to the cognitive and behavioral levels of the youth targeted. They should be sensitive to the typical ages of initiation for alcohol and drug use as well.

Most high school students who become daily smokers begin smoking every day in the seventh, eighth, or ninth grades. Alcohol use shows a similar pattern of early initiation with 56% of youth first drinking by the ninth grade. The ninth grade was also the most frequently reported time of first drunkenness.The most frequently reported time for first use of marijuana was also the ninth grade. Cocaine/crack showed a peak time of first use in the eleventh grade (US Public Health Service, 1989).

Although individual variations must be accounted for, the following breakdown of developmental stages for teenagers is suggested by the Office of Substance Abuse Prevention (US Public Health Service, 1989):

Fifth to Seventh Grades (10 to 12 years)

It is during this time that youth at highest risk for serious alcohol- and drug-related problems will initiate use. This is also, for many youth, the final years in which prevention efforts may be attempted in the absence of widespread peer use.

Most runaway youth are living within a peer culture in which other youth are using drugs and alcohol.

Eighth to Tenth Grades (13 to 15 years)

This is the time when most young people who are ever going to use drugs will begin and when their attitudes toward use are most likely to change from negative to positive. It is a difficult, but important, time for prevention efforts as youth shift allegiance between parental and peer values.

Eleventh to Twelfth Grades (16 to 17 years)

This can be a time of either intensification of drug and alcohol use or abandonment of using behaviors. For most youth in this stage, efforts must focus on reduction or termination of current use.

Most runaway youth, even those who have not yet used, are living within a peer culture in which other youth are using drugs and alcohol. For most of these youth, the second and third developmental stages outlined above are operant. Prevention activities with runaway youth should focus on those two stages.

SOUTHEASTERN NETWORK STUDY: ALCOHOL AND DRUG USE AMONG RUNAWAY AND HOMELESS YOUTH

A study of alcohol and drug use was conducted among runaway, homeless, and other high-risk youth in the eight southeastern states in February of 1989. The 253 youth participating in the study included all those youth in residence at the runaway programs during a predetermined one-week period. The survey instrument was adapted from one used extensively in previous research. The results are compared, on the charts below, to a study of in-school youth in Georgia (Fors and Rojek, 1987) and to a study of homeless youth in California (Robertson, Koegel, and Ferguson, 1990 and Robertson, 1989).

Prevalence of Use

Prevalence of use was measured on a five point scale:

1—Never used

2—Did use but not in past year

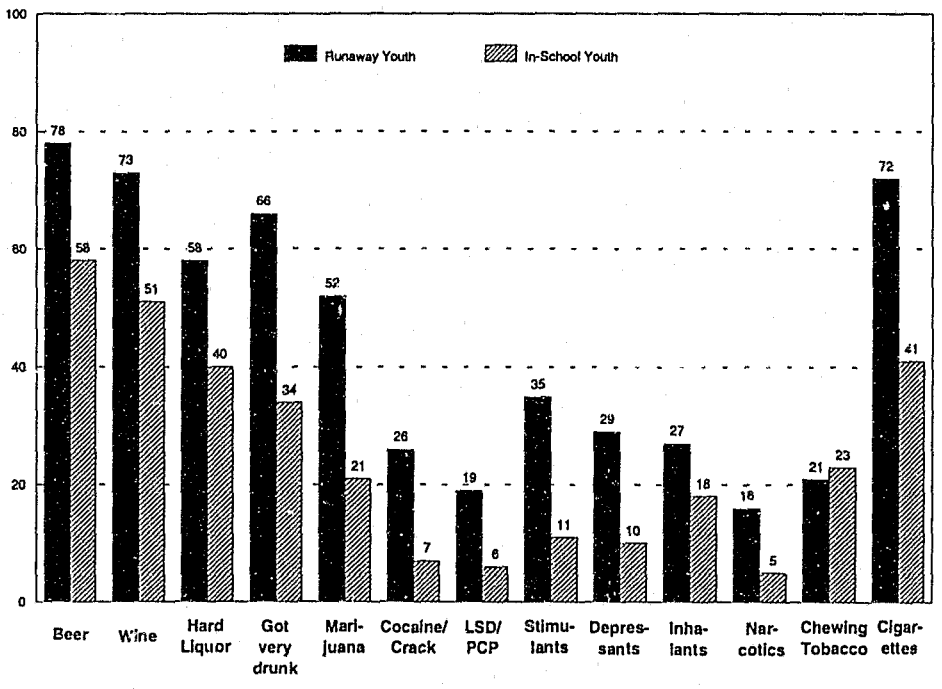
3—Did use during past year

4—Did use during past 30 days

5—Did use in the past week

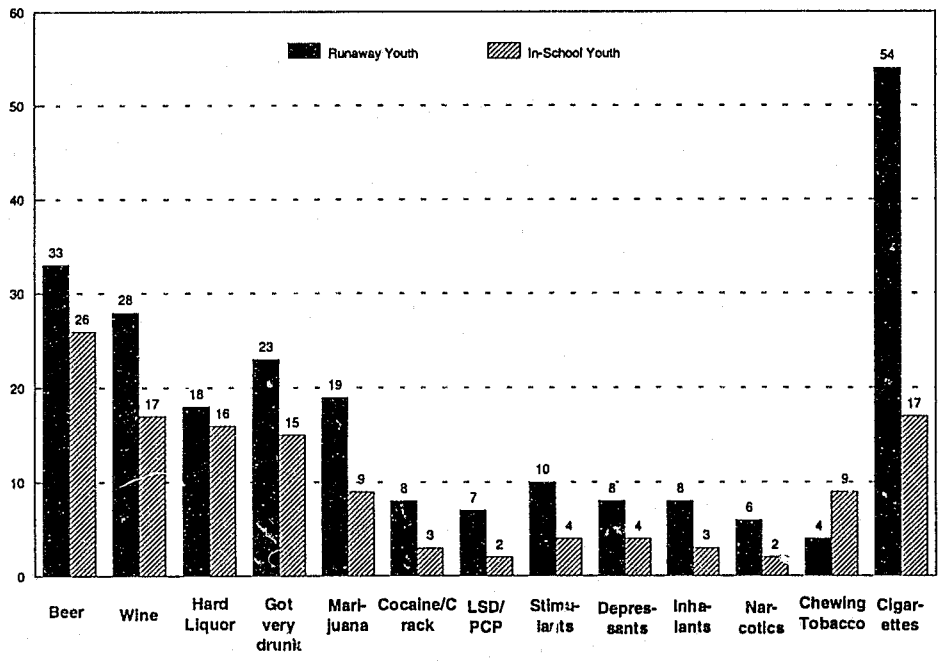
Figure 3 delineates reports of "Ever Used"; Figure 4 covers reports of "Regularly Used." Regular use was defined as use within the past month, combining the responses to categories 4 and 5. "Ever Used" reflects the combined responses to 2, 3, 4, and 5. In both charts the responses of runaway youth and in-school youth are compared.

Figure 3: Percent of Youth Who Ever Used



Runaway and in-school youth made similar choices in the substances they most frequently used (experimentally or regularly). The most frequent substances of choice for both groups were beer, wine, and cigarettes. Those least frequently used were narcotics, LSD or PCP, and (for runaways only) chewing tobacco.

Figure 4: Percent of Youth Who Used within the Past 30 Days



Rates of use by the two groups varied dramatically, however. The most dramatic differences in usage rates—both experimental and regular use—between the two groups were found in the rates of cigarette smoking. Runaway youths' experimental use of cigarettes was nearly twice that of in-school youth and their regular use was more than three times that of in-school youth.

In general, runaway youth reported higher rates of both experimental and regular use of various types of alcohol and drugs than did their in-school counterparts. While their regular use (defined as use within the past 30 days) was only slightly higher for most substances, their experimental use (defined as having ever used) was significantly higher than that of in-school youth.

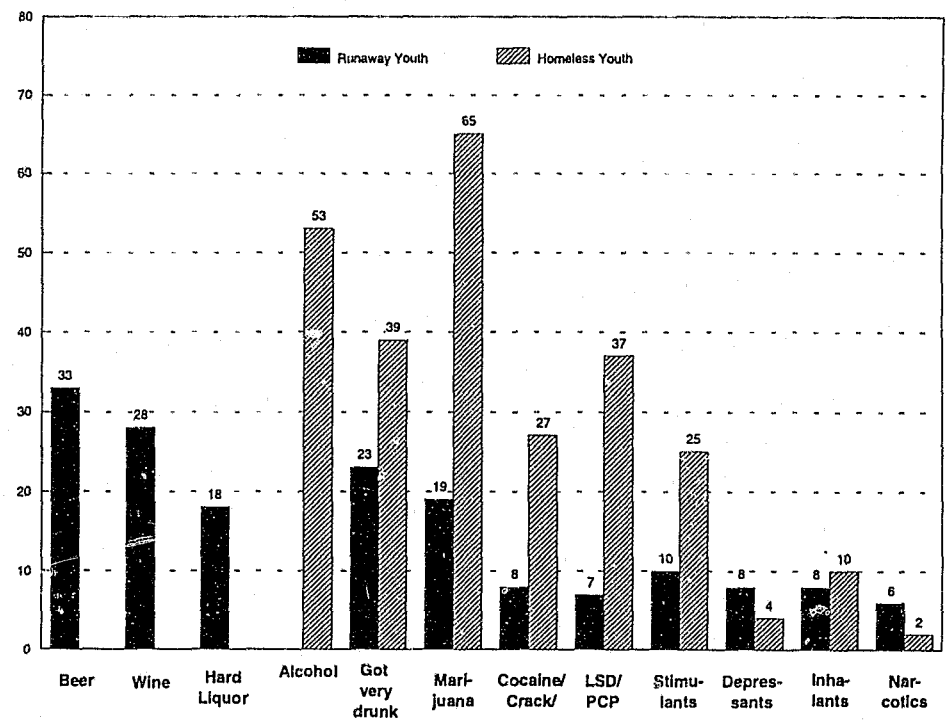
Such high levels of experimentation are cause for concern. Though experimentation does not necessarily lead to regular use and abuse, it should serve as a warning light for service providers—especially given what researchers report about gateway drugs.

Gateway drugs are those drugs whose use tends to precede the use and abuse of other substances. For example, researchers report that cigarettes, alcohol, and marijuana are the most common gateway drugs preceding the use and abuse of other illicit substances (Yamaguchi et al., 1984). In fact, the various drugs represent a progression in and of themselves. Cigarette use tends to precede alcohol use. Alcohol use tends to precede marijuana use. Marijuana use tends to precede use of other illicit drugs.

In the report of drug and alcohol use of homeless adolescents (defined as youth 17 or under who had spent the night on the streets or in a shelter), Robertson, Koegel, and Ferguson (1990) reported a higher regular rate of usage of alcohol, marijuana, cocaine/crack, LSD/PCP, and stimulants by homeless youth than was found among the runaway youth surveyed (Figure 5). The homeless youth they surveyed also reported a greater incidence of getting really drunk than did the runaway youth surveyed.

Many homeless youth were once runaways. For many runaway youth it is only a viable support system that stands between them and the streets. If those supports cease to function, runaway youth become homeless and subject to the elevated rates of alcohol and drug use found among homeless youth.

Figure 5: Percent of Runaway versus Homeless Youth Reporting Use in the Past 30 Days



Identification of Problems with Alcohol and Drug Use

High-risk youth, sampled in the Southeastern Network's study, were able to identify the alcohol and drug problems of others. Of their family members and/or friends who used, they reported that 54% of fathers, 42% of mothers, 37% of siblings, and 57% of friends had a problem with use of alcohol and drugs. However, these youth were less able to identify their own alcohol and drug problems. Only 23% of high-risk youth who used believed they themselves had a problem.

Link to HIV/AIDS

HIV (Human Immunodeficiency Virus) is the virus that causes AIDS. HIV is transmitted through contact with infected blood, semen, or vaginal secretions. Drug and alcohol use can expose a young person to the HIV virus in a number of ways. Just because they don't use needles doesn't mean they are not taking any risks. Listed below are six major ways a young person is exposed to HIV through drug and alcohol use:

1. *Lowered inhibition and self-control.* "If you don't have control of yourself, others will take control of you." Alcohol lowers inhibition very effectively. Our culture uses it for that. Marijuana and most other drugs do the same.
   - All decisions, all commitments to safe sex are put aside
   - Unprotected anal sex and other risky sexual practices become more likely
2. *Blackouts.* When youths experience the waking loss of memory characterized by the biological inability to recall information or the experience known as "blackouts," they are vulnerable to many kinds of risks, including sex with unknown individuals, rape, multiple rape, incest, and traumatizing and injurious sex. Depending on who these unknown partners are, the risk of HIV infection is increased.
3. *Change in Peer group.* With increased use of alcohol and drugs, there is a shift in the kinds of peers with whom a user associates. Increasingly, he or she takes up with new friends who share the same drug-using interests and are out for the same risk-taking adventures. Sooner or later, the youth spends most of his time with a high-risk group of teenagers, with the accompanying opportunity for needle use, unsafe sexual behaviors, sex with unknown partners, and/or violence.
4. *Increased readiness and opportunity to use new drugs.* As we have seen, some youths tend to move on to higher levels of use and more potent drugs. Once a teenager is casual or comfortable with using alcohol and marijuana, this youth can be said to be at the "gateway" to cocaine, if not heroin use. And this is where exposure to IV drug abusers and needles begins "for real."

5. *Needle use.* It is important to emphasize that HIV infection is associated with specific behaviors, not with membership in any group. Teenagers could very easily come upon their first opportunity or invitation for needle use without ever possibly thinking of themselves as an "IV user." Remember that it is not "dirty" needles or injected drugs that cause HIV infection, but HIV-contaminated blood.
6. *Other violence and injury.* Drug and alcohol use are notoriously associated with violence, injury, and death. The front pages of our urban papers are filled daily with reports of fights, shootings, knifings, murders, and car accidents—many of which are related to being drunk or "high" or to selling or buying drugs. If the environment in which these events occur is itself "high risk," the likelihood of contact with contaminated blood is also increased.

[from *AIDS High Risk Adolescent Prevention Project,* developed by Westover Consultants for National Institute on Drug Abuse]

The Progression of Dependency on Alcohol and Drugs

There is no general agreement on the meaning of term "addiction," but most discussions of it center around three concepts: tolerance, physical dependence, and psychological dependence.

There are basically two approaches to defining addictions: one which pre-dates the 1960's and a newer one which has developed over the past 15 to 20 years. The older view of addiction was based on observation of heroin addicts and was defined, primarily, by the presence of withdrawal symptoms. When the drug was stopped, the person got sick.

Tolerance is the reduced effectiveness of a drug after repeated administrations. Simply stated, it means that after taking a drug for a while, it takes more to generate the same effect. Your body begins to tolerate it.

Physical dependence is said to occur if there is a consistent set of symptoms when use of a drug is stopped. Those symptoms are referred to as the withdrawal syndrome.

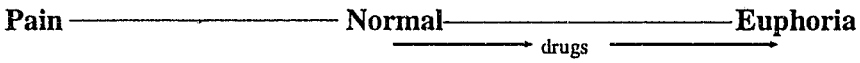
Psychological dependence or behavioral dependence is a strong tendency to repeat the use of a drug.

. . . psychological factors are the real driving force behind addictive behaviors.

However, as other drugs like marijuana and cocaine came into more common use, this definition seemed too restrictive. Marijuana and cocaine didn't seem to produce physical dependence, but there were people who seemed to be very dependent upon it. In the 1970's the definition of addiction began to change to include psychological dependence. Animal studies confirmed what treatment providers had been observing—that psychological factors are the real driving force behind addictive behaviors.

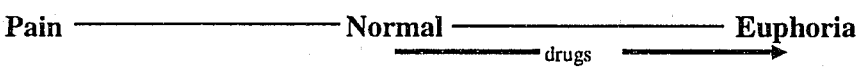
Perhaps the clearest and most simple way to look at dependency is through the Pain-Euphoria progression. This way of tracking a person's use of alcohol and drugs illustrates, in four stages, the difference in the use, effect, and importance of drugs in a person's life over time.

Stage One : Discovering Mood Swings



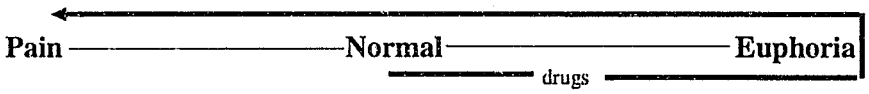
In stage one people learn that drugs can alter their moods temporarily in the direction of their choosing. They learn they can control the effects by regulating the amount taken.

Stage Two: Seeking Mood Swings



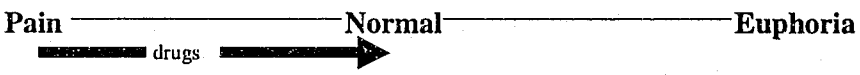
In this stage people begin to use drugs more frequently, following a self-imposed schedule (only on weekends, after work, etc.). They may sometimes over use and suffer through a hangover, but the use of the drug isn't generating any emotional or social costs. This is the social drinking or recreational user stage. Many people never progress beyond this point.

Stage Three: Dependency



At this stage, people sometimes lose control over their use. They are less able to predict the outcome of their use. As they lose control, they sometimes engage in behaviors that result in social and/or emotional costs. They begin to be preoccupied with use of the drug, and their lives begin to revolve around its use.

Stage Four: Using to Feel Normal



In this stage, people are using to avoid pain. They no longer can achieve the feeling of euphoria from use. They may black out frequently, develop physical dependence, and become paranoid. Their entire lives are focused on securing and using the drug.

Types of Drugs and Their Effects

Mixing drugs can have dangerous, even fatal, effects. Sometimes different drugs can act on the same system. The combined effect of low doses of different drugs (alcohol and Valium, for example) can have an effect that mirrors that of very high doses of one drug. Drug mixing becomes even more risky when street drugs are being used, since there is no way for the user to know what chemicals are being ingested.

Drugs may be categorized into seven major groups: stimulants, depressants, narcotics, hallucinogens, psychotherapeutic drugs, and two that don't really fit anywhere else—nicotine and marijuana. Each of these seven groups is discussed below.

Stimulants

Stimulants are drugs that create a sense of wakefulness, energy, and well-being. The more powerful stimulants (like cocaine and amphetamines) can produce extreme excitement along with paranoia and hallucinations when taken in high doses. Stimulants speed up heart rate and breathing and heighten blood pressure.

- Includes:
  Amphetamines
  Methamphetamine
    "crank"—liquid form for injection
    "crystal meth"—powdered form for inhaling
    "ice"—clear crystal form for smoking
  Cocaine
    "freebase"—cocaine mixed with a solvent, such as ether, and smoked
    "crack"—formed into small rocks and smoked
  Caffeine
  Diet pills

- Effects:
  increased heart rate and heightened blood pressure
  loss of appetite
  insomnia
  increased alertness and energy
  feelings of excitement

Depressants

At low doses, depressants lower inhibitions resulting in relaxation and talkativeness. As the dose increases, other functions are depressed resulting in lowered reaction times, uncoordinated movements, and unconsciousness. Regular use of these drugs can lead to withdrawal symptoms restlessness, shakiness, insomnia, nausea, vomiting, convulsions, and psychosis characterized by confusion, disorientation, agitation, delusions and hallucinations. This psychosis is clinically similar to alcoholic delirium tremens. Abrupt withdrawal from barbiturates and alcohol are quite similar and, generally, much more dangerous than withdrawal from narcotics.

- Includes:
  Methaqualone
    Quaaludes
    Sopors
    Barbiturates
    Seconal
    Tuinal
  Minor Tranquilizers
    Librium
    Valium
    Xanax
  Alcohol
  Inhalants/Solvents
    Gasoline
    Glue
    Amyl Nitrate (poppers)
    Butyl Nitrate (Rush, Locker Room)

- Effects:
  relaxation
  uncoordinated movement
  depressed respiration
  lowered energy level
  slowed reaction time
  sleepiness

Narcotics

Narcotics are a group of pain-killing (analgesic) drugs that produce a relaxed, dream-like state. Consciousness is clouded but without the slurring and staggering typical of other depressants. Regular use can lead to withdrawal characterized by diarrhea, cramps, chills, and sweating.

- Includes:
  Opium
  Prescription narcotics
    Morphine
    Codeine
    Demerol
    Darvon
  Percodan
    Dilaudid
    Talwin
    Methadone
  Heroin

- Effects:
  euphoria
  drowsiness
  slowed respiration

Hallucinogens

Hallucinogens produce altered perceptions including visual sensations and changes in perception of one's own body.

- Includes:
  d-Lysergic Acid Diethylamide (LSD)
  Psilocybin
    "magic mushrooms"
  Peyote/Mescaline
  Amphetamine derivatives
    DOM/STP
    MDA
    MDMA/Ecstasy
    PCP/Angel Dust
- Effects:
  hallucinations
  brain stimulation
  flashbacks

Psychotherapeutic Drugs

Psychotherapeutic drugs include a variety of drugs prescribed by physicians for control of mental problems. The antipsychotics or major tranquilizers can calm psychotic patients and help them control hallucinations and illogical thoughts. Anti-depressants help people overcome feelings of depression. Lithium is used to control mood swings among manic-depressives.

- Includes:
  Major Tranquilizers
    Thorazine
    Mellaril
    Stelazine
  Anti-depressants
    Elavil
    Sinequan
  Lithium
- Effects:
  reduce hallucinations
  control mood swings

Nicotine

Nicotine is often thought of as a mild stimulant, but it also seems to have some of the relaxing qualities of a low dose of depressants.

- Includes:
  Cigarettes
  Cigars
  Snuff/smokeless tobacco
- Effects:
  increased heart rate and blood pressure
  decreased emotional excitation

Marijuana

Marijuana is often thought of as a relaxing, mild depressant, but it doesn't share all the properties of depressants. It is also sometimes classified as an hallucinogen because, at high doses, it can produce altered perceptions.

- Includes:
  Marijuana
  Hashish
  THC (tetrahydrocannibinol)
- Effects:
  amotivational syndrome
  reddening of eyes
  dry mouth
  increased heart rate
  lowered immunity
  reduced testosterone levels in men

Administration of Drugs

There are four main avenues available to get drugs into the body: inhaling, injecting, oral administration, and through contact with the mucous membranes.

Inhaling gets the drugs into the system quite rapidly. It is the most common method used for nicotine, marijuana, and crack cocaine. Onset of effects is quite rapid because the capillaries in the lungs are quite accessible and allow the drug quick access to the rest of the body. Effects can be even faster than with direct injection into the veins. Blood leaving the lungs travels fairly directly to the brain—in 5 to 8 seconds. Blood from veins must first return to the heart and, therefore, takes 10 to 15 seconds to reach the brain.

Injecting can be done one of three ways. Intravenous (IV) injections are direct entries into a vein. Subcutaneous or skin popping is done into the fatty tissues of the body. Intramuscular injections are done into muscle tissue and,

because of the better blood supply to muscles, are more quickly absorbed than subcutaneous injections.

Oral administration, or through the mouth, is the preferred method for many drugs. It is not necessarily the most effective since it must contend with stomach acids and digestive enzymes before it can be absorbed.

Mucous membranes of the nose are used by those who "snort" cocaine. The mucous membranes have a rich supply of blood and, as a result, offer a fairly rapid mode of entry for drugs.

Intervention and Treatment for Drug Dependency

There is a wide variety of intervention and treatment programs for those having problems with alcohol and/or drug use. There is no single best treatment modality. What works well for one client may not work at all for another. In general, the best rule of thumb is to look for the least costly and least restrictive program that seems to offer the right array of services. If it seems a young person can be treated on an outpatient basis, don't put him/her in a hospital-based program. It will be a waste of money and may prove ineffective for addressing the issues related to that youth's drug abuse.

The program types listed below are not meant to be exhaustive but offer a quick overview of the types of programs available in most communities.

Crisis Lines and Hotlines

- What are they?
  They are telephone call-in services answered by staff persons or trained volunteers. They may advertise themselves as suicide or crisis intervention services, or they may be devoted to serving those with alcohol and drug services. Whatever their focus, staff and volunteers of such services can offer help with immediate problems and can usually refer a caller to other services for more help. Most local lines operate 24 hours a day.
- Who are they for?
  There are for anyone needing someone to talk to immediately, or for anyone trying to find a place to get help.

Outpatient Counseling Programs

- What are they?
  These services are staffed by trained professionals who work with individuals, groups, and/or families. They usually see people one or two times a week for an hour at a time. Some charge a fee, some are free. These programs may include any number of approaches. Some will focus on group or individual counseling, others will concentrate on family work. Most are linked with AA-type, self-help groups. Many offer a

combination of approaches designed to meet the needs of the clients. Some programs require a regular (or random) urine screen of all recovering clients to insure they are remaining drug free.

- Who are they for?
  They are for those who have been using alcohol or drugs for a relatively short period of time or only intermittently (using for several days,then not using for several days), for those who have friends/family nearby who can be supportive, for those whose withdrawal will not be life-threatening.

Residential (Non-Hospital) Programs

- What are they?
  They are live-in programs where those with alcohol and/or drug problems reside for several months at a time. They provide a lot of structure to everyday life and offer regular group and individual counseling.
- Who are they for?
  They are for those who need to get out of the environment they are in, those who need help structuring their lives to avoid alcohol and drug use, and for those who don't have a lot of support from family or friends.

Hospital Programs

- What are they?
  They are in-patient programs within hospital settings. Some are located on designated floors of a regular hospital, others are freestanding programs devoted to the treatment of alcohol and/or drug use.
- Who are they for?
  They are for those who are serious medical risks due to overdosing or for those who are at some physical risk from withdrawal. Most hospital programs also have detoxification units where those who are currently addicted can be safely withdrawn from drugs/alcohol.

Self-Help and AA-Type Programs

- What are they?
  They are groups of people who share a common problem with alcohol and/or drugs. There are groups for users of cocaine, narcotics, and alcohol. Although meetings are always open for individuals of any age, some communities offer groups for specifically for teens. They are run by the group members themselves and focus on providing support and encouragement for members.
- Who are they for?
  They are for anyone who wants or needs support dealing with an addiction to alcohol and/or drugs. Some people use them as their only mode of treatment, some use them along with other treatment, some use them as aftercare when they have been released from a treatment center.

WORKING WITH CULTURALLY DIVERSE COMMUNITIES

African Americans[1]

Alcohol and other drug use is one of the leading health and social problems in African-American communities throughout the United States. Although fewer African-American youth use alcohol and other drugs than do other ethnic groups, the prevalence of this problem remains a cause for special concern within African-American families and communities.

This fact sheet answers questions about alcohol and other drug use among African Americans in the United States. The information provided is based on current research efforts including surveys on trends, studies of the health and social consequences, and analyses of the effectiveness of recent prevention efforts in the African-American community.

The purpose of this publication is to present factual information about alcohol and other drug use in African-American communities and to identify organizations and resources that can help communities and families in creating and expanding prevention programs. Parents, educators, social service providers, community organizers, and healthcare professionals—in short, all people and groups concerned with reducing the use of alcohol and other drugs in African-American communities—are encouraged to use this fact sheet as a tool for developing community prevention programs and activities.

Are African-American youth more likely than other young people to use alcohol or other drugs?

According to recent surveys, African-American youth drink less than white, Hispanic, and Native American youth, and they are more likely to abstain from alcohol (see Table 1). They also have lower levels of drug use (see Table 2). However, the surveys are usually conducted on high school students, which exclude dropouts. It has not been determined whether more African-American students than white students drop out of high school, or whether dropouts are more likely to use alcohol and other drugs.

In the 1988 General Household Survey conducted by the National Institute on Drug Abuse (NIDA), statistics showed that in the 12- to 17-year-old age group,

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1 All material in this section on African-American issues is taken directly from the August, 1990 issue of *The Fact Is: Alcohol and Other Drug Use is a Special Concern for African-American Families and Communities,* published by the Office for Substance Abuse and Prevention, U.S. Department of Health and Human Services.

use of alcohol at least once was reported by 36.6% of African Americans, compared with 47.1% of Hispanics and 53.7% of whites. For drug use, the percentages are smaller but follow the same trend. In the 12- to 17-year-old age group, use of any illicit drug at least once was reported by 18.7% of African Americans, compared with 24.3% of Hispanics and 26% of whites.

The comparatively low rate of alcohol and other drug use among African-American adolescents has been verified by several recent independent surveys in nearly every region of the United States. In general, surveys of youth have consistently shown that fewer African-American adolescents drink at all. Those youth who drink get drunk less often and have lower rates of heavy and problem drinking than whites who drink (6,8,15,18,19,20,28,29).[2]

2 Citations refer to the items in this section under "References," beginning on page 43. They do not refer to items in the "Resources and References" section of the Manual.

Does alcohol and other drug use begin later among African-American youth than among whites?

Yes. Both the general population and school-based surveys report that use of alcohol begins later among African-American youth than among white youth (5,6).

TABLE 1

Percent Reporting Alcohol Use in the Past Month by Age Group and Demographic Characteristics

	Age Group (years)		
Demographic Characteristics	**12-17**	**18-25**	**Total**
Total	25.2	65.3	53.4
Sex			
Male	26.8	74.5	60.6
Female	23.5	56.6	46.7
Race/Ethnicity			
White	27.4	68.8	55.1
Black	15.9	50.0	44.3
Hispanic	25.4	61.4	49.2
Region			
Northeast	30.2	70.8	59.2
North Central	27.9	73.0	55.7
South	21.2	53.2	45.1
West	24.7	74.7	60.3

Source: Compiled and abstracted from National Institute on Drug Abuse, National Household Survey on Drug Abuse: Population Estimates, 1988. Department of Health and Human Services Pub. No. (ADM) 89-1636, 1989, Tables 13-A-B-C-D-E-F-G-H

Is the lower rate of alcohol use found among African-American youth also found among adults?

Yes, particularly among African-American women, who have a high percentage of abstainers. Almost one-third of all African-American women report that they never use alcohol or that they limit use to a few occasions each year. In contrast, a higher percentage of white women drink more often. There are fewer differences in alcohol use between African-American and white men, but African-American men are also more likely to report abstinence than white men (28). However, health problems related to alcohol use, such as cirrhosis of the liver and certain types of cancer, have been found to be more prevalent among African-American men than among white men (9)

TABLE 2

Percent Surveyed Reporting Drug Use, 1988 by Race: U.S. Civilian Non-Institutionalized Population

	White		Black		Hispanic	
	12-17 Years	18-25 Years	12-17 Years	18-25 Years	12-17 Years	18-25 Years
Drug	**Used Past Month**					
Marijuana	6.8	15.7	4.4	15.0	5.2	13.8
Cocaine/Crack	1.3	4.2	-*-	4.3	1.3	6.7
Crack	-*-	-*-	-*-	-*-	-*-	-*-
Inhalants	2.4	2.2	-*-	-*-	1.4	-*-
Hallucinogens	1.1	2.4	-*-	-*-	.5	-*-
Stimulants	1.5	2.6	-*-	-*-	.6	2.5
Tranquilizers	.3	1.2	-*-	-*-	-*-	-*-
Any	10.0	18.0	6.2	16.9	7.3	16.8
	Used Past Year					
Marijuana	13.0	29.2	9.1	23.5	12.8	22.1
Cocaine/Crack	3.2	12.6	1.4	8.1	3.6	12.6
Crack	.7	1.7	-*-	-*-	.9	3.5
Inhalants	4.7	5.2	1.6	-*-	2.4	1.5
Hallucinogens	3.6	6.5	-*-	-*-	1.7	5.1
Stimulants	3.4	6.8	.8	3.5	1.4	5.7
Tranquilzers	1.9	5.5	.6	-*-	-*-	3.8
Any	26.0	33.1	12.1	25.9	16.3	28.7
	Ever Used					
Marijuana	18.2	60.4	13.5	45.3	16.9	42.0
Cocaine/Crack	3.6	21.2	2.1	10.4	4.6	18.7
Crack	.9	3.3	.9	2.8	1.3	5.4
Inhalants	9.9	14.7	4.5	3.3	7.2	7.3
Hallucinogens	4.3	16.2	-*-	3.9	3.3	8.2
Stimulants	5.2	12.9	.8	3.9	2.0	8.5
Tranquilizers	2.5	9.4	.6	-*-	1.2	4.4
Any	26.0	62.5	18.7	47.0	24.3	47.6

*** Low Precisions; no estimates reported.**

Source: National Institute on Drug Abuse, National Household Survey on Drug Abuse: Population Estimates, 1988. Department of Health and Human Services Pub. No. (ADM) 89-1636, 1989.

If African-American youth have lower than average rates of alcohol use, why does alcohol and other drug use appear to be a major problem in African-American communities?

There are four main reasons alcohol and other drug use seem to be particularly problematic in some African-American communities.

1. African-American youth—and youth of other groups—who use alcohol often try other drugs or develop patterns of heavy drinking. For example, one survey found that African-American, female college students are unlikely to drink to intoxication, but an unusually high percentage of those who do also use marijuana (10). Although African Americans are more likely to be abstinent than are other Americans, African-American men who drink are more likely than white drinkers to use marijuana, cocaine, or heroin.
2. African Americans who use alcohol and other drugs experience much higher rates of serious health problems—including cirrhosis the liver and pharyngeal cancer—than do other groups of alcohol and other drug users (see later discussion).
3. According to some analysts, members of the African-American community cannot easily isolate or protect themselves from the indirect effects of alcohol and other drug use. These include family problems, effects on the local economy, and a high crime rate—particularly that of homicide.
4. Some African-American alcoholics and drug addicts encounter unique barriers to successful completion of treatment for addiction problems (see later discussion).

Why do some African-American youth "graduate" from occasional drinking to heavy drinking and use of other drugs?

Teenagers who use alcohol are more likely than those who abstain to increase consumption or to try other drugs (10). Although many researchers and policy-makers believe that African-American youth face greater risks than other teenagers, the scientific evidence does not support this view. In the end, scientists may find that the reasons African-American teenagers begin using alcohol and other drugs may not be much different from the reasons that teenagers of other ethnic groups do.

For example, the relative availability of illegal drugs in the inner city may play a role in drug use among African-American youth. Availability, however, is not the only variable. In one study, researchers found that African-American youth living in Harlem, New York, an area where heroin is inexpensive and accessible, are only slightly more likely to use heroin than are youth living farther from the "street" source of the drug (1).

Some social scientists believe that inner-city youth may be attracted to the "outlaw" nature of the drug-users' culture. According to this view, the use of drugs is less important than the adoption of street values in recruiting African-American

youth into the drug-using lifestyle (23). The search for "sensation" among young people who enjoy taking risks, perhaps as a means of escaping the monotony and hopelessness of poverty, is also cited as a possible source of the attractiveness of drug use to some African-American youth (12).

Other possible explanations for the "graduation" phenomenon include the impact of alcohol advertising targeted at African-American consumers, the wealth displayed by local drug dealers, and the publicity given to alcohol and other drug use among African-American entertainers and sports figures. Such influences may contribute to an environment in which alcohol and other drug use is perceived to be tolerated.

Sometimes family members may play a role in initiation of alcohol or other drug use. Children may imitate the drinking or drug use patterns of a parent, an older brother or sister, or another family member. There is also evidence that a predisposition for the use of alcohol and, possibly, other drugs may be biologically inherited, even when alcohol and other drugs are not used in the household.

What personal health problems related to alcohol or other drug use are widespread among African Americans?

African-American men are 10 times more likely than white men to develop esophageal cancer, which is linked to heavy drinking. Nonwhite men are several times more likely than white men to die of cirrhosis of the liver, an alcohol-related disease; nonwhite women are twice as likely as other women to die of this disease (9). (Often mortality rates are tabulated and reported only as "white" and "nonwhite," making it difficult to ascertain precise rates for African Americans and other minorities.) African Americans may be experiencing high rates of diseases such as esophageal cancer and cirrhosis because they are unable to receive access to timely treatment for their alcohol or other drug dependence. Health problems related to alcohol and other drug use are likely to increase as a user continues to use.

The U.S. Surgeon General reports that the prevalence of cigarette smoking is higher among African Americans, blue-collar workers, and less-educated persons than in the overall population. In particular, 41% of African-American men were smokers in 1987, as compared to 31% of white men. Recent research studies have identified the interaction effects of cigarette smoking with alcohol ingestion to increase the risk of cancer (32).

African Americans have one of the highest infant mortality rates of any group in the United States. In addition, many premature births, infant deaths, and infant diseases are related to alcohol or other drug use by the mother, and/or to the high rate of teen pregnancy. Epidemiological studies have demonstrated a greater susceptibility of African Americans to the harmful effects of prenatal alcohol exposure. Even when the infant of an alcohol- or drug-dependent mother survives, its physical health or mental abilities may be permanently damaged by exposure to alcohol or other drugs before birth.

African-American, intravenous drug users and their sexual partners run a high risk of contracting the Human Immunodeficiency Virus (HIV), which causes Acquired Immune Deficiency Syndrome (AIDS). Needles and other drug apparatus shared by intravenous drug users can be contaminated by this virus. In some areas, over half of all intravenous drug users who have been tested have been exposed to HIV. Of all AIDS cases among women in the United States, the majority are African American or Hispanic. A 1990 study conducted by researchers at the Federal Centers for Disease Control suggests that young African-American women are dying of HIV infection at a rate nine times higher than white women of the same age. In New Jersey alone, the death rate among African-American women was more than 40 deaths per 100,000 persons in the population, compared with a rate of about four per 100,000 for young white women. If such trends continue, the study predicted that by next year AIDS would
become the fifth-ranking cause of death among all women in the childbearing years nationwide. Researchers believe that most became infected either through drug use or through sexual contact with infected intravenous drug users. In some cities, most children with AIDS are young African-American children of infected intravenous drug users.

In addition, mental health problems resulting from drug use are often identified among African-American drug users. Some types of drug use are associated with a high rate of delirium and recurring violence; others can result in long-term brain damage, mental illness, and severe depression.

How does alcohol and other drug use affect African-American communities?

Research has shown that African-American neighborhoods with disproportionately large alcoholic populations demonstrate above average rates of overcrowded housing, juvenile crime, unemployment, and families on welfare (7). The economic, physical, and social environment itself may also encourage greater use of alcohol and other drugs. Thus, drug use and social problems may be interrelated in African-American neighborhoods. The effects of alcohol and other drug use are intensified when other factors exist, such as high unemployment, poverty, poor health care, and poor nutrition.

Does the use of drugs other than alcohol contribute to juvenile delinquency among African-American youth?

Although social scientists believe that more research on this subject is needed, some of their findings challenge popular beliefs about the relationship between juvenile crime and drug use.

For instance, delinquent behavior appears to begin before drug use. In other words, African-American youth tend to use drugs other than alcohol after they form the attitudes and adopt behaviors associated with delinquency (25). The most common crimes of young drug users tend to be nonviolent. These include drug dealing, shoplifting, petty theft, and "con games" (11). A 1990 study conducted in Washington, D.C. found that the vast majority of District residents charged with drug dealing in the late 1980s were African-American males aged 18-29. As many as one out of six African-American males born in 1967 were charged with drug distribution between ages 18 and 20. Two-thirds of those arrested for drug dealing were legitimately employed, earning a median income of $800 per month. Proceeds from drug dealing, for those who sold on a daily basis, averaged $24,000 per year (31).

The relationship between drugs and crime in the African-American community may be changing. Cocaine use, which has increased in some African-American neighborhoods, appears to be associated with a greater propensity to commit crimes (11), whereas PCP is linked to violent behavior. In 1982, less than 12% of all African-American homicides were related to criminal activities such as drug trafficking (26); by 1987, police in one major city identified more than half of the African-American homicides as drug-related. Researchers have pointed out that African Americans who support drug-using lifestyles do so primarily by victimizing members of their own community (3).

Is alcohol a factor in criminal activity among African-American youth?

Yes. The relationship between alcohol use among African-American youth and crime is better documented than the relationship between other drug use and crime. Among African-American youth, those who use alcohol are more likely to engage in delinquent behavior than those who do not drink (4). Alcohol use—rather than use of other drugs—is most decidedly linked to violent crimes in the African-American community.

Among heroin addicts in Harlem, New York, researchers found that alcohol is used more often than any other drug before commission of a crime. In addition, heroin users are more likely to spend the proceeds of crime on alcohol than on any other drug (24).

Such research findings lead social scientists to believe that a reduction of alcohol use in the African-American community may have a greater impact on crime than the reduction of any other form of drug use.

Do African-American youth encounter barriers to effective treatment of alcohol and other drug use problems?

Yes. Low-income, African-American youth—and low-income Americans in general—face economic barriers to treatment for alcohol and other drug use. These include lack of funds or insurance to pay for treatment, long waiting lists for admission to affordable programs, and lack of economic support to sustain them or their families during a typical 28-day, inpatient treatment stay. Low-income, single parents face particularly difficult barriers because of the lack of child-care options, possible loss of custody, and other threats to economic and family security posed by inpatient treatment.

Many communities are responding to these barriers by funding more treatment programs for low-income clients, by supporting outpatient alternatives to hospital stays, by advocating more effective treatment for alcohol and other drug users in correctional facilities, and by addressing the special needs of single parents.

Some analysts believe that African-American clients of alcohol and other drug treatment programs face cultural barriers to successful completion of treatment (13). Authors have suggested that white treatment professionals lack the cultural sensitivity needed to work successfully with African-American clients. Some of the same writers have also described major administrative problems experienced by programs that are designed to serve minority groups (16). There is no conclusive evidence, however, and some research studies of the 1970s suggest that African-American clients of treatment programs tend to be younger, more strongly motivated, and more cooperative than other clients (7).

Can we prevent alcohol and other drug use among African-American youth?

Yes. Long-term education and prevention programs, reinforced by messages in the mass media, have proven to be effective in reducing the incidence of some types of drug use problems among African-American youth (1). More progress can be made when communities and families provide full support to local prevention efforts targeted at minority youth (29).

Does prevention of alcohol and other drug use in the African-American community depend on major changes in economic and social conditions?

No. Positive factors preventing youth alcohol and other drug use already exist in nearly every African-American community. As several authors note, most African-American youth—even in low-income areas—escape from alcohol and

other drug problems (21). Some of the protective factors appear to be remaining in school, strong family bonds, strong religious beliefs, high self-esteem, adequate coping and social skills, and employment (3,14,17).

However, it is possible that reduction of alcohol and other drug use among African-American youth may not occur without major changes in the social and economic environment. Nevertheless, thousands of African-American teenagers can be spared the destructive effects of alcoholism and other drug dependence. Communities must decide not to tolerate alcohol and other drug use by youth and to invest community resources in long-term prevention programs and activities.

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Resources for African-American Programs

Books, Workbooks, Manuals, and Other Written Materials

Alcohol Abuse and Black America
This classic, written by F. Harper in 1976, includes chapters of discussion on the history and contemporary use of alcohol among African Americans. It describes theories of use, comparisons of use between urban and rural African Americans, counselling techniques, and training guidelines for professionals. It also discusses alcohol and its effects on the body, alcohol and crime, and special subpopulations. Availability: Douglass Publishers, Inc., P.O. Box 3270, Alexandria, VA 22302 (Cost $12.95), or check with your local librarian.

Alcohol and Drug Abuse in Black America: A Guide for Community Action
This 24-page booklet describes the status of alcohol and other drug abuse as well as strategies for communities to use in efforts to turn around the problem. The booklet briefly describes the historical legal measures prohibiting African Americans from using alcohol and then encouraging drunkenness during holidays. Also, bootlegging, the failure of social norms to regulate appropriate alcohol use, and the problem of denial of abuse in communities beset by racism and poverty are discussed. Single copy free. Contact the Institute on Black Chemical Abuse, 2614 Nicollet Avenue South, Minneapolis, MN 55408, (612) 871-7878.

Alcohol Use Among U.S. Ethnic Minorities
This research monograph contains five major articles on alcohol use among African Americans, covering epidemiology, drinking patterns, and a comparative analysis. The articles are the result of a 1985 conference sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Findings suggest that race or ethnicity may be less important than sociodemographic characteristics in assessing levels of alcohol consumption. Single copy free. Contact the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852, (301) 468-2600. Ask for NIAAA Research Monograph 18.

Alcoholism in the Black Community

This article, written by Frieda Brown and Joan Tooley, summarizes historical precedents, patterns and practices, developmental issues, prevention and treatment strategies in a readable, short chapter. In: *Alcoholism and Substance Abuse in Special Populations* (Gary W. Lawson and Ann W. Lawson, editors). 1989. $39. Available from Aspen Publishers, Inc. 7201 McKinney Circle, Frederick, MD 21701, (800) 638 8437, or (301) 251-5233.

Black Alcoholism: Toward a Comprehensive Understanding

In this book, the authors present an overview of alcoholism among African Americans through a series of articles. They include discussions of etiology, pertinent research on treatment, problems associated with the prevention of African-American alcoholism, the relationship of misuse of alcohol and alcoholism to mental health and the criminal justice system, and alcohol policy issues. T. Watts and R. Wright, eds. 1983. $32.50. Available from Charles C. Thomas, Publisher, 2600 South First Street, Springfield, IL 62717, (217) 789-8980.

Black Children of Alcoholic and Drug-Addicted Parents and a Model for Working with These Children

Written by Dr. Frances Larry Brisbane, the model described in this booklet was developed with Maxine Womble under the auspices of the National Black Alcoholism Council between 1985 and 1989. The model is designed for African-American children, with particular emphasis on altering those factors that inhibit the use of traditional treatment or participation in groups of children of alcoholics. The 18-page booklet provides many examples for group facilitators. Contact the National Black Alcoholism Council, Inc., 417 S. Dearborn Street, Suite 1000, Chicago, IL 60605, (312) 663-5780.

Black Parenting: Strategies for Training

Written by Dr. Kerby T. Alvy, this book describes the unique context of African-American parenting, compares it with white parenting attitudes and practices, and offers guidelines for effective African-American parenting. Specific strategies for implementing parenting programs in African-American communities are discussed. Contact the Center for the Improvement of Child Caring, 11221 Ventura Boulevard, Suite 103, Studio City, CA 91604, (818) 980-0903.

Development of Cultural-Specific Substance Abuse Prevention Programs for Black and Hispanic Populations: A Guidebook

The Guidebook reviews and evaluates 39 written and audiovisual resources for their cultural relevancy to the needs of urban American and Hispanic populations. Although somewhat dated, the Guidebook is valuable when supplemented with more current materials and information. In its overview, it contains a framework for sociological and cultural factors to be considered In

the evaluation of culture-specific materials. Limited number of copies. $25. Available from the Prevention Resource Center Clearinghouse, 901 South Second Street, Springfield, IL 62704, (217) 525 3456.

Marketing Booze to Blacks

This 54-page book, written by George A. Hacker, Ronald Collins, and Michael Jacobson, analyzes the ways in which African Americans are unique targets of alcohol producers in the United States. This report documents the extent of alcohol problems among African Americans and questions the alcoholic beverage marketers and producers who are "intent upon expanding their sales and profits" through massive advertising campaigns in the African-American community as well as appeals that include scholarship donations and sponsorship of African-American History Month. The authors conclude, "Unquestionably, alcohol producers (white-owned) and their ad agencies (many black-owned) have remained indifferent to the severity of alcohol problems confronting blacks." They add, "Many black civic and philanthropic groups have become addicted to the largesse of alcohol and tobacco producers." Published in 1987 by the Center for Science in the Public Interest (CSPI), the book covers the destructiveness of alcohol in the African-American community; television, magazine, and billboard advertising; celebrity promotions; and recommendations for public action. $4.95, plus $.75 postage. A video production of *Marketing Booze to Blacks* will be available in 1990 from the Institute on Black Chemical Abuse (see below) and the Center for Science in the Public Interest, 1501 16th Street, NW, Washington, DC 20036, (202) 332-9110 (also see separate entry on CSPI). The book is available from CSPI.

"We cannot stagger to freedom"

This article by Denise Herd appears in the *Yearbook of Substance Use and Abuse,* Volume 3 (L. Brill and C. Winick, eds.), published in 1985. It traces the history of African Americans and alcohol in the American temperance and prohibition periods. It concludes that the total upturn in drinking problems among African Americans since the nineteenth century relates to patterns of racial oppression and exploitation stemming from the prohibition era rather than to changes in cultural or psychological norms. She contends that efforts to reduce alcohol problems among African Americans must take into account their general interest in political and socioeconomic betterment. $44.95. Available from Human Sciences Press, 233 Spring Street, New York, NY 10012, (212) 620-8000.

Substance Abuse among Minority Youth: Blacks

This overview and research summary is the fourth in a series by Dr. Gregory Austin. Focusing on adolescent drug abuse and its prevention, the series is part of *Prevention Research Update,* a quarterly awareness service prepared by the Western Center for Drug-Free Schools and Communities. Austin

discusses the implications of new research and also publishes abstracts of the major studies cited. His goal is to help bridge the communications gap between the researcher, the practitioner, and the general population by disseminating research findings in an accessible manner. Single copies are free. Available from the Southwest Regional Educational Laboratory, 4665 Lampson Avenue, Los Alamitos, CA 90720, (213) 598-7661.

Winners, Vol. II and III
This culturally sensitive workbook by Darnell Bell is designed to be part of a comprehensive prevention effort. It encourages racial pride for African Americans and views self-esteem and a healthy self-concept as crucial. The two-volume workbook includes 102 creative writing activities, background information, and a sense of tradition and history through biographies of positive role models. Decision-making skills, feelings validation, and values clarification are also covered. Workbooks directed toward parents and communities are planned to supplement these volumes, which are directed toward youth. Contact Darnell Bell, 1576 E. King Jr. Blvd., Los Angeles, CA 90011, (213) 234-2350.

Organizations

Black Children of Alcoholic and Drug-Addicted Persons (B/COADAP)
This small but expanding organization provides mutual support for African-American men and women who have grown up in households where one or both parents were alcoholic. It operates on a club model and is not a "drop-in" group, though new members are welcome. African-American people wishing to join, establish a new chapter, or acquire further information should call or write Dr. Frances Larry Brisbane, 139 La Bonne Vie Drive West, East Patchogue, NY 11720, (516) 654-2378 or (516) 444-3168, or contact the National Black Alcoholism Council (listed below).

Center for Science in the Public Interest (CSPI)
This national consumer nonprofit advocacy and education organization recently initiated a Minority Health Project. The goal of the Health Project is to improve the health status of minority populations. They aim to build joint health promotion programs with other organizations, conduct research, and improve Federal policies and corporate practices on diet, alcohol, and tobacco. They also produce materials designed to publicize and reduce problems related to nutrition, alcoholic beverages, and cigarettes among African Americans, Hispanics, and other minorities. Contact the Center for Science in the Public Interest, 1501 16th Street NW, Washington, DC 20036, (202) 332-9110.

Cork Institute on Black Alcohol and Other Drug Abuse
Located at the Morehouse School of Medicine in Georgia, the Institute is primarily a training and research program designed to develop culturally specific curricula for alcohol and other drug use programs in medical schools and other public health programs. The Institute is building collections of printed material relating to chemical dependency, treatment, and prevention in the African-American community. The director is Dr. Omowale Amuleru-Marshall. For more information, contact the director at Morehouse School of Medicine, 720 Westview Drive SW, Atlanta, GA 30310, (404) 752-1780.

Institute for the Advanced Study of Black Family Life and Culture, Inc.
This community-based, nonprofit corporation specializes in the areas of scientific, educational, and cultural aspects of family life. The Institute is committed to the reclamation of African-American culture, the reunification of the African-American family, and the revitalization of the African-American community. As an independent "think-tank" that is both a scientific research corporation and a human development/social sciences organization, the Institute is concerned about the presence of drug trafficking and drug-related activities in African-American communities. They have issued a report, "A Clear and Present Danger: The Effects of Drug and Drug Trafficking on the Mental Health of Black Children and Families in Oakland," and other related reports. Request a catalog of materials, including training materials, from the Dissemination Division, Institute for the Advanced Study of Black Family Life and Culture, Inc., P.O. Box 24739, Oakland, CA 94623; (415) 836-3245.

Institute on Black Chemical Abuse (IBCA)
The Institute provides a range of services adapted to the African-American community, including prevention, intervention, drug and alcohol information, aftercare, and training of healthcare professionals. The Institute has an internship program and a resource center. They publish a newsletter. A home-based program for severely dysfunctional African-American families was recently initiated to help youth in trouble remain in the home and avoid institutionalization. Other IBCA programs focus on codependency, family violence, and community education. Training efforts include an IBCA Summer Institute that teaches an African American model of treatment and specific strategies for working with African-American clients, including children of alcoholics. The Institute has recently published a manual, *Developing Chemical Dependency Services for Black People,* which passes along to others details of the IBCA Model and what has been learned about successful programs for the reduction of alcohol and other drug use in the African-American community. Contact Peter Bell, Executive Director, Institute on Black Chemical Abuse, 2614 Nicollet Avenue South, Minneapolis, MN 55408, (612) 871-7878.

Multicultural Training Resource Center (MTRC)
Established in 1984 to provide culturally specific AIDS and alcohol and other drug use prevention service, MTRC's philosophy is based on the idea that prevention is a proactive process. It promotes the empowerment of people, families, and communities. MTRC provides information, technical assistance, and training. In addition, it develops materials to educate service providers. MTRC believes that a multicultural approach is necessary because "drug use patterns vary widely between and within cultural groups, illustrating the inappropriateness of any generic prevention model." Contact Ford Hatamiya, Multicultural Training Resource Center, 1540 Market Street, Suite 320, San Francisco, CA 94102, (415) 861-2142.

National Black Alcoholism Council (NBAC)
This organization has over 1,000 members in 20 chapters throughout the United States who work to raise the consciousness of the African-American community about the impact of alcohol and other drug use and to represent African-American concerns in national organizations. NBAC also publishes a semiannual newsletter, sponsors or cosponsors workshops and conferences (including the annual Black Alcoholism Institute), and supervises a national speakers' bureau. Contact NBAC, 417 Dearborn Street, Chicago, IL 60605, (312) 6635780.

National Clearinghouse for Alcohol and Drug Information (NCADI)
This Federal resource center for alcohol and other drug information is sponsored by the Office for Substance Abuse Prevention of the U.S. Department of Health and Human Services. NCADI distributes print and audiovisual materials and offers limited quantities free of charge. The Regional Alcohol and Drug Awareness Resource (RADAR) Network comprises resource centers in almost every State. NCADI will refer you to one in your area. NCADI also offers database services and, for a $15 annual handling fee, a subscription to *Prevention Pipeline,* the bimonthly news service of the alcohol and other drugs field. *Pipeline* is a forum, a news bulletin, and a research alert. Write for a free publication catalog. Contact NCADI, P.O. Box 2345, Rockville, MD 20852, (301) 468-2600 or 1 800-SAY-NO-TO (DRUGS).

OSAP Community Prevention Assistance Services
Operated under contract to the Office for Substance Abuse Prevention (OSAP), this program provides conference planning, referral services, and assistance to national, state, and local organizations. Its purpose is to help plan and conduct activities designed to prevent alcohol and other drug problems. The goal of the program is to identify the most promising prevention strategies, based on up-to-date research, and to help organizations in carrying out strategies that are appropriate for their target audiences. Contact Elaine Brady Rogers, TA Systems Manager, 8201 Greensboro Drive, Suite 500, McLean, Virginia 22102, (703) 556-0212.

Office of Minority Health Resource Center (OMH-RC)
This office brings health information and services to minorities and serves as a repository for health education materials. A computer database on African Americans, Hispanics, Native Americans, and Asian Americans/Pacific Islanders focuses on their six health priority areas: cancer, diabetes, heart disease and stroke, infant mortality, alcohol and other drug use, homicide, suicide, and unintentional injuries. They publish a newsletter, "Closing the Gap," and resource lists, including one on health materials for African Americans. Call the Resource Center at 1-800 444-6472 or (301) 587-1938, or write OMH-RC at P.O. Box 37337, Washington, DC 20013-7337.

People of Color Against AIDS Network (POCAAN)
POCAAN is a multiracial, educational coalition that provides training and works with existing AIDS programs on issues pertaining to people of color. It develops materials on AIDS education, such as comic books and pamphlets, for minority groups. Their pamphlet, "AIDS in the African-American Community," summarizes the important facts. Their poster series, "Famous Last Words," strikes at myths such as "AIDS is a white man's disease." POCAAN is made up of individuals and organizations. For more information call P. Catlin Fullwood, Director, 105 14th Ave., Suite 2D, Seattle, WA 98122, (206) 322-7061 .

Grants and Other Funding Opportunities

Prevention Demonstration Grants Targeting Youth at High Risk
The Office for Substance Abuse Prevention (OSAP) encourages applicants from community-based organizations to develop and test innovative models of prevention and treatment of alcohol and other drug use among high-risk youth, especially those that test primary prevention and early intervention models. Demonstration grants will be awarded to those community-based programs that develop and evaluate approaches addressing the following objectives:

- to decrease the incidence and prevalence of alcohol and other drug use among high-risk youth
- to reduce the risk factors for using alcohol and other drugs as they impact on individual high-risk youth, and on the environments in which high-risk youths and their families function
- to increase resiliency and protective factors within high-risk youth and within high-risk families and communities to reduce the likelihood that youths will use alcohol and other drugs
- to coordinate and integrate the nonuse messages and activities of the many human service systems and other social influences affecting high-risk youth into comprehensive, multilevel prevention communities

- to increase the availability and accessibility of prevention, treatment, and rehabilitation services for these populations
- to reduce the severity of impairment and promote the rehabilitation of youths already using alcohol and other drugs.

Model Projects for Pregnant and Postpartum Women and Their Infants
In a joint effort, OSAP and the Office of Maternal and Child Health are funding service demonstration grant projects that focus on prevention, education, and treatment. Successful applicants will propose service projects that include promising models or innovative approaches toward the prevention of fetal exposure to alcohol and other drugs as well as projects that coordinate existing community services with new or expanded services. OSAP seeks the development of a continuum of therapeutic programs that integrate comprehensive supportive services, which include health, education, voluntary, and other relevant, community-based organizations and service systems. Proposed programs should also increase the availability of services, decrease alcohol and other drug use, and reduce the effects of maternal alcohol and other drug use on infants. Proposed projects should address one or more of the following objectives:

- promote the involvement and coordinated participation of multiple organizations in the delivery of comprehensive services for alcohol and other drug-using pregnant and postpartum women and their infants
- increase the availability and accessibility of prevention, early intervention, and treatment services for these populations
- decrease the incidence and prevalence of alcohol and other drug use among pregnant and postpartum women
- improve the birth outcomes of women who used alcohol and other drugs during pregnancy and to decrease the incidence of infants affected by maternal alcohol and other drug use
- reduce the severity of impairment among children born to women who use alcohol and other drugs.

Films and Videotapes

A Thin Line: Recognizing Cultural Difference and Working with Black Chemically Dependent Clients
Produced by the Institute on Black Chemical Abuse, this film focuses on training counselors to work more effectively with African-American clients in treatment. 1989. $175, plus $3 Shipping and handling. Contact David Grant or Sandy Vadnais, Institute on Black Chemical Abuse, 2614 Nicollet Avenue South, Minneapolis, MN 55408, (612) 871-7878.

Long Road Home

This film portrays the development of a drinking problem in a young African-American family man named Willie. The origins of his drinking and its impact on his family life are described, as are the improvements resulting from his successful treatment. Intended mainly for rural populations, the film attempts to show the special character and problems of rural African-American culture. 20 minutes. 1977. $250, sale. $30, rental. Contact Elizabeth Peters at the South Carolina Commission on Alcohol and Drug Abuse, 3700 Forest Drive, Suite 300, Columbia, SC 29204, (803) 734-9559.

Straight Talk

This first-person story describes drug addiction as a desperate attempt to feel like the "king of the mountain." Former addict Roland Abner's "straight talk" describes what life is like when centered on drugs. He states emphatically that the wretchedness of addiction is not exclusive to the poor or downtrodden. "Narcotics is an equal opportunity destroyer," he says. For teenage and adult audiences and healthcare professionals. 24 minutes. Film, $475; video $395. Rental, $75. AIMS Media, 6901 Woodley Avenue, Van Nuys, CA 9140-4878, (800) 367-2467

Highlights: Expert Advisory Roundtable on African-American Issues, Morehouse College of Medicine, August 31- September 1, 1989

A panel of African-American experts, psychologists, healthcare professionals, and policymakers explores issues relevant to African-American families and communities in a videotape produced by the Office for Substance Abuse Prevention. This video is available as part of the audiovisual, free-loan program operated by the National Clearinghouse for Alcohol and Drug Information. For more information, call NCADI at 1(800)SAY-NO-TO (DRUGS), or write NCADI, P.O. Box 2345, Rockville, MD 20852.

Hispanics/Latinos[3]

The old adage, "Basically, people are all the same," may hold true. But when it comes to cultural backgrounds, people differ greatly. Therefore, all information intended to reach people of a particular culture must pass through cultural filters before it is received and acted upon. As information goes through these filters, it is colored by social norms, values, traditions, and history.

This filtering process is essential for information aimed at the Hispanics/Latinos, a diverse group of people of different origins living throughout the United States.

In working with this heterogeneous population, professionals and volunteers in prevention and treatment of alcohol and other drug problems must understand the Hispanic/Latino cultural filter, which influences comprehension and, ultimately, behavior. People who are sensitive to the values and traditions of the Hispanic/Latino community are more likely to overcome any barriers to prevention and intervention/treatment that may exist.

The original concept for developing this fact sheet was to give non-Hispanic and Hispanic/Latino professionals and volunteers an overview of some of the issues involved in working with this minority segment of the U.S. population. However, as information was gathered from various Hispanic/Latino leaders, it became increasingly clear that the transcultural understanding discussed in this fact sheet makes it recommended reading for a much wider audience.

Specifically, it will be well worth your time to read this fact sheet if you are a school teacher, Sunday school teacher, day-care worker, or student who has a Hispanic/Latino in the same class or program. This publication also will interest those who may have a Hispanic/Latino mate, co-worker, employer, neighbor, teacher, or friend.

Since cultural norms and ethnic nuances are usually not the focus of scientific research, much of the following information has been obtained directly from representatives of the Hispanic/Latino population who hold leadership positions in prevention. Their approaches to the sensitive issues that have implications for the prevention of alcohol and other drug problems will prove invaluable.

The general nature of this fact sheet has made it necessary to insert rather sweeping statements about cultural patterns, attitudes, and behaviors. Readers should recognize that there are always exceptions in dealing with any large population, and should use this document as a general guide for cultural exploration within the specific Hispanic/Latino subgroups with which they work.

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3 All material in this section on Hispanic/Latino issues is taken directly from the September, 1990 issue of *The Fact Is: Reaching Hispanic/Latino Americans Requires Cultural Sensitivity,* published by the Office for Substance Abuse and Prevention, U.S. Department of Health and Human Services

This fact sheet begins with a question-and-answer section that highlights information for anyone who wants to develop a sensitivity to the values and traditions influencing Hispanics/Latinos in the United States. The second section comprises a list of organizations, agencies, and projects promoting the prevention of alcohol and other drug use among Hispanics/Latinos. This listing includes brief descriptions, addresses, and telephone numbers. The third and final part of this fact sheet supplies a list of resources—audiovisuals, tapes, posters, and publications—for and about the Hispanic/Latino population. Addresses and ordering information are also provided.

Pertinent questions and answers about prevention for Hispanics/Latinos follow:

Who are Hispanics/Latinos?

The Hispanic/Latino population in the United States includes Mexican Americans, Puerto Ricans, and Cuban Americans; recent immigrants from El Salvador, Nicaragua, and the Dominican Republic; and immigrants from other Central and South American countries.The American public tends to regard Spanish-speaking people in the United States as one group because of their common language. However, the people from each of the countries are quite different and do not regard themselves as a homogeneous group. Therefore, program planners can avoid resentment and unintentional insult by taking time to become familiar with the Hispanic/Latino conversational styles and rules of etiquette.

How are the various Hispanic/Latino subgroups different?

Here is an exercise that will help Americans understand the frustration Hispanics/Latinos feel when they are grouped together. Imagine living in a foreign country where English-speaking peoples from all origins and regions are assumed to be the same. In that foreign country, all the native citizens assume that English-speaking people from the northern part of the United States share the same habits, customs, traditions, and values as people from the deep South—as well as people from the English-speaking countries of Ireland, Jamaica, England, India, Canada, Australia, and Scotland. Imagine being in a waiting room with a person from Ireland, and being told, "You two must have so much in common to chat about, we'll just leave you alone for a while." Imagine also, the irritation of a harried New Yorker being associated with a Jamaican, as he is told, "We didn't worry about being so late for our meeting with you because we knew that you people don't worry about time. Why, we heard that most of you don't even wear watches!"

Each Hispanic/Latino subgroup has brought from its native country a unique ethnic background—history, culture, and religious beliefs—that has evolved and endured over centuries. The people in each Hispanic/Latino subgroup have different needs and experiences that have shaped their attitudes toward health, family, and alcohol and other drug use. Lack of awareness and sensitivity to this fact can build formidable barriers in reaching Hispanic/Latino audiences.

How many Hispanics/Latinos are there In the United States?

According to the latest Census Bureau statistics, Hispanics/Latinos in the continental United States number nearly 20 million (not counting Puerto Rico's three million inhabitants). Approximately 62% are Mexican Americans; 13%, mainland Puerto Ricans; 5%, Cuban Americans; 12%, predominantly Central and South Americans; and 8%, of other Hispanic origins. These statistics do not include undocumented laborers and illegal immigrants in the United States.

Hispanics/Latinos constitute the second largest minority, after African Americans/blacks. They represent 8% of the total U.S. population and are expected to become the largest minority group early in the next century. The Hispanics/Latinos are increasing three times faster than the non-Hispanic U.S. population and may account for one-quarter of the nation's growth during the next 20 years alone. Besides being the fastest-growing minority, they are also the youngest, with a median age of 25. About 40% are under 21. As a young minority, a large proportion of Hispanics/Latinos are at risk for alcohol and other drug problems.

Are Hispanics/Latinos underserved in prevention and intervention/treatment of alcohol and other drug problems?

Relatively high proportions of Hispanics/Latinos in areas like New Mexico, Texas, California, Arizona, and New York have used more drug treatment services than other segments of the population. Collectively, however, they have received only 12% of total services.

Hispanics/Latinos are difficult to serve for many reasons, but primarily because of language and cultural barriers. Unless program planners or counselors have been raised in a Hispanic/Latino community, they must learn Spanish and become sensitive to the myriad ethnic nuances that can make or break interpersonal relationships. These professionals should take into account that, although language tends to make the various subgroups more homogeneous, other important aspects differ for each subgroup—such as education, income level, health status, and degree of assimilation to mainstream American culture.

Another reason causing neglect of the Hispanic/Latino population is that money is often scarce. Roughly 26% of all Hispanic families in the United States live below the poverty line. A great number of them do not have the basic insurance to cover treatment.

Finally, as a rule, Hispanics/Latinos are very proud—and very private—when it comes to family problems. It is very difficult for any family of any culture to stop enabling a member having problems with alcohol or other drugs and seek external help. For Hispanic/Latino families, revealing secrets and looking for answers outside the strong family unit goes against the grain of their culture.

Alcoholism has long been called **the family disease,** ***and many experts have said that*** **prevention begins at home.** ***What are some of the Hispanic/Latino family traditions and values that have implications for prevention?***

Traditionally, Hispanics/Latinos place utmost importance on family relationships. The family may include neighbors, owners of the small neighborhood grocery store down the street, godparents, grandparents, and close friends. The Hispanic/Latino family is group oriented, even in decision making. All members may have a say in adopting family rules and solving family problems. Thus, the family is often very much extended.

The ideal Hispanic/Latino family works as a team, with their focus on the good of the whole or the good of another. The emphasis on family encourages members toward interdependence, rather than independence. This natural support has implications in promoting prevention programs and in developing printed materials. For example, prevention programs may attract more attendance if advertisements appeal to individual members' commitment to the common good of the family. A print publication might start out with the appeal, "It will benefit your (husband, children, sister) if you learn more about alcohol and other drug problems."

How can family strength work in prevention and intervention/treatment for its children?

The strength of the family is valuable in coping with the stress that results from conflicts between mainstream American culture and Hispanic/Latino culture. Such conflicts, usually involving parents and children, may arise from negative messages like racism, low income, unemployment, poor school performance, peer value differences, and acculturation or adjustment to American culture. The family must counteract these negative messages in order to protect its members.

Traditional Hispanic/Latino family unity is important in dealing with conflicts between the value systems of parents and that of their children's peers. These acculturation problems may interplay with alcohol and other drug use.

What are other positive and negative implications for prevention among Hispanics/Latinos?

Many Hispanic/Latino families have the common bond of "cariño," a very deep sense of unqualified caring and protection. All family members are considered equal and unconditionally accepted. They are valued simply because they are, not because of what they have done or not done. A member is not usually expelled from the family as a result of unacceptable actions or attitudes.

However, cariño and protection can sometimes backfire in that some families are accepting of a family member even when he or she exhibits undesirable behavior. It may be harder for a Hispanic/Latino family to say to one of its members, "I will not accept/tolerate your use of drugs/alcohol." Such acceptance or tolerance, therefore, can interfere with setting effective limits on the members' behavior.

As a result of family cariño, Hispanic/Latino youth are more likely to live at home with their families longer. As one Hispanic/Latino expert put it, "Why leave home when you are so cherished?" It may be possible that cariño, when combined with strong family sanctions against alcohol and other drug use, may cause youth at home—under the loving-yet-firm supervision of the extended family—to be more likely to abstain. Because of later onset of use, the less likely one is to develop alcohol and other drug problems, living at home longer may be of further benefit. Cariño, strengthened by positive role modeling and firm family rules, may constitute a secret weapon for Hispanic/Latino parents in the war against drugs.

What is known about alcohol use among Hispanic/Latino youth?

First, it is important to note that obtaining significant information about the rates of alcohol and other drug use for Hispanic/Latino youth is difficult. Because of the practice of grouping all Hispanic/Latino subgroups into one category called Hispanic or Latino, major intergroup variances in use rates are lost—one group's low use rate often cancels out another's high use rate. Also, adolescent Hispanic/Latino females in many subgroups appear to have quite different use rates from those of adolescent males. Most studies do not separate the data by gender and, when the rates are averaged, the figures tend to be misleading.

Researching the Hispanic/Latino population involves special problems. Many Hispanic/Latino youth cannot communicate well in English; others may mistrust "official questions" because of their U.S. immigration status. Such problems have limited the amount of useful data that could be obtained about alcohol and other drug use.

However, despite such research constraints, a general picture may be drawn. It appears that the alcohol use rate of Hispanic/Latino youth is similar to that of Anglo youth. But it also appears that the Hispanic/Latino youth who do drink, drink larger quantities as they grow older, subsequently causing more drinking problems.

Hispanic/Latino boys are more likely to begin drinking at a younger age and to drink more than girls. More Hispanic/Latino girls are learning to drink, so that the gender gap may shrink in the future.

In regard to alcohol use within the principal Hispanic/Latino subgroups, a major survey indicates that alcohol has been used by the age of 18 by 53% of Cuban Americans living in Dade County, Florida; 50% of Mexican Americans in the Southwest; and 46% of Puerto Ricans in the New York City area.

What about use of other drugs by Hispanic/Latino youth?

As with alcohol, the data are sparse for other drug use by young Hispanics/Latinos. It appears that for most other drugs the level of use is comparable to, or just below, that of Anglos. Also, as with alcohol, Hispanic/Latino youth are more likely than Anglos to experience problems related to drug use.

Nearly 3.7 million, or 18.5%, of Hispanics/Latinos have used an illicit drug at least once in their lifetimes, with the levels and patterns of use by youth varying in the different subgroups. Mexican-American and Puerto Rican youth are more likely to have used marijuana, inhalants, and sedatives than Cuban Americans. Puerto Rican youth, on the other hand, are nearly twice as likely as the other two groups to have used cocaine.

Hispanic/Latino youth aged 12 to 17 are more likely than Anglo or African-American/black youth to have used cocaine at least once during their lifetimes. As with alcohol, there are important gender differences in the use of other drugs. Hispanic/Latino boys generally have higher use rates than girls, but this gap between genders, which is smaller among youth than among the Hispanic/Latino adult population, keeps narrowing.

Drug abuse among Hispanic/Latino youth has been found to be significantly associated with the high rate of school dropouts. In some localities, dropouts are estimated to have reached 45%, and at times as high as 85%. High school dropouts are more likely to use illicit drugs than high school graduates.

Program planners and care providers also should take into account traumas, such as being initiated into a different academic and cultural system and the experience of discrimination. Many Hispanic/Latino youth consider schools a second home and are accustomed to having relationships based on friendship with and respect for their teachers.

What role does gender play in Hispanic/Latino culture and drug use?

Machismo among Hispanics/Latinos is culturally expected conduct for men. Generally, men are expected to be dominant, strong, protective, brave, authoritarian, and good fathers. Although several of these cultural characteristics are positive, the ideal of machismo for many Hispanic/Latino males also includes drinking large quantities of alcohol without showing ill effects—"holding your liquor like a man." Even though heavy drinking is often considered masculine by Hispanics/Latinos, alcoholism is usually viewed as a weakness in moral character when it entails a loss of self-control. Thus, the man with machismo is encouraged to walk a shaky—if not impossible—line between alcohol consumption and alcoholism.

Conversely, Hispanic/Latino females are expected either to abstain or to drink very lightly if they drink at all. The cultural expectation for Hispanic/Latino females has been for them to act like virtuous ladies—to submit to the men in their lives and to serve their families selflessly. While Hispanic/Latino women

are generally assumed to be somewhat subservient, they are very much respected and cherished in the family structure.

Traditionally, drinking has been seen as a behavior verging on impropriety. Since women are supposed to be very moral, it is not surprising that Hispanic/Latino women are more likely than their Anglo and African-American/black counterparts to abstain from alcohol use. Of the Hispanic/Latino women who drink, the vast majority are light drinkers, regardless of their subgroup. This situation is changing as Hispanic/Latino women undergo acculturation or adjustment to U.S. society and achieve more years of education.

What are the Hispanic/Latino family's attitudes toward drinking?

For a Hispanic/Latino family, having an alcoholic son or father is embarrassing. But to have a mother or sister with an alcohol or other drug problem is a burning shame, because of the female ideal of purity, discipline, and self-sacrifice in body, mind, and spirit. Because of these strong cultural sanctions, it is possible that problems with alcohol and other drugs among Hispanic/Latino women may be seriously underreported. As a result, Hispanic/Latino women may be reluctant to seek help for alcohol or other drug problems, or even to admit they have such problems to researchers trying to gather anonymous data.

What implications do these traditional family and gender roles have for prevention and intervention/treatment?

Before the initiation of any prevention program, it is important to establish good rapport by listening to each subgroup's worries, needs, and questions that are part of their transcultural adaptation process. Also, a brief report on American ways of reacting, behaving, and their attitudes about everyday life will inevitably help to restructure their own beliefs, fears, and even prejudices about American people.

Though research has not been completed on this topic, some general conclusions may be drawn:

- Prevention and intervention efforts, to be more effective, should be targeted to include the entire family, and if possible, its religious leaders. Counselors should work toward strengthening the bonds among family members and toward helping women, men, and children to interact better within the family. Prevention efforts will be most effective if counselors reinforce family units and value them as a whole.
- Prevention programs are needed to help Hispanic/Latino fathers recognize how important their roles or examples are to their sons' self-images regarding alcohol and other drug use. Since being a good father is a part of machismo, it is essential that the men become full partners in parenting. Mothers must be encouraged to learn strategies for drawing their mates into family interaction at home. Counselors should work to strengthen parents' self-esteem, as it may have suffered during the acculturation process.

- Educational efforts to reduce the shame associated with reaching out for help with alcohol and other drug problems could benefit the entire Hispanic/Latino community—especially the female members. Programs aimed at this goal are needed for mothers and their daughters.
- In developing print materials, the emphasis should be on the family as a unit. In special cases, it may be desirable to tailor separate versions for males and females. For organizations that have the capability, separate focus groups for each gender could be helpful in determining the need for gender-specific materials.
- Stress reduction and recreational programs should be emphasized to help Hispanic/Latino families adjust to the mainstream American culture without abandoning their own.
- Reaching Hispanic/Latino audiences through Spanish-speaking, community-level organizations and leaders can greatly simplify group interaction. Hispanic/Latino families thus will realize they are not alone in their struggle to prevent alcohol and other drug abuse among their members.
- Teachers, counselors, and other helpers must be aware of the effects that traditional gender roles play in prevention and intervention/treatment. They must study the special role perceptions of the subgroups they will be working with in order to build bridges of sensitivity and awareness.

Can the strong ties that many Hispanics/ Latinos have to traditional religions help prevention planners reach their target population?

Recognition of the role of religion in the Hispanic/Latino community is crucial for program planners. By tying programs to the church in some fashion, planners may be more easily accepted and trusted within the community.

There are several ways to make the connection. Some program planners work closely with religious authorities, having them actively participate. Various religious authorities may bless a program or offer rooms to programs such as Alcoholics Anonymous or Narcotics Anonymous which often are held in meeting halls. Meetings or counseling sessions might also include prayer.

The Catholic, Jewish, Pentecostal, Seventh Day Adventist, Jehovah's Witnesses, and other religious institutions are on the front line of prevention for both Hispanic/Latino and Anglo youth. It appears that youth who are regularly involved in religious institutions are less likely to use alcohol and other drugs. When prevention program planners, parents, and churches or other religious organizations join forces to convey a clear, firm *no-use-by-youth* message, and when they back up their message with drug-free alterative activities, they make an army that is hard to defeat.

What role do nontraditional religions play In Hispanic/Latino communities?

Nontraditional religions are much more powerful than most people think, especially in Puerto Rican and Cuban-American communities. There are two popular nontraditional religions that draw heavily from the traditions of the Catholic church, mixing the belief in saints with psychic powers and the spirit world. Espiritismo is more popular among Puerto Ricans, while Santeria is more likely to be found in Cuban American communities.

Espiritismo and Santeria share some similarities: believers regularly follow spiritual leaders (espiritistas and santeros/as), who are supposedly born with or develop psychic powers and knowledge of spells, charms, and incantations.

Although Espiritismo and Santeria recognize saints and other tenets of Catholicism, the church does not recognize either religion. In the Christian faith, such "witchcraft" (brujeria) is believed to be an abomination to God.

There are many implications here for prevention program planners:

- Many followers of Espiritismo and Santeria are poor, uneducated, and at high risk for alcohol and other drug problems. In addition to this very significant target audience for prevention, there are wealthy, well-educated followers of these nontraditional religions. Community program planners would do well not to make socioeconomic judgments about the two without exploring the demographics or specific characteristics of the particular audience being targeted.
- Just as it is helpful to get the approval of religious authorities, it is important to get the approval of local espiritistas or santeros/as. They may tell their followers that the prevention program is good and should be supported—or they can destroy a community effort by withholding approval.
- Program planners who decide to seek the approval of religious authorities, espiritistas, and santeros, must remember that these three groups do not mix. Do not attempt to hold joint meetings, seminars, or fundraisers.
- If the population targeted for a prevention program is heavily Catholic, Jewish, Protestant, espiritista, or santera, make sure that learning about the particular religion is a part of the planning process. Insulting religious beliefs because of ignorance may be fatal for a community-based program.

Can music and folk expressions be a good way of reaching targeted Hispanic/Latino youth?

Most of the subgroups, particularly Hispanic/Latino youth in America, have their own folk and music expressions which give them a sense of belonging and the chance to practice activities they would have experienced in their countries. These activities also allow them to release negative feelings and to restructure a sense of cultural and ethnic identity that can be useful tools in developing prevention programs. An example of the impact that music and folk celebrations have

occurred with the 1990 Mexican Independence Party in Los Angeles organized by UNIVISION, which drew national recognition.

What is involved in translating print materials, public service announcements for radio, or dubbing videos in Spanish?

First, literal translation does not work. English and Spanish cannot be matched word for word, although many program planners are unaware of this fact. Also, a literal translation from English into Spanish can result in stilted words and stiff phrases that do not flow with the richness of the Spanish language. In addition, dialects of one of the subgroups (e.g., the Mexican Americans) may not be understood by other subgroups (e.g., the Puerto Ricans and Salvadoreans). Because Spanish usage patterns in the United States comprise at least seven Hispanic/Latino subgroups, it is advisable to adapt the text to a neutral, universal, simple, and grammatically correct language that can be understood by all or most subgroups.

Some people developing materials for Hispanic/Latino audiences use another method which offers a quality control check, known as "back translation." A translator will rewrite the text in Spanish, retaining the general content rather than the exact wording. Next, to ensure that the text carries the intended message, another writer will translate the text back into English.

Once a publication has been adapted to comprehensive Spanish, it must undergo testing with Hispanic/Latino focus groups (a sample of the target audience) to make sure the text does not unintentionally contain inappropriate language or, worse, expressions that might be insulting to a particular subgroup.

All the above underscores the importance of exploring the preferences, traditions, and cultural nuances of the particular subgroup targeted for prevention efforts.

What is the Office for Substance Abuse Prevention doing for the Hispanic community?

Through a partnership with the Coalition of Hispanic Health and Human Services Organizations (COSSMHO), OSAP has created a series of bilingual publications targeted to Hispanic/Latino parents, teachers, and children. Supplementary materials were produced to complement this national effort. Colorful posters and stickers were produced featuring Hispanic celebrities, including Linda Ronstadt, Gloria Estefan, Edward James Olmos, and other popular stars. The series emphasizes family solidarity, values, and practices of the Hispanic/Latino culture. In addition, these materials convey essential information on alcohol and other drugs.

This initiative includes outreach to Hispanic newspaper editors throughout the Nation, special packages of information for and about the Hispanic community, as well as information about the services available from OSAP and NCADI that have been developed. OSAP encourages newspaper editors to use NCADI's database services in writing news stories, and hopes that their readers will have the opportunity to learn more about NCADI's free materials and services.

In 1987 OSAP and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) launched a long-term "Stay Smart! Don't Start!" program aimed at youth aged 8-12. In the Fall of 1990, OSAP is launching the Dile Que No! "Piensalo" (Stay Smart! Don't Start!) campaign, aimed at Hispanic/Latino youth and those who influence their knowledge, attitudes, and behavior. The purpose of the campaign is to reach Hispanic/Latino preteens with "Stay Smart! Don't Start!" (alcohol and other drugs) messages through intermediaries, including the media, as a way to prevent alcohol and other drug problems.

In addition, OSAP has available several bilingual items, particularly the publication series, the Drug-Free Community Series which includes *What You Can Do About Drug Use in America (Que Puede Hacer Usted Para Prevenir el Uso de Drogas en America) and What Your Community Can Do About Drug Use in America (Que Puede Hacer su Comunidad Respecto al Uso de Drogas en America).* Also in the NCADI Inventory are *The 10 Steps Quick List (Guia Practica: 10 Pasos Que Ayudaran a Su Hijo a Decir NO)* for parents, *My Baby...Strong and Healthy (Mi Hijo... Fuerte y Sano), Taking Care of My Baby (Cuidando a Mis Hijos),* and *A Newcomer's Guide to Prevention (Una Guia Nueva para la Prevencion).*

Many videotapes available from OSAP's free, audiovisual loan program are targeted to Hispanic and Latino audiences. Also available are new, glossy, full-color posters of Hispanic role models, including Menudo, Edward James Olmos, and Gloria Estefan.

Grants and Other Funding Opportunities

OSAP offers a number of grants to communities and organizations interested in developing prevention programs. Each of the following funding programs has a Hispanic/Latino component.

Prevention Demonstration Grants Targeting Youth at High Risk

OSAP encourages applicants from community-based organizations to develop and test innovative models of prevention and treatment of alcohol and other drug use among high-risk youth, especially those that test primary prevention and early intervention models. Demonstration grants will be awarded to those community-based programs that develop and evaluate approaches addressing the following objectives:

- to decrease the incidence and prevalence of alcohol and other drug use among high-risk youth
- to reduce the risk factors for using alcohol and other drugs as they impact on individual high-risk youth, and on the environments in which high-risk youths and their families function
- to increase resiliency and protective factors in high-risk youth and within high-risk families and communities to reduce the likelihood that youths will use alcohol and other drugs
- to coordinate and integrate the non-use messages and activities of the many human service systems and other social influences affecting high-risk youth into comprehensive, multilevel prevention communities
- to increase the availability and accessibility of prevention, treatment, and rehabilitation services for these populations
- to reduce the severity of impairment and promote the rehabilitation of youths already using alcohol and other drugs.

For information on special Hispanic/Latino project grants, contact Dr. Stephen Gardner at (301) 443-0353.

Model Projects for Pregnant and Postpartum Women and Their Infants

In a joint effort, OSAP and the Office of Maternal and Child Health are funding service demonstration grant projects that focus on prevention, education, and treatment. Successful applicants will propose service projects that include promising models or innovative approaches toward the prevention of fetal exposure to alcohol and other drugs as well as projects that coordinate existing community services with new or expanded services. OSAP seeks the development of a continuum of therapeutic programs that integrate comprehensive supportive services, which include health, education, voluntary, and other relevant community-based organizations and service systems. Proposed programs should also increase the availability of services, decrease alcohol and other drug use, and reduce the effects of maternal alcohol and other drug use on infants. Proposed projects should address one or more of the following objectives:

- to promote the involvement and coordinated participation of multiple organizations in the delivery of comprehensive services for alcohol- and other drug-using pregnant and postpartum women and their infants
- to increase the availability and accessibility of prevention, early intervention, and treatment services for these populations
- to decrease the incidence and prevalence of alcohol and other drug use among pregnant and postpartum women
- to improve the birth outcomes of women who used alcohol and other drugs during pregnancy and to decrease the incidence of infants affected by maternal alcohol and other drug use

- to reduce the severity of impairment among children born to women who use alcohol and other drugs.

For more information on special Hispanic/Latino program grants, contact Marilyn Rice at (301) 443-4560.

Community Partnership Grants

OSAP has launched a Community Partnership Program to fight alcohol and other drug problems through community-based coalitions of public agencies and private organizations. The program is designed to demonstrate the effectiveness of providing long-term, multidisciplinary resources to assist communities in planning and implementing coordinated, comprehensive, communitywide prevention systems. The initiative will support an estimated 150 demonstration grants ranging in value from $100,000 to $500,000. To be eligible, a partnership or coalition must ordinarily consist of at least seven organizations or agencies. Support may be requested for a period of up to five years.

For more information on special Hispanic/Latino demonstration grants, contact David Robbins at (301) 443-9438.

Resources

Organizations, Agencies, and Projects

National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20852, 1-800-SAY-NO-TO (DRUGS)

NCADI supplies information and services to anyone with questions or concerns about alcohol and other drug abuse problems. Special target groups for NCADI are community leaders, people working with youth, parents, health and human service providers, and persons with alcohol- and other drug-related problems. NCADI distributes publications to a wide range of audiences. Attractive, readable pamphlets, booklets, posters, fact sheets, directories, and other useful products answer questions, offer new prevention ideas, and help groups to conduct community programs. NCADI is bilingual and some publications are available in Spanish.

National Coalition of Hispanic Health and Human Services Organizations (COSSMHO), Alcohol/Other Drug Programs, 1030 15th St., NW, Suite 1053, Washington, DC 20005, (202) 371-2100

This national Hispanic organization links community-based agencies involved in the prevention of alcohol and other drug abuse and AIDS. COSSMHO services Mexican-American, Puerto Rican, Cuban-American, and other Hispanic/Latino youth and their families. It publishes newsletters, educational and training material, support material, promotes media campaigns, and provides prevention/intervention training, materials, and technical assistance.

The Office of Minority Health Resource Center, Director of Information and Programs, P.O. Box 37337, Washington, DC 20013-7337, (800) 444-6472 (toll free).
Established by the U.S. Department of Health and Human Services' Office of Minority Health, the center provides health professionals with information aimed at minorities, including Hispanic/Latino youth and families. It maintains listings of prevention programs operating at the national, state, and community levels.

National Hispanic Family Against Drug Abuse, Rodolfo Balli Sanchez, Chairman and CEO, 1500 Farragut Street, NW, Washington, DC 20005, (202) 723-7227
This office supplies information about Hispanic families and runs annual conferences on drug abuse issues. It makes available a biannual newsletter (free of charge) and other reports and materials.

OSAP Community Prevention Assistance Services, Elaine Brady Rogers, Technical Assistance Systems Manager, 8201 Greensboro Drive, Suite 600, McLean, VA 22102, (703) 556-0212
This group's staff and regional consultants assist organizations and communities in developing, enhancing, or expanding efforts to prevent alcohol and other drug abuse. Its goal is to identify the most promising prevention initiatives and to assist organizations in implementing strategies aimed at prevention. Professional conference support and referrals are provided.

Center for Health Policy Development, Inc. (CHPD), Juan H. Flores, Executive Director, 2300 West Commerce, Suite 304, San Antonio, TX 78207, (512) 226-9743
CHPD is a Hispanic/Latino health resource and research organization. Its purpose is to promote and facilitate the health improvement of Hispanics/Latinos by providing technical assistance on AIDS and drug abuse prevention to community organizations serving Hispanics/Latinos.

National Council on Crime and Delinquency (NCCD), S.I. Newhouse Center, Orlando Rodriguez, East Coast Office Director, 15 Washington St., 4th Floor, Newark, NJ 07102, (201) 643-5805
NCCD is a criminal justice policy research organization that promotes alternatives to incarceration and delinquency as well as drug abuse prevention as a way of reducing imprisonment. It specializes in research and the causes of crime and other problem behaviors, with emphasis on providing school and job opportunities in its city communities. NCCD publishes booklets on Hispanics/Latinos.

Spanish Catholic Center (Centro Catolico), Washington Archdiocese, Father Julio Alvarez-Garcia, Executive Director, Mary Lynn Mercado, Social Services Coordinator, 2700 27th St., NW, Washington, DC 20008, (202) 483-1520, 8:30 AM to 5 PM, Monday-Friday.
This is a national center that refers (Spanish-English) Hispanic/Latino parents to counselors and social services and assists Hispanic/Latino families seeking, help for alcohol and other drug problems. The center also offers parental guidance on other issues. A brochure is available on the services, which include operation of Hispanic youth recreational and educational centers, teaching English as a second language and other subjects.
NCADI can provide a national listing of Diocesan Directors for Hispanic Affairs when requested.

Directory of Community Minority Organizations, NHLBI Minority Program Information Center, 4733 Bethesda Avenue, Suite 530, Bethesda, Maryland 20814, (301) 951 -3260
This minority organizations' directory has been created to support the dissemination of health information to minorities. NCADI has contacted the following Hispanic/Latino organizations, and has been authorized to include them in this fact sheet:

Hispanic Health Council
Dr. Candida Flores
96-98 Cedar Street
Hartford, CT 06106
(203) 527-0856

Latino Caucus of the APHA
c/o Jose D. Arron, M.A.
Midwest Hispanic AIDS Coalition
1725 W. North Avenue, Room 4C
Chicago, IL 60622
(312) 772-8195
The purpose of the Midwest Hispanic AIDS Coalition is to prevent HIV infection and AIDS among Hispanics living in the Midwest.

Mujeres Latinas en Acciòn
c/o Susan Grettenberger
1823 West 17th Street
Chicago, IL 60608
(312) 226-1544

Hispanos en Minnesota
c/o Ricardo Flores
179 East Robae Street
Saint Paul, MN 55107
(612) 227-0831

Illinois Prevention Resource Center
c/o Steven Guerra
407 South Dearborn, Suite1125
Chicago, IL 60605
(312) 663-3737

Selected Videos, Audio Visuals, and other Materials

Padre Kino Videolibrary, 5230 East Farness, Suite 106, Tucson, AR 85712, (800) 922-8638
The Videolibrary has 17 videos on alcohol and other drug abuse available in Spanish. These videos can be purchased or rented.

Narcotics Education, Inc., 12501 Old Columbia Pike, Silver Spring, MD 20904-1608, (202) 680-6740, (800) 548-8700 (toll-free orders).
This company specializes in audiovisuals, T-shirts, posters, books, and pamphlets dealing with drug prevention and health (including AIDS) for all ages. All materials (some in Spanish) are listed in a free catalog, "The Health •Connection," which can be obtained by calling the toll-free number.

The National PTA, 700 North Rush Street, Chicago, IL 60611-2571, (312) 787-0977
The National Association Congress of Parents and Teachers publishes kits, guides, flyers, and booklets (some in Spanish) about alcohol and drug education for parents and teachers. A catalog and order forms can be obtained by mail.

Selected Readings

Alcoholism and Substance Abuse in Special Populations written by Gary W. Lawson and Ann W. Lawson. Rockville, MD: Aspen Publications. 370 pp., 1989.
This book examines the special issues involved in the causes, treatment, and prevention of alcoholism and other types of drug abuse among specific populations. The groups have been chosen either because of their high risk for abuse problems in relation to the general population or because of a lack of resources available to provide up-to-date, appropriate information. Existing

literature is reviewed; information about demographics, drug abuse rates, and kinds of drugs abused by a particular population (including Hispanics/ Latinos) is included.

Choices and Consequences: What To Do When a Teenager Uses Alcohol/Drugs by D. Schaefer, Johnson Institute Books, 1987.
Discusses teenage alcohol and drug use and ways to intervene.

Focus on Family and Chemical Dependency. Los Niños: Intervention Efforts with Mexican-American Families by S. Rodriguez Andrews, 1984.
This book outlines an alcoholism primary prevention program within the Mexican-American community. It contends that careful, culture-sensitive planning in the context of the strengths of the Mexican-American family results in greater parent participation as well as the identification of both young and adult children of alcoholics.

Lo Que Todo el Mundo Debe Saber Sobre el Alcohol ("What Everyone Must Know About Alcohol") Pamphlet, 1980.
Channing L. Bete Co., Inc., 200 State Road, South Deerfield, MA 01371, (413) 665-7611.
This pamphlet uses a question-and-answer format to present the reader with information about alcohol. Discusses why people drink, what constitutes alcohol abuse, and how alcohol affects the drinker.

Breakthroughs in Family Therapy with Drug-Abusing and Problem Youth by Jose Szapocznik and William M. Kurtines, et. al., Springer Publishing Company, 1989
New family therapy techniques for working with families of drug-abusing and problem youth are presented in this book. The primary aim of the book is to make recent breakthroughs in the understanding of family functioning and treatment available to the practitioner. The authors have developed concepts and techniques called Brief Strategic Family Therapy (BSFT), which they apply to family assessment, treatment, engaging resistant families, working with one person, and research.

Family Effectiveness Training: An Intervention to Prevent Drug Abuse and Problem Behaviors in Hispanic Adolescents by J. Szapocznik, A. Rio, A. Perez-Vidal, D. Santisteban, and W. M. Kurtines, Hispanic Journal of Behavioral Sciences, 11(1):4-27, 1 989
Evidence is presented for the efficacy of Family Effectiveness Training (FET). FET is a prevention/intervention modality designed for use with Hispanic families of preadolescents who are at risk for future drug abuse. Seventy-nine Hispanic families meeting the criteria for at-risk families made up the subject population. Families were randomly assigned to either an FET

condition or to Minimum Contact Control Condition. Families in the FET condition showed significantly greater improvement than did control families on measures of structural family functioning, problem behaviors as reported by parents, and on a self-administered measure of child self-concept. FET impact was generally maintained at six-month followup.

Native Americans[4]

In the United States there are approximately 1.4 million Native Americans, who belong to many tribes and Alaska Native groups. Over 500 tribes are recognized by the Bureau of Indian Affairs (Federal Register, 1986). Native Americans are one of the fastest growing population groups in this country.

There are vast cultural differences among Native American groups. In fact, differences between some Native American groups (such as Alaska Natives and Cherokee Indians) are as great as the differences between Native Americans and the dominant American culture. (As a matter of policy, the Office for Substance Abuse Prevention refers to these groups consistently as Native Americans.) In addition, although Native Americans originally resided in less populated areas, today they live in large cities and on reservations (or other rural areas) in about equal numbers.

Among Native Americans, alcohol and other drug abuse results in large numbers of preventable deaths, injuries, and illnesses, especially among adolescents and young adults. Most tribes consider alcohol and other drug problems to be their most important health issue.

This fact sheet answers questions and provides resources for volunteers and professionals, such as teachers and prevention program planners, working with or preparing to work in Native American communities.

What type of drug is most commonly used among Native American young people?

Inhalants are among the drugs most frequently used by the Native American youth who use drugs. Although there is variation among tribes, Native American youth overall are much more likely to try inhalants than non-Native American youth. And more Native American than non-Native youth continue to use inhalants on a regular basis. Between 22% and 44% of different samples of Native American youth report having used inhalants. That compares with approximately 9.2% of a national sample of all youth between 12 and 17 who report ever having used inhalants. In the past, boys abused inhalants more than girls, but recent data show that, at the eighth-grade-level, boys and girls are using inhalants at nearly the same rate. In fact, the level for girls may be slightly higher. Reports also suggest that young adolescents are likely to continue using inhalants while adding other drugs.

Another commonly used drug is smokeless tobacco (snuff). In a Washington State survey of 1,180 sixth, ninth, and eleventh graders, it was found that 34% of

4 All material in this section on Native American Issues is taken directly from the September, 1989 issue of *The Fact Is: Alcohol and Other Drug Problems Are a Major Concern in Native American Communities,* published by the Office for Substance Abuse and Prevention, U.S. Department of Health and Human Services.

male Native Americans, 24% of female Native Americans, 20% of male non-Natives, and 4% of female non-Natives are current users of smokeless tobacco products.

References:[5] Beauvais and Oetting, 1988; Mail, 1987; National Institute on Drug Abuse, 1988; Oetting, Goldstein, Mason, Beauvais, Edwards, and Goldstein, 1978; Okwumabua and Duryea, 1987; Hall and Dexter, 1988.

What are the dangers of inhalant use?

Inhalant use can lead to irreversible brain damage, coma, and death. Even single-time users run the risk of sudden or accidental death. Other serious effects include depression, leukemia, anemia, liver damage, and immune system damage. Violent outbursts can accompany heavy chronic inhalant use. Many youth who continue to use inhalants over a long period become antisocial and withdrawn—warning signs that differ from those of the youthful alcohol users, who tend to drink in groups.

References: Berlin, 1986; Young, 1987.

Why do they do it? How old are the users?

Inhalants are probably the easiest mind-altering drugs to obtain. In addition, they are cheap, and they reportedly offer a "high" of short duration, so users may experience several "highs" in a short time period. A few Native American children as young as 6 years old report using inhalants, although the usual age to start using appears to be about 10 years old. While many users stop using inhalants in their teens, often shifting to use of other drugs, there are many other users who have continued into their thirties.

References: Burd, Shea, and Knull, 1987; Okwumabua and Duryea, 1987; Young, 1987.

What can be done about the use of inhalants and other drugs by Native American youth?

There are no easy answers. On an individual basis, Native American youth often feel hopeless and helpless, and they see no alternatives to alcohol and other drug use. To discourage use, parents, teachers, counselors, and others working with youth should keep glue, paint, aerosols, and gasoline locked up. They must also be aware of the signs of inhalant use; in all areas and groups, the best indicator of whether an adolescent is or will become a user is the use pattern of friends.

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5 References refer to the items in this section under "References," beginning on page 81. They do not refer to items in the "Resources and References" section of the manual

Since inhalants, snuff, and marijuana are often the gateway drugs for Native American youth, sometimes even preceding the first drink, it is important to begin prevention programs at young ages. Prevention programs need to be soundly planned, maintained over time, evaluated, and accompanied by economic and social improvement in realms other than health. See the Resource Section at the end of this fact sheet for more information on prevention.

References: Austin, 1989; Oetting and Beauvais, 1989.

What other drugs are commonly used by young Native Americans?

Marijuana, stimulants, tranquilizers, hallucinogens, and cocaine are used by some young Native Americans. Marijuana, in particular, is used frequently. Native American youth are more likely than white youth to use marijuana and to begin using it at younger ages. In fact, Indian youth have higher rates of drug use than non-Indian youth for nearly all drugs.

According to national survey data, approximately 24% of all American youth between 12 and 17 report having used marijuana at least once. In comparison, 46% of Native American youth in grades 7 to 12 report having tried marijuana at least once, according to data collected from several major reservations across the United States. About half of these youth had tried it by age 13. In a study of 7th to 12th graders between 1975 and 1983, it was found that 53% of Native American youth could be classified as "at risk" in their drug involvement, compared with 35% of non-Native American youth. Indian Health Service records over a three-year period indicate that almost two-thirds of all alcohol program clients also used marijuana.

References: Beauvais and LaBoueff, 1985; Beauvais, Oetting, and Edwards, 1985; Beauvais, Oetting, Wolf, and Edwards, 1989; Mail, 1987; National Institute on Drug Abuse, 1988, p. 32; Young, 1988.

Does this mean that few young Native Americans drink alcohol?

Unfortunately, no. Drinking is prevalent among adolescents and even younger Native American children. In a recent survey, 82% of Native American 7th to 12th graders living on several major reservations across the United States reported that they had used alcohol at least once. This compares with 66% of non-Native American youths sampled at the same time. Also, alcohol use appears to be heavy among Native American youth; reports of blacking out or being extremely intoxicated are common.

Reference: Beauvais and LaBoueff, 1985.

Is it true that most Native American people have trouble with alcohol? Are Native Americans more prone to alcoholism?

Native Americans and Native American tribes vary greatly with regard to alcohol use. Overall, a higher percentage of Native American adults never drink, compared to non-Native Americans. However, among Native American people who do drink, a large percentage drink heavily. And Native Americans have the highest prevalence of alcohol problems among all U.S. population groups. It appears that those Native Americans who do drink tend to drink heavily and to have problems associated with alcohol abuse. Some experts report that Native Americans run twice the risk of becoming alcoholic. But it is important to remember that many Native Americans drink very little, and many others have made the safe and healthy choice not to drink at all.

References: Jones-Saumty, Hochhyos, Dru, and Zeiner, 1983; National Institute on Alcohol Abuse and Alcoholism, 1978.

Do Native Americans suffer from poorer health or die from alcohol -and other drug-related problems at rates higher than the general U.S. population?

Yes, current information indicates that Native Americans have poorer health and are dying at far higher rates than the U.S. population. It has been thought that alcohol abuse plays a role in the poorer health of Native Americans, but few studies offer uncontested evidence. The Indian Health Service reports that hospital discharge rates during 1981 for Native Americans with alcohol-related diagnoses were three times higher than for people in the United States as a whole. A 1987 survey of 49 hospitals revealed that one out of four Native American inpatients was hospitalized for an alcohol-related condition. The Indian Health Service began collecting other drug-related health information in 1988, and reports on those relationships is forthcoming.

Although the age-adjusted alcoholism death rate for Native Americans has decreased in the last 10 years, the rate in 1985 was still 4.2 times the rate for the United States. The age-adjusted cirrhosis mortality rate for Native Americans in 1986 was 26.4, as compared to 9.2 for the general population. In addition, motor vehicle crashes and other accidents are among the leading causes of death for Native American people. Native American death rates for both is over two times the U.S. rate. Causes include death from drowning, fire and smoke, excessive cold, and firearms. While alcohol abuse is thought to be a major factor in motor vehicle crashes and other accidents, there has been little research into the extent of alcohol involvement.

References: Indian Health Service, 1988; Indian Health Service, 1989, Martin and Helgerson, 1987; National Institute on Alcohol Abuse and Alcoholism, 1987.

Are suicide rates high for Native Americans? Are these deaths related to alcohol and other drug use?

Suicide rates for Native Americans are higher than for other United States population groups, and current information indicates that alcohol and other drug use is an important factor. Over 80% of suicides among Native Americans appear to involve alcohol, according to several regional and tribal studies. This compares to other studies that show that 20 to 37% of suicides in general involve alcohol; however, research has not been reported for directly comparable population groups residing in the same parts of the country.

The highest suicide rates among Native Americans are among young men ages 15-34, whereas among all American men, the highest rates are among older men. Among Native Americans, as in the dominant society, more men complete their suicide attempts, while more women attempt suicide. Methods cited include firearms, hanging, and overdoses. The motive in most cases appeared to be "to change an important relationship or deal with an unacceptable interpersonal relationship." Violent death, suicide, homicide, accident, and alcoholism rates for Alaska Natives are higher than for Alaska non-Natives, Native Americans, and the U.S. population as a whole. It is important to note that there are significant differences in tribal rates, and there may be a tendency for suicide to be overreported on reservations and underreported elsewhere in the United States.

References: Berman, 1979; Conrad and Kahn. 1974; Indian Health Service, 1988; Kraus and Buffler, 1979; May, 1987; Shore, 1972; Shore, 1975.

Is the difference in rates of problem drinking and alcoholism due to a genetic difference?

Some studies report that Native Americans metabolize alcohol more rapidly than whites, and, therefore, they may be especially susceptible to alcoholism due to genetic or biological factors. However, little is known about the biological aspects of alcoholism in Native Americans. And, based on what we know, differences in rates of alcoholism cannot be tied to genetic or biological factors. Although many people believe biological factors play a role, the nature of that role is not known.

However, we do know that there appears to be a certain sensitivity to alcohol that is shared by Asians/Asian Americans and Native Americans of both North and South America. This sensitivity is shown in a rapid rushing of blood to the face when drinking alcohol. Called "facial flushing," this physical response is related to a genetic difference in the key enzyme involved in the oxidation (that is, breakdown) of acetaldehyde, which is the primary metabolic product when alcohol breaks down in the human body. It continues to puzzle researchers, then, that alcoholism is relatively uncommon among Asians but more common in Native Americans.

Adding to the puzzle, comparisons of metabolism of alcohol between white Americans and Native Americans frequently show no significant differences. The

data are so inconsistent that no firm hypothesis has been offered. A recent review points out that, in general, much greater genetic variation is found within ethnic groups; about 90% of genetic variability is within racial groups. And, in fact, Native Americans vary greatly among themselves in regard to alcohol sensitivity.

References: Bennion and Li, 1976; Farris and Jones 1978a, 1978b; Heath, 1989; LeLand, 1976; Reed, 1985; Reed et al., 1976; Rex, Bosron, Smialek, and Li, 1985; Zeiner, Paredes, and Cowden, 1976.

Are Indian people more prone to difficulties with alcohol because of social and cultural factors?

Some day researchers will probably discover that it is a complex mix of genetic, social, and cultural factors that leads to alcoholism in all peoples, not just Native American people. Nowhere are the answers to questions like this more uncertain than in the case of alcoholism. However, more researchers argue that sociocultural factors, rather than biological or psychological factors, underlie some Native Americans' abuse of alcohol. Theories that attempt to explain the role of environmental factors include the following:

1. *Stake-in-Society Theory*—that people with a stake in the dominant society, such as steady employment, will be less likely to become alcoholic.
2. *Defiance-Rebel Theory*—that alcohol gives many Native Americans a feeling of power, which they so often lack when dealing with modern society. Drinking has been viewed as defiance against white authority and against prohibition on the reservations.
3. *Invasion Reaction Theory*—that alcohol abuse among Native Americans is a reaction to the loss of tradition and culture. Native Americans abuse alcohol in mourning the loss of historical tradition and in reaction to the demands to integrate with mainstream culture.
4. *Social Learning Theory*—that the group drinking style (including drinking until supplies are depleted) that characterizes much Native American drinking actually was learned from the frontiersmen settling the West.
5. *Bicultural Theory*—that Native American children who are "bicultural" show the lowest use of alcohol and other drugs among Native American youth. Bicultural means identifying with both the traditional Native American culture and with the non-Native American world. It does not mean a blend of these cultures so much as it means an ability to adapt to each, depending on the circumstance.
6. *Chemical Warfare Theory*—that alcohol was used against Native American people as one of the first "chemical warfare" weapons deployed in the New World. It was used to cloud judgment and to cheat people in trade relations, particularly in the fur trade and land negotiations. Because of its addicting nature, Native American people continued to use and abuse it for the release that it provided.
7. *Socioeconomic Theory*—that poverty and the adversity of Native American life contribute to stress and provide an environment where

alcohol and other drug use can thrive. These background circumstances include social and economic disorganization resulting from the rapid, forced change in culture experienced by Native Americans. This has, in turn, resulted in economic dependency on the government as well as emotional depression in individuals.

Some experts warn that one must be careful with "cultural" interpretations of susceptibility to alcohol and other drug use and abuse. There is no evidence that there is anything inherent in Native American culture that leads to alcohol and other drug abuse. In fact, strong identification with one's culture may be a protective factor.

The "bottom line," of course, is that excessive drinking is destructive, no matter what the reasons for it. Some people, both Native American and white, who view themselves as being in a high-risk group for addiction problems choose to leave both alcohol and other drugs alone. Many Native American elders view abstinence as essential in the task of restoring tribal cultural values and traditions. Because times and cultures change, the reasons for excessive drinking may also be changing.

References: Austin, 1989; Beauvais and LaBoueff, 1985; Berlin, 1986; Ferguson, 1976; Honigmann and Honigmann, 1968; Jilek, 1981; Jilek-Aall, 1974; Lurie, 1971; Oetting, 1989; Oetting and 8eauvais, 1989; Westermeyer and Baker, 1986; Weisner, Weibel-Orlando, and Long, 1984.

What about Native American women? Do they have trouble with alcohol and other drugs?

In general, more men than women drink in all population groups. And more Native American males than Native American females drink. Still, Native American women have high rates of alcoholism and alcohol-related health problems.

For instance, one indicator of the rate of alcoholism in a population is the liver cirrhosis death rate. Native American women are dying of cirrhosis at high rates and frequently at young ages. The 1975 national cirrhosis death rate per 100,000 Native American women was more than six times the rate for white women. The 1975 national cirrhosis death rate for Native American women age 15 to 34 was 36 times the white rate. Cirrhosis mortality within the State of Minnesota was examined for the time period 1970 through 1981, and it was found that Native American women had the highest death rates of all groups (whites, blacks, Native Americans), and they had the lowest average age at death (44.5 years).

Also Native American women who use drugs begin using them at a young age, often at 10 or 11 years. Marijuana, stimulants, and inhalants are as popular with many young women as with young men.

References: Leland, 1984; Johnson, 1980; Hutchison, 1983.

Do many Native American women give birth to infants with fetal alcohol effects?

Virtually all tribes have fertility rates twice as high as the general U.S. rate. There is also a high rate of alcoholism among Native Americans. Therefore, it is not surprising that the rate of alcohol-related birth defects is higher among Native Americans, although there are marked intertribal differences in the rates of incidence.

Drinking alcohol during pregnancy can be dangerous to a developing baby. Alcohol passes freely from the mother's body to the baby's body and affects the developing systems of the unborn baby. The more a pregnant mother drinks, the greater the chances of harm to the unborn child. Children whose mothers drink frequently or heavily during pregnancy may be born with fetal alcohol syndrome (FAS). There are certain characteristics that constitute a diagnosis of FAS. If a child shows one or more signs in each of the following three categories, a diagnosis of FAS is likely: (1) prenatal or postnatal growth retardation; (2) central nervous system involvement, such as mental retardation or delayed development; and (3) characteristic cranial and facial abnormalities.

There are many more children who have been affected by alcohol in utero but who lack the full set of characteristics that define FAS. These babies may be at higher risk because they are too small at birth, or they may have some but not all of the features of FAS. These problems, when attributable to alcohol, are called fetal alcohol effects (FAE).

References: May et al., 1983; May, 1986.

What can be done about alcohol- and other drug-related birth defects?

Many organizations, tribes, and states have developed fetal alcohol syndrome prevention programs. See the Resource Section of this fact sheet for names and organizations to contact. Currently the Indian Health Service is increasing community awareness about the dangers of maternal alcohol and other drug use and encouraging clinical staff to emphasize screening and education to prevent these birth defects.

Such prevention programs can serve a twofold purpose. In addition to preventing alcohol- and other drug-related birth defects in newborns, the programs can be a starting point for talking in general about alcohol and other drugs in Native American communities.

According to Dr. Phil May of the University of New Mexico, Native Americans are eager for more information on how they can assure that their children are born healthy.

"In my experience spanning five years and over 400 presentations by myself and three colleagues, it has become obvious that the topic of fetal alcohol syndrome is universally well received among Indian groups," Dr. May says. "Our experience has shown that Indian groups of all ages are interested, motivated, and stimulated to action by this topic. It is a much more effective starting point to ongoing educa-

tion and exchange of information about alcohol and drugs than any other specific topic."

Reference: May, 1986

What about alcohol and other drug abuse treatment for Native Americans? We've heard that the usual treatment methods do not work for Native Americans.

It is not known which treatment approaches are most effective with different patients. According to Frank L. Iber of the Veterans Administration, it appears that the most effective programs are "run by persons of the same background who, by lifetime experiences, have the kind of understanding that is difficult to teach."

Unfortunately, there is a sense of futility felt by many Native American communities—as well as individuals—that alcoholism is inevitable and possibly untreatable. Therefore, one of the main messages of the Office for Substance Abuse Prevention (OSAP) is that alcohol and other drug problems are both preventable and treatable. OSAP also focuses attention on attempts that Native American people are making to free themselves of afflictions due to alcohol. There is a resurgence of interest in traditional culture in Native American country today, and this has resulted in treatment approaches that involve traditional healers, such as medicine men and women. See the Resource Section at the end of this fact sheet for additional information on treatment.

References: Beauvais and LaBoueff, 1985; Hall, 1986; Iber, 1986; Moss, Edwards, Edwards, Janzen, and Howell, 1985.

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Resources for Additional Information and Program Materials

Organizations, Agencies, and Projects

Four Worlds Development Project

Often used as a model by Native American prevention programs both in the United States and Canada, the Four Worlds Project is a multi-cultural, multi-racial team that delivers technical support and training to Native communities across North America in the areas of alcohol and other drug abuse prevention, community development, community crisis intervention, educational transformation, curriculum development, community-based research, health promotion, and program evaluation and management. The Four Worlds Project's approach to a community is as co-learners—it expects to be educated by the people it works with in the best ways to promote the self-development of those people. Based in the Department of Education at the University of Lethbridge, the Four Worlds Project has become an internationally recognized leader in the field of alcohol and other drug abuse prevention because of its unique focus on the importance of culture.

The project is based on the theory that the root causes of alcoholism and drug abuse, such as economic dependency, the loss of culture, and a prevailing climate of racism must be addressed in an effective prevention program. This can only happen when prevention efforts are linked to a learning and development process that includes individuals, families, communities, and the resource agencies serving them. A publications list is available from the Four Worlds Development Project, University of Lethbridge, Faculty of Education, 4401 University Drive, Lethbridge, Alberta, Canada T1K 3M4, (403) 328 4343.

Indian Health Service

In 1985 the Indian Health Service set a goal to lower the rate of alcohol abuse and alcoholism among American Indians and Alaska natives to a level at or below that of the general population in the United States within 15-year period. The Indian Health Service has started new programs as a means of achieving this goal. In general, the Alcohol Program Branch helps American Indian and Alaska Native groups start their own prevention and treatment programs. A newsletter, Linkages, is published to ensure communication between programs. The Indian Health Service is an agency within the U.S. Public Health Service of the Federal Government. Contact Dr. Thomas Burns or Russell D. Mason, Indian Health Service, Alcohol Programs, Room 6A53, 5600 Fishers Lane, Rockville, MD 20857, (301) 443-4297 for more information.

Minnesota Indian Women's Resource Center

Founded in 1984, the Minnesota Indian Women's Resource Center conducts workshops and staff training, provides program technical assistance, and serves as a clearinghouse for print and nonprint materials on Native American alcohol and other drug abuse and related issues. Specifically, the Center provides training in alcohol and other drug abuse for professionals and others who are working with Native American people. The Center operates a treatment and assessment program and offers child care and parenting groups. A resource list and 20 different lists of books for additional reading on particular topics, such as suicide, are available. Contact the Resource Center at 1900 Chicago Avenue, Attn: Shelley McIntire, Minneapolis, MN 55401, (612) 872-8211.

National Association for Native American Children of Alcoholics (NANACOA)

This group was formed in 1988 to provide a national network for Native American children of alcoholics. It also serves as a clearinghouse for information on children of alcoholics for the Native American community. It provides training and support for Native Americans on services needed by children of alcoholics, and it advocates for services at all policy levels affecting Native American communities. In addition, NANACOA publishes a regular networking newspaper for Native American children of alcoholics. A training manual for beginning NANACOA support groups in the community is available for $20. Contact NANACOA at 611 12th Avenue, South, Suite 200, Seattle, WA 98144, (206) 324-9360.

National Native American AIDS Prevention Center

According to the Center, Native American AIDS cases have been reported in 25 states and one Pacific Trust territory. The Center is combating AIDS with the "only known vaccine ... education." The Center is collecting Native American-specific AIDS education materials, developing a culturally relevant AIDS curriculum, and conducting AIDS prevention workshops. Other services include a clearinghouse for information, a Native American AIDS information hotline, and an on-line computer bulletin board for Native American healthcare providers. Training and technical assistance are provided to tribes, urban communities, and healthcare workers. A newsletter called

Seasons and a resource list are available. Contact the National Native American AIDS Prevention Center, Ron Rowell, Director, 6239 College Avenue, Suite 201, Oakland, CA 94618, (415) 658-2051 or the branch office of the National Native American AIDS Prevention Center, Attn: Lori K. Beaulieu, 1315 East 24th Street, Room 315, Minneapolis, MN 55404, (612) 721-3568 or call (800) 283-AIDS.

National Prevention Implementation Program
Operated under contract to the Office for Substance Abuse Prevention, this program provides professional conference planning, referral services, and limited financial support for speakers. Staff can suggest speakers and aid organizations in their networking. The goal of the program is to identify the most promising prevention strategies, based on the most up-to-date research, and assist organizations in implementing strategies appropriate for their own population. Services are provided by program staff and regional consultants. National, State, and local organizations that meet certain criteria are eligible for the support. Contact Elaine Brady Rogers, TA Systems Manager, 8201 Greensboro Drive, Suite 500, McLean, VA 22102, (703) 556-0212.

OSAP Multicultural Substance Abuse Prevention Project
Under contract to the Office for Substance Abuse Prevention (OSAP), this project offers on-site technical assistance and regional training workshops to multicultural groups (Asian/ Pacific Islanders, blacks, Hispanics, and Native Americans) throughout the country. The aim is to raise the level of awareness in multicultural populations about the harmful effects and negative consequences of alcohol and other drug use and to encourage multicultural organizations and organizations serving multicultural populations to include alcohol and other drug use prevention as an organizational program emphasis. The project is located at 8401 Colesville Road. You may write to Box 350A, Silver Spring, MD 20910, or call (800) 822-0047. In Maryland, call (301) 589-3272.

Films, Videos, and Slide Tape Presentations

Her Giveaway: A Spiritual Journey with AIDS
Profiling Carol LaFavor, an Ojibway woman with AIDS who was recently honored by the National Minority AIDS Conference for her work in AIDS education, this 25-minute, professionally produced video combines a strong sense of Native American tradition along with a narration that outlines clinical issues of AIDS. Carol was featured in the national AIDS mailout from the U.S. Surgeon General. The video is available at different costs, depending on the requesting organization. For philanthropic, governmental, educational organizations, and libraries, the cost is $362 (or $107 rental) . For Native American organizations and community-based nonprofit organizations, the cost is $92 (or $47 rental). Contact Minneapolis Indian Health Board, 1315 East 24th Street, Minneapolis, MN 55404, (612)721-7425.

The Honour of All

Made by the Alkali Lake Indian band in British Columbia, Canada, this prize-winning documentary tells the story of how one person can make a difference. When one woman member of this band decided to give up drinking, she was alone on a reserve where the alcoholism rate was close to 100 percent of the adult population. She was joined by her husband, and for the first two years Andy and Phyllis Chelsea were the only sober members of the Alkali Lake Indian band. Eventually, Andy was elected chief of the band, and visible changes began to occur. Over a 14-year period, an entire sober community began to take form. Part I is a 56-minute docudrama that recreates the story. Part II is a one-hour video documentary outlining the community development process that occurred at Alkali Lake as the community moved from alcoholism to sobriety. Part III is a 26-minute production expanding the theme of community development and personal growth. The entire series is available in VHS and Beta formats for $400 Canadian or $300 U.S. dollars (includes shipping and handling). Orders should be made prepaid or by purchase order to Phil Lucas Productions, Inc., P.O. Box 1218, Issaquah, WA 98027, (206) 392-9482. Or order directly from the Alkali Lake Indian Band, Box 4479, Williams Lake, British Columbia, Canada V2G 2V5, (604) 440-5611.

Jonathan

This 19-minute slide-tape presentation on inhalant use is based on a the story of a White Mountain Apache boy whose sniffing of chemicals resulted in brain damage and severely impaired speech. Jonathan tells how he got hooked and his feelings of sadness and anger at being unable to walk, talk, or care for himself: "old and ready to die at only 18." Actual photographs are used in this presentation of 57 slides. $85. Available from The White Mountain Apache Health Education Project, P.O. Box 1210, Whiteriver, AZ 85951, (602) 338-4953.

Poundmaker's Lodge: A Healing Place

Made by the Native American filmmaker, Alanis Obomsawin, for the National Film Board of Canada this 30-minute documentary relates the personal stories of four Native American people with alcohol and other drug problems and describes the treatment approach used at Poundmaker's Lodge. This approach is multitribal, incorporating elements of traditional culture in the therapeutic process. One of the oldest and largest Native American alcohol and drug abuse treatment centers in both the United States and Canada, Poundmaker's Lodge also offers informal technical assistance to Native American programs seeking to incorporate traditional cultural and healing practices into modern treatment programs. For information on the program, call Patrick Shirt, director, at (403) 458-1884. The film is available from the National Film Board of Canada, c/o Karol Media, 22 Riverview Drive, Wayne, NJ 07470, (201) 586-9111. Cost is $550 for the film, $350 for the video. The three-day rental fee is $60.

Someday, I'll Be an Elder
This 1988 film features Karuk tribal members as they conduct a three-week, summer camp program that emphasizes renewal of traditional ways and values. It points out the need for Native American/non-Native cooperation and an awareness of Native American customs as they are expressed by Native American people today. 25 minutes. Narrated by Will Sampson. Film sale, $425; rental, $48. Videotape, $375 (sales only). Available from Shenandoah Film Productions (a Native American-owned enterprise), 538 G St., Arcata, CA 95521, (707) 822-1030. Three network-quality TV spots are also available ($200), which are designed with room to add your organization's name at the end of each. One of these is on drinking and driving, and one is on alcohol-related birth defects.

Curricula, Pamphlets, Posters, and Other Written Materials

These materials can be used in prevention programs in communities and schools, or they can be used as background material for those developing such programs. The curricula are courses that can be offered by an educational institution or organization.

AA for the Native North American
Alcoholics Anonymous (AA) has prepared a pamphlet that is a compilation of stories of Native Americans who have gotten sober using the AA program. To obtain a copy of the 46-page pamphlet, write to AA, P.O. Box 459, Grand Central Station, New York, NY 10163, (212) 686-1100. Cost is 50 cents.

American Indian and Alaska Native Mental Health Journal
Scholarly articles in this journal stress new data, comparisons with previous data, and their relevance to Native American mental health. The emphasis is on "development of positive mental and social functioning of Native Americans through understanding the relevant processes and conditions." Articles on alcohol and other drug abuse appear frequently. Each issue is about 50 pages in length. An individual subscription is $35 (U.S. currency). Prepayment is required. Available from the Journal Manager, National Center for American Indian and Alaska Native Mental Health Research, University of Colorado Health Sciences Center, Box C249, 4200 East Ninth Avenue, Denver, CO 80262, (303) 270-4600.

Being Free: Prevention Curriculum for American Indian Youth
This curriculum was developed by Native American and non-Native curriculum writers for the Chippewa and Sioux tribes. The lessons are divided into Primary (K-3), Intermediate (4-6), Junior High (7-9), and Senior High (10-12). The lessons focus on attitudes, feelings, families, making choices, influences, information about alcohol and other drugs, and fetal alcohol

syndrome. Background information is provided for teachers. Contact Al Fredrickson, Minnesota Prevention Resource Center, 2829 Verndale Ave., Anoka, MN 55303, (612) 427-5310.

Cherish the Children

This curriculum presents parenting skills for Native American families and includes lessons on nutrition, health, safety, talking skills, and self-esteem for parent and child. It was designed to help Native American parents sort out their beliefs, values, and methods of parenting. It has been described as a "powerful change-making tool." The package includes trainer's manual, worksheets, and supplementary readings. Contact Shelley McIntire, Minnesota Indian Women's Resource Center, 1900 Chicago Ave., S., Minneapolis, MN 55404, (612) 872-8211.

Fetal Alcohol Syndrome Community Education Kit

This 17-component kit was developed to help people educate their communities about the risks of drinking alcohol during pregnancy. Prevention of fetal alcohol syndrome (FAS) depends on giving accurate information about the risks of drinking alcohol during pregnancy to women who are, or are contemplating becoming, pregnant. The kit includes a poster, bumper-stickers, resource guide, bibliography, glossary of FAS terms, pamphlets, and a set of fact sheets. Cost is $88. Contact the California Urban Indian Health Council, Inc., 2422 Arden Way, Suite A-32, Sacramento, CA 95825, (916) 920-0313.

Images of Indians

This curriculum is an in-depth study of Native issues. The program covers (1) the role of stereotyping in the vicious cycle of prejudice and the use of stereotypes of native people by the Hollywood movie industry, (2) how the misrepresentation of history and of Native peoples' customs and language in Hollywood movies has affected both Native and non-Native viewers, (3) the contributions of Native tribes to North American life and the effect of government policies designed to solve conflict between white settlers and the aboriginal people, and (4) contemporary Native issues. Cost is $250. Contact Phil Lucas Productions, Inc., P.O. Box 1218, Issaquah, WA 98027, (206) 392-9482. In Canada, contact Four Worlds Development Project, Faculty of Education, University of Lethbridge, 4401 University Drive, Lethbridge, Alberta, Canada T1K 3M4 (403) 328-4343.

The Sacred Tree

This curriculum package was designed to assist educators to lead a group of learners through a journey of self-exploration and development. The journey begins with a social research project focusing on the consequences of alcohol and other drug abuse in the learner's home community. It then goes on to demonstrate how the medicine wheel can be used as a symbol to learn about personal growth and about interpersonal communication. The Sacred Tree

curriculum package consists of a curriculum guide, a class set of student texts, four videos, six resource books, posters, and other visual aids. Contact the Four Worlds Development Project, University of Lethbridge, 4401 University Drive, Lethbridge, Alberta, Canada T1K 3M4 (403) 328-4343.

Working with Indian Women: A Community Education Approach
This curriculum was developed by a group of Native American people to promote a better understanding of issues facing Native American women and their children. The curriculum could be used effectively with Native American senior high students. The manual includes training modules on domestic violence, family dysfunction, fetal alcohol syndrome, leadership, and sexual assault. The modules include instructions for conducting various group activities, content information, lecture notes, worksheets, and resource bibliographies. Contact Shelley McIntire. Minnesota Indian Women's Resource Center, 1900 Chicago Ave., S., Minneapolis, MN 55404, (612) 872-8211.

Selected Readings

These articles usually can be found in a college or university library or with the help of a public librarian. The articles were selected to provide a reader with an overview and to stimulate interest in reading further. Most of these articles have substantial reference lists.

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PEER EDUCATOR/PEER FACILITATOR PROGRAMS:KEYS TO SUCCESS

Buy-in from the Administration and Board of Directors

It is important to have the administration (executive directors, management-level personnel, program directors, etc.) and the board of directors fully support the concept of involving youth in providing services to other youth in a human services agency. These can be the hardest people to sell on the concept, but without their buy-in and support, there is no reason to embark on a peer facilitator program. If the administration does not fully support the program, they will step in and stop the program, saying it is too much trouble or youth can't do it.

There are some techniques and strategies which can be used to get the buy-in of the administration and the board. One is to simply bring in a youth speaker from another agency or program which is already involving youth in service delivery and have one of those youth sell them on the idea. It's easier to do if this is a team with both youth and adults involved. Arranging an outside presentation for the board and administration will insure that the one staff member who wants to do this is not trying to sell it all on his/her own.

. . . securing the support of the administration has to be the first step in beginning a youth or peer involvement component in any agency.

Another approach is to have the administrator and/or board members attend a national event such as the National Network of Runaway Youth Services Symposium or the National Resource Center for Youth Services summer conference, "Working with America's Youth." There they will hear and see dynamic, youth keynote speakers and experience for themselves the power of youth involvement. This will make the battle much easier.

If these techniques are too expensive, there is still the option of using videos or resource materials from other successful programs to convince the board and administration. Whatever the mode selected, securing the support of the administration has to be the first step in beginning a youth or peer involvement component in any agency.

Anticipate their questions and be prepared to answer them. The first question the board or administrators will ask is about liability insurance. The second question will be about confidentiality. Do your homework and make sure you have determined the cost of adding a rider to the agency's insurance policy. Come to the meeting with the figures and estimates on hand. Have the agency's confidentiality policies with you, as well. Be ready to discuss how they will apply to youth staff.

Buy-In from Staff, Volunteers, and Any Other Critical Personnel

A Peer Educator/Peer Facilitator program can be successfully undermined if the rest of the agency staff, volunteers, and other key personnel do not support the concept of youth involvement. After getting the go-ahead from the administration and the board, it is important to do a sales job with all of these other people as well.

For adult staff and volunteers . . . the idea of youth as equal partners in service delivery can be a pretty foreign concept.

An in-service workshop is an excellent way to begin working with them. Use videos, curriculum materials, and resources which have been developed by other agencies in this area. Bring in outside facilitators/speakers, including youth, if possible, to help with the training.

For adult staff and volunteers who have been trained to see youth as troubled and in need of supervision, the idea of youth as equal partners in service delivery can be a pretty foreign concept. Understand where they are coming from and be prepared to spend a lot of time assisting them in overcoming their own barriers and attitudes towards youth empowerment and youth involvement.

The Importance of the Peer Educator Program Coordinator

The single most important element which can make any peer education or youth involvement program work successfully is the staff coordinator or director who is hired to run and manage the project. The right person will make the program fly; the wrong person will never get it off the ground.

The "right" person will be 100% sold on peer education and youth involvement models from the beginning.

The understandable fear and concern people have about finding the coordinator comes from being unsure about what constitutes the "right" person. Actually, that's easy. The "right" person will be 100% sold on peer education and youth involvement models from the beginning. If an individual has to be convinced of the value of peer education, this is the wrong person.

The right person is someone who is immediately stimulated, excited, and challenged by this idea from the first conversation. The right person is the kind of person who not only *likes* spending time with the youth in the program, but actually *wants* to spend time with them.

The person's age is not the important factor. Programs often make the mistake of thinking only young people in their early 20's, right out of college, will be able to do this job. Sometimes these folks can do the job. However, just as often a 40-, 50-, or 60-year-old man or woman who is really committed to the idea can make it work.

It is not necessary to look for a certain "degree" or certain level of work experience in filling this position. The right person may or may not be college educated. You are looking for a special person who really and truly believes in the value of youth. You want someone who wants to make a youth-adult partnership really work. You do not want someone who is caught up in "telling youth what to do" all the time, but rather someone who wants to work with youth in a partnership model.

Creating a RREFP for Youth and Adults in the Program

What in the world is an RREFP? It's just the secret to making all of this work once you have that "right" staff person. RREFP stands for **REAL, REWARDING, EMPOWERING, FUN, PARTNERSHIP.**

REAL—The job the youth are going to be performing must be "real." It must be something the agency truly needs. It can't be a "made-up" job created to meet the federal youth participation standard or to allow the agency to receive some special grant or reward. If possible, agencies should conduct some kind of needs assessment or analysis before beginning a peer education program to determine just what areas of the program would most benefit from youth involvement. The peer education program should be an important part of meeting the identified service or program needs. No one wants to work in a job that isn't real or necessary.

The program should be :
REAL
REWARDING
EMPOWERING
FUN
PARTNERSHIP

REWARDING—Youth, just like adults, need to be rewarded for the work they do. One of the rewards can be a paycheck, if the positions are going to be paid jobs. When using youth volunteers, a great deal of care and attention needs to be devoted to developing appropriate rewards and incentives. These can include certificates of achievement and appreciation, plaques, gifts, and recognition within the agency and in public events. Youth, themselves, can help you identify things that are viewed as rewarding. Even if youth are paid for their work in the program, there should be attention given to other, non-monetary rewards.

EMPOWERING—A youth involvement/peer education program should have as one of its main goals and purposes the empowerment of the youth staff. The youth who provide the services should, ideally, benefit as much as the recipients or clients. Youth should have an opportunity to grow from this experience and be able to use their skills in a professional and meaningful way. It should be a nurturing and empowering experience for everyone involved.

FUN—If youth don't have some fun doing this job, they will not want to stay with it for very long. Again, this is simple human nature and an easy concept to understand. Don't find the worst, most dreadful job in the whole agency and then decide the youth can do it. If you don't like some part of your job, chances are that the youth won't like it either! Again, with a little creativity, some advance planning, and incentives the peer education program can be fun for everyone!

PARTNERSHIP— A youth involvement program needs to be a true partnership between youth and adults. Adult facilitators should not make all the decisions They should not assume a power position from which they simply tell the youth what to do every step of the way. A partnership model should be developed for every aspect of the program with youth involved in planning and implementing the project along with the adult coordinators.

This does not mean no one is assigned as the supervisor or the taskmaster. It certainly does not mean that no one provides any structure or guidance for youth. An effective adult coordinator is able to work with the youth in establishing the necessary boundaries and laying out the parameters for the project. All of this can be done without generating the oppression of "adultism" or without turning the project into a total free-for-all. It's a fine line to walk. Again that "right" staff person is the key to making the partnership happen.

Choosing the Youth

Choosing youth to be peer educators is not nearly as overwhelming as people think. There are many youth in all of our communities who would love to get involved with a youth involvement program and who are capable of doing so. Each agency needs to establish its own guidelines for selecting the youth to be involved. It is important to do advance planning with regard to age, background, availability, and other key factors.

You don't have to choose youth who are your current clients!

Many short-term, crisis agencies like runaway programs believe they can't possibly run a youth involvement program because youth stay in the program only a few days or weeks. The answer is simple, yet it eludes many people who want to start a youth involvement component. You don't have to choose youth who are your current clients! You can use former clients who have remained in the area. You can use youth who have never been clients of any agency. You can ask other agencies to refer some of their longer-term clients.

Each of the possible choices presents its own strengths and challenges. Each can lead to a very successful peer education program. Whatever the choice you make, it should be made thoughtfully after planning and discussion about the program's needs and desires.

There are many successful recruitment strategies for peer educators. These include: employment ads in city newspapers, school newspapers, job service offices, and community bulletin boards; word-of-mouth-campaigns; campaigns through other social services agencies or contacts; campaigns utilizing outreach workers and/or youth recruiters. Technical assistance and ideas for conducting recruitment campaigns are available from those agencies already operating youth involvement projects.

Planning

Careful planning is one of the most important aspects of creating a successful youth involvement/peer education program. There are two critical stages to the planning process. The first stage begins once the agency makes the decision to develop the program. The second stage begins once the peer educators are on staff and involves them as key players in the planning of program activities.

The first stage, or initial planning, begins with basic preliminary tasks. These tasks precede the steps one through five outlined above and include the following:

- budgeting for the peer educator project
- reassigning workloads or hiring new personnel to carry out project activities
- providing space, equipment, and materials for the project
- developing strategies for implementing the project

Once the staff members have worked through these basic issues, they can begin to work on the following steps:

- getting buy-in from administration and board of directors
- getting buy-in from staff, volunteers, and other critical personnel
- selecting the right program coordinator
- creating a RREFP program for youth and adults
- selecting youth

The second stage involves planning for the actual service delivery. Some of this planning will take place before the peer educators are on board. However, the youth must be involved in at least some aspects of the service planning—particularly those activities they will be responsible for doing. This can be addressed during their orientation and training sessions. Involving the peer educators in planning creates a partnership from the beginning and helps you to insure the project is RREFP.

. . . youth must be involved in at least some aspects of the service planning . . .

There is nothing really different about planning for a peer education project. The planning rules and processes you follow throughout the agency pertain to doing the planning for a peer educator component. The only difference is that you must make room for youth input and involvement during the second phase.

Ongoing Management, Feeding, and Nurturing

The youth involvement/peer education component of your agency is as important as any other agency program. It needs the same level of management and support as any other program. This includes sound fiscal management, clerical support, administrative support, supervision, and planning and program development.

The youth involvement/peer education component . . . needs the same level of management and support as any other program.

Special "feeding and nurturing" may also be required. Peer education and youth involvement is new territory for many agencies and the fear of the unknown can make a challenging task even more difficult. Unfortunately, the adults and youth in the program are unlikely to find peer support in the local community. Many times the alternative youth services agency is the only organization in town operating a youth involvement project. The only folks involved in similar activities may be miles away, in a different city or state. Try

to help staff overcome their isolation through attending conferences and by identifying and communicating on a regular basis with those distant peers. On the home front, be prepared to give them the extra support they will need. The rule of thumb for success in a youth involvement program is to treat it as you would any other program—and then to give it a little extra every time you can!

Prepare for the Obstacles and Setbacks

A final key for success is to anticipate and be ready for the setbacks and the obstacles you may encounter. Running a youth involvement project is not easy work and there are bound to be some rough times along the way. You may very well be opposed by those who don't understand what the project is or why you are doing it. Listed below are some of the common problems encountered by youth involvement projects. Reviewing them and thinking through your responses to them will give you an opportunity to prepare yourself before it's your turn on the hot seat!

. . . anticipate and be ready for the setbacks and the obstacles you may encounter.

OBSTACLES AND PITFALLS

- **Inadequate Preparation**

  Failing to carry out the steps outlined above for a successful peer educator program—especially failing to plan or budget or staff the program appropriately—will get you into trouble fast. You've got to work through the steps outlined above, giving each step the amount of time it requires. Hurrying through the preparation and planning phases will only mean you have to go back and pick up the pieces later.

- **Not Enough On-the-Job-Training and Orientation**

  In their eagerness to actually get started, both the adults and the peer educators will want to get the initial orientation over as quickly as possible and get on with the real job. This can be a big mistake! It is important to slow down and take your time with the initial training and orientation. It is two or three times the work to correct bad work habits or misunderstandings about job duties *after* they have already occurred.

  It is two or three times the work to correct bad work habits or misunderstandings about job duties **after** *they have already occurred.*

  It may take longer to orient peer educators than it does your adult staff. That's okay. Build in extra time. Following the initial orientation and on-the-job training, peer educators should be offered, and expected to attend, regular in-service training sessions. These sessions can help peer educators continue to improve and polish their skills. It can also help adult staff identify areas in which further clarification and/or training is needed.

- **Supervision Issues**

  In some respects supervising peer educators is the same as supervising other program staff. In other respects it is totally different and unique. Supervision of youth may require more time than supervision of the

professional staff. It certainly requires more patience, more mentoring, and more ongoing education. The supervision of peer educators can be fun and challenging, or it can be a horrible, dreaded chore. Most of how it is perceived depends upon the coordinator's attitudes and abilities. Many agencies get into trouble with supervision of peer educators because they neglect this area or budget too little time for it. Again, this is a ghost that will come back to haunt you if it is not handled well from the very beginning.

- **Adult-ism**

  Adult-ism is a prejudice against anyone who is not an adult (i.e., children and youth). As an "ism," it is one of the more insidious ones in our world today. We are all taught to believe adults know more than children and youth. Adults are more valued in our society than are children and youth. Adults are to be respected and listened to, while children and youth are to be merely tolerated. As a result of the adult-isms that were forced on each one of us throughout our childhood, we have internalized this prejudice and are passing it on to our own children and to the children and youth we work with.

  One of the biggest obstacles to a successful youth involvement program is adult-ism.

  One of the biggest obstacles to a successful youth involvement program is adult-ism. When it rears its ugly head in an agency, the youth suddenly become second-class citizens and the youth-adult partnership is a thing of the past. Adult-ism must be kept in check by the peer education coordinator as well as all the rest of the staff, volunteers, and board. Some training in this area or consciousness raising on a periodic basis is a good strategy towards recognizing and eliminating adult-ism.

- **Community Response and Reactions**

  Remember, your community, including other youth-serving agencies, is quite likely *not* going to be ready for you. You will probably be breaking some new ground when you begin a youth involvement program. Remember some of the resistance you had to overcome within your own agency. It is going to be even more difficult dealing with outside resistance because many professionals and community agencies will not share your value base. They do not "value" youth in the way you do. They will, quite frankly, think you have gone astray and taken leave of your senses.

  One of the major difficulties you will face when you launch your youth involvement program is trying to move the community along with you when they aren't ready. One strategy is to conduct a workshop or training session for the other agencies you will be working with. If you can get their attention for an afternoon, you can do a successful youth empowerment workshop. This can help them identify and overcome some of their own barriers. Having the youth actually do some of this workshop with an adult trainer is an excellent way to tackle this event. If you

don't spend any time helping the community move along with you and gaining their support, your youth involvement program is in danger!

- **Burn-Out and Aging Out**

  Burn-out occurs in youth involvement programs among both youth and staff in much the same way it occurs in other programs. The strategies you already implement to avoid or reduce personal burn-out will work with your youth involvement program. Make sure you conduct some burn-out sessions during training with the youth. This will prepare all of you to identify and deal with the signs of burn-out when they occur. The youth can help monitor each other and can help develop prevention strategies for the whole group.

  Burn-out in a youth involvement program often occurs during the senior year of high school. It is not a coincidence that "senior-itis" and burn-out on the job occur at the same time. If you have youth who started working with you during their sophomore or junior years of high school, you can expect them to show some signs of burn-out during the senior year. Being prepared for this will assist you in dealing with it.

The problem of burn out among youth is compounded by the "aging out" process.

The problem of burn-out among youth is compounded by the "aging out" process. Unfortunately, one of the problems with involving youth in your agency is the fact they grow up! When you begin your youth involvement program, you will need to prepare to "age out" the first group and develop strategies for replacing them. If you fail to think about replacement, you will simply lose the program to attrition.

- **Unhealthy Peer Facilitators**

  No matter what criteria you use for selection of your peer educators, you may end up with a youth who is simply not well enough or stable enough to do the job. Most of the youth who end up working in youth involvement programs will find themselves in high-risk situations of some sort during the time they are working with the program. As we all know, recovering youth may relapse and start using again or may return to other destructive behaviors. Other youth, who have never had any major problems prior to working in the program, may develop some unhealthy behaviors while involved in the project.

The coordinator should not be a personal counselor to the youth in the program.

An agency involving youth in service delivery must be aware of the personal struggles and issues these youth are facing and be ready to take whatever action is needed. The coordinator should not be a personal counselor to the youth in the program. It may not even be a good idea for other social workers or counselors in the agency to provide personal counseling services to the peer educators. Instead, each peer educator should have an identified person to turn to for the personal counseling and assistance needed to deal with high-risk situations. Your job is to know the youth in the program and to be prepared to deal with unhealthy situations and behaviors when they occur.

- **Inappropriate Relationships**

  It is necessary to spend a great deal of time during the initial peer educator training dealing with relationships—between adult and youth staff, among youth staff, and between youth staff and clients. Peer educators are staff members. They need to be informed about the agency's guidelines and policies regarding staff relationships, chain of command, appropriate behavior during work hours, and the like. A discussion on the relationships the peer facilitators are expected to have with each other needs to be fully discussed as well. Finally, a great deal of attention needs to be given to the relationships the peer educators will be expected to maintain with the agency clients.

  In spite of all this training and all these guidelines, some of the established boundaries will be crossed. This is to be expected. The problem is in not being prepared for it or in over-reacting to it when it does occur. Anticipate the problem and be ready to deal with it in a constructive way. This allows the youth to learn from the experience and, if possible, to remain with the program.

  . . . through regular staffings and good supervision, inappropriate relationships can be stopped before they become destructive.

  One of the most common inappropriate relationships occurs when a program client, desperately in need of a friend, latches on to a peer educator in an unhealthy fashion. Often the peer educators, in their eagerness to help clients, will do things like give out their home phone numbers and inadvertently encourage a client to develop a dependency on them. If staff stay on top of these situations through regular staffings and good supervision, inappropriate relationships can be stopped before they become destructive.

- **Failure to Orient New Staff, Volunteers and Board Members**

  After the initial sales job with the administration, staff, volunteers, and board has been completed, it is easy to assume that the peer educator program is institutionalized and to ignore the important task of orienting new personnel to this aspect of the agency. When new people come into the agency all that initial resistance, adult-ism, and skepticism has to be overcome once again so the whole team remains committed to the agency's commitment to youth involvement.

- **Preparing for the "Worst-Case Scenario"**

  You have every reason to expect your youth involvement program to have smooth sailing all the way if you have followed these steps for success and prepared for the most obvious pitfalls and obstacles. None of us really expects the worst. In fact, most of us are rather optimistic in nature, and we expect things to work well.

No one ever thinks there will be a suicide in the shelter. No one wants to believe that a client or a client's family would sue the agency for an outrageous sum of money. Even still, the administration and board have prepared for these worst-case scenarios by carrying liability insurance, by establishing sound policies and procedures, and by carefully monitoring the program.

The key, as always, is to be ready . . . and avoid overreacting to the obstacles and pitfalls which present themselves.

It is important for the staff and board to conduct a worst-csre scenario meeting regarding the youth involvement program and develop the strategies, policies, and procedures necessary to deal with those worst cases. Even a worst-case scenario can be overcome. The youth involvement program can continue in spite of suffering setbacks. The key, as always, is to be ready. Have your plan in place and avoid overreacting to the obstacles and pitfalls that present themselves.

■ **Special Thanks!**

Materials in this section were developed by **Linda Wood** at Mountain Plains Youth Service, Bismark, ND.

WRITTEN MATERIALS

Leadership Development: A Handbook from the Youth Action Program, by Dorothy Stoneman, assisted by John Bell (1989).

This manual builds leadership skills in young people through a series of interactive and skill-building exercises. Topics addressed in the manual include counteracting the effects of oppression, communication, building leadership concepts and skills, organizing, and political action. For more information contact Youth Action Program, 1280 Fifth Avenue, New York, NY 10029 (212) 860-8170.

Peer Education in Sexuality and Health—YWCA of the U.S.A. (1989).

This manual explains the administrative and planning details of setting up and implementing a peer program. It covers teen recruitment and selection, empowering teens, training topics, fund raising, hiring staff, and building community support.
For more information contact Jan Sola, Director of Programs, YWCA of the U.S.A., National Board, 726 Broadway, New York, NY 10003. For ordering information contact Network Publications, P.O. Box 1830, Santa Cruz, CA 95061-1830 (408) 438-4081.

The Why and How of Teen Line, edited by Elaine Leader, Ph.D., Terry D. Lipton, M.D., and Patricia Wisne, Ph.D.

The manual describes the development, structure, and training format of a teen telephone helpline—TEEN LINE CARES— including a comprehensive description of the program and sample materials.
For more information contact Elaine Leader, Teen Line, Cedars-Sinai Medical Center, 8730 Alden Drive, Los Angeles, CA 90048-3811, (213) 855-HOPE.

Friends Helping Friends—A Manual for Peer Counselors and Leading a Friends-Helping-Friends Peer Program, by Carol Painter, Educational Media Corporation (1989).

This is a two-volume curriculum. One manual explains the administrative, program, and evaluation details that are necessary for a successful high school peer counseling program. The second manual covers the programmatic elements, including necessary skills and topic development and group activities.
For ordering information contact Education Media Corporation, P.O. Box 21311, Minneapolis, MN 55421 (612) 636-5098.

The Dynamics of Relationships, created and developed by Patricia Kramer (1988)

Although this is a teacher's manual for a school-based prevention program, the program can be adapted to other group situations. The manual covers such diverse topics as communication, conflict, expectations, gender roles, and alternative lifestyles. The purpose of the program is to allow students to explore their feelings and attitudes and to acquaint them with the many behavioral options

available to them. For ordering information contact Equal Partners, 11348 Connecticut Avenue, Kensington, MD 20895 (301) 933-1489.

SOS Runaways and Teen Suicides: Coded Cries for Help, by Sally Brown, MSW (1987).

This runaway-suicide prevention training manual includes a 12-hour training to provide a common base of knowledge and skills to runaway-shelter staff for understanding the depressed or suicidal adolescent, recognizing clues and coded messages that indicate a potential for suicide, and assessing the level of suicidal risk and appropriate intervention. For additional information contact the Human Services Development Institute, University of Southern Maine, 96 Falmouth Street, Portland, ME 04103 (207) 780-4430.

Life Planning Education: A Youth Development Program, the Center for Population Options (1989).

Here is a curriculum designed to help teenagers prepare for the decisions they will make about health, sexuality, parenthood, and work. Topics covered include personal values, decision making, employment, HIV/AIDS, and good communication. For additional information contact the Center for Population Options, 1025 Vermont Avenue N.W., Suite 210, Washington, DC 20005 (202) 347-5700.

Youth Reaching Youth Implementation Guide, The National Network of Runaway and Youth Services (1990).

A step-by-step approach to training youth to make significant contributions in reducing or preventing alcohol and other drug use among their peers. The guide was developed with and based on the expertise of three agencies that have implemented peer programs for many years: Briarpatch, Inc. in Madison, WI; The Youth Project in Ukiah, CA; and Youth Emergency Service in University City, MO.

Special thanks to Patty Dietz at the National Network for this listing of peer leadership curricula.

ORGANIZATIONS

WORLD YOUTH AGAINST DRUGS (WYAD)

Founded in 1986, WYAD has membership in 35 countries and an international pen pal program involving thousands of drug-free young people. An organization run by young people for young people who share the goal of drug-free youth. Quarterly newsletter and notice of local, national, and international meetings.
100 Edgewood Avenue, Suite 1216, Atlanta, GA 30303, (800) 241-9746.

YOUTH TO YOUTH

Founded in 1981, this organization stresses youth training youth to do prevention programs in their own schools. An annual five-day intensive prevention training program prepares junior and senior high school students to conduct local programs. Youth to Youth groups are active in over 25 states, with regional conferences, international youth exchanges, and a national speakers' bureau of high school students. Free quarterly newsletter.
700 Bryden Road, Columbus, OH 43215, (614) 224-4506.

EFFECTIVE USES OF GROUP EXPERIENCES

This training package includes several structured exercises for use in conjunction with the film and videotape. The exercises have clear and explicit instructions about how to prepare for and conduct the exercises. This package incorporates a variety of experiences including small group discussions, role plays, case studies, and other interactive group techniques.

Structured exercises are an effective way of helping groups to process and integrate information. It is important, however, to be knowledgeable of the effective methods and uses of various techniques.

The following section provides information on effective uses of the various techniques. You are encouraged to review these prior to using the exercises in this package. This will give you general knowledge about the techniques and increase your effectiveness in leading the exercises.

BASIC RULES FOR USE OF STRUCTURED EXERCISES

Investment and Involvement

It is important that every exercise/experience that you use involves all of the participants. There should be no passive audience; everyone should have something to do. For example, in a role play if only two people are role playing, it is important to give specific observation tasks to the viewers.
In a small group discussion everyone may not be actively, verbally participating. However, it is important to strive for all participants' involvement through listening and nonverbally participating in the discussion.

Sequencing

It is important to recognize what is going on in the group environment and build experiences on previous activities. Active experiences are best during slow times, such as after lunch and late afternoon. If the participants have come from a structured classroom experience to the group, it may be important to do more informal and relaxing exercises rather than structured exercises.

Content

The content of all experiences must be relevant to the audience. For example, using an exercise which asks rural youth to role play urban street youth will not work. The content needs to relate to the experiences of the participants and to give the participants an opportunity to work with situations that are close to their reality.

Processing

Many group experiences fail because the leaders do not process the experience. It is important to talk through the feeling and behavioral data of every experience. If you have done a role play, ask the role players how they felt about it; ask the participants how they felt about it. After you have done a group discussion, talk to the participants about what they learned from this, how they felt about some of the things that were said, what things they might do differently as a response to some of those discussions. It is important that you not leave unfinished business. When exercises are used without thoroughly processing, the information cannot be fully integrated.

Pacing

Structured group experiences need to move at a consistent pace. Sometimes group leaders tend to carry out exercises very slowly. This leaves plenty of time for the group to get bored or to lose their focus. On the other hand, some group leaders feel uncomfortable with silence or lack of participation and quickly "rescue" the group from their own goals and objectives. It is important to pace the experiences to meet the needs and timing of the group.

Goals

Every structured group experience needs to have goals that are clear. The goals should be clear in the group leader's mind and stated as clearly as possible to the group participants. When the group is aware of what goals it is trying to achieve, it is much more likely to achieve them.

Voluntariness

Group members should participate in structured group experiences on a voluntary basis. Leaders should be sensitive to the needs and learning styles of each participant. Group members will not involve themselves in the same way in each activity. A variety of group experiences should be presented to a group so that members may participate according to their own styles and needs in the activities.

Norms

In order to have successful group experiences, the group must have norms of openness, experimentation, and sensitivity to others. The group must feel comfortable in its ability to make mistakes and to try out and learn new things. They must feel safe that other groups members will not make fun of them or retaliate in any negative way.

Data

It is the role of the group leader to be constantly aware of the data that exists in the group at any time. This data consists of participant's thoughts, feelings and behaviors; environmental stimuli such as previous activities; activities happening at the same time that may draw the attention of participants; previous experiences or activities that are presently influencing the group; or upcoming activities or experiences that may have an impact on the group. The leader needs to utilize this data in planning successful group experiences.

Flexibility

Perhaps the most important skill of an effective group leader is the ability to be flexible. Group experiences, even when they are well planned and the leader is skillful in carrying out the experience, sometimes don't work. The leader needs to be flexible and responsive to the existing data in the group. If an activity that was planned is not working, it is important to change that activity and come up with another new activity.

SMALL GROUP DISCUSSIONS

Small groups can be used for various, different purposes in training. They can be used as "experiencing"—to draw on the experiences and prior knowledge of group members to generate lists of information, possibilities, problem areas, solutions, etc. More often, the small group discussion is used as "processing"—to allow group members the opportunity to react to a previous activity, to explore and share their feelings, to give their observations. Most discussion groups consider issues, problems, and concerns that involve values, attitudes, and refections rather than factual answers. Groups may close by moving into a summarizing, or "generalizing," phase.

Small group discussions may either be facilitated by group leaders, or they may be self-facilitated. In a small group, as much as possible, each group member ought to have ample time to contribute. No one person should monopolize the speaking or dominate the group. The goals of the discussion should be made clear from the outset, as should any ground rules regarding time, scope, responsibility for recording and/or reporting, etc. The group facilitator should feel free to keep the group within the agreed-upon parameters by identifying digressions or turning points. The facilitator may clarify, probe, and channel the discussion.

A feeling of closure should be reached at the end. A summary of the discussion, and conclusions or recommendations (if any) should be restated. If there is a need for follow-up, continuation, or new plans, these should be developed before the group is dissolved.

The most important skill a group leader needs in facilitating small group discussions is that of keeping the discussion going and keeping it on target. By being prepared with appropriate questions, the leader can help the group members to react, express, and share their feelings and observations, to interpret and analyze this information, and to draw useful learning from it.

A group leader may decide to have self-facilitated small groups. This is often necessary when there is only one leader and several groups (group size should be five to eight persons). The leader may either appoint a facilitator for each group or allow the groups to choose their own facilitators. In either case, the points described in the previous paragraphs should be discussed or reviewed with the groups and their facilitators. They should be directed to be prepared to report to the larger group; a recorder/reporter role may also be assigned or volunteered for in each group.

SMALL GROUP DISCUSSIONS

Advantages:

- Encourages sharing and collaboration
- Builds group cohesion
- Elicits information from participants

Tips for good discussion groups:

- Ensure equal opportunity to contribute; no monopolizers
- Make goals and ground rules clear
- Do summary or follow-up
- Be prepared with appropriate questions

Role of leader:

- Don't talk too much
- Don't impose your ideas
- React to comments
- Look at participants
- Don't put participants on spot

INTRODUCTION TO ROLE PLAYING

Why Role Play?

Different kinds of learning can take place through role playing:

- learning by doing (practice of desired skill)
- learning through imitation (of the desired behaviors)
- learning through observations and feedback on performance
- learning through analysis and conceptualization (repeated experience with role playing problem allows participants to learn principles of human relations)

Role playing can be highly engaging for participants, and, if it is well directed, a lot of fun. The more concrete your objectives are, the easier it will be to direct the role play.

Role playing, when done well, is one of the best learning tools a group leader has. When done poorly, it can create fear, resistance, and anger. Reviewing the next few pages of tips will help you prepare yourself and your group for good role plays.

What Can Be Gained from Role Playing

- understanding of all facets of the situation (insight into interaction patterns)
- trying out a particular strategy in a safe situation where there are no real consequences (practicing a desired skill or behavior)

What Are Your Concerns about Role Playing?

Most people are concerned about being judged or "on stage." Role play should not include either of these things. The director should be supportive as well as the audience, and no one should "have to" participate who doesn't want to.

Why Is It Important to Have the Topic, the Objectives, and the Time Limit Specified At the Beginning of the Role Play?

- so that the role play does not go off on a tangent that isn't relevant to the audience
- so that the role play can be concentrated, efficient, and effective

What Are Some Techniques Used During Role Playing?

- Role reversal—players switch roles with each other—creates understanding.
- Role rotation—different people the play same role—creates different approaches.
- Role interviewing—exploring feelings with the role players.

What Is the Final Stage of the Role Playing Processing? Why Is It Crucial?

Processing is the final stage. Players come out of their roles and talk about their feelings during the role play. Those who have been the supportive observers share situations in which they have felt similarly, and they give support.

WARMING-UP ACTIVITIES FOR ROLE PLAYING

When you use role playing, you need to give some thought to the development of motivation and involvement in the role play's topic. The participants must feel that the subject is relevant to their real life needs. Several warming-up techniques are described below.

- **The pre-role playing discussion**

  Start a discussion about the topic that is related to the role play you want to use. Encourage everybody to participate in the discussion and to air their feelings on the topic. Then, introduce the role play(s) as a way to experiment with "new" behaviors.

- **The problem-census (often used after the discussion mentioned above)**

  Ask the group where they might have problems regarding the training topic at hand, and put these on a flip chart. Summarize the problems, and introduce role playing as an exercise that will touch on some of the problems and might provide them with new insights.

- **The case discussion**

  A prepared, written case related to the topic you want to use in role playing is discussed first, and possible solutions are suggested. The role play is introduced as a method to demonstrate how different people would handle the problem in various ways.

- **Lecture, film**

  A presentation regarding the topic of the role play is given and the role playing is presented as an opportunity to put the new knowledge into practice.

HANDLING RESISTANCES TO ROLE PLAYING

After all your warming-up activities, there might still be some resistance to role playing. Several types of resistance you might encounter and suggested ways of handling them are listed below:

- **Fear of Exposure**

  This usually relates to people's fear of being exposed to the total group and acting as a fool. One way of handling this is to use multiple role playing rather than single role playing. The leader divides the group in pairs and asks them to do their own role playing in different corners of the room. In using this method, you will have to walk around a little to get a feel for how they are doing and whether the role play is being used the way you want it to be.

- **Can I Trust the Leader?**

  Group members usually want to know if the leader will take good care of them and not expose them to a lot of negative feedback. One way of handling it is to make sure the participants know you want to make it a good experience for the whole group and that you will direct the experiences as well as you can.

- **Can I Play this Role?**

  When you do use role playing in front of the group, sometimes asking the persons playing the same role to prepare together in a small group is a method to warm them up. It provides them with some support from their peers and stimulation to really get into the role.

- **What Is Going to Happen to Me?**

  Generally this refers to the person's fear of not knowing the procedures involved in role playing. Usually a good explanation of the different steps in the session (warming-up activities, role playing, discussion) clarifies the issue.

The most important thing in dealing with resistances seem to be to ALLOW them to be there, accepting the feelings and thoughts behind them. But, at the same time, the leader should try to be clear that he/she still would like to do the role play and why. If you feel good about it, this will be reflected by your group.

DISCUSSION AFTER ROLE PLAYING

When the role play has brought out the learning points, stop it, thank the role players and let them "blow off steam." They have worked hard and should be allowed to express their feelings first. Always let those in the role play discuss their experiences first.

Then, ask the observers about how it went, and how the previous discussion was applied in the role play. When making references to the role players, the participants should use their role names rather than their real names.

As a group leader, your attitude and direction in this discussion is very important. Try to protect the role players from too much exposure to negative comments, and try to get the observers to put their comments in the form of suggestions on how to improve the handling of the situation. The best way to do this is to set the example yourself. Attempt to be as non-evaluative as possible, try to invite people to talk freely about their own experiences, and summarize the comments given in relation to the learning points.

Communicate these ground rules for the discussion group:

- Make your comments in a self-oriented manner. Try to express your feelings as you were watching the role play. (For example: The interaction in the role play made me feel . . . .)
- Make your comments descriptive of what happened. (For example: I noticed that they really had little eye contact.)
- Try not to interpret the behavior of the players in terms of why they did what they did. If this seems necessary, however, ask the players this in an open-ended way rather than putting words into their mouths.

ROLE PLAYS: SUMMARY

Role Playing Can Foster Different Kinds of Learning:

- achieves insight into one's own/other's interaction patterns (experiencing)
- practices a desired skill or behavior (applying)
- modifies existing attitudes
- aids the development of new ways of dealing with problem situations

There Are Basically Two Kinds of Role Plays:

- spontaneous: Let's play this; you're the parent, I'll be the kid.
- structured around a specific problem/situation; usually prepared by group leader

Role Plays Work Best When You Do the Following:

- prepare yourself well for taking an active role in initiating and directing the role play
- instruct the group carefully through a warm-up discussion
- help the players get into their roles and tell them when to begin to play
- instruct the rest of the group to observe the role play
- direct the role play and use other techniques
- initiate the role play discussion and help summarize the learning points

Guidelines for Writing Role Plays:

- determine the topic and the objectives
- choose an appropriate situation and characters
- prepare role cards for each players, specifying situation and role
- indicate what the problem is and what you expect them to do
- do not suggest how they should solve the problem
- indicate what the problem is and what you expect them to do
- do not suggest how they should solve the problem

SESSION ONE: WHY DO PEOPLE USE DRUGS AND ALCOHOL?

PURPOSES OF THE SESSION

- *to provide a quick review of the types and effects of drugs*
- *to explore the reasons young people and adults use drugs and alcohol*

The first exercise is a quick review of drugs. The group will be asked to provide much of the information, but you will need to have a basic understanding yourself so that you can correct misinformation. Most of the information you will need is provided in this manual. However, there will be some questions you can't answer. That's okay. Just tell the group you don't know and will try to find out. Then check with a resource person or look it up in a reference book, and get back to the group with the information later.

The young people in the groups (during this and other sessions) will probably have a lot of different opinions on topics discussed. Some of those ideas may seem off base or even dangerous ideas to have. Don't try to correct their thinking—that will only make you look like an authority figure, and they will tune you out. Instead, listen carefully, acknowledge their opinions, and then move on. Often you will find that another young person in the group will challenge them or offer a different perspective. Encourage the expression of lots of different ideas and opinions.

SESSION OUTLINE

1. Introduce the session (see suggested introduction on the following page).
2. Do the exercise, *The Facts.*
3. Do the first two steps of the exercise, *Why Do They Do It?.*
4. Show the first vignette on the tape, "Numbers."
5. Finish the exercise and begin the tape.
6. Show the next two vignettes, "Backstage" and "Wallflower."
7. Do the exercise, *The Pressure Is On.*
8. Summarize the session, and thank group members for participating.
9. Complete Session Log Sheet.

INTRODUCTION TO SESSION ONE: WHY DO PEOPLE USE?

It's always best to say things in your own words. The following paragraph is a suggestion of how you might introduce this session. Read it over several times, then put it into your own words.

> We're going to spend the next hour or so thinking and talking about alcohol and drugs. We'll talk about what the different types of drugs do to you and why people use them. We'll also be looking at some videotapes done by a teen theater group to get us thinking along the same lines.

THE FACTS

GOAL

To provide all group members with a basic understanding of the types and effects of various drugs.

RATIONALE

Most young people think they know a lot about drugs: from drug education in school, from using or seeing others use, from overheard discussions among friends, and from television, radio, newspapers and magazines. Unfortunately, most know less than they think they do. This exercise provides a quick and fun opportunity to get everyone to the same level of knowledge about the different types and effects of drugs.

GROUP SIZE

Four or more

TIME REQUIRED

20 minutes

MATERIALS

- Information cards (copied and cut from the following page or transferred to 3 x 5 cards)
- Newsprint and markers
- Tape

PROCESS

1. Ask the group members to rate on a scale of 1 (know very little) to 10 (know everything) their own knowledge about drugs and the effects of drugs.
2. Comment on the range of responses and explain that, since the group will be discussing drugs, you are going to spend a few minutes reviewing the basics with them—hopefully in a fun way.
3. Tape newsprint on the walls with six different types of drugs listed:
   - narcotics
   - depressants (downers)
   - stimulants (uppers)
   - hallucinogens
   - marijuana
   - nicotine
4. Pass out the cards (copied from the next page) with drugs listed on them. Keep passing until all the cards are distributed.

5. Ask the group members to tape the drugs that they have drawn under the appropriate category.
6. Review their work and (using your cheat sheet from the following page) ask the group to correct those incorrectly placed.
7. Repeat the process using the "effects" cards (copied from the following page). Have them select cards until all are gone and have them tape them under the appropriate category. Review their work and ask the group to correct those incorrectly placed.

   [ALTERNATIVELY—IF TIME IS SHORT OR IF THE GROUP IS NOT CAPABLE OF READING THE CARDS EASILY—GENERATE THE INFORMATION ABOUT EFFECTS AND DRUGS FROM THE GROUP THROUGH DISCUSSION. PLACE NEWSPRINT ON THE WALLS AND ASK THEM, FIRST, FOR THE DRUGS THAT FIT IN EACH CATEGORY, THEN, FOR EXAMPLES OF THE TYPES OF EFFECTS.]

8. Ask for questions or areas needing more discussion.
9. Ask the group members to rate their knowledge on a scale of 1 (know very little) to 10 (know everything).

NOTES TO THE GROUP LEADER

If group members are going to tape cards on newsprint, it may make sense to put drugs and effects on 3 x 5 cards with large print so they can be seen from across the room.

Color coding cards (e.g., white cards for drugs and blue for effects) may help keep the information distinct.

Putting up alcohol/drug education posters with all or some of the information may help youth learn to use those printed resources.

DRUGS AND THEIR EFFECTS: A CHEAT SHEET

NARCOTICS

Types:	Effects:
OPIUM	stupor (acting and feeling stupid)
MORPHINE	euphoria (feeling terrific)
HEROIN	drowsiness (feeling sleepy)
CODEINE	respiratory depression (breathing slows down)
METHADONE	

DEPRESSANTS

Types:	Effects:
METHAQUALONE (QUAALUDES)	lowers energy level (no energy)
BARBITURATES (SECONAL, TUINAL)	reduces sensitivity to outside stimulation (slow to react)
MINOR TRANQUILIZERS (LIBRIUM, VALIUM, XANAX)	induces sleep
ALCOHOL	relaxed
INHALANTS/SOLVENTS (GASOLINE, GLUE, AMYL NITRATE—POPPERS, BUTYL NITRATE—RUSH LOCKER ROOM)	uncoordinated movements
	nausea/vomiting
	dizziness

STIMULANTS

Types:	Effects:
COCAINE/CRACK	feel increased alertness/energy
AMPHETAMINES (DEXADRINE)	insomnia (can't sleep)
COFFEE/CAFFEINE	activates nervous system (jumpy)
	increased pulse and blood pressure
DIET PILLS	loss of appetite (not hungry)

HALLUCINOGENS

Types:	Effects:
LSD	hallucinations (see/hear things)
MESCALINE/PEYOTE	stimulates brain
MDMA/ECSTACY	flashbacks
PCP/ANGEL DUST	
PSILOCYBIN/MUSHROOMS	

MARIJUANA

Types:	Effects:
POT	euphoria (feeling terrific)
THC	disorientation (spacy)
HASHISH	increased appetite (hungry)

NICOTINE

Types: CIGARETTES
CIGARS
SNUFF

Effects: increased heart rate and blood pressure
decreases emotional excitement

TYPES OF DRUGS

Copy this Sheet, Cut Out the Drug Names and Place Them in an Envelope.

OPIUM	MORPHINE
HEROIN	CODEINE
METHADONE	BARBITUATES (SECONAL, TUINAL)
MINOR TRANQUILIZERS (LIBRIUM, VALIUM, XANAX)	ALCOHOL
COCAINE/CRACK	AMPHETAMINES (DEXADRINE)
COFFEE/CAFFEINE	TOBACCO/NICOTINE
DIET PILLS	LSD
MESCALINE/PEYOTE	MDMA/ECSTASY
PCP/ANGEL DUST	PSILOCYBIN/MUSHROOMS
QUAALUDES	THC

POT	GASOLINE
HASHISH	AMYL NITRATE (POPPERS)
GLUE	BUTYL NITRATE (RUSH, LOCKER ROOM)

EFFECTS OF DRUGS

Copy this Sheet, Cut Out the Drug Effects, and Place Them in an Envelope.

drowsiness (feeling sleepy)	euphoria (feeling terrific)
lowers energy	slows breathing
induces sleep	reduces sensitivity to stimulation (makes you slow to react)
feel relaxed	increased alertness/energy
insomnia (can't sleep)	uncoordinated movements
increases heart rate and blood pressure	activates the nervous system (makes you jumpy)
hallucinations (makes you see or hear things that aren't there)	loss of appetite (not hungry)
euphoria (feeling terrific)	excites the brain
increased appetite	disorientation (feeling spacey)

nausea/vomiting	dizziness
increased heart rate and blood pressure	decreased emotional excitement

WHY DO THEY DO IT?

GOAL

To explore the reasons young people and adults use alcohol and other drugs.

RATIONALE

There are many different reasons for using alcohol and drugs. Often a person's use is driven by more than one thing. If we want to change our own patterns of use or to try to help others to change, it is important to understand the reasons for using in the first place. Without this understanding, we may simply help someone substitute one crutch or one addiction for another.

GROUP SIZE

Unlimited

TIME REQUIRED

10 minutes

MATERIALS

- Newsprint and markers
- Tape

PROCESS

1. Put a piece of newsprint on the wall. Write "Why People Use" across the top.
2. Ask the group to call out all the reasons people use alcohol and drugs. Write the reasons as they say them. List all the reasons. Do not challenge anyone's ideas.
3. Show the first vignette on the tape entitled "Numbers."
4. Turn off the tape and ask them if they want to add any reasons to the list.
5. Note that there are a wide range of reasons why people use alcohol and drugs.
6. Move the newsprint out of your way while the tape is playing, but leave it where you can see it as you may be referring to it during later exercises.

GROUP LEADER'S NOTES

THE PRESSURE IS ON

GOALS

To explore the ways others pressure us to use drugs and alcohol. To practice ways of resisting pressures to use.

RATIONALE

It's not easy for adults or young people to resist the pressures others put on us to use alcohol and drugs. The first step is to recognize how those pressures operate. The next is to practice ways of resisting without losing face. This exercise offers an opportunity to do both.

GROUP SIZE

Five or more

TIME REQUIRED

25 minutes

MATERIALS

- Newsprint and markers
- Tape
- Role-play cards

PROCESS

1. Ask the group why they think the characters in "Backstage" and in "Wallflower" were using alcohol and drugs.
2. One of the reasons for using for both characters is the pressure they felt from others. Talk about the difficulty of resisting pressures even when you know it is the right thing to do.
3. Put up a piece of newsprint labeled "Pressures" at the top. Draw a line dividing the sheet in half lengthwise.
4. Ask the group to list things people say to pressure someone to use. Write their ideason the left side of the newsprint.
5 Then ask them to list things someone might say or do — without losing face—to resist. Write those ideas on the right side of the newsprint.
6. Have group members pick role cards (or assign roles) and play out the following situation for five minutes or until the person attempting to resist the pressure decides whether to use or not. Tell them to use the information generated on the newsprint to help them think of things to say if needed.

One person is pushing a friend to use alcohol or drugs.
He/she has an advisor giving them suggestions.

One person is trying to resist the pressure to use.
He/she has two advisors:
One encourages use.
One discourages use.

7. When the role play is over, ask the role players to discuss the role play.

How did it feel to be pushed?
How did it feel to push?
How did it feel to advocate for or against use?
How did it feel to have successfully resisted or to have given in?
Which lines and responses were the most powerful?
What made him/her make the decision to use or not to use?

NOTES TO THE GROUP LEADER

An advisor is someone who helps those more actively involved in the role play. An advisor never talks to anyone except the person being advised. When two advisors are used for one person, they act in "angel" and "devil" roles—one encourages responsible, safe behavior and the other encourages risk and danger.

Youth may be unclear about advisors' roles. Be sure to explain it carefully. It may help to physically move the role players into their spots. Explain to them, as you place them, what their roles and expected behaviors are. Make sure everyone understands what to do before you start. Let them know you will stop the interaction in just a few minutes.

If role players get stuck and advisors offer no help, prod the advisors a bit rather than offering help yourself.

Review the information on role plays at the beginning of the manual.

If advisors to a role palyer are talking simultaneously and making the role player's talk more difficult, it may help to have them share a "talking stick." An advisor would then be able to speak only when holding the stick.

MATERIALS FOR THE PRESSURE IS ON

Copy this Sheet and Cut Out the Roles for Group Members.

You are *trying to resist* pressure to use alcohol/drugs, but your friend is really pushing you.

You are *pressuring your friend to use* alcohol/drugs. Try everything you can think of to get him/her to use.

You are an advisor to the person who is being pressured to use alcohol/drugs. Encourage him/her to *resist the pressure*. Don't talk to anyone else.

You are the advisor to the person who is trying to pressure a friend into using alcohol/drugs. Help him/her *think of things to say*. Don't talk to anyone else.

You are an advisor to the person who is being pressured to use alcohol/drugs. Encourage him/her to *give in and use*. Don't talk to anyone else.

SESSION TWO:
WHO'S AFFECTED?

PURPOSE OF THE SESSION

- ***to understand that the effects of drug and alcohol use reach beyond the user to others who care about or are touched by him/her***

The exercises outlined in this section are designed for exploring, thinking about, and talking about alcohol and drug use. They are not true/false, multiple choice, or essay exams that have a correct answer.

As in the previous session, the young people in the groups will probably have a lot of different opinions on the topics discussed. Some of those ideas may seem off base or even dangerous ideas to have. Don't try to correct their thinking—that will only make you look like an authority figure, and they will tune you out. Instead, listen carefully, acknowledge their opinions, and then move on. Often you will find that another young person in the group will challenge them or offer a different perspective. Encourage the expression of lots of different ideas and opinions.

SESSION OUTLINE

1. Introduce the session (see suggested introduction on following page).
2. Show three vignettes, "Bright Lights," "Cocaine Mama," and "The Fact Is."
3. Do the exercise, *No One Is An Island.*
4. Show "I Wanna Be Just Like You" and "The Fact Is."
5. Do the exercise, *Who's In Charge Here?*
6. Summarize the session and thank group members for participating.
7. Complete Session Log Sheet.

INTRODUCTION TO SESSION TWO: WHO'S AFFECTED

It's always best to say things in your own words. The following paragraph is a suggestion of how you might introduce this session. Read it over several times, then put it into your own words.

> We're going to spend the next hour or so thinking and talking about alcohol and drugs. This session sort of follows from the one yesterday where we talked about why people use and how they sometimes pressure others to use. Today we're going to focus on how one person's use can affect lots of different people. Like last time, we'll look at some video tapes done by a teen theater group to get us thinking along the same lines.

NO ONE IS AN ISLAND

GOAL

To understand how our own behavior—particularly alcohol and drug use—can affect other people.

RATIONALE

For many young people (and adults) alcohol and drug use is seen as an individual choice. They fail to see why or how it might affect anyone else. Through this discussion, group members will gain an understanding of the way their behaviors connect them to others and of the importance of thinking about the broader impact of their actions.

GROUP SIZE

Four or more

TIME REQUIRED

20 minutes

MATERIALS

None

PROCESS

1. Ask the group how the characters in "Bright Lights" and in "Cocaine Mama" were affecting other people.

   Who—besides themselves—were they affecting?

   How were they affecting them?

   How did it make those other people feel?

2. Ask them to think of other effects that someone's drug and alcohol use could have on others (e.g., drunk driving accidents, restrictive laws, damage to property, etc.).
3. Ask them to think about situations in which they have been affected by someone else's use (loud partying and couldn't sleep, threw up in my car, got blamed for their mess, etc.).
4. Ask them to talk about how it felt to be affected by someone else's use. (If they've never been affected, ask them to imagine how they might feel.) Did it make them angry, sad, hurt?

GROUP LEADER'S NOTES

WHO'S IN CHARGE HERE?

GOAL

To explore attitudes about responsibility for others—particularly as it relates to influencing others to use alcohol and drugs.

RATIONALE

Many people deny they are influencing anyone else. They may not intend to influence anyone. They may not even be aware they are influencing anyone. However, their behaviors set an example that others may choose to follow. This exercise explores the issues of responsibility and influence.

GROUP SIZE

Four or more

TIME REQUIRED

20 minutes

MATERIALS

- Newsprint and markers
- Tape

PROCESS

1. Explain to the group that this exercise is a chance for everybody to explore his/her own ideas about responsibility—for one's self and for others—and about influence —how what we do can affect others. There are no right or wrong answers. Everyone's opinion is equally valid.
2. Label a piece of newsprint "Strongly Disagree" and place it at one end of the room. Label another piece "Strongly Agree" and place it at the other end. Explain that these represent two ends of an imaginary line.
3. Ask group members to stand at the point on the line that represents his/her own feelings/opinions about the following statements. They are ***not to discuss*** their reasons or to comment on anyone else's position.
4. Read each of the statements from the following page, allowing time for everyone to move to the place he/she feels most comfortable.
5. When you finish reading the statements, ask everyone to sit down.

6. Ask group members for their reactions to the exercise:

   How did it feel to have to "take a stand" on issues?
   How did it feel not to be able to explain their reasons for their positions?

   Did it feel funny being at different places than others?
   Did they feel like moving to be with the others?
   Did they find that others' positions affected where they stood?

   Which was the most difficult statement to react to?
   What made it the hardest?

NOTES TO GROUP LEADER

If the room is too small for easy movement, group members can be given cards with numbers to raise after the statement is read.
An alternative apporach is to ask the group to process their feelings after each question (or after only a few questions are read). This may help them remember feelings related to particular issues. However, this exercise is designed as a values exploration, not as a debate. If individual statements are discussed, be sure to set clear ground rules first:

- no making fun of others' opinions
- no harrassment of others
- no telling others what to think

VALUES AND ATTITUDES EXPLORATION: WHO'S IN CHARGE HERE?

Read each statement clearly. Allow participants to position themselves and to observe others' positions before moving on. Remind the group members that there is to be ***no talking*** during the exercise.

The older sister in the last vignette should feel ashamed for having exposed her little sister to pot.

The little sister in the vignette will be more likely to use pot in the future after learning that her sister uses.

Now that her little sister knows she uses, the older sister shouldn't try to hide her use anymore and should let her little sister join in if she wants to.

The mother in the earlier vignette ("Cocaine Mama"), who was using drugs and stealing her daughter's money, should be arrested.

If the daughter in the "Cocaine Mama" vignette becomes an alcoholic or drug addict, it will be her mother's fault.

If your parents are alcoholics, you might as well accept the fact that you'll be one too.

Athletes who get drunk and pass out every weekend should be barred from play.

People in the public eye (like the rock star in the first vignette or elected officials) have a greater responsibility to set a good example than the average person.

If someone kills someone else while driving drunk, he/she should be imprisoned for life.

If a baby is born addicted to drugs, its mother should be charged with child abuse.

When someone dies from an overdose, the person who sold him/her the drugs should be held responsible.

Athletes who use illegal drugs should be barred from play.

Being addicted to alcohol is worse than being addicted to marijuana.

SESSION THREE:
WHAT CAN YOU DO ABOUT IT?

PURPOSES OF THE SESSION

- *to identify ways to intervene in a friend or family member's alcohol and/or drug use*
- *to practice intervening in others' use*

The exercises in this section are designed for exploring ways to intervene in others' alcohol and drug use and to practice caring interventions. There are no absolutely right or wrong ways to intervene. Different approaches work with different people. Group members will be able to generate different approaches that might work with those they care about.

SESSION OUTLINE

1. Introduce the session (see suggested introduction on the following page).
2. Do *The Best and The Worst* exercise.
3. Show the first two vignettes, "Cocaine Baby" and "Pick Up."
4. Do the exercise, *Risky Business.*
5. Show the vignette, "DUI."
6. Do the exercise, *The Key.*
7. Summarize the session and thank group members for participating.
8. Complete Session Log Sheet.

INTRODUCTION TO SESSION THREE: WHAT CAN YOU DO?

It's always best to say things in your own words. The following paragraph is a suggestion of how you might introduce this session. Read it over several times, then put it into your own words.

> All of us probably know someone who has a problem with alcohol or drugs. It might be a family member or a friend. Often we feel like we should do or say something to let that person know we want to help, but it's a hard thing to do. This next session is focused on how we can do that. We'll talk about ways to intervene and even practice confronting someone in a caring way.

THE BEST AND THE WORST

GOAL

To explore ways of intervening with those who have alcohol and/or drug problems.

RATIONALE

Many young people have family members or friends with alcohol or drug problems. Some have problems themselves. Intervening in others' use (or listening to others' concerns about one's own use) is very difficult. This exercise helps group members begin to think through how to approach others by outlining how group members themselves could be approached.

GROUP SIZE

Four or more

TIME REQUIRED

20 minutes

MATERIALS

- Newsprint and markers
- Tape

PROCESS

1. Put a piece of newsprint on the wall. Write "The Worst" across the top. Make three columns underneath and write "Who," "When/Where," and "How" at the top of the columns.
2. Ask the group to imagine that they had some kind of problem. It could be any kind of problem: bad breath, skipping school, using alcohol or drugs. What would be the worst way to approach them to insure that they would not hear the other person's comments? What would make them tune out the other person? Specifically:

   Who would be the worst person to approach them (a friend, a parent, a teacher, a sibling)?

   Where and when would be worst to be approached (at home, at school, at a party)?

   What kind of approach would be the worst? Should they come alone or with others?

   List their responses in the appropriate columns.
3. Write "The Best" across the top of another sheet. Put the same three columns below and repeat the same three questions, but this time ask what would be the best way to approach them so that they could really hear and not get defensive. List their responses.

4. Summarize the discussion. Circle or star those few, key comments from "The Best" and "The Worst" sheets about which there seemed to be a wide agreement. Explain that this is just the beginning, that this entire session will be focused on how best to approach a friend or family member with an alcohol or drug problem.

GROUP LEADER'S NOTES

RISKY BUSINESS

GOAL

To identify caring ways of intervening with friends who are endangering themselves and others.

RATIONALE

It's never easy to confront someone. It's even harder to do it in a way that does not turn them off. Group members will focus on how to intervene with others, building on the approaches they identified as best for themselves.

GROUP SIZE

Four or more

TIME REQUIRED

20 minutes

MATERIALS

- Worksheets
- Newsprint and markers
- Tape

PROCESS

1. Ask the group to discuss the two situations they just watched:

   What sorts of risks were the coke addict and the girl abandoned in the park exposing themselves to?

   Were they endangering others besides themselves?

2. Who could have intervened? Should they have intervened? What might have happened if they had intervened?
3. Ask the group to assume that they are friends who are concerned about two friends (the two in the previous vignettes). They want to help them see they might have a problem and have come together to figure out the best approach. If the group is large (six or more) split them into two small groups and give each group the problem of dealing with one of the young women in the vignettes. If the group is small, let them pick which one they want to deal with.
4. Pass out the worksheets, and give them a few minutes to work on the problem. Move around the groups to offer help and suggestions.
5. While the groups are working put up a piece of newsprint with "Tips" at the top. When most seem to have their ideas together bring the large group together again and ask for their solutions. Make notes of new ideas on the "Tips" sheet, and star or circle ideas used from the "Best" sheet from the previous exercise.

6. After each report, ask the other groups to critique the group's plan. What might go wrong? What might work better? (If you have only one group, ask them to critique their own plan.) Add their ideas to the "Tips" sheet.
7. Thank the groups for their work, collect their worksheets, and move to the next vignette.

NOTES TO GROUP LEADER

The group exercise following the video can be introduced with a brief description of the continuum of use (discussed in the "Drugs and Drug Abuse" section of this manual under "The Progression of Dependency on Alcohol and Drugs"). Explain that we are assuming, for the purpose of this exercise, that both the coke addict and the girl abandoned in the park were abusers.

WORKSHEETS FOR *RISKY BUSINESS*

1
WHO WILL APPROACH OUR FRIEND?

2
WHEN AND WHERE WILL SHE BE APPROACHED?

3
WHAT WILL WE SAY?

4
WHAT MIGHT BE SOME NEGATIVE REACTIONS FROM HER?

5
HOW WILL WE DEAL WITH THEM?

THE KEY

GOAL

To practice intervening with an intoxicated friend who is about to drive home.

RATIONALE

Intervening with an intoxicated person may seem impossible—he/she is not rational, probably belligerent, and absolutely sure he/she is okay to drive. However, many young people face situations like this all the time. This exercise allows them to practice intervening with an intoxicated friend and offers them some preparation for such situations.

GROUP SIZE

Five or more

TIME REQUIRED

20 minutes

MATERIALS

- Role play cards

PROCESS

1. Ask the group to discuss the vignette. Should he have tried harder to get his friend's keys away? What could he have said or done to keep his friend from driving?
2. Explain to the group that it is not easy to reason with a drunk person, but that it's important to try to keep friends from hurting themselves. The role play they are about to do will give them a chance to practice keeping a friend safe.
3. Have group members pick role cards (or assign roles). Instruct any youth who are not participating in the role play to watch carefully and to imagine what they might do in that situation. Ask the role players to play out the following situation for five minutes or until the intoxicated person decides to go or stay:

   One person is intoxicated and is ready to go home.
   He/she has two advisors:
   One encourages him/her to give up the car key.
   One encourages him/her to drive home.

   One person is trying to talk the intoxicated friend out of driving home.
   He/she had an advisor giving suggestions.

4. Lead a discussion beginning with the role players.

   How did it feel to be confronted about driving?
   How did it feel to confront a friend who was loaded?
   What was it like being an advisor?
   Which arguments were the most convincing?
   Which arguments were the least convincing?
   What made the intoxicated friend make the decision?
   If no decision was made, what direction was he/she leaning?
   If there were observers who were not involved in the role play, what did they see as the turning point?
   What suggestions do the observers have?

5. Thank the role players, collect the role cards, and move to the next vignette.

NOTES TO THE GROUP LEADER

An advisor is someone who helps those more actively involved in the role play. An advisor never talks to anyone except the person being advised. When two advisors are used for one person, they act in "angel" and "devil" roles—one encourages responsible safe behavior and the other encourages risk and danger.

Youth may be unclear about advisors' roles. Be sure to explain it carefully. It may help to physically move the role players into their spots. Explain to them, as you place them, what their roles and expected behaviors are. Make sure everyone understands what to do before you start. Let them know you will stop the interaction in just a few minutes.

If role players get stuck and advisors offer no help, prod the advisors a bit rather than offering help yourself.

Review the information on role plays at the beginning of the manual.

MATERIALS FOR *THE KEY*

Copy this page and cut out the roles for group members.

You are intoxicated. You're tired of this party and *want to go home.*	You are concerned about your friend who is clearly in no shape to drive anywhere. Try to convince him/her *not to drive home.*
You are an advisor to the person who is intoxicated. Encourage him/her to *avoid driving.* Don't talk to anyone else.	You are advising the person trying to keep an intoxicated friend off the streets. Help him/her think of things to say. Don't talk to anyone else.
You are an advisor to the person who is intoxicated. Encourage him/her to *drive home.* Don't talk to anyone else.	

SESSION FOUR: WHERE DO YOU TURN?

PURPOSES OF THE SESSION

- ***to learn about the various types of intervention and treatment resources available for those with alcohol and drug problems***
- ***to explore which kinds of resources fit which kinds of problems***

It's not enough to confront alcohol/drug abusers about their use. We must also be prepared to direct them to places where they can get the help and support they need to address their addiction.

In this session, group members will learn about intervention and treatment services for those with alcohol and drug problems. They will explore the different types of service, they will identify services within the local community, and they will talk about what types of service make sense for what types of problems.

SESSION OUTLINE

1. Introduce the session (see suggested introduction on the following page).
2. Show "That's What Friends Are For" and "The Fact Is."
3. Do the exercise, *Help!*
4. Show the vignette, "Acid Blues."
5. Do the exercise, *Where To Turn?*
6. Show the vignette, "Breaking the Cycle."
7. Do the exercise, *What's Needed?*
8. Summarize the session and thank group members for participating.
9. Complete Session Log Sheet.

INTRODUCTION TO SESSION FOUR: WHERE DO YOU TURN?

It's always best to say things in your own words. The following paragraph is a suggestion of how you might introduce this session. Read it over several times, then put it into your own words.

> Most people with alcohol and/or drug problems need a lot of help and support to break their dependency. Sometimes they can get the help they need from friends and family, but often they need the assistance from others—like self-help groups or treatment professionals. In this session we're going to talk about the different kinds of intervention and treatment services available for those in need.

HELP!

GOAL

To practice helping a friend or family member with an alcohol or drug problem get help.

RATIONALE

It's not an easy task to confront a friend or family member about an alcohol or drug problem. Denial—of the problem and of the possibility that anyone would notice the problem—is to be expected as is defensiveness, anger, hostility, and fear. By practicing such confrontations in artificial settings and being exposed in a more gentle way to those typical reactions, group members will be better prepared to confront those they care about.

GROUP SIZE

Five or more

MATERIALS

- Role play cards
- Newsprint and markers
- Tape

TIME REQUIRED

20 minutes

PROCESS

1. Ask the group what approach they think might have worked better with the friend. What things might they have said or done to let her know they were concerned about her?
2. Explain that it is very difficult to confront someone you care about. Most people get defensive or angry or just stomp away like she did. The role play they are about to do will give them a chance to practice confronting someone in a caring way.
3. Have group members pick role cards (or assign roles). Instruct any youth who are not participating in the role play to watch carefully and to imagine what they might do in that situation. Ask the role players to play out the following situation for 5 minutes or until the intoxicated person decides to go or stay:

One person has a problem with alcohol/drugs.
He/she has two advisors:

One encourages him/her to listen to the friend.
One encourages him/her not to listen.

One person is trying to convince the person with the problem to seek help.
He/she has an advisor giving suggestions.

4. Lead a discussion beginning with the role players.

   How did it feel to be confronted about your alcohol/drug use?
   How did it feel to confront a friend who was having a problem?
   What was it like being an advisor?
   Which arguments were the most convincing?
   Which arguments were the least convincing?
   What made the friend with the problem make the decision?
   If no decision was made, what direction was he/she leaning?
   If there were observers who were not involved in the role play, what did they see as the turning point?
   What suggestions do the observers have?

5. Thank the role players, collect the role cards, and move to the session summary.

NOTES TO THE GROUP LEADER

An advisor is someone who helps those more actively involved in the role play. An advisor never talks to anyone except the person being advised. When two advisors are used for one person, they act in "angel" and "devil" roles—one encourages responsible safe behavior and the other encourages risk and danger.

Youth may be unclear about advisors' roles. Be sure to explain it carefully. It may help to physically move the role players into their spots. Explain to them, as you place them, what their roles and expected behaviors are. Make sure everyone understands what to do before you start. Let them know you will stop the interaction in just a few minutes.

If role players get stuck and advisors offer no help, prod the advisors a bit rather than offering help yourself.

Review the information on role plays at the beginning of the manual.

MATERIALS FOR *HELP!*

Copy this page and cut out the roles for group members.

You use a lot of alcohol and/or drugs	You are concerned about your friend who is using a lot of alcohol/drugs. Try to convince him/her to *get some help.*
You are an advisor to the person who uses a lot of alcohol and/or drugs. Encourage him/her to *listen to what the friend is saying.* Don't talk to anyone else.	You are an advisor to the person who is trying to help a friend seek help for an alcohol/drug problem. Help him/her *think of things to say.* Don't talk to anyone else.
You are an advisor to the person who uses a lot of alcohol and/or drugs. Encourage him/her *NOT to pay attention to what the friend has to say.* Don't talk to anyone else.	

WHERE TO TURN?

GOAL

To explore the types of treatment and intervention services available so that youth are better prepared to direct those in need to appropriate services.

RATIONALE

The array of intervention and treatment services available for alcohol and drug problems can be confusing to adults and to youth. Looking at the different types of services available and the specific services available in the particular community will help youth direct those in need.

GROUP SIZE

Four or more

TIME REQUIRED

20 minutes

MATERIALS

- Information sheets
- Newsprint and markers

PROCESS

Part One: Types of Service

1. Introduce the session by commenting that the guy was in a treatment center. Do any of the group members know about treatment centers? Do they know about the different types of treatment available for people with alcohol and drug problems?
2. Ask them to list the kinds of places they know about. Write the types of treatment services on newsprint as they list them, leaving space below each type for information to be added later. Use the information sheet (provided on the following page) as a guide for yourself to make sure the major types of treatment are covered.
3. Group the services together to correspond to the services listed on the next page. For each of these five major types of service, ask group members to try the following:

   - to identify what each of these five major type of service does
   - to identify who the service is for

   Note their correct responses on the newsprint. Correct—or let the group correct—responses that are off base.

Part Two: Local Examples

4. Ask group members how they would find out about services if they were new in a community (call a drug treatment program, look in the yellow pages under drugs or alcohol services, etc.).
5. Explain that it is important to be able to find services no matter where they are. Every community has a telephone directory so that's a dependable resource no matter where they are. Gather the participants into small groups (four to six per group) and pass out local telephone books to each group.
6. Provide each group a work sheet and tell them they have 10 minutes to find as many resources using the telephone book as possible. Someone in the group needs to record the name and telephone number of each resource. Encourage competition between the groups.
7. At the end of 10 minutes (or sooner if they run out of resources), call time and have each group report.

GROUP LEADER'S NOTES

INFORMATION ON INTERVENTION AND TREATMENT SERVICES

Crisis Lines and Hotlines

- What are they?

  They are telephone call-in services answered by staff persons or trained volunteers. They offer help with immediate problems and can usually refer callers to other services for more help.

- Who are they for?

  The are for anyone who needs someone to talk to immediately or who is looking for a place to get help.

Outpatient Counseling Programs

- What are they?

  They are services staffed by trained professionals who work with individuals, groups, and/or families. They usually see people one or two times a week for an hour at a time. Some charge a fee, some are free.

- Who are they for?

  They are for those who have been using alcohol or drugs for a relatively short period of time or only intermittently (using for several days and then not using for several days), for those who have friends/family nearby who can be supportive, for those whose withdrawal will not be life-threatening.

Residential (Non-Hospital) Programs

- What are they?

  They are live-in programs where those with alcohol and/or drug problems reside for several months at a time. They provide a lot of structure to every day life and offer regular, group and individual counseling.

- Who are they for?

  They are for those who need to get out of the environment they are in, those who need help structuring their lives to avoid alcohol and drug use, and for those who don't have a lot of support from family or friends.

Hospital Programs

- What are they?

  They are in-patient programs within hospital settings. Some are located on designated floors of a regular hospital, others are freestanding programs devoted to the treatment of alcohol and/or drug use.

- Who are they for?

  They are for those who are serious medical risks due to overdosing, or who are at some physical risk from withdrawal. They have detoxification units where those who are currently addicted can be safely withdrawn from drugs/alcohol.

Self-Help and AA-Type Programs

- What are they?

  They are groups of people who share a common problem with alcohol and/or drugs. There are groups for users of cocaine, narcotics, and alcohol. They are run by the group members themselves and focus on providing support and encouragement for members.

- Who are they for?

  They are for anyone who wants or needs support dealing with an addiction to alcohol and/or drugs. Some people use them as their only mode of treatment, some use them along with other treatment, some use them as aftercare when they have been released from a treatment center.

LOCAL DRUG AND ALCOHOL SERVICES

CRISIS LINES AND HOTLINES

Local Hotlines

Name

Telephone

State and National Hotlines

Name

Telephone

SELF-HELP AND AA-TYPE PROGRAMS

Name

Telephone

OUTPATIENT COUNSELING

Name

Telephone

RESIDENTIAL PROGRAMS

Name

Telephone

HOSPITAL PROGRAMS

Name

Telephone

LOCAL ALCOHOL AND DRUG TREATMENT SERVICES

NAME OF PROGRAM

ADDRESS

TELEPHONE

ELIGIBILITY

age limits
participation by others required
parent permission for minors
insurance required
self-referrals accepted

DESCRIPTION OF PROGRAM

program description
average length of care
type of treatment services offered
- individual counseling
- group counseling
- family counseling
- AA-type meetings
- detoxification
- residential care

COST

sliding scale
insurance or Medicaid accepted
payment plan available

WHAT'S NEEDED

GOAL

To match individuals with alcohol/drug problems with the types of service that they need.

RATIONALE

There is no simple answer to the question of what kind of intervention works best. That is a complex issue that even professionals in the field struggle with. However, exploring some of the things that must be considered in matching people in need with appropriate services will help group members become more sensitive to the different things offered by the various types of service.

GROUP SIZE

Four or more

TIME REQUIRED

20 minutes

MATERIALS

- Case study work sheets

PROCESS

Part One: Connection To Treatment

1. Gather the group members into small groups of four to six each. Pass out the case study work sheets, and explain that each group is to come to an agreement about which type of service makes the most sense for each person outlined in the case study AND why that service is better for that person than the others.
2. Walk around and help groups keep on task. Offer assistance if they request it, but don't simply tell them what you think is best. Let them struggle with the problem.
3. After about 10 minutes (or sooner if the groups finish or lose interest), bring the groups back together, and ask them to report. What service did they choose and why? What would this service give them that the others wouldn't?
4. The groups will probably have some similarities and some differences in their solutions. Explain that there are no right or wrong answers—the point is to think the problem through and to gain an understanding of the complexity of the issue.

Part Two: Being Supportive

5. Ask the group if they have ever had contact—or known anyone who has had contact—with any one of the five types of services listed on the case study sheet. What was the service like? Were they (or their friends) treated well? Did it help?
6. Explain that people with alcohol and drug problems (particularly adults who have been using for a long time, but sometimes youth as well) don't immediately get better. Sometimes they have to go into treatment several times before they make a major change. Do group members know of people who have been in and out of treatment several times?
7. These people need support for staying in treatment and working on their addictions. Ask the group to list ways they could be supportive of someone in treatment. What kinds of things would NOT be supportive?

GROUP LEADER'S NOTES

CASE STUDIES FOR *WHAT'S NEEDED*

COCAINE BABY

She's seven months pregnant and smokes crack every chance she gets. She knows her use will hurt her baby, and she has tried to quit several times. She just can't resist when she sees people selling on the streets.

What type of service does she need?

Why is that the best for her?

BRIGHT LIGHTS

She a singer with a big future. She rocketed to the top in just a year and a half, but it's been a costly trip. Being on the road is hard for her. She started using sleeping pills after shows to calm down and was snorting coke before shows to get up. Now it's out of control, and all she thinks about is getting high.

What type of service does she need?

Why is that the best for her?

DUI

He only drinks on the weekends, but he drinks until he passes out. Lately, he's been passing out a lot. He woke up this morning in a crashed car in a ditch. He wasn't really hurt, but he's really scared. He doesn't remember anything after he arrived at the party.

What type of service does he need?

Why is that the best for him?

RESOURCES AND REFERENCES

This curriculum supplies you with the basic information you need to lead drug abuse prevention groups with youth. As you get more involved with the issues around alcohol and other drugs, you may find you need more information and assistance. The resources listed on the following pages will help guide you to those who can provide you the help you need in finding treatment services for youth and their families, getting written and video materials on alcohol and other drug use, and learning about drug prevention programming and funding opportunities.

TREATMENT RESOURCES FOR YOUTH AND THEIR FAMILIES

NATIONAL HOTLINES

Operators at these toll-free numbers can help you locate treatment resources throughout the country.

National Institute on Drug Abuse
(80) 662-HELP
9am to 3am (EST) 7 days a week
for drug abuse information and referral to treatment services

Psychiatric Institutes of America
(800) COCAINE
24 hours, 7 days a week
for drug abuse information and referral to treatment services

ORGANIZATIONS AND PROGRAMS

These are national programs that provide treatment services. If you can't find a local chapter in your community, contact the national office.

Alcoholics Anonymous (AA)
With more than a million members in 114 countries, AA is the largest self-help group for recovering alcoholics. Alcoholics of all ages are welcome in any group. Some communities offer youth AA groups as well. Local groups are listed in all telephone directories. P.O. Box 459, Grand Central Station, New York, NY 10163, (212) 686-1100.

Al-Anon Family Groups
Al-Anon Family Groups, with includes Al-Anon for adults and Al-ateen for youth, are self-help groups for family members and friends of persons with alcohol-related problems. Local groups are listed in all telephone directories. P.O. Box 862, Midtown Station, New York, NY 10018, (212) 302-7240.

Narcotics Anonymous (NA)
Narcotics Anonymous is a self-help program based on the 12 steps of Alcoholics Anonymous. NA members are people for whom drugs had become a major problem. It is a program of complete abstinence from all mind-altering drugs. If a local group is not listed in your telephone directory, the World Services Office can provide information. World Service Office, P.O. Box 9999, Van Nuys, CA 91409, (818) 780-3951.

MATERIALS AND PROGRAM INFORMATION

Alcohol and Drug Problems Association of North America

The association is a policy advocate for those measures that offer a positive impact on alcohol and other drug problems, and provides a forum and opportunity for professionals to improve the quality of prevention and treatment services. The association also provides training and professional development programs for professionals, and timely, useful information via newsletters and bulletins. 444 N. Capitol Street, NW, Suite 181, Washington, DC 20001, (202) 737-4340.

American Council for Drug Education

This is a resource for information on drug use. Develops media campaigns, reviews scientific findings, and publishes books and a newsletter. Offers films and curriculum materials for teens. 204 Monroe Street, Rockville, MD 20850, (301) 294-0600.

Institute on Black Chemical Abuse (IBCA)

IBCA provides training and technical assistance to programs that want to service black clients and others of color more effectively. Training includes a look at how "culture" affects both addiction and recovery. A resource center that has reprints from scholarly journals concerning black alcohol and other drug abuse is also available to the public through IBCA. 2614 Nicollett Ave., Minneapolis, MN, 55408, (612) 871-7878.

National Association for Children of Alcoholics

A national, nonprofit membership organization for children of alcoholics and those in a position to help them. Maintains a clearinghouse of resources. 31582 Coast Highway, Suite B, South Laguna, CA 92677, (714) 499-3889.

National Clearinghouse for Alcohol and Drug Information (NCADI)

This new Federal clearinghouse for information and services on alcohol and other drugs is the largest, most comprehensive resource on alcohol and other drug information in the world. It prepares pamphlets, booklets, posters, fact sheets, directories, resource lists, and other useful products; answers inquiries; offers new prevention ideas; coordinates Regional Alcohol and Drug Awareness Resource (RADAR) Network among state and national organizations' clearinghouses; and reviews and compiles lists of audiovisual materials. Most of NCADI's materials are free to the public. P.O. Box 2345, Rockville, MD 20852, (301) 468-2600.

Parents' Resource Institute for Drug Education (PRIDE)

This is a national resource and information center. It offers assistance to parent groups; provides a drug-use survey service; publishes newsletters, handbooks, and brochures; sells books, films, and videos; and also publishes a catalog of videos, pamphlets, and books available free or for a nominal fee. 100 Edgewood Ave., Suite 1216, Atlanta, GA 30303, (404) 310-9000. The PRIDE HOTLINE at (800) 241-9746 operates from 9am to 5pm (EST) Monday through Friday for parents looking for information and support.

FUNDING OPPORTUNITIES

Office for Substance Abuse Prevention (OSAP)

OSAP is a Federal office established to address alcohol and other drug problems, and develop strategies for preventing them. OSAP has a commitment to supporting programs that address the needs of high-risk youth. Activities include the development of prevention messages and materials, coordination of media campaigns, funding and administering a grant program, and operating the National Clearinghouse for Alcohol and Drug Information. 5600 Fishers Lane, Rockwall II Building, Rockville, MD 20852, (301)443-0373.

U.S. Department of Education, Alcohol and Drug Abuse Education Program

Assistance in developing the capability of local schools to prevent and reduce alcohol and other drug use is provided in three major ways: (1) grant program for state and local government, institutions of higher education, materials development; (2) federal activities such as drug-free schools recognition program, network of drug-free colleges, drug use curricula guide, workshops, and The Challenge, a program to encourage and sustain a national network of drug-free schools; and (3) regional centers providing training and expertise to achieve drug-free schools located in New York, (516) 589-7022; Atlanta, (404) 651-2548; Chicago, (312) 324-9500; Oklahoma, (405) 325-1711; and Oregon, (503) 275-9500. 400 Maryland Avenue, SW, Room 4145, MS 6411, Washington, DC 20202.

ORGANIZATIONS

World Youth Against Drugs (WYAD)

Founded in 1986, WYAD has membership in 35 countries and an international pen-pal program involving thousands of drug-free young people. It is an organization run by young people for young people who share the goal of drug-free youth. Quarterly newsletter and notice of local, national, and international meetings. 100 Edgewood Avenue, Suite 1216, Atlanta, GA 30303, (800) 241-9746.

Youth to Youth

Founded in 1981, this organization stresses youth training youth to do prevention programs in their own schools. This annual, five-day intensive, prevention training program prepares junior and senior high school students to conduct local programs. Youth to Youth groups are active in over 25 states, with regional conferences, international youth exchanges, and a national speakers' bureau of high school students. Free, quarterly newsletter. 700 Bryden Road, Columbus, OH 43215, (614) 224-4506.

THE RADAR NETWORK

The Regional Alcohol and Drug Awareness Resource (RADAR) Network consists of state clearinghouses, specialized information centers of national organizations, and the Department of Education Regional Training Centers. Each RADAR Network member can offer the public a variety of information services. Check with the representative in your area to find out what services are available. Call the National Clearinghouse at (800)729-6686.

STATE ALCOHOLISM AND DRUG ABUSE PROGRAM DIRECTORS

Call the National Clearinghouse for Alcohol and Drug Infromation at (301)468-2600 for the name of your state's Program Director for Alcohol and Drug Abuse.

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